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

May, 2024

F550 Resident Rights/Exercise of Rights

NW: SS=D: Failed to treat 1 resident with dignity when staff failed to close window curtain during personal care of G-tube placing resident at risk for undignified experience & embarrassment

- Resident with MS & dependent on staff for ADLs; with feeding tube; observed LN entered room & shut door; resident in electric w/c & faced window; with window blinds wide pen, LN pulled resident's shirt up revealed abdomen & G-tube & administered resident's meds thru tube while resident visible to other residents & family members thru window; failed to treat resident with dignity when staff left window blinds wide open with resident facing window while administering meds per resident's G-tube placing resident at risk for undignified experience & embarrassment

F689 Free of Hazards/Supervision/Devices

NW: SS=G: Failed to ensure environment free of accidents when staff placed resident's electric lift chair remote in reach, despite safety eval which indicated not safe; as result, resident fell & required sutures to head laceration; facility continued to leave lift control within resident's reach placing resident at continued risk for falls, injuries & associated pain

- CP documented resident with multiple back surgeries with mobility & pain issues r/t back; 1 leg did not work well; multiple falls prior to admission & since admission; CP instructed resident had lift chair from home but could no longer safely operate chair; CPOA aware & safety risk of falling; DPOA would like staff to operate chair for resident & if needed DPOA would provide mechanical recliner in future; 3 Lift Chair Safety Assessment documented resident not meet safety requirements for lift chair unless under supervision; NN documented staff found resident on floor & large amount of blood r/t head laceration & bruising noted to eyebrow; resident stated trying to go to BR; sent to ER; call light on when resident found on floor; observed resident in recliner with footrest elevated with remote on top of nightstand next to recliner; resident reported blind in 1 eye & stated fell trying to "go upstairs"; observed resident in recliner & footrest of lift chair elevated & remote on chair arm rest within resident's reach & no staff present; failed to ensure environment free from accidents when staff place resident's lift chair remote in reach despite safety evaluation which indicated it was not safe; as result resident fell & required sutures to head laceration; facility continued to leave lift control within resident's reach placing resident at continued risk for falls, injuries, & associated pain

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NW: SS=D: Failed to ensure 1 resident's PRN Xanax had 14-day stop date &/or rationale for extended use with specified stop date placing resident at risk of receiving unnecessary psychotropic meds

- Resident with Bipolar; POS for Xanax 0.25mg PRN q 8 hours for anxiety; order lacked stop date; Pharmacist recommendation documented resident receiving PRN Xanax & requested stop date &/or rationale & physician documented to continue for 6 months but only recorded benefits in relieving symptoms outweighed risk & facility did not enter physician's order for stop date in EMR or MAR; failed to ensure 1 resident's PRN antianxiety med had stop date placing resident at risk for adverse medication side effects & unnecessary psychotropic meds

F880 Infection Prevention & Control

NW: SS=F: Failed to implement water management program for Legionella disease & other waterborne pathogens; staff failed to change gloves while providing incontinent care for 1 resident placing residents in facility at risk for infectious disease

- Adm Nurse stated unaware of what facility's measures were to prevent growth of Legionella & other waterborne pathogens in building water systems & emergency manager gone all week; Maintenance Staff stated had started program but unaware of what to do r/t Legionella prevention; failed to develop water management plan for detecting & mitigating Legionella & other waterborne pathogens in facility water system placing all residents at risk for developing infection
- CP documented resident required staff assist with toilet hygiene; observed 2 CNAs performed incontinent care; both applied gloves, removed incontinent brief then wearing same gloves assisted resident to turn, touching clothing, then provided perineal care to buttocks then with same gloves assisted in repositioning resident then provided perineal care to genitals & wearing same gloves removed pants & placed clean pants on resident & dressing resident then assisted resident to transfer to Geri-chair then wearing same gloves changed resident's shirt then retrieved wet washcloth, washed resident's face, placed hearing aid, placed glasses, placed foot pedals on chair, picked up soiled clothing & placed soiled cloths from floor to bag then removed discarded gloves, tied trash bag & left room w/o washing hands; failed to change gloves & wash hands when providing resident incontinent care & continued to provide care with same soiled gloves placing resident at risk for infection

June, 2024

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SE: SS=D: Failed to ensure appropriate monitoring of psychotropic meds for 1 resident r/t use of antidepressant meds

- POS for Bupropion for major depressive disorder (MDD) with psychotic symptoms, Wellbutrin for MDD, Effexor for MDD; EMR lacked documentation of side effects &/or effectiveness of antidepressant meds; failed to appropriately monitor use of antidepressant meds for dependent resident

F851 Payroll Based Journal

SE: SS=F: Failed to electronically submit to CMS with complete & accurate direct staffing information based on payroll & other verifiable & auditable data in uniform format according to PBJ r/t LN & CNA staffing information when facility failed to accurately report weekend staffing for 3rd quarter 2023 April thru June

- Nursing staff schedule for 3rd quarter revealed lack of completed daily staff posting for 3 days; PBJ triggered for "excessively low weekend staffing"; Adm revealed system used may have caused errors in reporting on PBJ report; failed to accurately report weekend staffing for 3rd quarter, 2023

F880 Infection Prevention & Control

SE: SS=F: Failed to ensure a plan to monitor effectiveness of recommended measures put in place following ID of positive Legionella detected in facility water system in March & April, 2024; additionally facility failed to ensure 5 combs & 1 hair brush were stored in sanitary manner in beauty shop

- Review of Legionella Testing & Remediation" documented facility obtain water test results for water collected on 2-12-24 on 2-21-24 & testing revealed following 3 positive test results for Legionella; retest of facility water on 3-13-324 revealed 2 positive test results of "uncontrolled growth" by CDC & positive results indicating well controlled; staff revealed facility drained hot water tanks, flushed them, cleaned tanks & increased water temp to 130 degrees F & facility drained hot water tanks monthly; facility did not retest water since 3-22-24 report; failed to enact follow up monitoring to ensure effectiveness of increase in hot water temp & monthly draining, flushing & inspection of hot water heaters to provide sanitary water supply for residents to prevent waterborne illness
- Observed beauty shop with unlabeled hairbrush & 5 unlabeled combs that had hair which remained in bristles of brush & teeth; failed to prevent cross contamination & spread of infection r/t maintaining sanitary storage of personal hygiene supplies in beauty shop for residents of facility

