May, 2025 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

January, 2025

F657 Care Plan Timing & Revision

SW: SS=D: Failed to accurately revise 3 resident CP's failed to revise CP for 1 resident who had increased exiting behaviors, & actual elopements from facility; additionally failed to update & place appropriate fall interventions for 2 residents who had multiple falls placing residents at risk for uncommunicated care needs

- Failed to review & revise 1 resident's CP prior to 9-22-24 for exit seeking & elopement behaviors with potential to lead to uncommunicated needs which could result in additional falls with potential for injury or actual harm
- Failed to revise 1 resident's CP for 30 days after a fall with potential to lead to uncommunicated needs which could result in additional falls with potential for injury or actual harm
- Failed to review & revise 1 resident's person-centered CP r/t accident hazards & falls when facility failed to conduct appropriate fall investigations on 6-1-24, develop interventions to mitigate risk of falls or develop CP interventions to prevent additional falls on 9-12-24 & 1-8-25 with potential to lead to uncommunicated needs which could result in additional falls with potential for injury or actual harm

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=D: Failed to provide an environment that remained free from accident hazards for 4 residents; failed to ID, implement & re-evaluate fall prevention interventions to prevent falls for 2 residents: 1 resident with multiple falls with lack of appropriate fall interventions; additionally failed to implement new interventions to prevent 1 resident after resident had elopement from facility; failed to put effective smoking plan in place for 1 resident with potential to result in injury

- Failed to evaluate cognitively impaired resident smoking eval for safety & failed to CP resident's smoking privileges when resident admitted 78 days prior with potential to result in injury
- Failed to provide environment free of accident hazards when facility failed to conduct appropriate fall investigations on 6-1-24, develop interventions to mitigate risk of falls or develop CP interventions to prevent additional falls on 9-12-24 & 1-8-25 with potential to lead to additional falls with potential for injury or actual harm

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=D: Failed to ensure environment free of accident hazards when CNA did not follow standard of care & utilize another staff member assist during transfer of 1 resident from w/c to bed using Hoyer lift

- *Observed CNA transferred resident from w/c to bed using Hoyer lift by self; failed to ensure environment free of accident hazards when CNA transferred resident from w/c to bed with use of Hoyer lift & did not have additional staff member present for transfer*

SW: SS=G: Failed to follow 2 residents' CP's: 1 resident who sustained tibia fx during ambulation & 1 resident who slid off bed while on bedpan placing residents at risk for further falls & avoidable injury

- *Resident with partial staff assist for mobility & other ADLs; MDS documented resident with upper functional impairment on 1 side & had no falls; resident receiving Hospice services; quarterly MDS documented resident did not ambulate; resident with fall risk; CP with fall prevention interventions; Witness statement documented CNA sat resident up on side of bed, grabbed walker, counted to 3 & stood resident up; CNA stated stood behind resident as resident ambulated to BR "hovered hands around resident's waist as walked with resident"; resident's knee gave out & CNA put arms under resident's armpits & knee touched ground; CNA stated held resident's body off ground except for right knee; CNA then rotated resident to toilet, sat resident down & went to get assistance; facility called family & Hospice & family declined X-ray unless things seemed to get worse; NN documented right knee with swelling & resident c/o knee pain; NN documented knee swollen, bruised & tender to touch; family arrived & stated believed X-ray should be done; X-ray report documented acute fx of right tibia; POS for non-weight bearing; EMR documented resident expired 3 months later; failed to follow 1 resident's CP which resulted in tibia fx placing resident at risk for further falls & avoidable injury*
- *Resident with DM, HTN, CHF, edema, trochanteric fx rt femur & a-fib; CP documented staff to use cloth chucks as resident may slide off with paper chucks; fall investigation documented resident with unwitnessed fall & resident slid off bed while resident placed on bedpan; RCA documented paper chucks had been placed under resident; investigation documented resident placed on bedpan at 7:15am & at 7:42am staff heard resident yell for help when resident slid off bed; failed to follow resident's CP of not using paper chucks under resident which resulted in resident sliding off bed placing resident at risk for further falls & avoidable injury*

SW: SS=G: Failed to ensure 1 resident remained free of accident hazards r/t mechanical lift transfers when 1 resident obtained injury on 11-15-24 at approximately 7pm when unknown staff member failed to safely operate mechanical lift & transferred resident w/o another staff member present resulting in fx of resident's patella

- *Failed to ensure 1 resident remained free of accident hazards related to mechanical lift transfers when resident obtained an injury on 11/15/24 at approximately 07:00 PM when an unknown staff member failed to safely operate the mechanical lift. This deficient practice resulted in a fracture of resident's left patella and had the potential to negatively affect physical & psychosocial wellbeing of resident*

F692 Nutrition/Hydration Status Maintenance

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

- POS & CP directed staff to monitor for fluid overload & ensure resident on 2000cc mL per 24-hr fluid restriction; TAR lacked documentation staff monitored for resident's fluid restriction on 4 days in November; 11 days in December; 8 days to date in January; failed to monitor 1 resident's physician-ordered fluid restriction placing resident at risk of complications r/t fluid overload

NE: SS=G: Failed to implement interventions t prevent further weight loss for 1 resident after resident experienced significant weight loss & facility implemented initial intervention in September 2024; resident continued to experience significant weight loss & Consultant followed resident but did not recommend further interventions to prevent weight loss & facility failed to implement further weight loss prevention interventions resulting in significant weight loss of 25.6% for resident

- *Resident with generalized muscle weakness, mild intellectual abilities, cognitive communication deficit, need for assist with personal care & anxiety; set-up assist with eating; POS on 7-11-24 (admission date) for Juven BID for wound healing & DC'd 9-5-24; POS on 7-11-24 & DCd on 11-20-24 for liquid protein supplement BID; supplemental shakes ordered in Sept 2024; admission weight 199.0 #'s; 12-13-24 weight 164.2 #'s (25.6% loss); RD note documented suggestion for re-weight because suspected error in weight entry; physician progress notes noted weight loss; Mighty Shake administration w/o % of intake included; failed to implement interventions to prevent further weight loss for resident after she experienced a significant weight loss, and the facility implemented an initial intervention in September 2024. Resident continued to experience significant weight loss and Consultant followed resident but did not recommend further interventions to prevent weight loss and the facility failed to implement further weight loss prevention interventions resulting in a significant weight loss of 25.6% during her admission*

F695 Respiratory/Tracheostomy Care & Suctioning

SW: SS=D: Failed to properly clean nebulizer after each medication was administered for 2 residents in accordance with standards of care with potential to spread possible lung infections to residents

- Failed to provide respiratory care consistent with professional standards of care for 2 residents r/t cleaning of nebulizer equipment after each use when medication was administered with potential to spread possible lung infections to residents

NE: SS=D: Failed to provide necessary respiratory care & services for 1 resident placing resident at risk for infection & unwarranted physical complications

- *CP documented resident with COPD & emphysema; EMR documented Ipratropium-Albuterol q 8 hrs for COPD; TAR revealed lack of documentation that resident received treatments for 26/90 scheduled treatments in November, 17/93 scheduled treatments in December & 9/81 treatments from 1-1-25 to 1-27-25; observed nebulizer mask with tubing disconnected from mask & laid on floor; resident stated had not received breathing tx's as scheduled but could ask for them; failed to provide necessary respiratory care & services for 1 resident with risk for infection & unwarranted physical complications for 1 resident*

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

SW: SS=F: Failed to complete annual performance review at least once every 12 months for 2 CNAs reviewed to ensure adequate appropriate cares & services provided to residents of facility; facility ID'd 12 CNAs employed over 12-month period

- Failed to complete annual performance review at least once every 12 months for 2 CNAs reviewed, to ensure adequate appropriate cares & services provided to residents of facility with potential to negatively affect physical & psychosocial wellbeing of all residents in facility

F755 Pharmacy Services/Procedures/Pharmacist/Records

NE: SS=D: Failed to ensure availability of physician-ordered medications for 2 residents with risk for physical complications & less than desired/therapeutic effects of prescribed medications for 2 residents

- *CP documented resident received anticoagulant medication Eliquis r/t a-fib; POS for Eliquis 5mg BID for anticoagulant therapy; MAR documented for 10-12-24 to 1-9-25 documentation as "Hold/See Progress Notes" morning & evening doses; Admission note documented resident new residents & facility waited on delivery of Eliquis; multiple further notes documented "facility waited on delivery of Eliquis; EMR lacked evidence facility notified provider about Eliquis supply issue; POS for Montelukast in evening for allergies; MAR documented med held until available; multiple NN documented facility waited on delivery of med; EMR lacked facility notified resident's provider about med supply issue; POS for Ropinirole for Parkinson's disease; multiple NN documented facility did not have med & med held until delivered; EMR lacked evidence facility notified provider of supply issue; failed to ensure availability of physician-ordered meds for 1 resident with risk for physical complications & less than desired/therapeutic effects of prescribed meds for 1 resident*
- *CP documented resident with chronic pain r/t arthritis & POS for Tramadol scheduled; POS for Tamsulosin HCl for BPH; Multiple NN documented facility waited on delivery of medication; POS for tramadol qid for pain; multiple NN documented resident "out" of*

drug & waited on delivery; failed to ensure availability of physician-ordered meds for 1 resident with risk for physical complications & less than desired/therapeutic effects of prescribed meds for resident

F756 Drug Regimen Review, Report Irregular, Act On

SW: SS=E: Failed to ensure Consultant Pharmacist (CP) reviewed each resident's drug regimen monthly & reported irregularities to attending physician, facility Medical Director, & DON monthly for 5 residents

- EMR from 1-1-24 thru 1-1-25 lacked monthly CP regimen reviews for last year; Adm nurse stated "it had been awhile since she had received any information regarding monthly CP regimen reviews"; failed to ensure CP completed monthly medication regimen reviews for 5 residents placing residents at risk for receiving inappropriate doses of medications

SW: SS=F: Failed to ensure physician responded in timely manner to monthly medication regimen reviews for 3 residents r/t psychotropic meds & for 1 resident when physician failed to provide appropriate rationale when declined a CP recommended GDR for psychotropic meds with potential to lead to residents receiving meds unnecessarily

- Failed to ensure that 1 resident's medication remained free of unnecessary meds when facility failed to ensure resident's physician responded in timely manner to GDR request from CP for multiple residents

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SW: SS=D: Failed to ensure 4 residents remained free of unnecessary psychotropic meds when facility failed to ensure physician responded in timely manner to monthly MRRs for 3 residents & for 1 resident when physician failed to provide appropriate rationale when they declined MRR for GDR for psychotropic meds with potential to lead to residents receiving meds unnecessarily

- Cited findings noted in F756 r/t lack of physician or complete physician response to consultant pharmacist MRRs r/t psychotropic meds; failed to ensure residents' meds remained free of unnecessary psychotropic meds when facility failed to ensure that resident's physician responded in timely manner to GDR request from consultant pharmacist with potential to lead to residents receiving unnecessary psychotropic meds with negative physical & psychosocial outcomes for multiple residents
- Failed to have PRN anti-anxiety med re-evaluated every 14 days
- Failed to ensure 14-day stop date or physician rationale for continued use beyond 14 days for 1 resident's PRN psychotropic med, Restoril with potential for resident to receive unnecessary psychotropic med

F760 Residents are Free of Significant Med Errors

SW: SS=D: Failed to ensure 2/5 residents reviewed during medication administration pass remained free of medication errors for 2 residents placing residents at risk for adverse reactions from medication

- POS for Protonix DR 1 tab daily for maintenance therapy; observed LN crushed resident's morning meds I plastic med cup then poured pills in plastic med bag & crushed med then placed crushed med in plastic med cup & added applesauce then administered crushed med to resident; LN stated crushed med r/t difficult swallowing of resident; staff verified extended-release meds should not be crushed; failed to ensure resident remained free from med errors when staff crushed delayed-release med prior to administration placing resident at risk for adverse reactions from medication
- POS for Oxybutynin XL ER daily for overactive bladder; observed LN crushed meds including extended-release Oxybutynin; failed to ensure resident remained free from med errors when staff crushed extended-release med prior to administration placing resident at risk for adverse reactions from med

