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

December, 2023

F550 Resident Rights/Exercise of Rights

NE: D: Failed to ensure dignified care environment for 1 resident r/t incontinence management placing resident at risk for unnecessary embarrassment & decreased psychosocial wellbeing

- Observed resident's room with heavy urine smell & floor with wet substance leading around room & into restroom & parts of floor had a dried/sticky substance covering it; failed to ensure a dignified care environment for 1 resident r/t incontinence management placing resident at risk for unnecessary embarrassment & decreased psychosocial wellbeing

F565 Resident/Family Group & Response

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

- Resident Council meeting minutes with recurring concerns with call light response times; forms did not list actions taken or resolutions provided; minutes indicated concerns r/t Hoyer lifts being left in resident rooms & form did not list actions taken or resolutions provided & issue not addressed by facility; failed to adequately address & resolve recurring issues reported by Resident Council placing residents at risk for decreased psychosocial wellbeing & impaired quality of life

F582 Medicaid/Medicare Coverage/Liability Notice

NE: SS=C: Failed to ensure issued correct CMS form 10055 ABN for 2 residents

- Failed to issue 2 residents correct ABN form CMS-10055; staff stated form used was form corporate office provided & not provided with correct form

F585 Grievances

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

- Observed no designated grievance drop box or alternative system available accessible to residents & visitors of facility to allow submission of grievances anonymously; Resident council members unaware if facility provided a way to complete anonymous grievance; staff unaware of anonymous way residents could report grievances other than giving staff forms directly; failed to implement system to allow anonymous grievance placing all residents at risk for decreased psychosocial wellbeing

F600 Free from Abuse & Neglect

NE: SS=E: Failed to ensure 4 residents remained free from abuse when CNA recorded residents with phone & sent videos to individual outside facility placing residents at risk for further abuse & decline in psychosocial wellbeing

- *Investigation Report documented Adm received phone call from law enforcement officer stating through routine audits of inmates' tablet correspondence, 2 videos noted to contain what law enforcement believed were residents at facility which they concluded based on knowledge of sender's employment at facility; Adm & Adm nurse viewed videos at station & observed multiple videos of multiple residents; upon return to facility, CNA was terminated & was asked if CNA had any resident images or video clips saved to personal device & CNA stated did not & videos no longer accessible within app; CNA apologized & insisted actions purely innocent & boyfriend in corrections interested in what CNA did for living; failed to ensure 4 residents remained free from abuse when CNA recorded residents with phone & sent videos to individual outside facility placing residents at risk for further abuse & a decline in psychosocial wellbeing*

NW: SS=D: Failed to ensure 1 resident was free from abuse when other resident touched resident in sexually inappropriate manner; resident, who was severely cognitively impaired, was unable to consent placing resident at risk for continued abuse & impaired psychosocial wellbeing

- *Resident with dementia, major depressive d/o & HTN; communication to physician documented staff notified resident's PCP by phone that male resident touched resident inappropriately & provider gave no further orders; family notified; progress notes documented CNA reported to LN that resident observed touching resident inappropriately & CNA removed resident from situation & Adm notified; CP updated; behavioral health notified of consult orders; resident placed on 15 minute checks; LTC Ombudsman notified & visited; failed to prevent an incident of resident to resident abuse to 1 resident placing resident at risk for further abuse & impaired psychosocial functioning*

F604 Right to Be Free from Physical Restraints

NW: SS=J (Past Non-Compliance): Failed to ensure residents remained free from abuse including physical restraint when staff manually restrained resident to administered medications

- *On 11-10 CMA asked 2 CNAs to hep administer eye ointment to 1 resident; CMA & 2 CNAs went to resident's room & CMA climbed on top of resident, straddled resident & pinned arms under blankets while resident attempted to resist; CNA told CMA actions were inappropriate but CMA ignored CNA; staff failed to ensure 1 resident remained free from abuse when staff physically restrained resident placing resident in immediate jeopardy*
- *Abatement Plan:*
    - *QAPI meeting with facility Medical Director*
    - *Staff completed assessment of resident*
    - *All employees educated on abuse, neglect, restraints & reporting policies*
    - *CMA suspended then terminated*

F609 Reporting Alleged Violations

SW: SS=D: Failed to report allegation of abuse by 1 resident when resident made allegation of sexual abuse

- *Resident with schizophrenia with PASARR level II IDing hallucinations; Progress note documented resident called police & informed police that resident believed resident had been sexually assaulted while sleeping sometime in past 2 months & unable to stated who had assaulted resident & resident also stated to police that resident wanted to kill self at time; police took resident to psychiatric care center for further evaluation; Adm stated facility did in-house investigation but did not report incident of allegation of being sexually abused to state agency as required; failed to report allegation of abuse by resident who made allegation of sexual abuse*

NW: SS=L (Past Non-Compliance): Failed to ensure staff IDd & reported immediately to Adm episode of abuse when staff manually restrained resident to administer meds

- *Cited findings noted in F604; staff reported CMA had "done it again"; CMA suspended & police were called & facility filed a report; resident w/o injury; failed to ID abuse & report to Adm staff immediately as required placing resident & all other residents in facility in immediate jeopardy*
- *Abatement Plan*
    - *QAPI meeting with facility Medical Director*
    - *Staff completed assessment of resident*
    - *All employees educated on abuse, neglect, restraints & reporting policies*
    - *CMA suspended then terminated*

F623 Notice Requirements Before Transfer/Discharge

NE: SS=D: Failed to written notice as soon as practicable for facility-initiated transfer to 2 residents/representatives when they were transferred to hospital placing residents at risk for uninformed care choices

- *Record lacked evidence resident/representative was provided written notice when resident transferred to hospital; failed to provide 1 resident/representative written notice as soon as practicable r/t resident's facility-initiated transfer to hospital placing resident at risk of uninformed care choices for 2 residents*

NE: SSS=D: Failed to provide written notification of facility-initiated transfers with required information to 1 resident/representative in practicable amount of time with risk of miscommunication between facility & resident/family & possible missed opportunity for healthcare service for 1 resident

- Facility lacked written notification of transfer for 1 resident's facility-initiated transfer to hospital; failed to provide written notification of transfer with required information to 1 resident/representative in practicable amount of time with risk of miscommunication between facility & resident/family & possible missed opportunity for healthcare service for 1 resident

F625 Notice of Bed Hold Policy Before/Upon Transfer

NE: SS=D: Failed to provide copy of "Bed Hold" notice to 1 resident/representative upon discharge to hospital placing resident at risk to not be allowed to return to same room upon discharge from hospital

- Failed to provide copy of "Bed Hold" notice to resident/representative upon discharge to hospital placing resident at risk to not be allowed to return to same room upon discharge from hospital

NE: SS=D: Failed to provide 2/3 residents reviewed for hospitalization/representative with written information r/t facility bed hold policy when transferred to hospital placing residents at risk for not being permitted to return & resume residence in nursing facility

- *Record lacked evidence resident/representative was provided bed hold policy when transferred to hospital; failed to provide resident/representative with bed hold policy when transferred to hospital placing resident at risk for not being permitted to return & resume residents in facility for 2 residents*

F655 Baseline Care Plan

NE: SS=D: Failed to develop a person-centered baseline CP to include indwelling catheter for 1 resident placing resident at risk for impaired care related to uncommunicated care needs

- CP lacked reason for indwelling catheter but documented staff would provide catheter care per facility policy; record lacked evidence of catheter cares provided for indwelling catheter; failed to develop a person-centered baseline CP to include indication & type of indwelling catheter for 1 resident placing resident at risk for impaired care related to uncommunicated care needs

NW: SS=D: Failed to provide a baseline CP within 48 hours of admission for 1 resident placing resident at risk for unmet care needs

- *Record lacked baseline CP which was completed within 48 hours of resident's admission on 12-22-23; failed to provide baseline CP within 48 hours of admission for 1 resident placing resident at risk for unmet care needs*

F676 Activities of Daily Living (ADLs)/Maintain Abilities

NE: SS=D: Failed to provide appropriate ADL care & assist for 1 resident when staff left resident on toilet in shower room unsupervised placing resident at risk or impaired ADL & decreased quality of life

- *Incident Report documented CMA assisted resident to shower room toilet, gave resident call light, instructed resident to use call light when finished then left shower room; CMA returned 10-15 minutes later & resident not finished so CMA left shower room to assist other residents; CMA thought someone else assisted resident off toilet & started passing meds then housekeeper notified resident still sitting on toilet in shower room & CMA went to shower room to assist resident; failed to provide necessary ADL care & assist for 1 resident when staff left resident unattended on toilet in shower room placing resident at risk for impaired ADL & decreased quality of life*

NE: SS=D: Failed to provide adequate care & services for ADLs when staff failed to provide supervision with eating during meals for 1 resident placing resident at risk for complication r/t aspiration & decline of overall abilities

- Staff reported resident preferred to eat in room due to not wanting to eat around other residents & stated resident is aphasic & got anxious around large groups of resident; CP documented resident to be provided "distant supervision" for eating r/t risk of aspiration; staff unaware of what "distant supervision" was; failed to provide adequate ADL cares when staff failed to provide supervision during meals for 1 resident placing resident at risk for complication r/t aspiration & overall decline

F677 ADL Care Provided for Dependent Residents

NE: SS=D: Failed to provide consistent bathing opportunities for 3 residents placing residents at risk for complications r/t hygiene & infections & impaired psychosocial wellbeing

- "Documentation Survey Report" for 48 days indicated resident received a bath on 3 occasions with no refusal documented; resident reported hadn't had a bath "in weeks" & only 1 who bathed resident was hospice staff & facility staff repeatedly told resident facility didn't have enough staff; failed to ensure 1 resident received consistent bathing opportunities form facility in addition to supplemental services provided by hospice placing resident at risk for complications r/t hygiene & infections
- Documentation revealed resident lacked documentation for bathing on 3 scheduled opportunities in 1 month; 8 opportunities in 1 month; bathing did not occur in 1 month; failed to ensure consistent bathing provided to dependent resident placing resident at risk for skin breakdown & possible injury/infection placing resident at risk of skin breakdown, infection & impaired psychosocial wellbeing
- Documentation for 140 days revealed resident with 7 scheduled occasions w/o documentation of refusals; observed resident with uncombed & matted hair; failed to provide consistent bathing for 1 resident placing resident at risk for complications r/t poor hygiene & impaired dignity

F678 Cardio-Pulmonary Resuscitation (CPR)

NE: SS=E: Failed to establish & maintain a system to ensure nursing staff maintained current CPR certification for healthcare providers placing all residents who desired CPR at risk for inadequate resuscitative measures

- LN's CPR expired; failed to establish & maintain system to ensure nursing staff maintained current CPR certification for healthcare providers placing all residents who desired CPR at risk for inadequate resuscitative measures

F679 Activities Meet Interest/Needs Each Resident

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

- Review of Activity Calendar revealed 2 consistent activities, "movie matinee" & "activities connection" for both Saturday & Sundays & Church services for Sunday mornings & "B-fit" provided by therapy dept on weekends; Resident Council reported activities minimally occurred on weekends due to low staffing; resident unaware facility provided activities on weekend & resident w/o activity calendar in room; failed to provide consistent activities for residents during weekends placing affected residents at risk for decreased psychosocial wellbeing & boredom

F684 Quality of Care

NE: SS=D: Failed to ensure staff physician ordered daily weights were obtained & monitored for 1 resident with CHF; failed to ensure staff applied resident's TED hose placing resident at risk for unwanted weight/fluid gain & 1 resident at risk for swelling & possible complications

- POS for daily weight & notification parameters & monitor/document/report s/sx of CHF; MAR/TAR lacked multiple documentation of daily weights in multiple months; failed to ensure staff obtained physician-ordered daily weight for 1 resident who had CHF placing resident at risk for fluid overload & other possible complications
- Documentation lacked evidence staff measured & recorded resident's weight on 22 occasions from 10-20 to 12-17 & record lacked documentation of physician notification of daily weight not obtained; failed to follow physician order for daily weights to monitor weight gain for flid overload for 1 resident with CHF placing resident at risk for adverse side effects for unnecessary medication or complications r/t fluid overload

NW: SS=D: Failed to provide quality care & treatment for 1 resident when staff failed to apply ACE wraps to 1 resident's bilateral legs daily for lymphedema placing resident at risk for edema, skin infections & skin breakdown

- *CP failed to address resident's need for ACE wraps to bilateral lower extremities to be applied every morning taken off every night; eTAR directed staff to apply ACE wraps to 1 resident's bilateral lower extremities daily in morning & take off ACE wraps at night; observed resident used call light to request nurse apply ACE wraps & told ADON that resident had been asking ACE wraps to be applied all morning; observed LN applied ACE wraps at 11:30am; resident sated there were times when ACE wraps never got applied & had to nag staff repeatedly & felt neglected; failed to provide quality care & treatment for 1 resident when they failed to apply ACE wraps to resident's bilateral legs as required for lymphedema placing resident at risk for edema, skin infections & skin breakdown*

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

NE: SS=D: Failed to ensure staff implemented appropriate infection control practices during wound care for 1 resident with hx of wound infection; also failed to ensure pressure reducing measures in place for 1 resident placing residents at risk of development of PUs, wound worsening & complications r/t infections

- Observed wound care & during treatment LN dropped Wound Vac tubing to floor & failed to replace tubing; observed LN failed to provide hand hygiene while changing gloves; failed to ensure 1 resident provided wound care following professional standards of infection control placing resident at risk of further infection & worsening of wounds
- POS for PRAFO boots; observed resident in room w/o PRAFO boots; failed to implement/ensure pressure reducing measures in place for 1 resident who was at risk for pressure injuries placing resident at increased risk for pressure/skin injuries

NW: SS=D: Failed to provide interventions to prevent skin breakdown for 1 resident who had shearing placing resident at increased risk for PU & delayed healing

- *Baseline CP directed staff to provide pressure reducing device & inspect skin according to facility policy; record lacked evidence staff monitored resident's time up in chair; LN stated resident should have pressure relieving cushion in chair but said had no knowledge of resident's turquoise cushion; failed to provide interventions to monitor & treat skin breakdown for 1 resident placing resident at risk for further skin breakdown & delayed healing*

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=J (Past Non-Compliance): Failed to ensure staff provided a safe environment as free of accidents as possible when SS staff propelled resident in w/c backwards out of facility's transport van but failed to ensure mechanical lift platform was in proper "up position; resident flipped backwards in w/c out of van; resident stated could not breath as was upside down having approximately 2 feet from van door to lift platform which was at ground level; resident struck shoulder & back on lowered platform & head on ground; resident required EMS for evaluation & treatment after fall where resident dx'd with concussion; resident had pain following fall & suffered significant bruising to shoulder, back, head & elbow, laceration to head & nausea & vomiting as well placing resident in immediate jeopardy

- *Failed to provide safe environment as free of accidents as possible resulting in harm to 1 resident when SS staff failed to ensure van lift platform was at proper position before moving resident backwards out of van causing resident to flip backwards in w/c upside down resulting in injuries & placing resident in immediate jeopardy*
- *Abatement Plan:*
  - *SS staff placed on suspension*
  - *Resident's Emergency Contact notified of event*
  - *Physician notified of event*
  - *Skin assessment completed upon return from ER & CP revised*
  - *Additional education of all staff who drove van with demonstration or proper loading & unloading with skills check completed*
  - *QAPI meeting held r/t incident*
  - *All new staff hired with authorization to drive van will have skills check completed prior to authorizing transportation of resident in van*
  - *Adm/designee will audit monthly random selection of staff on proper loading & unloading of residents*
  - *"Van Safety Orientation & In-Service" form utilized for skills checks & verified as completed before any new drivers are authorized to drive van*
  - *All authorized drivers & skills checks will be reviewed for compliance & results reported to QAPI committee*
  - *All staff in-services on ANE & any staff not completed in-service placed on suspension until completed*

SE: SS=D: Failed to ensure staff provided fall intervention as CP'd for 1/3 residents

- *Post fall intervention instructed staff to add dycem to recliner to keep resident from sliding out; observed resident in recliner in room & recliner lacked dycem material to prevent slipping/falls; failed to ensure staff provided dycem to resident's recliner t prevent slipping falls & possible injury as CPd*

SW: SS=J (Abated to D): Failed to ensure a safe environment

- *On 12-10-23 when facility staff member gave their personal vaping pen which allegedly contained THC to cognitively intact resident who had known hx of substance abuse; resident used staff member's vape pen & was found by staff & resident unable to function & required transfer to ER for evaluation placing resident in immediate jeopardy; resident able to relate that had obtained vape from laundry staff but didn't want to get anyone in trouble & had 3-4 "big hits"; laundry staff denied giving resident vape pen; resident stated group of resident in 1 room that passed a vape pen around for each to use & share & shared that resident had used marijuana & methamphetamine prior to admission; failed to ensure safe environment for 1 resident who had hx of substance abuse when facility staff member gave personal vaping pen, allegedly containing THC to 1 resident; resident used pen & staff found resident lethargic & required EMS transfer to ER for evaluation*
  - *Abatement Plan*
    - *Special Resident Council meeting to educate residents on substance abuse, smoking policy to include vape pens not sharing of smoking material & used only during smoking time in designated smoking area & if any suspicious activity or illegal activity report to charge nurse immediately*
    - *Staff education for:*
      - *Accidents-Substance Use Disorder (SUD) Policy*
      - *Safety for resident with SUD*
      - *Warning signs of SUD*
      - *Review of Drug & Alcohol Policy Handbook*
      - *Staff shall not share smoking paraphernalia or drugs with resident that are not prescribed to residents*

- ❖ *All residents smoking paraphernalia must be kept locked up & used only at the designated smoking times in designated smoking area including "vaping pens" & "e-cigarettes"*