S1364 Electrical Requirements

SS=E: Facility lacked ground fault circuit indicator electrical plug for hydrotherapy unit in therapy room as required

- Observed therapy consultant with hydrocollator in therapy room plugged into 4-way non-GFCI plug; staff unaware device required GFCI plug; failed to ensure GFCI electrical outlet for hydrocollator in therapy room as required

July 2024

F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to ensure 1 resident had a call light within reach to communicate need for staff assist placing residents at risk for preventable falls & injuries

- Observed resident called out "help" multiple times & call light attached to bed & out of resident's reach then continued to call for help; resident confirmed called for assist to toilet resident; failed to ensure 1 resident had call light in order to communicate need for staff assist placing residents at risk for preventable falls & injuries

F582 Medicaid/Medicare Coverage/Liability Notice

NE: SS=D: Failed to issue CMS NOMNC form 10123 which contained required information for 1 resident placing resident at risk for decreased autonomy & impaired right to appeal

- SSD stated facility did not have NOMNC for resident & stated thought if resident initiated discharge to home, NOMNC did not need to be issued; SSD confirmed planned discharge date to home during CP meetings was not spontaneous resident-initiated discharge & even residents who discharge & even residents who discharge on agree-upon date have right to appeal; failed to provide NOMNC to 1 resident placing resident at risk for decreased autonomy & impaired right to appeal

F584 Safe/Clean/Comfortable/Homelike Environment

SE: SS=E: Failed to provide a clean home-like & sanitary environment for 11 residents residing in SCU; additionally failed to provide sanitary environment for 2 residents who had cracked fall mats with uncleanable surfaces in rooms

- SCU with urine odor throughout unit & extended 10-12 feet beyond locked doors in main hallway; maintenance stated r/t resident who would urinate in random places & nursing staff have performed multiple interventions to combat smell of urine; failed tot provide clean home-like & sanitary environment for all residents residing in SCU
- Observed fall mats by residents' beds with multiple cracks & areas of worn surface; failed to ensure sanitary, safe & homelike environment for 2 residents with cracked & worn fall mats

NW; SS=E: Failed to clean dining chairs in DR placing residents who ate meals in DR at risk for impaired comfort & decreased quality of life

- Observed dining observation & multiple dining chairs with numerous areas of what appeared to be a liquid blackish=brown stain on seats & appeared unclean & dirty; staff verified used shampooer every other week to clean & deodorize chairs but cleaning did not remove

stains due to age of chairs; failed to provide homelike dining experience for residents who ate meals in DR by having unclean & soiled DR chairs placing residents who ate meals in DR at risk for impaired comfort & decreased quality of life

F585 Greivances

NE: SS=F: Failed to provide method for residents to submit grievances anonymously with risk of loss of resident rights, unresolved grievances & loss of dignity for residents in facility

- Observed no submission box or method for filing anonymous grievances; SSD stated if resident had concern they told SSD & SSD would not put resident's name on grievance form; failed to provide method for residents to submit grievances anonymously with risk of loss of resident rights, unresolved grievances & loss of dignity for residents in facility

F600 Free from Abuse & Negect

SE: SS=J (Abated to G): Failed to prevent sexual abuse of cognitively impaired resident who lacked ability to consent; on 7-9-24 at 3:30pm CNA observed cognitively intact resident with hx of touching another resident with hand inside other resident's pant leg to groin area; other resident with severe cognitive impairment & inability to consent, placing other resident in immediate jeopardy, based on reasonable person concept & at risk for trauma & negative psychosocial impact

- *CP lacked any interventions r/t other resident's ability to consent to touching by resident; Grievance Report dated 7-1-24 revealed unidentified nursing staff reported concern to Adm Nurse & SS r/t resident & staff saw resident holding other resident's hand & touching other resident's thigh; resident acted like did not know what staff were talking about & agreed to no physical contact with any other resident; staff failed to update resident's CP; Incident Report documented CNA witnessed resident in doorway & other resident directly at doorway & resident had hand inside other resident's pant leg all the way to groin & CNA stated "Hey (other resident)" & then resident pulled hand out; next day SS documented family of other resident contacted, make police report, contacted stated & was conducting investigation; NN lacked documentation of specific incident of contact by resident or any other instances prior to date of note; NN lacked behavior issues or contact with any other residents; resident was discharged from facility on 7-11-24; failed to prevent sexual abuse of other resident who had severe cognitive impairment & inability to consent when resident put hand up other resident's pant leg to groin area placing other resident at risk for immediate jeopardy & at risk for trauma & negative psychosocial impact*
- *Abatement Plan:*
  - *Resident no longer resides at facility*
  - *All staff re-educated on & provided copy of ANE policy by 7-26-24*

SW: SS=K (Abated to E): Facility deprived 1 resident care when facility failed to ensure call lights were working appropriately to address care needs of all residents residing on 1/4 hallways; on 7-16-24 during initial screening, reported issues with call light response times & surveyor observed a 42 minute call light response time for resident; facility reported issues with call light system for months & used staff at nurses' station to watch system; however on 7-17-24 at 7:25am no staff were at nurses' station watching call light system placing residents in immediate jeopardy; additionally facility failed to ensure staff IDd & responded appropriately to all allegations of abuse & reporting for 1 resident who had large bruise across chest; on 7-16-24, resident's family stated facility reported to family resident had a bruise located across lower chest; further more facility failed to respond appropriately to 1 resident's allegations of sexual assault placing residents at risk for abuse & continued negative impact on physical, mental & psychosocial wellbeing

