January, 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

September, 2023

F600 Free from Abuse & Neglect
NW: SS=D: Failed to ensure 1 resident remained free from neglect when facility failed to provide necessary care & service as directed by resident's CP, on more than 1 occasion, despite being aware of what care resident required placing resident at risk for ongoing neglect & related complications

- Resident with hemiparesis/hemiplegia following CVA affecting left dominant side; CP documented resident continued to self-transfer self w/o assist; CP directed staff to use full body lift for transfers; observed staff transfer resident with stand up lift & resident's foot moved off foot stand & resident leaned to dominant affected side; observed sling wrong size for resident; observed staff attempted to transfer resident to w/p tub using stand up lift & resident unable to stand; failed to ensure 1 resident remained free from neglect when facility failed to provide necessary care & service as directed by resident's CP on more than 1 occasion despite being aware of what care resident required placing resident at risk for ongoing neglect & related complications

F656 Develop/Implement Comprehensive Care Plan
NW: SS=D: Failed to develop a comprehensive CP for 2 residents for PTSD placing 2 residents at risk for unmet care needs

- CP did not ID resident had PTSD & interventions to prevent traumatization triggers; CNA unaware of resident's dx of PTSD; failed to develop a comprehensive CP to include resident's PTSD placing resident at risk for unmet care needs
- EMR revealed resident admitted with PTSD; CP lacked direction r/t resident's PTSD dx & interventions to prevent traumatization triggers; multiple staff unaware of resident's dx of PTSD; failed to develop comprehensive CP to include resident's PTSD placing resident at risk for unmet care needs

F657 Care Plan Timing & Revision
NW: SS=D: Failed to revise 1 resident's CP to reflect current needs & use of mechanical lift for transfers placing residents at risk for preventable accidents & injuries due to uncommunicated care needs

- Cited findings noted in F600 r/t appropriate use of full body lift; DON stated unaware of where to find any CP conference documentation & hoped to hire someone soon to do CPs; failed to revise resident's CP to reflect need for mechanical lift for transfers placing resident at risk for accident or injury r/t uncommunicated care needs

F661 Discharge Summary
NW: SS=D: Failed to complete a discharge summary, a reconciliation of pre and post discharge medications & post-discharge plan of care for 1 resident who discharged from facility placing resident at risk for unmet care needs

- EMR lacked physician order for discharge; EMR lacked evidence of summary or recapitulation of resident's stay, reconciliation of meds, post-discharge plans & needs & any services required; failed to complete discharge summary, a reconciliation of pre and post-discharge plan of care for 1 resident placing resident at risk for unmet care needs

F689 Free of Accident Hazards/Supervision/Devices
NW: SS=D: Failed to provide an environment free from preventable accidents & falls for 3 residents placing residents at risk for further falls & injury

- Resident with high fall risk with multiple falls; 1 fall with record lacking interventions addressing air mattress r/t fall; fall with no interventions r/t falls for multiple falls; observed resident w/o CP fall prevention interventions; failed to ID relevant interventions after falls to prevent further falls for cognitively impaired resident; further failed to ensure staff implemented CP r/t fall prevention when staff failed to place pillows as directed by resident's CP placing resident at risk for further falls & injury
- Failed to ensure environment free from preventable accidents & hazards when staff performed unsafe transfers with 1 resident resulting in assisted fall placing resident at increased risk for preventable falls & related injuries
- Failed to provide appropriate amount of assist to prevent accidents & falls for 1 resident placing resident at risk for further falls & injury

F695 Respiratory/Tracheostomy Care & Suctioning
NW: SS=D: Failed to ensure 1 resident who required continuous supplemental O2 received adequate respiratory care & services placing resident at risk for physical decline

- POS for O2 4l continuous via nasal cannula; observed resident in DR & O2 tubing & cannula laid on DR floor; observed resident self-propelled in w/c into common area & O2 tubing & cannula wound around w/c wheel; observed O2 tank resident using empty & O2 sat

70%; failed to ensure resident who required continuous supplemental O2 received proper respiratory care & services placing re sident at risk for physical decline

F699 Trauma Informed Care

NW: SS=D: Failed to ensure 2 residents received trauma informed care to eliminate or mitigate triggers that may cause re-traumatization placing residents at risk for unmet behavioral health care needs & impaired psychosocial wellbeing

- Cited findings noted in F656; Failed to ensure resident received trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of resident placing resident at risk for unmet emotional & psychosocial needs
- 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 emotional & psychosocial needs

F732 Posted Nurse Staffing Information

NW: SS=C: Failed to display current daily nursing staffing hours as required

- During 2 survey dates nursing hours posted with date 20 days previously; failed to display current daily nursing hours as req uired

F760 Residents are Free of Significant Med Errors

NW: SS=D: Failed to ensure residents remained free from significant med errors when med was not administered per physician orders for 1 resident placing resident at risk for decreased physical & mental wellbeing

- POS for Abilify 2mg q hs; MAR lacked evidence resident received physician ordered Abilify in August or September; failed to ensure residents remained free from significant med errors when med was not administered per physician orders for 1 resident placing resident at risk for decreased physical & mental wellbeing

F761 Label/Store Drugs & Biologicals

NW: SS=E: Failed to adequately label & store insulin for 5 residents in facility's med room placing affected residents at ris k for ineffective med regimens

- Observed med room fridge with open insulin pens in use lacking date when opened &/or discard date; failed to label & store in sulin pen with opened & expiration dates for 5 residents placing affected residents at risk for ineffective med regimens

F812 Food Procurement, Store/Prepare/Serve-Sanitary

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

- Observed ceiling light fixtures above stove, grill top, steam table & 3-compartment sink with dead insets in them; DR ceiling light cover with dead insects; front sheath & blades of fan & venting ducts with brown, fuzzy material hanging from them; large number of flies noted landing on food prep tables in kitchen, DR tables & food on plates which residents had to wave away during meals

F851 Payroll Based Journal

NW: SS=F: Failed to submit complete & accurate staffing information to federal regulatory agency through PBJ when facility failed to submit information for LNs 24 hr/day staffing as required placing residents at risk for unidentified & ongoing inadequate staffing

- PBJ report for 2 quarters indicated facility did not have LN coverage 24 hrs/day, 7 days a week on over 75 dates; facility provided staffing information revealed facility had LN 24 hr/day, 7 days a week; failed to submit accurate information to CMS PBJ placing resid ents at risk for unidentified & ongoing inadequate staffing

F880 Infection Prevention & Control

NW: SS=F: Failed to maintain acceptable infection control practices during 1 resident's feeding assistance, 1 resident's bathing on enhanced precautions, 1 resident's wound dressing change, & care of 1 resident's O2 tubing; further failed to implem ent water management program to prevent Legionella; practices placed residents at risk for transmission of infectious disease

- Cited findings noted in F695 r/t respiratory care; failed to provide infection control practices for 1 resident when O2 tubin g & cannular dragged on floor & not bagged
- Maintenance staff stated had testing material for water management process but had not started yet; failed to implement a water management program to test & manage waterborne pathogens placing residents who resided in facility at risk of contracting Leg ionella pneumonia
- Observed CNA assisting resident with eating sandwich & CNA handled sandwi ch w/o use of gloves while giving bites to resident; failed to provide standard infection control practice for 1 resident who was fed by staff with ungloved hands placing resident at incre ased risk of illness & infection
- Failed to ensure staff followed enhanced barrier precautions while giving direct care for 1 resident increasing risk of transmission of infectious disease
- Failed to follow acceptable infection control measures during wound care for 1 resident by not changing soiled gloves before applying a clean dressing placing resident at risk for wound infection

F925 Maintains Effective Pest Control Program

NW: SS=F: Failed to maintain effective pest control program for all residents residing in facility placing residents at risk for illness & uncomfortable environment

- Observed 1 resident with flies land on food; 1 resident c/o all flies that landed on food & on table; observed 1 resident's room with multiple flies landing on & around resident as resident was transferred by staff; resident stated flies terrible in room & as spoke fly landed on resident's nose; observed resident in common area with fly swatter in hand & resident trying to kill flies; Observed resident with several flies landed on resident while resident in recliner; obser4ved flies on 1 resident as resident in common area; failed to maintain effective pest control program for all residents r/t flies in building placing residents at increased risk for illness & uncomfortable environment

October 2023

F550 Resident Rights/Exercise of Rights

NE: SS=D: Failed to maintain environment that promoted dignity for 3 residents placing residents at risk for undignified experience & embarrassment

- Observed resident in DR w/o privacy bag; failed to provide a privacy bag for 1 resident's catheter during dining placing resident at risk for undignified dining experience & embarrassment
- Observed resident in DR & resident's dress pulled up to things & adult incontinence brief between legs in full view from hallway; observed resident in DR hollering "help, help" & resident stated going to have BM in pants over & over & 3 staff observed in area but did not talk to or respond to resident or provide resident with assistance; failed to promote care for 1 resident in manner to maintain & enhance dignity & respect placing resident at risk for impaired psychosocial wellbeing
- Observed LN obtained resident's BS then administered insulin at DR table & another resident seated at table & other resident seated in DR eating lunch when occurred; failed to promote care for resident in manner to maintain & enhance dignity & respect placing resident at risk or impaired psychosocial wellbeing

NW: SS=D: Failed to protect 1 resident's dignity placing resident at risk for impaired psychosocial wellbeing

- *Resident with Alz & EPS; Grievance Form documented CNA had been informed by 1 of resident's representatives that CNA was telling people that when CNA put resident to bed previous night or night before that resident grabbed CNA by neck & forced CNA to "make out" with resident; CNA statement documented then CNA assisted resident to stand resident leaned over & kissed CNA on side of neck & placed hand on CNAs lower buttock & CNA stated leaned away from resident & told resident CNA was going for a walk & removed resident's hand from buttock & stated did not tell any other staff member of event; other CNA stated CNA told that resident had grabbed CNA's buttock & "made out" with CNA but other CNA did not witness event; all witness statements showed CNA made statements exaggerating kiss & pulling of back & shirt; from investigation, witness statements & video footage, facility deducted that CNA exaggerated inappropriately about innocent kiss & included employee training &/or in-service which covered prevention & reporting of ANE as well as protection of privacy & procedure for reporting to family; resident's representative stated upset that staff spread rumors about loved one & facility should take care of resident & not allow anything bad to happen to resident; failed to protect resident's right to dignity placing resident at risk for impaired dignity & decreased psychosocial wellbeing*

F553 Right to Participate in Planning Care

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

- EMR lacked documentation of care conferences; resident reported living at facility for 2 years & had not participated in recent CP process but desired to participate; failed to include 1 resident in development & planning of resident's CP placing resident at risk for impaired care & autonomy

F554 Resident Self-Administration of Meds-Clinically Appropriate

NE: SS=D: Failed to ensure 1 resident was assessed for ability to safely self-administer nasal spray medication placing resident at risk for improper use of medication & related side effects

- POS for Fluticasone Propionate; resident stated had received meds earlier than usual & kept Flonase in drawer & used it in evenings & observed Flonase nasal spray in nightstand drawer; failed to ensure 1 resident was assessed for ability to safely self-administer nasal spray placing resident at risk for improper use of medication & related side effects

F561 Self-Determination

NE: SS=D: Failed to support 1 resident's bathing preferences placing residents at risk for impaired rights to exercise autonomy r/t those things that are important in life

- MDS documented with intact cognition & lacked evidence Preference for Customary Routine & Activities interview conducted; resident stated would like bathing 2x/wk but usually only received 1/wk; failed to honor 1 resident's preference of bathing 2x/wk consistently placing resident at risk of inability to exercise autonomy r/t those things that are important in resident's life

F565 Resident/Family Group & Response

NE: SS=E: Failed to act upon concerns for resident council group r/t issues of care & life in facility placing residents at risk of decreased quality of care & services

- Multiple months of resident council meeting notes documented lengthy call light responses, bed making not done; lack of adequate staff; cold meals; food & dietary issues; late room trays; failed to act promptly on concerns of resident council groups concerning issues of care & life in facility placing residents residing in facility at risk for decreased quality of life

F567 Protection/Management of Personal Funds

SW: SS=E: Failed to safeguard cash in facility safe located in business office for 2/8 residents reviewed resulting in theft of cash for 1 resident in amount of $2,300 & 1 resident in amount of $4000; facility replaced missing cash for these 2 residents but this practice left any other resident who placed cash or valuables in facility safe at potential for loss

- *On 109-23 Adm noted cash funds missing from facility safe totaling $6300; Adm notified consultant who arrived at facility, completed search of safe & confirmed funds were missing; 2 residents had previously placed funds in total amount of $6300 in safe; staff notified local law enforcement who arrived, took pictures of office door & safe & reported no signs of forced entry; investigation revealed 5 team members had access to business office safe from time money was last seen to time discovered missing; after interviews & investigation, detective nor facility could determine alleged perpetrator; facility was in process of replacing missing cash for 2 residents; observed keypad noted missing from safe & door handle of safe had a place to insert a key; facility lacked cameras in hallway; Adm stated facility lacked cameras anywhere in building & office door did not automatically lock when door shut & required to be locked manually; Adm stated key to safe left in unlocked door of desk; missing money not deposited in trust account; failed to safeguard resident money resulting in theft of 2 resident's cash totaling $6300 from facility safe; facility replaced missing cash for 2 residents but practice left any other resident who placed cash or valuable in facility safe at potential for loss*

F569 Notice & Conveyance of Personal Funds

SW: SS=E: Failed to provide notification of 5 selected residents who received Medicaid benefits when amount in trust account reached $200 less than SSI resource limit to prevent loss of eligibility for Medicaid or SSI

- *Census revealed 4 residents with Medicaid primary payor source; Statement revealed from 1-3-23 through 9-11-23 account balance ranged from $7891 to $11,231; 3 other residents' balance exceeding SSI limit; failed to show documentation of when notifications had been provided for balances approaching or over $2000 for 5 residents; failed to provide notification to 5 selected residents who received Medicaid benefits when amount in trust account reached $200 less than SSI resource limit to prevent loss of eligibility for Medicaid or SSI*

