December, 2024 Kansas Survey Findings
Normal Font-Health Survey
Italics= Complaint Survey
Findings in Red=G+ Scope & Severity
Findings in Green from State Regulations
SS=Scope & Severity; LN=Licensed Nurse
TX=treatment; Dx=Diagnosis; Fx=Fracture
CP=Care Plan; CP in pharmacy regulations=Consultant Pharmacist
PU=Pressure Ulcer; ID=identify; Hx=History

August 2024

551 Rights Exercised by Representative

SE: SS=E: Failed to ensure 1 resident had a right to designate a representative of choice who could exercise rights as delegated to representative w/o fear of reprisal &/or honoring resident's right to have representative present during interactions with facility staff

- *NN documented resident's Guardian called facility & stated "I don't want no one talking to her or going in her room unless they get permission from me first."; guardian asked staff to leave resident alone & stated staff present just did not listen then asked staff again to be called before speaking to resident &/or performing any cares on resident; EMR lacked evidence facility followed up with resident about wishes r/t guardian's request; CP lacked evidence resident required 2 staff present during cares or follow up with resident &/or guardian about change in resident's care; failed to ensure 1 resident had a right to designate representative of choice who could exercise rights as delegated to representative w/o fear of reprisal &/or honoring resident's right to have representative present during interactions with facility staff*

F561 Self-Determination

SE: SS=D: Failed to ensure 1 resident had right to make choices about life in facility that were significant to resident including right to have only 1 staff present during cares as requested by resident when facility failed to provide valid rationale to resident for use of 2 staff for cares & interactions with resident

- *CP lacked evidence or rationale as to why facility initiated 2 staff for cares & interactions with 1 resident; failed to ensure 1 resident had right to make choices about life in facility that were significant to resident including right to have only 1 staff present during cares as requested by resident when facility failed to provide valid rationale to resident for use of 2 staff for cares & interactions with resident*

F570 Surety Bond-Security of Personal Funds

SE: SS=F: Failed to provide evidence of current Surety Bond to ensure security of resident funds as required with potential to affect all residents with personal funds accounts

- *Surety Bond in amount of $20,000.00 & noted bond was effective from 3-1-22 to 3-1-23; failed to provide evidence/documentation of active & current surety bond to ensure security of resident funds as required with potential to affect all residents with personal funds accounts*

F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directives

SW: SS=D: Failed to ensure 1 resident who was cognitively intact sign a completed DNR instead they had family member sign directive

- Observed DNR signed by resident's family member who was not resident's DPOA & was witnessed by LBSW; EMR revealed hospital note from physician which documented discussed code status with resident & resident wanted to be a full code; failed resident w ho was cognitively intact by having family member that was not resident's DPOA sign a completed DNR with potential to lead to uncommunication needs specifically to end-of-life care

F585 Grievances

SE: SS=F: Failed to support resident's rights to voice any grievance w/o discrimination, reprisal or fear of discrimination & reprisal; further failed to ensure residents knew how to file a grievance, failed to provide information on how to file a grievance anonymously, failed to ensure grievance forms were available to residents, failed to include a summary statement of resident's grievance or steps taken to investigate grievance & failed to ensure all grievances were documented on grievance log with potential to affect all residents in facility

- *Grievance form lacked area to record summary/nature of grievance; facility provided grievance forms for June 2024 & July 2024 & did not include any grievance entry r/t to 1 resident with multiple grievances r/t care & mistreatment by other resident; staff unaware of how residents filed grievance; failed to support resident's rights to voice any grievance w/o discrimination, reprisal or fear of discrimination & reprisal; further failed to ensure residents knew how to file grievance, failed to provide information on how to file grievance anonymously, failed to ensure grievance forms were available to residents, failed to include summary statement of resident's grievance or steps taken to investigate grievance & failed to ensure all grievances were documented on grievance log*

F600 Free from Abuse & Neglect

SE: SS=J (Past Non-Compliance): Failed to prevent neglect of quadriplegic, dependent resident when facility nursing staff did not adequately monitor or follow up on decreased urinary output & decline of resident experienced on 7-23-24, just 1 day after resident completed ABT for UTI

- *On 7-24-24 at 1:15am, staff found resident unresponsive, cyanotic with "wet" lung sounds & no urinary output; staff did not apply O2 & did not ensure staff member stayed with resident during critical incident; LN left rom & called physician, discussed situation, received order to call 911 then called 911, printed & filled out papers then went to BR; when EMS arrived, EMS found no staff in hallway & found resident alone in room with no O2 applied even though staff notified resident displayed obvious signs of airway distress; resident admitted to hospital with acute respiratory failure, pneumonia, sepsis & comfort care; resident noted to be in "severe distress, poorly groomed, disheveled, malodorous"; resident expired on 7-24-24 at 9:08am; failure of facility staff to adequately follow up on resident's decreased urinary output, decreased O2 sat level & decline in status placed resident in immediate jeopardy*
- *Abatement Plan:*
    - *Suspended LN on 7-24-24 at 5pm*
    - *Adm Staff re-educated facility leadership r/t ANE policy & process at 3:30pm on 7-24-24*
    - *Ad Hoc QAPI meeting using 5-why & RCA*
    - *VP of Clinical Services reviewed resident's record with no finding of neglect*
    - *Facility conducted safe surveys on 6 residents with no concerns or additional findings noted*
    - *Facility re-educated current team members at mandatory training*
    - *When new team members begin employment will receive ANE training as part of initial onboarding & all employees annually & with any allegations or investigation r/t ANE*

F603 Free from Involuntary Seclusion

SE: SS=D: Failed to ensure staff assessed for preferences of 1 resident to prevent potential involuntary seclusion of resident; staff did not know why they continued to place resident into same spot of facility each day, taking all meals in same spot removed from dining area & other residents & spending much of resident's day in same spot w/o staff offering to include resident in main dining or into another area; further failed to ensure staff did not involuntarily seclude resident to room at night when surveyors entered facility at 11:17pm & found resident's w/c, resident's only mode of transportation to be in hallway outside of resident's room with room door closed, failures, using reasonable person concept, involuntarily secluded resident to room

- *Law Enforcement Officer interview revealed officers in facility multiple times/wk (3-4 times/wk) & stated night shift does not provide cares & stated that every time had been in facility over past 2 years, resident was sitting in same place & had never seen resident anywhere else in facility but was always by front door; failed to ensure staff did not involuntarily seclude 1 resident when facility staff did not assess for preference of location for spending majority of time & when staff removed w/c from room, positioned it in hallway & closed door to room at night*

F622 Transfer Discharge Requirements

SE: SS=G: Failed to provide evidence 1 resident met discharge requirement as outlined in Appendix PP when facility issued involuntary discharge notice to 1 resident but failed to recognize impact to resident after another resident entered room, uninvited, attempted to get in resident's bed, touched resident's "private parts" and facility failed to recognize impact to resident's psychosocial wellbeing; since incident with other resident, staff reported resident isolated self more, changed in day-to-day behavior, & resident reported felt "punished by facility", embarrassed at multiple requests for skin checks of "private parts" & had to minimize existence in daily life

- *Resident with paranoid schizophrenia, major depressive d/o, need for assist with personal care, PTSD, problems r/t living in residential institution & suicidal ideation; CP lacked any interventions recognizing widespread impact of trauma, signs & symptoms of trauma &/or knowledge of resident's trauma r/t incident on 5-19-24 & lacked interventions r/t PTSD dx; CP lacked individualized discharge plan; failed to provide evidence resident met discharge requirement as outlined in Appendix PP when facility issued involuntary discharge notice to 1 resident but failed to recognize impact to resident after another resident entered resident's room, uninvited, attempted to get in bed with resident, touched resident's "private parts" & failed to recognize impact to resident's psychosocial wellbeing; since incident with other resident, staff reported resident isolated self more, changed in her day-to-day behaviors & resident reported felt "punished by facility", embarrassed at multiple requests for skin checks of "private parts" & had to minimize existence in daily life*

F623 Notice Requirements Before Transfer/Discharge

SE: SS=D: Failed to ensure contents of involuntary, facility-initiated discharge included all required elements at time they provided notice to 1 resident

- *Cited findings noted in F622 r/t facility-initiated discharge; failed to ensure contents of involuntary, facility-initiated discharge included all required elements at time they provided notice to 1 resident; discharge letter lacked elements of information r/t specific instructions on how to obtain an "appeal form" & information r/t obtaining assistance completing & submitting the "appeal form" specifically*

NE: SS=D: Failed to provide written notification of transfer to 1 resident/representative with a written notice specifying the location & reason for resident's facility-initiated transfer placing resident at risk for miscommunication between facility & resident/representative & possible missed opportunities for healthcare services

- Resident admitted to hospital; EMR lacked documentation showing written notification of transfer was provided to resident/representative; ; SS stated written notification of transfer not issued to resident/representative because facility believed resident was coming back & would usually just call family to inform of transfer rather than provide written notification; failed to

provide written notification of transfer for 1 resident placing resident at risk for miscommunication between facility & resident/representative & possible missed opportunities for healthcare services

F625 Notice of Bed Hold Policy Before/Upon Transfer

NE: SS=D: Failed to provide a copy of facility bed hold policy to 1 resident/representative with a written notice specifying duration & cost of bed hold policy at time of resident's transfer to hospital with risk of impaired ability to return to facility & to previous room for 1 resident

- Failed to provide bed hold policy notice for 1 resident/representative when resident transferred to hospital with risk of impaired ability to return to facility & to previous room for 1 resident

F637 Comprehensive Assessment After Significant Change

NE: SS=D: Failed to complete a Sig Change MDS within 14-days as required for 2 residents r/t admission onto hospice care

- Adm nurse stated facility unaware of need to complete significant change MDS when resident admitted to hospice; failed to complete significant change MDS within 14-days as required for resident who admitted to hospice care for 2 residents

F641 Accuracy of Assessments

NE: SS=E: Failed to completed accurate MDS for 4 resident r/t siderails used as restraints

- Multiple MDS documented bedrails used as restraint; resident reported requested bedrails at head of bed & did not restrict movement in any way & used rails to reposition self & would object to removal; failed to complete accurate MDS r/t bedrails used as restraints
- Failed to complete accurate MDS for 1 resident r/t bedrails used as restraint for multiple residents

F656 Develop/Implement Comprehensive Care Plan

NE: SS=D: Failed to ensure 1 resident's comprehensive CP addressed functional abilities & how much assist was needed from staff; failed to ensure resident's comprehensive CP included care area & interventions for Foley catheter placing resident at risk of impaired care due to uncommunicated care needs

- Urinary CAA documented resident required assist with toileting hygiene & had indwelling catheter & resident at risk for UTI; CP lacked care area & interventions to direct staff on amount of assist resident required with ADLs; CP lacked care area & interventions to address resident's Foley catheter; failed to ensure 1 resident's comprehensive CP addressed functional abilities & how much assist needed from staff for ADL care & Foley catheter placing resident at risk of impaired care due to uncommunicated care needs

NE: SS=D: Failed to complete comprehensive CP for 1 resident r/t admission onto hospice

- Failed to complete comprehensive CP for resident who admitted to hospice care as CP lacked staff instruction r/t hospice care

F657 Care Plan Timing & Revision

SE: SS=E: Failed to ensure 6 resident's CPs were revised based on each resident's changing goals, preferences, needs of resident & in response to current interventions required for resident

- *CP lacked evidence facility provided medically related social services to develop person-centered CP for 1 resident when another resident came into resident's room, touched her "private parts" & resident had change in behaviors after stressful event*
- *CP lacked instruction to staff or interventions r/t resident having low hemoglobin, at risk for internal bleeding &/or recently receiving blood products*
- *CP revealed no focus dedicated solely to G-tube & interventions lacked instructions for staff in preventing G-tube dislodgment/displacement & further lacked interventions for staff in case it became dislodged or pulled out; CP further lacked mention of prior incidents where resident's G-tube was pulled out that required EMS transport & immediate treatment*
- *CP lacked further direction to staff r/t resident unable to participate in most activities due to mobility; further lacked direction to staff r/t oral/dental health problems r/t edentulous oral cavity; CP for cognitive/dementia had unfinished focus & bowel incontinence*
- *CP lacked preference to sit by front door, eat by front doors in w/c & use of bedside table staff provided &/or spending most of time near front doors seated in w/c in front of activity calendar wall/area; Cp did not account for keeping resident's w/c in hallway at night, outside resident's room*
- *CP lacked updates r/t resident having increased tearfulness & statements indicating increased depression & CP lacked direction to staff to monitor resident for increased auditory & visual hallucinations which included expressions of thoughts to "do naughty things with other residents"; CP lacked instruction to staff to assist resident to go outside more per resident's request &/or encouraging resident to walk to dine per resident's desire to ambulate more*

SW: SS=E: Failed to accurately revise 4 resident's CPs after falls experienced by 4 residents; additionally 1 resident's bilateral hearing aides not addressed on resident's CP placing residents at risk for uncommunicated care needs

- CP lacked fall prevention intervention r/t causal factors of resident's fall with minor injury with skin-tear & bruise; CP lacked fall prevention interventions r/t causal factor for 2 falls in May; CP lacked intervention r/t fall until 16 days after fall with injury; CP lacked intervention r/t fall but noted resident had 2 non-injury falls; failed to revise 1 resident's CP after multiple falls placing resident at risk for uncommunicated care needs with potential to have negative effect on overall physical & psychosocial wellbeing of resident in facility

- Failed to revise 1 resident's CP after fall placing resident at risk for uncommunicated care needs with potential to have negative effect on overall physical & psychosocial wellbeing of resident in facility for multiple residents
- CP lacked documentation/interventions r/t resident's bilateral hearing aides; failed to revise 1 resident's CP after received new hearing aides placing resident at risk for uncommunicated care needs with potential to have negative effect on overall physical & psychosocial wellbeing of resident in facility
- Failed to review & revise CP for 1 resident after resident with 1 fall with potential to lead to ongoing increased risk for falls & possibility of additional injuries from falls

NE: SS=D: Failed to revise 1 resident's CP to reflect bowel incontinence needs; additionally failed to revise 1 resident's CP to include preventative offloading of heels & ankles placing both residents at risk for complications r/t uncommunicated care needs

- CP lacked documentation r/t assessed bowel incontinence & need for disposable incontinence products; failed to revise 1 resident's CP to reflect bowel incontinence needs placing resident at risk for incontinence complications & uncommunicated care needs
- CP lacked evidence of any pressure-reducing measures for 1 resident's bilateral lower extremities to prevent PUs; failed to revise CP with intervention for pressure-reducing measures for 1 resident's bilateral lower extremities to prevent development of further Pus placing resident at risk for increased risk for PU development due to uncommunicated care needs