- Resident stated having severe pain & call light frequently did not work appropriately & resident had to yell for help; staff reported 1 hallway's call lights did not alarm to all pagers & call light system had not been working correctly for several months; observed 1 CNA had pager but it was out of battery; observed call light response times for extended period of time i.e., 62 minutes, 43 minutes, 36 minutes, 89 minutes, 51 minutes, 30 minutes, 65 minutes, 43 minutes, 33 minutes, & MULTIPLE others with extended response times
  - Abatement Plan:
    - All residents immediately checked on to address any needs
    - Continual rounding conducted to monitor & assess resident needs until all pagers were verified functioning appropriately
    - All pagers checked to ensure functioning properly & all CNAs & CMAs checked to ensure they were wearing their functioning pagers
    - Immediate education conducted with all CNAs, CMAs, Charge Nurses to ensure all CNAs, CMAs & 1 assigned charge nurse were wearing pager during shift
    - Walkie talkies implemented for increased communication for resident care needs; walkie talkies carried by all nursing staff during shift to assist with call light response time
    - Call light company contacted & corrected float pager, ensuring pager received resident call lights from all hallways
    - Walkie talkies to be carried by all nursing staff during shift to assist in call light response time
    - Order placed for additional pages & when arrive, all nursing staff will carry pagers including Nursing leadership, during shift to assist in call light responses
    - At beginning of each shift, huddle conducted by charge nurse to ensure all CNAs & CMAs are carrying pagers on person
    - Leadership will implement Angel Rounding, resident rounding interview & observation system to ensure resident care needs addressed including call light response times
- Resident with hemiparesis & hemiplegia & TBI; MDS lacked BIMS & depression not scored & lacked staff interview; resident with behaviors including hitting & yelling; CP documented resident full lift with 2 persons, weekly skin assessment by LN with documentation & reporting concerns to physician; observed resident with old bruise across lower chest area, under arms & 1 shoulder area; bruise

determined to be from inappropriate gait belt used for transfer; Skin observation with no skin conditions documented or resolved; family member stated notified of large bruise by staff, "possibly from gait belt"; family observed large bruise across chest from armpit to armpit with several different colors of healing & spoke to Adm who no longer works at facility; family asked SSD why family just being notified of bruise that looked to be healing & was referred to DON who stated bruise from gait belt & now resident full body lift to avoid use of gait belt; Adm stated no investigation completed & bruise occurred when family transferred resident by selves but no progress note mentioned family caused bruise; failed to ensure staff IDd & responded appropriately to all allegations of abuse & reporting for resident with large bruise across chest

- Resident with TBI, BIMS of 13; anxiety d/o, need for assistance with personal care, lack of coordination, & problem r/t care provider dependency; observed resident spoke in Spanish to dietary staff who translated interview to English on behalf of resident; resident stated 2 men sexually assaulted resident in facility; resident stated had bruises & bite marks across breast & abdomen when made report to nurses at facility; stated nurses did not respond to report of assault & did not assess resident for injury; stated assault happened in facility; resident anxious, tearful & hands trembling; resident stated no one did anything in response to allegation & confirmed law enforcement had not talked to resident & resident did not feel safe in facility; incident not included on Grievance Log; failed to ensure resident remained free from sexual abuse when failed to acknowledge allegation, initiate investigation, report allegation to law enforcement &/or state agency & protect resident from further abuse after resident alleged sexually assaulted by 2 men in room at facility

F609 Reporting of Alleged Violations

SW: SS=J (Abated to D): Failed to report allegation of sexual assault when resident reported sexual assault by 2 male perpetrators on 5-16-24; on 5-24-24 resident went to hospital for chest pain & reported to hospital staff resident was sexually assaulted in facility; resident re-admitted to facility; hospital notified facility of resident's report of sexual assault on 5-24-24 & on discharge on 5-29-24; facility failed to respond to resident's allegation of abuse, failed to investigate allegation of abuse, did not report to state agency & did not notify law enforcement until 7-16-24 when resident reported assault to surveyor during survey placing resident in immediate jeopardy & at risk for continued negative impact on physical, mental & psychosocial wellbeing

- Cited findings noted in F600 r/t allegation of sexual assault by resident; failed to report allegations of abuse/sexual assault to appropriate state agency to ensure protection of resident as well as other residents of facility placing resident in immediate jeopardy & at risk for continued negative impact on resident's physical, mental & psychosocial wellbeing
    - Abatement Plan
        - Resident assessed for Abuse, neglect or trauma
        - All nursing staff education initiated on 7-16-24 for "Recognizing & Reported Abuse & Neglect Allegation" by Clinical Learning & Development Specialist
        - Trauma Informed care assessment completed on 7-17-24 & resident's CP updated to reflect new trauma informed care interventions
        - Law enforcement contacted & resident interviewed
        - Leadership educated on "Recognizing & Reporting Abuse & Neglect Allegation" conducted by Regional Clinical Services Director on 7-18-24
        - All education completed by 7-18-24 or prior to next to working shift
        - All residents at risk for trauma informed care reviewed for care & CP addressed & interventions added as needed
        - Angel Rounding initiated to ID areas of concern & ensure resident safety

NW: SS=J (Abated to D): Failed to ensure staff immediately reported 1 resident's allegation of sexual abuse to LNHA & further failed to report sexual abuse allegation to required stated agencies including law enforcement

- *On 7-24 at 9:37pm resident told representative that "dirty old man" came into room & tried to get into her pants; at 10pm resident's representative call facility & reported allegation to LN & LN told representative there were no male staff working & had not seen anyone walking in hallway & LN would go down & talk to resident & report incident to Adm Nurse; at 11pm resident asked LN if LN had told nurse that she was molested; LN did not report abuse allegation until 7-25 at 9:03pm; Adm stated allegation of sexual abuse not reported to appropriate state entities because LN determined resident had been dreaming; failed to ensure staff reported allegation of sexual abuse to LNHA immediately & further failed to report sexual abuse allegation to required state entities including law enforcement placing resident in immediate jeopardy*
- *Abatement Plan:*
    - *Facility initiated investigation on 7-31-24 for allegations of abuse & neglect for resident*
    - *Abuse allegation reported to appropriate state agency, law enforcement, medical director & resident's family*
    - *Immediate education initiated for all nursing staff on recognizing & reporting A & E*
    - *All interviewable resident interviewed to ID any safety concerns*