NE: SS=J (Past Non-Compliance): Failed to provide adequate supervision to prevent 1 resident who was cognitively impaired & at risk for elopement from exiting facility w/o staff knowledge or supervision; pushed on door leading to stairwell for 15 seconds & able to open door; door alarm sounded but roam alert system did not alert even though resident wore roam alert bracelet; staff reset door alarm but did not check stairwell then went down flight of stairs & exited through outside door in stairwell; resident walked along sidewalk around building to front of building where entered front door & was intercepted by dietary staff then escorted resident back to LTC

- *Failed to provide adequate supervision & appropriate response to door alarms to prevent elopement placing resident in immediate jeopardy*
- *Abatement Plan*
  - *All elopement risk residents placed on 15-minute checks until roam alert system was fixed*
  - *Resident's CP updated*
  - *Security system company replaced circuit board & changed door alarm to sound when doors were pushed*
  - *Elopement drill completed followed by 2 more elopement drills*
  - *Staff educated on responding to door alarms*
  - *CNA received final written warning for responding to door alarms*

NE: SS=G (Past Non-Compliance): Failed to ensure 1 resident remained free from preventable accidents; resident fell forward from w/c while being lowered on facility bus lift, after staff failed to ensure brakes were fully engaged & no staff were present on ground monitoring lift resulting in emergent transfer of resident to hospital where resident dx'd with subdural hematoma placing resident at further risk for injury & pain

- *Failed to ensure 1 resident remained free from accidents when resident fell forward from w/c while being lowered on facility bus lift resulting in resident being transferred to hospital where resident found to have subdural hematoma*
- *Abatement Plan*
  - *Staff educated on driver safety along with completed competencies*
  - *Ad Hoc QAPI meeting held*
  - *Facility bus taken in for inspection & servicing with replacement of lift occupant belt & outer barrier screw completed*

NW: SS=G: Failed to prevent a fall out of a w/c when staff failed to place foot pedals on w/c before assisting resident outside in w/c; LN propelled resident down sloped sidewalk w/o foot pedals on w/c & resident planted feet on sidewalk & leaned forward, causing resident to fall face first on sidewalk; fall resulted in forehead hematoma & laceration which required sutures to close, abrasions & cervical fx of resident's 1st vertebrae placing resident at risk for increased pain & impaired mobility

- *CP lacked any direction to staff about use of foot pedals on resident's w/c when propelled by staff; during day of incident resident with increased confusion and crying; ER reported resident reported pain to neck, face, knee & headache; resident presented in c-collar, mild tenderness, lt periorbital hematoma & laceration to forehead; Incident Report documented LN took resident outside due to resident's delusions of needing to leave & look for family & resident leaned forward, planted feet on ground & tried to stand up from w/c & LN could not get resident to sit back or lean back & resident fell to ground & had laceration to head; LN stated could not stop fall; failed to prevent fall out of w/c by not placing foot pedals on w/c before assisting resident outside in w/c resulting in facial abrasions, hematoma, laceration requiring sutures, increased pain & neck fx for resident*

NW: SS=G: Failed to ensure staff repositioned resident safely while in Broda chair & resident sustained right proximal humerus fx placing resident at risk for pain

- *CP directed resident with total assist with use of Hoyer lift for transfers & total assist with mobility & extensive assist with bed mobility; NN documented LN & CNA repositioned resident in w/c & heard a "pop" in resident's back & resident c/o mild discomfort at the time; assessment revealed extremities moved with passive ROM at baseline; resident did not c/o any additional discomfort with ROM; next day resident yelled out in pain even after receiving pain med & undirectable & staff did not have any PRN anxiety medication to give to resident; resident sent to ER & radiology report documented resident with sustained closed fx of rt proximal humerus; incident report documented LN & CNA repositioned resident by placing 1 hand under each of resident's arm & 1 hand under each of resident's legs & first attempt did not get resident back far enough on sling then lifted resident a 2nd time & when they performed 2nd attempt, heard "pop"; staff failed to lay the Broda chair into back position rather than sitting position; POS for sling to arm; observed resident with sling & resident stated arm very painful & rated pain 8/10; staff stated all staff had been educated on arm & leg technique for moving residents; failed to ensure staff repositioned resident safely while in Broda chair resulting in proximal humerus fx; also placing resident at risk for increased pain*

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=G: Failed to provide appropriate catheter cares for 1 resident's indwelling urinary catheter when staff failed to provide flushes as ordered by physician to prevent UTIs; failed to ensure catheter cares were provided using acceptable standards of infection control practices & failed to ensure interventions were consistently & correctly implemented to anchor catheter to prevent worsening of catheter associated trauma resulting in catheter-related complications including UTI & traumatic injury caused by indwelling urinary catheter

- *CP did not address need to ensure securement device in place to decreased tension & stabilize tubing during routine cares or when resident moved to catheter bag independently until during onsite survey when intervention was initiated which directed staff to ensure securement device in place to decrease tension of tubing; CP did not address catheter care including flushing to prevent sediment build up, frequency of catheter changes & monitoring of penile changes & treatments r/t long-term catheter usage; record lacked any wound assessment or documentation r/t resident's penile wound which included measurement, treatments, peri wound assessment or signs of infection; failed to provide adequate catheter cares for 1 resident's indwelling urinary catheter when staff failed to provide flushes as ordered by physician to prevent UTI, failed to ensure catheter cares were provided using acceptable standards of infection control practices, & failed to*

ensure interventions were consistently & correctly implemented to anchor catheter to prevent worsening of catheter associated trauma resulting in catheter related complications including UTI & traumatic injury caused by indwelling urinary catheter

NE: SS=D: Failed to ID changes in 1 resident's bowel & bladder incontinence patterns & implement individualized toileting interventions; additionally failed to ensure 1 resident's indwelling catheter had appropriate indication & physician's order to provide catheter & related care placing both residents at risk for complications r/t bladder management & incontinence

- Cited findings noted in F550 r/t resident's incontinence; resident representative stated resident recovering from stroke & had declined since stroke; observed heavy urine smell in resident's room; failed to ID changes in resident's increased incontinence patterns & implement individualized toileting interventions placing resident at risk for complications r/t incontinence
- POS lacked physician order for Foley catheter placement & medical indication & catheter related care; record lacked evidence of catheter cares provided for indwelling catheter; Observed staff perform incontinent cares; staff removed 2 wipes from package & placed wipes on resident's thigh then used 1 wipe to clean resident's foreskin & around base of penis then placed soiled wipe on bed between resident's legs then used 2nd wipe to clean tip of penis & wiped away from tip of penis down tubing with wipe then removed soiled wipes & placed items into trash can next to bed then with same gloves, assisted resident onto side provided peri-care & placed clean brief on resident then doffed 1 glove only, donned clean glove w/o performing hand hygiene then adjusted 1 resident's clothes & bedding & wearing same gloves, CNA touched multiple items in room & removed soiled trash from resident's room; failed to ensure 1 resident had appropriate indication for ongoing use of indwelling catheter; further failed to ensure appropriate Foley care orders were in place to direct staff on Foley catheter care for 1 resident placing resident at increased risk for catheter related complications

F725 Sufficient Nursing Staff

NE: SS=F: Failed to ensure sufficient staffing provided to maintain residents' physical & psychosocial wellbeing placing residents at risk for impaired quality of life

- PBJ indicated facility had "excessively low" weekend staffing; Resident Council Minutes indicated council had recurring concerns with call light response times; observed resident in bed & staff delivered & prepped meal then staff left room with door slightly propped open & resident ate w/o supervision or check-in provided during meal on multiple occasions
- Observed resident with hair uncombed & matted upward; resident stated facility slow to get resident up & had not given resident at bath in weeks
- Adm Staff stated facility currently attempting to improve staffing by hiring more permanent staff & getting rid of agency & had PIP to address low staffing & issues r/t care concerns affected by staffing; CNA stated weekend staffing a "struggle" & didn't have enough help to complete assist resident's needs; failed to ensure sufficient staffing provided to maintain resident's physical & psychosocial wellbeing placing residents at risk for impaired quality of life

F726 Competent Nursing Staff

NE: SS=G: Failed to ensure staff possessed appropriate knowledge, skills & training t provide resident care in safe manner when uncertified Nurse Aide Student (NAS) transferred resident w/o facility staff member or nursing instructor present & NAS could not complete transfer with resident which resulted in assisted fall & resident subsequently dx'd with femur fx

- *Failed to ensure trained staff with appropriate skills & knowledge necessary were present during transfer; as result 1 resident had assisted fall which resulted in distal femur fx*

NW: SS=E: Failed to provide competent staff with appropriate training, skills & knowledge with 2 CNAs administered medication to 8 residents at direction of Adm Nurse because LN on duty did not feel comfortable passing medications placing residents at risk for medication errors & complications r/t incompetent staff

- *State Agency intake reports CMA called in due to weather which left agency LN to pass medication; intakes alleged DON gave permission for 2 CNAs on duty to assist LN to pass meds to residents & administrations were documented under LN name; Adm Nurse stated LN (agency nurse) not familiar with residents & therefore did not feel comfortable passing meds; Adm nurse gave permission for LN to pop medications for alert & oriented residents who did not need assist & permitted 2 CNAs to hand meds to residents; failed to provide competent staff who possessed appropriate training, skills & knowledge to administer meds placing residents at risk for medication errors*

F732 Posted Nurse Staffing Information

NW: SS=C: Failed to display accurate & up to date nursing personnel hours for staff responsible for providing direct care accessible to residents & visitors

- *Failed to display accurate & up to date nursing personnel hours for staff responsible for providing direct care accessible to residents & visitors*

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) recommendations for physician documented rationale for continued use of antipsychotic medication for 1 resident were addressed by physician placing 1 resident at risk for unnecessary psychotropic medication & related complications

- POS for Olanzapine for dementia; MMR from January to Octo with recommendations for GDR & physician documentation for risk versus benefits for continued use of antipsychotic med with dx of dementia & Alzheimer's disease; record lacked physician documented response to MRR which included rationale & risk/benefits for continued use of antipsychotic med with dx of dementia & Alz disease; failed to ensure CP recommendations for physician documented rationale for continued use of antipsychotic med for 1 resident were addressed by physician placing resident at risk for unnecessary psychotropic med & related complications

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to ensure dosing instructions for Voltaren gel for 1 resident placing resident at risk for unnecessary medication use & physical complications for affected resident

- POS for Volaren external gel1% apply to affected area q 4 hours PRN; order lacked dose; failed to ensure dosing instructions for Voltaren gel for 1 resident placing resident at risk for unnecessary medication use, side effects & physical complications

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure appropriate indication or documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefit for continued use of antipsychotic for 2 residents placing residents at risk for unnecessary psychotropic meds & related complications

- Cited findings noted in F756 r/t antipsychotic use for dementia; record lacked physician documented rationale which included multiple unsuccessful attempts for nonpharmacological interventions & risk versus benefits for continued use of antipsychotic medication; failed to provide physician documented rationale which include multiple unsuccessful attempts for nonpharmacological interventions & risk versus benefits for continued use of antipsychotic medication for 1 resident for insomnia placing resident at risk for unnecessary psychotropic medication & related complications
- Failed to provide physician documented rationale which included multiple unsuccessful attempts for nonpharmacological interventions & risk versus benefits for continued use of antipsychotic medication for 1 resident with dx of dementia & Alzheimer's disease placing resident at risk for unnecessary psychotropic medication & related complications

F760 Residents are Free of Significant Med Errors

NW: SS=J (Abated to G): Failed to ensure 1 resident remained free from significant medication errors

- *On 12-7-23 resident admitted to facility with POS for Glimepiride 2mg BID; staff incorrectly transcribed order as Glimepiride 4mg BID & resident received total of 7 doses of Glimepiride at twice prescribed dosage before staff caught error on 12-22-23 at 9:30pm; staff did not check resident's blood sugar but notified resident's representative & physician & stated no adverse effects from error; short while later, at 10:15pm, staff found resident face down on floor of room with call light still hooked to shirt; resident was drowsy with non-reactive pupils then became non-verbal; staff called EMS & EMS arrived & initiated transport to ER; EMS assessed resident's blood sugar at 36 mg/dL; DON stated facility did not check blood sugars unless ordered by physician, even if resident was showing signs of hypoglycemic crisis facility would have to obtain an order to check any resident's blood sugar & none of resident who were just on oral anti-diabetic medication received blood sugar checks; failed to ensure resident remained free from significant medication errors placing resident in immediate jeopardy*
    - *Abatement Plan:*
        - *Ad Hoc QAPI meeting held & plan of correction developed & implemented*
        - *All med orders were audited to verify orders were entered accurately*
        - *All residents with diabetic medications were reviewed for blood sugar monitoring & provider notified for orders for any resident found w/o order for blood sugar monitoring*
        - *Current nurse associates re-educated by DON/designee or prior to working next scheduled shift on order transcription & medication reconciliation*
        - *IDT reviewed "Admission Assessment & Follow Up" policy & procedure for compliance with CMS regulation F760*

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to ensure safe & secure storage of meds & biologicals creating a risk for adverse side effects & ineffective medication administration

- Observed med cart left unsecured & unlocked in area where residents were present; observed treatment cart in hallway left unsecured & unlocked; failed to ensure safe & secure storage of medications & biologicals creating a risk for adverse side effects & ineffective medication administration

F775 Lab Reports in Record-Lab Name/Address

NE: SS=D: Failed to ensure physician ordered lab test results for 1 resident were included in clinical record with potential to result in unnecessary tests & delayed treatment

- POS for CBC monthly & notify physician of results; EMR lacked lab tests for 3 months; failed to ensure physician ordered lab test results for 1 resident were signed & included in clinical record with potential to result in unnecessary tests & delayed treatment

F805 Food in Form to Meet Individual Needs

NW: SS=D: Failed to provide a dysphagia diet for 1 resident as ordered by physician placing resident at risk of choking & decreased nourishment

- *POS for regular dysphagia diet; observed meal of ground ham, mashed potatoes, mixed fruit, chocolate ice cream & whole Brussel sprouts; DON checked with dietary dept & verified resident's Brussel sprouts should have been cut into smaller pieces for dysphagia diet; failed to provide dysphagia diet as physician order for 1 resident when resident was served whole Brussel sprouts placing resident at risk for choking & decreased nourishment*

F812 Food Procurement, Store/Prepare/Serve-Sanitary

NE: SS=F: Failed to ensure kitchen staff appropriately sanitized probe-type thermometer used to check food temps prior to meal service; failed to ensure staff cleaned & maintained satellite kitchen ice machine leaving residents at risk for foodborne illnesses & cross-contamination

- Observed ice machine on 1 hallway with brown "gooey" substance on inside drain & outside of ice machine visibly soiled

- Observed dietary staff prepared to check temp of hot foods on steam table & donned gloves w/o performing hand hygiene & grabbed probe-type thermometer, removed cover of probe & placed probe end of thermometer into metal container with meat w/o sanitizing probe first then removed probe & inserted probe into other food item then removed probe & continued to check temps of each food item on steam table w/o sanitizing probe after insertion into each food item; staff reported did not have any sanitizing wipes to sanitize probe & unsure where to find them

F880 Infection Prevention & Control

NE: SS=F: Failed to ensure infection control standards were followed r/t COVID-19 isolation precautions, clean supply/equipment storage, & hand hygiene during cares placing residents at risk for infectious diseases

- Observed staff member at front desk wore face mask around chin while seated at desk & facility ID'd 2 residents as positive for COVID
- Observed clean linen rooms on 2 halls with dirty vacuums stored next to uncovered linen; green lift slings sat directly on floor in both store rooms
- Observed supplemental O2 nasal cannula & O2 tubing directly on seat of resident's recliner & no storage bag present for cannula or tubing on multiple occasions
- Observed 1 resident's room with no signage indicating droplet precautions or required PPE & isolation cart placed outside resident's room; observed resident's room w/o wearing PPE for resident in isolation & staff unaware resident was in isolation
- Observed wound care & removed 1 resident's dressing & changed gloves but failed to complete hand hygiene between glove change & cleansed wound & touched personal phone during cleansing & again changed gloves but failed to complete hand hygiene between glove change; new dressing applied
- Observed LN prepared to administer meds through feeding tube & failed to complete hand hygiene prior to preparing medication, upon entering room or upon administering med using feeding tube
- Cited findings noted in F690 r/t catheter care provided by staff; failed to ensure infection control standards were followed r/t COVID-19 & isolation precautions, clean supply/equipment storage & hand hygiene during cares placing residents at risk for infectious diseases

NW: SS=F: Failed to provide a safe, sanitary & comfortable environment to help prevent development & transmission of disease & infection when reusable equipment was not disinfected between resident use &/or storage in common areas; further failed to ensure CNA informed facility CNA had COVID symptoms & tested positive for COVID placing residents at risk for infection

- *Facility's COVID staff infection log documented CNA tested positive for COVID on 11-29-23 but had symptoms that started on 11-23; staffing sheet documented staff member worked 11-23, 24, & 12-1; COVID resident infection log documented 26 residents since 11-17 were ill with COVID-19; observed Adm nurse entered resident's room with tote with thermometer, wrist BP monitor & pulse ox to take resident's vital signs after fall; observed Adm nurse obtained resident's vitals, placed equipment back into tote & took tote to nurses' station w/o disinfecting reusable equipment; observed CNA took tote with same equipment & went back to resident's room & obtained vital signs then returned tote back to nurses' station & set it down on counter & did not sanitize equipment because nurse usually did it & verified vital sign equipment in tote was not designated to single resident but was used for any residents who did not have COVID; failed to disinfect reusable medical equipment between resident use & failed to ensure staff informed facility of presence of COVID symptoms &/or positive test placing residents at risk for infection*

F883 Influenza & Pneumococcal Immunizations

NE: SS=D: Failed to provide pneumococcal vaccinations or informed refusals for 1 resident & failed to provide influenza vaccinations or informed refusals for 1 resident placing residents at risk for complication r/t infectious diseases

- 1 resident's record evidence indicating resident/representative was offered, consented, refused or had received pneumonia vaccination since admission in 2019
- 1 resident's record lacked evidence indicating resident/representative had received influenza vaccination since admission in 2023; failed to provide pneumococcal vaccination or informed refusals for 1 resident & failed to provide influenza vaccinations or informed refusals for 1 resident placing residents at risk for complication r/t infectious diseases