F659 Qualified Persons

SE: SS=D: Failed to ensure qualified staff performed a medical technique to assess for resident's level of consciousness when 2 CNAs performed sternal rub on unresponsive resident prior to notifying LN

- *CNA Competency Review revealed no mention of sternal rub medical technique; failed to ensure only qualified staff performed medical techniques to assess for resident's level of consciousness*

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to ensure staff provided ADL care to dependent residents to ensure highest physical, mental & psychosocial wellbeing & to decrease risk of infection

- *On 7-24-24 when EMS transferred 1 resident, EMS staff noted brief needed changed & resident had odor; local hospital further described resident as looking "disheveled" & "malodorous"; failed to ensure staff provided ADL care to dependent, quadriplegic resident*

F684 Quality of Care

SE: SS=G (Past Non-Compliance): Failed to properly ID & monitor 1 resident when resident received blood/blood products at hospital on 6-7-24 between 10:55am & 7:27pm; upon resident's return from hospital, facility failed to monitor resident for signs of adverse reaction which included respiratory distress or bronchospasm; at 11:13pm resident used emergency call light to inform staff having a hard time breathing; after 10-15 minutes of waiting on nurse with no response, resident called EMS self & roommate assisted in reporting concerns to EMS; when nurse entered room, failed to obtain resident's vital signs even after resident reported respiratory distress & being "scared"; nurse scolded resident for not waiting on staff response before calling EMS self & documented resident's actions as being "rude"; resident sent back to hospital due to low O2 levels & exacerbation of COPD

- *CP lacked instruction to staff or interventions r/t resident having low hemoglobin, at risk for internal bleeding &/or recently receiving blood products; failed to properly ID & monitor resident when resident received blood/blood products at hospital on 6-7-24; upon resident's return from hospital, failed to monitor resident for signs of adverse reaction including respiratory distress or bronchospasm;*
- *Abatement Plan:*
  - *Resident sent to ER*
  - *LN suspended pending investigation*
  - *Policy aware due to resident calling 911*
  - *Next day facility notified resident's physician of breathing issue*
  - *Next day all staff educated on s/sx of neglect; clinical staff re-educated on neglect including breathing issues*
  - *Staff assessed resident upon return from hospital & increased monitoring for changes in condition & respiratory status*
  - *LNs notified with change in condition & anytime resident transferred out*
  - *All current residents monitored for changed in condition with routine daily clinical start ups M-F*
  - *Audits of NN & verbal questioning of residents along with taking O2 sats completed by DON*

F686 Treatment/Services to Prevent/Heal PU

NE: SS=D: Failed to ensure 1 resident's low air-loss mattress pump was appropriately set to recommended weight range placing resident at risk for complications r/t skin breakdown & Pus

- CP lacked indication r/t low air-loss mattress weight setting & monitoring requirements; POS with order for low air-loss mattress & order indicated bed weight was 430 pounds; manufacturer recommendations reviewed & indicated bed's weight capacity 80-1000 pounds & pressure should be adjusted to patient's weight; Observed resident set at 300 pounds, 180 pounds; failed to ensure 1 resident's low air-loss mattress pump was appropriately set to weight range placing resident at risk for complications r/t skin breakdown & Pus

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=D: Failed to transfer 1 resident according to CP resulting in fall; further failed to ensure staff provided adequate supervision while providing 1:1 supervision to 1 resident & resident fell out of bed & sustained laceration to back of head

- *Failed to transfer 1 resident according to resident's CP which resulted in fall*
- *CP lacked direction to staff to ID what "waking hours" were for resident to continue 1:1 monitoring; failed to ensure staff provided adequate supervision while providing 1:1 supervision to resident & resident fell out of bed & sustained laceration to back of head*

SW: SS=G: Failed to ensure 4 residents remained free of accident hazards r/t falls who continued to fall & obtained additional injuries; additionally, facility failed to ensure 1 resident remained free of accident hazards when staff pushed resident's w/c w/o foot pedals & feet were suspended above ground with potential to negatively affect physical & psychosocial wellbeing of residents

- Failed to ensure resident remained free of accident hazards r/t falls when facility failed to review & revise CP for 1 resident with potential to lead to ongoing increased risk for falls & possibility of additional injuries from falls
- Failed to provide environment free of accident hazards when staff assisted resident with w/c locomotion w/o foot pedals installed on w/c with potential to negatively affect resident's physical & psychosocial wellbeing
- Failed to keep resident safe, r/t fall hazards with potential lead to negative psychosocial effects r/t safety & uncommunicated needs for multiple residents

F692 Nutrition/Hydration Status Maintenance

SE: SS=G: Failed to ensure adequate hydration for quadriplegic, dependent Resident who experienced decreased urinary output and decline; on 07/23/24, one day after resident completed antibiotic treatment for a UTI. On 07/24/24 at around 01:15 AM, staff found the resident unresponsive, cyanotic, with "wet" lung sounds, and with no urinary output. Resident required EMS response and treatment to include a systolic blood pressure of 44 millimeters of mercury and could not obtain her diastolic pressure. EMS took resident to the local hospital for treatment. The Emergency Department staff documented resident appeared in poor health, appeared toxic, in severe distress, with flat jugular veins, cyanotic nail beds, lethargic, confused, only made sounds of moan/groans, and appeared "poorly groomed, disheveled, malodorous". The ED placed a urinary catheter and noted 10 ml of dark orange/red urine with obvious pus and resident required placement of an intraosseous to her right lower tibia. The hospital admitted resident with acute respiratory failure, pneumonia, sepsis, and comfort care with an onset date of 07/24/24. Hospital staff noticed 25 ml of a creamy white/green substance in resident's urinary catheter tube and resident died at 09:08 AM on 07/24/24.

- *Cited findings noted in F600 r/t neglect; failed to ensure staff provided adequate hydration to quadriplegic, dependent resident who became unresponsive, displayed trouble breathing, and had decreased urinary output. On 07/24/24 at around 01:15 AM, staff found the resident unresponsive, cyanotic, with "wet" lung sounds, and with no urinary output. Resident required EMS transport to a local hospital where she received fluids through an IO, had minimal urinary output of dark orange/red urine and then creamy white/green urine in her urinary catheter tubing. Resident died approximately 8 hours later, from sepsis.*

F693 Tube Feeding Management/Restore Eating Skills

SE: SS=D: Failed to ensure staff provided feeding tube care in accordance with professional standards of practice; on 6-16-24 CNA pulled out 1 resident's feeding tube which required emergency medical transportation to local hospital for surgical replacement

- *NN documented staff called LN to resident's room because CNA pulled resident's G=tube out while changing resident's shirt; failed to ensure staff provided feeding tube care in accordance with professional standards of practice when on 6-16-24 CNA pulled out resident's feeding tube which required emergency medical transportation to local hospital for surgical replacement*

F695 Respiratory/Tracheostomy Care & Suctioning

SE: SS=G: Failed to ensure staff provided oxygen to quadriplegic, dependent Resident, who became unresponsive and displayed trouble breathing. On 07/24/24 at around 01:15 AM, staff found the resident unresponsive, cyanotic, with "wet" lung sounds, and with no urinary output. The staff did not apply oxygen and did not ensure a staff member stayed with resident during the critical incident. LN S left the room and called the physician, discussed the situation, received an order to call 911, then she called 911, printed and filled out papers, then went to the bathroom. When emergency responders arrived, they found no staff in the hallway and found the resident alone in her room and with no oxygen applied, even though the staff noted resident displayed obvious signs of airway distress. Resident required EMS response and treatment to include obtaining her oxygen saturation level of 77%, a systolic blood pressure of 44 mmHg and could not obtain her diastolic pressure. Resident required supplemental oxygen and EMS took resident to the local hospital for treatment. The Emergency Department ED staff documented resident appeared in poor health, appeared toxic, in severe distress, with flat jugular veins, cyanotic nail beds, lethargic, confused, only made sounds of moan/groans, and appeared "poorly groomed, disheveled, malodorous". The ED placed a urinary catheter and noted 10 ml of dark orange/red urine with obvious pus and resident required placement of an intraosseous to her right lower tibia. The hospital admitted resident with acute respiratory failure, pneumonia, sepsis and comfort care with an onset date of 07/24/24. Resident died at 09:08 AM on 07/24/24.

- *Cited findings noted in F600 & F695; failed to ensure staff provided O2 to quadriplegic, dependent resident who became unresponsive & displayed trouble breathing; on 7-24-24 at around 1:15am staff found resident unresponsive, cyanotic with "wet long sounds & with no urinary output; staff did not apply O2 & did not ensure staff member stayed with resident during critical incident*
- *Abatement Plan:*
    - *Suspended LN on 7-24-24 at 5pm*

- *Adm Staff re-educated facility leadership r/t ANE policy & process at 3:30pm on 7-24-24*
- *Ad Hoc QAPI meeting using 5-why & RCA*
- *VP of Clinical Services reviewed resident's record with no finding of neglect*
- *Facility conducted safe surveys on 6 residents with no concerns or additional findings noted*
- *Facility re-educated current team members at mandatory training*
- *When new team members begin employment will receive ANE training as part of initial onboarding & all employees annually & with any allegations or investigation r/t ANE*

NE: SS=D: Failed to provide appropriate nebulizer equipment for 1/2 residents

- POS for nebulizer tx; Observed CMA prepared to administer nebulizer tx & noted mask used to place over nose & mouth was pediatric size & did not fit resident & CMA searched for appropriately sized mask or handheld inhalation device & was unable to locate one; failed to provide proper nebulizer equipment for 1 resident to ensure optimal effectiveness of nebulizer tx

F699 Trauma Informed Care

SE: SS=J (Abated to G): Failed to ensure 1 resident received trauma informed care in accordance with professional standards of practice, accounting for experiences & preferences & eliminating or mitigating triggers that could cause re-traumatization when facility failed to implement person-centered interventions for 1 resident after another resident entered resident's room, uninvited, attempted to get n bed, touched resident's "private parts" and facility failed to recognize impact to resident's psychosocial wellbeing; since incident with other resident, facility staff reported resident isolated self more & had changed in day-to-day behavior & resident reported felt "punished by facility", embarrassed at multiple requests for skin checks of "private parts" & had to minimize existence in daily life

- *Failed to ensure R1 had trauma informed care in accordance with professional standards of practice, accounting for her experiences and preferences, and eliminating or mitigating triggers that could cause re-traumatization when the facility failed to implement person centered interventions for resident after another resident entered her room, uninvited, attempted to get in her bed, touched her "private parts", and the facility failed to recognize the impact to resident's psychosocial wellbeing. Since the incident with other resident, facility staff reported resident has isolated herself more and had changed in her day-to-day behavior and resident reported she felt "punished by the facility", embarrassed at multiple requests for skin checks of her "private parts", and had to minimize her existence in her daily life.*
- *Abatement Plan:*
  - *Staff educated on Trauma Informed Care*
  - *All current staff education on how to know preferences using resident's CP*
  - *CP for resident updated to ID resident standards/preferences*
  - *Staff meet with resident for preferences on how often resident would like facility to check in including date, time, & personnel*
  - *Resident offered to have new trauma informed care assessment & completed if agreed upon by resident*

F741 Sufficient/Competent Staff-Behavioral Health Needs

SE: SS=G: Failed to ensure sufficient staff who provided direct services to residents with appropriate competencies & skill sets to provide nursing & related services for 1 resident who was dx'd with mental d/o & failed to ensure resident received appropriate treatment & services to attain highest practicable mental & psychosocial wellbeing when resident became notable more tearful over few weeks, voiced auditory & visual hallucinations & reported resident had voices telling resident to "doing something naughty" to other residents

- *POS for Risperidone, Cymbalta; orders lacked monitoring for increased symptoms of depression; Failed to ensure sufficient staff who provided direct services to residents with appropriate competencies & skill sets to provide nursing & related services for 1 resident who was dx'd with mental d/o & failed to ensure resident received appropriate treatment & services to attain highest practicable mental & psychosocial wellbeing when resident became notable more tearful over few weeks, voiced auditory & visual hallucinations & reported resident had voices telling resident to "doing something naughty" to other residents*

F742 Treatment/Services Mental/Psychosocial Concerns

SE: SS=G: Failed to ensure 1 resident who was dx'd with mental d/o, received appropriate treatment & services to attain highest practicable mental & psychosocial wellbeing when resident became notably more tearful over few weeks, voiced auditory & visual hallucinations & reported had voices telling him to "doing something naughty" to other residents

Cited findings noted in F741; Failed to ensure 1 resident who was dx'd with mental d/o, received appropriate treatment & services to attain highest practicable mental & psychosocial wellbeing when resident became notably more tearful over few weeks, voiced auditory & visual hallucinations & reported had voices telling him to "doing something naughty" to other residents

F745 Provision of Medically Related Social Service

SE: SS=D: Failed to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility failed to provide medically-related social services to serve as an advocate in asserting 1 resident's rights as a resident and further failed to meet the needs of resident when she began showing signs of distress after a traumatic event and through the transition process with resident.

- *Cited findings noted in F585 & F699 r/t lack of SS after resident began showing signs of distress after traumatic event & through discharge/transition process with resident & Guardian*

F759 Free of Medication Error Rates 5% or More

NE: SS=E: Failed to ensure medication error rate did not exceed 5% when staff crushed & mixed 1 resident's meds w/o physician order to administer via G-tube resulting in med error rate of 23.08%

- POS lacked physician's order to crush & mix meds for administration; failed to ensure med error rate did not exceed 5% when staff failed to ensure 1 resident had physician order to administer meds mixed via G-tube resulting in med error rate of 23.08%

F761 Label/Store Drugs & Biologicals

SW: SS=E; Failed to ensure 1/2 med carts observed were locked while unattended with potential to affect all residents located on 1 unit

- Observed unlocked med cart on 1 unit as LN seated behind nurses' station desk with back to unlocked med cart that was positioned on outside of nurses' station; LN had been communicating with hospice nurse; med cart drawer opened w/o LN noticing; failed to provide proper storage of meds in safe locked med cart with potential to have negative effect of residents in facility

F812 Food Procurement, Store/Prepare/Serve-Sanitary

NE: SS=F: Failed to prepare & serve food under sanitary conditions to residents of facility appropriately to prevent potential foodborne bacteria

- Observed: trash can in dishwashing area with dried-on food & liquid substances on all sides & lid; trash can by hand washing sink with dried-on food & liquid substances on all sides & lid; shelf under prep table with equipment with food debris; inside of microwave with dried-on food; cutting boards with deep grooves & discolored; fan with dust build up; stove with dried-on food; freezers with buildup of food substances on bottom; freezers with buildup of food substances on bottom & buildup of black substance in rubber door seals; 3 plastic tubs with utensils with sticky substance on bottom of tubs; plastic containers with heavy buildup of food debris & sticky substance on container latches; table holding large stand mixer with buildup of food substance on bottom shelf

F835 Administration

SE: SS=I: Failed to ensure the facility was ran in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. The outcome of these failures placed 2 residents in immediate jeopardy. The failures further caused harm to 4 other residents

- *Cited all other findings in complaint survey including: F551, F561, F570, F585, F600, F603, F622, F623, F657, F659, F677, F684, F689, F692, F693, F695, F699, F741, F742, F745, F867 & F880*

F851 Payroll Based Journal

NE: SS=F: Failed to submit complete & accurate staffing information thru PBJ as required placing residents at risk for unidentified & ongoing inadequate nurse staffing

- PBJ report for 3 quarters indicated facility did not have LN coverage 24 hrs/day, 7 days/wk on 20 dates; timeclock data revealed facility had LN as required; failed to submit complete & accurate staffing information thru PBJ as required placing residents at risk for unidentified & ongoing inadequate nurse staffing

F867 QAPI/QAA Improvement Activities

SE: SS=F: Failed to ensure an effective Quality Assurance and Performance Improvement (QAPI) program. The QAPI program failed to develop, implement, and maintain an effective, comprehensive, data driven program that focused on indicators of outcomes of quality of care and quality of life for residents in the facility as evidenced by the number and severity of tags cited on the 08/12/24 survey with event ID SW0D11.