F610 Investigate/Prevent/Correct Alleged Violation

SE: SS=J (Abated to G): Failed to protect cognitively impaired resident who lacked ability to consent from sexual abuse

- *Cited finding of F600 r/t sexual abuse of resident by resident with hx of placing hand up pant leg of resident up to groin; failed to protect resident with severe cognitive impairment & inability to consent from sexual abuse when other resident put hand up resident's pant leg to groin area placing resident at risk for immediate jeopardy & at risk for trauma & negative psychosocial impact*
- *Abatement Plan:*
    - *Resident no longer resides at facility*

- *All staff re-educated on & provided copy of ANE policy by 7-26-24*

SW: SS=J (Abated to D): Failed to thoroughly investigate 1 resident's allegations of sexual assault & failed to protect resident from potential further sexual abuse

- Cited findings noted in F600 & F609 r/t allegation of sexual assault by resident; failed to respond to resident's allegation of abuse & did not notify law enforcement when resident reported assault to surveyor during survey placing resident in immediate jeopardy & at risk for continued negative impact on physical, mental & psychosocial wellbeing
  - Abatement Plan
    - Resident assessed for Abuse, neglect or trauma
    - All nursing staff education initiated on 7-16-24 for "Recognizing & Reported Abuse & Neglect Allegation" by Clinical Learning & Development Specialist
    - Trauma Informed care assessment completed on 7-17-24 & resident's CP updated to reflect new trauma informed care interventions
    - Law enforcement contacted & resident interviewed
    - Leadership educated on "Recognizing & Reporting Abuse & Neglect Allegation" conducted by Regional Clinical Services Director on 7-18-24
    - All education completed by 7-18-24 or prior to next to working shift
    - All residents at risk for trauma informed care reviewed for care & CP addressed & interventions added as needed
    - Angel Rounding initiated to ID areas of concern & ensure resident safety

NW: SS=K (Abated to E): Failed to investigate allegation of sexual abuse & initiate protective measures until investigation was completed

- *Cited findings in F609 r/t allegation of sexual abuse that was reported on 7-24-24 & investigation started on 7-31-24; failed to investigate 1 resident's allegation of sexual abuse & initiate protective measure until investigation was completed placing resident in immediate jeopardy & placed all cognitively impaired residents at risk for unidentified & ongoing abuse*
- *Abatement Plan:*
  - *Facility initiated investigation on 7-31-24 for allegations of abuse & neglect for resident*
  - *Abuse allegation reported to appropriate state agency, law enforcement, medical director & resident's family*
  - *Immediate education initiated for all nursing staff on recognizing & reporting A & E*
  - *All interviewable resident interviewed to ID any safety concerns*

F620 Admissions Policy

NE: SS=C: Failed to establish & implement admission agreement that protected resident rights to personal property by not waiving facility's liability

- Admission Agreement stated, "facility could not guarantee safety of personal items & the facility was not responsible for loss, theft, or damage to resident's personal property"; Adm stated facility reviewed admission agreement annually; failed to establish & implement admission agreement that protected resident right to personal property by not waiving facility's liability

F623 Notice Requirements Before Transfer/Discharge

NE: SS=D: Failed to provide written notification of transfer to 2 residents/representatives; further failed to notify State Long-Term Care Ombudsman of transfers/discharges for 1 resident with risk of miscommunication between facility & resident/representative & possible missed opportunities for healthcare services for 2 residents & impaired resident rights

- Record lacked evidence facility sent written notification of transfer to resident/representative for transfer to hospital; Adm nurse confirmed facility did not complete written notification of transfer for resident's transfer to hospital; failed to send written notification of transfer for 1 resident placing resident at risk for miscommunication between facility & resident/representative & possible missed opportunities for healthcare services
- Failed to send written notification of transfer of 1 resident placing resident at risk for miscommunication between facility & resident/representative & possible missed opportunities for healthcare services

F625 Notice of Bed Hold Policy Before/Upon Transfer

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

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

F641 Accuracy of Assessments

SE: SS=D: Failed to accurately complete MDS for 3 residents, 2 r/t antiplatelet med use & 1 r/t contractures not documented as impairments under Section G & GG on MDS placing residents at risk for uncommunicated care needs

- MDS documented resident received anticoagulant & did not receive antiplatelet med; CAA lacked documentation r/t anticoagulant or antiplatelet med use; POS for ASA daily for CAD; MAR documented ASA but lacked documentation of any anticoagulant; failed to accurately complete MDS for 1 resident r/t antiplatelet use placing resident at risk for uncommunicated care needs for multiple residents
- Resident with hand contracture & arthritis with hand splint & carrot; MAR & TAR lacked documentation of hand splint to be applied; NN lacked documentation r/t contractures or hand splint & carrot; observed resident lacked placement of hand splint; failed to accurately

MDS for resident r/t contractures not documented as impairments under section G or GG on MDS placing resident at risk for uncommunicated care needs

F656 Develop/Implement Comprehensive Care Plan

SE: SS=D: Failed to develop a comprehensive person-centered CP for 1 resident; comprehensive CP not completed in timely manner of 21 days from admission as required with potential to lead to uncommunicated needs leading to negative impacts on resident's physical, mental & psychosocial wellbeing

- CP lacked staff interventions to provide person-centered care; failed to develop a comprehensive person-centered CP for 1 resident; comprehensive CP not completed in timely manner of 21 days from admission with potential to lead to uncommunicated needs which could lead to negative impacts on resident's physical, mental & psychosocial wellbeing