F761 Label/Store Drugs & Biologicals

SW: SS=E: Failed to provide safe environment by failure to ensure med cart containing prescription meds, narcotic meds in locked box within med cart & OTC & tx cart containing insulin, topical ointments & creams, remained locked when not in direct line of vision of nurse in area where residents could access it

- Failed to provide safe environment for residents by failure to ensure med care & nurse tx cart remained locked when not in direct line of vision of licensed nurse responsible for carts

F801 Qualified Dietary Staff

SW: SS=F: Failed to employ a full-time CDM for all residents residing in facility & receiving meals from facility kitchen placing residents at risk for inadequate nutrition

- Failed to employ a full-time CDM for all residents residing in facility & received meals from kitchen placing residents at risk of not receiving adequate nutrition

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SW: SS=F: Failed to store, prepare, distribute & serve food by professional standards for food service safety in facility kitchen placing residents receiving meals from facility's kitchens at risk for foodborne illness

- Observed: multiple unlabeled, undated food items; sherbet container with dried substance on outside of container; dry storage area with ceiling with dried brown stain; missing drawers in cabinet; cabinet with peeling paint; wall above dishwasher with multiple paint chips; pipes under dishwasher with gray-black substance; freezer with unsealed food items

SW: SS=F: Failed to store prepare & serve food in sanitary manner for all residents receiving meals from facility kitchen

- Observed: multiple opened, undated food items; floor storage in freezer; utensil drawers with wrinkled paper towel soiled utensils in drawers, drawers with dried food & spills in bins; 1/6 fluorescent light covers with cracks

SW: SS=F: Failed to follow sanitary dietary standards r/t storage of food placing residents at risk for foodborne illnesses

- Observed open, undated food items; unlabeled food items in fridge

F880 Infection Prevention & Control

SW: SS=F: Failed to implement a water management program for waterborne pathogens including Legionella disease placing residents in facility at risk for infectious disease

- Maintenance staff stated did not have any type of diagram of facility's water system or a water management program in place to prevent growth of Legionella or any other waterborne pathogen; failed to implement a water management program to test & manage waterborne pathogens placing residents at risk residing in facility at risk for contracting Legionella pneumonia

SW: SS=F: Failed to implement water management program for Legionella disease placing residents at risk for contracting infectious processes

- Adm staff reported facility lacked waterborne pathogen/Legionella program; failed to implement water management program & manage waterborne pathogens placing residents residing in facility at risk for contracting Legionella pneumonia

SW: SS=F: Failed to maintain an effective infection control program related to the lack of hand hygiene when incontinent care was provided to 1 resident and improper removal of PPE after care provided to 1 resident. The facility staff failed to wear proper PPE when emptying a drainage bag and when changing the leg bag to the gravity drainage bag. The facility failed to provide respiratory care consistent with professional standards of care for 2 residents, regarding the cleaning of the nebulizer equipment after each use when medication was administered with potential to spread possible infections to the residents in the facility

- Failed to maintain an effective infection control program related to the lack of proper hand hygiene when incontinent care was provided to 1 resident and improper removal of PPE after cares were performed. The facility staff failed to wear proper PPE when emptying a catheter, a drainage bag and when changing the leg bag to the gravity drainage bag. The facility failed to provide respiratory care consistent with professional standards of care for 2 residents regarding the cleaning of the nebulizer equipment after each use when medication was administered. This deficient practice had the potential to spread possible infections to the residents in the facility

F883 Influenza & Pneumococcal Immunizations

SW: SS=D: Failed to provide proper documentation of vaccination or declination of vaccines for COVID-19 for 1 resident; also failed to provide documentation of pneumococcal for 1 resident

- EMR lacked documentation that COVID vaccine was offered or had been declined
- EMR for 1 resident lacked documentation of any pneumococcal vaccine or COVID vaccine being given or declination of vaccines; failed to provide proof of vaccination or declination of vaccines for COVID vaccine & pneumococcal vaccines for 2 residents with potential to lead to outbreak or respiratory infections with residents in facility

F947 Required In-Service Training for Nurse Aides

SW: SS=D: Failed to ensure 3/5 CNAs completed required 12-hour annual in-service placing residents at risk for receiving unskilled care

- 3 CNA & CMA files lacked evidence staff had required 12 hours of in-service training; failed to ensure CNAs received annual required 12-hour in-services placing residents at risk for receiving unskilled care

February, 2025

F550 Resident Rights/Exercise of Rights

SE: SS=D: Failed to show respect & dignity to 1 resident r/t staff dressing resident in tops which were too large for resident & hung on resident, exposing bare skin

- Observed resident in w/c & collar of t-shirt hung down low, exposing much of resident's bare chest on multiple occasions; CNA stated resident had lost weight & clothing no longer fit appropriately; failed to dress dependent resident in well-fitted clothing instead of too large of clothing which was sliding down & exposing resident's bare skin

F600 Free from Abuse & Neglect

NE: SS=J: Past Non Compliance to G: Failed to prevent an episode of resident-to-resident sexual abuse for cognitively impaired resident; on 2-8-25 facility staff witnessed resident groping other resident's nipples, breast, & buttocks while both were seated at dinner table on locked unit for cognitively impaired residents; other resident voiced did not consent to resident touching other resident placing other resident in immediate jeopardy & at risk for ongoing &/or unidentified abuse & feelings of fear for other resident based on reasonable person concept

- *CP documented resident with hx of inappropriate or unacceptable sexual behaviors r/t psychiatric illness; CP documented resident had been moved to another unit due to exhibiting sexually inappropriate behaviors r/t sexual behavioral episode with other resident; incident report documented resident observed by staff touching other resident's breast & buttocks during meal service & resident moved away from other resident & placed on 1:1 supervision; failed to ensure cognitively impaired resident remained free from abuse when facility failed to prevent episode of resident-to-resident sexual abuse placing resident at risk for ongoing &/or unidentified abuse & mistreatment based on reasonable person concept; practice resulted in feelings of fear for resident & placed resident at risk for further psychosocial harm, intimidation & neglect; facility failed to ID & implement preventative interventions r/t resident's sexual behaviors upon moving resident to new unit placing 19 female residents at risk for sexual abuse*
- *Plan of Removal:*
    - *Resident immediately placed on 1:1 supervision until psychiatric eval completed*

- *Facility ID'd all at-risk resident on new unit*
- *Staff provided in-service upon hire, annually & post-allegation on ANE with comprehensive testing*
- *Safe survey conducted on female residents of new unit*
- *Psychiatric eval to be completed*

F610 Investigate/Prevent/Correct Alleged Violation

NE: SS=G: Failed to implement effective preventative interventions r/t 1 resident's sexual behaviors to protect female resident sin facility including cited other resident placing 19 female residents at risk

- *Cited findings noted in F600 r/t witnessed resident-to-resident sexual abuse; failed to implement effective preventative interventions r/t 1 resident's sexual behaviors to protect female residents of facility placing other resident & 19 female residents at risk*

F623 Notice Requirements Before Transfer/Discharge

SE: SS=D: Failed to provide written notification of reason & location for facility-initiated transfer for 1 resident placing resident at risk for delayed care or uncommunicated care needs

- Failed to provide written notification of reason & location for facility-initiated transfer to hospital for 1 resident/representative placing resident at risk of delayed care or uncommunicated care needs

F625 Notice of Bed Hold Policy Before/Upon Transfer

SE: SS=D: Failed to provide 1 resident/representative with written notice specifying duration & cost of bed hold policy at time of resident's transfer to hospital

- Resident admitted to hospital with sepsis; EMR lacked signed bed-hold for resident's hospital admission; failed to provide resident/representative with written notice specifying duration & cost of bed-hold policy at time of resident's transfer to hospital

SW: SS=D: Failed to provide 1 resident with written information r/t facility bed hold policy when resident transferred to hospital placing resident at risk for not being permitted to return & resume residence in nursing facility

- EMR with copy of bed hold policy lacing resident/representative signature, instead had signature of Adm Nurse; failed to provide 1 resident's representative with copy of facility bed hold policy when resident transferred to hospital placing resident at risk for not being permitted to return & resume residence in nursing facility

F641 Accuracy of Assessments

SE: SS=E: Failed to accurately complete MDS for 3 residents: 2 r/t falls; 1 r/t antidepressant med placing residents at risk for uncommunicated care needs

- Failed to accurately complete MDS r/t falls placing resident at risk for uncommunicated care needs
- Failed to accurately complete MDS for 1 resident r/t continence status & restorative care placing resident at risk for uncommunicated care needs
- Failed to complete accurate MDS for dependent resident who received antidepressant medication
- Failed to complete accurate MDS for dependent resident with falls

F656 Develop/Implement Comprehensive Care Plan

SE: SS=D: Failed to develop & implement comprehensive person-centered care plan for 1 resident r/t use of electric recliner

- Failed to develop & implement comprehensive person-centered CP for dependent resident who used electric recliner in room

F657 Care Plan Timing & Revision

SE: SS=E: Failed to review & revise CPs for 5 residents including 3 residents r/t failure to review & revise CP to include EBP; 1 resident r/t use of antianxiety medication & 1 resident r/t use of footrests on resident's w/c

- CP lacked staff instruction r/t EBP for use of indwelling urinary catheter; failed to review & revise CP to include EBP r/t indwelling urinary catheter for 2 residents
- CP lacked staff instruction on use of antianxiety medication & need for EBP due to resident's PU; failed to review & revise resident's CP to include EBP r/t PU & failed to review & revise resident's CP r/t use of antianxiety medication
- CP lacked staff instruction r/t resident's need for staff assist with propelling w/c & use of foot pedals while staff propel resident in w/c; failed to review & revise CP to include staff instruction to use footrests while propelling resident in w/c

SE: SS=D: Failed to accurately revise 1 resident's CP after falls & failed to revise 1 resident's CP for PU care placing residents art risk for uncommunicated care needs

- Failed to revise 1 resident's CP after falls placing resident at risk for uncommunicated care needs with potential to have a negative effect on overall physical & psychosocial wellbeing of resident in facility
- Failed to revise 1 resident's CP to reflect care need for pressure area placing resident at risk for uncommunicated care needs with potential to have negative effect on overall physical & psychosocial wellbeing of resident in facility

SE: SS=D: Failed to revise 1 resident's CP to reflect current transfer requirements; additionally failed to revise 1 resident's hospice (dialysis?) CP'd interventions placing residents at risk for impaired care due to uncommunicated care needs

- Failed to revise 1 resident's CP to reflect current transfer requirements placing resident at risk for impaired care due to uncommunicated care needs when resident required transfer with Hoyer lift with 2 staff members assist
- Failed to revise 1 resident's CP to include change in dialysis days & monitoring of fluid restriction r/t CKD placing resident with unmet care needs or complications r/t dialysis

SW: SS=D: Failed to implement a person-centered care plan with individualized interventions to address 1 resident's post-traumatic stress disorder, trauma, triggers, and interventions to prevent re-traumatization. These deficient practices placed resident at risk for decreased psychosocial well-being and ineffective treatment.

- CP lacked CAA to address dx of PTSD to direct staff on triggers or interventions to prevent further re-traumatization; failed to have a person-centered care plan with individualized interventions to address resident's PTSD triggers and interventions to prevent re-traumatization. These deficient practices placed resident at risk for decreased psychosocial well-being and ineffective treatment.