F583 Personal Privacy/Confidentiality of Records

NE: SS=D: Failed to ensure privacy for 1 resident when staff audio recorded medical treatment w/o consent placing resident at risk for decreased psychosocial wellbeing & impaired rights

- EMR documented resident found unresponsive by staff & staff initiated CPR but resident expired during compressions; Facility report documented emergency incident was videotaped & updated to a social media video platform belonging to a LN; LN stated as walking down hallway turned video feed off but live audio recording remained on; failed to ensure privacy for 1 resident when staff audiotaped medical treatment as it occurred w/o resident's permission placing resident at risk for decreased psychosocial wellbeing

F584 Safe/Clean/Comfortable/Homelike Environment

SW: SS=F: Failed to provide housekeeping & maintenance services to maintain a sanitary, orderly, & comfortable interior in resident rooms, shower rooms & hallways for all residents of facility

- *Observed fire door with scraped paint; resident room with scraped paint along doorways, base of toilet, several walls, brown splatters on wall, handrail, peeling paint, bent floor vent with rust spots, floor tile missing; BR with rust stains around sink drain, paint scrapes, crack in flooring; BR with cracked flooring, rust spots on sink; sink faucet with white substance; rust color around faucet base; rust stain on wall; room with gap between tile & wall; missing wallpaper; peeling wallpaper; holes in flooring; MULTIPLE other environmental observations as mentioned; failed to provide housekeeping & maintenance services to maintain sanitary, orderly & comfortable interior in resident rooms, shower rooms & hallways for all residents of facility*

NE: SS=E: Failed to maintain clean, comfortable homelike environment when lights in DR were nonfunctioning, light fixtures contained dead insects & dining chairs stained & had food particles placing residents at risk for decreased comfort & impaired psychosocial wellbeing

- Failed to maintain a clean, comfortable homelike environment when lights in DR were nonfunctioning, light fixtures contained dead insects & dining chairs were stained & had food particles placing residents at risk for decreased comfort & impaired psychosocial wellbeing

F585 Grievances

NE: SS=E: Failed to discuss with resident council how to file a grievance r/t care & treatment in facility placing residents at facility at risk for unresolved resident concerns & decreased quality of life

- Review of Resident Council meeting minutes for Sept & Oct revealed no discussion with council members r/t grievances; facility lacked council minutes from Oct 2022 to Sept 2023; grievance log lacked evidence of grievances verbalized by council; failed to discuss process of grievances with resident council placing residents in facility at risk for unresolved concerns & decreased quality of life

F600 Free from Abuse & Neglect

SW: SS=J (Past Non-Compliance): Failed to

- *Prevent sexual abuse on 9-26-23 at approximately 7pm when dietary staff failed to immediately separate 1 resident away from other resident after staff saw resident lift other resident's dress; after witnessing incident staff went into kitchen & told other dietary staff leaving 2 residents unsupervised as no other staff in DR at that time; other dietary staff member saw resident had other resident's dress pulled up with 1 hand & other hand on resident's thigh; other resident seemed "flustered" & "irritated"; other staff went to get nurse which again left residents unsupervised while staff got CNA; CNA entered DR & resident facing other resident with arm up dress & CNA could not see where resident's hand was, but saw resident's hand up other resident's dress; other resident "teary eyed" & stated "kept*

telling him to stop & he wouldn't"; practice allowed resident to continue to sexually abuse other resident placing resident in immediate jeopardy; investigation lacked any witness statements with dietary staff r/t incident; failed to separate resident from other resident after witnessing unwanted touching, staff twice left 2 residents unsupervised in DR after observing resident lifting other resident's dress then again observing resident lift other resident's dress & place hand on resident's thigh allowing resident to continue to sexually abuse other resident causing other resident to be tearful & reported to staff other resident had told resident to stop & resident would not

- *Abatement plan:*
  - *Residents separated & resident placed on 1:1 supervision*
  - *Emotional supportive care & safety reassurance provided*
  - *Other resident interviewed*
  - *Assessment completed of both residents*
  - *Resident's responsible party & physician notified*
  - *KDADs & police notified*
  - *Both residents referred to consulting licensed clinical social worker for emotional support*
  - *Interviews completed of residents & team members*
  - *All staff educated or prior to working on ANE, Elder Justice Act & Trauma Informed Care*

F609 Reporting of Alleged Violations

NE: SS=J (Past Non-Compliance): Failed to ensure staff immediately reported allegations of abuse to facility administrator

- *On 10-7-23 at 4:45pm dietary aide (DA) heard loud verbal interaction between Adm nurse & resident which DA perceived as verbal abuse; DA reported alleged verbal abuse to another dietary staff member on evening of 10-8-23 & that dietary staff reported event to Adm at 6:10am on 10-9 almost 2 days later; CNA also perceived interaction as abuse but did not report to Adm because CNA did not know who to report to in Adm's absence; On 10-8- at 6pm, Activity staff noted another resident upset by interaction which alleged verbal abuse or mistreatment by Adm nurse earlier that day though Activity staff did not alert Adm until 10-9 at 10:10am more than 16 hours later; staff failed to ID potential abuse & report immediately to Adm placing 2 residents in immediate jeopardy; facility failed to ID & report alleged abuse which delayed investigation, protective measures & increased potential of impaired psychosocial wellbeing due to potential prolonged abuse, or mistreatment for affected residents*
- *Abatement Plan:*
  - *All staff educated on ANE including IDing & reporting to Adm any allegations of abuse*
  - *Adm nurse suspended pending completion of ANE education prior to working*

NE: SS=D: Failed to ensure 1 resident received necessary protective oversight to prevent potential abuse &/or neglect when facility failed to report a fracture of unknown origin as potential abuse or neglect to State Agency within mandated time frames placing resident at risk for unresolved & ongoing abuse, a decrease in psychosocial wellbeing & further injuries

- *CP documented resident at fall risk r/t frequent falls; CP documented interventions r/t fall; NN documented resident with unwitnessed fall & CNA stated left resident's room to get sheets for bed & by time CNA came back resident was on floor; 2 days later resident's wrist red & swollen & physician ordered X-Rays; resident with new hairline right hand fx & severe osteopenia; X-ray reports documented acute fx's of distal radius & ulna; Adm nurse stated some confusion on if wrist was fx'd or not fx'd & not reported to State Agency; failed to ensure 1 resident received necessary protective oversight to prevent potential abuse &/or neglect when facility failed to report fx of unknown origin as potential abuse or neglect to SA within mandated time frame placing resident at risk for unresolved & ongoing abuse, a decrease in psychosocial wellbeing & further injuries*

F610 Investigate/Prevent/Correct Alleged Violation

NE: SS=D: Failed to ensure 1 resident received necessary protective oversight to prevent potential abuse &/or neglect when facility failed to investigate fx of unknown origin as potential abuse or neglect & send completed investigation to SA within required timeframe placing resident at risk for unresolved & ongoing abuse, a decrease in psychosocial wellbeing & further injuries

- *Cited findings noted in F609 r/t unwitnessed fall resulting in hand/wrist/arm fx; failed to ensure 1 resident received necessary protective oversight to prevent potential abuse &/or neglect when facility failed to investigate fx of unknown origin as potential abuse or neglect & send completed investigation to SA within required timeframe placing resident at risk for unresolved & ongoing abuse, decrease in psychosocial wellbeing & further injuries*

F623 Notice Requirements Before Transfer/Discharge

NE: SS=D: Failed to provide written notice of discharge for 1 resident's immediate involuntary discharge placing resident at risk for impaired rights

- *Behavior note documented incident when resident sat in DR & SS & 2 police officers talked to resident; resident stood up & walked away; resident turned, pointed at SS & stated SS lied; police office put arm up to keep resident from hurting anyone & resident then assaulted police officer; resident handcuffed & escorted to jail; SS stated verbally informed resident & representative that resident not allowed back at facility & documented in record & SS stated did not provide resident anything written as resident left AMA; failed to provide resident &/or representative with written notice of discharge as soon as practical when facility determined resident unsafe to return to facility after getting out of jail for assault*

NE: SS=D: Failed to notify State LTC Ombudsman of 1 resident's discharges to hospital in July 2023 & in Sept 2023 placing resident at risk for decreased oversight of transfers

- Failed to notify State LTC Ombudsman of 1 resident's discharge to hospital in July 2023 & in Sept 2023 placing resident at risk for decreased oversight of transfers

F625 Notice of Bed Hold Policy Before/Upon Transfer

NE: SS=D: Failed to provide a "Bed Hold Notice" to 1 resident upon discharge to hospital in July 2023 & Sept 2023 placing resident at risk or making uninformed decisions r/t care

- Failed to provide 1 resident "Bed Hold Notice" upon discharge to hospital placing resident at risk to make uninformed decisions r/t care

NW: 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 for not being permitted to return & resume residence in nursing facility

- Record lacked evidence resident/representative was provided facility bed hold policy; failed to provide 1 resident/representative with bed hold policy when resident transferred to hospital with risk for not being permitted to return & resume residence in facility

F641 Accuracy of Assessments

SW: SS=D: Failed to complete accurate MDS for 1/12 residents sampled r/t life expectancy of 6 months or less for resident that received hospice services

- Failed to complete accurate MDS for resident on hospice services

F655 Baseline Care Plan

NE: SS=D: Failed to develop a baseline CP to include 1 resident's smoking placing resident at risk for impaired safety due to uncommunicated care needs

- Baseline CP lacked information r/t resident's smoking; failed to include smoking on baseline CP for 1 resident placing resident at risk for impaired safety due to uncommunicated care needs

F656 Develop/Implement Comprehensive Care Plan

NE: SS=D: Failed to develop a comprehensive CP for 1 resident's PTSD dx placing resident at risk for uncommunicated care needs

- CP lacked information r/t PTSD dx; record lacked evidence facility assessed & attempted to ID traumatic event & related triggers associated with resident's PTSD; failed to develop a comprehensive CP including trauma informed to address resident's PTSD placing resident at risk for unmet & uncommunicated care needs

NE: SS=D: Failed to develop a person-centered comprehensive CP for 1 resident r/t limited ROM placing resident at risk of loss of ability to perform ADLs & development or worsening contractures due to uncommunicated care needs

- CP lacked direction for care & prevention of worsening contractures; EMR lacked clinical evidence a consistent program or exercises aimed to maintain abilities & prevent loss of function; failed to develop a person-centered comprehensive CP for 1 resident r/t limited ROM placing resident at risk of loss of ability to perform ADLs & development or worsening contractures due to uncommunicated care needs

NW: SS=D: Failed to develop a comprehensive CP for 1 resident which addressed edema & related needs placing resident at risk for impaired due to uncommunicated care needs

- CP lacked documentation of dx of edema & interventions to prevent edema; observed resident w/o compression socks as ordered on multiple occasions; failed to develop CP for resident's edema placing resident at risk for impaired care due to uncommunicated care needs

F657 Care Plan Timing & Revision

NW: SS=D: Failed to revise 1 resident's CP to include fluid restriction quantities placing resident at risk of complication r/t hydration status, dialysis, tx & hx of UTIs due to uncommunicated care needs

- CP lacked direction lacked direction to staff as to dietary & nursing dept specification on interdisciplinary communication of fluid intake; EMR lacked evidence staff monitored & recorded physician ordered fluid intake; EMR further lacked documentation of fluid intake for day shift 2/14 opportunities; 8/14 evening shift; & 11/14 night shift; failed to revise 1 resident's CP to include fluid restriction quantities between nursing & dietary departments placing resident at risk of complications due to uncommunicated care needs

F661 Discharge Summary

NW: SS=D: Failed to develop a discharge summary for 1 resident reviewed for discharge that included a completed recapitulation of resident's stay & post discharge plan for 1 resident placing resident at risk for receiving inadequate care & missed care opportunities

- EMR lacked evidence of complete discharge summary which included recapitulation of stay; failed to complete discharge summary that included recapitulation of 1 resident's stay & post discharge plan placing resident at risk for receiving inadequate care & missed care opportunities

F677 ADL Care Provided for Dependent Residents

NE: SS=E: Failed to provide personal hygiene assistance & consistent bathing for 11 residents placing residents at risk for impaired dignity, increased risk for skin issues & other complications

- Documentation revealed resident with: 21 days no bath, 11 days no bath, 23 days no bath; observed resident with shoulder length hair appeared greasy, uncombed & ratted on back side & resident unkempt & wore wrinkled dress; failed to provide necessary care & bathing services for 1 resident placing resident at risk for poor hygiene
- Documentation revealed resident with: 12 days no bath; 12 days no bath, 9 days no bath, 13 days no bath, 19 days no bath; observed with unkempt with long, white beard appearing dirty, greasy hair & not combed in back & appeared stringy; failed to provide necessary care & bathing services for 1 resident placing resident at risk for poor hygiene