NW: SS=E: Failed to develop a comprehensive CP that addressed individual resident needs for 5 residents placing residents at risk for impaired care due to uncommunicated needs

- CP lacked documentation & instruction for 1 resident's heel & great toes wounds; failed to develop a comprehensive CP r/t resident's wound care placing resident at risk for impaired care due to uncommunicated care needs
- CP lacked mention of nonpharmacological approaches to try before use of PRN Ativan; failed to complete comprehensive CP r/t resident's use of PRN Ativan placing resident at risk for impaired care due to uncommunicated care needs
- CP lacked interventions r/t use of antibiotics daily for UTIs; failed to develop a comprehensive CP r/t resident use of daily ABT for hx of UTI placing resident at risk for impaired care due to uncommunicated care needs
- CP lacked interventions for ruse of antipsychotic med & any related BBW; failed to develop a comprehensive CP for resident's use of antipsychotic med placing resident at risk for impaired care due to uncommunicated care needs
- CP lacked documentation diabetes CP implemented to provide direction to staff to care for resident with dx of diabetes & resident's insulin pump; failed to develop a comprehensive CP for resident's DM & insulin pump placing resident at risk for impaired care due to uncommunicated care needs

F657 Care Plan Timing & Revision

SE: SS=D: Failed to review & revise CP for 1 resident's controlled ankle movement (CAM) boot

- CP lacked revision to include physician's order for use of CAM boot except for skin checks & ROM; observed resident w/o CAM boot prior to transfer & staff applied boot after transfer; failed to review & revise resident's CP to include use of CAM boot except for skin checks & ROM as ordered by physician

SW: SS=E: Failed to capture a significant change on 1 resident when resident had 2 areas of decline (toileting, showering, dressing, hygiene, transfers, oral care in ADLs & increase behaviors with potential to lead to negative impacts on resident's physical, mental & psychosocial wellbeing

- Failed to capture a significant change on 1 resident with 2 areas of decline in ADLs & increased behaviors with potential to lead to negative impacts on resident's physical, mental & psychosocial wellbeing

NW: SS=D: Failed to revise resident's CP to reflect resident's current health needs for 1 resident placing resident at risk for impaired care due to uncommunicated care needs

- CP lacked direction to staff on prevention or tx of skin tears; failed to revise CP for resident's skin tears placing resident at risk for impaired care due to uncommunicated care needs

NW: SS=D: Failed to revise 1 resident's CP to include guidance to staff r/t 1 resident exiting building w/o staff supervision placing resident at risk for impaired care due to uncommunicated care needs

- CP lacked guidance to staff on what to do if resident exited building unsupervised; Observed resident walking with walker & then opened door & went outside w/o staff supervision & no alarm heard at exit door then resident ambulated thru open gate & sat on bench outside facility; CMA stated all facility doors were unlocked but did alarm at nurses' station whenever someone went out w/o putting in code & when resident exited facility through exit door it alarmed nurses' station & staff could see resident exit from nurses' station & tried to keep an eye on resident when exited; CMA stated staff knew resident allowed to exit building unsupervised; failed to revise 1 resident's CP to include guidance to staff r/t resident exiting building unsupervised placing resident at risk of impaired care due to uncommunicated care needs

NW: SS=D: Failed to revise 1 resident's CP to reflect Hoyer lift transfer requirements placing resident at risk for impaired care due to uncommunicated care needs

- CP lacked indication resident required a Hoyer lift for transfers; failed to revise 1 resident's CP to reflect Hoyer lift transfer requirements placing resident at risk for impaired care due to uncommunicated care needs

F641 Accuracy of Assessments

SW: SS=E: Failed to accurately complete MDS for 5 residents: 2 residents r/t personal alarm use; 1 for urinary catheter, 1 for antiplatelet medication use & 1 for restraint use placing residents at risk for uncommunicated care needs

- Failed to accurately complete MDS r/t chair alarm use placing resident at risk for uncommunicated care needs
- Failed to accurately complete MDS for 1 resident r/t personal alarm use placing resident at risk for uncommunicated care needs
- Failed to accurately complete MDS for 1 resident r/t urinary catheter use placing resident at risk for uncommunicated care needs
- Failed to complete accurate MDS for resident r/t use of physical restraints
- Failed to complete accurate MDS for resident who received ASA & antipsychotic meds

F657 Care Plan Timing & Revision

SW: SS=D: Failed to accurately update 1 resident's CP for fall interventions placing residents at risk for uncommunicated care needs

- Resident with multiple falls with injury & w/o injury & witnessed & unwitnessed; failed to accurately update resident's CP with fall interventions placing resident at risk for uncommunicated care needs

F661 Discharge Summary

NE: SS=D: Failed to document a recapitulation of stay for 2 residents placing residents at risk for miscommunication of services received during stay in facility & of post-discharge care needs

- Failed to document a recapitulation of stay for resident placing resident at risk for miscommunication of services received during stay in facility & post-discharge care needs for multiple residents

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

- Resident admitted on 4-6-24; CAA documented resident planned to return to community with assist for possible home health; discharged on 5-6-24; EMR lacked discharge summary including complete recapitulation of stay; failed to develop a discharge summary that included a complete recapitulation of resident's stay & post-discharge plan placing resident at risk for receiving inadequate care

F677 ADL Care Provided for Dependent Residents

NW: SS=D: Failed to provide necessary services to maintain good personal hygiene including bathing for 1 resident placing resident at risk for poor personal hygiene & impaired dignity

- April 2024 bathing report documented resident received 2 baths during month; 1 in May (30 days with no shower); 1 in June (19 days with no shower); July with 3 showers (13 days, 6 days x 2 with no shower); report lacked documentation resident refused showers; observed resident in w/c in room & hair uncombed & appeared greasy; failed to provide necessary care & bathing services for 1 resident placing resident at risk for poor hygiene & impaired dignity