January, 2024

F550 Resident Rights/Exercise of Rights

NE: SS=E: Failed to treat residents with respect, dignity & privacy r/t blood glucose testing, insulin administration, eye drop administration & unintentional skin exposure from too-large clothing placing affected residents at risk for impaired psychosocial wellbeing

- Observed LN obtained 1 resident's blood sugar reading using glucometer from resident's index finger at the DR table with 11 other residents seated in DR on multiple occasions; continued observation revealed resident pulled up shirt & LN administered insulin injection subq into resident's abdomen on multiple occasions; observed resident in Broda chair at DR table & resident's top slid off shoulder exposing 4 inches of resident's chest & skin; observed LN administered eye drops while resident sat at DR table with other residents present on multiple occasions; failed to promote care in manner to maintain & enhance dignity & respect placing affected residents at risk for impaired psychosocial wellbeing

NE: SS=E: Failed to promote & provide dignity for 1 resident who had uncovered urinary catheter bag; further failed to promote dignity & respect during dining for 15 residents seated in DR when staff discussed personal issues & looked at cell phones when assisting residents eating meals placing residents at risk for undignified experience & impaired quality of life

- Failed to promote & maintain dignity for 1 resident by not covering urinary catheter; further failed to promote & provide dignity for residents during dining placing residents at risk for undignified experience & impaired quality of life

F553 Right to Participate in Planning Care

NE: SS=D: Failed to inform resident/DPOA orally or in writing date & time of resident's quarterly CP meetings placing resident at risk for impaired care & decreased autonomy

- Record lacked documentation resident/DPOA was invited to or participated in quarterly CP meetings in last year but documentation indicated resident & DPOA had attended 1 meetings; resident & DPOA stated staff had not invited them to any CP meetings in last year; failed to provide notification to & include resident &/or DPOA of quarterly CP meetings for 1 resident placing resident at risk for impaired care & decreased autonomy

F558 Reasonable Accommodations Needs/Preferences

SW: SS=D: Failed to provide reasonable accommodation of needs r/t appropriately sized mechanical lift sling for 1 resident

- Failed to provide resident with reasonable accommodations of needs & preferences for appropriately sized mechanical lift sling

NE: SS=D: Failed to accommodate 1 resident's preferences when staff delivered resident's meal trays with other facility room trays even though resident's representative would not be coming until later to feed resident placing resident at risk for impaired nutrition as well as decreased quality of life

- Failed to accommodate 1 resident's preferences when staff delivered resident's meal trays with other facility room trays even though resident's representative would not be coming until later to feed resident placing resident at risk for impaired nutrition as well as decreased quality of life

F582 Medicaid/Medicare Coverage/Liability Notice

NE: SS=D: Failed to failed to provide CMS form 10055 ABN which included estimated cost to continue skilled services to resident/representative for 2 residents placing 2 residents at risk for unanticipated costs or uninformed decisions

- EMR lacked documentation 2 residents were provided CMS form 10055 for services ending; facility unable to provide evidence form was provided to 2 residents/representative; facility failed to provide 2 residents a CMS form 10055 to provide cost estimate for further services placing residents at risk for unanticipated costs or uninformed decisions

F584 Safe/Clean/Comfortable/Homelike Environment

SE: SS=E: Failed to maintain a clean, comfortable & homelike environment in 3 resident rooms & 1/2 med rooms

- Observed room with floor with multiple areas of sticky substance; over bed table with rust & build up of grime on base; recliner with multiple pillows w/o pillowcases & dresser tops with unorganized supplies & personal items
- Observed unopened box of tube feeding supplies stored on floor in med room
- Resident room with fall mat with multiple tears making it unsanitizable & room with build up of dirt & grime around perimeter of room
- Resident room with headboard with missing/chipped varnish making it unsantizable
- Failed to maintain clean, comfortable & homelike environment in resident rooms & medication room

F600 Free from Abuse & Neglect

SE: SS=K (Abated to E): Failed to ensure residents remained free from resident-to-resident abuse/sexual abuse on multiple occasions when cognitively ipaired resident had aggressive behaviors directed to residents & staff, wandered into other resident rooms, exposed self to other resident & facility failed to take action to prevent further resident-to-resident altercations &/or abuse with multiple documented incidents of resident-to-resident aggression placing resident & all other residents in immediate jeopardy

- *CP lacked any intervention r/t trying to take female resident into room & locking door; CP lacked updates of individualization when resident had multiple behaviors noted in "Behavior" & "Event" notes; EMR lacked evidence staff assessed other resident after resident exposed self to resident & both resident's EMR revealed staff failed to initiate interventions to protect other residents when resident had multiple resident-to-resident altercations with other resident including hitting & exposed self to resident; lacked any investigation r/t resident exposing self to other resident; failed to ensure residents remained free from resident-to-resident abuse/sexual abuse on multiple occasions when cognitively impaired resident had aggressive behaviors directed to residents & staff, wandered into other resident rooms, exposed self to other resident & facility failed to take actions to prevent further resident-to-resident altercations &/or abuse placing other residents & all other residents in immediate jeopardy*
- *Abatement Plan:*
  - *Reviewed & updated resident's CP to reflect current & past known behaviors & triggers*
  - *Resident's PCP notified of alleged incident*
  - *Ad Hoc QAPI meeting held with Medical Director to address alleged deficient practice*
  - *SSD assessed other resident with no psychosocial concerns ID'd*
  - *Psychosocial assessment, "Trauma Informed Care Assessment" completed on other resident to assess for issues r/t events & no negative outcomes ID'd*
  - *IDT reviewed plan*
  - *SSD interviewed all current residents to determine if anyone had experienced or witnessed abuse in facility*
  - *Regional Director of Clinical Services educated DON & Adm on Incident & Reportable Event Management*
  - *Regional Director of Clinical Services educated SSD on assessing each resident following abuse*
  - *DON reviewed behavior notes, progress notes, psychosocial notes, health status notes, event notes & CP for all residents for last 90 days to audit for potential abuse related events*
  - *Staff education on reporting suspected ANE & staff to have education provided prior to working next scheduled shift*

- *Staff educated on Behavioral Health Policy*
- *Staff educated on Incident & Reporting Event Management*
- *Staff educated on ANE Allegation Investigation*
- *All staff educated on ANE/Behavior Monitoring; Reporting; Mental Health & Substance Abuse*

NW: SS=D: Failed to prevent resident-to-resident abuse when 1 resident was unwantedly kissed on hand & mouth by other resident placing resident at risk for unwanted sexual advances anxiety & impaired psychosocial functioning

- *Resident totally dependent of 1-2 staff; incident report documented other resident approached resident & touched resident's hand then kissed resident's hand & leaned in & kissed resident on mouth; resident put hand up to attempt to block action; CMA & dietary staff immediately removed other resident from situation & staff initiated 1/1 observation with other resident; failed to prevent resident-to-resident abuse when resident was unwantedly kissed on resident's hand & mouth by other resident placing resident at risk for unwanted sexual advances, anxiety & impaired psychosocial functioning*

F602 Free from Misappropriation/Exploitation

NE: SS=G: Failed to ensure 1 resident remained free from misappropriation of property when checks were stolen from resident's room then cashed causing resident to feel anger & frustration as resident blamed self for misappropriation of funds while resident was a resident in facility further placing resident at risk for further misappropriation of funds & continued decline in psychosocial wellbeing

- *Investigation documented resident's representative reported to Adm that resident had multiple checks missing from checkbook & bank reported fraudulent check cased for approximately $1200 & 2nd check attempted to be cashed but bank caught it; representation reported total of 8 checks missing; representative closed account & took remaining checks home; Adm notified policy immediately when representative made report; facility interviewed staff & found no leads; checks taken within 17-day period; facility unable to provide inventory log of resident's belongings; resident reported kept checkbook on counter in room; failed to ensure 1 resident remained free from misappropriation of property when resident had checks stolen from room at facility which were then cashed for approximately $1200 causing resident to feel mad & frustrated as resident blamed self for misappropriation of funds while resident in facility; failure further placed resident at risk for further misappropriation of funds & decline in psychosocial wellbeing*

F609 Reporting of Alleged Violations

SE: SS=L (Abated to F): Failed to report resident-to-resident abuse/sexual abuse to State Agency (SA) &/or law enforcement when cognitively impaired resident tried to get another resident into resident's room, stating resident wanted to "have her come in room & lock door"; incident when resident had pulled brief down, exposed penis & told CNA "This is what she wants"; failures placing other resident & all other residents in immediate jeopardy

- *Cited findings noted in F600 r/t multiple incidents of abuse & sexual abuse; failed to report resident-to-resident abuse/sexual abuse to SA &/or law enforcement when cognitively impaired resident tried to get another resident in room, stated resident wanted to "have her come in room and lock the door" & incident when resident pulled brief down, exposing penis & told CNA "This is what she wants" placing other resident & all other residents in immediate jeopardy*
- *Abatement plan: same as F600*

NE: SS=D: Failed to report to State Agency (SA) within required timeframe resident's black eye received from unknown origin placing resident at risk for further injury & unidentified abuse or mistreatment

- CP lacked interventions for prevention of injuries r/t tremors; record documented staff informed LN that resident had black eye; resident nonverbal & unable to say what happened but had not fallen; investigation documented resident had anxiety & was noted to be restless & agitated & concluded root cause of black eye was that resident hit self on bed rail; observed resident in bed partially uncovered & rails not padded; DON stated facility should have called black eye into SA; failed to report to SA within required timeframe resident's injury of unknown origin placing resident at risk for further injury & unidentified abuse or mistreatment

F610 Investigate/Prevent/Correct Alleged Violation

SE: SS=L (Abated to E): Failed to ensure residents remained free from resident-to-resident abuse/sexual abuse on multiple occasions when cognitively impaired resident had aggressive behaviors directed toward residents & staff, wandered into other resident rooms, exposed self to other resident & facility failed to investigate & take action to protect other residents & prevent further resident-to-resident altercations &/or abuse

- *Cited findings noted in F600 & F609; failed to ensure residents remained free from resident-to-resident abuse/sexual abuse on multiple occasions when cognitively impaired resident had aggressive behaviors directed toward residents & staff, wandered into other resident rooms, exposed self to other resident & facility failed to investigate & take actions to protect other residents & prevent further resident-to-resident altercations &/or abuse placing other resident & all other residents in immediate jeopardy*
- *Abatement Plan: same as F600 & F609*

NE: SS=D: Failed to investigate 1 resident's bruises of unknown origin placing resident at risk for unidentified & ongoing abuse &/or neglect

- NN documented staff observed scratches & multiple bruises to both arms & hands with noted measurements; record revealed facility did not obtain witness statements or interviews from any staff & spoke only to 3 residents before ruling out abuse; observed resident's husband transferred resident from w/c to bed using bearhug method & assisted resident to lay back then lifted resident's feet into bed; failed to thoroughly investigate resident's injuries of unknown origin placing resident at risk for unidentified & ongoing abuse &/or neglect

NE: SS=D: Failed to thoroughly investigate injury of unknown origin for 1 resident who had black eye placing resident at risk for further injury & unidentified abuse or mistreatment

- Cited findings noted in F609; failed to thoroughly investigate injury of unknown origin for 1 resident with black eye placing resident at risk for further injury & unidentified abuse or mistreatment

NW: SS=E: Failed to implement interventions to protect 19 cognitively impaired residents during investigation of resident-to-resident abuse which occurred when other resident unwantedly & inappropriately touched & kissed a resident, a cognitively impaired resident unable to consent placing 19 cognitively impaired resident who were unable to consent to sexual affections at risk for sexual abuse & psychosocial impairment

- *Cited findings in F600 r/t other resident kissing resident on hand & mouth w/o resident's consent; failed to implement interventions to protect 19 cognitively impaired residents at risk from being placed in position to have unwanted touching & kissing during investigation of resident-to-resident abuse placing 19 cognitively impaired residents who were unable to consent to sexual affections at risk for sexual abuse & psychosocial impairment*

F623 Notice Requirements Before Transfer/Discharge

NE: SS=D: Failed to notify State LTC Ombudsman as required of 1 resident's discharge from facility placing resident at risk for impaired rights &/or advocate involvement

- EMR lacked evidence bed hold was issued when resident hospitalized & unable to provide evidence LTC Ombudsman notified of facility-initiated discharge; failed to notify LTC Ombudsman of 1 resident's facility-initiated discharge placing resident at risk for impaired rights &/or advocate involvement

F625 Notice of Bed Hold Policy Before/Upon Transfer

NE: SS=D: Failed to provide 1 resident/representative with facility Bed Hold upon a facility-initiated discharge/transfer to hospital placing resident at risk for impaired rights

- Cited findings noted in F623 r/t resident's transfer to hospital; failed to provide 1 resident or representative a Bed Hold notice placing resident at risk for impaired rights

F656 Develop/Implement Comprehensive Care Plan (CP)

SE: SS=D: Failed to develop CAA which defined resident issues/conditions &/or problems for 2 residents

- *Cited findings noted in F600, F609 & F610 r/t resident-to-resident abuse & resident behaviors; CAA lacked in-depth, resident specific assessment of triggered care area; failed to develop CAA which defined resident issues/conditions &/or problems for 1 resident*
- *Behavioral Symptom CAA lacked in-depth, resident specific assessment of triggered care area; failed to develop CAA which defined resident issues/conditions &/or problems for 1 resident*

NE: SS=D: Failed to develop an individualized comprehensive person-centered CP for 2 residents placing residents at risk for unmet mental health care needs r/t past trauma

- Per EMR resident with extensive hx of trauma throughout life with ideation of suicide; record lacked provider notes from Consultant for visit, lacked evidence facility did anything in response to resident's expressions of suicidal intent &/or ideation other than talking to resident & setting up counseling sessions for following week; record lacked documentation of any safety or protective interventions initiated; record lacked evidence of person-centered interventions to address suicidal ideation or hx of traumatic experiences; failed to develop individualized comprehensive person-centered CP for 1 resident who had expressions or indications of distress placing resident at risk for unmet mental health care needs r/t past trauma
- Resident with hx of trauma experiences; CP documented resident with current &/or historical psychosocial events that affected mood & behavior due to time in military; CP lacked any further interventions r/t "Life Stressor Assessment" triggers; POS for Lorazepam PRN; Staff verified CP had not been developed to address resident's PTSD despite that trauma-informed care assessment completed on admission showed hx of trauma; failed to develop comprehensive CP that included interventions for 1 resident's PTSD placing resident at risk for unmet behavioral health care needs

NE: SS=D: Failed to develop CP for 1 resident with tremors placing resident at risk for unmet care needs

- CP lacked interventions for prevention of injury r/t resident's tremors; failed to develop care for 1 resident who had tremors placing resident at risk for unmet care needs

F657 Care Plan Timing & Revision

SE: SS=D: Failed to revise 1 resident's CP to include care & tx of urinary catheter & failed to revise 1 resident's CP to include use of pressure reducing device when sitting in recliner

- Failed to revise 1 resident's CP to include use of resident's urinary catheter
- Failed to revise 1 resident with stage 3 PU to include pressure reducing device in recliner to aid in healing current PU & prevention of further PUs

SE: SS=D: Failed to review & revise CPs for 2 residents when they exhibited behaviors directed toward other residents & staff

- *CP lacked any intervention r/t trying to take a female resident in resident's room & locking door; CP further lacked updates or individualization when resident had multiple behaviors noted in "Behavior" & "Event" notes; CP lacked updated interventions r/t resident's behaviors following multiple documented incidents of behaviors; failed to review & revise CP for 1 resident when resident exhibited multiple behaviors directed toward other residents & staff*
- *CP lacked any interventions which included triggers &/or directions to staff r/t resident-to-resident altercations on 2 occasions; ; CP lacked direction to staff r/t resident's refusals to care; failed to review & revise CP for 1 resident when resident exhibited multiple behaviors directed toward other residents & staff*

NE: SS=D: Failed to revise CP with effective person-centered interventions for 1 resident who had falls r/t toileting & failed to revise CP for 1 resident who no longer had enhanced barrier precautions (EBP) placing residents at risk for further injury & unmet care needs

- LN stated resident should be repositioned every 2 hours & observed resident had not been repositioned, checked or changed for 8 hours & LN stated staff "very busy and had not even had lunch yet" at 2:15pm; failed to revise 1 resident's CP with effective person-centered interventions placing resident at risk for further falls & injury
- Failed to revise 1 resident's CP after resident no longer needed EBP placing resident at risk for impaired care due to uncommunicated care needs

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to provide facial grooming for 1/2 residents r/t trimming of beard & mustache

- Resident dependent for ADLs; Observed resident with beard & mustache which was long & unkempt which curled over lips & into mouth area; failed to provide dependent resident with necessary personal hygiene assistance r/t trimming of facial hair

NE: SS=E: Failed to provide ADL care & assistance to 4 residents placing residents at risk for poor hygiene & impaired dignity

- Observed resident unshaven & hands & nails visibly soiled with dark brown & yellow substance & wearing soiled shirt on multiple occasions; failed to provide ADL assistance for 1 resident placing resident at risk for poor hygiene & impaired dignity
- Shower sheets documented resident with shower 3 x's in Sept, 3 x's in Oct, 1 x in Nov, 1 x in Dec, 1 x in January; observed resident with hair matted all over head on multiple days & wearing same clothes on multiple days; failed to provide bathing regularly for 1 resident placing resident at risk for poor personal hygiene
- Failed to provide assistive care for 1 resident for 8 hours which caused buttocks to be red & excoriated placing resident at risk for further skin breakdown
- Failed to provide assistive cares & services for eating for 1 resident placing resident at risk for weight loss & unmet ADL needs

F678 Cardio-Pulmonary Resuscitation (CPR)