- *Cited other findings in complaint survey including: F551, F561, F570, F585, F600, F603, F622, F623, F657, F659, F677, F684, F689, F692, F693, F695, F699, F741, F742, F745, F835, & F880*
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F880 Infection Prevention & Control

SE: SS=F: Failed to ensure staff provided care to 1 resident according to standard infection control practices with potential to affect all residents

- *CP noted resident at risk for MDRO r/t invasive devices G-tube & instructed EBP; observed staff pushing resident in w/c with feet dangling down with no socks on & feet looked darkened & dirty; resident had 2 fingers in mouth with band of darkly discolored visibly dirty ring around base of 2 fingers; LN did not don gloves then just used a few wipes to clean resident's dirty fingers; failed to ensure staff provided care to 1 resident according to standard infection control practices*

SW: SS=D: Failed to maintain effective infection control measures with CMA poked a straw through potentially contaminated plastic film on top of cup containing house supplement shake then assisted resident in drinking part of shake with potential to contaminate shake & lead to foodborne illness

- Observed CMA knocked over cup containing unknown liquid & covered with plastic film sitting on med cart then picked up cup, removed straw from paper wrapper & poked straw thru plastic film then walked into resident's room & assisted resident in drinking liquid; staff failed to sanitize plastic film prior to inserting straw or removed small portion of covering to insert straw; failed to maintain effective infection control program when CMA poked straw through a potentially contaminated plastic film on top of cup

containing house supplement shake then assisted resident in drinking part of shake with potential to contaminate shake & lead to foodborne illness

NE: SS=E: Failed to implement signage or indicators within physical environment to alert staff & visitors of required EBP placing residents at risk for infectious diseases

- Failed to implement signage or indicators within physical environment to alert staff & visitors of required EBP placing residents at risk for infectious diseases

F883 Influenza & Pneumococcal Immunizations

SW: SS=D: Failed to provide pneumococcal vaccine declination form for 2/5 residents reviewed

- Failed to provide proof of declination of pneumococcal vaccine for 2 residents

September 2024

F550 Resident Rights/Exercise of Rights

SE: SS=D: Failed to provide grooming for 1 resident in manner of resident's choosing

- Failed to provide grooming services for 1 resident who required assist with personal hygiene which included facial hair removal & fingernail trimmings to maintain self in dignified manner

NE: SS=E: Failed to ensure 2 resident's dignity was maintained while being aided with meals; failed to ensure staff maintained 1 resident's dignity during incontinent accident; failed to ensure staff maintained 1 resident's dignity while personal care was provided; failed to ensure staff treated 1 resident in Memory Unit with respect while assistance was provided during mealtime; failed to ensure staff maintained 1 resident's dignity when staff stated that resident was a "Feeder" placing residents at risk of decreased self-esteem & decreased self-worth

- Observed staff stood over 2 residents & assisted residents with meal
- Observed resident in DR when resident had accident where urine leaked from brief onto floor during meal & other residents noticed resident's accident & yelled out at staff but staff waited several minutes before removing resident from DR & taking resident to room
- Observed resident laying in bed with only incontinent brief on & blankets pulled down below knees & room door open while CNA provided personal care
- Observed Activity staff assisted resident with meal & positioned between 2 residents then engaged in conversation about residents eating with another staff standing by nurses' station
- Observed CNA carried lunch tray down hall & yelled ½ way down hallway to another CNA that resident was a "feeder"
- Failed to ensure staff protected & maintained 5 residents' dignity placing residents at risk of decreased self-esteem & decreased self-worth

NE: SS=D: Failed to ensure staff treated resident with dignity placing resident at risk for decreased self-esteem & dignity

- *Video footage revealed interactions between 1 resident & CNA; resident in bed & covers at feet & staff walked into resident's room & up to resident's bed & asked resident what needed then placed hands on hips while looking down at resident; in raised voice, staff stated to resident not going to do this & it was 2nd time resident was on light & asked resident what needed resident unable to understand or hear resident's response due to TV volume; CNA than grabbed brief out of closet, closed resident's blinds, moved bedside table then went back to resident's bedside then asked resident about what time resident goes to dialysis; CNA then assisted resident with incontinence care then stated to resident not getting anybody up that morning then would be there to get everybody up with breakfast & all that; then asked resident to lift bottom then unfastened brief & pulled brief down in front & resident stated "ow"; resident stated "ow" multiple times during incontinent care; failed to ensure staff treated resident with dignity placing resident at risk for decreased self-esteem & dignity*

NE: SS=D: Failed to maintain environment that treated 1 resident with respect & dignity & maintained resident's quality of life placing resident at risk for impaired dignity

- *Resident with CVA with rhabdomyolysis, UTI, with expressive aphasia; Witness Statement documented Adm Nurse observed consultant assess resident & noted resident not responding to verbal & tactile stimuli & consultant stated to Adm nurse that "was not sure if resident was just playing opossum or not" & family in room but did not respond to comment; representative stated statement made them uncomfortable & uncertain that resident was being assessed appropriately; failed to maintain environment that treated resident with respect & dignity & maintained or enhanced resident's quality of life placing resident at risk for impaired dignity*

F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to ensure 1 resident's call light was within reach leaving resident vulnerable for unmet care needs due to inability to call for staff assist

- Observed resident in bed & call light on floor on side of bed on multiple occasions; failed to ensure resident's call light was within each leaving resident vulnerable for unmet care needs

F582 Medicaid/Medicare Coverage/Liability Notice

NW: SS=D: Failed to provide correct CMS Form 10055 ABN to resident/representative for 2 residents placing residents at risk for uninformed decisions r/t skilled services

- Facility's ABN form staff provided to resident/representative was CMS-R-131 when resident's skilled services ended for multiple residents; SSD stated did not realize had been providing families with incorrect CMS form; failed to provide 2 residents correct ABN form CMS 10055 as required placing residents at risk for uninformed decisions r/t skilled services

F584 Safe/Clean/Comfortable/Homelike Environment

SE: SS=E: Failed to maintain clean, comfortable, & homelike environment on 4/5 resident hallways

- Observed strong urine odors; shower room with rust around drain & large amount of loose hair; clean linen cart uncovered; handrails loose; beauty shop with large glob of cut hair in sink drain; laundry room with sink with dead bugs & small pieces of trash; shower room with toilet riser stored directly on floor next to toilet; cove base peeling from floor & wall in disrepair with peeling & broken tile; failed to maintain clean, comfortable & homelike environment on 4/5 hallways

F600 Free from Abuse & Neglect

SE: SS=J (Abated to G): Failed to prevent neglect of 1 resident when staff did not utilize appropriate transfer equipment to safely meet needs of 1 resident who displayed signs of weakness during cares

- *On 08/28/24 at 02:40 PM, LN, 1 CNA & 1 CMA 1 assisted resident to stand, with use of a gait belt that was not the appropriate size for resident. As two of the staff members attempted to pull resident's incontinence brief up, resident's legs became weak, & staff lowered resident to the floor. During the lowering, resident's left leg buckled underneath the resident and rotated outward, causing a "popping noise."; facility called EMS to transfer resident to the ED; resident admitted to the hospital with an obliquely oriented fracture through the middle to distal femoral diaphysis; placing resident in immediate jeopardy*
- *Abatement Plan:*
  - *Staff assessed resident*
  - *Updated resident's CP r/t transfer & all will have transfer ability assessed with revision CP as necessary*
  - *Nursing staff educated on resident to be Hoyer lift transfer upon return from hospital*
  - *Nursing staff educated that if resident transfer required more than 2 staff, staff were to use full body mechanical lift & report to DON immediately*
  - *LN educated on updating CPs upon readmission, education*
  - *Staff educated upon hire & prior to working next scheduled shift*
  - *ANE training completed with all staff*
  - *Staff educated to use appropriate size gait belt*

F609 Reporting of Alleged Violations

SE: SS=J (Abated to D): Failed to report elopement of 1 resident to State Agency (SA) as required

- *On 08/27/24 at 08:48 PM resident left the facility without staff knowledge or supervision and at approximately 10:41 PM, Law Enforcement called the facility to advise them they had received calls noting that resident was walking on the highway, entered a gas station approximately 0.9 miles from the facility. Law Enforcement advised LN that someone needed to come to their location because Law Enforcement had the resident surrounded with their patrol cars due to his threats to Law Enforcement and the store clerk, yelling, cursing and agitation. The LN reported she immediately drove to the gas station in her personal vehicle, without contacting Adm or DON and returned to the facility with the resident. While LN drove back to the facility, she reported the resident made several attempts to grab the steering wheel of the car while she was driving. The failure of the facility to report an elopement to the State Agency as required, placed resident in immediate jeopardy. Facility failed to report elopement to SA as required*
- *Abatement Plan:*
  - *Staff educated on "elopement" policy & accountability of resident location*
  - *Adm, DON received education on Federal Required Reporting*

F625 Notice of Bed Hold Policy Before/Upon Transfer

NE: SS=D: Failed to provide a bed hold policy notice to 2 residents/representatives when residents transferred to hospital with risk of impaired ability to return to facility & to previous room for 2 residents

- Failed to provide bed hold policy notice to resident/representative when resident transferred to hospital with risk of impaired ability to return to facility & to previous room for multiple residents

F637 Comprehensive Assessment After Significant Change

SE: SS=D: Failed to complete accurate Sig Change as required r/t falls

- Failed to complete accurate Sig Change MDS for resident with hx of falls

F657 Care Plan Timing & Revision

SE: SS=D: Failed to review & revise CP for 1 resident r/t skin tear prevention placing resident at risk for repeated skin tears

- CP lacked intervention for tx of current hand skin tear & lacked updated revision to interventions to prevent further skin tears to resident's skin tear to resident's arm & interventions to prevent further injuries to arms; failed to review & revise CP for 1 resident r/t skin tear prevention placing resident at risk for repeated skin tears

NE: SS=D: Failed to revise 1 resident's CP to reflect current toileting needs after discontinuation of Foley catheter placing resident at risk for impaired care due to uncommunicated care needs

- CP indicated resident had Foley in place; POS revealed Foley catheter DC'd; failed to revise 1 resident's CP to reflect DC'd Foley catheter & current toileting needs placing resident at risk for impaired care due to uncommunicated care needs

F676 Activities Daily Living (ADLs)/Maintain Abilities

NE: SS=D: Failed to ensure 1 residents received supportive care & services to promote & maintain quality of life when facility did not implement tools &/or strategies to allow resident to communicate wants, needs, or feelings placing resident at risk for decreased quality of life, isolation & impaired dignity

- CP instructed staff that resident had cognitive impairment, required interpreter, re-direct when wandered & promote consistent routines; NN documented resident attempted to move into & slept in old room & staff unable to reach family (interpreter); failed to utilize provided translation services to ID resident's care needs placing resident at risk for decreased quality of life, isolation & impaired dignity

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to provide care & services for ADLs for 1 dependent resident r/t proper fingernail trimming/hygiene

- *Observed CNA provided morning cares & CMA assisted with transfer & resident with nails with brown substance under nails & should be trimmed & cleaned on bath days; failed to provide care & services for ADLs for 1 dependent resident r/t proper fingernail care*

NE: SS=D: Failed to ensure staff provided ADL assist for 1 resident who was dependent on staff for ADLs; also failed to ensure staff provided assist for toileting & eating for 2 residents placing residents at risk for impaired care & decreased quality of life

- Observed resident in DR & had urine leaking from brief onto DR floor; numerous residents in DR at time & several residents yelled to staff members that resident needed to be taken to get changed; several minutes later staff propelled resident back to room; CNA stated resident on 2-hour checks; failed to ensure staff provided adequate ADL assist to 1 resident who was dependent on staff assist for toileting placing resident at risk for impaired care & decreased quality of life
- CP instructed staff to provide checks & changes; observed resident in Broda chair at 7:09am & remained in same position until 11:25am; failed to provide resident with ADL assist required for toileting placing resident at risk for complications r/t incontinence & impaired quality of life
- Documentation lacked documentation for morning meal assistance; observed resident in bed with call light on floor & breakfast tray on side of bed & resident stated had asked to get up to go to DR for breakfast but CNA told resident was only staff person & would have to wait & stated CNA stated would be fed meal in room; resident grabbed fried egg on plate 1 hour after meal provided & got part of egg in mouth & other part of egg went on bed; CNA removed resident's tray w/o waking resident & majority of meal was untouched & uneaten; failed to provide adequate assist with ADL including transfers & eating for 1 resident who was dependent on staff for both placing resident at risk for impaired nutrition, impaired ADLs & decreased quality of life

F684 Quality of Care

SE: SS=D: Failed to ensure 1 resident received tx & care in accordance with professional standards of practice, comprehensive person-centered CP & residents' choices & provide adequate tx & monitoring of 1 cognitively impaired, dependent resident's skin condition to ensure resolution of multiple reoccurring skin areas & prevention of further injury

- CP lacked intervention for tx of current hand skin tear & updated revision to interventions to prevent further skin tears to resident's skin tears to arm & interventions to prevent further injuries to resident's arms; failed to ensure 1 resident received tx & care to provide

SE: SS=D: Failed to ensure staff applied 1 resident's compression wraps in manner to prevent potential skin damage