F684 Quality of Care

SE: SS=D: Failed to apply sheepskin padding to 1 resident's arm rests of w/c with potential to place resident at increased risk for additional skin injuries

- CP documented resident to have sheepskin padding applied to w/c arm rests r/t skin tear; observed resident's w/c arm rests lacked sheepskin; failed to apply sheepskin padding to 1 resident's arm rests of w/c with potential to place resident at increased risk for additional skin injuries

SW: SS=D: Failed to implement interventions to prevent skin tears for 1 resident & failed to provide general skin care & services for 1 resident who had multiple sores on arms placing residents at risk for further skin injury & related complications

- CP lacked direction to staff on prevention or treatment of skin tears; failed to implement interventions including dressing & wound care to prevent & treat skin tears for 1 resident placing resident at risk for further skin injuries
- EMR lacked orders or tx r/t resident's skin sores; observed multiple unopened sores on forearm, unopened sore between 1st & 2nd finger by knuckle on hand & 5 unopened sores on other forearm; resident stated sores from scratching arms because they itched; failed to provide treatment for sores on resident's arms & failed to implement interventions to prevent sores on resident's arms placing resident at risk for ongoing skin sores & related complications

F688 Increase/Prevent Decrease in ROM/Mobility

SW: SS=E: Failed to provide treatment & services for 4/5 sampled residents r/t lack of restorative nursing programs

- Resident with potential for contractures with instructions for resident to wear resting hand splint during day; EMR lacked documentation of restorative nursing program; observed resident w/o palm protector in either hand & with bruises on hand from banging on bottom of table; staff reported being Restorative Adie but currently not providing routine restorative programs because responsible for transportation in addition to other duties & did not have time for restorative programs; failed to provide treatment & services r/t lack of restorative nursing programs for resident with contractures
- Failed to provide treatment & services r/t lack of restorative nursing programs for resident with contractures for multiple residents
- Failed to provide restorative nursing program for 1 resident to prevent further decline of contractures with potential to place resident at increased risk for development of additional medical problems & discomfort

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=G: Failed to ensure resident safety for 1/6 residents, during transfer of 1 resident; On 4-11 staff used facility shower chair to transport resident & in doing so, wheel on chair broke, resident fell forward to floor & sustained fx'd tibia; additionally, on 6-4 staff did not ensure safe transfer for resident into electric w/c while using mechanical lift resulting in laceration on lower leg requiring sutures

- Investigation documented wheel chair front wheel did not swivel causing it to fold backward when staff turned chair & provided forward momentum causing chair to tip forward & resident fell forward; cited findings noted in F657 r/t transfer with mechanical lift resulting in laceration requiring sutures; failed to ensure resident safety during 2 transfers for 1 resident, 1 when staff used facility shower chair to transport resident & in doing so, wheel on chair broke & resident fell forward to floor & sustained fx'd tibia; additionally facility staff did not ensure safe transfer for electric w/c while using mechanical lift resulting in laceration on anterior lower leg requiring sutures

SW: SS=D: Failed to provide an environment that remained free from accident hazards for 2 residents when facility failed to appropriately place a fall mat on floor next to1 resident's bed with potential result in injury; failed to ensure safe transfer for 1 resident when staff utilized a full body mechanical lift w/o a 2nd staff member present with potential result in mechanical lift transfer accident

- CP instructed staff to place fall mat at bedside when resident in bed & bed in low position; observed resident on multiple occasions in bed w/o floor mat & mat folded up & placed by window; failed to provide environment that remained free from accident hazards for resident when facility failed to appropriately place fall mat on floor next to resident's bed with potential result in injury
- Resident with transfers with mechanical lift; Investigation documented CNA transferred resident by self with full body mechanical lift; LN walked into resident's room when CNA requested help to reposition resident in w/c & realized CNA transferred resident w/o 2nd staff member; failed to ensure safe transfer for 1 resident when staff used full body mechanical lift w/o 2nd staff member present with potential to result in mechanical lift transfer accident

SW: SS=J (Past Non-Compliance): Failed to ensure safe environment when staff allowed 3 residents to hold lit fireworks, one which mis-fired & blew up in cognitively impaired resident hand

- *Failed to provide a safe environment for 3 residents IDd when facility staff allowed 3 residents to hold lit fireworks in hands during Independence Day Celebration that resulted in injury to 1 confused resident*
- *Past Non-Compliance Plan:*
  - *Staff counseled on reading all labels on any fireworks for safe lighting instructions*
  - *No staff or residents to hold fireworks while being lit*
  - *Facility gave SS & CMA written disciplinary warning*

NE: SS=G: Failed to ensure adequate supervision resulting in preventable fall for 1 resident resulting in pelvic fx for 1 resident & created risk for pain & impaired mobility; additionally failed to safely secure hazardous materials, cleaning chemicals & supplemental O2 cylinders from 8 cognitively impaired ambulatory mobile residents placing residents at risk for preventable accidents & injuries

- Resident with multiple falls; resident impulsive & CP instructed staff to supervise resident when out of room; Failed to ensure adequate supervision to prevent falls for 1 resident resulting in pelvic fx; further failed to use foot pedals when propelling resident in w/c placing resident at risk for accidents
- Failed to store pressurized O2 cylinders & hazardous chemicals securely & safely with risk of accidents & injuries to affected residents

NW: SS=D: Failed to ID & implement interventions to prevent 2 residents from falling placing residents at risk for further falls & injuries

- CP lacked documentation of falls or immediate actions placed to prevent resident from falling; NN documented resident with 4 falls; staff confirmed resident's falls had not been recorded in CPs nor had interventions been implemented & facility had not done root cause analysis to determine reasons for falling; failed to ID & implement interventions to prevent resident from falling placing resident at risk for further falls & injuries
- Resident assessed as high risk for falls; Resident with multiple unwitnessed falls; Adm nurse stated had not done root cause analysis for resident's falls but did have Resident at Risk meetings to discuss falls & fall interventions; Adm nurse stated resident should have a toileting plan to help with fall reduction; failed to ID root cause of resident's falls & implement meaningful person-centered interventions to prevent further falls placing resident at risk for further falls & injury