- Documentation revealed resident with: 13 days no bath, 9 days with no bath, 27 days with no bath, 19 days with no bath; observed resident with hair uncombed; failed to provide necessary care & bathing services for 1 resident placing resident at risk for poor hygiene
- Documentation revealed resident with: 13 days, 17 days, 2 refused baths, 31 days w/o bath, 7 days w/o bath, 26 days w/ bath; failed to provide consistent bathing & grooming for 1 resident placing resident at risk for complications r/t poor hygiene
- Observed resident with toenails long & grown over tips of toes & toes dry with flaking skin; failed to provide consistent bathing for 1 resident as CPd placing resident at risk for complications from poor hygiene
- Sept ADL log documented resident did not receive oral care on 8 occasions; observed resident unshaven & with visible food debris in teeth; observed resident attempting to dress self & with difficulty getting pants on & became agitated r/t getting catheter bag through pants & resident indicated staff did not usually help resident get dressed; failed to assist 1 resident who received hospice services with personal hygiene, oral care & assistance with dressing placing resident at risk for unmet care needs & complications from poor hygiene
- Documentation revealed resident with: 14 days w/o bath, 13 days w/o bath; failed to provide consistent bathing & grooming for 1 resident placing resident at risk for complications r/t poor hygiene
- Documentation revealed resident with: 17 days w/o bath, 13 days w/o bath, observed resident with teeth with food debris despite having not eaten breakfast yet; resident with dry crusty skin around lips, greasy hair, dirty glasses & facial hair on chin; failed to provide consistent bathing & grooming assistance for resident placing resident at risk for complications r/t poor hygiene
- NN documented family member spoke with SS r/t issues with resident's neck & resident not being bathed; bathing records documented resident was bathed 2x in July, 2x in August, 2x in Sept & 2x's in October; observed resident in bed with breakfast tray on table wrapped in clear plastic & resident unable to get plastic wrap off plate; failed to provide resident assistance with bathing placing resident at risk for poor hygiene
- Documentation revealed resident bathed 3x in July, 1 x in August, 1 bath in Sept & no baths to date in October; resident stated "I just pee & they come & then they wipe me" several times; failed to provide 1 resident assist with bathing placing resident at risk for poor hygiene
- Documentation revealed resident received 3 baths in July, 8 occasions documented as "not applicable"; resident refused 3 x between 7-1-23 to 10-3-23; observed resident who stated did not received shower if only 2 staff assigned to each hallway & staff reported to resident they would not have enough time to complete showers & was able to wash self up in BR sink but still felt dirty; failed to ensure shower/bath provided for 1 resident who required assistance with ADLs with potential to cause skin breakdown &/or skin complications due to poor personal hygiene & impaired psychosocial wellbeing

NE: SS=D: Failed to provide consistent bathing opportunities for 2 residents placing residents at risk for skin complications & impaired dignity

- EMR documented resident had 4 baths between 8-31 & 9-27; observed resident with hair & face greasy; failed to provide consistent bathing opportunities for 1 resident placing resident at risk for infections & skin breakdown due to poor hygiene
- Resident admitted then discharged back to hospital on multiple occasions & documented had 2 showers in 62 day period including days of hospitalization; Observed resident's room smelled of urine; failed to ensure shower/bath provided for 1 resident who was dependent on staff assist with ADLs which had potential to cause skin breakdown &/or skin complications due to poor personal hygiene & impaired psychosocial wellbeing

F679 Activities Meet Interest/Needs Each Resident

NE: SS=D: Failed to consistently provide activities for all residents residing on locked dementia unit with risk for decline in physical, mental & psychosocial wellbeing & independence for residents

- 4 residents of locked dementia unit lacked evidence of activity participation documentation; observed multiple scheduled activities not provided as scheduled; failed to consistently provide activities for all residents residing on locked dementia unit with risk for decline in physical, mental & psychosocial wellbeing & independence for residents

F684 Quality of Care

NE: SS=D: Failed to implement interventions to prevent skin tears & failed to follow CP for 1 resident; further failed to monitor daily weights for 1 resident placing residents at risk for further injury & declining health

- CP instructed staff to offer Geri-sleeves; observed resident with large purple bruise to arm & resident w/o Geri-sleeves; failed to implement CPd interventions to prevent skin tears & bruises for 1 resident placing resident at risk for further injury
- POS to elevate LUE to decrease edema, edema glove to hand & daily weights with notification parameters; TAR lacked evidence staff measured & recorded weights on 9 occasions from 6-27- to 9-4; observed resident w/o edema glove on or tubi-grips on lower extremities; failed to follow physician order for daily weights to monitor weight gain for fluid overload for 1 resident; further failed to ensure resident's edema glove & tubi-grips were on as ordered by physician placing resident at risk of adverse side effects for unnecessary complications r/t fluid overload & edema

NE: SS=D: Failed to complete physician ordered daily weights for 2 residents placing both residents at risk for complications r/t edema

- Resident with CHF; CP documented resident on low sodium diet, fluid restriction and daily weight monitoring; POS for daily weights with notification parameters; resident with diuretic; 116 days reviewed indicating missed 22 daily weights; resident stated not weighed every day; failed to complete daily weights for 1 resident placing resident at risk for complications r/t edema
- Resident with fluid overload with CP for daily weights; MAR & TAR documented 171 lacked evidence of daily weight for resident documenting 9 occurrences of recorded weight; failed to follow physician order for daily weights to monitor weight gain for fluid overload for 1 resident placing resident at risk for adverse side effects for unnecessary complications r/t fluid overload & edema

NW: SS=D: Failed to ensure 1 resident had physician-ordered compression socks onto resident's legs daily due to edema placing resident at risk for complications from edema

- CP lacked documentation of dx of edema & interventions to prevent edema; POS for diuretic; POS for compression stockings ; observed resident on multiple occasions w/o physician-ordered compression stockings; failed to ensure 1 resident had physician-ordered compression socks applied to legs daily to treat edema placing resident at risk for complications from edema

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

NE: SS=G: Failed to prevent PUs for 1 resident who developed 2 stage 3 PUs & 1 stage 4 PUs & 1 resident who developed stage 4 PU; also failed to promote healing of pressure injury for 1 resident placing resident at risk of further unhealed pressure injuries

- Adm MDS indicated admitted at risk for PU but no ulcers; quarterly MDS revealed resident with 2 unhealed stage 3 PUs & 1 stage 4 PU; no turning or repositioning programs; failed to provide care & services including offloading or pressure reduction for heels to prevent development of resident's hell & ankle PUs & further failed to ensure resident received required pressure reducing mattress when changed rooms which resulted in development of stage 4 coccyx ulcer; also placing resident at risk for continued PUs
- EMR lacked wound assessments & measurements from 8-31-22 when order received for wound until 12-14-22; failed to monitor interventions & revise as needed to prevent development of facility acquired stage 4 PU; further failed to promote healing of pressure injury when they failed to implement nutritional interventions for many months after wound identified

NW: SS=G: Failed to provide 1 resident with care consistent with professional standards of practice to prevent PU development ; resident admitted to facility w/o any skin issues to buttock but had crevices to bilateral heels from previous PUs failed to initiate a turning/repositioning program, cushion for w/c or bilateral heel protectors/offloading to prevent 1 resident from developing PUs; on 3-27-23 resident obtained suspected deep tissue injuries to sacrum & bilateral heels; resident's sacrum wound later progressed into stage 4 PU & heel ulcers progressed to stage 3 placing resident at risk for further skin breakdown, delayed healing & infection

- *Resident at risk for developing PUs; Facility failed to address PU/pressure injury on resident's CP until after resident had obtained PUs; documentation lacked task for heel protectors to resident's bilateral heels; skin assessment dated 3-31-23 documented pressure injuries to buttock, bilateral heels & lacked any measurements &/or description; resident required Augmentin for wound infections; LN verified resident not on turning repositioning program, pressure reducing mattress or w/c cushion after obtained wound; failed to initiate a turning/repositioning program, cushion for w/c or bilateral heel protectors to prevent resident from developing PUs resulting in resident developing pressure injuries which evolved into stage 3 & 4 wounds; also placing resident at risk for further skin breakdown, delayed healing & infection*

NW: SS=D: Failed to implement interventions placed to prevent, or promote healing of PUs for 1 resident when facility failed to implement pressure reducing cushion as directed by resident's CP & resident developed Stage 2 pressure injury to coccyx placing resident at risk for further unhealed pressure injuries, pain & infection

- Resident at risk for PUs & other skin impairment r/t stroke & hemiplegia; with air mattress in bed & Roho cushion in recliner & w/c; with revision for PU boots on at all times & tx order for stage 2 PU; Skin eval documented bruise to heel & 2 days later fluid filled blister; observed resident w/o Roho cushion at meal; failed to ensure placement of Roho cushion for resident who developed stage 2 PU to coccyx placing resident at risk for further skin breakdown, delayed healing & other wound complications

F687 Foot Care

NE: SS=D: Failed to provide foot care to 1 resident who had dx of DM type 2 & required foot care from LN placing resident at risk for complications, poor hygiene & injuries

- Observed resident with toenails long & grown over tips of toes; failed to provide foot care to 1 resident who had overgrown t oenails on both feet placing resident at risk for foot complications

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to implement a ROM program to help maintain & prevent a decrease in ROM/mobility for 1 resident placing resi dent at risk of loos of ability to perform ADLs & development of worsening contractures

- Resident dependent on 2 staff for ADLs; CP lacked direction for care & prevention of worsening contractures; LN stated resident did not have restorative/exercise program in place to prevent contractures for worsening; failed to implement a ROM/restorative progr am to help maintain & prevent potential decrease in ROM/mobility for 1 resident placing resident at risk of loss of ability to perform or participate in ADLs

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=D: Failed to assess 1 resident for safety while smoking placing resident at risk for accidents while smoking

- Cited findings in F655 r/t smoking risks; failed to assess 1 resident for safety while smoking placing resident at risk for accidents while alone outside smoking

NE: SS=E: Failed to prevent accidents for 2 residents who both fell out from mechanical lifts; failed to utilize 2 staff during a fully body mechanical lift transfer for 1 resident & failed to put foot pedals on 1 resident's w/c while transporting resident placing residents at risk for increased risk for falls & related injury

- Failed to ensure safe transfer for 1 resident when resident slipped from sit to stand lift while only 1 staff member present & using lift; failed to ensure safe transfer for resident placing resident at risk for preventable accidents & injury
- NN documented resident transferred with sit to stand lift over bed when resident reported knee giving out & staff lowered res ident to bed then resident slid to edge of bed to floor; resident's representative present at time of fall; resident not CPd for use of sit to stand lift; failed to ensure 1 resident safely transferred per CP resulting in preventable fall placing resident at risk for further fall s & injuries

- Observed resident suspended in air in sling by Hoyer operated by 1 staff; CMA stated usually, around 90% of time only 1 staff member assigned on dementia household; failed to ensure safe use of Hoyer lift for total lift transfer for 1 resident placing resident at risk of preventable accidents & related injuries
- Observed CMA pushing resident in w/c from TV area down hallway with bare feet sliding on floor; observed Hospitality Aide pushing 1 resident up & down hallway on dementia household with resident's bilateral feet sliding on floor; CMA stated residents did not use w/c pedals because pedals would be trip hazard & it was facility policy that on dementia household, foot pedals were not used; failed to ensure safe environment free from accident hazards when staff failed to use foot pedals on 1 resident's w/c when staff pushed w/c placing resident at risk of accident & related injuries

NE: SS=J (Past Non-Compliance): Failed to provide adequate supervision to cognitively impaired resident who was at risk for elopement & exited facility

- *On 10-6 at 6:21pm resident pressed on exit door for 30 seconds, which opened door; door alarm sounded but staff failed to promptly respond to alarm; resident wore WanderGuard on w/c which alarmed as well but staff failed to respond; an independent living resident in parking lot saw resident outside of facility & brought resident back into facility near kitchen where dietary staff then escorted resident to nurses' station; resident was outside unattended for approximately 4 minutes & it was 7 minutes before staff were aware of exit; facility's failure to respond to door alarm which allowed cognitively impaired resident to exit facility w/o staff knowledge into unsupervised location placing resident in immediate jeopardy*
- *Abatement Plan:*
  - *Updated resident's CP on day of incident*
  - *Security completed daily door checks starting on day of incident*
  - *Completed staff education r/t "Alarms Response & Missing Resident" from 10-9 to 10-11*
  - *Conducted QAPI meeting on 10-12 with discussion of elopement*

NE: SS=G (Past Non-Compliance): Failed to follow fall interventions to prevent fall with major injury for 1 resident

- *CNA forgot to place fall mat on floor next to resident's bed; resident subsequently found on floor with hematoma, skin tear & thumb fx resulting from deficient practice placing resident at risk for pain; resident with no falls since admission; BIMS 10; NN documented resident left on stretcher to hospital due to development of hematoma on back of head & swelling, bruising & pain on thumb r/t falls; NN documented resident found sitting on floor next to bed with skin tear on forehead above eye & no other injuries noted at that time; NN documented CNA that assisted resident to bed forgot to place floor mat next to resident's bed; assessment noted hematoma to head; ER visit results were resident returned to head with contusion, fx to hand & head injury; resident with 2nd fall resulting in skin tear above eye; failed to follow fall interventions to prevent fall with major injury resulting in thumb fx*
  - *Abatement Plan*
    - *Resident's CP updated*
    - *CNA received education on fall precautions & interventions*
    - *CNA received counseling on inadequate implementation of fall interventions*
    - *Staff educated on falls during monthly in-service*

NE: SS=E: Failed to secure 33 pressurized medical O2 tanks in safe, locked area & out of reach of 2 cognitively impaired independently mobile residents; failed to ensure safe environment free from accident hazards when staff failed to use foot pedals on 1 resident's w/c when staff pushed w/c; further failed to assist 1 resident while walking w/o walker placing residents at risk for preventable accidents & injuries

- Failed to secure 33 pressurized medical O2 tanks in safe, locked area & out of reach of 2 cognitively impaired independently mobile resident placing residents at risk for preventable accidents & injuries
- Failed to ensure safe environment free of accident hazards when staff failed to use foot pedals on 1 resident's w/c when staff pushed w/c placing resident at risk of accident & related injuries
- Failed to assist/intervene while 1 resident ambulated in hallway w/o walker placing resident at risk for further falls & potential injury

NW: SS=D: Failed to provide adequate supervision & safe environment, free from preventable accident hazards, for 3 resident who had falls placing residents at risk for further falls & injury