NW: SS=K (Past Non-Compliance; Abated to G): Failed to ensure staff provided CPR to 1 resident who desired resuscitative measures as indicated by full code status; at 11:08am staff entered resident's room & IDd resident not breathing; staff applied O2 but noted resident had no vital signs at that time; RN on duty called ER at local hospital & spoke with physician who LN referred to resident's PCP; LN reported receiving instruction form PCP not to initiate any resuscitative measures as PCP coming to facility to assess resident; staff failed to provide CPR to resident who had full code status & failed to activate EMS services upon ID of emergent situation; resident died in facility placing resident & all residents with a full code status in immediate jeopardy

- *LN stated had not performed CPR because physician said not to & CNA was very upset about not performing CPR & called police; LN stated had received education about performing CPR on residents with full code status immediately if found w/o pulse or respirations; when interviewed, person IDd as PCP denied being resident's physician & was "on-call" physician & denied telling facility not to start CPR or to stop anything that staff had already initiated; failed to provide 1 resident CPR who had full code status & failed to activate EMS upon IDs of emergent situation & resident died in facility placing resident & all residents with full code status in immediate jeopardy*
- *Abatement Plan:*
  - *Reviewed policies & procedures r/t code status*
  - *100% audit of code status completed*
  - *Staff re-educated on facility policies*
  - *Any staff that did not attend training not permitted to work until training complete*
  - *QAPI meeting in response to immediacy conducted including Medical Director*

F684 Quality of Care

NE: SS=D: Failed to ensure staff accurately transcribed orders from hospital on admission & failed to follow physician's orders for 1 resident placing resident at risk for unwarranted physical complications & less-than-therapeutic effects r/t medication use

- *EMR lacked evidence Prednisone order was entered & administered; consult report documented resident an order for Prednisone but no current order in EMR; failed to ensure staff accurately transcribed orders from hospital on admission & failed to follow physician's orders for 1 resident placing resident at risk for unwarranted physical complications & less-than-therapeutic effects r/t medication use*

NE: SS=D: Failed to follow-up with 1 resident's physician when resident experienced change in condition placing resident at risk for delayed treatment & unwarranted physical complications

- *Documentation revealed CNA reported to LN that resident had difficulty forming words & was pale; resident responded to LN by turning head only & mouth moved but no words verbalized; BP 97/61, respirations 20, pulse 111; O2 sat at 95%; LN called on-call service & was on hold for 10 minutes then voice stated all providers busy & to leave call back number; LN left message & awaited call back & CNA advised to check on resident hourly; record lacked evidence physician followed up with after change in condition on that day; failed to follow up with resident's physician when resident experienced change in condition with risk for delayed treatment & unwarranted physical complications*

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

SE: SS=D: Failed to provide sanitary dressing change for 1 resident's PU & failed to implement pressure relieving device in resident's recliner

- Resident with Stage 3 PU with wound consultant debridement; wound became infected; failed to provide sanitary wound care, adjustments of linen to ensure decrease of pressure areas & removal of soiled linen to prevent further infection in 1 resident's stage 3 PU to promote optimal wound healing when observed staff placed wound supplies placed on plastic bag on resident's over bed table w/o sanitizing surface; when positioned for wound care bed linen contained wrinkles under resident's back & lower back; & when LN removed soiled dressing failed to change gloves between removing soiled dressing & performing treatment & applying new dressing

- Failed to ensure staff provided resident with stage 3 PU pressure relieving devices when seated in recliner & adequate toileting routine to promote optimal wound healing

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to provide 1 resident restorative therapy as CP'd placing resident at risk for decline in mobility & function

- EMR lacked evidence resident received PROM daily as ordered & as CP'd; failed to provide restorative services for 1 resident as CP'd placing resident at risk for decline in mobility & function

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=D: Failed to ensure 1 resident was kept free of accident hazards by failing to ensure urinary catheter tubing was contained to prevent tripping hazard

- Failed to ensure fall interventions were being practiced for dependent resident with hx of falls when catheter tubing caused resident to fall

SW: SS=D: Failed to provide a safe environment when staff failed to carry call light pagers hooked to call light system to alert staff when resident moved; resident with fall with minor injury & staff were unaware alarm sounded to resident's movements prior to fall

- Failed to provide safe environment when staff did not ensure dycem pad in 1 residents w/c as documented in CP creating an accident hazard r/t falls
- Failed to provide safe environment when staff failed to follow CP'd interventions including carry call light pagers on night shift when resident had fall with minor injury & staff unaware resident had called for help

SW: SS=G: Failed to ensure 1 resident who required staff assistance with meals remained free from preventable accidents when resident spilled hot tea on self, resulting in 2nd degree burn to thigh placing resident at risk for increased pain

- *CP did not address hot liquids safety before incident of burn; facility unable to provide evidence facility assessed resident's ability to safely manage hot liquids prior to incident of burn; failed to ensure resident, who required staff assist with meals, remained free from preventable accidents when resident spilled hot tea on self, resulting in burn to thigh & placing resident at risk for increased pain*

NE: SS=E: Failed to ensure safe environment free of accidents & hazards for 4 cognitively impaired, independently mobile residents who resided in facility

- Observed unlocked shower room door on 1 hallway with chemicals labeled with warnings; failed to store hazardous chemicals in safe environment & failed to ensure electrical panels were safely secured, placing 4 cognitively impaired independently mobile residents in facility at risk for injury

NE: SS=G (Past Non-Compliance): Failed to ensure 1 resident received adequate supervision & assistance to prevent a serious injury accident

- *On 11-14 during assisted transfer, staff failed to ensure resident's w/c brakes were locked & resident slid to floor, complained or hip pain & was transferred t local hospital for eval & tx & X-ray revealed resident sustained proximal femur fx; resident subsequently transferred to metropolitan hospital for orthopedic consult & surgical repair of hip fx; resident sustained post-surgical complications & ultimately returned to facility; practice also placed resident at risk for increased pain, decreased mobility & impaired quality of life; failed to ensure environment free from preventable accidents when staff failed to lock brakes on resident's w/c before transfer & as result of deficient practice, resident fell & required emergency services & surgical repair of hip fx, also placing resident at risk for increased pain, decreased mobility & impaired quality of life*
- *Abatement Plan*
  - *Staff educated on transfer training & progression with attention to every detail such as preparation & implementation of equipment used & different types of transfers; emphasis noted in written handouts on locking w/c brakes*

NE: SS=J (Past Non-Compliance): Failed to ID likely avenues of exit, including windows & failed to ensure windows were secured to prevent cognitively impaired resident who was at high risk for elopement from exiting facility through window

- *On 12-28-23 at 1:45pm CNA observed resident pacing in room at 2:13pm dietary staff returned to facility after lunch & observed resident walking down street approximately 150 feet from facility; temp outside was 40 degrees at time; no injuries noted upon assessment; window open & resident stated jumped out of window; facility failed to ID & secure likely avenues of exit for 1 resident who was at high risk for elopement & severely cognitively impaired & as result of failure, resident eloped from facility via bedroom window placing resident in immediate jeopardy*
- *Abatement Plan:*
  - *Windows in facility were secured with screw in window to prevent window rom opening farther than 3-4 inches & wooden dowl placed on top of window pan to prevent windowpane from being lifted out of window frame*
  - *Staff received training on elopements & procedures for handling elopements*

NE: SS=D: Failed to implement fall prevention interventions for 1 resident who had falls r/t toileting & failed to provide padded bed rails for 1 resident who had tremors & hit bed rails which resulted in bruising placing residents at risk for injury

- Failed to implement fall interventions for 1 resident who had falls r/t toileting placing resident at risk for preventable accidents & injury
- Failed to implement interventions to prevent injury for 1 resident who had tremors & was believed to have been injured by bed rails placing resident at risk for preventable accidents & related injury

NW: SS=G (Past Non-Compliance): Failed to follow 1 resident's fall interventions which resulted in fall from resident's bed & resident sustained broken nasal bone

- *N 1-7 staff provided care to resident but did not replace fall mat next to resident's bed when leaving room; CMA later found resident lying on floor on stomach with face in pool of blood & blood running out or resident's nose; resident transferred to ER where resident dx'd with*

broken nasal bone placing resident at risk for injury, pain & bruising; failed to ensure safe environment for 1 resident when staff failed to place fall mat at bedside as directed by resident's CP resulting in facial fx due to fall from bed & placed resident at risk for pain

- *Abatement Plan:*
  - *Facility ID'd & completed all corrective actions including staff education on following residents' CPs & fall prevention interventions*

NW: SS=G (Past Non-Compliance): Failed to prevent a fall with major injury to 1 resident; on 12-11 at 7:45am CNA failed to apply safety belt in bath chair & as result resident sustained displaced intertrochanteric fx of femur placing resident at risk for pain, decreased mobility & impaired quality of life

- *Incident Report documented resident in bath house & resident did not have bathtub safety belt in place & fell out of bath chair; failed to ensure environment free from preventable accident hazards when staff failed to apply safety belt to 1 resident while resident was in w/c bath chair & as result resident fell & sustained fx placing resident at risk for pain, decreased mobility & impaired quality of life*
- *Past Non-Compliance Plan:*
  - *Staff education on ANE & bathing, w/p & shower clinical skills*

F690 Bowel/Bladder Incontinence, Catheter, UTI

SE: SS=D: Failed to ensure proper catheter care with securing catheter for 1/3 residents reviewed to prevent urethral trauma

- Resident with indwelling catheter for neurogenic bladder; observed CNA repositioned resident in bed & catheter gab attached to bed frame with lower part of bag directly on floor; anchoring device for catheter no attached to resident as it was twisted & stuck to itself around catheter tubing; failed to provide anchoring device for resident's catheter to prevent dislodgement or urethra trauma

SW: SS=J (Abated to G): Failed to ensure appropriate indwelling urinary catheter care for 1 resident

- *On 12-24-23 LN flushed 1 resident's indwelling urinary catheter w/o physician order & used a non-sterile 50 mL syringe from resident's BR which possible contained bleach & water mixture; resident c/o burning pain immediately upon injecting flush & LN realized performed flush on "wrong patient"; then LN flushed catheter again with same non-sterile 60 mL syringe using tap water from sink to "take out whatever was making it burn"; approximately 15 minutes later, resident required Tylenol for pain & LN flushed resident's urinary catheter again using new syringe & saline solution; LN did not notify resident's physician r/t incident; during night LN applied ice pack wrapped in towel to resident's brief to "help with pain"; Adm Nurse contacted on-call provider following morning at 9am when resident c/o still feeling burning & pain & staff administered additional Tylenol to resident for pain at level "5"; practice of failing to provide appropriate indwelling urinary catheter care placed resident in immediate jeopardy*
- *Abatement Plan*
  - *Procedure changes made to eliminate use of chlorine for cleaning catheter bags & use of white vinegar mixture*
  - *P/P change to "Catheter Irrigations & Catheter Bag Cleaning implemented*
  - *Procedure change to stress written order from doctor has to be in EMR before proceeding with procedure of irrigation*
  - *Procedure change to include care of syringe for both irrigation & cleansing of bag to date & change out syringe every 7 days*
  - *Training on all LN staff with competency training on procedures for irrigation of resident bladders & cleansing catheter bags*
  - *Training of all new LN staff on nursing procedures before staff are allowed on floor*
  - *Monthly clinical competency training schedule presented at January QAPI meeting & QAPI will follow up at each meeting thereafter to ensure competency training completed for all clinical staff based on scheduled*

F693 Tube Feeding Management/Restore Eating Skills

NE: SS=Failed to provide physician-ordered residual checks & water flushes for 1 resident's feeding tube placing resident at risk for aspiration & inadequate hydration

- Observed LN checked for gastric residual with tube feeding syringe then flushed tube with 90 mL water then administered meds through G-tube & put 90 mL water in with last of meds & administered by gravity drip then administered tube feeding bolus of 250 mL & closed port w/o flushing G-tube as ordered; observed LN crushed meds & did not check for residual before administering meds them provide 10 mL flush between each medication & 30 mL flush after them administered MiraLAX in 180 mL water, 200 mL free water with tube feeding & 90 mL water flush at end of tube feeding but never checked residual as ordered; failed to provide physician-ordered residual check & water flushes for 1 resident's feeding tube placing resident at risk for aspiration & inadequate hydration

F699 Trauma Informed Care

NE: SS=J (Abated to G): Failed to provide trauma-informed care for 1 resident who had extensive hx of trauma

- On 5-11 facility performed SS assessment which revealed extensive hx of traumatic relationships, experience with disaster, profound feelings of helplessness, hx of serious accidents &/or injuries & hx of abuse & sexual harassment; facility did not develop CP which IDd & addressed triggers in order to prevent recurring traumatization; on 11-1 resident told activity staff abut hx of traumatization, previous suicide attempts & feelings of wanting to shoot self; resident cried & stated felt sad & suicidal; facility's failure to ID & implement person-centered interventions to address psychosocial wellbeing for resident with extensive of trauma placed resident in immediate jeopardy; facility further failed to ensure trauma informed care was developed & implemented for 2 other residents; facility's failure to ID & implement person-jeopardy
- Failed to ensure 1 resident received trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization of resident placing resident at risk for unmet behavioral health care needs
- Failed to ensure 1 resident who was dx'd with PTSD, received trauma-informed care & services for behavioral health needs placing resident at risk for unmet behavioral healthcare needs
- Abatement Plan

- Resident interviewed for current thoughts of harmful self & plan to execute & resident denied any thoughts of self-harm or plan to execute
- Resident had trauma-informed care assessment completed to ID experiences, triggers, stressors, & preferences to eliminate or mitigate triggers that may cause re-traumatization of resident
- Facility scheduled mental health counseling service provider to visit with resident
- Resident placed on 30 minute checks to be monitored by nursing staff for statements of self-harm or usual behaviors with immediate escalation to licensed staff
- Staff received education on monitoring for self-harm statements & usual behaviors with physician notification if indicated
- Nursing initiat6ed monitoring of resident's for mood & behavior changes, statements of self-harm & usual behaviors each shift with physician notification of any changes & resident placed on 1:1 if self-harm is ID'd
- Resident's CP revised to reflect traumatic experiences, triggers, de-escalation & interventions based on current assessment to minimize triggers &/or re-traumatization

F726 Competent Nursing Staff

NE: SS=E: Failed to complete competency assessments for staff to ensure staff possessed skills & abilities necessary to provide care to facility residents placing residents who used mechanical lifts at risk for impaired care & decreased quality of life

- Facility lacked documentation of any skills competency checks for any LNs or CNAs for 2023; Cited multiple incidents r/t lack of competency checks; failed to complete competency assessments for staff to ensure staff possessed skills & abilities necessary to provide care to facility residents placing residents who used mechanical lifts at risk for impaired care & decreased quality of life

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

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

- Review of working schedule revealed facility lacked RN coverage for 8 consecutive hours on 19 days from 10-10 thru 1-17; failed to provide RN coverage 8 consecutive hours 7 days a week placing all residents at risk for lack of assessments & inappropriate care

SW: SS=J (Abated to G): Failed to ensure nursing staff competency when LN flushed resident's indwelling urinary catheter w/o physician order & used non-sterile 60 mL syringe from 1 resident's BR which possible contained some bleach & water mixture

- *Cited findings noted in F690 r/t bladder injury r/t bladder irrigation; failed to ensure competent nursing staff for appropriate urinary catheter care resulting in resident experiencing pain & hematuria placing resident at increased risk for infection & bladder tissue damage*
- *Abatement Plan:*
  - *Procedure changes made to eliminate use of chlorine for cleaning catheter bags & use of white vinegar mixture*
  - *P/P change to "Catheter Irrigations & Catheter Bag Cleaning implemented*
  - *Procedure change to stress written order from doctor has to be in EMR before proceeding with procedure of irrigation*
  - *Procedure change to include care of syringe for both irrigation & cleansing of bag to date & change out syringe every 7 days*
  - *Training on all LN staff with competency training on procedures for irrigation of resident bladders & cleansing catheter bags*
  - *Training of all new LN staff on nursing procedures before staff are allowed on floor*
  - *Monthly clinical competency training schedule presented at January QAPI meeting & QAPI will follow up at each meeting thereafter to ensure competency training completed for all clinical staff based on scheduled*

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

SE: SS=C: Failed to complete annual performance review at least once every 12 months for 4/4 CNAs & 1/1 CMA

- 4/4 CNA files lacked annual performance review in personnel files; failed to complete annual performance reviews for 4/4 CNAs & 1/1 CMA who had been employee for over 1 year

NE: SS=F: Failed to ensure CNAs received 12 hours in-services annually as required placing all residents of facility at risk for inadequate care

- Facility lacked evidence that any CNAs had required 12 hours of in-services for 2023; failed to ensure CNA staff received 12 hours in-services annually as required placing all residents of facility at risk for inadequate care

F732 Posted Nurse Staffing Information

NE: SS=C: Failed to post nursing staffing information in each facility building daily

- Upon entry 1 building posted staff hours dated 3 days prior & lacked census; in other building no posted staff hours found; failed to post nursing staffing information in each facility building daily as required

F740 Behavioral Health Services

SE: SS=D: Failed to provide 2 residents with appropriate treatment & services to attain their highest practicable mental & psychosocial wellbeing when staff failed to implement interventions r/t outbursts towards other residents & staff & failed to acknowledge & assess underlying causes of resident's expressions of distress

- *Failed to provide 1 resident appropriate treatment & services to attain highest practicable mental & psychosocial wellbeing when staff failed to control 1 resident's outbursts towards other residents & staff & failed to acknowledge & assess underlying causes of resident's expressions of distress*
- *CP lacked interventions which included triggers &/or directions to staff r/t resident-to-resident altercations on 2 occasions; failed to provide 1 resident appropriate treatment & services to attain highest practicable mental & psychosocial wellbeing when staff failed to control resident's outbursts towards other residents & staff & failed to acknowledge & assess underlying causes of resident's expressions of distress*