- *Resident with lymphedema, chronic venous HTN & venous ulcer; POS for single layer of Tubigrip & light ace wrap bilateral & heel protector boots at all times; observed resident in bed with offloading boots & wraps on; ; observed Adm Nurse removed boot & removed Tubigrip & unwrapped ace wrap & resident stated painful area below knee that persisted all night then Adm Nurse measured 14-cm red, slow blanching red indented ridged area around anterior of upper calf along edge of ace wrap & 12 cm less reddened area around lateral side of outer aspect of upper calf area; resident stated had notified charge nurse during night of discomfort but staff did not examine leg or adjust pressure bandage; failed to ensure staff maintained resident's compression wrap to extremity in manner to prevent discomfort & undue pressure areas per standards of practice*

F686 Treatment/Services to Prevent/Heal Pressure Ulcer (PU)

NE: SS=D: Failed to ensure 1 resident's pressure-reducing interventions were implemented correctly when low air-loss mattress pump was set at inappropriate weight for resident placing resident at risk for complications r/t skin breakdown & Pus

- Failed to ensure 1 resident's low air-loss mattress pump appropriately set to current weight placing resident at risk for complications r/t skin breakdown & Pus placing resident at risk for complications r/t skin breakdown & Pus

NE: SS=D: Failed to implement pressure-reducing interventions for 1 resident placing resident at increased risk for PU development & worsening of present PUs

- Failed to ensure 1 resident's heels were floating on pillow while in bed placing resident at increased risk for PU development & worsening of heel pressure wound

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=J (Past Non-Compliance): Failed to ensure adequate supervision & safe & secure environment to prevent elopement of cognitively impaired resident

- On 8-29-24 resident who was assessed as high elopement risk, had dementia & poor safety awareness, exited facility unsupervised & w/o staff knowledge; at 10:05am resident ambulated 248 feet, across lawn, 2 parking lots & 2-way egress street to arrive at a dentist office; staff from dentist office phoned facility at 10:15am to inquire if resident was resident of facility placing resident in immediate jeopardy
- Abatement Plan:
    - LN completed full body assessment of resident upon return to facility
    - Resident place on 1:1 for remainder of investigation
    - Maintenance & door alarm company provide door alarm testing
    - LN notified representative & physician of elopement
    - DON documented alert in electronic software of any CP changes
    - DON notified SA of elopement on day of incident
    - DON reviewed MAR & progress notes to determine risk factors present
    - Reviewed all residents for elopement risk for accuracy & updated elopement book & CPs as needed
    - Mandatory Elopement Policy training to all staff
    - QAPI meeting held with Medical Director r/t incident
    - All staff completed mandatory Elopement Policy training

SE: SS=J: Failed to protect 1 resident from possible harm when resident exited facility unsupervised & w/o staff knowledge (elopement) & resident walked approximately 0.9 miles from facility, threatened store clerk & wanted to buy cigarettes with postage stamps; local law enforcement informed LN someone needed to come to location because LE had resident surrounded with patrol cars due to threats of yelling, cursing & agitation to LE to officers & store clerk; LN immediately drove personal vehicle to gas station w/o contacting Adm or DON & returned to facility with resident & during drive back to facility, resident made several attempts to grab steering wheel of car while driving placing resident in immediate jeopardy

- *Cited findings noted in F609*
- *Abatement Plan:*
    - *Resident assisted back to facility by LN & resident refused assessment*
    - *Resident's guardian approved walking privileges for resident with CP revised*
    - *Resident educated on sign-out process with CP revised*
    - *Resident assessed to determine sign out privileges & safe walking with CP revised*
    - *Staff educated on "elopement" policy & accountability of resident location*

NE: SS=D: Failed to implement fall intervention of anti-rollback devices per 1 resident's CP; additionally failed to ensure safe environment free from accident hazards when 1 resident's bed was left in high position placing residents at risk for preventable accidents & injuries

- Failed to implement fall intervention of anti-rollback devices per resident's CP placing resident at risk for preventable falls & injuries
- Failed to ensure safe environment free from accident hazards when 1 resident's bed was left in high position placing resident at risk for injury from falls

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to ensure 1 resident had anchor for suprapubic catheter on abdomen per standards of practice to prevent pulling & injury placing resident at risk for catheter-related complications

- Failed to ensure standard of practice was followed for placement of anchor of 1 resident's suprapubic catheter tubing on abdomen to prevent pulling or injury placing resident at risk for catheter-related complications

F695 Respiratory/Tracheostomy Care & Suctioning

NE: SS=D: Failed to ensure 1 resident's CPAP mask & nasal cannula was stored in sanitary manner placing resident at increased risk for respiratory infection & complications

- Observed CPAP mask on bedside table & not stored in dated bag; Failed to ensure 1 resident's CPAP mask was stored in sanitary manner placing resident at increased risk for respiratory infection & complications

F698 Dialysis

NE: SS=D: Failed to consistently communicate 1 resident's medical condition with dialysis center placing resident at risk for potential adverse outcomes & physical complications r/t dialysis

- Record lacked evidence of pre-dialysis assessment for 7 dialysis dates & record lacked evidence of post-dialysis assessment on 12 dialysis dates; failed to consistently communicate 1 resident's medical condition to dialysis center placing resident at risk of potential adverse outcomes & physical complications r/t dialysis

F726 Competent Nursing Staff

NW: SS=D: Failed to ensure staff possessed necessary knowledge & competency to respond immediately when hospice CNA removed 1 resident's fentanyl patch & further failed to dispose of patch per standards of practice & manufacturer instructions placing residents at risk for inadequate care

- Resident on hospice stated hospice CNA removed fentanyl patch while providing resident bed bath after stating that it was expired; LN stated hospice CNA told LN that patch cam off when providing resident bed bath; 2 LNs searched BP trash can & bedside trash can but patch unfound; CNA reported taking trash to shower room across hall; LN found patch folded in ½ in trash can; LN discarded patch in Sharp's container on med cart; failed to ensure staff possessed skill & competency required to safely monitor & dispose of 1 resident's fentanyl patch placing residents at risk for inadequate care

F727 RN 8 Hrs/7 days/Wk, Full Time DON

NE: SS=F: Failed to provide RN coverage 8 consecutive hours/day, 7 days/wk placing all residents who resided in facility at risk of lack of assessment & inappropriate care

- Nursing schedule lacked evidence of RN coverage on 5 days in 1-24 thru 4-24; facility unable to provide verifiable, auditable evidence of RN coverage; Adm stated previous DON was coverage those dates & DON was salaried & had no documentation to provide to show evidence of working 8 consecutive hours; failed to provide RN coverage 8 consecutive hours/day, 7 days/wk as required placing residents residing in facility at risk of lack of assessment & inappropriate care

F730 Nurse Aide Performance Review-12 hr/yr In-Service

SE: SS=F: Failed to provide annual performance reviews for CNAs & CMAs as required

- Failed to ensure certified nursing staff received annual evals to ensure competency & ID of training needs as required

NE: SS=F: Failed to ensure 3/3 CNA staff reviewed had required yearly performance evals completed placing residents at risk for inadequate care

- Failed to ensure 3 CNA staff reviewed had required yearly performance evals completed placing residents at risk for inadequate care

F732 Posted Nurse Staffing Information

SE: SS=C: Failed to complete "Daily Staff Posting" to include total & actual hours worked by direct care staff as required

- Failed to calculate total & actual hours worked by direct care staff on "Daily Staffing Sheet" &/or on Daily Staff Posting as required

NE: SS=C: Failed to post daily staffing with census & maintain 18 months of daily posted staffing hours as required

- Observed daily posted staffing & sheet dated 3 days earlier & lacked census; failed to post daily staffing with census & maintain 18 months of daily posted staffing hours as required

F744 Treatment/Service for Dementia

NE: SS=D: Failed to provide dementia-related care services for 1 resident to promote resident's highest practicable level of wellbeing placing resident at risk for decreased quality of life, isolation & impaired dignity

- Resident documented as requiring interpreter; NN documented resident with dementia attempted to move into old room & staff attempted to redirect resident to new room but resident unable to understand; staff attempted to contact interpreter but unable to reach; NN documented resident eventually calmed down while sat on hallway couch outside room; observed resident made several attempts to wake another resident up & staff intervened; staff did not attempt to use translator service or cue card to assess resident's needs or intentions during event; failed to provide dementia-related services for 1 resident placing resident at risk for decreased quality of life, isolation, & impaired dignity

F755 Pharmacy Services/Procedures/Pharmacist/Records

NE: SS=D: Failed to ensure controlled substances were accounted for & reconciled between shifts placing residents at risk for misappropriation &/or diversion of controlled substances

- Review of July, August, & September count sheet on 1 hall with missing signature on 7 shifts on morning shifts, 11 evening shifts; failed to ensure accurate reconciliation of controlled meds completed placing residents at risk of med misappropriation & diversion

NE: SS=E: Failed to ensure controlled substances were accounted for & reconciled between shifts placing residents at risk for misappropriation &/or diversion of controlled substances

- Count Sheet for 7-24 thru 9-24 with 32 missing signatures for on-coming shifts; for 7-24 thru 9-24 for off-going shift with 16 missing signatures; failed to ensure accurate reconciliation of controlled meds completed placing residents at risk of medication misappropriation & diversion

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure CP ID'd & reported missing dosage & location of application for 1 resident's physician-ordered diclofenac; further failed to ensure CP recommendations for 1 resident were submitted to physician for review placing residents at risk for unnecessary medication side effects

- POS lacked dosage amount or specific location to be applied; CP MRR from May 2024 to August 2024 lacked evidence CP ID'd & reported missing dosage & affected area for diclofenac; failed to ensure CP ID'd & reported 1 resident's physician-ordered diclofenac lacked dosage amount & specific area to be applied placing resident at risk for unnecessary medication side effects
- MDS lacked evidence MRR completed during observation period; failed to ensure physician reviewed & addressed CP recommendations for 1 resident placing resident at risk for unnecessary medication use, side effects & physical complications

NE: SS=D: Failed to ensure MRR addressed by physician for 2 resident; also failed to ensure CP ID'd & recommended GDR for 1 resident's psychotropic meds; failed to ensure CP ID'd & reported irregularities for 1 resident's non-CMS approved indication for antipsychotic med & lack of physician documentation for ongoing use w/o GDR attempted placing residents at risk for unnecessary med use, side effects & physical complications

- Failed to ensure CP ID'd & recommended GDR for resident's Ambien; failed to ensure physician had reviewed & addressed CP's MRR for resident placing resident at risk for unnecessary med administration & possible adverse side effects
- Failed to ensure CP's MMR had been reviewed or addressed by physician for 1 resident placing resident at risk for unnecessary meds & adverse side effects
- Record lacked physician documentation fo rationale for non-approved CMS indication for continued use of antipsychotic med Risperdal & for continued use of psychotropic med; failed to ensure CP ID'd & reported that resident had non CMS-approved indication for use of antipsychotic meds placing resident at risk for unnecessary med administration & possible adverse side effects

NW: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported 1 resident's PRN Haldol did not have 14-day stop date placing resident at risk for unnecessary psychotropic meds

- POS for Haldol q 1 hr PRN for aggression; order lacked stop date; MAR documented resident had received PRN med on 2 occasions in previous month & 1 x in current month; MRR lacked evidence CP ID'd & reported PRN Haldol with no stop date; failed to ensure CP ID'd & reported 1 resident's PRN Haldol did not have 14-day stop date placing resident at risk for unnecessary psychotropic meds

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to ensure 1 resident's physician ordered diclofenac had indicated dosage or an indicated location to apply medication placing resident at risk of unnecessary medication administration & possible adverse side effects

- Cited findings noted in F756 r/t diclofenac dosage & location; failed to ensure 1 resident's physician-ordered diclofenac indicated dosage amount & specific area to be applied placing resident at risk for unnecessary medication administration & side effects

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SE: SS=D: Failed to monitor 1 resident for use of antipsychotic meds

- POS for Risperidone for schizophrenia; CP recommended facility complete DISCUS at least q 6 months on multiple occasions; failed to monitor resident who received antipsychotic meds for use of antipsychotic meds

NE: SS=D: Failed to ensure 1 resident had CMS-approved indication for use of antipsychotic or required physician documentation; further failed to ensure GDR was attempted or documented as contraindicated by physician with supporting rationale for 2 residents placing residents at risk for unnecessary meds & adverse side effects

- Cited findings noted in F756; failed to ensure resident had CMS-approved indication or required physician documentation for use of antipsychotic meds w/o GDR attempts placing resident at risk for unnecessary medication administration & possible adverse side effects
- Failed to ensure resident had GDR or required physician documentation for use of hypnotic meds w/o GDR attempts placing resident at risk for unnecessary medication administration & possible adverse side effects

NW: SS=D: Failed to ensure 1 resident's PRN antipsychotic had 14-day stop date placing resident at risk for unnecessary meds & related complications

- Cited findings noted in F756 r/t lack of stop date for PRN Haldol for aggression; failed to obtain required 14-day stop date for 1 resident's PRN antipsychotic med placing resident at risk for unnecessary meds & related complications

F760 Residents are Free of Significant Med Errors

NW: SS=D: Failed to ensure 1/5 residents reviewed during med administration pass remained free of med errors placing resident at risk for adverse reactions from meds

- Observed LN crushed 1 resident's meds including Wellbutrin XL then placed crushed med in plastic med cup, took spoon, removed pill coating & discarded it then administered crushed med with water in resident's G-tube; LN stated had voiced concern about crushing XL med to hospice & order had not been changed; failed to ensure 1 resident remained free from med errors when staff crushed extended-release med prior to administration placing resident at risk for adverse reactions from med

F801 Qualified Dietary Staff

NE: SS=F: Failed to provide services of full-time CDM for all residents residing in facility & receiving meals from kitchen placing residents at risk for inadequate nutrition

- Failed to employ a full-time CDM to evaluate residents' nutritional concerns & oversee ordering, preparing, & storage of food for all residents in facility placing residents at risk for inadequate nutrition

NE: SS=F: Failed to ensure director of food & nutrition services had required qualifications of CDM placing residents at risk for unmet dietary & nutritional needs

- Failed to ensure director of food & nutrition services had required qualifications of CDM placing residents at risk for unmet dietary & nutritional needs

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NW: SS=D: Failed to correctly prepare puree diet for 3 residents who required modified textured food to retain both nutritive value & palatability placing affected residents at risk for impaired nutrition & decreased quality of life

- Observed dietary staff prepare pureed foods; upon questioning amount of liquid, CDM instructed staff to use 1 cup of milk & add more if needed; observed consistency runny liquid after adding 1 cup milk so staff added 4 tsp thickener to obtain correct pureed texture; staff verified did not follow pureed recipe; failed to prepare 3 pureed diets using professional standards for food service to maintain both nutritive & palatability placing affected residents at risk for impaired nutrition & decreased quality of life

F806 Resident Allergies, Preferences, Substitutes

NE: SS=E: Failed to accommodate dietary preferences placing residents at risk for impaired nutrition & decreased psychosocial wellbeing