- Resident at high risk for falls; LN stated if resident found on fall mat, it was not considered a fall because resident would put self down on map; failed to provide supervision & safe environment by investigating causative & contributing factors when resident found on floor placing resident who had falls out of bed & w/c at risk for further falls & injury & potential unidentified abuse &/or neglect
- Resident at high risk for falls; resident with multiple falls; EMR lacked documentation an assessment to determine if resident could safely use lift chair completed; observed no Dycem in w/c or recliner as CPd; failed to ensure resident remained free from preventable accidents & hazards placing resident at risk for further falls & injuries
- Resident at high risk for falls; resident with multiple falls; EMR lacked evidence staff assessed resident for ability to safely use lift chair; failed to ensure safe environment free from accident hazards for 1 resident placing resident at risk for further falls & injury

NW: SS=J (Past Non-Compliance): Failed to provide a safe environment free from preventable accidents for 2 residents

- *CMA picked 1 resident up from ER using facility transportation van; CMA assisted resident who used a w/c into van & failed to secure 2 front straps as well as lap strap; as CMA made first left hand turn after leaving hospital, resident's w/c tipped backward & resident fell from chair & hit head; resident returned to ER where dx'd with fx of cervical vertebrae; further failed to ensure another resident remained free from preventable accident hazards when staff allowed cognitive impaired resident outside w/o staff supervision; failed to recognize resident who was at risk for elopement & wore a WanderGuard as a resident & failed to respond appropriately to WanderGuard alarms, allowing resident to exit facility through AL wing & remain outside w/o staff supervision for 8 minutes until resident went back to door to be allowed in; failures placed both residents in immediate jeopardy*
- *Past Non-Compliance Plan:*

- *QAPI meeting held after van incident*
- *All associates retrained on vehicle competency during skills fair*
- *CMA transporter fired from facility*
- *Resident that eloped placed on 15-mintue checks immediately & continued until discharge to home*
- *Adm nurse reviewed other residents at risk for elopement*
- *Mass text alerts sent out to staff r/t elopement risk residents*
- *QAPI meeting held after elopement incident*

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to ensure 1 resident who had indwelling catheter had physician order for catheter which included dx or indication for indwelling catheter placing resident at risk for catheter related complications

- *Failed to ensure 1 resident had physician's order which included reason or indication for indwelling catheter placing resident at risk for catheter related complications*

NE: SS=D: Failed to ensure 1 resident received services & assistance to maintain continence &/or improve incontinence & faile d to manager resident's catheter in sanitary manner placing residents at risk for increased incontinence & UTIs r/t complications

- EMR lacked bowel & bladder diary completed; observed resident in w/c & commented "I just pee & they come & then they wipe me" several times; observed staff took resident to DR w/o offering toileting assist; failed to ensure resident received services & assist to maintain continence & improve incontinence placing resident at risk for related complications
- Observed 2 CNAs provide catheter care; during transfer from bed to w/c, drainage bag fell onto floor; CNA placed catheter drainage bag onto resident's lap then finished transferring resident to w/c then placed bag into privacy bag under seat of w/c w/o cleanin g drainage bag which touched floor; failed to ensure 1 resident's catheter drainage bag was managed in sanitary manner when it touched floor & further failed to ensure bag remained below bladder to prevent backflow placing resident at increased risk for continued UTIs & catheter related complications

NW: SS=D: Failed to provide 1 resident with sanitary indwelling urinary catheter care which placed resident at risk for UTIs

- Resident with indwelling urinary catheter; family requested not to put pants on resident r/t catheter; resident developed UTI ; observed CNA & CMA with morning hygiene care; resident with soft BM which took significant amount of cleansing due to dryness of old fecal material around edges; observed open area to resident's coccyx area; observed staff cleansed & treated rectal area then cleansed catheter insertion site & tubing w/o changing gloves; failed to provide resident with sanitary indwelling catheter ca re placing resident at risk for ongoing complications of UTIs

F691 Colostomy, Urostomy, or Ileostomy Care

NE: SS=D: Failed to ensure 1 resident received appropriate treatment & services r/t nephrostomy catheter placing resident at risk for complications r/t nephrostomy catheter

- *POS for urostomy & both nephrology tubes cares; POS lacked care orders prior to noted orders & review of EMR lacked evidence any cares were provided prior to 10-8-23; resident developed infection around wound; failed to ensure resident received appropriate treatment & services r/t nephrostomy catheter placing resident at risk for complications r/t nephrostomy catheter*

F692 Nutrition/Hydration Status Maintenance

NE: SS=D: Failed to monitor fluid intake for 1 resident as ordered by physician placing resident at risk for fluid overload

- POS for staff to monitor resident's weight on non-dialysis days & for heart failure & fluid overload & notification parameters; POS for fluid restriction; EMR lacked specific fluid amounts to be provided each shift by dietary & nursing & lacked evidence staff monitored resident's intake of fluids; failed to monitor fluid intake for 1 resident as physician ordered placing resident at risk for fluid overl oad

NE: SS=D: Failed to follow recommendations from dietitian & failed to provide consistent weight loss interventions for 1 resident who had significant weight loss of 16.3% from 8-14-23 to 10-9-23 placing resident at risk for further weight loss & physical complications

- POS for dietary supplements & weight monitoring; MAR lacked documentation that weights were obtained as ordered on 7 occasions between noted dates; lacked documentation that snacks offered & provided on multiple occasions; failed to follow recommendati ons from dietitian & failed to provide consistent weight loss interventions for 1 resident who had significant weight loss of 16.3% from 8-14 to 10-9 placing resident at risk for further weight loss & physical complications

NE: SS=D: Failed to provide consistent weekly weight monitoring as required by 1 residents physician orders placing resident at risk for complication r/t weight loss & malnutrition

- CP documented resident at risk for malnutrition; EMR revealed missing weights for 3 weeks in October during which resident ha d COVID; staff unaware of how to weigh resident when on isolation; failed to provide consistent weekly weight monitoring as required by 1 resident's physician orders placing resident at risk for complication r/t weight loss & malnutrition

NW: SS=D: Failed to monitor resident's physician ordered fluid restriction placing resident at risk of complication r/t hydration status due to need of dialysis treatment & hx of UTIs

- CP lacked direction to staff as to dietary & nursing department specification on which department coordination of fluid intak e; POS for 1500 fluid restriction; EMR lacked evidence staff monitored & recorded fluid intake for extended period of time; after facili ty started documenting fluid intake, EMR lacked documentation of fluid intake for day shift for 2/14 opportunities; evening shift f or 8/14 opportunities & night shift for 11/14 opportunities; failed to monitor physician ordered fluid restriction for 1 resident who received dialysis tx's had UTI hx placing resident at risk for complications r/t hydration status

F695 Respiratory/Tracheostomy Care & Suctioning

NE: SS=D: Failed to provide necessary respiratory care & services for 1 resident when staff stored uncovered nebulizer masks on top of nebulizer machine placing resident at increased risk for respiratory infection & complications

- Observed unbagged nebulizer mask, tubing & nebulizer cup on multiple occasions; failed to properly store 1 resident's nebulizer mask when staff stored it uncovered on top of nebulizer machine placing resident at risk for infection & respiratory complications

F698 Dialysis

NW: SS=D: Failed to ensure 1 resident received care & services for dialysis consistent with professional standards of practice which included ongoing assessments of resident's condition & ongoing communication & collaboration with dialysis facility placing resident at risk for complications & unmet care needs r/t dialysis treatments

- CP directed staff to monitor shunt thrill & bruit every shift & report concerns to dialysis; education resident & family to any restrictions r/t dialysis & weigh resident before & after dialysis treatment; POS for 1500cc fluid restriction; EMR lacked evidence staff monitored & recorded fluid intake for 17 days after physician order then EMR with holes in intake documentation; facility failed to weight before & after dialysis treatments 3/6 times for Sept & 5/11 times for October; EMR lacked accessibility of communication tool between facility & dialysis provider; failed to provide care & services consistent with professional standards of practice which included ongoing assessment of condition, communication, & collaboration with dialysis treatment placing resident at risk for complications & unmet care needs r/t dialysis treatment

F699 Trauma Informed Care

NE: SS=D: 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

- CP lacked information r/t PTSD dx; records lacked evidence facility assessed & attempted to ID traumatic event & related triggers associated with resident's PTSD; observed resident in w/c in hallway, near med cart, tearful, asking for medication; failed to ensure 1 resident received trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of resident which placed resident at risk for unmet care emotional & psychosocial needs

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

- Resident with dx of PTSD, anxiety d/o & insomnia; CAA lacked documentation r/t resident's PTSD; CP lacked documentation IDing trauma-based trigger & individualized interventions to prevent reoccurring episodes r/t PTSD; Resident reported suffered from PTSD r/t early sexualized trauma in childhood & felt comfortable with some of the males at facility but facility used agency staff & new people were brought in & facility was aware of PTSD; Adm nurse unaware of resident's hx of abuse from males; failed to ID trauma-based triggers r/t resident's childhood abuse & implement individualized interventions to prevent re-traumatization placing resident at risk for decreased psychosocial wellbeing & ineffective treatment

F700 Bedrails

SW: SS=E: Failed to perform routine inspections of bed rails to ensure they met safety standards & were not a risk for resident entrapment or perform safety assessments of residents with bed rails attached to beds; facility reported 24 residents with rail or other assistive device on bed & 9 of those bedrails were loose leading to possibility of injury or entrapment for 24 residents

- Failed to perform routine inspections of bed rails to ensure they met safety standards & were not a risk for resident entrapment or perform safety assessments of residents with bed rails attached to beds with possibility of injury or entrapment for 9 residents

F726 Competent Nursing Staff

NE: SS=D: Failed to ensure certified staff possessed competencies & skill sets necessary to provide nursing & related services to meet residents' needs safely & in manner that promoted each resident's rights, physical, mental & psychosocial wellbeing when CMA did not administer meds as ordered or within acceptable standards of practice placing affected resident at risk for decreased quality of care

- POS for Fluticasone Propionate q AM for allergies; competency checklist for medication administration for CMA not dated; resident stated had received meds earlier than usual & resident kept Flonase in drawer & used it in evening & observed bottle of Flonase in nightstand drawer; observed CMA administered meds to resident in sitting area; resident took one pill at time out of med cup & dropped one of pills between cushion & arm of couch then resident dug for pill & found it; pill had hair & lint on it but CMA let resident take med; failed to ensure certified staff possessed competencies & skill sets necessary to provide nursing & related services to meet residents' needs safely & in manner that promotes each resident's rights, physical, mental & psychosocial wellbeing when CMA did not administer physician ordered nasal spray to 1 resident as ordered placing resident at risk for decreased quality of care

NW: SS=E: Failed to ensure licensed nursing staff had appropriate competencies & skill set to provide nursing related services to assure resident safety & to attain or maintain highest practicable physical, mental & psychosocial wellbeing of each resident placing resident at risk of injury during transfers & ongoing wound assessments & all residents at risk for decreased quality of care

- Adm nurse provide 3 nursing staff competencies & 1/3 did not have competencies required & had not yet completed competencies for al nursing staff; Failed to ensure licensed staff had appropriate competencies & skill sets to provide nursing related services to assure resident safety & attain or maintain highest practicable physical, mental & psychosocial wellbeing of each resident placing all residents at risk for decreased quality of care
- Observed LN provide wound care to skin tear on resident's back; LN stated thought resident sustained skin tear as result of staff's use of gait belt & planned to contact resident's physician to get TAO DC's; Adm nurse stated skin tear happened after resident fell; failed to

ensure staff possessed required skill & knowledge to safely apply & use gait belt for assisted transfer; as result resident sustained large skin tear on back placing resident at risk for further injuries or complications r/t improper transfers &/or use of gait belt

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

NE: SS=F: Failed to ensure 5/5 CNSs reviewed for regular in-service education, completed an annual performance review placing residents at risk for unskilled care

- Failed to ensure 4 CNAs & 1 CMA completed annual performance review placing residents at risk for unskilled care

F732 Posted Nurse Staffing Information

NE: SS=C: Failed to ensure daily staff nursing hours were posted for 3/4 survey onsite days

- Failed to post daily nurse staffing hours for 3 days of onsite survey

NE: SS=C: Failed to display current daily hours for nursing staff

- During survey process on 10-3 to 10-9, observation revealed nursing staff list was in schedule book & did not contain actual nursing staff hours; failed to display current daily nursing hour information

F744 Treatment/Service for Dementia

NE: SS=D: Failed to provide dementia care & services for 1 resident who had behaviors placing resident at risk for increased behaviors, confusion, & decline in ability to maintain highest practicable mental & psychosocial wellbeing

- CP lacked documentation of how to address dementia care needs; NN documented resident with aggressive behaviors; tried to strike TV screen; documentation lacked what interventions or approach that staff did to redirect resident at that or to prevent or redirect future incidents; observed resident walked up & down hallway with one shoe off & talked to self, attempted to exit unit by pressing on secured exit door; entered other residents' rooms, spoke very loudly to other residents; failed to develop & implement a person-centered dementia CP for 1 resident to receive treatment & services to attain &/or maintain practicable physical, mental, & psychosocial wellbeing placing resident at risk for increased confusion, behaviors, isolation, & lack of appropriate activities & interaction

F755 Pharmacy Services/Procedures/Pharmacist/Records

SE: SS=E: Failed to maintain accurate accounting system of residents' controlled narcotic meds to enable accurate reconciliation & to prevent potential loss or diversion of narcotic meds; failure to maintain system resulted in 1 card with 31 tablets of resident's MS Contin missing from facility with potential to affect all residents that received controlled meds

- *Review of Controlled Medication Inventory Sheet from 8-24-23 through 10-5-23 revealed lack of documentation at each shift change to determine how many controlled meds were in med cart; inventory sheets also lacked end of each shift nurse signatures to verify reconciliation of controlled meds completed with 2 nurses; LN verified nursing staff do not reconcile number of controlled meds at shift change with oncoming nurse; failed to maintain accurate accounting system of residents' controlled narcotic meds to enable accurate reconciliation & to prevent potential loss or diversion of narcotic meds; failure to accurately maintain system resulted in 1 card with 31 tablets of resident's MS Contin discovered missing from facility with potential to affect all residents that received controlled meds*