F742 Treatment/Services Mental/Psychosocial Concerns

NE: SS=J (Abated to D): Failed to implement immediate protective measures when 1 resident verbalized suicidal intent &/or ideations; facility further failed to assess resident's underlying causes of distress & failed to implement person-centered interventions to address distress & prevent recurring or ongoing distress

- Cited findings noted in F699 r/t extensive hx of trauma with ideations & verbalizations of suicide; failed to implement immediate protective measures when resident verbalized suicidal intent &/or ideations; further failed to assess resident's underlying causes of distress & failed to implement person-centered interventions to address distress & prevent recurring or ongoing distress placing resident in immediate jeopardy;
- Abatement Plan
  - Resident interviewed for current thoughts of harmful self & plan to execute & resident denied any thoughts of self-harm or plan to execute
  - Resident had trauma-informed care assessment completed to ID experiences, triggers, stressors, & preferences to eliminate or mitigate triggers that may cause re-traumatization of resident
  - Facility scheduled mental health counseling service provider to visit with resident
  - Resident placed on 30 minute checks to be monitored by nursing staff for statements of self-harm or usual behaviors with immediate escalation to licensed staff
  - Staff received education on monitoring for self-harm statements & usual behaviors with physician notification if indicated
  - Nursing initiat6ed monitoring of resident's for mood & behavior changes, statements of self-harm & usual behaviors each shift with physician notification of any changes & resident placed on 1:1 if self-harm is ID'd
  - Resident's CP revised to reflect traumatic experiences, triggers, de-escalation & interventions based on current assessment to minimize triggers &/or re-traumatization

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) IDd & reported lack of appropriate indication or required physician documentation for 1 resident's use of antipsychotic & failed to ID & report lack of 14-day stop date or specific duration for 1 resident's PRN psychotropic medication placing resident at risk for unnecessary psychotropic medication & related side effects

- POS for Lorazepam oral concentrate 2 mg, 0.5 mL PRN for anxiety TID & order lacked stop date; POS for Seroquel 25mg daily for dementia; EMR lacked documented physician rationale which included unsuccessful attempt for nonpharmacological symptom management & risk versus benefits for continued Seroquel use & lacked end date for Lorazepam; MRR for 7 months lacked recommendation for appropriate indication for continued use of Seroquel; failed to ensure CP reported inappropriate indication for continued use of Seroquel & failed to ensure 14-day stop date for use of Lorazepam for 1 resident placing resident at risk for unnecessary psychotropic medication & related side effects

NE: SS=D: Failed to address admission medication regimen review for 1 resident when Consultant Pharmacist (CP) found irregularities with admission orders placing resident at risk for unwarranted physical complications & unnecessary medication use for 1 resident

- *Failed to address admission MRR for 1 resident when CP found irregularities with admission orders placing resident at risk for unwarranted physical complications & unnecessary medication use for 1 resident*

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported 1 resident's BPs outside physician-ordered parameters placing 1 resident at risk for unnecessary medication side effects

- POS for Metoprolol with holding parameters; MAR documented multiple occasions in multiple months when BP was outside holding parameters & med administered; CP failed to ID & report resident's systolic BPs were out of ordered parameters placing resident at risk for unnecessary medication side effects

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to hold Metoprolol when BPs were out of parameters for 1 resident placing resident at risk for physical decline & medication complications

- Cited findings noted in F756 r/t staff administering Metoprolol when BP outside holding parameters; failed to hold Metoprolol when 1 resident's systolic BPs were out of parameters placing resident at risk for physical decline & complications r/t low BP

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure appropriate indication or documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of 1 resident's antipsychotic & failed to ensure 14-day stop date or specified duration with rationale for 2 resident's ongoing PRN antianxiety medication placing residents at risk for unintended effects r/t psychotropic drug medications

- Cited findings noted in F756; Failed to ensure 1 resident did not receive antipsychotic medication w/o appropriate indication or required documentation for its use & failed to ensure 1 resident's Lorazepam had 14-day stop date or specified duration placing resident at risk for adverse side effects
- Failed to obtain stop date or list a specified duration with physician rationale for extended use of PRN Klonopin placing resident at risk for receiving unnecessary psychotropic medication

NE: SS=D: Failed to obtain a physician rationale & risk versus benefit explanation for continued use of Risperidone for 1 resident placing resident at risk of receiving unnecessary antipsychotic drugs

- Multiple MRR recommended evaluation for Risperidone use; record lacked physician rationale r/t benefit of continued use of Risperidone versus risks; failed to obtain risk versus benefit explanation for continued use of Risperidone for 1 resident placing resident at risk of receiving unnecessary antipsychotic drugs

F760 Residents are Free of Significant Med Errors

NW: SS=D: Failed to prevent a significant medication error when staff administered amlodipine instead of amiodarone to 1 resident placing resident at risk for health complications & medication-related adverse effects

- *EMR documented resident prescribed Amiodarone 200mg po daily; POS documented resident's PCP DC'd Amlodipine 10mg daily; incident report documented resident received wrong medication (Amlodipine) from 11-18- through 11-24 due to medication card not being removed from med cart & staff administered Amlodipine incorrectly instead of Amiodarone; failed to follow standards rights of drug administration in checking for right medication which resulted in significant medication error for 1 resident placing resident at risk for health complications & medication-related adverse effects*

NW: SS=G (Past Non-Compliance): Failed to follow physicians orders for 1 resident's insulin administration which resulted in resident's blood sugar decreased to 44 mg/dL & had to be transferred to higher level of care

- *LN administered 8 U of insulin aspart to resident right as resident started to eat super, despite POS which directed staff to only give insulin aspart if resident ate greater than 50% of meal; resident only ate 3-4 bites of supper resulting in hypoglycemic episode & placed resident at risk for other related complications; failed to follow physician orders for 1 resident's insulin administration resulting in hypoglycemia episode requiring emergent treatment placing resident at risk for related complications*
- *Abatement Plan:*
  - *All nurses received education r/t physician orders & insulin administration*
  - *All residents who received insulin were reviewed & had CPs updated as needed*
  - *Risk meeting held & presented to QAPI*
  - *Insulin orders audited*

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to discard outdated medication in 1/2 med rooms placing residents at risk for ineffective meds

- Failed to discard 2 expired Pneumovax vaccination vials placing residents at risk of receiving ineffective meds

F812 Food Procurement, Store/Prepare/Serve-Sanitary

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

- Observed plastic cutting boards with deep grooves making boards unsanitizable; observed large cutting board put away as clean but contained large coffee stain; cabinet with stained shelving paper & build up of dust along edges of cabinet & dried on food substances; wire racks with tops missing coating; can opener with buildup of black, sticky substance around point of opener; unopened box stored on floor of store room

NE: SS=E: Failed to store, prepare, distribute & serve food in accordance with professional standards for food service safety, in 1/2 kitchens placing residents who received meals from facility's south kitchen at risk for foodborne illness

- Observed fridge with 9 uncovered, undated, unlabeled cinnamon rolls; fridge with 27 unlabeled, undated sandwich ½'s; freezer with unlabeled, undated, container of ice cream; fridge with unlabeled, undated bag with produce with black substance on them; freezer with unlabeled, undated, unsealed box of bread sticks, frozen mixed vegetables; frozen meats unlabeled & undated
- Observed pipes under 3-compartment sink with black substance & leaked water on floor; faucet with slow stream of water continuously running unless turned off at main valve & mopboard under sink & 3 feet of pipe pulled away from wall; perimeter of kitchen floor with black substance

F835 Administration

NE: SS=F: Failed to provide administration services in manner that enabled effective & efficient use of resources to attain/maintain each resident's highest practicable physical, mental & psychosocial wellbeing as evidenced by deficiencies cited on health survey with potential to affect all residents

- Cited: F699, F742, F865, F841; failed to provide administration services in manner that enabled effective & efficient use of resources to attain/maintain each resident's highest practicable physical, mental & psychosocial wellbeing as evidenced by deficiencies cited on health resurvey with potential to affect all residents

F841 Responsibilities of Medical Director

NE: SS=F: Failed to ID how facility's Medical Director would fulfill his/her responsibilities to effectively implement resident care policies & coordinate medical care for residents in facility; facility lacked medical director's job description or separate facility policy placing all residents at risk for inadequate care & decreased quality of life

- Facility unable to provide contract for Medical Director or any documentation that indicated role & responsibility of facility's Medical Director for 2023; Adm staff stated facility's Medical Director had been doing it for years, but facility never had contract with Medical Director; facility provided typed statement stating Medical Director would be terminated effective 1-2-24; Adm stated Medical Director should attend QAPI meetings every month but did not even attend quarterly; failed to ID how facility's Medical Director would fulfill responsibilities to effectively implement resident care policies & coordinate medical care for residents in facility; lacked Medical Director's job description or separate facility policy placing all residents at risk for inadequate care & decreased quality of life

F851 Payroll Based Journal

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

- Failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing r/t PBJ report indicating no LN on duty but facility able to provide information that LN were on duty at questioned times

SW: SS=F: Failed to submit complete & accurate staffing information to CMS thru PBJ when facility failed to accurately submit hurly staffing data for all nursing personnel

- Failed to submit complete & accurate staffing information to CMS thru PBJ when facility failed to accurately submit hourly staffing data for all nursing personnel

F865 QAPI Program/Plan, Disclosure/Good Faith Attempt

NE: SS=F: Failed to ensure procedures were implemented to address facility's QAPI plan & program; current QAPI program failed to gather & analyze data, implement & re-evaluate to address adverse events & potential deficient practices specific to facility with potential to affect all residents residing in facility

- Referenced: F550, F553, F582, F610, F656, F689, F699, F727, F742, F756, F758, F801, F880, F883
- Failed to ensure procedures were implemented to address facility's QAPI plan & program; current QAPI program failed to gather & analyze data, implement & re-evaluate to address adverse events & potential deficient practices specific to facility with potential to affect all residents residing in facility

F868 QAA Committee

NE: SS=F: Failed to ensure QAPI team meet quarterly with required members in attendance placing all residents at risk for ineffective care

- QAPI team meeting sign-in sheets for 2023 indicated QAPI meetings were held each month; sign in sheets revealed facility Medical Director did not attend any of the QAPI meetings in 2023 & DON & Infection Preventionist did not attend any meetings for last quarter of 2023; failed to ensure QAPI team met quarterly with required personnel in attendance placing all residents at risk for ineffective care

F880 Infection Prevention & Control

SE: SS=D: Failed to maintain effective infection control program with failure to provide sanitary room environment for 1 resident & failed to provide sanitary drainage of urinary catheter for 1 resident to prevent cross contamination & infections

- Observed resident in bed & resident on contact isolation for wound infection; LN removed pillow from resident's side which contained dried brown substance IDd as vomit; room floor with multiple areas of sticky substance & multiple blankets piled on floor; foam positioning wedge laying directly on floor; pillows laying directly on floor; failed to ensure staff provided sanitary room environment for resident to prevent spread of infection
- Observed 2 CNAs emptied urine from catheter bag & staff used graduate from BR with bare hands & held graduate against top as waited to drain urine from catheter bag, drained yellow cloudy urine from bag & reattached nozzle to port w/o cleansing it with alcohol swab; while leaning over to pour urine into toilet, gait belt bumped against toilet multiple times, rinsed graduate in sink, poured water into toile, dried inside of graduate with paper towel & with bare hand placed graduate on paper towel on back of toilet; failed to properly provide catheter care for dependent resident with urinary catheter t prevent cross contamination & infections

NE: SS=D: Failed to implement acceptable infection control practices when staff failed to properly store 2 resident's O2 tubing & nasal cannula in sanitary manner & staff failed to properly store 1 resident's used urinary catheter bag when not in use during day placing residents at increased risk for infection & communicable diseases

- Failed to store catheter bag & tubing & O2 cannulas in sanitary manner placing residents at risk for infection

F881 Antibiotic Stewardship Program

SE: SS=F: Failed to ensure 1 resident received appropriate ABT based on culture report; failed to track & trend causative microorganisms for infection & use of appropriate antibiotics

- POS for Bactrim DS BID x 3 days for UTI; culture report indicated no growth of bacteria in resident's urine
- Review of Monthly surveillance report lacked ID of causative microorganisms from culture reports; failed t ID causative organisms for infections on monthly report to determine appropriate antibiotic usage to ID trends & determine interventions t prevent spread of infections as required

F883 Influenza & Pneumococcal Immunizations

NE: SS=E: Failed to prov ide latest guidance from CDC when they failed to offer, obtain an informed declination or physician-documented contraindication for pneumococcal PCV 20 vaccination placing residents at risk for acquiring, spreading & experiencing complications from pneumococcal disease

- Review of 5 records lacked evidence facility or resident representative received or signed consent or informed declination for current pneumococcal vaccine PCV20; staff stated unaware of current pneumococcal PCV20 vaccine & lacked knowledge of new CDC vaccination recommendation & facility had not implemented any system to address PCV20; failed to offer PCV20 pneumococcal vaccination placing residents at risk of acquiring, spreading & experiencing complications from pneumococcal disease

NE: SS=E: Failed to follow latest guidance from CDC when facility failed to offer, obtain informed declination for PCV20 vaccination placing residents at risk to acquire, spread & experience complications from pneumococcal disease

- Review of 5 clinical records & all lacked evidence of consent, informed declination or physician documented contraindication for current PCV20; failed to offer PCV20 vaccinations per CDC recommendations placing residents at risk to acquire, spread & experience complications from pneumococcal disease

F908 Essential Equipment, Safe Operating Condition

NE: SS=E: Failed to ensure 1/2 kitchens' plate warmer was in safe & operable condition placing residents who received meals from kitchen at risk of receiving cold food

- Observed kitchen plate warmer not working; staff confirmed had not been working "for some time"; failed to maintain all mechanical equipment in safe operating condition placing residents who received meals from kitchen at risk of receiving cold food

F921 Safe/Functional/Sanitary/Comfortable Environment

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

- Observed perimeter of floor & floor where table legs rested with heavy build up of dirt, trash & discolored grime

February, 2024

F550 Resident Rights/Exercise of Rights

SE: SS=D: Failed to show respect & dignity to 1 resident while transporting resident in sit to stand mechanical lift from bed to bathroom with blinds partially open

- Observed CNA & CMA transferred resident with sit to stand mechanical lift from bed to BR to toilet & window blinds in resident's room which looked out to facility's patio area pulled up approximately 12inches & resident's brief hung down low exposing most resident's buttocks to anyone outside on patio; failed to show respect & dignity to dependent resident while giving cares

SW: SS=D: Failed to protect privacy & dignity of 2 residents; practice led to 2 resident's respective urinary catheter bags to be visible to visitors & other residents with potential to lead to negative psychosocial effects r/t dignity

- Failed to protect privacy & dignity of 1 resident leading to resident's urinary catheter bag to be visible to visitors & other resident with potential to lead to negative psychosocial effects r/t dignity
- Failed to protect privacy & dignity of 1 resident by not providing dignity bag to cover catheter drainage bag

NW: SS=D: Failed to treat 1 resident with dignity when staff checked resident's blood glucose at DR table with 2 other residents able to view procedure placing resident at risk for undignified experience

- Failed to treat resident with dignity when staff checked resident's blood glucose level at DR table during meals placing resident at risk for undignified experience

F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to accommodate 1 resident's need & preference for a transfer pole placing resident at risk of decreased mobility & impaired autonomy

- *CP lacked direction on how resident transferred or assistance required; PT Eval documented resident reported used transfer pole at prior facility & was independent at baseline with transfer pole; failed to accommodate 1 resident's need & preference for transfer pole to assist with bed transfers placing resident at risk of decreased mobility & impaired autonomy*

F561 Self-Determination

NE: SS=D: Failed to accommodate 1 resident's preferred sleep schedule placing resident at risk for decreased psychosocial wellbeing

- MAR revealed resident's insulin not administered on 16 occasions for 99 day period & missed occurrences occurred during resident's scheduled 8am administration; resident stated often missed medication due to resident sleeping in & facility had not offered to adjust meds to fit preferred sleep schedule & was often awakened by staff right when attempted to go to bed; failed to accommodate & personalize services around resident's preferred sleep schedule placing resident at risk for decreased psychosocial wellbeing

F565 Resident/Family Group & Response

NW: SS=E: Failed to resolve grievances recorded during resident council meetings placing residents at facility at risk for unresolved grievances & decreased quality of life

- Review of Resident Council Minutes documented concerns r/t CNAs & staff on personal phones during care, too much noise at nights & TV too loud in common area, short staffing & various other concerns not addressed; Grievance/Variance Log recorded grievances that were unresolved or ongoing; residents stated would file a grievance & discuss concerns over & over each month but staff would not inform residents of resolution or concern r/t grievance or resolution r/t expressed grievance & no system in place they knew about to address grievances & resolutions; staff verified lack of system in place for residents to express grievances or system to respond to residents for resolution or follow through of grievances; failed to respond to resident council grievances & failed to have system in place to inform residents of concerns or grievance resolution from concerns expressed in resident council meetings placing residents at risk for unresolved issues

F577 Right to Survey Results/Advocate Agency Info

NE: SS=C: Failed to post previous state inspection information in location accessible to residents & visitors

- Failed to post state inspection results from recent complaint survey on 11-29-23 for residents & family

F582 Medicaid/Medicare Coverage/Liability Notice

NE: SS=ensure a CMS form 10055 provided to 1 resident placing residents at risks of uninformed treatment decisions & unexpected costs

- Resident discharged from Medicare Part A & resident remained in facility; EMR lacked CMS 10055; failed to ensure 1 resident was provided with CMS ABN Form 10055 placing resident at risk for uninformed treatment decisions & unexpected costs

NW: SS=D: Failed to provide resident/representative a fully completed ABN for 3 skilled service for residents which included estimated cost of services placing residents at risk for uninformed care decisions

- CMS form 10055 lacked estimated costs of services for 3 residents; failed to provide 3 resident/representatives completed CMS 10055 form when discharged from skilled services which included estimated cost of continued services placing residents at risk of making uninformed decisions for skilled services