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to ensure 2 residents regarding staff not dressing resident in clean clothing for 1 resident & 1 resident regarding not assisting resident at meal times as CP'd

- Observed resident in recliner wearing sweatshirt with dried liquid & food on front on multiple occasions; failed to ensure dependent resident was dressed in clean clothing at all times
- CP instructed staff that resident required staff to feed resident at mealtimes; Adm nurse placed spoon in resident's hand & encouraged resident to feed self; resident made multiple attempts but unable to get food from plate to mouth with spoon; staff did not offer to "feed" resident; failed to feed dependent resident who required staff assist at mealtimes

F684 Quality of Care

SE: SS=D: Failed to leave shoes off 1 resident r/t resident having abrasions on 2nd toe of rt foot & 2nd & 3rd toe of lt foot

- Failed to leave shoes off 1 resident as ordered due to abrasions on 2nd toe of rt foot & 2nd & 3rd toe of lt foot

SE: SS=D: Failed to evaluate 1 resident's risks & abilities r/t handling hot liquids placing resident at risk for preventable accidents & injuries

- EMR lacked documentation that indicated facility followed up with risk assessment to ensure resident could safely manage hot liquids, if resident required assistance or if resident required special utensils for heated drinks; resident reported had spilled coffee on self but not able to ID what caused spill & stated resident sometimes struggled to hold cups; failed to evaluate 1 resident's risks & abilities r/t handling hot liquids placing resident at risk for preventable accidents & injuries

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

SE: SS=D: Failed to care & provide services to promote healing of existing PU for 1 resident r/t stage 2 PU behind lt ear & 1 resident for failure of ensuring resident with pressure reducing cushion to w/c

- Failed to provide care & services to promote healing of existing PU r/t padding to back of resident's lt ear
- Failed to properly assess PU & revise resident's CP to reflect care need for pressure area placing resident at risk for uncommunicated care needs

F688 Increase/Prevent Decrease in ROM/Mobility

SE: SS=D: Failed to ensure 1 resident was provided services & tx to prevent worsening of contractures in lt hand placing resident at risk for discomfort & decreased ROM

- Observed resident with lt hand hung down with fingers slightly closed; resident stated did not have anyone who assisted resident with ROM to hand r/t case he did not have insurance to cover cost of therapy; Adm nurse stated CNAs would provide any restorative programs for residents & would be referred to therapy if declined in ROM; failed to ensure 1 resident received services & tx for contractures to prevent avoidable reduction in ROM leaving resident at risk for further decline & discomfort

F689 Free of Accident Hazards/Supervision

SE: SS=D: Failed to provide safe transportation for 1 dependent resident r/t failure to use footrests while transporting resident in w/c; also failed to ensure CP'd fall interventions were in place

- Observed CMA propelled resident in w/c & resident wore non-skid socks which skimmed floor during transport; w/c lacked footrests on multiple occasions; failed to provide safe transportation for dependent resident by failing to use footrests while being propelled in w/c
- Resident with dementia; fall risk with hx of falling; CP lacked mention of w/c resident used when resident had pain or weakness; resident with multiple documented falls with & w/o injuries; observed resident with no fall mat in place as CP'd; no non-skid strips as CP'd on multiple occasions; observed resident w/o shoes removed & non-skid socks put on as CP'd; failed to ensure CP'd fall interventions were in place for 1 resident placing resident at risk for continued falls

SE: SS=E: Failed to ID, implement & re-evaluate fall prevention interventions to prevent falls including failing to provide a call light within reach for 1 resident, when staff performed unsafe transfers & failed to follow CP for 1 resident & failed to follow CP by failing to provide call light within reach for 2 residents placing residents at risk for falls with injury

- Failed to implement new interventions to prevent falls after multiple falls placing resident at risk for further falls
- Failed to follow fall prevention interventions to prevent falls for cognitively impaired resident with hx of falls at facility when staff did not ensure resident's call light was within reach & functioning placing resident at risk for further falls with injury

- Failed to practice safe transfers for dependent resident who was unable to bear weight during transfers; furthermore, failed to complete "Electric Recliner Assessment" for confuse resident who was fund to be physically & cognitively unable to safely operate electric lift chair
- Failed to ensure dependent resident had call light within reach for resident to use to call for staff assistance

SE: SS=D: Failed to safely transfer resident

- CP instructed staff resident required 2 staff & use of gait belt when transferred; observed staff transferred resident & resident unable to bear any weight; failed to safely transfer dependent resident who was unable to bear any weight

SE: SS=D: Failed to ensure 1 resident's safety r/t following CP'd fall interventions placing resident at risk for preventable falls

- CP instructed staff that resident always to have Dycem in chair; observed resident w/o Dycem in place on multiple occasions; failed to ensure resident's safety r/t following care-planned fall interventions of Dycem in chair placing resident at risk for preventable falls & injuries

SW: SS=D: Failed to promote an environment free of hazards for 1 resident who smoked cigarettes but was assessed for supervised safe smoking practices by the facility, however the resident revoked the assessment, and smoked without supervision. This placed the resident at risk for avoidable injuries and fire related hazards

- Resident's " Care Plan" for smoking recorded resident had been "sneaking out" with independent smokers and was continually educated that resident was a "supervised" smoker. The 08/06/24 updated care plan documented the resident was required to wear a smoking apron when smoking. On 05/26/23 the facility provided the resident with a "smoking apron"; resident documented with burn on wrist from cigarette; resident received further injuries from burns while sneaking out to smoke w/o supervision; failed to promote safe environment for 1 resident & all residents residing in facility placing residents at risk for smoke or fire

NW: SS=G: Failed to ensure 1 resident was secured with safety belt in mechanical spa lift chair during transfer out of spa tub resulting in resident falling from spa lift chair & resident sustained fx'd femur

- *NN documented nurse alerted by spa tub & spa toilet call lights & LN observed resident laid in spa tub on hip with arm tucked behind resident's back; spa lift chair beside tub; resident with blood visible to lt nostril & bruise on nose; resident c/o feeling sore & called out, "it hurts"; during transfer resident called out in pain when rt lower extremity moved; rt leg noted shorter than lt; DPOA wished resident sent to ER for eval; resident admitted to hospital & referred to ortho for femur fx; failed to ensure staff safely secured resident in spa lift chair safety belt resulting in resident falling from spa lift chair & resident sustained rt femur fx requiring surgical repair*

F692 Nutrition/Hydration Status Maintenance

SE: SS=D: Failed to ID & implement nutritional interventions r/t 1 resident's continued weight loss placing resident at risk for malnourishment-related complications

- EMR documented resident with weight loss of 26.4 #'s; nursing staff unaware of weight loss; failed to ID ongoing weight loss & implement nutritional interventions r/t resident's weight loss placing resident at risk for malnourishment-related complications

F697 Pain Management

NW: SS=G: Failed to obtain PRN pain med prescribed to resident after total hip replacement; further failed to follow resident's discharge orders r/t acetaminophen being given qid on scheduled basis & instead put order into EMR as PRN requiring resident to ask for pain medication

- *Resident admitted to facility for skilled care for rehab after total hip replacement; POS for Oxycodone 5mg PRN q 6 hrs; Acet 1000mg q 6 hrs scheduled & to DC Norco; facility failed to try to obtain oxycodone 5mg med until following day; local pharmacy did not have any Oxycodone & instead of checking with 12 other pharmacies in town to see if they had Oxycodone 5mg, they had medical director prescribe Norco 5/325 q 6 hrs PRN; resident told nursing staff multiple times over weekend resident was taking Oxycodone 5mg PRN & Norco 5/325 PRN at home before hip replacement & Norco 5/325 did not help pain & staff did nothing to help alleviate resident's pain over weekend after Friday admission placing resident at risk for unalleviated pain, decreased ability to participate in rehab, inability to sleep & psychosocial impairment; failed to obtain PRN pain med resident was prescribed after total hip replacement; further failed to follow resident's dismissal orders r/t acetaminophen being given 4x/day on scheduled basis & instead put order into EMR for PRN requiring resident to ask for pain med w/o resident's knowledge placing resident at risk for unalleviated pain, decreased ability to participate in rehab, inability to sleep & psychosocial impairment*

F698 Dialysis

SE: SS=D: Failed to ensure 1 resident had physician order for hemodialysis that included indication; also failed to follow physician order for fluid restriction for resident placing resident at risk for adverse outcomes & physical complications r/t dialysis

- Record lacked physician order for dialysis; record lacked documentation of fluid restriction was monitored for fluid overload or dehydration; failed to monitor 1 resident's fluid restriction & ensure resident had physician for dialysis placing resident at risk of potential adverse outcomes & physical complications r/t dialysis

SW: SS=D: Failed to provide ongoing care plan communication and documentation of 1 resident who received dialysis treatment, including updated care, and services required for resident. This deficient practice placed resident at risk for inadequate care, complications, and health decline.

- Failed to provide staff with accurate dialysis CP communication with updated care information for 1 resident placing resident at risk for unmet needs & care & health decline

F699 Trauma Informed Care

SW: SS=D: Failed to identify trauma-based triggers related to 1 resident's PTSD. The facility failed to implement individualized interventions to prevent re-traumatization to resident. These deficient practices placed resident at risk for decreased psychosocial well-being and ineffective treatment.

- CP lacked CAA to address resident's dx of PTSD to direct staff on triggers or interventions to prevent further re-traumatization; failed to ID trauma-based triggers r/t resident's PTSD; further failed to implement individualized interventions to prevent re-traumatization to resident placing resident at risk for decreased psychosocial wellbeing & ineffective treatment

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

SE: SS=F: Failed to complete annual performance review at least once every 12 months for 2/5 CNAs to ensure adequate appropriate cares & services provided to residents of facility

- Failed to complete annual performance review at least every 12 months for 2 CNAs employed greater than 1 year, to ensure appropriate cares & services were provided to residents of facility

F740 Behavioral Health Services

NE: SS=D: Failed to implement effective behavioral monitoring & interventions r/t 1 resident's ongoing sexual behaviors toward female residents placing resident at risk for continued behavioral episodes & unmet care needs

- *Cited findings noted in F600 & F610 r/t inappropriate sexual behaviors to 1 resident then lack of new interventions when resident moved to a different unit with 19 other female cognitively impaired residents; failed to implement effective behavioral monitoring & interventions r/t 1 resident's ongoing sexual behaviors toward female residents placing resident at risk for continued behavioral episodes & unmet care needs*

F744 Treatment/Service for Dementia

SE: SS=D: Failed to ensure staff provided necessary person-centered activities & interventions to address 1 resident's dementia dx which included need for close supervision to prevent resident from wandering & falls placing resident at risk for ineffective tx & decreased quality of care

- CMA stated usually only person working on memory care unit so unable to provide activities as time was spent providing personal cares; CMA stated this resident did not usually attend activities off the memory care unit; failed to ensure staff provided necessary person-centered activities & interventions to address resident's dementia dx which included need for close supervision to prevent resident from wandering & falls placing resident at risk for ineffective treatment & decreased quality of care

F755 Pharmacy Services/Procedures/Pharmacist/Records

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

- Review of Dec, Jan & Feb count sheets revealed lack of 2 signatures on 5 occasions; overstock counts missing signatures on 4 days in Jan & Feb; 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

SE: SS=D: Failed to ensure Consulting Pharmacist (CP) ID'd & made recommendations r/t 1 resident's Midodrine placing resident at risk for unnecessary meds & potential side effects

- POS for Midodrine po TID for orthostatic hypotension; no BP monitoring parameters listed in orders; multiple doses administered outside physician-ordered parameters; failed to ensure CP ID'd & made recommendations r/t 1 resident's Midodrine medication placing resident at risk for unnecessary meds & potential side effects

SW: SS=D: Failed to ensure the Consultant Pharmacist (CP) identified and reported when 1 resident's physician ordered insulin administration and finger stick blood sugar had not been completed as ordered. This deficient practice placed resident at risk for unnecessary medication administration and related complications.

- Resident with POS for sliding scale insulin administration; TAR documented blood sugars to be obtained 4x/day; MAR/TAR documented lack of staff sign-off on Lantus insulin on 4/30 opportunities & lacked staff sign-off on Humalog insulin on 8/90 opportunities in 1 month; TAR lacked staff sign-off of 12/120 blood sugar readings; multiple months with similar findings; Review of CP monthly MRR lacked ID & reporting of missed physician-ordered insulin administrations & blood sugar readings; failed to ensure the CP identified and reported when 1 resident's physician-ordered insulin administration and finger stick blood sugar had not been completed as ordered. This deficient practice placed resident at risk for unnecessary medication administration and related complications.