NE: SS=D: Failed to establish a system to enable accurate medication reconciliation & maintenance of 1 resident's controlled hypnotic medication records placing affected residents at risk for medication diversion &/or misappropriation

- Resident with POS for Lunesta for insomnia; Controlled Drug Record from June 2023 to October 2023 revealed August & September's records were missing & facility unable to provide missing documentation as requested; Adm nurse stated facility had no record keeping process to track & maintain controlled medication sheet until took over & put 1 in place & was unable to find missing med sheets for August & September; failed to establish a system to enable accurate medication reconciliation & to maintain records of 1 resident's controlled hypnotic medication placing resident at risk for unnecessary medication & misappropriation

F756 Drug Regimen Review, Report Irregularities, Act On

NE: SS=D: Failed to follow consultant pharmacist's (CP) recommendation & obtain a specific approved indication for use of Seroquel placing resident at risk for inappropriate use of antipsychotic medication

- POS for Seroquel 100mg TID for psychosis; MAR documented no behaviors of agitation or restlessness from 10-1-through 10-16; CP documented need for specific dx for Seroquel on multiple occasions including need for specific targeted behaviors, non-pharmacological interventions & ongoing monitoring; recommendations not acted on; failed to act on CP recommendation to obtain appropriate indication for use of Seroquel placing resident at risk for inappropriate use of antipsychotic medication

NW: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported lack of appropriate indication for 1 resident's Zyprexa placing resident at risk for unnecessary medications & adverse side effects

- POS for Zyprexa 5mg BID for "psychological & behavioral factors associated with disorders or diseases classified elsewhere";

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure appropriate indication or a documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of antipsychotic for 1 resident who had dx of dementia placing resident at risk for unnecessary psychotropic

- EMR lacked evidence of documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of antipsychotic; failed to obtain appropriate indication or required documentation for continued use of Seroquel placing resident at risk for unnecessary antipsychotic medication & related side effects

NE: SS=D: Failed to ensure 1 resident's PRN psychotropic had a stop date or physician ordered specified duration for administration placing resident at risk for potential harm & adverse side effects r/t unnecessary meds

- POS for Clonazepam ½ tab (0.5mg) po PRN for anxiety or agitation: violent or aggressive behavior to staff or residents BID as needed; hold if somnolent; PRN med lacked 14 day stop date or physician ordered specified duration; failed to ensure resident's PRN psychotropic Clonazepam had stop date or physician ordered specified duration for administration placing resident at risk for potential harm & adverse side effects r/t unnecessary meds; MRR recommended a detailed statement from physician noting benefit outweighed risk; staff reported resident did not have any behaviors; failed to ensure Cp IDd & reported lacked of appropriate dx indication for 1 resident's Zyprexa placing resident at risk for unnecessary meds & adverse side effects

NW: SS=D: Failed to ensure appropriate indication, or a documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of antipsychotic for 1 resident who had dx of dementia placing resident at risk for unnecessary psychotropic meds & related complications

- Cited findings noted in F756 r/t antipsychotic medication Zyprexa; failed to ensure appropriate indication or required physician documentation of continued use of 1 resident's Zyprexa placing resident at risk for unnecessary adverse effects

F761 Label/Store Drugs & Biologicals

SW: SS=F: Failed to secure & provide appropriate storage of meds in med cart

- Observed med cart not locked & left unattended; failed to secure & provide appropriate storage of meds in med cart

NE: SS=E: Failed to label insulin when opened & dispose of expired meds in timely manner placing residents of facility at risk to receive expired or ineffective meds

- Med cart with multiple expired meds; insulin undated when opened; failed to label insulin when opened, & dispose of expired meds in timely manner placing residents of facility at risk to receive expired or ineffective meds

NE: SS=E: Failed to label 3 residents' insulin flex pens with date opened & discard date on 1 med cart & failed to discard expired stock meds in 1 med room placing affected resident at risk for ineffective meds

- Observed 3 med carts with 3 residents' insulin flex pens lacked open date & discard date; observed e-kit in fridge with expired meds; failed to label & date residents' flex pens with date opened & expiration dates & failed to dispose of expired med placing residents at risk for ineffective medication

NE: SS=E: Failed to ensure safe storage & handling of resident's medications placing residents at risk for unnecessary medication & administration errors

- Observed unsecured treatment cart in DR; failed to ensure safe storage & handling of resident's medications placing residents at risk for unnecessary medication & administration errors

F779 X-Ray Diagnostic Report in Record Sign/Dated

NE: SS=D: Failed to ensure physician ordered chest x-ray results for 1 resident were signed & scanned into clinical record which could result in unnecessary tests & delayed treatment

- POS for chest X-ray 2 views to r/o pneumonia dated 7-21-23 & again on 9-15-23; record lacked chest x-ray results & upon request facility provided unsigned copies of results; failed to ensure physician ordered chest x-ray results for 1 resident were signed & scanned into record which could result in unnecessary tests & delayed treatment

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NW: SS=E: Failed to provide food prepared by methods that conserve nutritive value, flavor & appearance when dietary staff failed to follow recipe while preparing 4 residents' pureed diets placing affected residents at risk for impaired nutrition

- Observed dietary staff failed to follow recipe when pureeing foods; failed to follow recipe when preparing 4 residents' pureed diet placing affected residents at risk for impaired nutrition

F812 Food Procurement, Store/Prepare/Serve-Sanitary

NE: SS=E: Failed to store foods & monitor fridge temps for resident food storage in nourishment rooms in accord with professional standards for food safety placing residents who received food from or stored food in nourishment fridges on 2/2 resident halls

- Observed nourishment room with multiple food items & fridge of temp of 39 degrees; lacked evidence of temp monitoring for 2 nourishment fridges

NE: SS=F: Failed to ensure refrigerated food items were covered, labeled & dated & failed to ensure consistent temp monitoring for fridges & freezers with risk to spread foodborne illness to residents

- Observed multiple undated, uncovered & unlabeled food items; temp logs for fridge & freezer with holes in logs

NW: SS=F: Failed to prepare food in accordance with professional standards for food service safety when staff used contaminated gloves to transfer food items from 1 container to another while preparing 4 residents' pureed diets, failed to use gloves when cutting & handling food items, & failed to ensure clean & sanitary food prep areas placing residents at risk for foodborne illness

- Observed staff washed hands, applied gloves, then touched food prep counter then used contaminated gloved hand to transfer cooked, cubed carrots from container to blender container then with same contaminated gloves retrieved scoop from hanging utensil device & placed it on same food prep counter, then retrieved utensils with same gloves; observed staff handles & sliced ham with ungloved hands then touched counter, touched veggies with contaminated gloves; failed to prepare food in accordance with professional standards for food service safety placing all residents who received meals from facility kitchen at risk for foodborne illness

- Observed wall behind oven hood with streaks running below; oven hood with brown substance; seam between back of oven hood with missing caulk; bins with gray substance all around outside of them; deep fat fryers with streaks of brown substance on side; toaster with dried food particles

F851 Payroll Based Journal

SW: SS=C: Failed to electronically submit to CMS with 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 LN staff coverage & decrease in weekend staffing

- PBJ revealed lack of N for 24/7 for 9 days in Quarter 1; 9 days in Quarter 2; 4 days in Quarter 3; above dates on PBJ did not reflect LN staffing included weekends, additional staff due to lack of cross over to capture agency staffing; failed to report accurate staffing information as part of PBJ staff reports to CMS as required when facility failed to electronically submit to CMS with 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 LN staff coverage & decreased in weekend staffing

NE: 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 facility failed to report PBJ data for 1 quarter in 2023; Adm verified facility had not reported PBJ for 1 quarter in 2023; failed to submit PBJ data for Quarter 3 2023 placing residents at risk for unidentified & ongoing inadequate staffing

F868 QAA Committee

NE: SS=F: Failed to ensure required committee members attended QAPI Committee quarterly meetings placing residents residing in facility at risk for decreased quality of care

- QAPI meeting attendance sheets lacked signature that Infection Preventionist attended meetings; failed to ensure required member, including IP attended QAPI meetings at least quarterly placing resident at risk of unidentified quality of care issues

NW: SS=F: Failed to maintain QAA Committee that met quarterly & had required membership in attendance when Medical Director did not attend 1 quarterly meeting placing residents at risk for decreased quality of care

- Review of 1-18-23 roster revealed Medical Director or designee did not attend; failed to maintain QAA that met quarterly & had required membership in attendance placing residents at risk for decreased quality of care

F880 Infection Prevention & Control

SW: SS=F: Failed to maintain sanitary environment to help prevent cross contamination & spread of infections in laundry & to ensure appropriate handling, storage, processing, & transportation of linen for residents of facility

- Laundry staff reported did not use gown, goggles/face shield when sorting soiled laundry & only used gloves when sorting soiled laundry & unaware laundry staff should wear gown & goggles/face shield when sorting contaminated soiled laundry to prevent cross contamination spread of infections; failed to maintain sanitary environment to help prevent cross contamination & spread of infections in laundry & to ensure appropriate handling, storage, processing & transportation of linen for residents of facility

NE: SS=F: Failed to maintain an infection control program to recognize occurrence of infections, recording number & frequency, detect outbreaks & unusual pathogens with infection control implications in facility from October 2022 to April 2023; failed to provide appropriate infection control practices when performing wound care for 4 residents placing residents at risk for infection

- DON verified facility lacked infection control tracking from October 2022 until April 2023; Adm verified facility lacked effective infection control program from Oct 2022 until April 2023; failed to have effective infection control program placing residents residing in facility at risk for infection
- Failed to ensure thorough infection control during wound care dressing changes placing resident at risk for infection when staff failed to wash hands after handling soiled items
- Observed LN changed gloves w/o washing hands on multiple occasions during dressing change; failed to ensure thorough infection control during wound care dressing changes placing residents at risk for infection for multiple residents
- Failed to follow standard infection control procedures when staff failed to perform hand hygiene in between glove changes & failed to ensure sanitary practices when providing wound care for 1 resident placing resident at risk for infection

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

- Adm stated last maintenance supervisor was fired a few months ago & facility unable to locate or retrieve information r/t water testing if or when it had been completed & testing results; Adm had information material for water management process however lacked documentation process was completed; failed to implement water management program to test & manage waterborne pathogens placing residents residing in facility at risk of contracting Legionella pneumonia

NE: SS=E: Failed to ensure infection control standards were followed r/t isolation precautions signage, water management for Legionella & laundry services placing residents at risk for infectious diseases

- Laundry temp logs revealed no temp testing after March 2023
- Observed isolation carts outside rooms but no signs posted indicating required precautions to enter rooms or to seek nurse prior to entering
- Review of Legionella revealed facility not actively monitoring water after April 2023; failed to ensure infection control standards were followed r/t isolation precaution signage, water management monitoring & laundry services placing residents at risk for infectious diseases

F882 Infection Preventionist Qualifications/Role

NE: SS=F: Failed to employ a designated Infection Preventionist as required placing residents in facility at increased risk for infection & related complications

- Failed to employ an IP as required placing residents who reside in facility at increased risk of infection & related complications

F883 Influenza & Pneumococcal Immunizations

NE: SS=D: Failed to obtain pneumococcal &/or influenza vaccination consent & administer vaccines, or obtain informed declinations for 3 residents after residents were admitted to facility placing residents at risk to acquire, spread & experience complications from pneumo coccal & influenza disease

- Failed to offer & obtain signed consent or declination of influenza & pneumococcal vaccination for 3 residents placing residents at risk to acquire, spread & experience complications from influenza & pneumococcal disease

F920 Requirements for Dining & Activity Rooms

NE: SS=E: Failed to provide adequate lighting in main DR placing residents at risk for impaired quality of life

- Observed main DR with fluorescent light with nonfunctioning bulbs on ceiling above DR door where STOP sign posted; 2 ceiling fluorescent light fixtures close to kitchen entrance with nonfunctioning light bulbs; failed to provide an adequate lighting in main DR for residents who ate meals there placing all residents at risk for impaired quality of life

F921 Safe/Functional/Sanitary/Comfortable Environment

NE: SS=E: Failed to provide a safe & sanitary environment when 6 fluorescent ceiling light fixtures had numerus bugs, sink counter top edge with missing pieces of laminate in main DR & chairs in rehab DR with stains & food particles 3 days of onsite survey placing residents at risk for decreased quality of care & life

- Failed to provide safe & sanitary environment when 6 fluorescent ceiling light fixture had numerous bugs, sink counter top edge with missing pieces of laminate in main DR & chairs in rehab DR with stains & food particles 3 days of onsite survey placing residents at risk for decreased quality of care & life

F947 Required In-Service Training for Nurse Aides

SW: SS=F: Failed to develop, implement & permanently maintain in-service training program for staff that is appropriate & effective to ensure continuing competence of CNAs & appropriate care & services to residents of facility

- 2/4 CNAs lacked all 12 hours of required trainings which included dementia training, resident abuse prevention, social media training & cares for individuals with cognitive impairments; failed to maintain in-service training program records that was appropriate & effective for 2 CNAs who lacked all required 12 hours of in-services within prior year to ensure continuing competence of CNAs appropriate care & services to all residents of facility

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

- Failed to ensure CNAs received annual required 12 in-services placing residents at risk for receiving unskilled care

November 2023

F550 Resident Rights/Exercise of Rights

SE: SS=D: Failed to show respect & dignity to 1 resident by not having dignity bag for indwelling urinary catheter collection bag

- CP lacked staff instruction on use of dignity bag for resident's catheter bag; failed to ensure reasonable dignity for dependent resident whose urinary catheter bag was visible to anyone in areas resident went