- Observed Memory Care Unit & resident stated multiple times that would like pancakes for breakfast & ws told by staff that pancakes were not available & resident would have to eat what was served; after ate what was on plate resident asked for toast & was told that toast not available & was given bowl of Cheerios; resident complained not give option for meal or side items; staff announced 2nds not available for residents; resident asked for coffee & was told coffee not available & would have to wait until dinner cart arrived; observed another resident served Cheerios & asked for another type of cereal & was told only had Cheerios; Resident Council reported facility did not provide options or alternatives for breakfast; failed to accommodate dietary preferences of residents placing residents at risk for impaired nutrition & decreased psychosocial wellbeing

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=F: Failed to prepare, store, & serve food under sanitary conditions to residents of facility

- Observed wood shelving used to stack dishes & glasses with loose chunks of dirt on shelves where plates & glasses were stored upside down in direct contact with shelving; ice machine/storage room needed housekeeping & maintenance to clean repair room to ensure safe & sanitary environment for residents & staff & reported being unaware of who was responsible for cleaning
- Observed opened box of foam cups box of bowls with floor storage

NE: SS=F: Failed to ensure big cooler maintained appropriate temperature range, failed to ensure staff consistently monitored cooler & freezer temps, & failed to ensure staff consistently monitored dishwasher temps & chemical sanitation levels; further failed to ensure adequate hand hygiene during meal service placing residents at risk for foodborne illnesses

- Observed big cooler at 46-48 degrees F on multiple occasions
- Observed DON delivered bowl to resident in DR then assisted resident with clothing protector then w/o performing hand hygiene, DON grabbed plate, sat it down then touched another plate on another cart then grabbed empty tray &moved plates; DON moved another covered plate then pushed cart then placed clothing protector which had fallen to floor on table, then moved hair away from face then delivered fluids to resident then performed hand hygiene
- Multiple holes in temp logs for cooling devices
- Dish machine chemical logs with multiple holes;

F838 Facility Assessment (FA)

NE: SS=F: Failed to conduct a thorough facility-wide assessment to determine resources necessary to care for residents competently during both day-to-day operations & emergencies placing all residents residing in facility at risk for inadequate care

- FA did not ID facility's resident capacity; means of input gathered from residents/representatives when formulating assessment data; did not ID specific staffing needs of each unit based on type of resident population within unit; did not ID competencies & skill sets needed by nursing staff to provide care for resident's resident population; failed to conduct thorough, facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations & emergencies affecting all residents residing in facility at risk for inadequate care

NE: SS=F: Failed to conduct a thorough facility-wide assessment to determine resources necessary to care for residents competently during both day-to-day operations & emergencies affecting all residents residing in facility

- FA failed to ID specific staffing levels needed for each unit & ID number of RNs, LN, CMA, CNAs, needed for each unit, patient acuity & census; lacked staffing levels required for each shift; lacked informed contingency plan for events that do not required activation of facility's emergency plan but have potential to impact resident care; lacked contingency plan to maximize recruitment & retention of direct care staff; failed to ID means of input gathered form residents & representatives when formulating assessment data; failed to conduct thorough, updated facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations & emergencies affecting all residents residing in facility

F849 Hospice Services

NE: SS=D: Failed to ensure collaboration r/t 2 resident's care between nursing home & hospice 24 hours a day, 7 days a week including documentation of description of services, medication & equipment provided to these residents by hospice creating risk of missed opportunities for services & delayed physical, mental & psychosocial needs for residents

- Failed to ensure collaborative process in place to communicate necessary information r/t resident's care between nursing home & hospice 24 hrs/day, 7 days/wk including documentation of communications with potential for negative outcomes for 2 residents

NE: SS=D: Failed to ensure collaboration r/t 1 resident's care between nursing home & hospice 24 hrs/day/7 days/wk including documentation of description of services, medication, & equipment provided to residents by hospice creating a risk of missed opportunities for services & delayed physical, mental & psychosocial needs for 1 resident

- Failed to ensure a collaborative process was in place to communicate necessary information r/t 1 resident's care between nursing home & hospice 24 hrs/day/7 days/wk including documentation of communications with potential for negative outcomes for 1 resident

NW: SS=D: Failed to ensure coordinated plan of care which coordinated care & services provided by facility with care & services provided by hospice was developed & available for 2 residents placing residents at risk for inappropriate end-of-life care

- Failed to coordinate care between facility & hospice services placing residents at risk for inappropriate end-of-life care for multiple residents

F851 Payroll Based Journal

SE: SS=F: Failed to electronically submit to CMS with complete & accurate direct staffing information based on payroll & other verifiable & auditable data in uniform format per CMS specifications r/t LN information when facility failed to accurately report 24 hr/day LN coverage on 4 days between 7-1-23 & 9-30-23 & 6 days between 10-1-23 & 12-31-23

- Failed to electronically submit to CMS with complete & accurate direct staffing information based on payroll & other verifiable & auditable data in uniform format per CMS PBS specifications when failed to accurately report 24 hr/day LN coverage on 4 days between 7-1-23 & 9-30-23 & 6 dates between 10-1-23 & 12-31-23

F880 Infection Prevention & Control

SE: SS=F: Failed to track & trend infections to prevent spread of infections amongst residents

- IC Surveillance logbook lacked culture reported to determine causative organisms for infection for 2 wound infection, 3 UTIs & 2 oral infections; failed to monitor infections in facility to determine trends in causative organisms & types of infections to prevent spread of infections

SW: SS=D: Failed to implement infection control measurements by failure to cleansing hands between glove changes during wound dressing change

- *Observed LN provide wound care & failed to cleanse hands after removing soiled gloves & donning on clean gloves throughout dressing changes; failed to implement infection control measurements for 1 resident by not cleansing hands between gloves during wound care*

NE: SS=D: Failed to ensure staff prevented cross-contamination during incontinence care for 1 resident & failed to disinfect Hoyer lift between resident usage placing affected residents at risk for infection & related complications

- *Cited findings noted in F550 r/t inappropriate incontinent care; failed to ensure staff prevented cross-contamination during incontinence care for 1 resident & failed to disinfect Hoyer lift between resident usage placing affected residents at risk for infection & related complications*

NE: SS=E: Failed to implement signage or indicators within physical environment to alert staff & visitors of required EBP; failed to sanitize shared equipment between use; failed to ensure staff performed adequate hand hygiene, ensure trash was stored & contained properly & that spills or leakage was cleaned under DR sinks placing residents at risk for infectious diseases

- Observed 2 large trash gabs on floor; observed cabinet area with puddle of brown substance in lower cabinet; observed PPE room w/o signage or indicators that resident on EBP for resident with PEG tube; observed room with EBP w/o signage or indicators resident on EBP for resident with open wound; observed CNA used Hoyer & did not disinfect Hoyer lift before used lift then took same lift to another room & transferred resident w/o cleaning or disinfecting lift; observed CNAs provide perineal care w/o changing gloves between soiled & clean areas

NE: SS=E: Failed to implement signage or indicators within physical environment to alert staff & visitors of required EBP; failed to sanitize shared equipment between use; failed to ensure staff performed adequate hand hygiene; failed to ensure respiratory equipment was stored in sanitary manner when not in use placing residents at risk for infectious diseases

- Failed to implement signage or indicators within physical environment to alert staff & visitors of required EBP; failed to sanitize shared equipment between use; failed to ensure staff performed adequate hand hygiene & that respiratory equipment was stored in sanitary manner placing residents at risk for infectious diseases

NE: SS=F: Failed to ensure staff followed EBP & failed to ensure staff performed appropriate hand hygiene during med pass failed to assess, ID risks & create plan to address risk for Legionella disease or other opportunistic waterborne pathogens placing residents at risk for infectious diseases

- Resident on EBP w/o sign on room door denoting type of isolation or PPE required; observed LN performed wound care w/o wearing isolation gown; CNA performed catheter care w/o wearing isolation gown

- CMA performed BP & after doffed gloves & did not perform hand hygiene prior to preparing meds; CMA prepared meds & placed Seroquel in pill cutter & disinfected tablet cutter with disinfectant wipe then doffed gloves but did not perform handy hygiene before continuing med pass
- Facility unable to provide Legionella water management plan & maintenance staff reported had not done anything with Legionella plan

NW: SS=F: Failed to conduct risk assessment to ID risks & implement water management program to mitigate risk of Legionella disease placing residents in facility at risk for infectious disease

- Failed to conduct a risk assessment to ID risks & implement water management program to mitigate risk of waterborne pathogens placing residents who resided in facility at risk for contracting Legionella disease

F881 Antibiotic Stewardship Program

SE: SS=F: Failed to ensure staff adhered to principles of antibiotic stewardship thru monitoring for appropriate use of ABT prescribed for residents to prevent antibiotic resistance & spread of multidrug resistant organisms within facility

- DON stated lacked training on facility's computerized infection monitoring system; DON confirmed lack of completion of computerized infection monitoring system & lack of antibiotic stewardship for residents of facility; failed to provide ongoing antibiotic stewardship to ensure appropriate antibiotic use for residents of facility to prevent antibiotic resistance & spread of multidrug resistant organisms

F882 Infection Preventionist Qualifications/Role

NE: SS=F: Failed to designate a staff member employed by facility at least part-time with required qualification & certification as Infection Preventionist (IP) who was responsible for facility's Infection Prevention & Control Program placing all residents at risk for lack of ID, tracking, trending, & tx of infections

- DON stated facility w/o IP currently & nurse consultant had been conducting IP duties currently; Failed to designate a staff member employed by facility at least part-time with required qualification & certification as Infection Preventionist (IP) who was responsible for facility's Infection Prevention & Control Program placing all residents at risk for lack of ID, tracking, trending, & tx of infections

F883 Influenza & Pneumococcal Immunizations

NE: SS=D: Failed to offer &/or obtain informed declination for 2 resident's PCV20 placing residents at increased risk for complications r/t pneumonia

- Failed to offer &/or obtain informed declination for PCV20 vaccine for 2 residents placing residents at increased risk for pneumonia

F921 Safe/Functional/Sanitary/Comfortable Environment

SE: SS=F: Failed to ensure safe & sanitary environment for residents & staff of facility

- Observed floor covered with black grime build up at entrance directly in front of ice machine throughout floor; direct storage on wood shelving; crumpled paper towels directly on floor; walls with missing paint on edges of wall; floor unsanitizable due to missing paint/sealant directly in front of ice machine

F941 Communication Training

NE: SS=F: Failed to ensure agency staff received required communication training placing residents at risk for impaired care & decreased quality of life

- Failed to ensure completion of required communication training for staff who provided care in facility placing residents at risk for impaired care & decreased quality of life

NE: SS=E: Failed to ensure CNA received required effective communication training placing residents at risk for impaired communication

- *Cited findings noted in F550 r/t interaction with CNA & resident; failed to ensure CNA received required effective communication training placing residents at risk for impaired communication*

F942 Resident Rights Training

NE: SS=F: Failed to ensure agency staff received required resident rights training placing residents at risk for impaired care & decreased quality of life

- Failed to ensure completion of required resident rights training for staff who provided care in facility placing residents at risk for impaired care & decreased quality of life

NE: SS=E: Failed to ensure CNA received required resident rights training placing residents at risk for impaired resident rights & loss of dignity

- *Cited findings noted in F550, F942; failed to ensure CNA received required resident rights training placing residents at risk for impaired resident rights & loss of dignity*

F945 Infection Control Training

NE: SS=F: Failed to ensure agency staff received required infection control training placing residents at risk for impaired care & decreased quality of life

- Failed to ensure completion of required infection control training for staff who provided care in facility placing residents at risk for impaired care & decreased quality of life

NE: SS=F: Failed to ensure agency direct care staff had received required infection control training placing residents at risk for impaired care & decreased quality of life

- Records for multiple agency staff revealed lack of training completed for infection control; failed to ensure agency direct care staff had received infection control training placing residents at risk for impaired care & decreased quality of life

F947 Required In-Service Training for Nurse Aides

NE: SS=F: Failed to ensure 1/3 CNAs sampled had required 12 hours of in-service education placing residents at risk for decreased quality of life & inadequate care

- Records revealed 1 CNA had not completed any of required in-services in past 12 months; failed to ensure 1/3 CNAs reviewed had required 12 hours of in-service education placing residents at risk for decreased quality of life & inadequate care

October 2024

F550 Resident Rights/Exercise of Rights

NW: SS=D: Failed to provide dignity & quality of life for 2 resident by having uncovered urinary collection bag visible to guests other residents placing residents at risk of embarrassment & undignified living environment

- Failed to cover residents' urinary catheter bag placing resident at risk for embarrassment & undignified living environment
- Failed to ensure dignity for 1 resident when staff took resident to DR with catheter bag uncovered & urine visible to other residents placing resident at risk for impaired dignity & decreased quality of life

F553 Right to Participate in Planning Care

SE: SS=E: Failed to provide CP meetings for 4 residents as required

- Failed to provide CP meeting for resident/representative as required for multiple residents

NE: SS=D: Failed to include 1 resident's representative in development & planning of resident's CP placing resident at risk of impaired care & decreased autonomy

- EMR lacked documentation resident or representative was invited to care conferences on 2 occasions in 2024; representative stated had only been invited to 1 CP & desired to attend each care conference; failed to include 1 representative in development & planning of resident's CP placing resident at risk for impaired care & decreased autonomy

F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to ensure 1 resident's call light was within reach leaving resident vulnerable to unmet care needs due to inability to call for staff assistance

- Observed resident in bed with call light on floor out of resident's reach; failed to ensure 1 resident's call light was within reach leaving resident vulnerable to unmet care needs

NE: SS=D: Failed to ensure 1 resident was given a lipped plate & meat was cut up into bite-size portions; further failed to ensure 1 resident's call light was within reach leaving 2 residents vulnerable to unmet care needs

- Failed to ensure 1 resident was given a lipped plate & meat was cut up into bite-size portions per CP instructions leaving resident vulnerable to unmet care needs
- Failed to ensure 1 resident had call light to communicated needs placing resident at risk for unmet care needs

F561 Self-Determination

SE: SS=D: Failed to ensure 1 resident received appropriate preparations for scheduled surgery

- Resident with paraplegia; POS for Eliquis; NN documented lack of pre-op orders realized by nursing staff when resident refused to take blood thinner for planned surgery; observed gauze pad covering old PEG site with drainage; resident stated desired to return home but had to overcome many obstacles & return home; resident stated PEG had been surgically closed but failed & scheduled for another attempt at closure but staff did not hold blood thinner & iron & surgery had to canceled & had been rescheduled which resident felt further delayed plans to return home; failed to ensure preop orders were obtained for resident's planned procedure which resulted in rescheduling of procedure for 27 days further delaying resident's progress toward goal of returning home

F565 Resident/Family Group & Response

NE: SS=E: Failed to address & resolve recurring issues reported by Resident Council placing residents at risk for decreased psychosocial wellbeing