F584 Safe/Clean/Comfortable/Homelike Environment

SE: SS=E: Failed to maintain clean, comfortable & homelike environment on 1/3 hallways of facility

- Observed resident room with hole through sheetrock & visible dirt & grime around perimeter of room; shelf in BR with worn, missing paint & sink with large blackened on front of where porcelain had worn away
- Resident room with broken wood & missing, chipped paint on closet door TB stand with chipped, missing paint; seat riser with dried, brown substance
- Resident room with wall with missing paint & tile flooring behind toilet discolored
- Resident room with wall with missing paint & closet doors with missing, chipped paint & perimeter of floor with dirt & grime
- Resident room with soiled & dirty fall mat; toilet riser with rusted areas on all 4 legs & rusted area around sink drain; perimeter of floor with dirt & grime
- Resident room with multiple areas of missing paint next to bed

SW: SS=E: Failed to maintain clean, comfortable & homelike environment to residents that reside in facility

- Observed broken fiberglass reinforced panel with jagged edge on door to shower room
- 17 areas where carpet frayed at seams in DR, hallway, nurses' station, 2 hallways
- Broken transition & frayed carpeting between hallway & shower room
- Broken tiles in shower room
- Ceiling in nursing station with seam where drywall panels separated & seam fallen away from ceiling
- Wall in resident room & hallway with wallpaper peeling away from wall
- Ceiling & wall with wallpaper held in place with scotch tape

F623 Notice Requirements Before Transfer/Discharge

NE: SS=D: Failed to provide written notification of reason & location for facility-initiated transfer for 2 residents placing residents at risk of delayed care or uncommunicated care needs

- Record lacked evidence written notification of facility-initiated transfer which included location & reason for transfer provided to resident or representative; 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
- Failed to provide written notification of transfer with required information for 1 resident in practicable amount of time with risk of miscommunication between facility & resident/family & possible missed opportunity for healthcare service for 1 resident

NE: SS=D: Failed to provide written notice of transfer with required information to 1 resident/representative in a practicable amount of time; also failed to send notification to Office of State LTC Ombudsman of facility's transfers & discharges with risk for miscommunication between facility & residents & possible missed opportunities for healthcare service for residents

- Record lacked evidence facility provided written notification of discharge which contained required information to 1 resident/representative; Adm stated SSD had emailed wrong person r/t notice for discharges & transfers from facility; failed to provide written notice of transfer with required information to 1 resident/representative & notify LTC Ombudsman's office of any transfers or discharges since March 2023 with risk of miscommunication between facility & resident/family & possible missed opportunities for healthcare service for residents

NW: SS=D: Failed to notify state LTC Ombudsman as required of 1 resident's discharge from facility placing resident at risk for impaired rights &/or advocate involvement

- EMR documented resident hospitalized on 4 occasions & facility unable to provide evidence of LTC Ombudsman notification for any of 4 discharges &/or transfers; failed to notify state LTC Ombudsman as required of 1 resident's discharge from facility placing resident at risk for impaired rights &/or advocate involvement

F625 Notice of Bed Hold Policy Before/Upon Transfer

SE: SS=D: Failed to issue "Bed Hold" as required for 1/3 residents reviewed for transfer to hospital

- Failed to issue resident/representative bed hold policy upon transfer to acute care as required

NE: SS=D: Failed to provide bed hold notice with 1 resident was hospitalized placing resident at risk of uninformed choices

- Failed to provide bed hold notice for 1 resident's hospitalization placing resident at risk of delayed care or uninformed choices

NW: SS=D: Failed to provide 1 resident with Bed Hold Notice placing resident at risk of not being allowed to return to same room upon discharge from hospital

- Resident discharged to hospital on 4 occasions & facility unable to provide evidence that resident received Bed Hold Notice prior to hospitalizations; failed to provide 1 resident Bed Hold Notice prior to 4 hospitalizations placing resident at risk of not being allowed to return to same room upon discharge from hospital

F641 Accuracy of Assessments

SE: SS=D: Failed to accurately complete MDS for 2 residents r/t documentation for falls & regarding discharge

- Failed to accurately complete "Discharge MDS" for resident who discharged to home
- Admission MDS documented resident had no falls since admission; CAA documented resident had 3 falls; failed to accurately complete "Discharge MDS" for resident who had experienced 3 falls, 1 with major injury

SW: SS=D: Failed to accurately complete MDS for 1 resident r/t use of indwelling urinary catheter placing resident at risk for uncommunicated care needs

- Failed to accurately complete MDS for 1 resident r/t use of indwelling urinary catheter placing resident at risk for uncommunicated care needs

F655 Baseline Care Plan

SE: SS=D: Failed to develop individualized baseline CP for 1 resident r/t indwelling urinary catheter

- Resident admitted with dx of urinary retention; POS for urinary catheter; failed to develop baseline CP for resident with indwelling urinary catheter

NE: SS=D: Failed to develop a person-centered baseline CP to include pressure relieving measures to prevent PUs for 1 resident placing resident at risk for impaired care r/t uncommunicated care needs

- Record lacked evidence baseline CP was developed; EMR lacked evidence of treatment, interventions for pressure-related injuries & physician notification; Record lacked evidence preventive measures were started prior to 1-17-24 when pressure-related injury noted on heel; failed to develop person-centered baseline CP to include pressure relieving measures t prevent PUs for 1 resident placing resident at risk for impaired care r/t uncommunicated care needs

F656 Develop/Implement Comprehensive Care Plan

SW: SS=D: Failed to develop comprehensive person-centered CP for 1 resident r/o need for isolation

- CP lacked interventions for isolation for RSV care of resident; failed to develop & implement resident's CP to include isolation status & treatment for RSV placing resident at risk to not receive appropriate cares & treatment

NE: SS=D: Failed to ensure 1 resident's comprehensive CP was updated to reflect what services &/or equipment were provided by hospice within required 7 days after completion of comprehensive assessment; also failed to update 1 resident's CP to address catheter use & care placing residents at risk of impaired care due to uncommunicated care needs

- Failed to ensure 1 resident's comprehensive CP was updated in required timeframe to reflect resident being placed on hospice services placing resident at risk for impaired care due to uncommunicated care needs
- CP lacked any direction for care of resident's indwelling catheter to staff to prevent infection & injury; failed to develop & implement an adequate comprehensive person-centered CP for 1 resident's indwelling catheter care placing resident at risk for impaired care due to uncommunicated care needs

F657 Care Plan Timing & Revision

SE: SS=D: Failed to review & revise CPs for 1 resident r/t fall interventions

- Failed to review & revise CP with appropriate fall intervention following dependent resident's fall

SE: SS=D: Failed to review & revise CPs for 1 resident r/t use of antidepressant medication

- Resident with major depressive d/o; CP lacked staff instruction r/t resident's use of antidepressant medication; resident with Wellbutrin for MDD; failed to review & revise resident's CP to include staff instruction r/t use of antidepressant medication

SW: SS=D: Failed to review & revise 1 resident's CPs r/t adequate monitoring & care of 1 resident's multiple skin areas/wounds

- CP lacked address of resident scratching legs that resulted in multiple scabbed areas on legs; CP lacked interventions for monitoring areas or treatment for multiple scabbed areas on bilateral legs; failed to review & revise CP r/t monitoring & care of resident with multiple skin areas/wounds
- Failed to update CP when Buspar DCd; failed to update resident CP when antianxiety medication DC'd

NE: SS=D: Failed to revise Cp with relevant hospice information for 1 resident; also failed to revise 1 resident's CP with unsuccessful attempts for nonpharmacological interventions that had been tried prior to administration of PRN psychotropic medication placing residents at risk for impaired care due to uncommunicated care needs

- Failed to ensure relevant hospice information was on CP placing resident at risk of impaired care due to uncommunicated care needs
- Failed to ensure nonpharmacological attempts of symptom management prior to administering PRN psychotropic meds was included in CP placing resident at risk for impaired care due to uncommunicated care needs

NE: SS=D: Failed to revise CP with effective person-centered interventions for 2 residents: 1 resident to include interventions r/t bolus feeding by G-tube & 1 resident who had PTSD with no person-centered interventions to address PTSD placing residents at risk for impaired care due to uncommunicated care needs

- CP lacked interventions for assessing gastric contents before administration of feedings; POS to check for gastric residual before each feeding; failed to revise 1 resident's CP with person-centered interventions r/t gastric residual checks before administering feedings through resident's feeding tube placing resident at risk for impaired care due to uncommunicated care needs

- CP lacked specifics r/t PTSD triggers or specific interventions r/t triggers; failed to ID & implement interventions which included trauma information to resident's CP placing resident at risk for impaired care due to uncommunicated care needs

NW: SS=D: Failed to revise CP with interventions to prevent avoidable accidents placing resident at risk for further accidents due to uncommunicated care needs

- EMR lacked documentation resident assessed for safety with hot liquids after resident spilled hot tea on 2 occasions & lacked evidence of interventions to address hot liquid spills; failed to revise 1 resident's cp with interventions to prevent further accidents with hot beverages placing resident at risk for further injury due to uncommunicated care needs

F661 Discharge Summary

NE: SS=D: Failed to ensure 1 resident's discharge summary included medication reconciliation & instructions placing resident at risk for not receiving timely & appropriate care

- Failed to ensure 1 resident's discharge summary included medication reconciliation & instructions placing resident at risk for not receiving timely & appropriate care

F676 ADLs/Maintain Abilities

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

- Failed to ensure 1 resident received supportive care & services to promote 7 maintain resident's ability to communicate wants, needs or feelings placing resident at risk for decreased quality of life, isolation & impaired dignity when no communication board provided to resident

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to provide 1 resident which shaving opportunities in manner of resident's preference

- Resident with dementia, CVA, chronic kidney disease, DM; observed resident with several days of facial hair growth under chin & on neck area; resident stated had electric shaver & staff assisted resident with set up for shaving but could not shave area under chin & neck as resident preferred; failed to ensure resident received assistance to shave under chin & neck region in manner resident preferred to enhance resident's sense of wellbeing

NE: SS=D: Failed to provide ADL care including trimming fingernails/toenails for 1 resident; failed to provide ADL care & assist to resident placing residents at risk for poor hygiene, decreased self-esteem & impaired health

- Failed to provide ADL care for 1 resident including trimming fingernails & toenails with risk for poor hygiene, decreased self-esteem & impaired health for 1 resident
- Failed to provide ADL assist & services for dependent resident for transfers & toileting placing resident at risk for avoidable complications & impaired quality of life

F684 Quality of Care

SE: SS=D: Failed to ensure 1 resident received appropriate tx to bilateral lower extremity cellulitis & received proper ear care

- Resident with Parkinson's, schizophrenia, narcolepsy & encephalopathy; POS for Nystatin cream to toes & POS for Debrox to ears; MAR/TAR with holes for treatment & ear wash as ordered; staff reported failed to perform ear irrigation prior to audiology appointment as ordered by physician; Failed to provide ear irrigation to resident in manner of professional standards to prevent trauma to resident's ear canal; failed to provide/clarify wound care to resident's lower legs as ordered

SW: SS=D: Failed to ensure adequate monitoring of 1 resident's skin condition to ensure resolution of multiple skin areas/wounds

- Failed to ensure adequate monitoring of resident's skin condition to ensure resolution of multiple skin areas/wounds dependent diabetic resident

NE: SS=D: Failed to apply Geri Sleeves to 1 resident per resident's CP & failed to follow physician ordered daily weights for 1 resident who required use of diuretic placing resident at risk for skin injury & placed resident at risk for excess fluid accumulation & physical complications

- Failed to apply CP'd Geri Sleeves to 1 resident placing resident at risk for skin injury
- Failed to follow physician's order for daily weights to monitor weight gain for fluid overload for 1 resident who had edema & received diuretic medication placing 1 resident at risk of adverse side effects from unnecessary medication or complications r/t fluid overload

NW: SS=D: Failed to ensure 1 resident received treatment & care in accordance with professional standards of practice r/t CHF placing resident at risk for complications from CHF that included weight gain, edema & difficulty breathing

- *Failed to ensure 1 resident received treatment & care in accordance with professional standards of practice r/t CHF placing resident at risk for complications from CHF which placed resident at risk for weight gain, edema & difficulty breathing*

NW: SS=D: Failed to assess & treat 1 resident's alteration in bowel movements placing resident at risk of ongoing constipation & possible fecal impaction complications

- Resident's BM record documented resident with 5 days, 7 days, 4 days, 5 days, 5 days, 4 days, 7 days with no BM; failed to treat 1 resident's lack of BMs placing resident at risk of ongoing constipation & fecal impaction complications

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

NE: SS=D: Failed to ensure pressure reducing measures were in place for 1 resident who developed deep tissue injuries on bilateral heels placing resident at risk for development of PUs & of wound worsening

- Record lacked evidence that baseline CP developed; EMR lacked evidence of treatment, interventions for pressure-related injuries & physician notification; record lacked evidence preventive measures were started when pressure-related injury noted on heel; failed to ensure pressure-reducing measures were in place for 1 resident to prevent pressure-related injuries placing resident at risk of developing PUs & wound worsening

NE: SS=D: Failed to ensure staff implemented Cp interventions for 1 resident with multiple pressure-related injuries & remained at risk for development of PUs placing resident at risk for delayed healing, new pressure injuries & related complications

- Failed to ensure 1 resident's interventions were implemented consistently to prevent new pressure injuries & to promote healing of existing pressure wounds placing resident at risk for delayed healing, new pressure injuries & related complications

NW: SS=G: Failed to implement interventions to prevent a Stage 3 PU to 1 resident's buttocks & then failed to provide routine treatment & nutritional interventions to promote healing of resident's PU placing resident at risk for PU development, pain, infection & complications from delayed healing

- *TAR documented order for Santyl to be placed in wound bed & covered with Optifoam & TAR documented treatment completed for 2-24 & 2-25 & facility did not receive Santyl until afternoon of 2-6; observed bed w/o overlay mattress as CP'd; observed resident's w/c where resident sat all morning with fabric pillow cushion & zippered pouch that appeared to have items in it; observed staff changed resident's saturated brief; failed to implement interventions to prevent Stage 3 PU from developing to resident's buttock & failed to provide physician-ordered treatment & other routine interventions such as RD involvement to promote healing of resident's PU placing resident at risk for PU development, pain, infection & complications from lack of healing*

NW: SS=D: Failed to implement nutritional interventions to promote healing for 1 resident after development of stage 2 PU placing resident at risk for complications from pressure injuries & delayed healing

- Resident with development of stage 2 PU; RD with recommendations for supplement & EMR lacked evidence resident provided recommendations from RD & lacked evidence physician presented with recommendations &/or declined recommendations; failed to implement nutritional interventions to promote healing for 1 resident's pressure injuries placing resident at risk for complications r/t pressure injuries & delayed healing

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to provide ROM to hep maintain & prevent a potential decrease in ROM/mobility for 1 resident placing resident at risk of loss of ability to perform ADLs & worsening or development of contractures

- CP lacked evidence of direction to staff to assist resident in maintaining mobility & prevent contractures in knees from worsening; EMR lacked evidence ROM or restorative care provided to 1 resident; failed to provide ROM to help maintain & prevent potential decrease in ROM/mobility for 1 resident placing resident at risk of loss of ability to perform ADL & worsening or development of contractures

NE: SS=D: Failed to ensure 1 resident received services/interventions to prevent reduction of ROM & contractures leaving resident at risk for further decline & decreased ROM or mobility

- CP lacked evidence of any interventions to address contractures to hands & arms; Failed to ensure 1 resident received services/interventions to prevent reduction of ROM & contractures with risk for further decline & decreased ROM or mobility

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=D: Failed to initiate appropriate intervention following 2 non-injury fall for resident to prevent further falls

- Resident with schizoaffective d/o; resident at high risk for falls with 2 documented falls; Adm Nurse confirmed "re-education" was inappropriate for resident for fall prevention intervention; failed to initiate appropriate intervention for dependent resident following non-injury fall

NE: SS=D: Failed to ensure 1 resident's fall investigation included a root cause analysis of fall & failed to ensure that appropriate intervention was implemented to prevent further falls placing resident at risk for additional falls &/or injuries

- Resident with multiple falls; 1 fall w/o intervention implemented; 11 investigation lacked root cause analysis (RCA) & interventions put into place to prevent future falls; 1 with no RCA or new intervention; failed to ensure 1 resident's fall investigation analyzed root cause of fall & failed to ensure appropriate interventions were placed placing residents at risk for additional falls &/or injuries

NE: SS=D: Failed to ensure staff followed CP for safe transfers for 1 resident & facility also failed to ensure staff placed fall mat next to residents bed per CP placing resident at risk for falls & possible injuries r/t falls

- Failed to ensure staff transferred 1 resident with Hoyer lift & assistance of 2 staff members as CP'd to prevent falls or injuries placing resident at risk for falls & possible injuries
- Failed to ensure 1 resident's bed was in lowest position & fall mat was in place per CP placing resident at risk for falls & fall-related injuries

NW: SS=D: Failed to ensure environment free from preventable accident hazards for 1 resident who spilled hot tea onto lap twice in 1 week placing resident at risk for injury

- Documentation revealed resident assessed as safe with hot liquids; 2 months later, resident spilled hot tea on lap & resident assessed w/o injury then 4 days later spilled hot tea on lap again EMR lacked documentation resident assessed for safety with hot liquids after spilled x 2 in 1 week & lacked evidence of interventions to address hot liquid spills; failed to ensure environment free from preventable accident hazards for 1 resident placing resident at risk for preventable injury

F690 Bowel/Bladder Incontinence, Catheter, UTI

SW: SS=D: Failed to provide appropriate treatment & services of 1 resident when resident was transported with urinary collection bag above level of bladder with potential to negatively affect 1 resident

- Failed to ensure appropriate treatment & services to prevent possible UTIs to resident who required urinary catheter

NW: SS=D: Failed to provide 1 resident with sanitary indwelling catheter care & treatment placing resident at risk for UTIs