F757 Drug Regimen is Free from Unnecessary Drugs

SE: SS=D: Failed to keep residents free from unnecessary drugs when facility gave an excessive dose of medication w/o provider notification that meds were held causing adverse complications for 2 residents placing residents at risk for future adverse complications

- Failed to keep residents free from unnecessary drugs when they gave excessive dose of antihypertensive med w/o notifying provider of holding meds causing adverse complications for 1 resident placing resident at risk for future adverse complications

- Failed to keep residents free from unnecessary drugs when failed to notify provider that insulin required to be held 9 times in 10 days with risk for adverse complications for 1 resident placing resident at risk for future adverse complications

SE: SS=D: Failed to ensure safe medication administration for 1 resident's Midodrine placing resident at risk for unnecessary meds & potential side effects

- Cited findings noted in F756 r/t administration of Midodrine outside physician-ordered parameters; failed to ensure safe medication administration for 1 resident's Midodrine medication placing resident at risk for unnecessary medications & potential side effects

SW: SS=D: Failed to ensure facility staff administered 1 resident's physician-ordered insulin and obtained finger stick blood sugars as ordered. This deficient practice placed resident at risk for unnecessary medication administration and related complications.

- Cited findings noted in F756 r/t multiple missing insulin administration & missing blood sugar levels in multiple months; failed to ensure staff documented and reported when 1 resident's physician-ordered insulin administration and finger stick blood sugar were not completed as ordered. This deficient practice placed resident at risk for unnecessary medication administration and related complications

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SE: SS=E: Failed to monitor 2 residents r/t failing to have stop date for PRN Lorazepam

- CP documented resident on comfort are; POS for Lorazepam 0.5mg po or sl q 4 hours PRN for anxiety & lacked stop date; failed to ensure 1 resident's PRN Lorazepam order had stop date
- CP lacked any documentation of Ativan as needed; POS for Ativan 0.5mg po PRN restlessness or yelling out with no stop date; failed to provide stop date for PRN Ativan medication for 1 resident

SE: SS=E: Failed to monitor 4 residents for use of antipsychotic meds & antipsychotic meds; further more, facility failed to monitor use of antianxiety medication

- Failed to complete an "Informed Consent" for dependent resident who received psychotropic meds for multiple residents

SE: SS=D: Failed to ensure an appropriate indication or a documented physician rationale for antipsychotic medication, and a gradual dose reduction was not attempted for 1 resident. The facility also failed to ensure 1 resident had physician rationale for continued use of as-needed psychotropic medications for an extended period beyond 14 days. These deficient practices placed the residents at risk for adverse medication effects and unnecessary medications.

- POS for Olanzapine 5mg po BID r/t violent behaviors dated 11-29-24; Adm nurse stated had noticed physician had not documented rationale for no GDR or approved indication for antipsychotic; failed to ensure appropriate indication or documented physician rationale for resident's Olanzapine med & physician rationale for no GDR on all psychotropic meds placing resident at risk for unnecessary psychotropic meds & related complications
- POS for Ativan 0.5mg po q 6 hrs PRN anxiety; Adm nurse stated physician had not documented rationale for continued use of resident's Ativan; failed to ensure physician provided appropriate rationale for continued use of PRN Ativan for 1 resident placing resident at risk for unnecessary medication administration & related complications

SW: SS=D: Failed to ensure 3 residents had an adequate CMS-approved indication for the use of an antipsychotic medication. This deficient practice placed 1 resident at risk for unnecessary medication administration and related complications.

- POS for Vraylar & physician response to CP's MRR documented "resident had a history of hallucinations. The resident tolerated the current dosage and a decrease would likely lead to increased signs and symptoms"; failed to ensure the physician provided a CMS-approved indication for the use of the antipsychotic medication Vraylar for 1 resident. This deficient practice placed resident at risk for unnecessary medication administration and related complications
- Resident with Alzheimer's disease POS for Risperidone 0.5mg BID for dementia with psychotic disturbances; MRR documented recommendation Risperidone not approved for anxiety with physician response r/t GDR per psychiatrist; failed to ensure physician provided CMS-approved indication for use of antipsychotic medication Risperidone for 1 resident placing resident at risk for unnecessary med administration & related complications
- Resident with dementia, anxiety d/o, psychosis; POS for Seroquel for major neurocognitive d/o; record lacked physician documentation which included rationale & risk vs benefit for continued Seroquel use; failed to ensure appropriate indication for use or required physician documentation for resident's Seroquel placing resident at risk for unnecessary psychotropic meds

F760 Residents are Free of Significant Med Errors

NW: SS=G: Failed to obtain (PRN) pain medicine prescribed to 1 Resident after total hip replacement. The facility further failed to follow resident's discharge orders regarding acetaminophen being given four times a day on a scheduled basis and instead put the order into resident's EMR as needed, requiring resident to ask for the pain medication. These significant medication errors placed resident at risk for unalleviated pain, decreased ability to participate in rehabilitation, inability to sleep, and psychosocial impairment.

- *Cited findings noted in F697 r/t lack of appropriate & accurate pain medication orders following total hip replacement; failed to obtain PRN pain med resident was prescribed after total hip replacement; further failed to follow resident's dismissal orders r/t acet being given 4x/day on scheduled basis & instead put order into EMR for PRN requiring resident to ask for pain med w/o resident's knowledge placing resident at risk for unalleviated pain, decreased ability to participate in rehab, inability to sleep & psychosocial impairment*

F761 Label/Store Drugs & Biologicals

SE: SS=E: Failed to ensure safe medication storage of 1/4 med carts placing residents at risk for diversion & ineffective medication regimen

- Observed unsecured tx cart outside 1 resident's room & no staff present in hallway to monitor cart; failed to ensure safe medication storage of 1/4 med carts placing residents at risk for diversion & ineffective medication regimen

SW: SS=D: Failed to discard 1 resident's flex pen, 1 resident's vial of expired insulin, and further failed to label 2 residents' insulin flex pens when opened to use and when they expired. This deficient practice placed the affected residents at risk for ineffective medications.

- Observed tx carts with multiple insulin pens with expired dates; failed to discard expired insulin pens & insulin vials; failed to date insulin flex pens when opened & expiration dates placing residents at risk for ineffective medication; observed insulin lacking open date; failed to place open date on 1 resident's insulin pen placing resident at risk of receiving ineffective doses of insulin

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=F: Failed to prepare & serve food to residents under sanitary conditions to prevent potential for foodborne bacteria

- Observed: pp machine with standing liquid in spill tray; trash can over-flowing with trash & with dried-on liquid & food debris on top & sides of trash can; bags of pop syrup with dried on several areas of shelves; cabinet & drawer doors with dried-on food & fluids; inside of microwave with heavy build up of food on top & all sides; juice machine with dried-on juice on back splash & in spill tray; dried-on food on counter
- Fridge with dried-on food on front of doors & inside doors & vents of machine & in handles of doors; fridge with dried-on spilled foods & liquids; milk w/o open dates; pitcher of supplements undated; multiple foods unlabeled & undated; coffee maker with dried-on coffee; tables with food debris; trash can with dried on food; cold cereals with dried-on sticky foods on lids;

SW: SS=E: Failed to store, prepare, distribute & serve food by professional standards for food service safety in 1 kitchen placing residents receiving meals from facility's kitchens at risk for foodborne illness

- Observed fridge with uncovered meats on shelf above box of bulk port sausage; outside of ice machine with streaks of white substance & drain pipe touched floor drainage area
- 4-5 inches above mop board under 3 sinks with missing tile; missing floor tiles; pipes under sinks with gray-black substance; storage closet with peeling sheetrock under shelf around top of mopboard; missing tile under dishwasher; expired test strips; ceiling vent with lint

F838 Facility Assessment

SE: 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

- Failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census.
- The facility assessment lacked staffing levels required for each shift, to include, evenings and weekends. The facility assessment indicated the facility would develop a comprehensive staffing plan utilizing the staffing model.
- The facility assessment lacked informed contingency plans for events that did not require activation of the facility's emergency plan but had the potential to impact resident care. The facility assessment noted the facility would determine the resources necessary to care for residents successfully throughout the day, night, weekends, & emergencies
- Failed to identify the means of input gathered from the residents and their representatives when formulating the assessment data; failed to conduct a 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

SW: SS=D: Failed to ensure there was a collaboration of care between 1 resident's hospice provider and the facility. This deficient practice placed resident at risk of inadequate end-of-life care.

- CP lacked staff direction on how to contact resident's hospice provider; provided medical supplies, DME & meds provided by hospice & schedule of when & how often hospice staff would make visits; failed to ensure collaboration of care between 1 resident's hospice provider & facility placing resident at risk for inadequate end-of-life care

F880 Infection Prevention & Control

SE: SS=E: Failed to maintain effective ICPC program r/t failing to clean vent on O2 concentrator for 2 residents; failed to clean nebulizer supplies for 1 resident; allowing Foley catheter tubing to rest on floor for 1 resident & failed to follow EBP for 3 residents with potential to spread possible infections to residents in facility

- Observed 1 resident in bed with eyes closed & nebulizer not put away properly with face mask & med barrel still attached & face mask with dried debris on inside & mask rested on top of dresser & lacked cover on multiple occasions; O2 concentrator with heavy build up of dust & debris covering vent on back of concentrator; resident with PU & door to room lacked EBP instructions for staff & CNA unaware of what EBP was
- Failed to maintain effective infection control program r/t improper infection control practices which included failed to wear proper PPE when staff cared for residents on EBP to prevent cross contamination in facility

SE: SS=F: Failed to maintain an effective infection control program related to the staff improper hand hygiene with wound dressing changes and catheter care. The facility failed to follow EBP. This deficient practice had the potential to spread possible infections to the residents in the facility.

- Failed to maintain effective infection control program r/t improper hand hygiene after removal of soiled gloves & failed to wear proper PPE when staff cared for residents on EBP to prevent cross contamination in facility

SE: SS=E: Failed to sanitize the glucometer between use and the failure to perform proper hand hygiene. This deficient practice had the potential to spread possible infections to the residents in the facility.

- Observed CMA perform finger stick then removed gloves w/o performing hand hygiene then walked to nurses' station & threw away gloves & donned other gloves w/o performing hand hygiene; CMA did not sanitize glucometer; failed to sanitize glucometer between use & failure to perform proper hand hygiene with potential to spread possible infections to residents in facility

SE: SS=F: Failed to ensure used face masks were stored or disposed of in a sanitary manner, the facility further failed to ensure all oxygen cannulas were stored in a sanitary manner and further failed to ensure a Legionella disease program specific to the facility was put in place. These deficient practices placed the residents at risk for infectious diseases

- Observed nasal cannula not stored in sanitary manner on multiple occasions
- Facility lacked documentation of implementation of water system program for waterborne contamination specifically for Legionella diseases; failed to ensure used face masks were stored or disposed of in sanitary manner, facility further failed to ensure a Legionella disease program specific to facility was implemented placing residents at risk for infectious diseases

SW: SS=F: Failed to implement a water management program for Legionella disease; failed to implement acceptable infection control practices when staff failed to properly store 2 residents' O2 tubing and nasal cannula in a sanitary manner. This deficient practice placed the residents in the facility at risk for infectious diseases.