NW: SS=E: Failed to ensure environment free from accident hazards when facility failed to secure fully pressurized supplemental O2 cylinders in safe, locked area & out of reach of 5 cognitively impaired independently mobile residents; additionally failed to ensure interventions were put in place for 22 of resident's 41 falls placing residents at risk for preventable accidents, falls & injuries

- Failed to ensure environment free from accident hazards when facility failed to secure pressurized medical O2 cylinder tanks in safe, locked area & out of reach of 5 cognitively impaired, independently mobile residents placing residents at risk for preventable accidents & injuries when O2 storage room was found unlocked
- Resident with 41 documented falls since admission & no CP revisions with new interventions for 22/41 falls; failed to ID & implement effective interventions to prevent further falls for 1 resident placing resident at risk for further falls & injury

NW: SS=D: Failed to ensure safe care practices were followed during staff-assisted care resulting in multiple preventable falls for 1 resident placing resident at risk for further falls & injuries

- Resident with multiple falls witnessed & unwitnessed; multiple falls w/o no new interventions r/t fall; multiple falls w/o investigation; failed to ensure safe care practices were followed during assisted care resulting in multiple falls for 1 resident placing resident at risk for further falls & injuries

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to implement timed toileting interventions as indicated in assessment & failed to assess ongoing patterns of incontinence to establish bowel & bladder patterns to maintain or improve resident's incontinence placing resident at risk for complications r/t incontinence

- Failed to implement assessed timed toileting interventions & assess ongoing patterns of incontinence to establish bowel & bladder patterns to maintain or improve resident's incontinence placing resident at risk for complications r/t incontinence

NW: SS=D: Failed to implement individualized toileting interventions to improve 1 resident's bowel & bladder incontinence or prevent worsening based on incontinence evaluation placing resident at risk for complications r/t incontinence

- CP lacked interventions r/t resident's occasional bowel incontinence & CP lacked individualized interventions to maintain & promote resident's highest level of functioning r/t incontinence; failed to implement individualized toileting interventions to improve &/or maintain resident's bowel & bladder function based on resident's incontinence evaluation placing resident at risk for complications r/t incontinence

F699 Trauma Informed Care

SE: SS=D: Failed to develop & implement approaches to care that were both clinically appropriate & person-centered for 1 resident with hx of personal trauma

- CP lacked any interventions to address resident's past trauma; further CP failed to address resident's adjustment difficulties &/or hx of trauma; CP lacked any description of resident's indications of distress &/or interventions intended to assist resident to reach & maintain highest level of mental & psychosocial wellbeing; observed resident in room & anxious when speaking, wringing hands together & kept moving around room; CP lacked any interventions for resident's past trauma; failed to develop & implement approaches to care that were both clinically appropriate & person-centered for 1 resident with hx of trauma with potential to lead to uncommunicated needs which could lead to negative impacts on resident's physical, mental & psychosocial wellbeing

F700 Bedrails

NE: SS=D: Failed to ensure resident's bed rails were removed as indicated per side rail assessment placing resident at risk for impaired safety r/t risks associated with use of side rails

- Bed Rail Assessment completed & indicated resident was non-ambulatory & revealed side rails or assist bars not indicated at time of assessment; observed resident in bed with bilateral grab bars; failed to ensure resident's bed rails were removed per assessed needs placing resident at risk for impaired safety r/t risks associated with use of side rails

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

SE: NSS=F: Failed to have RN coverage for at least 8 continuous hours on 29 days as required placing residents in facility at risk for unsupervised nursing care & services

- Daily Staff Postings from 4-1-23 thru 3-31-24 revealed facility lacked RN coverage on 29 days; failed to ensure 8 consecutive hours of RN nursing coverage to ensure adequate nursing cares provided to residents of facility for total of 29 days

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

NW: SS=F: Failed to ensure 5/5 CNA staff reviewed had required yearly performance evaluations completed placing residents at risk for inadequate care

- Review of employment records documented 5 CNAs had no yearly performance evaluations upon request; failed to ensure 5 CNA staff reviewed had required yearly performance evals completed placing residents at risk for inadequate care

F742 Treatment/Services Mental/Psychosocial Concerns

SW: SS=J (Abated to D): Failed to acknowledge & respond appropriately to 1 resident's allegations of sexual assault & her display of behaviors, which align to trauma response, based on reasonable person concept, when resident expressed feelings of fear, anger, & aggressiveness associated with reported allegation of sexual assault while a resident of facility placing resident in immediate jeopardy & at risk for untreated trauma & negative impact to mental, physical & psychosocial wellbeing

- Cited findings noted in F600, F609, F610 r/t allegation of sexual assault; failed to acknowledge & respond appropriately to 1 resident's allegations of sexual assault & her display of behaviors which align to trauma response, based on reasonable person concept, when resident expressed feelings of fear, anger, & aggressiveness associated with reported allegation of sexual assault while a resident at facility
    - Abatement Plan
        - Resident assessed for Abuse, neglect or trauma
        - All nursing staff education initiated on 7-16-24 for "Recognizing & Reported Abuse & Neglect Allegation" by Clinical Learning & Development Specialist
        - Trauma Informed care assessment completed on 7-17-24 & resident's CP updated to reflect new trauma informed care interventions
        - Law enforcement contacted & resident interviewed
        - Leadership educated on "Recognizing & Reporting Abuse & Neglect Allegation" conducted by Regional Clinical Services Director on 7-18-24
        - All education completed by 7-18-24 or prior to next to working shift
        - All residents at risk for trauma informed care reviewed for care & CP addressed & interventions added as needed
        - Angel Rounding initiated to ID areas of concern & ensure resident safety

NW: SS=D: Failed to provide 1 resident with appropriate treatment & services to attain highest practicable mental & psychosocial wellbeing placing resident at risk for unmet mental health care needs