- Review of Resident Council meeting noted indicated council with recurring concerns with food choices, menus, temps & availability & concerns r/t maintaining & cleaning shower rooms & getting showers as scheduled; failed to adequately address & resolve recurring issues reported by Resident Council placing residents at risk for decreased psychosocial wellbeing & impaired quality of life

F567 Protection/Management of Personal Funds

NE: SS=E: Failed to ensure residents had same-day access to funds for amounts less than $100 placing residents at risk for decreased psychosocial wellbeing & impaired rights

- Sign on hallway door read "Bank open 3p-5p Monday through Fridays"; observed resident outside business office & resident stated waiting for bank to open to get funds; 3 resident council members reported bank only open on Mondays thru Fridays for 2 hours;

Adm stated residents could not access money outside listed hours or at all on weekends; failed to ensure residents had same-day access to funds for amounts less than $100 placing 29 residents at risk for decreased psychosocial wellbeing

F576 Right to Forms of Communication with Privacy

NE: SS=C: Failed to provide mail delivery on Saturdays

- Failed to provide mail delivery on Saturdays

NE: SS=D: Failed to deliver mail to facility residents on Saturdays

- Failed to deliver mail to residents in facility n Saturdays

F580 Notify of Changes

NE: SS=D: Failed to notify 1 resident's representative of changes r/t falls placing resident at risk for uninformed treatment or care decisions

- NN documented resident with fall with possible injury & was sent to hospital & representative notified; multiple NN documented resident with falls & representative notified; representative stated had only been notified of 1 fall; failed to notify 1 resident's representative of changes r/t falls placing resident at risk for uninformed treatment decisions

F582 Medicaid/Medicare Coverage/Liability Notice

NE: SS=D: Failed to provide form CMS-10055 ABN for 2 residents placing residents at risk for uninformed decisions

- Failed to issue 2 residents correct SNF ABN form CMS-10055 placing residents at risk for uninformed decisions

F584 Safe/Clean/Comfortable/Homelike Environment

NE: SS=E: Failed to promote sanitary, homelike environment with potential for decreased psychosocial wellbeing & impaired safety & comfort for affected residents

- Observed strong urine odor on 2 hallways upon entrance; observed multiple food trays with previous evening's partially eaten meals on kitchen transport cart & multiple flies landed on food; dining hall with flies in area of exposed food & trays; DR with dried food particles & residue on floor throughout DR; observed resident in w/c in DR & multiple flies continued to land on resident as slept at table; numerous residents swatted flies away from meals as ate meals in DR; resident council acknowledged fly issues

NE: SS=E: Failed to promote a safe, homelike environment with potential for decreased psychosocial wellbeing & impaired safety & comfort for affected residents

- Observed wedge cushions, BR commode, walker & IV pole in hall; shower bed & w/c's stored in resident area; step ladder, walker & w/c stored in resident area; w/c & Broda stored next to emergency exit in hall; BR with soiled towels on floor & substance o floor of lower tiles on shower; Resident Council reported repeated concerns r/t cleanliness of BR

F585 Grievances

NE: SS=E: Failed to implement system to allow residents & representatives to file grievances anonymously placing residents at risk for decreased psychosocial wellbeing & unresolved grievances & concerns

- Observed no designated grievance drop boxes or system available in areas accessible to residents & visitors of facility; resident council reported unaware facility provided way to complete anonymous grievances & took grievance to staff member; failed to implement a system to allow residents &/or representatives to file grievances anonymously within facility placing residents at risk for decreased psychosocial wellbeing & unresolved grievances

F604 Right to be Free from Physical Restraints

SE: SS=J (Abated to G): Failed to ensure 1 resident who had hx of self-harm & physically & verbally aggressive behaviors, remained free of physical or chemical restraints when on 9-8-24, 9-19-24 & 9-20-24 resident attempted to injure self & became combative with staff & staff chemically & physically restrained resident; failed to ID resident's Medical/behavioral symptoms that warranted use of chemical restraint, physical restraint of 5-6 staff & use of bedsheet to further restrain resident

- *Record lacked any physician orders r/t use of restraints, any specific documentation r/t assessment of resident for restraint use &/or person-centered CPing which included use of physical restraints or least amount of restriction/time possible &/or ongoing evaluation placing resident in immediate jeopardy*
- *Abatement Plan:*
  - *Facility completed violence risk screening on all current residents*
  - *Revised CP for residents ID'd at high risk for assault ID'd in screening tool*
  - *Educated staff on Federal Guidelines on use of restraints*
  - *Assigned online training for Handling Aggressive Behaviors, Overview of ANE of Individuals with IDD, Understanding Wandering & Elopement & Meaning Behind Behaviors*

F623 Notice Requirements Before Transfer/Discharge

NE: SS=D: Failed to provide written notification of transfer to 1 resident/representative for facility-initiated transfers; also failed to notify LTC Ombudsman for 1 resident with risk of miscommunication between facility & resident/family & possible missed opportunities for healthcare service for resident

- Facility unable to provide evidence that LTCO notified of resident's facility-initiated transfer to hospital on 3 hospitalizations; facility unable to provide evidence that written notification of transfer issued for 1 resident for 3 hospitalizations; failed to provide written

notification of transfer to resident/representatives for facility-initiated transfer; failed to provide notification to LTCO for resident with risk of miscommunication between facility & resident/family & possible missed opportunities for healthcare service for resident

NE: SS=D: Failed to provide written notice for facility-initiated transfers for 3 residents/representatives when residents were transferred to hospital; also failed to notify LTC Ombudsman of resident's discharges placing residents at risk for uninformed care choices

- Failed to provide written notice of facility-initiated transfer to resident/representative when resident transferred to hospital & also failed to notify LTC Ombudsman of discharge placing resident at risk for uninformed care choices & impaired resident rights for multiple residents

F625 Notice of Bed Hold Policy Before/Upon Transfer

NE: SS=D: Failed to provide bed hold policy notice to 1 resident/representatives when resident transferred to hospital with risk for impaired ability to return to facility & to previous room

- Failed to provide bed hold notice to 1 resident/representative when resident transferred to hospital with risk of impaired ability to return to facility or same room for resident

F636 Comprehensive Assessments & Timing

SE: SS=E: Failed to complete an accurate MDS for 3 residents r/t incomplete triggered Behavioral Symptoms & Psychosocial Wellbeing CAAs for triggered area of Behavioral symptoms for 1 resident & r/t to incomplete CAAs for all triggered area

- Behavioral Symptoms CAA & Psychosocial Wellbeing CAA both triggered but lacked analysis of findings; failed to complete accurate MDS for dependent resident with behaviors by failing to complete triggered CAAs on admission MDS
- Behavioral Symptoms & Psychosocial Wellbeing CAAs triggered but lacked analysis of findings; failed to complete accurate MDS for dependent resident with behaviors by failing to complete triggered CAA on admission MDS
- CAA triggered but lacked required analysis of findings r/t causes, contributing factors &/or rationale for: urinary incontinence, falls, nutritional status, psychotropic drug & pain CAAs; failed to complete CAA analysis of findings as required r/t comprehensive VMD for resident to address underlying cause, risk factors & other contributing factors to ensure resident received care based on individual needs

NE: SS=D: Failed to fully complete annual MDS for 1 resident by not completing documentation analysis for triggered care areas placing resident at risk for inaccurate reflections of resident's status & inaccurate CP

- Failed to ensure staff fully completed annual comprehensive MDS for 1 resident when staff did not complete documentation analysis for triggered care areas placing resident at risk for inaccurate reflections of resident's status & incomplete comprehensive CP

F641 Accuracy of Assessments

SE: SS=D: Failed to complete accurate MDS for 4 residents r/t antipsychotics for 1 resident, rejection of care for 1 resident, hospice for 1 resident & CPAP for 1 resident

- MDS lacked accurate documentation to reflect use of antipsychotic med when resident with POS for Lurasidone HCl for bipolar d/o; failed to complete accurate MDS for resident r/t use of antipsychotic med
- BIMS of 13 & received antipsychotic & antidepressant; MDs lacked indication of behavior of rejection of care & CP documented resident with not complying with tx or care; failed to accurately assess resident's behavior of refusal of meds as rejection of care on Sig Change MDS as required
- Resident with MS, BIMS of 11 & on hospice; failed to complete 2 MDSs for dependent resident on hospice
- CP lacked staff instruction r/t use & care of CPAP; MDS inaccurately documented resident did not use CPAP during assessment period; failed to accurately complete 2 MDS for dependent resident with CPAP machine

F656 Develop/Implement Comprehensive CP

SE: SS=D: Failed to develop comprehensive CP for 3/18 residents reviewed; 1 resident lacked Cp for use of CPAP, 1 resident for hx of suicide ideation & 1 resident lacked personalized fluid restriction CP

- Failed to develop comprehensive CP to include resident's hx of suicide ideation to ensure optimal psychosocial functioning
- Failed to develop comprehensive CP for resident's fluid restriction to ensure optimal psychosocial functioning
- Failed to complete comprehensive CP for dependent resident who used CPAP machine while resident slept

SE: SS=D: Failed to complete a comprehensive CP for 1 resident r/t care & maintenance of personal humidifier

- Failed to complete comprehensive CP to include staff instruction for care & maintenance for dependent resident with personal humidifier

F657 Care Plan Timing & Revision

SE: SS=D: Failed to review & revise CPs for 2 residents r/t footrests for w/c's

- Failed to review & revise dependent resident's CP to include staff instruction r/t use of footrests while being propelled by staff for multiple residents

NW: SS=D: Failed to revise CP for 1 resident on EBP placing resident at risk for impaired care due to uncommunicated care needs

- CP lacked any direction for staff r/t EBP care & precautions; failed to revise CP to include EBP placing resident at risk for impaired care due to uncommunicated care needs

F661 Discharge Summary

NW: SS=D: Failed to provide a resident-specific detailed discharge summary & complete recapitulation of stay for 1 resident placing resident at risk for unidentified & unmet care needs

- Record lacked evidence of recapitulation of resident's stay in facility; failed to provide a resident-specific detailed discharge summary & complete recapitulation of stay for resident placing resident at risk for unidentified & unmet care needs

F676 Activities of Daily Living (ADLs)/Maintain Abilities

NE: SS=D: Failed to provide required ADL assistance for 1 resident for dressing placing resident at risk for impaired independence & loss of ADL function

- Failed to provide assistance for 1 resident with dressing placing resident at risk for impaired independence with loss of ADL function
-

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to ensure 2 residents received grooming assistance

- Observed resident with several days' worth of facial hair; failed to ensure dependent resident received grooming to maintain personal comfort & appearance to enhance dignity
- Observed resident with brown substance running down lower lip to bottom of chin & staff did not wipe substance from resident's face; failed to provide personal hygiene r/t facial hygiene to resident requiring staff assist

F679 Activities Meet Interest/Needs Each Resident

NE: SS=E: Failed to provide consistent activities for residents placing affected residents at risk for decreased psychosocial wellbeing, isolation & boredom

- Activity Calendar indicated 4 scheduled staff-led activities throughout day for each day; observed no staff-led morning or afternoon activities occurred on multiple days; on 10-7 walkthrough of facility revealed September activity calendars still posted thru facility; failed to provide consistent activities for residents placing affected residents at risk for decreased psychosocial wellbeing, isolation & boredom

F680 Qualifications of Activity Professional

NE: SS=E: Failed to provide a certified activity professional to direct activity program in facility placing affected residents at risk for impaired quality of life

- Facility unable to provide evidence for activity coordinator as requested; Adm Nurse stated facility's AD recently "let go" & facility didn't currently have anyone to fill role; failed to provide certified activity professional to lead facility activities program placing affected residents at risk for impaired quality of life

F684 Quality of Care

SE: SS=D: Failed to properly position 2 residents r/t footrests for w/c's

- Failed to properly position dependent resident in w/c while propelling resident by not having footrests for resident's feet for multiple residents

NE: SS=D: Failed to follow a physician's order for weight monitoring for fluid overload & further failed to ensure 1 resident's PRN diuretic administered per orders when needed placing resident at risk for fluid overload & related complications

- Failed to follow a physician's order for weight monitoring for fluid overload & further failed to ensure resident's PRN diuretic was administered per orders when needed placing resident at risk for fluid overload & related complications

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to ensure 1 resident's palm splint was available placing resident at risk for discomfort & decreased ROM

- EMR lacked direction for staff to apply palm splint; EMR lacked documentation or evidence of refusals to wear palm splint; failed to ensure 1 resident's palm splint was placed in palm placing resident at risk for discomfort & decreased ROM

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=E: Failed to secure potentially hazardous equipment, O2 tanks & chemicals in safe, locked area & out of reach of 11 cognitively impaired independently mobile residents placing affected residents at risk for preventable accidents & injuries

- Observed unsecured O2 storage room contained 40 pressurized supplemental O2 cylinders in storage rack; observed unsecured furnace closets with multiple bottles of labeled hazardous chemicals; observed beauty shop with labeled accessible hazardous chemicals

NE: SS=E: Failed to secure potentially hazardous cleaning chemicals in safe, locked area, & out of reach of 10 cognitively impaired independently mobile residents; additionally failed to ensure implemented CP'd fall interventions were in place for 2 residents placing affected residents at risk for preventable accidents & injuries

- Failed to ensure safe environment free from hazardous chemicals for 10 cognitively impaired independently mobile residents placing residents at risk for preventable accidents & injuries
- Failed to promote safe care environment r/t implementing CP'd fall mat & ensuring bed remained in low position placing resident at risk for falls & related injuries
- Failed to ensure 1 resident's call light was within reach & further failed to ensure resident's wedge was placed appropriately to ensure resident would not fall out of bed placing resident at risk for further falls

NE: SS=G: Failed to ensure 1 resident remained free from avoidable accidents when staff failed to provide care safely using required number of staff per resident's CP; subsequently resident sustained dislocated shoulder & fx'd humerus placing resident at risk for increased pain & impaired wellbeing

- *NN documented representative expressed concerns about resident being transferred with mechanical lift & felt it was not being used consistently by all facility staff & requested order to have PT screen resident for falls, transfers & recliner safety; staff reported not consistently able to access EMR for instructions on cares for residents; CNA stated not fully aware of how resident transferred or how resident received cares; LN stated CNA informed LN that CNA attempted to get resident's wet gown off when resident jolted forward & CNA could not catch resident; failed to ensure resident remained free from avoidable accidents resulting in dislocated shoulder & fx'd humerus placing resident at risk for increased pain & impaired wellbeing*

NW: SS=J (Past Non-compliance): Failed to ensure 1 resident's safety needs were met during transportation from dialysis