- Observed unbagged O2 tubing & nasal cannula & laying inside & outside room for multiple residents & on multiple occasions; failed to implement water management program to test & manage waterborne pathogens placing residents who reside in facility at risk for contracting Legionella pneumonia

F883 Influenza & Pneumococcal Immunizations

SE: SS=E: Failed to offer or obtain informed declinations or a physician-documented contraindication for PCV20 pneumococcal vaccination for 4 residents placing residents at increased risk for complications r/t pneumonia

- Failed to offer & administer PCV20 or obtain informed declinations for 4 resident who were eligible to receive vaccination placing 4 residents at increased risk for acquiring, transmitting or experiencing complications from pneumococcal disease

SW: SS=E: Failed to offer or obtain informed declination or physician-documented contraindication for PCV20 vaccination per latest guidance from CDC placing residents at risk for pneumococcal infection & related complications

- 4 resident records lacked evidence facility or resident representative received or signed consent or informed declination for PCV20; failed to offer PCV20 pneumococcal vaccination for residents placing residents at risk of acquiring, spreading, & experiencing complications for pneumonia

F919 Resident Call System

SE: SS=F: Failed to maintain a functional emergency call system which allowed residents to call for staff assistance from each resident's room, bedside, BR area & /or bathing facilities & alarmed at centralized staff work area

- Multiple staff reported did not have pager; observed call lights not within reach of residents in rooms; observed 1 resident room that only activated after 3 attempts & shower room had 2 call lights that did not work; call light observations revealed 16 emergency call lights that malfunctioned; failed to maintain emergency call system which allowed residents to call for staff assist from each resident's room, bedside, BR area &/or bathing facilities & alarmed at centralized staff work area

F921 Safe/Functional/Sanitary/Comfortable Environment

SE: SS=F: Failed to provide safe, functional, sanitary & comfortable environment for all residents & staff

- Observed floor throughout kitchen with heavy build up of blackish substance at end of all table legs & legs of kitchen equipment; floor in kitchenette with dried-on red liquid; floor of dry storage with sticky substance throughout

SW: SS=F: Failed to provide a safe, functional, sanitary & comfortable environment for residents who ate in main DR & resided in 1 hallway placing residents who ate in main DR at risk for impaired health & wellbeing & residents residing on 1 hallway at risk for falls

- Observed hallway with 18 inch wide x 5 feet long, ½ inch deep in front of hallway shower room with missing flooring down to concrete
- Observed main DR with 4 floor vents with black fuzzy substance; 2 window AC units with black fuzzy substance; windows all around DR with streaks of gray-black areas on them; below window AC with 5ft x 3 in of missing mopboard; area under shelf with 1 ft x 3 ft mopboard sticking out from wall; failed to provide sanitary environment in main DR & 1 hallway placing residents who ate in main DR at risk for impaired health & wellbeing & residents residing on 1 hallway at risk for falling

F925 Maintains Effective Pest Control Program

SE: SS=F: Failed to maintain effective pest control program to ensure facility remained free of pests, specifically cockroaches & affected all residents in facility

- Cited findings noted in F812; multiple residents stated facility had roaches in kitchen & DR & resident able to see them crawling on walls in DR; multiple staff stated had roaches in kitchen area; failed to maintain effective pest control program to ensure facility was free of pests, specifically roaches & affected all residents in facility

March, 2025

F550 Resident Rights/Exercise of Rights

NW: SS=F: Failed to maintain environment that promoted dignity of 1 resident who had blood sugar testing & insulin administration & 1 resident who also had insulin administration in facility's dining room with other residents, staff, & visitors placing residents at risk for undignified experience & embarrassment

- Observed LN performed finger stick to obtain drop of blood for testing 1 resident's blood sugar & other resident across table stated, "I'm glad that's not me, I don't like needles"; LN then retrieved insulin pen & injected insulin into residents arm at DR table; Observed LN administered 1 resident's insulin subcutaneously in DR with other residents nearby; failed to maintain environment that promoted dignity of 2 residents who had insulin administered in DR with other residents, staff & visitors present placing residents at risk for undignified experience & embarrassment

F558 Reasonable Accommodations Needs/Preferences

SW: SS=D: Failed to ensure 1 resident's call light was within reach & further failed to provide foot pedals for 1 resident while pushing resident in hall leaving resident vulnerable to unmet care needs due to inability to call for staff assistance & placing resident at increased risk for preventable falls & injuries

- 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
- Failed to ensure use of w/c foot pedals for 1 resident while being pushed in w/c placing resident at risk for preventable accidents & injuries

F571 Limitations on Charges to Personal Funds

SW: SS=D: Failed to prevent unnecessary charges to 1 resident bank account resulting in multiple charges to bank account placing resident at risk for misappropriation of funds

- EMR documented payor source was private pay; Admission Agreement indicated facility was aware resident received Medicaid/Medicare services; Service Invoice revealed bank account successfully charged $1850 for 1 month services, $2494.73 for 1 month & $215.27 for 1 month, $2279 for 1 month but charges to bank account declined due to insufficient funds; Adm staff stated billing code set up incorrectly resulting in appropriate charging of bank account & facility would reimburse resident's accounts for errors; failed to prevent unnecessary charges to 1 resident's bank account resulting in multiple charges to bank account placing resident at risk for misappropriation of funds

F580 Notify of Changes

NE: SS=D: Failed to notify 1 resident's representative of plan of care changes with risk of miscommunication between resident, representative & facility

- *Resident with G-tube; Feeding Tube CAA lacked analysis of findings; POS for Augmentin q 12 hrs x 10 days for bacterial infection; NN documented resident's abdomen distended & tender; NN documented LN held tube feeding; NN documented resident with swollen abdomen with "huge" palpable mass predominately around PEG tube side extending to side of abdomen; area inflamed, warm & tender to touch with pus noted from PEG tube site; Consultant & representative & oncoming nurse notified; EMR lacked evidence facility notified representative of POS for Augmentin for PEG tube site cellulitis; failed to notify resident's representative of plan of care changes with risk of miscommunication between resident, representative & facility*

F582 Medicaid/Medicare Coverage/Liability Notice

SW: SS=D: Failed to issue CMS SNF ABN form 10055 for 1 resident placing resident at risk for decreased autonomy & impaired decision-making

- Failed to ensure forms provided at end of skilled services contained required information for residents to make informed choices & appeal non-coverage decisions placing residents at risk for decreased autonomy & impaired decision-making

F583 Personal/Privacy/Confidentiality of Records

SW: SS=E: Failed to keep 1 resident's PHI private on med cart parked in main DR placing resident at risk for impaired privacy

- Failed to maintain 1 resident's privacy r/t PHI placing resident at risk for impaired privacy

F600 Free from Abuse & Neglect

NE: SS=J (Removal Plan to G): Failed to prevent neglect of 1 resident when staff did not provide adequate monitoring & timely care & attention to resident's PEG tube site which became infected, abdomen became swollen & inflamed & right lower abdomen developed darkening which staff documented as bruising

- *On 02/18/25 at 05:34 AM, resident had a swollen abdomen and a large palpable mass around the PEG tube, with pus noted coming from the site. Staff notified Consultant, who assessed resident, and a note at 08:40 AM documented resident had cellulitis (skin infection caused by bacteria) surrounding resident's PEG tube site with the skin indurated (hardened, firm) and erythematous*

(redness). Six days later, on 02/24/25 at 12:13 PM, LN documented resident's PEG tube balloon appeared displaced and noted bruising around resident's right lower abdomen. LN documented a new PEG tube was placed with a KUB x-ray ordered. LN documented leaving a message for Consultant with the KUB results. On 02/25/25 at 05:59 AM, LN documented resident continued on an antibiotic for bacterial infection, resident's right side of her abdomen remained very swollen, inflamed, had blisters, the PEG tube stoma size increased and the inflated balloon was visible. At 06:52 AM, LN notified Consultant that no new orders were received. On 02/25/25 at 10:15 AM, LN documented resident's PEG site was very inflamed with bruising noted from the PEG tube site across resident's left breast and down her left side to her hip. LN notified Consultant GG and received an order to send resident out to the hospital. Resident died at the hospital the same day. The facility's failure to ensure resident remained free from neglect placed resident in Immediate Jeopardy.

- *Plan of Removal:*
  - *The facility educated all LN in an in-service provided by Administrative Nurse prior to their next scheduled shift on PEG tubes, notification of changes, and abuse/neglect/exploitation.*
  - *Administrative Nurse rounded on all residents with PEG tubes on 02/27/25 to ensure proper placement.*
  - *Administrative Nurse or designee rounded daily using the "PEG Tube Nursing Audit Tool".*
  - *Administrative Nurse reviewed the information from the audits and reported findings to the Quality Committee Quarterly.*

F602 Free from Misappropriation/Exploitation

SW: SS=D: Failed to ensure 1 resident remained free from misappropriation of medications when on 2-4-24 LN removed resident's second care of 3 with 45 tablets of hydrocodone 10/325 from facility placing resident at risk for missed medication, unrelieved pain & further misappropriate of medications

- *Resident with paraplegia, muscle spasms; resident with acute & chronic pain r/t lupus & chronic back pain r/t vertebral fx; POS for hydrocodone with acetaminophen PRN pain; resident stated aware that cards of pain meds taken from facility & that received pain medications & currently not in pain; investigation revealed LN worked 3-1-24 night shift & on 3-5-25 returned to work & noticed card of hydrocodone missing & notified unit manager who notified Adm nurse; LN placed on suspension pending investigation & notified to come into facility for drug screen; LN called facility & self-confessed to taking card of narcotics & tried to replace it with tabs of hydrocodone by re-ordering; Pharmacist completed audit on all scheduled meds with no other diversion discovered; failed to ensure 1 resident remained free from misappropriation of meds when LN removed resident's car with 45 hydrocodone placing resident at risk for missed medications, uncontrolled pain & further misappropriate of meds*

NE: SS=E: Failed to ensure residents with trust accounts managed by facility remained free from misappropriation when Adm Staff misappropriated funds from resident trust fund account placing all residents with trust accounts managed by facility at risk for misappropriation, financial instability & impaired rights

- *Investigation documented on 12/11/24 the facility initiated an investigation after finding credit card fraud on the company credit card attributed to an administrative staff. The facility noted several large checks from the resident funds account written to the administrative staff member with withdrawals not matching up with the written checks. On 12/16/24, Corporate Administrative Staff flew in to assist with the audit of the facility's RFMS account. On 12/17/24, the facility identified several withdrawals from 3 Resident accounts without receipts signed by the residents. The facility also noted several checks written out of the RFMS account that were not attached to any specific resident. On 12/18/24, AP Administrative Staff came to the facility to give an account of discrepancies. Staff member stated could not remember details but stated the money was accounted for. The facility placed AP Administrative Staff on suspension pending further investigation. On 12/19/24, the facility implemented new policies and procedures related to withdrawals from the resident trust account. On 12/30/24, AP Administrative Staff resigned from the facility effective immediately. On 01/16/25, the facility reimbursed the missing funds to the resident trust account. On 01/16/25, the facility notified the State Agency of the issues. On 01/22/25, the facility notified law enforcement. Failed to prevent misappropriation of resident trust funds from resident trust account & form 3 residents' trust accounts placing all residents with trust accounts managed by facility at risk for misappropriation, financial instability & impaired rights*

NW: SS=D: Failed to keep 1 resident free from verbal abuse during transport in facility bus placing resident at risk for fear or mental anguish

- Grievance Log documented on 11-4-24 new residents c/o being treated horribly by transportation aide on way to facility; resident reported resident was yelled at & cursed at several times because resident kept sliding out of w/c; resident reported resident was told "F***, I have stopped every five miles for you, and I am not going to keep stopping for this"; resident stated felt like resident shouldn't be yelled at for something he could not help & reported slid completely out of w/c then transportation aide got really mad & started yelling; resident also called family & told them how resident was treated; resolution: Transportation Aide educated on ANE; observed resident in bed with 3-inch pommel cushion in room resident reported had been verbally abused on van ride to facility when resident first admitted; failed to keep resident free from verbal abuse during transport in facility bus placing resident at risk for fear or mental anguish

F609 Reporting of Alleged Violations

NE: SS=D: Failed to report suspicion of misappropriation of resident funds to SA & law enforcement within required timeframe placing all residents with trust accounts managed by facility at risk for unidentified & ongoing misappropriation

- *Cited findings noted in F602 r/t missing & unaccounted funds from resident trust fund; failed to report suspicion of misappropriation of residents funds to SA & law enforcement within required timeframe placing all residents with trust accounts managed by facility at risk for unidentified & ongoing misappropriation*

NW: SS=D: Failed to ensure staff reported allegation of verbal abuse from 1 resident to Adm immediately to investigate placing resident at risk for ongoing abuse &/or mistreatment

- Cited findings noted in F600 r/t verbal abuse to resident by transportation aide during van transport when resident kept sliding down & out of w/c; Failed to report allegation of verbal abuse from 1 resident to Adm & state agency placing resident at risk for ongoing abuse & mistreatment

F610 Investigate/Prevent/Correct Alleged Violation

NW: SS=D: Failed to thoroughly investigate allegation of verbal abuse immediately placing resident at risk for ongoing abuse &/or mistreatment

- Cited findings noted in F600 & F609 r/t verbal abuse to resident by transportation aide during van transport when resident kept sliding down & out of w/c; failed to thoroughly investigate allegation of verbal abuse immediately placing resident at risk for ongoing abuse &/or mistreatment