- Observed LN provided catheter care by cleansing catheter insertion site with disposable wipes then applied prescribed ointment w/o changing gloves; failed to provide 1 resident with sanitary indwelling catheter care & treatment placing resident at risk for continued complications of UTIs & fungal skin conditions

F692 Nutrition/Hydration Status Maintenance

SE: SS=D: Failed to provide 1 resident with access to fresh water throughout day

- Observed resident in family room & CNA & CMA transferred resident from w/c to recliner & resident did not have water available to resident; CP instructed staff to ensure resident had access to water; failed to ensure resident had access to water when seated in w/c & recliner as CP'd to ensure adequate hydration

NE: SS=G: Failed to implement RD interventions for 1 resident's significant weight loss, resulting in 12.61% loss over 3 months placing resident at risk for continued weight loss

- Resident with CHF; record lacked evidence psychiatry visited with resident per physician documentation; RD noted documented interventions recommended to increase supplement; record lacked evidence facility increased resident's supplement to BID daily & lacked evidence recommendation for appetite stimulant forwarded to physician; failed to respond to 1 resident's weight loss & act on RD's recommendation placing resident at risk for complications r/t significant weight loss of 12.61% in 3 months

F693 Tube Feeding Management/Restore Eating Skills

NE: SS=D: Failed to assess gastric contents before administering bolus feeding by G-tube for 1 resident placing resident at risk for aspiration & inadequate nutrition

- CP directed staff to monitor nutrition intake & provide G-tube feedings; POS to check for gastric residual before each feeding; observed staff failed to check for residual prior to administration of feeding; failed to provide physician-ordered gastric residual check before administering feeding through 1 resident's feeding tube placing resident at risk for aspiration & inadequate nutrition

F695 Respiratory/Tracheostomy Care & Suctioning

NE: SS=D: Failed to ensure physician indication for O2 administration for 1 resident & failed to ensure O2 tubing stored in sanitary manner to decrease exposure & contamination placing resident at increased risk for respiratory infection & complications

- Failed to ensure an indication for O2 administration & O2 tubing was stored in sanitary manner to decrease exposure & contamination placing resident at increased risk for respiratory infection & complications

NW: SS=D: Failed to provide appropriate respiratory care & services when staff failed to store O2 cannula & tubing in sanitary manner for 1 resident placing resident at risk for respiratory infections

- Failed to provide appropriate respiratory care & services when staff failed to store O2 cannula & tubing in sanitary manner for 1 resident placing resident at risk for respiratory infections

F698 Dialysis

NE: SS=D: Failed to obtain 1 resident's weight before hemodialysis treatment placing resident at risk for complications r/t dialysis

- Failed to obtain 1 resident's weight before hemodialysis treatment placing resident at risk for complications r/t dialysis

F699 Trauma Informed Care

NE: SS=D: Failed to ID trauma-based triggers r/t 1 resident's PTSD & failed to implement individualized interventions to prevent re-traumatization placing resident at risk for decreased psychosocial wellbeing & ineffective treatment

- EMR documented dx of PTSD; CP lacked direction for staff to prevent traumatization for 1 resident's PTSD; multiple staff unaware of resident with PTSD; failed to ID trauma-based trigger r/t resident's dx of PTSD & implement individualized interventions to prevent re-traumatization placing resident at risk for decreased psychosocial wellbeing & ineffective treatment

NE: SS=D: Failed to ensure 1 resident received trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization r/t dx of PTSD placing resident at risk for unmet mental health care needs

- Resident with dx of PTSD; CP lacked specifics r/t PTSD triggers or specific interventions r/t triggers; failed to ensure 1 resident received trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization of resident placing resident at risk for unmet care, emotional & psychosocial needs

F726 Competent Nursing Staff

NE: SS=E: Failed to ensure LN staff possessed required skills & competencies to administer i IV placing all residents with IV medications at risk for medication errors & adverse outcomes

- Failed to ensure LN staff possessed required skills & competencies to administer IV medication placing all residents with IV meds at risk for med errors & adverse outcomes

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

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

- 5/5 CNAs lacked annual performance review in personnel file; failed to complete annual performance review for 5 CNAs employed by facility for greater than 1 year to ensure adequate appropriate cares & services provided to residents of facility

SW: SS=D: Failed to conduct annual performance reviews for 1/2 CNAs that facility had employed over 1 year

- Failed to conduct annual performance reviews for 1/2 CNAs that facility had employed over 1 year which provide care for residents of facility

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

- CNA with no yearly performance evals; CNA w/o evidence yearly evaluation performed in 2023; CNA hired 8-4-20 & provided performance eval dated 2-27-24 but no prior performance evals; failed to ensure 3 CNA staff had yearly performance evals completed as required placing residents at risk for inadequate care

F732 Posted Nurse Staffing Information

SE: SS=C: Failed to post "Direct Care Staff Nursing Hours" in manner to reflect scheduled hours & actual hours worked by staff as required

- Observed posted staffing lacked indication of actual hours worked by staff at end of shift; failed to update "Direct Care Staff Nursing Hours" to reflect actual hours worked by nursing staff as required

F756 Drug Regimen Review, Report Irregular, Act On

SE: SS=D: Failed to ensure timely follow-up of pharmacist's recommendations for 2/6 sampled residents

- MRR recommended lab work annually & BMP q 6 months based on drug regimen; Adm Nurse confirmed MRR not followed up on & to date labs not obtained or performed for resident to monitor meds ordered; failed to follow up on pharmacist's recommendation for lab for resident taking multiple meds to ensure resident did not have adverse reactions or subtherapeutic levels
- MRR recommended DC ASA while resident on Eliquis & physician accepted recommendations & staff noted order; staff continued to administer ASA; failed to follow up & act on MRR to DC ASA for dependent resident in timely manner

NE: SS=D: Failed to ensure CP IDd & reported missed medication administrations r/t resident's prescribed insulin & metoprolol on monthly reports placing resident at risk for unnecessary medication administration & unwarranted side effects

- Failed to ensure CP IDd & reported missed medication administrations r/t resident's prescribed insulin &metoprolol medications on monthly reports placing resident at risk for unnecessary medication administration & unwarranted side effects

NW: SS=D: Failed to ensure Consultant Pharmacist (CP) IDd & reported inappropriate indication or documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptoms management & risk versus benefit for continued use of 1 resident's antipsychotic medication placing resident at risk for unnecessary meds & related side effects

- MRR for 4 consecutive months lacked recommendation for appropriate indication for use of Zyprexa ordered for dementia with behavioral disturbance; record lacked evidence of documented physician rationale that included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefit for continued use of resident's Zyprexa; failed to ensure CP IDd & reported inappropriate indication for 1 resident's use of Zyprexa placing resident at risk for unnecessary use of antipsychotic medication

F757 Drug Regimen is Free from Unnecessary Drugs

SE: SS=D: Failed to prevent 2 residents from unnecessary meds including 1 resident r/t giving medication outside parameters & 1 resident r/t pharmacy consultant's recommendations to acquire labs

- Failed to hold medication when resident's SBP was out of physician ordered parameters to ensure no unnecessary meds or adverse reactions
- Cited findings noted in F756 r/t labs not performed as recommended; failed to follow up with physician r/t labs to monitor resident taking multiple meds to ensure resident did not have adverse reactions or subtherapeutic levels

NE: SS=D: Failed to consistently administer 1 resident's prescribed insulin & metoprolol medications placing resident at risk for unnecessary medication administration & unwarranted side effects

- Cited findings noted in F558, F756 r/t missing insulin & Metoprolol administration r/t resident's preferred sleeping patterns; failed to consistently administer resident's prescribed insulin & Metoprolol medication placing resident at risk for unnecessary medication administration & unwarranted side effects

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure nonpharmacological attempts of symptoms management prior to administering PRN psychotropic meds for 1 resident; also failed to ensure duration for PRN psychotropic meds for 1 resident placing residents at risk for unnecessary psychotropic meds & related complications

- Failed to ensure nonpharmacological attempts at symptoms management prior to administering PRN psychotropic medication for 1 resident placing resident at risk for unnecessary psychotropic medication & related complications
- Failed to ensure 1 resident's PRN psychotropic Lorazepam had a stop date or a physician-ordered specified duration for administration placing resident at risk for potential harm & adverse side effects r/t unnecessary meds

NW: SS=D: Failed to ensure appropriate indication or documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefit for continued use of antipsychotic for 1 resident placing resident at risk for unnecessary psychotropic medication & related complications

- Cited findings noted in F756 r/t dx for Zyprexa for dementia with behavioral disturbance; failed to ensure appropriate indication or required documentation fore use of resident's Zyprexa placing resident at risk for adverse side effects

F760 Residents Are Free of Significant Med Errors

NE: SS=D: Failed to prevent significant med error when 1 resident received incorrect antibiotic IV placing resident at risk for adverse drug effects & ineffective antibiotic therapy

- Failed to prevent significant medication error when 1 resident received incorrect IV antibiotic placing resident at risk for adverse drug effects & ineffective antibiotic therapy

F761 Label/Store Drugs & Biologicals

SW: SS=F: Failed to store Controlled Medications permitting only authorized personnel to have access r/t diversion of controlled medication for 3 residents; 1 resident for unknown quantity of Lorazepam 0.5mg tablets, 1 resident for unknown quantity of Oxycodone 10/325 mg tablets & 1 resident for unknown quantity of Lorazepam; additionally facility failed to provide safe environment for all residents by failure to ensure 1/2 med carts used to store residents' medications remained locked when not in direct line of vision of LN passing meds from carts

- On 2-22-24, DON confirmed diversion of controlled meds reported on 12-8-23 of 2 residents resulting in discovery of additional missing controlled med card for other resident; failed to store Controlled Medications permitting only authorized personnel to have access r/t diversion of controlled medication for residents of facility
- Observed nurse tx cart with wound care supplies & medicated ointments unlocked & unattended; failed to provide safe environment for all residents by failure to ensure medication cart used by facility remained locked when not in direct line of vision of LN passing medications from carts

NW: SS=E: Failed to label insulin pens or vials with opened date or discard date placing residents who received insulins at risk for expired or ineffective insulin

- Observed med cart with 6 insulin pens that had not been dated when opened; failed to label insulin pens or vials with opened date or discard date placing residents who received insulins at risk for expired or ineffective insulin

F801 Qualified Dietary Staff

NE: SS=F: Failed to provide services of fulltime CDM for residents who resided in facility & received meals from kitchen placing residents at risk for inadequate nutrition

- Failed to provide services of fulltime CDM for residents residing in facility & receiving meals from kitchen placing residents at risk for inadequate nutrition

F803 Menus Meet Resident Needs/Prep in Advance/Followed

NW: SS=D: Failed to prepare a nourishing well-balanced pureed diet that followed menu & included vegetable for resident who requested vegetables placing resident at risk for dissatisfaction & impaired nutrition

- Observed dietary staff & staff did not prepare any vegetables & staff reported resident had not requested any vegetables; observed order sheet & resident had soft-cooked vegetables circled; failed to prepare 1 resident's requested pureed diet food items placing resident at risk for dissatisfactio9n & impaired nutrition

F806 Resident Allergies, Preferences, Substitutes

NE: SS=D: Failed to ensure facility staff accommodated 1 resident's food allergies & food choices with potential for adverse food reactions & negative outcomes

- MDS documented resident required substantial/maximal to dependent assist with functional abilities; resident with regular diet & regular texture; EMR documented allergies to milk & milk products; meal tickets documented milk & milk product allergies & dislikes; resident stated allergy but was served eggs with cheese & other foods with cheese in them causing resident to have diarrhea & often was served gravy on foods & other foods resident disliked; failed to ensue resident's allergy & food preferences were accommodated at mealtimes placing resident at risk for adverse food reactions & possible negative outcomes

F812 Food Procurement, Store/Prepare/Serve-Sanitary

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

- Observed: rolling cart with visible ground-in dirt on all 3 tiers of multiple carts; buckets with water & chemicals with dispensing hose left directly inside bucket under water level; shelf with dust & debris; fridges with build up of food debris on bottom for 2 fridges; fronts of fridges with dried on food debris; handle to fridge with greasy substance covering entire handle; runner of can rack with build up of dust & dried food debris; shelf paper on worktable peeling back & with dirt & food debris along edges; work table with legs chipped, missing paint; cutting boards with deep grooves; oscillating fan with build up of dust on blades & cage

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

- Observed food prep & serving areas with 18 approximately 2 feet x 3 feet ceiling tiles which contained black dust like substances & grime & several tiles with brown discolorations resembling handprints
- Observed ceiling light in food prep area with black dust like substance & white dust like substance & ceiling light in kitchen with black & white dust like substances
- 2 stove vents with accumulation of grime
- Multiple large cookie sheets with accumulation of black substance around perimeter & extending into mid area
- 2 skillets with scratches & build up of grime over entire interior surface
- 1 large & 1 small cutting board with multiple deeply grooved scratches

- Bottom shelf of freezer with food debris
- Dishwasher with accumulation of lime like substance
- Freezer in family room with debris & food particles
- DR with popcorn machine with yellow substance dripping down interior walls & staff reported had used machine 7 days before & should be cleaned after each use

SW: SS=F: Failed to store, prepare, distribute & serve food in accordance with professional standards for food service safety for residents of facility to prevent possible foodborne illness

- Observed uncovered trash can/barrel uncovered at handwashing station; gallon bottle of opened Worchester sauces with sticky brown hardened rim around exterior of jug; floor soiled with black substance & debris throughout kitchen & dish room; pot rack with rusted legs; can opener with black debris hardened on spike & metal within bracket used for storage; multiple flat baking sheets with brown substance on cooking surface of pan in direct contact with food
- Commercial vent over stove in food preparation are with bubble appearance & missing paint on exterior of hood

NW: SS=F: Failed to ensure appropriate sanitation of dishware used for preparing & serving residents' meals & failed to prepare, store, distribute & serve food under sanitary conditions for all residents in facility who receive meals from kitchen placing residents at risk for foodborne illness

- Observed dietary staff operated dishwasher & attempted to test dishwasher rinse for chemical sanitation; wash & rinse temps were 105 degrees & staff used sanitizer testing strips which indicated no chemicals; dishwasher connected to Betco low-temp machine sanitizer & used Fury All Temp Rinse Aide & Fury All Temp Dish Machine Detergent; documented chemical sanitation checks recorded 200 ppm
- Observed 4 ft x 3 ft ceiling-mounted heater & AC unit at entrance of kitchen & blowing air directly across food prep area & air vent grill covered with brown grease/sticky substance & gray fuzzy substance & airflow register/vent directly above dishwashing area covered with brown grease/sticky substance & gray fuzzy substance; failed to ensure appropriate sanitation of dishware used for preparing & serving residents' meals & failed to prepare, store, distribute & serve food under sanitary conditions for all residents residing in facility who received meals from kitchen

NW: SS=F: Failed to store, prepare, distribute & serve food in accordance with professional standards for food service safety for all residents who received meals from facility's kitchens when staff stored unlabeled, undated food in fridges; staff did not sanitize thermometer between food items when checking food temps & failed to ensure clean & sanitary prep areas placing all residents at risk for foodborne illness

- Observed unlabeled bag with liquid coffee; uncovered undated & unlabeled food items
- Observed kitchen staff checked food temps w/o cleansing or disinfecting thermometer between different food items
- Observed unlabeled, undated flour containers, 3 ceiling vents with gray substance around vents, bucket filled with black, greasy substance on floor by 3-well sink in dishwashing area
- Observed undated shakes, multiple other undated food items

F838 Facility Assessment

NE: SS=F: 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

- Assessment sections not completed in sections that documented staffing level, competencies required, equipment & physical or environmental needs t address facility's specific resident population & acuity; 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

F842 Resident Records-Identifiable Information

SW: SS=D: Failed to provide appropriate treatment & services of 1 resident from lack of documented catheter care with potential to negatively affect 1 resident

- Failed to provide appropriate treatment & services of personal hygiene needs with incontinence for 1 resident when staff failed to document catheter care 16/55 times between 1-6-24 & 2-22-24 with potential to develop into negative outcomes including UTIs

F849 Hospice Services

NE: SS=D: Failed to establish a communication process, including how communication will be documented between facility & hospice provider for 1 resident; facility failed to ensure resident's written CP included both most recent hospice CP & description of services furnished by both facility & hospice placing resident at risk of decline &/or from maintaining highest practicable physical, mental & psychosocial wellbeing

- Failed to establish a communication process, including how communication will be documented between facility & hospice provider to ensure needs of resident were addressed & met for 1 resident; failed to ensure resident's written CP included both most recent hospice CP & description of services furnished by both facility & hospice placing resident at risk of decline &/or from maintaining highest practicable physical, mental & psychosocial wellbeing

NE: SS=D: Failed to ensure communication process was implemented which included how communication would be documented between facility & hospice provider & failed to provide description of services, medication & equipment provided to resident by hospice with risk for missed or delayed services & impaired physical & psychosocial care for 1 resident

- Failed to ensure communication process was implemented which included how communication would be documented between facility & hospice provider & failed to provide description of services, medication, & equipment provided to 1 resident by hospice placing resident at risk for delayed services which could affect resident's mental & psychosocial wellbeing

NE: SS=D: Failed to ensure 1 resident received hospice services as agreed in hospice CP placing resident at risk for inappropriate end-of-life care

- Record lacked hospice documentation to verify CP'd number of nurse visits for 3 month period; staff reported hospice staff failed to coordinate care for resident with all departments including SS; CP noted revealed hospice failed to attend resident's CP meeting; Failed to ensure 1 resident received hospice services as agreed in hospice CP placing resident at risk for inappropriate end-of-life care

F851 Payroll Based Journal

SE: SS=F: Failed to electronically submit to CDC PBJ r/t LN staffing information when facility failed to accurately report 24 hour4/day LN coverage on 24 dates in 1 year