- *On 10-21-24 resident was picked up from dialysis by transportation driver CNA, 21 miles from facility; CNA failed to strap resident's w/c into van with front safety harnesses; stopped at stop light & when drove away, resident's w/c fell backwards in van & resident hit head on w/c ramp; CMA pulled over & was able to get resident back in w/c & transported resident to ER; at ER resident dx'd with multiple cervical spine fx's placing resident in immediate jeopardy*
- *Abatement Plan:*
  - *Completed ANE education with all facility staff*
  - *Performed Driver Basic Skills Validation with approved drivers*
  - *Implemented Pre-Transportation Safety Checklist & would be monitored weekly x 4 weeks, every 2 wks x 4 weeks then monthly x 4 months*
  - *CMA terminated*

F690 Bowel/Bladder Incontinence, Catheter, UTI

NW: SS=D: Failed to provide catheter care & services consistent with standards of practice for 1 resident when staff failed to monitor urine output, failed to ensure tubing was anchored appropriately & failed to manage tubing & urine collection bag in sanitary & dignified manner placing resident at risk for catheter-related complications including dislodgement & UTI

- Failed to provide catheter care consistent with standards of practice when staff failed to monitor urine output, failed to ensure tubing was anchored appropriately, & failed to manage tubing & urine collection bag in sanitary & dignified manner placing resident at risk for catheter-related complications including dislodgement & UTI

F692 Nutrition/Hydration Status Maintenance

NW: SS=D: Failed to monitor 1 resident's physician-ordered fluid restriction placing resident at risk of complications r/t fluid overload

- POS for fluid restriction of 2000 mL per 24-hr period; record lacked evidence staff monitored & recorded fluid intake; failed to monitor resident's physician-ordered fluid restriction placing resident at risk for complications r/t fluid overload

F695 Respiratory/Trach Care & Suctioning

SE: SS=D: Failed to provide 2 residents who required respiratory care, including trach care & tracheal suctioning provided such care, consistent with professional standards of practice, comprehensive person-centered CP, residents' goal & preferences r/t storage of suctioning cannulas/tubing to when not in use to prevent infection

- Failed to provide required respiratory care to resident including trach care & tracheal suctioning, consistent with professional standards of practice r/t storage of suctioning cannulas/tubing to when not in use to prevent infection & cross contamination to prevent infection for multiple residents

SE: SS=D: Failed to properly clean & maintain humidifier in 1 resident's room

- Failed to properly clean & maintain dependent resident's personal humidifier

F698 Dialysis

SE: SS=D: Failed to ensure staff accurately monitored 1 resident fluid restriction as ordered by physician

- Failed to ensure all staff were aware of resident's fluid restriction & failed to develop a personalized plan for fluid restriction per resident's preferences to ensure compliance

SE: SS=D: Failed to ensure staff provided assessment & monitoring for 1 resident who received dialysis 3x/wk

- Failed to evaluate resident's status pre-dialysis 3/10 dialysis tx's from 9-30-24 thru 10-16-24 & failed to evaluate resident's status post-dialysis tx 10/10 times from 9-30-24 thru 10-16-24 to ensure resident had no adverse effects of tx

F730 Nurse Aide Performance Review-12 hr/yr In-Service

NE: SS=F: Failed to ensure 3/5 CNA staff reviewed had yearly performance evals completed placing residents at risk for inadequate care

- Failed to ensure 3/5 CNAs reviewed had required yearly performance evals completed placing residents at risk for inadequate care

F732 Posted Nurse Staffing Information

NE: SS=C: Failed to maintain 18 months of daily posted nurse hours as required

- Failed to retain daily posted nursing staffing data for 18 months as required

F742 Treatment/Services Mental/Psychosocial Concerns

SE: SS=J (Abated to G): Failed to acknowledge & respond appropriately to 1 resident's behaviors which aligned to treatment & services r/t psychosocial d/o & physical aggression r/t dx

- *Cited findings noted in F604; Resident made multiple threats of violence against multiple others including guardian & self with multiple stated of self-harm ideation; staff chemically & physically restrained resident causing harm to resident; failed to acknowledge & respond appropriately to resident's behaviors which aligned to treatment & services r/t psychosocial d/o & physical aggression r/t dx; resident with hx of self-harm & physically & verbally aggressive behaviors, remained free of physical or chemical restraints on 3 days when resident attempted to injure self & became combative with staff & facility staff chemically & physically restrained resident*
- *Abatement Plan:*
    - *Facility completed violence risk screening on all current residents*
    - *Revised CP for residents ID'd at high risk for assault ID'd in screening tool*
    - *Educated staff on Federal Guidelines on use of restraints*
    - *Assigned online training for Handling Aggressive Behaviors, Overview of ANE of Individuals with IDD, Understanding Wandering & Elopement & Meaning Behind Behaviors*

F755 Pharmacy Services/Procedures/Pharmacist/Records

SE: SS=F: Failed to establish a system to keep drug records in order for all controlled drugs to be maintained & reconciled

- Narc count on 1 hall lacked 63 staff signatures from 10-1 thru 10-27; 1 hall lacked 30 signatures 10-1 thru 10-27; failed to establish a system to keep drug records in order for all controlled drugs to be maintained & reconciled

NE: SS=E: Failed to ensure controlled substances were accounted for & reconciled between shifts placing residents at risk for misappropriation &/or diversion of controlled substances

- Failed to ensure accurate reconciliation of controlled meds was completed placing residents at risk of medication misappropriation & diversion

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported inappropriate indication or lack of dx for 1 resident's Risperdal placing resident at risk for unnecessary meds & side effects

- POS for 0.5mg Risperdal q hs for "antipsychotic"; CP did not ID inappropriate indication listed for Risperdal; failed to ensure CP ID'd & reported lack of dx &/or inappropriate indication for 1 resident's Risperdal placing resident at risk for unnecessary meds & side effects

NE: SS=D: Failed to ensure CP ID"d & reported when 1 resident's BP med was given outside physician-ordered parameter placing resident at risk for unnecessary med administration & adverse side effects

- Failed to ensure CP ID'd & reported when 1 resident's Midodrine was given outside physician-ordered parameter placing resident at risk for unnecessary medication administration & adverse side effects

F757 Drug Regimen is Free from Unnecessary Drugs

SE: SS=D: Failed to ensure meds monitored & administered to treat resident's heart failure

- Resident with CHF; POS for Metoprolol Succinate ER with holding & notification parameters; MAR for previous month revealed drug outside ordered parameters on 5 occasions & record lacked documentation of resident's physician notification of meds administered outside prescribed parameters; failed to ensure meds monitored & administered to treat resident's heart failure

SE: SS=E: Failed to ensure 19 residents received physician ordered meds scheduled on 4-8-24 during 6pm-9pm med pass

- *Incident Report documented on 4-8-24 at 6pm Adm Nurse was working as charge nurse when CMA stated needed to leave; Adm Nurse misunderstood thinking CMA told had given all but 1 resident meds; on 4-9-24 at 5:30pm Adm Nurse received call from CMA asking who administered meds previous evening & that multiple residents had not received meds; failed to ensure 19 residents received physician ordered meds scheduled 4-8-24 during 6p-9p med pass*

SE: SS=D: Failed to ensure 1 resident received meds within physician ordered parameters

- Failed to ensure staff administered resident's Midodrine, used to increase BP was administered following physician's ordered parameters to prevent adverse reactions

NE: SS=D: Failed to ensure 1 resident's BP medication was given within physician-ordered parameter placing resident at risk for unnecessary medication administration & adverse side effects

- Cited findings noted in F756 r/t BP meds outside parameters; Failed to ensure 1 resident's Midodrine given within physician-ordered parameters placing resident at risk for unnecessary medication administration & adverse side effects

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SE: SS=E: Failed to ensure 10 residents received physician ordered psychotropic meds scheduled on 4-8-24 during 6p-9p med pass

- *Cited findings noted in F757 r/t meds not administered on 1 evening med pass; failed to ensure 10 residents received physician ordered psychotropic meds scheduled on 4-8-24 6p-9p med pass*

SE: SS=D: Failed to assess 1 resident for adverse effects of antipsychotic med

- Failed to ensure resident who received antipsychotic med did not display adverse effects of med through assessment of extra pyramidal movements

NE: SS=D: Failed to obtain physician-ordered test to monitor for side effects r/t use of psychotropic med for 1 resident; also failed to ensure 1 resident had CMS approved indication or appropriation dx for use of antipsychotic placing residents at risk for adverse medication effects & unnecessary meds

- EMR lacked evidence of EKG results for Nov 2023 & Aug 2024 & facility unable to provide evidence of EKG test results; failed to obtain physician-ordered EKG testing for 1 resident to monitor psychotropic med use placing resident at risk for adverse med effects & unnecessary meds
- Failed to ensure 1 resident's Risperdal med had appropriate CMS-accepted indication for use placing resident at risk for unnecessary meds & side effects

F760 Residents are Free of Significant Med Errors

NE: SS=G: Failed to ensure 1 resident remained free of significant med errors; on 12-28-23 facility received order from resident's psychiatric provider to DC AM dose of Clozaril but not hs double dose; LN DCd both morning & bedtime dose creating abrupt DC of medication resulting in increased auditory & visual hallucinations for resident causing resident significant psychosocial distress

- Resident with chronic schizophrenia; failed to ensure 1 resident remained free of significant med errors causing resident significant med errors causing resident significant psychosocial harm as evidenced by resident having increased auditory & visual hallucinations causing resident significant distress

F803 Menus Meet Resident Needs/Prep in Advance/Followed

NE: SS=E: Failed to ensure dietary staff provided posted menu items to residents when kitchen ran out of bacon & sausage for breakfast meal placing residents at risk of nutritional needs & preferences not being met

- Failed to ensure dietary staff provided posted menu items to residents when kitchen ran out of bacon & sausage for breakfast meal placing residents at risk of nutritional needs & preferences not being met

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NE: SS=E: Failed to ensure meals were served at palatable, safe, & appetizing temps for 4 residents placing residents at risk for risks r/t impaired nutrition & weight loss

- Failed to ensure meals were served at palatable, safe & appetizing temps placing residents at risk for risks r/t impaired nutrition & weight loss

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=D: Failed to ensure foods were stored, prepared & distributed in manner to prevent foodborne illness to residents

- Observed fridge with condiments lacking coverings over tips of squirt bottles; handwashing sink with black substance along back edge caulking & discolorations on sink back edges; air fryer/convection oven with splatters in interior; ice machine drain laid directly in drain w/o 2-inch air gap

NE: SS=F: Failed to ensure staff stored food items in accordance with professional standards for food service safety placing residents at risk of foodborne illness & cross-contamination

- Observed open bag of foods items stored on floor; fridge with open & undated condiments; undated, uncovered silver pan with produce & desserts

NE: SS=F: Failed to prepare, store, distribute & serve food under sanitary conditions for all residents in facility receiving meals from kitchen placing residents at risk for foodborne illness

- Observed fridge with opened, undated food items, expired/outdated items; observed fluorescent lights with stained covers, 1 pulled down & not adhered to ceiling, cracked; ceiling mounted AC unit blew air directly across food prep area & vent grills, water & condensation pipes covered with brown, greasy substance & with gray fuzzy substance

F838 Facility Assessment

NE: SS=F: Failed to conduct a thorough facility-wide assessment to determine resources necessary to care for residents competently during both day-to-day operations & emergencies placing all residents in facility at risk for unidentified care needs & inadequate care

- Facility Assessment lacked information stating specific staffing needed for each unit including nights & weekends & lacked number of RNs, LPNs, CMA, & CNAs needed for each unit; assessment lacked informed contingency plan for events that did not require activation of facility's emergency plan but had potential to impact resident care; assessment lacked plan to maximize recruitment & retention of direct care staff; failed to conduct a thorough facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations & emergencies placing all residents in facility at risk for unidentified care needs & inadequate care

F849 Hospice Services

NE: SS=D: Failed to ensure a collaborated CP which coordinated care & services provided by facility with care & services provided by hospice was developed & available for 1 resident creating risk for missed or delayed services & impaired care for 1 resident

- Failed to ensure collaboration between facility & hospice provider for 1 resident's end-of-life care creating a risk for missed or delayed services & impaired care for 1 resident

NE: SS=D: Failed to ensure a coordinated CP which coordinated care & services provided by facility with care & services provided by facility with care & services provided by hospice, was developed & available for 1 resident placing resident at risk for inappropriate end-of-life care

- Failed to ensure coordinated CP which coordinated care & services provided by facility with care & services provided by hospice was developed & available for 1 resident placing resident at risk for inappropriate end-of-life care

F851 Payroll Based Journal

SE: SS=F: Failed to electronically submit to CMS complete & accurate direct staffing information based on payroll & other verifiable & auditable data in uniform format according to specifications established by CMS when facility failed to accurately report weekend LN staffing for month of August 2024

- PBJ staffing report for August 2024 revealed facility failed to accurately report weekend LN staffing for month of August, 2024 on 9 occasions; DON stated would come in & work during weekends in August & hours not counted on PBJ r/t staff being salaried failed to electronically submit to CMS with complete & accurate direct staffing information based on PBJ specification established by CMS r/t LN staffing information when facility failed to accurately report weekend staffing for month f August 2024

F880 Infection Prevention & Control

SE: SS=D: Failed to ensure staff provided incontinence care in manner to prevent spread of infection for 1 resident with open wound on sacrum

- Observed CNA provided peri-care with wound; CNA used peri wipe to cleanse rectal area & wiped resident from rectum over wound; failed to ensure staff provided resident with bowel incontinence with appropriate incontinence care to prevent spread of infection

SE: SS=F: Failed to ensure staff provided EBP for 2 residents; failed to provide cleaning of 1 resident's CPAP & failed to provide urinary catheter care in sanitary manner to prevent spread of infections; failed to ensure 1 resident's dog maintained up-to-date vaccine status

- Resident with MRSA (a known MDRO) with wound; CP lacked intervention to include EBP; observed 2 LNs perform wound care & neither wore gown during procedure & both were unaware resident should be on EBP; failed to ensure staff implemented EBP for resident with chronic abscess & hx of MRSA to prevent spread of infection
- Resident with dialysis with dialysis port & observed CAN aided resident with dressing w/o donning PPE; failed to ensure staff implemented EBP for resident with dialysis access port & hx of MDRO infections to prevent spread of infection
- Failed to ensure 1 resident obtained annual vaccines for dog as required to prevent spread of infection
- Failed to clean resident's face mask of CPAP each morning after use
- Observed resident with catheter bag with tubing resting directly on floor under seat of w/c; failed to always keep catheter bag & tubing for dependent resident off floor

SE: SS=D: Failed to use proper hand hygiene while completing wound care for 1 resident

- Observed Adm nurse performed wound care & cleansed wound with wound cleanser & patted area dry then measured wound w/o changing gloves or performing hand hygiene; failed to perform proper hand hygiene while completing resident's wound care