F622 Transfer & Discharge Requirements

NW: SS=D: Failed to ensure 1 resident's transfer or discharge was documented in resident's medical record & appropriate information was communicated to receiving healthcare institution or provider placing resident at risk for delayed treatment at receiving institution

- Record lacked nursing assessment & transfer documentation as to why or how resident left facility; failed to ensure that transfer/discharge was documented in resident's medical record & appropriate information was communicated to receiving health care institution or provider which placed resident at risk for delayed treatment in receiving facility

F625 Notice of Bed Hold Policy Before/Upon Transfer

NW: SS=D: Failed to provide 1 resident with appropriate bed hold policy as required placing resident at risk of being unable to return to facility in same room or bed

- Record lacked nursing assessment & transfer documentation as to why or how resident left facility; failed to provide resident's representative with bed hold policy placing resident at risk of being uninformed of bed hold requirements

F677 ADL Care Provided for Dependent Residents

SW: SS=E: Failed to ensure a shower/bath was provided for 4 residents who were dependent on staff assist with ADLs with potential to cause skin breakdown &/or skin complications due to poor personal hygiene & impaired psychosocial wellbeing

- EMR lacked evidence resident offered or refused care during 61 days reviewed; observed resident with hair oily & uncombed & resident stated had not received bath/shower yet this week & felt dirty & neglected & facility still charged full price for care; failed to provide consistent bathing for 1 resident with risk of poor hygiene & decreased self-esteem & dignity
- EMR revealed no bathing within last 30 days; observed resident's hair greasy & room smelled of body odor & resident stated felt dirty & unclean due to facility not providing bathing for last month
- EMR not consistently receive 2 showers/wk from 1-16 thru 3-2-25; resident stated no shower for 15 days & knew smelled of urine & not getting shower made resident "feel bad"
- EMR lacked documentation of any shower from 1-7-25 thru 3-3-25; hair matted on 1 side & ungroomed & tangled

F679 Activities Meet Interest/Needs Each Resident

SW: SS=E: Failed to provide resident directed, interactive activities based on resident preferences for residents on weekends placing affected residents at risk for decreased psychosocial wellbeing, boredom & isolation

- Activity Calendar lacked engaging staff-led activities for Sundays; resident council reported facility rarely provided activities on weekends; failed to provide consistent activities on weekends which reflected residents' interests & preferences placing affected residents at risk for boredom, isolation & decreased quality of life

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

SW: SS=D: Failed to ensure 1 resident's heels were offloaded, heel protectors applied to both heels & further failed to monitor 1 resident's low air loss mattress placing resident at increased risk for developing PUs

- Observed resident with low air loss mattress set at inappropriate setting of too high for resident's weight & heels laid directly on mattress & w/o heel protectors; failed to ensure 1 resident's heels were offloading, heel protectors applied to both heels as ordered & CP'd & failed to monitor resident's low air loss mattress placing resident at increased risk for developing PUs

NW: SS=D: Failed to provide an appropriate cover or dressing for 1 resident's open PU of heel placing resident at risk for pain or infection

- Resident with dementia & hip fx; MDS documented resident had PU & PU care provided; POS for tx orders; Observed resident eating breakfast then CMA took resident to room & transferred resident to toilet & resident w/o dressing or covering on heel; failed to provide appropriate cover or dressing for 1 resident's open PU on heel placing resident at risk for pain or infection

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=J (Removed to G): Failed to ensure 1 resident remained free of accident hazards during transportation

- *On 1-21-24 transportation staff & CNA did not ensure 1 resident was safely secured in transportation vehicle before operating vehicle; CNA, who secured resident in vehicle lacked appropriate training & competency evaluation; transportation staff failed to ensure resident's w/c was appropriately secured then operated vehicle in manner that caused CNA to fear for CNA's safety of*

resident by frequently looking at phone which caused vehicle to cross rumble strips on right & left sides of road multiple times during transportation; driver rapidly brought vehicle to stop at intersection causing resident to slide partially out of w/c to floor, injuring ankle; transportation staff & CNA failed to accurately communicate facility that resident was injured & failed to activate 911 so resident could be appropriately assessed; additionally staff continued to doctor's appointment then drove approximately 50 miles back to facility where resident was then assessed to have injury placing resident in immediate jeopardy

- *Plan of Removal*
  - *All staff received education r/t roles & responsibilities of staff during transportation outside facility*
  - *All staff authorized to drive for facility were re-educated r/t roles & responsibilities*
  - *Transportation staff terminated*

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=E: Failed to secure areas of containing hazardous materials out of reach of 7 cognitively impaired/independently mobile residents in secured unit; further failed to implement interventions r/t 1 resident's falls placing affected residents at risk for preventable injuries & accidents

- Observed supplemental O2 storage room with unlocked door; shower room with unsecured chemical with warning labels; unsecured maintenance office with accessible hazardous chemicals; failed to secure areas containing hazardous materials out of reach of 7 cognitively impaired/independently mobile resident in secured unit placing affected residents at risk for preventable injuries & accidents
- Failed to ensure gripper strips were in place in front of resident's bed as CP'd placing resident at risk of falls & possible injuries

F690 Bowel/Bladder Incontinence, Catheter, UTI

NW: SS=D: Failed to ensure 1 resident had physician-ordered fluid intake, placing resident at risk for ongoing UTIs

- Resident with heart failure, weakness, intellectual disabilities, neuromuscular dysfunction of bladder, DM & chronic kidney disease; resident with urinary catheter, renal insufficiency & neurogenic bladder; CP directed staff to monitor & documented I&O & report to MD s/sx of UTI; POS for resident to drink 2 quarts of water daily q 24 hours; NN documented resident hospitalized with UTI; EMR documented resident lacked amount of physician-ordered intake daily from 2-24- thru 3-12; failed to ensure resident had physician-ordered fluid intake placing resident at risk of ongoing UTIs

F692 Nutrition/Hydration Status Maintenance

NW: SS=D: Failed to ensure 1 resident had physician-ordered fluid intake placing resident at risk of ongoing dehydration & UTIs

- Cited findings noted in F690 r/t resident with physician order for 2 quarts of water intake q 24 hours; failed to ensure resident had physician-ordered fluid intake placing resident at risk for ongoing dehydration & UTIs

F698 Dialysis

SW: SS=D: Failed to consistently monitor & document 1 resident's dialysis shunt for bruit, thrill & dressing placing resident at risk for potential adverse outcomes & physical complications r/t dialysis

- EMR lacked documentation or direction for nursing staff to check resident's dressing, bruit, & thrill daily; failed to consistently monitor & document resident's dialysis shunt for bruit, thrill & dressing placing resident at risk of potential adverse outcomes & physical complications r/t dialysis

F755 Pharmacy Services/Procedures/Pharmacist/Records

SW: 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 Irregularities, Act On

SW: SS=E: Failed to ensure physician reviewed & addressed Consultant Pharmacist (CP) recommendations for 1 resident's PRN antipsychotic med; also9 failed to ensure CP ID'd & reported irregularities r/t lack of dosing instructions for Voltaren get; also failed to ensure physician reviewed & addressed CP's recommendations for re-education of 1 resident's analgesics; also failed to ensure physician had reviewed & addressed CP'd recommendation for 1 resident's antidepressant med placing residents at risk for adverse medication effects & unnecessary meds

- Failed to ensure physician reviewed & addressed CP recommendations for 1 resident's antipsychotic medication for unnecessary med use, side effects, & physical complications
- Failed to follow CP's recommendations r/t 1 resident's Diclofenac medication placing resident at risk for unnecessary meds & potential side effects
- Failed to ensure CP ID'd & made recommendations r/t 1 resident's antidepressant meds & analgesics placing resident at risk for unnecessary psychotropic meds & possible toxicity-related complications

- Failed to ensure CP ID'd & made recommendations r/t 1 resident's Sertraline placing resident at risk for unnecessary psychotropic meds & related complications

NW: SS=D: Facility's consultant pharmacist failed to notify DON or resident's physician of lack of monitoring resident's BP as physician ordered to monitor effectiveness of medication placing resident at risk for receiving unnecessary medication

- POS for Losartan with holding parameters; BP documentation revealed staff obtained BP weekly from 12-14-24 to 3-24-25 even though 8-31-24 order was still active & resident still received same medication; Consultant Pharmacist failed to notify DON or resident's physician of lack of monitoring resident's BP as physician ordered to monitor effectiveness of medication placing resident at risk of receiving unnecessary medication

F757 Drug Regimen is Free from Unnecessary Drugs

SW: SS=D: Failed to ensure 1 resident's Diclofenac med had dosage administration amount placing resident at risk for unnecessary meds & potential side effects

- Failed to ensure 1 resident's Diclofenac's order contained dosage amount to be administered placing resident at risk for unnecessary meds & potential side effects

NW: SS=D: Failed to monitor 1 resident's BP as physician ordered to monitor effectiveness of medication placing resident at risk of receiving unnecessary medication

- Citing findings noted in F756 r/t staff taking resident's BP weekly for order for Losartan with holding parameters; failed to monitor 1 resident's BP as physician ordered to monitor effectiveness of medication placing resident at risk of receiving unnecessary medication

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SW: SS=E: Failed to implement 14-day stop date for 1 resident's PRN Lorazepam order or provide documentation showing clinical necessity to continue medication placing resident at risk for unnecessary meds & side effects

- POS for Lorazepam Oral Concentrate 0.5mg q 4 hours PRN for anxiety & order lacked stop date or intended duration

F760 Residents are Free of Significant Med Errors

SE: SS=D: Failed to prevent a med error when LN did not follow physician order & incorrectly administered five times the ordered amount of Ativan to 1 resident who was on hospice

- *Resident receiving Hospice services; POS for Ativan 1 mg q 4 hrs PRN anxiety & use only 0.1mg of syringe per dose; syringe contained 5 doses in 1 syringe; prn & apply to inner wrist or back of neck; NN lacked documentation r/t resident's response to amount of Ativan given in error; interview revealed LN gave wrong dose of Ativan by instead of administering 1 dose as ordered, gave 5 doses of resident's topical Ativan all at once; error not discovered until 2 days later when another nurse discovered wrong dose had been given; Adm nurse stated completed teachable moment of education r/t med error; failed to prevent med error for 1 resident when LN administered 5 times physician ordered dose of Ativan to hospice resident*

F761 Label/Store Drugs & Biological

SW: SS=D: Failed to properly label med in 1/3 med carts placing residents at risk for adverse outcomes or ineffective med regimens

- Observed opened, undated insulin pen; failed to properly label meds with potential to cause adverse consequences or ineffective tx to affected residents

NW: SS=E: Failed to remove expired medication from use & failed to date 1 insulin pen when opened placing residents who may have received those medications at risk for ineffective medication

- Observed med room with suppositories with expired date & pain/sleep aide with expired dates; observed tx cart with opened, undated insulin pen; failed to remove expired medications from use & failed to date 1 insulin pen when opened placing residents who may have received meds at risk for ineffective medication

F801 Qualified Dietary Staff

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

- 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

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SW: SS=F: Failed to ensure that staff members properly tested & recorded dish machine temps placing residents at risk for contamination & foodborne illness

- Failed to ensure staff members properly tested & recorded dish machine temps placing residents at risk for contamination & foodborne illness

F838 Facility Assessment

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

- Assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census. The assessment lacked staffing levels required for each shift to include evenings and weekends. Failed to ID means of input gathered from residents/representatives when formulating assessment data; lacked informed contingency plans for events that do not require activation of facility's emergency plan but have potential to impact resident care

F880 Infection Prevention & Control

SW: SS=E: Failed to store O2 saturation equipment & nebulizer tubing in sanitary manner & further failed to ensure required PPE was worn while doing trach care placing residents at risk for infectious diseases

- Failed to store O2 saturation equipment & nebulizer tubing in sanitary manner & further failed to ensure required PPE worn while doing trach care placing residents at risk for infectious diseases

NW: SS=F: Failed to maintain infection monitoring surveillance plan & EBP as staff wore gown & gloves in hallway placing residents at risk for exposure to infectious processes