NW: SS=D: Failed to honor resident rights when facility revoked 1 resident's smoking privilege as a form of reprisal for facility's inadequate supervision which allowed resident to obtain cigarettes & lighter from another resident's room; resident lit a cigarette in the hall outside the smoking-room placing resident at risk for impaired self-determination about things that were important to resident including smoking

- LN stated resident could no longer smoke because resident was able to get cigarettes from someone else's room & lit up & smoked in hallway & occasionally resident's visitor would bring in lighters & resident would stash them in resident's room; revoking of resident's smoking privileges as a form of reprisal placed resident at risk for loss of self-determination r/t what was important to resident

F565 Resident/Family Group & Response

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

- Failed to resolve recurring issues reported by Resident Council placing residents at risk for decreased psychosocial wellbeing

F567 Protection/Management of Personal Funds

NE: SS=E: Failed to ensure resident funds accounts were accessible 24 hours a day 7 days a week placing all residents at risk for decreased psychosocial wellbeing

- Resident stated ongoing concerns with accessing facility-controlled funds & funds locked up on weekends & only available to residents Monday thru Friday during business hours; failed to ensure resident funds accounts were accessible 24 hours a day 7 days a week placing all resident at risk for decreased psychosocial wellbeing

F582 Medicaid/Medicare Coverage/Liability Notice

NW: SS=D: Failed to provide 2 residents/representatives, completed ABN form 10055 which included cost to continue services placing residents at risk of uninformed decisions about skilled services

- Form provided to 2 residents revealed form lacked cost of continued service; failed to provide 2 residents/representatives completed 10055 form which included an estimated cost of continued services when discharged from skilled care placing residents at risk for uninformed decisions about skilled services

F583 Personal Privacy/Confidentiality of Records

NE: SS=D: Failed to ensure staff secured and protected privacy & confidentiality of 3 resident's medical record placing residents' personal & confidential information at risk of being accessed by unauthorized individuals

- Observed MAR left open, visible & unattended on med cart on multiple occasions for multiple residents; observed laptop screen left open & unlocked with screen showing resident names & photo & med on med cart; failed to ensure staff secured & protected privacy & confidentiality of 3 resident's medical record placing residents' personal & confidential health information at risk of being accessed by unauthorized individuals

F584 Safe/Clean/Comfortable/Homelike Environment

SE: Failed to ensure safe, sanitary & homelike environment for residents of facility in identified resident areas

- Observed multiple resident rooms with accumulation of dirt & grime in corners of room; BR with staining over surface, accumulation of dirt & grime along perimeter of floor; shower room with corners with accumulation of grime; utility room floor with grime & debris around perimeter of floor & across surface of floor; phone room with perimeter with grime & black discolorations; exit door with grime & dead insects; corners of floor at doors to hallways with accumulation of grime

F602 Free from Misappropriation/Exploitation

NE: SS=E: Failed to ensure residents remained free from abuse when multiple residents' medications were misappropriated placing all residents who had controlled meds stored in facility at risk for further misappropriation, abuse & impaired care r/t missing or stolen medications

- Facility's investigation documented 2 LNs noted resident's entire card of oxycodone missing; documentation indicated when LN signed med administered in MAR but not controlled substance logbook & multiple nurses administered resident's med as well as instance of LN left facility & facility uncertain if LN conducted reconciliation of controlled meds with another LN; investigation revealed: 1 resident's entire card of oxycodone missing; 1 resident with 14 oxycodone missing; 3 resident's Tramadol missing 60 tabs; 1 resident's Percocet missing 41 pills; 1 resident's oxycodone missing 30 pills; all medication replaced at facility cost; LN stated drug reconciliation confusing & difficult to follow; failed to ensure residents remained free from abuse when multiple residents' medications were misappropriated placing all residents who had controlled meds stored in facility at risk for further misappropriation, abuse, & impaired care r/t missing or stolen meds

F606 Not Employ/Engage Staff with Adverse Actions

NE: SS=E: Failed to ensure a criminal background check was performed prior to allowing access to residents for 2 employees placing affected residents at risk for abuse, neglect, misappropriation or mistreatment

- Personnel file revealed LN with hire date of 8-18-23 & CBC dated 11-7-23; LN with hire date of 11-19-23 & no CBC completed; failed to conduct a criminal background check as required for 2 employees; the 2 employees were allowed access to residents w/o knowing if they had been found guilty of ANE, misappropriation of property or mistreatment by court of law placing affected residents at risk for ANE & mistreatment

F620 Admissions Policy

NW: SS=C: Failed to establish & implement an admissions agreement that explained & protected resident's right to personal property, safeguarded by facility in manner which allowed full accessibility to valuable by resident

- Admission Agreement stated resident, or responsible party accepted responsibility of safeguarding all valuables, money, appliances & all other pieces of resident's personal property while resident stayed at facility…facility was not responsible for replacing any missing items, other than required by applicable law; failed to establish & implement an admissions agreement that explained & protected resident's right to personal property, safeguarded by facility in manner which allowed full accessibility to valuable by resident

F623 Notice Requirements Before Transfer/Discharge

NE: SS=D: Failed to ensure a discharge location was documented on a "30-Day Discharge Notice" issued to 2 residents placing residents at risk of inappropriate placement at end of 30-day notice

- 2 "30-Day Discharge Notices" lacked discharge location; SS stated unsure why location not listed on discharge notice but actively working on appropriate placement for both residents; failed to ensure discharge location was documented on "30-Day Discharge Notice" issued to 2 residents placing residents at risk for inappropriate placement at end of the 30-day period

F636 Comprehensive Assessments & Timing

NE: SS=D: Failed to complete CAAs r/t Significant Change MDS within required time frame for 1 resident to address underlying cause, risk factors, & other contributing factors to ensure resident received care based on individual needs placing resident at risk for unidentified care needs

- Resident's CAA not completed within required 14 days of significant change MDS; failed to complete CAAs within 14 days of completion of MDS placing resident at risk of potential of ineffective ID of strengths, goals, preferences & care needs for person-centered care plan

F641 Accuracy of Assessments

NE: SS=D: Failed to ensure 1 resident's MDS was accurately coded as required by RAI Manual placing resident at risk for inaccurate CP & unmet care needs

- Quarterly MDS inaccurately coded section P 0100 which indicated truck restraint was used, but less than daily; Consultant stated resident never used trunk restraint because belt on chair not large enough to fit around resident's abdomen; failed to ensure 1 reside nt's quarterly MDS Section P 0100 Physical Restraint was accurately coded a required by RAI Manual placing resident at risk for inaccurate CP & unmet care needs

F655 Baseline Care Plan

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

- Baseline Care Plan marked "No" for dialysis & lacked any information r/t resident's central line/access site ; failed to develop a person-centered baseline CP to include dialysis for 1 residents placing resident at risk for impaired care r/t uncommunicated care needs

F657 Care Plan Timing & Revision

SE: SS=D: Failed to review & revise CP for 1 resident with failure to include staff instructions of use of dignity bag in CP for resident's indwelling urinary catheter collection bag

- CP lacked staff instruction on use of dignity bag for resident's catheter bag; observed catheter bag lacked dignity bag & visible to other residents & staff on multiple occasions; failed to review & revise CP for dependent resident with indwelling catheter bag for staff to use as dignity bag

NE: SS=D: Failed to revise 1 resident's CP to reflect level of care & assistance needed for ADLs placing resident at risk for preventable falls & injuries due to uncommunicated care needs

- Cp failed to ID resident's ADL needs, level of assist as IDd in care assessment; failed to revise 1 resident's CP to reflect level of care & assist needed for ADLs placing resident at risk for preventable falls & injuries due to uncommunicated care needs

NW: SS=E: Failed to revise, update, & individualize CPs for 1 resident who received O2 & respiratory tx; 1 resident with urinary catheter; f1 resident who received insulin and dx of DM; 1 resident who was on fluid restrictions & 2 residents who were at risk for falls p lacing residents at risk for inadequate &/or inappropriate care r/t uncommunicated care needs

- CP lacked revision or updates for use of O2 & respiratory tx's; failed to update CP for 1 resident's O2 & respiratory tx's pl acing resident at risk for inadequate care due to uncommunicated care needs
- CP lacked revision or update for use of urinary catheter; failed to update CP for 1 resident's catheter use placing resident at risk for inadequate care due to uncommunicated care needs
- CP lacked update or revision for assessment & monitoring for hyper-/hypoglycemia or for use of insulin; failed to update 1 resident's CP placing resident at risk for inadequate care due to uncommunicated care needs
- CP lacked update of interventions for 1 resident's fluid restriction for resident on dialysis; failed to update 1 resident's CP placing resident at risk for inadequate care due to uncommunicated care needs
- CP lacked intervention with instructions to staff to keep resident from falling in shower; failed to update 1 resident's CP w ith intervention & instructions to staff after resident's fall to prevent resident from repeating fall from shower chair placing resident at risk for future falls due to uncommunicated care needs
- CP lacked section r/t falls with instructions to staff r/t interventions to use to prevent resident from falling; failed to u pdate 1 resident's CP with fall interventions & instructions to staff after a fall to prevent future falls placing resident at risk for future falls due to uncommunicated care needs

F677 ADL Care Provided for Dependent Residents

NE: SS=D: Failed to ensure 1 resident received necessary assist required with eating & failed to ensure 1 resident received n ecessary assist with bathing placing residents at risk for impaired quality of care & at risk for further decline

- CAA documented resident required set-up assist & supervision during meals r/t dysphagia; observed resident in DR in reclined position & attempted to eat meal; resident coughed repeatedly as fed self & staff passed other residents' trays but did not cue resident to slow down or adjust resident's positioning; another resident cued resident to eat slower & later staff cued resident to slow down eating after resident coughed for almost 10 minutes but still did not adjust positioning; failed to provide necessary ADL assist for 1 resident while eating placing resident at risk for impaired nutrition & aspiration
- CP documented resident required assist with ADLs r/t fatigue; documentati on of ADLs revealed resident missed 3 scheduled bathing opportunities & no documentation of refusals; resident stated told on some nights that resident could not receive a shower due to lack of staff; resident stated had asked for shower but had not received one in about a week; failed to provide consistent bathing for 1 resident who was dependent & required staff assist for ADLs/bathing placing resident at risk for poor hygiene & decreased dignity for 1 resident

F678 Cardio-Pulmonary Resuscitation (CPR)

NE: SS=E: Failed to ensure staff maintained current CPR certification for healthcare providers through a CPR provider whose tr aining included hand-on practice & in-person skills assessment placing all residents who desired CPR at risk for inadequate resusci tative measures

- 2 staff records revealed 2 LNs had online CPR training & training lacked hand-on/in-person skills component as required; failed to ensure staff maintained current CPR certification for healthcare providers through a CPR provider whose train ing included hand-on practice & in-person skills assessment placing all residents who desired CPR at risk for inadequate resuscitative measures

F684 Quality of Care

SE: SS=D: Failed to draw physician ordered labs for 1 dependent resident to monitor wellbeing & physical/mental health

- POS for CBC q 3 months; CMP q 3 months; review of resident's lab reports revealed staff failed to obtain ordered tests in 1 month when lab was due to be drawn; Adm stated resident had account balance due to lab so lab would not run ordered labs; failed to draw physician ordered labs for dependent resident to monitor wellbeing & physical/mental health

NE: SS=J (Past Noncompliance): Failed to apply ordered treatment for 1 resident who had dx of peripheral arterial disease & lower extremity wound

- Resident received order to apply rolled gauze to lower extremity & wrap with single layer of Coban; on 10-28, dressing applied by LN; on 10-31 wound care specialists evaluated resident in facility; wound specialist noted resident with Unna boot applied to both legs though resident did not have an Unna boot ordered for right leg; when staff removed Unna boot, wound specialist noted extensive mace ration from toes to below knee & weak pedal pulse; specialist noted Unna boot not appropriate if circulation compromised & ordered arterial Doppler; wound care specialist ordered resident be sent to ER for concern of potential decreased blood flow causing loos of limb; resident admitted to acute hospital & subsequently underwent right BKA; failure to apply appropriate ordered tx to resident's leg resulted in wound deterioration & impaired circulation which required amputation placing resident in immediate jeopardy; failed to apply appropriate ordered treatment to resident's lower leg which resulted in wound deterioration & impaired circulation & amputation of right lower leg placing resident in immediate jeopardy
- Abatement Plan:
  - Facility IDd incorrect wrap for 1 resident & replaced with appropriate ordered treatment
  - Education provided to LN r/t treatment orders; all relevant staff received in-service education r/t "rights" of medication administration & treatment application, wound care, & prevention of abuse & neglect
  - All residents with skin/wound treatment orders audited by wound nurse to ensure treatment orders in place & implemented correctly
  - Ad hoc QAPI meeting conducted with facility staff & Medical Director r/t event including root cause, plan for change & ongoing monitoring

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

NE: SS=D: Failed to remove resident's Hoyer lift sling while resident slept in bed placing resident at risk for complication r/t skin breakdown & PUs

- Resident Council Minutes documented concerns that resident was non-verbal & often ignored & staff put resident in bed & often forgot about resident; observed resident in bed with Hoyer lift sling under resident; failed to remove resident's Hoyer lift sling while resident slept in bed placing resident at risk for complication r/t skin breakdown & PUs

F688 Increase/Prevent Decreased in ROM/Mobility

NE: SS=D: Failed to ensure 1 resident's hand splint & 1 resident's palm protector was applied as directed to prevent an avoidable reduction in ROM &/or mobility leaving 2 residents at risk for further decline & decreased ROM or mobility

- TAR for 11-27-23 documented resident wore palm splint & observed resident on 11-27 w/o hand splint & observed splint on nightstand on other side of room, out of reach of resident; staff reported resident applied splint self; failed to ensure 1 resident's hand splint was applied as directed to prevent avoidable reduction of ROM &/or mobility placing resident at risk for further decline & decreased ROM or contractures
- Failed to use 1 resident's left-hand palm protector per CP contracture tx placing resident at risk for decline in ROM & contractures