NE: SS=E: Failed to ensure staff performed adequate hand hygiene, ensure respiratory equipment was stored in sanitary manner & further failed to ensure linens were stored in sanitary manner placing residents at risk for infectious diseases

- Observed nebulizer mask directly on bedside table & mask not in sanitary container
- Observed w/c with unbagged O2 tubing coiled around back arm of w/c
- Observed clean linen next to soiled linen bin & clean linen cover left open next to soiled bin
- Observed 1 CNAs donned gloves w/o performing hand hygiene & after procedure removed gloves w/o performing hand hygiene after removing gloves or upon leaving room
- Failed to ensure staff performed adequate hand hygiene, ensure respiratory equipment stored in sanitary manner & further failed to ensure linens stored in sanitary manner placing residents at risk for infectious diseases

NE: SS=E: Failed to implement signage or indicators within physical environment to alert staff & visitors of required EBP; additionally failed to follow sanitary infection control practices r/t O2 equipment, laundry services, & wearing PPE placing residents at risk for infectious diseases

- Failed to implement signage or indicators within physical environment to alert staff & visitors of required EBP; additionally failed to follow sanitary infection control practices r/t O2 equipment, laundry services, & wearing PPE placing residents at risk for infectious diseases

NW: SS=D: Failed to adhere to infection control for EBP for 1 resident who had open wound on calf placing resident at risk for infection

- Observed LN entered room & donned gloves to perform wound care but failed to wear full PPE in EBP room & was unaware needed to wear appropriate PPE for EBP; failed to adhere to infection control standards & policies for 1 resident who required EBP placing resident at risk for infection

F883 Influenza & Pneumococcal Immunizations

NE: SS=D: Failed to administer PCV20 vaccination for 1 resident placing resident at increased risk for complications r/t pneumonia

- Failed to provide 1 resident with PCV20 vaccination as consented placing resident at increased risk for acquiring, transmitting or experiencing complications from pneumococcal disease

F908 Essential Equipment, Safe Operating Condition

SE: SS=D: Failed to maintain patient care equipment in safe operating conditions to ensure 2 resident's commode grab bars & over toilet commode

- Observed over-toilet commode contained legs that wobbled when pressure applied to armrests, making it unstable
- Observed commode grab bars in resident's BR unstable & moved when resident attempted to sit or rise from commode; failed to ensure commode grab bars for 1 resident & over toilet commode for 1 resident were maintained in safe condition to prevent accidents

SE: SS=E: Failed to ensure all resident equipment in 1/4 neighborhoods were in clean, safe condition r/t 1 toilet seat riser with legs & handles

- Observed toilet seat riser with multiple rusty areas over all leg & plastic toilet seat with crack where it met residents' buttocks; failed to ensure all resident equipment in 1 neighborhood was clean & in safe condition

NE: SS=E: Failed to ensure necessary equipment remained in safe & functional status placing residents at risk for impaired quality of life

- Failed to ensure necessary equipment remained in safe 7 functional status placing residents at risk for impaired quality of life r/t broken pipe in shower room & out-of-order sink in med room

F921 Safe/Functional/Sanitary/Comfortable Environment

SE: SS=E: Failed to ensure clean environment in 1/4 neighborhoods r/t soiled, stained privacy curtains in shower room in 1/4 neighborhoods

- Observed 2 privacy curtains with multiple areas dirty & stained; failed to ensure clean environment in 1/4 neighborhoods r/t soiled, stained privacy curtains in shower room in 1/4 neighborhoods

F925 Maintains Effective Pest Control Program

NE: SS=E: Failed to provide effective pest control to ensure facility was free from pests placing residents at increased risk for impaired comfort & disease

- Cited previous findings r/t multiple flies in DR & vending area & on residents; failed to provide effective pest control to ensure facility was free from pests placing residents at increased risk for impaired comfort & disease

November, 2024

F600 Free from Abuse, Neglect & Exploitation

SE: SS=J (Abated to D): Failed to ensure staff ID'd & responded appropriately to all allegations of abuse to include resident-to-resident sexual abuse when independently mobile resident grabbed other resident's breast without other resident's consent; failure placed resident in immediate jeopardy due to lack of facility response & reasonable person concept r/t sexual assault & negative impact on other resident's psychosocial wellbeing & feelings r/t other resident's safety; facility also failed to thoroughly investigate 2 employee-to-resident abuse allegations which involved a 3rd resident when several bruises were documented & facility did not investigate as potential abuse &/or report to state agency or local police of multiple bruises of unknown origin placing residents at risk for abuse & continued negative impact on physical, mental & psychosocial wellbeing

- *CP lacked any interventions r/t sexual abuse incident directed to female resident; POS lacked documentation directing staff to monitor for behaviors of anxiety/agitation; NN documented resident grabbed at staff & had been sexually inappropriate when resident slapped/spanked CNA on buttocks on multiple occasions; observed resident located directly across hallway from other resident's room; other resident reported resident had grabbed breast when other resident was leaving DR & other resident reported was in "shock, scared, uncomfortable & embarrassed" during incident & was glad someone intervened that day; during interview other resident had tears in eyes; failed to ensure staff ID'd & responded appropriately to all allegations of abuse including resident-to-resident sexual abuse when independently mobile resident when resident grabbed other resident's breast w/o consent placing residents in immediate jeopardy due to lack of facility response & reasonable person concept to sexual assault & negative impact to other resident's psychosocial wellbeing & feeling safe*
    - *Abatement Plan*
        - *Resident placed on 1:1 & would remain on 1:1 until alternative living arrangements made &/or medication implemented to decrease sexual urges*
        - *Follow up interview conducted & other resident denied being afraid of resident or that other resident was fearful of living across hall from resident & felt safe living at facility & had no complaints*
- *Failed to thoroughly investigate 2 employee-to-resident abuse allegations which involved 3rd resident when several bruises were documented & facility did not investigate as abuse &/or report to state agency or local police of multiple bruises of unknown origin placing residents at risk for abuse & continued negative impact on physical, mental & psychosocial wellbeing*

F610 Investigate/Prevent/Correct Alleged Violation

SE: SS=J (Abated to D): facility failed to ensure staff protected residents from sexual abuse, when independently mobile Resident grabbed other resident's breast without other resident's consent. This failure placed other resident and other female residents in immediate jeopardy

due to the facility did not place interventions to protect other residents and other female residents who resided in the facility, from other resident's unwanted sexual abuse/assault. This failure placed the residents at risk for abuse and continued negative impact on their physical, mental, and psychosocial well-being.

- *Cited findings noted in F600; failed to ensure staff protected residents from sexual abuse, when independently mobile resident grabbed other resident's breast without her consent. This failure placed other resident and other female residents in immediate jeopardy due to the facility did not place interventions to protect other resident and other female residents who resided in the facility, from resident unwanted sexual abuse/assault. This failure placed the residents at risk for abuse and continued negative impact on their physical, mental, and psychosocial well-being.*
- *Abatement Plan:*
    - *Resident placed on 1:1 & would remain on 1:1 until alternative living arrangements made &/or medication implemented to decrease sexual urges*
    - *Follow up interview conducted & other resident denied being afraid of resident or that other resident was fearful of living across hall from resident & felt safe living at facility & had no complaints*

F657 Care Plan Timing & Revision

SE: SS=D: Failed to revise 1 resident's CP to include resident's ID'd behaviors toward male residents placing resident at risk for impaired care due to uncommunicated care needs

- CP did not address resident's behaviors towards male peers; NN documented resident walked around unit holding hands with male residents & both residents observed entering other resident rooms with resident leading male resident; failed to revise resident's CP to include identified behaviors toward male residents placing resident at risk for impaired care due to uncommunicated care needs

F679 Activities Meet Interest/Needs of Each Resident

SE: SS=E: Failed to provide activities on weekends that reflected residents' interests & preferences placing affected residents at risk for decreased psychosocial wellbeing, boredom & isolation

- Sept, Oct, & Nov Activity Calendar revealed no activities scheduled on any Saturdays for all months reviewed & church services on Sunday mornings & reading activity on Sunday afternoons; resident council reported facility did not provide activities on Saturdays & would like more activities than just Church; failed to provide activities on weekends which reflected residents' interests & preferences placing affected residents at risk for boredom, isolation & decreased quality of life

F689 Free of Accident Hazards/Supervision/Devices

NW: SS=J (Past Non-Compliance): Failed to ID & implement interventions & failed to provide adequate supervision to prevent elopement for 1 resident who was cognitively impaired & at high risk for elopement

- *On 8-8-24 & 10-28-24 facility documented resident elopement risk but did not implement any interventions or update resident's CP to alert staff r/t resident's elopement risk; on 10-30-24 staff last saw resident at 7:30am & at approx. 10:30am facility received phone call from community member stating elderly man walking on grounds of facility; facility did head count & realized resident not in facility; window open & resident had chiseled wooden blocks that were screwed into windowsill with butter knife, allowing resident to open & exit window; resident walked to farm store in locality 0.3 miles from facility*
- *Past Non-Compliance Plan:*
    - *Resident placed on 1:1 with staff & facility notified resident's PCP & resident's representative*
    - *New wandering assessment completed*
    - *Elopement book reviewed & updated*
    - *CP updated*
    - *AdHoc meeting held with Medical Director*
    - *Maintenance secured windows in resident's room*
    - *Maintenance checked all windows in facility to ensure stoppers in place*
    - *Education provided to all staff on elopement & ANE*

NW: SS=G (Past Non-Compliance): Failed to transfer 1 resident safely with gait belt & in process of transfer staff lifted resident by both arms & resident sustained broken humerus placing resident at risk for injury, pain, & delayed healing

- *Incident Note documented CNA asked for assist from LN for assist of transfer of resident; resident limp & flaccid, unresponsive & skin clammy; staff transferred resident into bed & heard & felt a loud "pop" in resident's arm when lifted resident for transfer; LN noted resident's deltoid area bulging out & shoulder higher than other; failed to transfer resident safely with gait belt resulting in broken humerus placing resident at risk for injury, pain, & delayed healing*
- *Past Non-Compliance Plan:*
    - *Educated all staff r/t gait belt use with transfers & following CPs*
    - *Performing gait belt audits randomly throughout varying shifts x 4 wks*
    - *"Gait Belts & Transfer Policy" revised & documented gait belts provided to assist staff in safely transferring or ambulating residents & note use of gait belt in CP*

F756 Drug Regimen Review, Report Irregular, Act On

SE: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported antipsychotic med used w/o CMS approved indication for use for 3 residents placing residents at risk for adverse med effects & unnecessary meds

- Resident with dementia & increased issues with mood & behaviors; POS for Seroquel for delusion r/t depression; POS for Seroquel r/t psychotic d/o with delusions; MRRs from November 2023 thru October 2024 lacked evidence or documentation that CP ID'd unapproved indication for resident's Seroquel; LN unaware of approved indication for use of antipsychotic; failed to ensure CP ID'd & reported non-CMS-approved indication for 1 resident's antipsychotic med placing resident at risk for adverse med effects & unnecessary meds
- POS for Seroquel for depression for psychotic features & refractory severe depression; MRRs lacked evidence or documentation that CP ID'd unapproved per CMS indication for Seroquel; failed to ensure CP ID'd & reported non-CMS-approved indication for 1 resident's antipsychotic med placing resident at risk for adverse med effects & unnecessary meds
- POS for Lorazepam for restlessness or anxiety routinely; & PRN; EMR lacked evidence of physician-documented rationale including risk vs benefits for antipsychotic med w/o CMS-approved indication; EMR also lacked physician-documented rationale for extended duration of PRN Lorazepam; failed to ensure CP ID'd & reported non-CMS-approved indication for 1 resident's antipsychotic med placing resident at risk for adverse med effects & unnecessary meds

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SE: SS=E: Failed to ensure a CMS-approved indication of use or a documented physician rationale & risk vs benefits for continued use of antipsychotic for 4 residents; additionally failed to ensure physician documented rationale for extended duration of 1 resident's PRN psychotropic med placing residents at risk for adverse med effects & unnecessary meds

- Cited findings noted in F756; Failed to ensure appropriate indication of use or a documented physician rationale & risk vs benefits for continued use of antipsychotic for 1 resident placing resident at risk for unnecessary med effects
- Failed to ensure appropriate indication for use or a documented physician rationale & risk vs benefits for continued use of antipsychotic for 1 resident placing resident at risk for unnecessary med effects
- Failed to ensure physician-documented rationale which included risk vs benefits for 1 resident's Seroquel med given w/o CMS-approved indication placing resident at risk for unnecessary psychotropic meds & related complications
- Failed to ensure CMS-approved indication of use or documented physician rationale & risk vs benefits for use of Haldol for 1 resident; also failed to ensure physician documented rationale for extended use of PRN Lorazepam placing resident at risk for possible adverse effects & unnecessary meds

F760 Residents are Free of Significant Med Errors

SW: SS=J (Past Non-Compliance): Failed to prevent significant med error of cognitively impaired resident

- *On 10-11-24 CMA incorrectly administered resident's meds to another resident with J-tube which included Clopidogrel, MS ER, Acetaminophen; CMA drew a line thru resident's meds & documented "do not give meds"; later LN heard resident coughing, assessed oral cavity & found 4 tablets in resident's mouth, removed tablets to prevent coughing or choking due to resident's hx of aspiration pneumonia; failed to prevent significant med error of dependent & cognitively impaired resident when CMA incorrectly administered resident's meds, orally to resident who had J-tube placing resident in immediate jeopardy*
- *Past Non-Compliance Plan:*
  - *Facility asked CMA to complete witness statement & was escorted out of facility & placed CMA on "Do Not Return" list*
  - *LNs & CMAs provided education r/t med administration*
  - *LN & CMAs completed med administration checkoff observed by Unit Managers*

F849 Hospice Services

SE: SS=D: Failed to ensure collaboration r/t 1 resident's care between nursing home & hospice creating a risk for impaired end-of-life care for resident

- CP lacked which meds were provided by hospice, what equipment hospice supplied, frequency & dates hospice would assist with bathing, & frequency of hospice nurse visits; failed to ensure collaborative process was in place to communicate necessary information r/t 1 resident's care between nursing home & hospice placing resident at risk for impaired end-of-life care

F883 Influenza & Pneumococcal Immunizations

SE: SS=D: Failed to offer & administer or obtain an informed declination for PCV20 vaccination for 1 resident placing resident at increased risk for complications r/t pneumonia

- Resident administered PCV13 on 12-10-10 & PCV23 on 10-28-13; record lacked documentation PCV20 was discussed & offered; EMR lacked documentation of historical administration, informed declination or physician-documented contraindication for PCV20; failed to discuss & offer PCV20 or obtain informed declination for 1 resident placing resident at increased risk for complications r/t pneumonia