- Observed CNA wore gown & gloves while pushing resident in w/c to DR, then opened closet in DR wearing same PPE then wore gown in hallway "so that the surveyor would know what she looked like in one"; DON confirmed infection tracking system had not been correctly implemented before January 2025 when another DON was working at facility; failed to ensure disposal of PPE before leaving resident's rooms & failed to maintain infection monitoring surveillance plan placing residents at risk of infectious disease processes

April, 2025

F582 Medicaid/Medicare Coverage/Liability Notice

SW: SS=D: Failed to provide 2 residents with CMS form CMS-10055; SNF ABN which provide recipient with information r/t right to choose continued services & associated charges for continued services & associated charges for continued skilled services after termination of Medicare Part A services for 2 residents placing residents at risk for uninformed decisions & unanticipated costs r/t skilled services

- Facility did not provide resident with CMS-10055 SNF ABN to allow resident to make an informed decision r/t continuation of skilled services & associated costs for 2 residents

F584 Safe/Clean/Comfortable/Homelike Environment

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

- Observed resident rooms with no threshold noted in entrance of room; windowsill missing tile & standing floor fans missing front cover
- Hallway with large gouges missing from wall & areas of baseboard peeling back in hallway; built-up dirt on wall & floor cover
- Observed resident rooms with missing ceiling tiles; wardrobe closet & drawers with chipped paint & broken areas on drawers; windowsill tiles covered with black electrical tape
- Resident room with no name on door & dresser with top drawers missing & blanket covering window
- Resident's BR with exposed drywall & metal floor vent laying on floor; floor vent bent & rust on vent; windowsill tile cracked & missing corner of window
- Observed resident room smelled of cigarettes; BR floor with missing tiles & baseboard peeled back
- Resident room window blinds broken & resident had blanket for curtain; baseboard peeled off & holes noted in walls where baseboard would have been on wall & visible build up dirt on flooring
- Activity room with missing floor tiles; staff reported had tripped over flooring in activity room & had reported to Adm

F600Free from Abuse & Neglect

NW: SS=D: Failed to ensure staff responded appropriately with adequate supervision to prevent potential abuse & or mistreatment of 1 resident, a cognitively impaired resident placing resident at risk for potential abuse &/or mistreatment

- *NN documented staff assisting resident get dressed for day & noted new bruise on upper arm consistent with resident scratching arm; resident with frequent bruising; NN documented resident's husband visited & husband reported assisted resident with getting ready for bed & while assisting resident's arm got stuck in sweater so husband grabbed arm to help pull arm out of sleeve; evening staff reported large bruise on forearm after husband left; EMR lacked further documentation r/t large black/purple bruise on resident's forearm; Adm notified & had impression bruise from previous noted bruise; LN concerned that new bruise from physical abuse & statements from resident (that "brother" had hit resident) & husband on evening of incident; during surveyor interview resident stated bruise from dog jumping into resident's lap; failed to ensure staff responded appropriately with adequate supervision to prevent potential abuse &/or mistreatment of resident, a cognitively impaired resident placing resident at risk for potential abuse &/or mistreatment risk of abuse*

F609 Reporting of Alleged Violations

NW: SS=D: Failed to report allegation of abuse for 1 resident immediately but not more than 2 hours to required entities including Law Enforcement & State Agency placing resident at risk for unidentified & ongoing abuse or treatment

- *Cited findings noted in F600 r/t bruising of cognitively impaired resident during husband's visit for resident with frequent bruising; resident, husband & resident's son verbalized denial that husband had intentionally caused bruising & felt supervised visits were unnecessary; failed to report allegation of abuse for 1 resident immediately but not more than 2 hours to required entities including Law Enforcement & State Agency placing resident at risk for unidentified & ongoing abuse or mistreatment*

F610 Investigate/Prevent/Correct Alleged Violation

NW: SS=D: Failed to immediately investigate allegation of abuse for 1 resident & initiate protective measures to prevent further potential abuse until investigation was completed placing resident at risk for ongoing abuse &/or mistreatment

- *Cited findings noted in F600 & F609 r/t bruising following visit & assistance by husband; failed to immediately investigate allegation of abuse for 1 resident & initiate protective measures to prevent further potential abuse until investigation completed placing resident at risk for ongoing abuse &/or mistreatment*

F625 Notice of Bed Hold Policy Before/Upon Transfer

SW: SS=D: Failed to provide bed hold notice to 2 residents/representatives at time of residents' transfers to hospital placing residents at risk for impaired ability to return to facility in same room

- EMR for 2 residents lacked evidence facility provided bed hold notice for transfer/discharge to hospital LN reported would not complete bed hold form when resident transferred to hospital & had never seen a bed hold form & was unsure who provided bed hold to resident; SSD reported bed hold not one of SSD's responsibilities; Adm reported no bed hold notices for residents

F641 Accuracy of Assessments

NW: SS=D: Failed to ensure 1 resident's MDS had fully developed CAAs

- Following CAAs lacked analysis or further development: Functional Abilities; Urinary Incontinence & Indwelling Catheter; Pain; PU/Injury; failed to provide policy for MDS or CAA development

F645 PASARR Screening for MD & ID

SW: SS=D: Failed to obtain PASARR Level 2 for 1 resident placing resident at risk for unidentified care needs & impaired quality of care

- Resident with dx of suicidal ideation, auditory hallucination, major depressive d/o, generalized anxiety d/o, schizoaffective d/o primary insomnia; EMR lacked documentation that PASARR level 2 had been completed

F657 Care Plan Timing & Revision

SW: SS=D: Failed to review & revise comprehensive CPs for 1 resident r/t bathing placing resident at risk for poor hygiene due to uncommunicated care needs

- CP lacked guidance to staff r/t resident's preferences for bathing &/or schedule for bathing to include type, frequency &/or time of day for bathing; resident stated wanted 3 baths/wk & when resident asked staff for shower, staff "just put him off"; resident stated needed staff assist to wash back & lower legs & staff said not safe for resident to shower by self

NW: SS=D: Failed to revise 1 resident's CP to address effective communication placing resident at risk for isolation & impaired psychosocial wellbeing

- CP lacked preferences or direction for effective staff communication when resident stuttered & was not understood

F677 ADL Care Provided for Dependent Residents

SW: SS=D: Failed to provide necessary services in accordance with preferences & in keeping with CP for 3 residents placing affected residents at risk for decreased quality of care

- CP lacked guidance to staff r/t resident's preferences for bathing &/or schedule for bathing to include type, frequency, &/or time of day for bathing; ADL Task of EMR documented resident scheduled for showers 3 days/wk & as needed; bathing documentation for March documented staff provided 5/12 opportunities for bathing & resident did not refuse any bathing; resident stated asked for 4 baths/wk w/o getting response from staff
- Observed resident attempting to eat bowl of oatmeal & glass of juice with clear plastic wrap covering glass; 1 hour later observed resident leaning with spoon on floor & bowl next to resident on chair & resident eyes closed; 1 hour later resident remained in same position; observed resident wearing same clothing as previous day; failed to provide assist for eating that resident required with potential to negatively affect resident's physical wellbeing
- CP documented resident required assist to personal hygiene; observed resident with approximately ¼ inch facial whiskers & resident reported would like to have shave but staff would not let resident have a razor; failed to provide assist for removal of facial hair for 1 resident with potential to negatively affect resident's physical wellbeing

F686 Treatment/Services to Prevent/Heal PU

SW: SS=G: Failed to prevent the development of facility-acquired PUs on 1 resident's right & left buttocks when staff failed to adequately monitor wounds after initial development including measurements, presence of infection, drainage & effectiveness of treatments, failed to implement routine repositioning in bed & w/c until after wounds progressed & did not implement standard interventions such as low air loss mattress until after PUs worsened; facility did not immediately implement nutritional interventions to address wound prevention or healing; as result resident developed a facility-acquired Stage 3 pressure injury & placed resident at risk for development of new PUs & delayed healing & worsening of existing ulcers

- *Resident with OA, weakness, UTI; BIMS 15; required moderate assist with ADLs & risk for PUs & not on turn & reposition schedule; Braden documented low risk for skin impairment; Admission CP lacked reposition schedule; CP revised on 3-3-25 with reposition schedule q 2-3 hours in bed & when resident uncomfortable in w/c; tasks in EMR lacked turn & reposition program; weekly skin assessments documented resident w/o skin issued from 1-15-25 thru 2-28-25; NN of 2-26 documented resident's representative called & informed nurse that resident told rep had wound on coccyx & nurse informed rep no new wounds reported but would follow up; POS for tx dated 2-26-25; MAR/TAR lacked evidence staff performed tx; NN dated 2-28-25 documented small open wounds to scrotum & bilateral buttocks & noted tx in place; weekly skin assessment tool lacked measurements of open areas, assessment of peri-wound & presence of drainage or signs of infection; POS dated 3-1-25 for new tx; NN dated 3-5-25 documented buttocks wound started to open with bloody drainage & note lacked physician notification; wound care company documented on 3-17-25; resident transferred to hospital for possible sepsis on 3-24-25; resident remained in hospital at time of survey; PA stated expected facility to apply air mattress sooner than it was*

SW: SS=D: Failed to ensure environment fee from accident hazards for 2 resident when staff failed to provide adequate hands-on stabilization of resident from 2ndd staff member during full body mechanical lift transfers placing 2 residents at risk for accidents & injuries r/t mechanical lift transfers

- *Observed 2 CNAs performed full body mechanical lift transfer for 1 resident from recliner to w/c using mechanical lift & 1 CMA operated controls of lift with legs positioned wide; while resident in raised position CNA released physical control & stabilization of resident, walked around lift, resident & CMA & stood behind resident's w/c; CMA then pushed lift with resident in up & dangling position over to resident's w/c as CNA then guided resident down into w/c as CMA operated control; 2 staff then unhooked sling from lift & repositioned resident in w/c*
- *Observed transfer of 2nd resident performed by 2 different staff members with same procedure as previous resident observed; Adm nurse stated procedure by 1 staff operating controls & other maintaining hands-on contact with resident to ensure safety o resident & legs of lift should always be in wide position for safety & stability*

SW: SS=J (Past Non-Compliance): Failed to provide adequate supervision to ensure a safe and secure environment and prevent an elopement for cognitively impaired 1 resident, who was at moderate risk for elopement. On 03/13/25 at approximately 11:40 AM, resident left the second floor, went to the first floor, and then exited the facility. Between 11:45 AM and 12:00 PM, resident's representative called the facility to alert the facility that she had received a call from a community member who reported they saw resident outside the facility. Upon learning this information, staff conducted a search, and staff located resident outside the facility. Resident returned to the facility uninjured. The facility's failure to ensure resident had interventions in place in response to his elopement risk as well as the failure to provide adequate supervision to prevent an elopement placed R1 in immediate jeopardy.