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=J (Past Non-Compliance): Failed to ensure staff provided safe & secure environment to include adequate supervision for cognitively impaired resident who facility CPd for 15-minute checks due to hx of making elopement statement; on 10-22-23 resident left facility & walked approx. 0.6 miles to local grocery store; resident observed in grocery store eating at salad bar; facility did not realize resident was missing for 4 hours 23 minutes when local police called facility to report resident located & then returned resident facility placing resident in immediate jeopardy

- CP instructed staff to perform 15-minute checks r/t comments & hx of elopement; failed to ensure 1 resident remained free of accident hazards when resident exited building unsupervised & w/o staff knowledge & remained unaccounted for 4 hours 23 minutes; facility did not realize resident was missing until police department notified facility that resident was found at grocery store & brought resident back over 4 hours after last being seen at facility
- Abatement Plan:
  - Resident placed on 1:1 immediately following return from elopement
  - QAPI meeting held with Medical Director & IDT
  - Checked door alarms for functioning
  - All staff in-serviced on general policy & procedures on elopement & elopement drills completed on all 3 shifts
  - Elopement training completed for all staff
  - Elopement drills completed for all staff
  - Resident Council held with residents on sign-out process
  - Resident screened for inpatient hospitalization & transferred to acute care psychiatric hospital
  - Elopement book updated as needed
  - All residents at high risk for elopement would be reviewed & clinical excellence for change in behaviors as needed
  - Front door alarm installed & activated when opened from 7p to 7a daily

- QAPI meeting to review ongoing processes monthly

NE: SS=E: Failed to secure a container of germicidal wipes & failed to securely lock a closet containing hazardous materials to keep out of reach of 27 cognitively impaired/independently mobile residents placing 27 residents at risk for preventable injuries & accidents

- Failed to secure container of germicidal wipes & failed to securely lock closet containing hazardous materials to keep out of reach of 27 cognitively impaired/independently mobile residents placing 27 residents at risk for preventable injuries & accidents

NW: SS=Failed to ensure an environment free from accident hazards with staff left 1/2 treatment carts unsupervised & unlocked in hall by living room area placing 6 cognitively impaired, independently mobile residents at risk for preventable accidents or injuries

- Observed treatment cart unlocked & unsupervised with multiple hazardous supplies and biologicals; failed to ensure residents environment was free from accident hazards when staff left 1/2 treatment carts unsupervised, unlocked & accessible to 6 cognitively impaired, independently mobile residents who resided in facility placing residents at risk for preventable accidents & injuries

NW: SS=D: Failed to provide CPd amount of staff assistance for 1 resident to prevent falls, failed to provide supervision for 1 resident who entered another resident's room & engaged in unsafe activity placing affected residents at risk for further falls & preventable injury

- Failed to follow 1 resident's Cp to ensure 2 staff for transfers which resulted in fall placing resident at risk for further falls & preventable injury
- Failed to provide adequate supervision for 1 resident who had hx of taking unsafe items from another resident's room, which allowed resident to wander into other resident's room, obtain smoking materials & light a cigarette in hall outside smoking area placing resident at risk for preventable accidents & injuries

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to ensure 1 resident had physician's order & appropriate indication for indwelling catheter; additionally failed to implement a bladder retraining program to improve/maintain 1 resident's bowel & bladder incontinence placing both residents at risk for complications r/t UTIs

- CP lacked mention of indwelling catheter & lacked any directives r/t catheter cares or bowel/bladder management; failed to ensure 1 resident's Foley catheter had active order including appropriate indication placing resident at risk for complications r/t indwelling catheter use
- Record lacked evidence bladder retraining program developed or implemented; failed to implement bladder retraining program to improve/maintain 1 resident's bowel & bladder incontinence placing resident at risk for complications r/t incontinence

F698 Dialysis

NE: SS=D: Failed to monitor 1 resident's central venous catheter for signs of infection, bleeding & status of dressing & failed to obtain indication for dialysis placing resident at risk for potential adverse outcomes & physical complications r/t dialysis

- Record lacked indication for dialysis & documentation of monitoring or care of resident's central line; failed to monitor 1 resident's dialysis access site for signs of infection, bleeding, & status of dressing in place & failed to obtain indication for dialysis placing resident at risk of potential adverse outcomes & physical complications r/t dialysis

NW: SS=D: Failed to adhere to 1 resident's fluid restriction placing resident at risk for fluid overload & dialysis complications

- POS for fluid restriction; TAR with breakdown of fluids by shifts; resident stated had cans of pop & juice drinks in room fridge & stated on fluid restriction but did not follow restriction; staff unsure if resident on fluid restriction; failed to adhere to resident's fluid restriction placing resident at risk for fluid overload & dialysis complications

F726 Competent Nursing Staff

NE: SS=G (Past Noncompliance): Failed to ensure staff possessed knowledge & skills necessary to ensure 1 resident received appropriate physician's ordered wound care to right lower leg; practice resulted in inappropriate placement of Unna boot on right leg & loss of circulation & eventual amputation of right lower leg

- Cited findings noted in F684 r/t inappropriate dressing applied to lower leg; competency packet provided to new LNs included trach care, transferring/mechanical lift & application of PPE & did not include wound care; failed to ensure staff possessed knowledge & skill necessary to ensure resident received appropriate physician's ordered wound care to right lower leg resulting in inappropriate placement of Unna boot on right leg & loss of circulation & eventual amputation of right lower leg
- Abatement Plan:
  - Incorrect wrap for 1 resident & replaced with appropriate ordered treatment
  - Education provided to LN r/t wound care; all relevant staff received in-service education r/t treatment application, wound care & prevention of abuse & neglect
  - All residents with skin/wound treatment orders audited by wound nurse to ensure treatment orders in place & implemented correctly
  - Ad hoc QAPI meeting conducted with facility staff & Medical Director r/t event including root cause, plan for change & ongoing monitoring

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

NE: SS=F: Failed to ensure 2/4 CNA staff reviewed had required yearly performance evals completed & 3/4 CNAs reviewed had required 12 hours of in-service education per year placing residents at risk for inadequate care

- 1 CNA with 2.3 hours of in-service in past 12 month & no yearly performance evaluations provided upon request; 1 CNA with 10.5 hours of in-service & no yearly performance eval; 1 CNA 2.3 hours in-service & had yearly performance eval; failed to ensure 2/4 CNA staff reviewed had required yearly performance evals completed & 3/4 CNAs had required 12 hours of in-service education per year placing residents at risk for inadequate care

F740 Behavioral Health Services

NE: SS=D: Failed to implement behavioral care interventions to prevent IDd triggers for 1 resident placing resident at risk for behavioral outburst & injuries

- Observed resident with schizophrenia w outbursts unsupervised & resident continued w/o staff or offer of diversion activities or assist throughout meal service on multiple occasions; Resident Council notes documented resident's yelling & cursing behaviors & staff ignored behaviors & continued with meal service w/o intervention with resident; failed to implement behavioral care interventions to respond to behaviors for 1 resident placing resident at risk ongoing behavioral outburst, unmet needs & decreased quality of life

F742 Treatment/Services Mental/Psychosocial Concerns

NE: SS=D: Failed to complete accurate assessment r/t resident's hx of spousal/partner abuse placing resident at risk for decreased psychosocial wellbeing

- SS staff stated unsure why resident's spousal/partner abuse dx not factored into initial SS assessment & should have been addressed; failed to provide accurate mental assessment r/t resident's hx of spousal/partner abuse placing resident at risk for decreased psychosocial wellbeing

NW: SS=D: Failed to provide appropriate treatment & services to attain 1 resident's highest practicable mental & psychosocial wellbeing when staff failed to provide resident with mental & behavioral health services placing resident at risk for decreased quality of care & life

- Resident with major depressive d/o; documentation revealed resident with "behaviors" including numerous periods of medication & meal refusals, rejection of care, yelling out & behaviors of throwing food & objects on floor which had increased in frequently throughout last year; SSD stated had not done much with resident & had not reviewed behavior notes in record; failed to seek appropriate treatment & services to attain 1 resident's highest practicable mental & psychosocial wellbeing when staff failed to provide resident with mental & behavioral health services placing resident at decreased quality of care & life

F745 Provision of Medically Related Social Service

NW: SS=D: Failed to provide adequate mental social services to meet 1 resident's mental & behavioral health needs placing resident at risk for decreased quality of care & life

Cited findings noted in F742 r/t behavioral health needs of 1 resident; SSD stated she had not done much with resident but went on to say she spoke with his daughters; SSD stated she had not viewed any behavior notes in resident's record. SSD stated she had noticed when one family member visited, resident's behaviors got worse. SSD stated resident did not have behaviors prior to admittance to facility; failed to provide sufficient & appropriate medical social services to meet 1 resident's mental & behavioral health needs placing resident at risk for decreased quality of care & life

F755 Pharmacy Services/Procedures/Pharmacist/Records

NE: SS=D: Failed to ensure nursing staff performed accurate reconciliation of controlled substances which included 2-nurse shift count of all controlled substances per acceptable standards of practice r/t controlled meds; further failed to ensure meds were received from pharmacy & available for administration per physician orders for 1 resident placing all residents in facility who had controlled narcotics or received meds from facility at risk for ineffective medication regimens & misappropriation

- Cited findings noted in F602 r/t inappropriate narcotic reconciliation involving multiple medications with missing/stolen medications; failed to ensure nursing staff performed accurate reconciliation of controlled substances which included a 2-nurse shift count of all controlled substances per acceptable standards of practice r/t controlled meds placing resident at risk for misappropriation of medication & related complications
- Failed to ensure 1 resident's Temazepam was available for administration as ordered placing resident at risk for unnecessary medication administration & possible adverse side effects

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) IDd & reported 1 resident's metoprolol was administered outside physician ordered parameters placing resident at risk for unnecessary medication & possible adverse side effects

- POS for Metoprolol BID with holding & notification parameters; failed to ensure CP IDd & reported when resident's metoprolol not held when 1 resident's BP &/or pulse were outside physician ordered parameters placing resident at risk for unnecessary medication administration & possible adverse side effects

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to ensure that resident's metoprolol was administered within physician ordered parameters placing resident at risk for unnecessary medication & possible adverse side effects

- Cited findings noted in F756 r/t metoprolol; failed to ensure 1 resident's Metoprolol was held when resident's BP &/or pulse were outside physician ordered parameters placing resident at risk for unnecessary medication administration & possible adverse side effects

F760 Residents are Free of Significant Med Errors

NE: SS=D: Failed to ensure 1 resident was free from significant med errors when staff failed to administer Temazepam in acceptable time frame as scheduled placing resident at risk for adverse side effects & medical complications

- Cited findings noted in F755 r/t availability of Temazepam; Resident stated had not been getting sleeping pill at night when should & at times it would as late as midnight or even 2AM causing resident to sleep half morning away; failed to ensure 1 resident was free from

med errors when physician ordered Temazepam given outside scheduled time frame placing resident at risk for adverse side effe cts & medical complications

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to properly label & store meds in 1 med room; further failed to store insulin & related supplies in secure m anner placing resident at risk for adverse outcomes or ineffective medication regimens

- Observed med fridge with opened, undated vial of TB serum; observed LN left med cart unlocked & unattended with 3 resident's diabetic supply bag containing insulin pens for each resident on top of cart while administering meds to another resident in resident's room; failed to properly label & store meds in 1 med room & failed to store insulin & supplies in secure manner placing residents at risk for advers e outcomes or ineffective med regimens

NW: SS=E: Failed to discard expired stock medication placing resident at risk for ineffectiv e medications

- Observed med cart with multiple bottles of stock medications expired; failed to dispose of expired meds placing residents at risk for ineffective medication

F790 Routine/Emergency Dental Services in SNFs

NW; SS=D: Failed to facilitate necessary dental care services for 1 resident placing resident at risk for pain, weight loss & worsening dental issues

- Failed to facilitate necessary dental care for 1 resident's broken, decaying teeth placing resident at risk for pain, weight loss & worse ning dental issues

F803 Menus Meet Resident Needs/Prep in Advance/Followed

NW: SS=F: Failed to provide adequate nutritional servings during a meal as specified in recipe placing residents who received meals from facility kitchen at risk for inadequate nutrition

- Observed dietary staff prepare pureed diets for 3 residents; staff failed to provide serving size as specified by recipe; fai led to provide adequate nutritional servings during a meal as specified in recipe placing residents who received meals fr om facility kitchen at risk for inadequate nutrition

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 potentia l for spread of foodborne bacteria

- Observed front of cabinet doors of handwashing sink visibly soiled; trash can with dried-on food debris; rolling carts with build up of dirt & grime on grooved handles; rolling cart with rusty legs & wheels; oven doors had build up of sticky subs tance on handles of doors; oven doors with dried food debris covering most of surface; can opener with dried on sticky food substance on cutting blade tip; c utting boards with heavy gouging; door of fridge with chipped missing paint; plastic storage rack discolored from build up of dirt & grime; fridge with build up of food debris in rubber door seals; rubber trash can with dried-on debris; freezers in dry storage room with heavy build up of food in rubber door seals; 2 plastic storage containers of sugar & flour with dusty substance on lids; plastic containers with pie filling & pudding mixes with build up of dusty debris on lids; insides of microwave with dried on food substances

NE: SS=E: Failed to follow sanitary dietary standards r/t hand hygiene during meal service placing residents at risk r/t foodborne illnesses & food safety concerns

- Observed CNA passed out meals & delivered drinks to 5 residents & served residents individually but did not complete hand hyg iene between preparing & serving drinks though touched multiple surfaces during preparation; CNA touched multiple contaminated ite ms then assisted resident with repositioning in w/c w/o hand hygiene

NW: SS=E: Failed to serve food in 1/2 DRs in sanitary manner placing residents at risk for foodborne illness