- Failed to electronically submit PBJ information r/t LN staffing information when facility failed to accurately report 24 hr/day LN coverage on 24 days for 1 calendar year

SE: SS=F: Failed to electronically submit to CMS with complete & accurate direct staffing information based on payroll & other verifiable & auditable data in uniform format according to specifications established by CMS r/t licensed nursing staffing information when facility failed to accurately report LN coverage for 24/day on 12 days during 3rd quarter

- Failed to electronically submit to CMS with completed & accurate direct staffing information based on payroll & other verifiable & auditable data in uniform format according to specifications established by CMS r/t LN staffing information when facility failed to accurately report 24 hr/day LN coverage on 12 dates between 4-1-23 & 6-30-23 as required

SW: SS=F: Failed ot electronically submit to CMS complete & accurate direct care staffing information, including information for agency & contract staff, based on payroll & other verifiable & auditable data in uniform format according to specifications established by CMS r/t weekend staffing data excessively low

- Failed to electronically submit to CMS complete & accurate direct care staffing information including information for agency & contract staff, based on payroll & other verifiable & auditable data in uniform format according to specifications established by CMS r/t weekend staffing data is excessively low

NE: SS=F: Failed to submit complete & accurate staffing information to federal regulatory agency through PBJ when facility failed to submit staffing hour data for all nursing personnel by required deadline placing residents at risk for impaired care due to unidentified & ongoing staffing issues

- Failed to submit complete & accurate staffing information to CMS through PBJ when facility failed to submit staffing hour data for all nursing personnel by required deadline placing residents at risk for impaired care due to unidentified & ongoing staffing issues

NE: SS=F: Failed to submit complete & accurate staffing information to PBJ when facility failed to submit staffing hour data for all direct care personnel as required placing residents at risk for impaired care due to unidentified staffing issues

- PBJ report indicated data was suppressed though facility did not meet reasons for suppressed data other than inaccurate data or failure to report; Adm verified lack of PBJ reporting due to change of staff responsible for reporting; failed to submit accurate information to CMS PBJ placing residents at risk for impaired care due to unidentified staffing issues

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

- PBJ report documented Quarter 2 with excessively low weekend staff & Quarter 3 with no LN coverage 24 hours a day 7 days week on 18 occasions & excessively low weekend staff
- Staff confirmed facility failed to send in correct data to CMS for PBJ & verified facility did have LN coverage; failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

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

- Failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

F880 Infection Prevention & Control

SE: SS=F: Failed to maintain effective IPCP that would ensure infection surveillance for infections & determine causative organism when cultured to prevent spread of infections amongst residents

- Infection Control logs lacked clinical data collection which included lack of causative organisms for infections of cultured infections to determine trends in types of infections & prevalence in facility for 9 months; failed to provide infection surveillance to include pathogens to determine trends within facility to prevent spread of infections amongst residents

SE: SS=F: Failed to maintain infection prevention & control program to proactively monitor infections in facility to help prevent spread among residents of facility

- Facility lacked surveillance plan for IDing, tracking, monitoring & reporting infections among residents; Adm Nurse stated facility did not currently use any criteria for tracking & trending infections; facility lacked policy for infection control surveillance; failed to maintain infection prevention & control program to proactively monitor infections in facility to help prevent spread of infections among residents of facility

SW: SS=F: Failed to provide safe, functional, sanitary environment for residents & staff in facility kitchen for residents of facility to help prevent development & transmission of infections

- Dish room hand washing sink with uncovered trash barrel/can lacking foot operated lid closure to prevent staff from having to touch lid to dispose of paper towels; food prep area with barrel trash at handwashing sink with uncovered trash barrel/can lacking foot operated lid closure to prevent staff from having to touch lid to dispose of paper towels; kitchen & dish room floor with black substance & debris throughout; dish room with 30 4-inch tiles missing with black substance build up on floor which could not be sanitized; metal shelving unit with soiled vinyl/linoleum covered bottom shelf with 8 dish racks & legs of shelving unit with rust which could not be sanitized; food prep area

with hanging rack for pots & pans with rusty poles & unable to be sanitized; commercial spike can opened with black debris hardened on spike & inside metal bracket mounted on food prep counter

SW: SS=F: Failed to maintain effective infection control program with failure of staff to follow infection control standards when delivering laundry to resident rooms & failure to follow standard of practice when performing partial bed bath to 1 resident's perineum; with potential to lead to cross contamination between residents & to place residents receiving bed baths at increased risk of developing infections

- Failed to maintain effective infection control program with failure of staff to follow infection control standards for handling & transporting linens to prevent spread of infection with potential to lead to cross contamination between residents & negatively affect every resident in facility
- Failed to follow infection control standards when delivering laundry to resident rooms & failed to follow standard of practice when performing partial bed bath to 1 resident's perineum with potential to lead to cross contamination between residents & to place residents receiving bed baths at increased risk of developing infections

NE: SS=D: Failed to ensure proper infection control standards were followed r/t hand hygiene during peri-care & disinfecting of shared equipment placing residents at risk for complications r/t infectious diseases

- Observed 2 CNAs perform peri-care; 1 CNA did not change gloves after removing soiled brief; but proceeded to provide peri-care; , then wearing same soiled gloves CNA opened bedside drawer, removed skin protective cream from drawer & applied cream from drawer & applied cream to resident's rectal area, buttocks & coccyx with same soiled glove; CNA removed glove & hand sanitized 1 hand only & donned new glove the taped brief then touched resident's bedding with soiled glove
- Observed CNA removed Hoyer lift from resident's room w/o disinfecting lift, pushed lift into another resident's room & used lift; failed to ensure staff practiced standard infection control precautions to prevent spread of infection when staff failed to change gloves perform hand hygiene during peri-care & perform disinfecting of shared equipment with potential to increase risk for transmission of infectious diseases to residents

NE: SS=F: Failed to ensure proper infection control standards were followed r/t implementation of procedures to monitor & prevent Legionella disease or other opportunistic waterborne pathogens & failed to ensure sanitary storage of respiratory equipment placing residents at risk for complications r/t infectious diseases

- Failed to implement appropriate infection control practices placing residents at risk or transmission of infectious diseases

NW: SS=D: Failed to ensure adequate infection control measures when staff did not practice appropriate hand hygiene when providing incontinence care for 1 resident or for 1 resident during medication administration placing residents at risk for infection

- Observed staff perform incontinent care & staff failed to change gloves or perform hand hygiene between soiled & clean process then removed soiled gloves but failed to perform hand hygiene; failed to use adequate hand hygiene when staff did not change gloves & wash hands when providing 1 resident incontinent care placing resident at risk for infection
- Observed LN prepared & administered resident's morning inhalation, nasal & ophthalmic treatments & retrieved meds from locked cabinet in resident's room then donned gloves & placed med & treatments on overbed table then primed inhalation & handed it to resident for inhaling then removed cover from nasal spray & handed it to resident who administered it, then adjusted head of bed then touched urinal & bed controls w/o changing gloves then administered ophthalmic wipes & drops to both eyes then took treatments & placed back in locked cabinet; failed to change gloves between different administrations of meds; failed to ensure sanitary administration of 1 resident's treatments placing resident at risk for contaminated possible infectious process

F881 Antibiotic Stewardship Program

SE: SS=D: Failed to ensure 1 resident received antibiotics appropriately fur UTI

- POS for UA with C&S with order for Keflex x7 days & POS for Pyridium TID for bladder discomfort; record lacked culture results; failed to ensure resident's UA was processed in manner to obtain culture results to ensure proper antibiotic use

NE: SS=F: Failed to develop & implement core elements of antibiotic stewardship to ensure effective infection prevention & control program including antibiotic stewardship for residents of facility

- Infection Control Log from Feb 2023 through Jan 2024 lacked evidence of organisms IDs, duration of antibiotic prescribed & infections treated; unable to provide evidence of tracking on request; failed to proactively apply principles of antibiotic stewardship for residents of facility from Feb 2023 thru Jan2024 to ensure antibiotics were administered in safe & effective manner to prevent unnecessary side effects of antibiotics & antibiotic resistance

F883 Influenza & Pneumococcal Immunizations

SE: SS=D: Failed to ensure 1 resident was offered influenza vaccine

- EMR revealed resident lacked influenza vaccine & Adm nurse stated facility failed to offer influenza vaccine to resident; failed to offer influenza vaccine to dependent resident

NE: SS=E: Failed to obtain consent or declinations for influenza vaccination for 2 residents; also failed to offer or obtain declinations for pneumococcal vaccination consents, declinations or administration information for 4 residents placing residents at increased risk for influenza, pneumonia & related complications

- Record lacked documentation influenza vaccine or pneumococcal vaccine offered or declined & lacked documentation of historical administration for multiple residents
- Failed to obtain influenza & pneumococcal vaccination consents, declinations or administration information for 4 residents placing residents at increased risk for influenza, pneumonia, & related complications

NE: SS=D: Failed to provide 1 resident with pneumococcal conjugate vaccine as consented placing 1 resident at increased risk for complications r/t pneumonia

- Failed to provide 1 resident with PCV20 vaccination as consented placing resident at increased risk for complications r/t pneumonia

NW: SS=E: Failed to follow latest guidance from CDC when facility failed to offer, obtain informed declination or physician-documented contraindication for PCV20 vaccination placing residents at risk for acquiring, spreading & experiencing complications for pneumococcal disease

- Review of 6 records lacked evidence facility or resident representative received or signed consent or informed declination for current PCV20; failed to offer PCV20 pneumococcal vaccination placing residents at risk for acquiring, spreading & experiencing complications from pneumococcal disease

F908 Essential Equipment, Safe Operating Condition

SW: SS=F: Failed to maintain all mechanical & electrical equipment in safe operating condition in kitchen

- Multiple dish racks with soiled vinyl linoleum covering shelf & shelf with rust on legs
- Commercial spike can opened with build up of hardened black debris on spike with metal black dried hard substance within bracket housing can opener
- Upright poles attached to pot rack rusted; failed to maintain all mechanical & electrical equipment in safe operating condition in kitchen

F921 Safe/Functional/Sanitary/Comfortable Environment

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

- Observed floor throughout kitchen with areas which contained build up of dirt; perimeter of floor with heavy build up of dirt & grime; floor where table legs stood with build up of grime

SW: SS=F: Failed to ensure safe & sanitary environment for residents & staff in facility kitchen

- Kitchen dish room floor with 30 4-inch tiles missing with black substance build up on bare concrete where floor tiles missing

SW: SS=F: Failed to ensure safe sanitary environment for residents & staff in facility laundry

- Failed to ensure safe sanitary environment for residents & staff in facility laundry r/t multiple environmental issues

F947 Required In-Service Training for Nurse Aides

SW: SS=D: Failed to ensure no less than 12 hours per year required in-service training to ensure continuing competence of nurse aides for 1/2 nurse aides employed for year or more

- Failed to ensure no less than 12 hours per year required in-service training to ensure continuing competence of nurse aides which provided care for residents of facility

NE: SS=F: Failed to ensure 4 CNA staff reviewed had required 12 hours of in-service education including required topics per year placing residents at risk for inadequate care

- Failed to ensure CNA staff reviewed had required 12 hours of in-service education per year placing residents at risk for inadequate care

March, 2024

F623 Notice Requirements Before Transfer/Discharge

NE: SS=provide a written notice for a facility-initiated transfer to 1 resident/representative when resident was transferred to hospital & failed to notify LTC Ombudsman of discharge placing resident at risk for uninformed care choices

- Record lacked evidence resident/representative was provided written notice when resident was transferred to hospital; facility unable to provide evidence LTCO notified of transfer; failed to provide 1 resident/representative written notice r/t resident's facility-initiated transfer to hospital & failed to notify LTCO of transfer placing resident &/or representative at risk for uninformed care choices

F625 Notice of Bed Hold Policy Before/Upon Transfer

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

- Record lacked evidence resident/representative was provided facility's bed hold policy when resident went to hospital; failed to provide 1 resident/representative with bed hold policy when resident was transferred to hospital placing resident at risk of not being permitted to return & resume residence in nursing facility

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

NE: SS=F: Failed to provide RN coverage 8 consecutive hours a day, 7 days a week & failed tot employ a full-time DON placing all residents residing in facility at risk for decreased quality of care

- Review of August, Sept & October 2023 nursing schedule revealed no RN for 8 consecutive hours on 14 days; At entrance, Adm stated facility did not have current DON but RN that had been a facility for a long time that was in charge; failed to provide RN coverage 8 consecutive hours/day, 7 days/wk & failed to employ a fulltime DON placing residents residing in facility at risk of decreased quality of care

F801 Qualified Dietary Staff

NE: SS=F: Failed to employ a fulltime CDM for all residents residing in facility & received meals from facility kitchen placing residents at risk for inadequate nutrition

- Dietary staff verified not a CDM & was on last section of CDM class; failed to employ a fulltime CDM for all residents residing in facility & received meals from kitchen placing residents at risk for inadequate nutrition

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NE: SS=E: Failed to check food temps of pureed foods & regular breakfast food items before serving to ensure appropriate food temps for food safety & palatability placing residents at risk for foodborne illness & impaired palatability

- Observed staff prepared pureed meat only, placed food items on plastic divided plate on counter next to microwave & covered it with room tray lid, pureed potato salad & placed it in same divided plate then placed other pureed foods in same divided plate; then handed staff pureed diet plate then upon surveyor request temped the food items; food temp sheet lacked pureed food temps for all meals; failed to measure & record pureed & breakfast food item temps before serving them placing residents at risk for foodborne illness & impaired palatability

F812 Food Procurement, Store/Prepare/Serve-Sanitary

NE: SS=F: Failed to store, prepare, distribute & serve food in accordance with professional standards for food service safety when staff stored unlabeled, undated, expired food in fridges placing all residents who received meals from facility's kitchen at risk for foodborne illness

- Observed fridge/freezer with expired dates; unsealed cheese slices; fridge/freezer in DR with expired Ensure
- Kitchen with mopboard around edge of kitchen with black substance around edge of kitchen; under steam table in outside corner, mopboard coming away from wall; edge of oven hood with paint peeling; bottom & top cabinets with wood missing; lower cabinet drawers with screws sunk inside of hole; cabinet drawers with screws sunk inside; cabinet with missing cupboard door & missing top layer of wood; under ice machine were blue gowns in plastic packages & plastic cup lid; legs under counter in soiled dish room rusted from top to bottom & pipi under dishwasher to garbage disposal with brown substance & above window with missing top layer of wood

F851 Payroll Based Journal

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

- PBJ report documented facility w/o LN coverage 24 hours/day, 7 days/wk on 15 dates; review of LN timeclock data for dates revealed LN on duty for 24 hrs a day 7 days a wk; failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

F868 QAA Committee

NE: SS=F: Failed to have required members participate & attend QAPI meetings at least quarterly for QAA program placing all residents residing in facility at risk for decreased quality of care

- Failed to have required members attend & participate at least quarterly in QAPI when DON & IP lacked presence on 4 quarterly meetings placing residents at risk for decreased quality of care

F882 Infection Preventionist Qualifications/Role

NE: SS=F: Failed to ensure facility employed a designated staff person for the Infection Preventionist who was responsible for facility's IPCP & who completed specialized training in infection prevention & control placing residents at increased risk for infections

- Staff reported facility did not currently have IP; nurse consultant stated had been tracking infections but facility did not employ onsite IP; failed to employ a designated staff person as IP who possessed required certification placing residents at increased risk for infection

April, 2024

F609 Reporting of Alleged Violations

SW: SS=D: Failed to ID 1 resident's multiple unwitnessed falls with fx's as possible neglect & report to State Agency (SA) as required placing resident at risk for unidentified &/or ongoing abuse

- Resident with unwitnessed fall resulting in fx clavicle & resident wore sling & no corrective action noted; EMR/report lacked evidence issue was IDd as possible neglect & reported to SA; resident with multiple further falls & EMR &/or report lacked evidence issue was IDd as possible neglect & reported to SA; failed to ID resident's multiple unwitnessed falls which resulted in fx's as potential neglect & report to SA as required placing resident at risk for unidentified &/or ongoing abuse or neglect

F623 Notice Requirements Before Transfer/Discharge

SW: SS=D: Failed to provide written notice of transfer as soon as practicable to 1 resident/representative for facility-initiated transfer &/or discharge with risk of miscommunication between facility & resident/family & possible missed opportunity for healthcare service for 1 resident

- Failed to provide written notice of transfer as soon as practicable to 1 resident/representative of facility-initiated transfer with risk of miscommunication between facility & resident/family & possible missed opportunity for healthcare service for 1 resident

F657 Care Plan Timing & Revision

SW: SS=D: Failed to revise CP with effective interventions for 2 resident who had falls with injuries placing resident at risk for ongoing falls & injury due to uncommunicated care needs

- Resident with multiple unwitnessed falls with injury & CP lacked corrective actions noted for multiple falls; Failed to revise CP with interventions to prevent falls for resident placing resident at risk for further falls r/t uncommunicated care needs

- CP lacked interventions directing staff r/t falls; fall investigation lacked root cause analysis & new fall intervention following multiple falls; failed to revise 1 resident's CP with interventions to prevent further falls placing resident at risk for further falls due to uncommunicated care needs

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=G: Failed to ID causal factors for falls, provide adequate supervision & implement effective interventions to prevent avoidable accidents for 1 resident when resident had multiple falls over various dates resulting in fx's, contusions, increased pain & multiple trips to hospital; also failed to ID causal factors & implement interventions to prevent falls for 1 resident causing actual harm to resident & placed resident & other residents at risk for continued accidents & injuries

- Failed to provide adequate supervision, ID causal factors & implement effective interventions to prevent resident from multiple falls resulting in contusions, fx's increased pain, & hospitalizations resulting in actual harm to resident & placing resident at risk for further falls with injuries
- Failed to ensure staff completed thorough fall investigation for 1 resident which included a root cause analysis for fall & failed to ID & implement interventions to prevent further falls placing resident at risk for further falls & possible injury