- *Resident admitted on 3-4-25; BIMS 10; wandering risk assessment documented resident with moderate risk for elopement; which increased over days after admission; CP lacked interventions r/t moderate elopement risk; CP revised after incident noting hx of wandering*
- *Plan of Removal:*
  - *In-service on 3-13-25 by Adm/designee to all staff who were in building to ensure facility follows facility's elopement policy*
  - *In-service on 3-13-25 by Adm/designee to all LNs to ensure elopement assessment & CPs updated for all new admission; CPs for all resident ID'd as high risk for elopement updated*
  - *Elopement drills continued to be conducted quarterly to ensure staff members aware of what to do when elopement occurred*
  - *Binder at front desk updated on 3-13-25 to include pics & information of resident at high risk for elopement & reviewed & updated daily for new admissions*
  - *Wander risk assessments reviewed on 3-13-25 & updated daily for new admissions*
  - *Resident remained on 1:1 until discharged*

NW: SS=D: Failed to ensure 2 residents' low air-loss mattresses were set to appropriate settings; further failed to ensure 1 resident had pressure relieving boots on when in bed placing both residents at risk for complications r/t skin breakdown & PUs

- Resident at risk for skin breakdown; dependent for ADLs; weight 305.8 #s; observed resident in bed with air loss set to 450 #s on multiple occasions; resident stated staff do not adjust setting
- CP lacked direction to staff to monitor resident's low air-loss mattress; observed resident in bed with low air-loss mattress set at yellow & pressure relieving boots did not have boots on & heels laid directly on mattress on multiple occasions

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=E: Failed to ensure safe environment free from accident hazards when multiple residents had lighters in rooms; additionally 1 resident had unsecured meds & 1 resident had unsecure 1.75 liter bottle of vodka along with firecrackers & 2-inch pocketknife; additionally facility failed to store chemicals in secure safe manner placing affected residents at risk for preventable accidents & related injuries

- Observed workstation & unlocked cupboard under sink with spring-loaded mouse trap & multiple chemicals with warning labels
- Observed resident with lighter & 2 cigarettes in room & vape & vape supplies & resident had O2 cannula & reported used O2 at night
- Observed resident room with lighter & cigarettes in room
- Observed resident in room & on bedside dresser were 2 Pantoprazole Na & 1 Seroquel meds

- Observed resident in room & had medicated chest rub & albuterol sulfate inhalation at bedside & resident reported 1.75 liter bottle of Vodka & 2 375 mL bottles of Vodka which had been consumed by resident in bag in closet along with firecrackers & 2-inch pocketknife
- Observed resident who reported had lighter & cigarettes in room & showed items when asked

NW: SS=D: Failed to ensure safe care environment r/t resident's call light placement placing resident at risk for preventable accidents & injuries

- Resident with dementia; resident with multiple falls; CP instructed staff to ensure call light remained within reach at all times; observed resident with call light on floor under bed on multiple occasions

F695 Respiratory/Tracheostomy Care & Suctioning

NW: SS=D: Failed to ensure 1 resident's CPAP was stored in sanitary container when not in use placing resident at increased risk for respiratory complications

- MDS lacked indication of resident's CPAP; CAA lacked analysis; CP lacked direction to staff to clean & store CPAP mask; POS to clean CPAP supplies weekly with vinegar & water q day shift on Saturdays; observed resident in bed resting with CPAP on bed & stuffed between side rail & low air-loss mattress; resident stated removed mask self & did not have bag for mask & staff did not tell resident that needed to ensure mask stored in sanitary manner

F699 Trauma Informed Care

NW: SS=D: Failed to ID, implement & utilize trauma-based care strategies r/t resident's reported hx of PTSD placing resident at risk for decreased psychosocial wellbeing & increased behaviors

- MDS documented resident with PTSD & dependent on staff for ADLs; CAA documented resident indicated depressed about admission into nursing home & recent time in jail & resident felt lonely; Cp lacked information r/t resident's potential effects r/t hx of trauma or PTSD; resident reported nightmares improving but still present & believed tremors from anxiety & had PTSD from childhood abuse & anxiety from recent court-related issues; resident stated had ongoing fears from childhood trauma & legal issues & stated was forced to move to care facility & felt it fed into resident's anxiety & resident stated felt like facility had addressed trauma concerns & was supposed to have behavioral support in future; Adm nurse unaware of trauma or PTSD-related concerns for resident & unaware of resident's hx of childhood abuse or nightmares r/t trauma

F700 Bedrails

NW: SS=D: Failed to ensure 2 residents had safety assessments for use of side rails that acknowledged risks of low air-loss mattress placing both residents at risk for uninformed decisions & impaired safety related to risks associated with use of side rails

- CAA documented resident dependent on staff for ADLs & at risk for skin impairment; CP lacked information r/t low air-loss mattress; MDS lacked documentation of bed rails; No documentation showing ID'd risks r/t use of low air-loss mattress in conjunction with side rails; observed resident in bed with low air-loss mattress at incorrect setting per resident's weight & bed had bilateral assist rails at head of bed;
- Resident with MS, DM, edema; kypokalemia, COPD; muscle weakness; dementia; behavioral disturbance; HTN; MDD; obesity; side rail assessment did not include assessment to include low air-loss mattress; EMR lacked evidence of risk vs benefits & education provided to resident/representative r/t risk associated with use of side rails; observed resident in bed & side rails on both sides up on multiple occasions

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

SW: SS=F: Failed to complete annual performance review at least once q 12 months for 5 CNAs reviewed to ensure adequate appropriate care & services provided to residents of facility

- Personnel files revealed lack of performance evaluations signed by management for 5/5 CNAs employed over 1 year

F732 Posted Nurse Staffing Information

NW: SS=C: Lacked census on posted staffing reports

- Observed no posted staffing documentation posted in facility on multiple occasions;1 observation with report did not include daily census on multiple occasions

F740 Behavioral Health Services

NW: SS=D: Failed to ID, implement & monitor 1 resident's behavioral care needs placing resident at risk for continued behavioral episodes & unmet care needs

- Resident with dx of PTSD, intracranial brain injury, cognitive impairment, accidental gunshot wound to head; CP lacked interventions r/t wandering, behaviors & allowing female residents to enter room; NN documented resident with "extreme behaviors: r/t removing clothing from wardrobe & walked down hall & yelled vulgarities & returned to room; NN documented resident wandered down hall opening other residents' doors; multiple other notes on behaviors r/t wandering & behaviors toward other residents; observed resident wandered down hallway, entered another resident's room & started looking thru other resident's personal items & other resident asked resident to stop & leave & resident complied but returned to other resident's room & stood looking around then exited room & walked back toward DR & no staff present to monitor resident's wandering; failed to ID,

implement & monitor resident's behavioral care needs placing resident at risk for continued behavioral episodes & unmet care needs

F744 Treatment/Service for Dementia

NW: SS=D: Failed to provide dementia-related behavioral services for 1 resident to promote highest practicable level of wellbeing resulting in numerous non-injury falls placing resident at risk for decreased quality of life, isolation & impaired dignity

- Resident with dx of acute encephalopathy, abnormal behaviors & acute kidney injury; CAA documented resident wandered daily & easily redirectable; NN documented resident continued to go into other resident's room & attempt to remove clothing; note documented resident made multiple attempts to go back into other resident's room; cited findings noted in F740 r/t wandering into other resident room; other resident stated resident frequently went into other resident's room & messed with things & tried to change room & other resident felt sorry for resident but had told staff numerous times that resident should not be in other resident's room; observed resident walked down hall & attempted to remove shirt then entered other resident's room & closed door & other resident reopened door & exited room

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NW: SS=D: Failed to provide a 14-day stop date, intended duration of therapy & rationale for extended use r/t 2 residents PRN antianxiety meds placing residents at risk for ineffective treatment & unnecessary side effects

- Resident with PTSD, intercranial brain injury, mild cognitive impairment & accidental gunshot wound to head; POS for Lorazepam 0.5mg q 6 hours PRN; order contained no stop date & was set to "indefinite"; physician rationale from Consultant Pharmacist stated, "it benefited him & he needed it"
- POS for Clonazepam 0.5mg PRN for anxiety r/t Bipolar d/o; lacked end date & end date documented indefinitely; EMR w/o physician-documented rationale for continued use of clonazepam for Bipolar d/o or DC date

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SW: SS=F: Failed to store, prepare & serve food in sanitary manner to prevent possible foodborne illness to residents of facility placing residents at risk for foodborne illness

- Observed multiple food items in fridge & in dry storage areas uncovered & undated; expired foods; multiple unsealed items

NW: SS=F: Failed to follow sanitary dietary standards r/t food preparation placing residents at risk for foodborne illness

- Observed sausages cooking on stop top & food prep area with dietary staff preparing food w/o wearing hairnet then exited cooking area, put hairnet on & returned to cooking area

F814 Dispose Garbage & Refuse Properly

SW: SS=C: Failed to maintain &/or dispose of garbage & refuge properly & in sanitary condition ensuring lids were down to cover disposed waste

- Observed outside trash dumpsters with 3 bags of trash lying next to portable dumpster with no lid; 2 doors open on 1/2 stationary dumpsters

F838 Facility Assessment

NW: 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 with potential to affect all residents currently residing in facility

- Facility Assessment failed to ID specific staffing levels needed for each unit & to ID number of RNs, LN, CMA, CNAs needed for each unit, patient acuity & census; assessment lacked staffing levels required for each shift to include evenings & weekends

F851 Payroll Based Journal

NW: SS=F: Failed to submit accurate staffing information to CMS thru PBJ when facility failed to submit accurate LN coverage & weekend staffing hours placing residents at risk for unidentified & ongoing inadequate staffing

- PBJ report for multiple quarters indicated facility failed to provide LN coverage 24 hours/day; working schedule, time sheets & clock in & out information & posted staffing hours completed for ID'd days missing required LN coverage or gaps with no missing or gaps in staffing; failed to ensure accurate staffing hour information submitted to PBJ when facility failed to submit accurate data r/t weekend staffing & LN coverage placing residents at risk for unidentified & ongoing inadequate staffing

F880 Infection Prevention & Control

SW: SS=E: Failed to ensure staff utilized acceptable infection control practices to mitigate spread of infections when staff failed to cover clean clothes left in folding area & under areas with noted debris & insulation; failed to use EBP when providing a dressing change for 1 resident & additionally failed to use EBP for 1 resident when staff administered tube feeding; further failed to use proper hand hygiene & standard infection control practices for 2 residents when staff failed to completed proper hand hygiene & cleansing during peri-care wit potential to spread possible infections to residents in facility

- Observed no EBP signage or precautions noted outside any resident doors in any hallways during tour of facility; observed LN provided tube feeding for 1 resident & LN did not don gown, only wearing gloves during observed tube feeding
- Observed CNA applied gloves & grabbed garbage can for incontinence care, retrieved wash clothes & placed them in lined wash basin with plastic bag then stroked several times with same part of washcloth when washed peri-area as cloth hit urine soiled brief

under resident then completed care using same soiled gloved pulled out of jar of unlabeled ointment & applied that clear ointment to resident's skin

- Observed 2 CNAs performed incontinence care & dropped glove onto ground, picked back up & placed it on hand then removed brief & used wipe in same area for more than 1 stroke; CNA finished front peri-care then threw soiled linen directly on floor, removed gloves & failed to perform hand hygiene & then cleaned back area soiled with feces & again threw soiled linen on floor & used same gloved hands to perform front area & back area & after removing gloves failed to perform hand hygiene
- Observed LN did not perform hand hygiene prior to applying gloves to perform dressing change
- Observed clean personal clothing hanging directly under exposed insulation that covered duct work & folding & sorting of clean linen with no ceiling & pipes covered with dust

SW: SS=C: Failed to develop & implement, including an annual review of facility's infection control policy

- Interview with Adm Nurse reported facility lacked annual review of infection control policy that was last reviewed on 11-22-20; additionally DON expected staff to remove PPE correctly to prevent cross-contamination

NW: SS=F: Failed to ensure 1 resident's CPAP & 1 resident's nasal cannula were stored in sanitary manner & further failed to ensure laundry employees had PPE in soiled laundry area to sort soiled laundry placing residents at risk for infections

- Observed CPAP on bed stuffed between side rail & low air-loss mattress; observed 1 resident's nasal cannula laid over back of w/c not stored in sanitary manner
- Observed laundry with cleaning rags left in washer overnight & soiled laundry & sorting room w/o PPE for staff to wear to sort dirty laundry

F909 Resident Bed

SW: SS=D: Failed to ensure 2 resident beds was in safe & operable condition placing residents at risk for discomfort & decreased safety

- Observed resident's bed frame broken & bed would not sit level
- Observed remote to resident's bed under it & stuck in frame; sheathing stripped from wires & wires unraveled; bed rested almost completely on ground; resident reported bed would go up & down but head o bed would not work to be raised or lowered

F947 Required In-Service Training for Nurse Aides

SW: SS=F: Failed to develop, implement & permanently maintain in-service training program for CNAs with required topics & no less than 12 hours/year; 5 CNAs lacked required training topics & 5 CNAs lacked required 12 hours/yr on in-service training

- 5 CNAs records revealed all 5 had less than 12 hours documented in-service & all residents only ANE training for education

SW: SS=F: Failed to develop, implement, & permanently maintain in-service training program for CNAs with required topics & no less than 12 hours per year; 5 CNAs lacked required training topics & 5 CNAs lacked required 12 hours per year of in-service training placing residents at risk for decreased quality of care

- Adm nursing staff reported aware may not have all required in-service hours for CNAs & had recently acquired new program to help with training in future & have just started using program