- Observed dietary staff dropped lid from soda bottle, picked it up from floor & did not wash hands before obtaining & placing unwrapped straw in resident's glass; observed dietary staff touched resident on shoulder, cut up food then handled another resident's silverware to cup up food w/o washing or sanitizing hands then went to anothe r table & accepted a resident's silverware from resident & cut up food w/o handwashing or using sanitizer; failed to serve food in 1/2 DRs in sanitary manner placing residents at risk for foodborn e illness

F849 Hospice Service

NE: SS=D: Failed to ensure correct hospice listed on CP for 1 resident & failed to ensure a communication process implemented which included how communication would be documented between facility & hospice provider & failed to provide description of services, medication & equipment provided to 2 resident residents by hospice creating a risk for missed opportunities for services & delayed physical, mental & psychosocial needs for residents

- CP lacked direction r/t services provided by hospice in collaboration with facility CP; failed t o ensure correct hospice provider was CPd & ensure a 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
- CP lacked documentation r/t hospice services, medications covered by hospice, medical equipment provided by hospice, contact information & visit frequency; failed to ensure collaborative communication process in place to communicate necessary informa tion r/t 1 resident's care between nursing home & hospice 24 hours a day, 7 days a week including documentation of communications with potential for negative outcomes for 1 resident

F880 Infection Prevention & Control

SE: SS=D: Failed to ensure containment of biohazardous waste in manner to prevent spread of infection for 1 resident & failed to obtain ID of causative organism for resident's chronic wound

- Observed LN provided wound vac care to 1 resident & LN stated resident on contact precautions due to osteomye litis; r/t wound on resident's foot; upon completion of procedure, LN placed soiled dressing & used wound vac supplies in trash can in resident's room when

room contained large box lined with red bag which was uncovered & contained tubing exposed out of re d bag near room door to hallway; observed box remained full of tubing not contained within box & trash can with discarded dressing, tubing from IV li ne remained full on further observation; failed to contain biohazardous waste in sanitary manner to prevent spread of infections

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 perform adequate hand hygiene, failed to ensure sanitary storage of O2 equipment, failed to ensure laundry temps for laundry including laundry from rooms with infectious disease & on transmission based precautions was assessed for appropriate temps; further failures included allowing indwelling catheter bags to rest on floor & failure to place signage to alert staff for residents on enhanced barrier precautions placing residents at risk for complications r/t infectious diseases

- Failed to ensure proper infection control standards were followed related to implantation of procedure or plan to monitor and prevent Legionella disease or other opportunistic waterborne pathogens, hand hygiene during a Hoyer lift transfer of a resident, stor age of oxygen equipment, monitoring of washing machine water temperature logs in the facility with known colonized infections, catheter bags resting on the floor, and signage was available for residents on enhanced barrier precautions. This deficient practice placed the residents at risk for complications related to infectious diseases

NW: SS=F: Failed to implement a water management program for Legionella disease placing residents at increased risk of infecti ous disease

- Failed to implement a water management program to test & manage waterborne pathogens placing residents who resided in facility at risk of contracting Legionella pneumonia

F883 Influenza & Pneumococcal Immunizations

NE: SS=D: Failed to obtain pneumococcal vaccination consents, declinations or administration information for 1 resident placing resident at risk for pneumonia & related complications

- Record lacked documentation pneumococcal vaccine offered or declined & lacked documentation of historical administration; fai led to obtain pneumococcal vaccination consents, declinations or administration information for 1 resident at rime of admission pla cing resident at increased risk for acquiring, transmitting or experiencing complications from pneumococcal disease

F908 Essential Equipment, Safe Operating Condition

NW: SS=F: Failed to ensure kitchen walk-in freezer was in safe operating condition when freezer door continued to build up with ice & failed to completely shut placing all residents who resided in facility & received meals from facility kitchen at risk for foodborne il lness

- Observed ice buildup on frame of door & would not stay closed; staff reported door had been faulty & allowed ice build up for at least 6 months; failed to ensure kitchen walk-in freezer was in safe operating condition when freezer door continued to build u p with ice & would not completely shut placing all residents who resided in facility & received meals from facility kitchen at risk for fo odborne illness

F921 Safe/Functional/Sanitary/Comfortable Environment

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

- Observed kitchen floor throughout kitchen & storage room with build up of dirt & grime around parameters of rooms & heavy bui ld up of dirt & grime around feet of tables & equipment of kitchen

F943 Abuse, Neglect, & Exploitation Training

NE: SS=F: Failed to provide evidence of required prevention of abuse, neglect & exploitation training for 4 licensed staff th at were sampled

- Facility failed to provide evidence that 4 LNs received required ANE training; failed to provide evidence of required training for prevention of ANE for 4 LNs sampled

F947 Required In-Service Training for Nurse Aides

NE: SS=F: Failed to ensure 8/9 CNA staff reviewed had required 12 hours of in-service education including required topics per year placing residents at risk for inadequate care

- CNAs reviewed had: 2.3 hours, 10.5 hours, 2.3 hours, 5 agency staff had: 30 minutes of documented in-service training, 0 hours of in-service for 4 agency staff; failed to ensure 8/9 CNA staff reviewed had required 12 hours of in-service education per year placing residents at risk for inadequate care

S505 Nursing Services

SE: SS=F: Failed to ensure direct care staff were available to provide resident care in accordance with the following minimum requirements r/t weekly average of 2.0 hours of direct care staff time per resident & a daily average of not fewer than 1.85 hours during any 24-hour period; licensing agency may require an increased in number of nursing personnel above minimum levels under certain circumstances such as health & safety needs of residents are not being met

- Review of nursing schedule from 10-1-23 through 11-1-23 revealed facility routinely scheduled less than 2.09 hours PPD of direct care staff for each of 61/64 residents during that timeframe; Daily Staff Posting, Actual Hours Worked dated 10-1-23 through 11-1-23 revealed direct care staffing actual hours worked per PPD ranged from 0.79-1.42 PPD; daily hours never reached minimal requirement IDd by state regulation; staff posting review of actual direct care hours worked lacked evidence facility provided direct care staff that met required state minimum on any day during reviewed time frame regardless of day of week; failed to ensure direct care staff were available to provide resident care in accordance with state minimum requirements

December 2023

F550 Resident Rights/Exercise of Rights

SE: SS=D: Failed to show respect & dignity to 1 resident when staff failed to close window blinds in resident's room while performing catheter care

- Observed 2 CNAs performed catheter care & bed directly next to windows & part of window blinds were fully open; staff pulled resident's gown up to mid chest & removed brief exposing resident to anyone outside window; during cares, CNA opened shared BR door which exposed resident in bed with genitals exposed to 2 residents on other side of BR; failed to show respect & dignity to depende nt resident while providing catheter care

F656 Develop/Implement Comprehensive Care Plan

SE: SS=D: Failed to complete individualized CP r/t ADLs for 1 dependent resident r/t facial shaving

- CP lacked staff instruction r/t ADLs for resident including facial shaving; observed resident in w/c in DR unshaven; failed t o provide individualized CP for dependent resident's ADL cares

F657 Care Plan Timing & Revision

SE: SS=D: Failed to review & revise CP for 2/17 residents; 1 resident for decline in eating & 1 resident for intervention for use of antipsychotic medication use

- Failed to review & revise CP to include nutritional interventions for resident with identified weight loss who refused staff assist with eating
- CP lacked staff instruction of resident receiving antipsychotic med & what interventions to try to assist resident with any b ehaviors resident might display; failed to review & revise CP to include antipsychotic med use for dependent reside nt

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to provide appropriate assistance with personal hygiene needs for 2 dependent residents r/t facial shaving & bathing

- CP lacked staff instruction r/t ADLs for resident; resident required independent to dependent staff assist for ADLs; observed resident in DR unshaven for extended period of time during day of observation on multiple days; staff reported resident shaved on shower days; failed to provide appropriate ADLs assist for dependent resident r/t facial shaving
- CP documented resident preferred morning showers 2-6 x/wk; CNA stated resident on list for 1 bath/wk on Wednesdays; resident stated would like a shower more frequently than 1x/wk; failed to provide frequent bathing opportunities for resident per resident's choice to ensure resident maintained a sense of wellbeing

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

SE: SS=G: Failed to assess & provide preventive PU treatment for 2/3 residents reviewed; 1 resident developed unstageable pressure injuries on bilateral heels, lateral foot & anterior foot placing resident & any other resident with potential skin issues, at risk of fu rther pressure injury development

- Baseline CP documented resident not at risk for skin breakdown & no PU/injury present at admission; record lacked documented skin assessment to address specifics of noted blanchable areas; daily skilled notes lacked documentation of resident's PU/injurie s; observed resident's bilateral heels lay directly on bed with no pressure relieving devices available & foot had 2 black areas & 1 black area on top of foot; observed resident in recliner & both heels laid directly on footrest lacking pressure relieving devices; LN unaware resident with skin breakdown; LN stated did not complete skin assessment of resident's skin as resident refused to lay in bed or get into reclin er upon admission; failed to assess 1 resident's skin upon admission or implement pressure i njury preventative measures after resident admitted after surgical repair of femur fracture & foot drop resulting in development of unstageable/deep tissue injuries to residents right & left heel, anterior & lateral foot

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=D: Failed to ensure staff followed CP interventions for 1/4 residents reviewed for accidents; resident sustained 2 fal ls w/o use of interventions with nonskid socks/slippers when in bed as CPd

- CP instructed staff to ensure resident wore slippers or nonskid socks when in bed due to resident attempting to get up on own; fall investigation revealed resident found in room & resident lacked socks/slippers on feet; 2nd fall investigation revealed resident w/o wearing socks/slippers; observed resident with bare feet; failed to ensure staff placed nonskid socks/slipper on resident when in bed as CPd to reduce risk of repeated falls

F690 Bowel/Bladder Incontinence, Catheter, UTI

SE: SS=D: Failed to use a leg anchor to prevent tubing from being tugged on for dependent resident's indwelling urinary catheter

- Observed 2 CNAs entered resident's room to perform catheter care with resident & when staff removed covers from resident, cat heter tubing not anchored to resident's leg; CNA stated staff do not use anchor because resident only had 1 leg; failed to use leg anchoring device for dependent resident with indwelling urinary catheter to prevent trauma/injury from unnecessary pulling

F692 Nutrition/Hydration Status Maintenance

SE: SS=Failed to ensure RD assessed 3/7 residents reviewed for nutritional needs in timely manner; failed to evaluate & implement strateg ies for optimal nutritional intake for 1 resident following esophagus surgery, 1 resident with post-operative wound & multiple PUs & 1 resident to maintain weight

- POS with dx of aftercare of paraoesophageal hernia, dysphagia, post-operative anemia; dietary staff confirmed did not conduct assessment until 10 days after admission; staff confirmed resident requested gelatin but staff did not make gelatin for resident or obtain gelatin from grocery store; staff confirmed resident required frequent (5-6) servings of full liquid diet due to post operative status but dietary staff did not know this until 10 days after admission; failed to assess resident's dietary needs to ensure optimal healing & comfort

- Failed to assess resident's dietary needs to ensure optimal nutrition for post operative healing & comfort for resident with multiple PUs & pressure injuries
- CP documented resident at risk for nutritional compromise r/t DM, constipation & mechanically altered therapeutic diet; resident with POS for consistent carbohydrate diet with regular texture for resident; resident with facial pain & swelling r/t nasal bone f x & on pureed diet & speech therapy for swallow issue; resident with problems with hands in holding utensils; failed to assess resident's dietary needs to ensure optimal nutrition to maintain resident's weight

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 bact eria & facility failed to utilize pasteurized eggs for soft, cooked eggs for residents

- Observed freezers with food & frozen liquid debris on bottom; fridge with food debris; white wooden box containing sugar, flour & brown sugar containers with dusty, sticky substance covering surface; rolling carts with food debris & food debris in grooves of handles of cart; shelf with layer of food debris & dust; covered trash can with dried food debris & dried on splattered liquid debris on container lid; cutting boards heavily grooved & discolored; fridge with 2 dozen unpasteurized eggs & staff stated had cooked & served to res idents approximately 60-8- soft-cooked eggs over previous 10 days; facility lacked cleaning schedule for kitchen

F851 Payroll Based Journal

SE: SS=F: Failed to electronically submit to CMS complete & accurate direct care staffing information including information f or agency & contract staff based on payroll & other verifiable & auditable data in uniform format according to specifications established by CMS r /t LN staff coverage 24 hours a day & excessively low weekend nursing staff

- Quarter 4 of 2022 lacked LN on 4 days; quarter 3 of 2023 with excessively low weekend staffing; review of facility posting, schedule & agency staffing invoices for quarter 4 revealed facility had LNs on duty on cited days; review of agency staffing invoices de monstrated PBJ did not reflect total nursing hours of direct care provided by agency staff; nursing schedule revealed facility had LN staff on duty 24/7; review of schedule & staff posting revealed facility exceeded state minimum requirement for direct care staff & staffing patt ern did not significantly vary from scheduling from weekdays with PPD of direct care by nursing staff ranging from 2.8 to 3.6 ppd; failed to electronically submit to CMS complete & accurate direct care staffing information for facility

F880 Infection Prevention & Control

SE: SS=E: Failed to follow appropriate infection control guidelines to prevent UTIs for 1 dependent resident r/t catheter care & failed to provid e appropriate infection control techniques in beauty shop to prevent spread of infections to residents

- Observed 2 CNAs provide catheter care & CNA wiped catheter tubing from out to into urinary meatus; failed to follow appropriate catheter care guidelines to help prevent UTIs for dependent resident with indwelling urinary catheter
- Observed beauty shop with: hair build up in sink drain; countertop around sink with hair clippings; drawer of sink counter with debris & unlabeled hair pick with hair in teeth & unlabeled combs; failed to provide sanitary environment to help prevent cross contam ination & infections for residents of facility that used beauty shop