- CP lacked resident-specific interventions based on resident's preferred activities or to address resident's difficulty adjusting to facility & loss of independence; record lacked evidence of nonpharmacological interventions implemented or action taken to address resident's verbalizations of loss, embarrassment, sadness & feelings of wanting to die; SSD stated had not spent time with resident r/t anxiety & depression; Adm nurse verified lack of SSD involvement or mental health support provided to resident prior to starting meds to treat resident's mental health; failed to provide resident with appropriate mental health support services before administering psychotropic meds to attain highest practicable mental & psychosocial wellbeing placing resident at risk for unmet mental health care needs

F755 Pharmacy Services/Procedures/Pharmacist/Records

SW: SS=D: Failed to ensure 2 residents' meds received & documented as ordered by physician; failed to administer scheduled Tramadol to 1 resident for 7 days; furthermore facility failed to administer 1 resident's insulin on 1 day per sliding scale orders

- Facility unable to locate resident's narc sheet for 6-17-24 after 8am to 6-24-24 at 4:44pm; CMA reported med was not received from pharmacy; Failed to administer scheduled Tramadol to 1 resident for 7 days as ordered by physician placing resident at risk for development of additional medical problems & discomfort
- CP lacked guidance r/t insulin; POS for FBS TID with parameters to administer insulin; staff documented resident to blood sugar of 248 & documented med not available; LN reported resident ran out of Aspart insulin & 4pm dose of Aspart insulin not administered; failed to administer ordered insulin to 1 resident as ordered by physician placing resident at risk for development of additional medical problems

F756 Drug Regimen Review, Report Irregularities, Act On

SW: SS=D: Failed to follow Consultant Pharmacist (CP) recommendation to complete AIMS for 1/5 residents reviewed for unnecessary meds; resident received Risperidone, an antipsychotic

- 7-26-23, 8-22-23, 9-20-23, MRR recommended AIMS or other appropriate assessment to assess for TD r/t resident's Risperidone use; AIMS completed on 9-25-23; failed to follow CP recommendation to complete AIMS for 1 resident who received Risperidone with potential to lead to uncommunicated needs which could lead to negative impacts on resident's physical, mental, & psychosocial wellbeing

NW: SS=D: Failed to ensure Consultant Pharmacist (CP) IDd & reported 2 resident's PRN antianxiety meds w/o a stop date & lack of approved indication or required documentation for use of antipsychotic meds for 2 residents placing residents at risk for inappropriate &/or unnecessary med

- Resident with HTN, major depressive d/o, PVD, dementia, anxiety d/o, occlusive & stenosis of carotid artery, hypothyroidism, chronic kidney disease, Alz disease, dysphagia; POS for Venlafaxine, Ativan PRN, Olanzapine; MAR documented PRN Ativan administered 3x in March, 6 x in April, 8 x in May & June, 4x in July; MRRs w/o recommendations; CP reviews lacked recommendations for Olanzapine w/o approved indication & did not ID lack of stop date or specified duration for use of PRN Ativan; failed to ensure CP IDd & reported resident's unapproved indication or lack of required physician documentation for ongoing use of antipsychotic medication placing resident at risk for inappropriate use of antipsychotic meds
- Resident with chronic kidney disease, Poly osteoarthritis, weakness, displaced fx of humerus; POS for Quetiapine BID for anxiety; CP recommended attempting GDR twice within first year, then yearly;; CP requested physician evaluate current therapy & document accordingly; DP documented physician requested no changes & would consider GDR; documentation lacked reason for continued use w/o GDR; record lacked evidence of documented nonpharmacological interventions attempted & failed of risks versus benefits of continued use w/o GDR; failed to ensure CP IDd & reported resident's unapproved indication or lack of required physician documentation for ongoing use of antipsychotic med placing resident at risk for inappropriate use of antipsychotic meds
- POS for Ativan PRN for agitation; order lacked stop date; CP failed to ID & report lack of stop date for 1 resident's PRN Ativan placing resident at risk for inappropriate use of psychotropic med

NW: SS=D: Failed to ensure Consulting Pharmacist (CP) ID'd & notified facility & physician of numerous times staff administered 2 BP meds to 1 resident when physician order indicated meds should have been held in April, May & June 2024 placing resident at risk for unintended results from meds

- Resident with HTN; POS for Amlodipine with holding parameters & Benazepril with holding parameters; MAR documented staff administered both meds when resident's BP was lower than physician-ordered parameter 11 times in April, 16 times in May, 10 times in June, 8 times in July; MRR lacked notes r/t administration of meds when BPs out of physician-ordered parameters; failed to ensure CP IDd & notified facility & physician of numerous times staff administered 2 BP meds to resident outside physician-ordered parameters placing resident at risk for unintended results from meds

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to notify physician of elevated BP as directed & failed to administer antihypertensive meds as needed for 1 resident placing resident at risk for unnecessary meds & physical complications r/t uncontrolled BP

- POS for Hydralazine HCl q 8 hours PRN for HTN with administration parameters; MAR documented SBP higher than ordered parameter on 17 occasions from 4-9-24 to 7-30-24; record lacked evidence facility notified physician as directed for BP; failed to notify physician of elevated BP as directed & failed to administer antihypertensive meds as needed for 1 resident placing resident at risk for unnecessary meds & physical complications r/t uncontrolled BP

NW: SS=D: Failed to hold 1 resident's BP meds per physician-ordered BP parameters placing resident at risk for unnecessary meds & related complications

- Cited findings noted in F756 r/t administration of meds outside physician-ordered BP parameters; failed to hold 1 resident's BP meds per physician-ordered BP parameters placing resident at risk for unnecessary meds & related complications

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NW: SS=E: Failed to ensure appropriate indication or a documented physician rationale, which included unsuccessful attempts for nonpharmacological symptom management & risk vs benefit for continued use for 4 residents antipsychotic med & failed to ensure 14-day stop date or specified duration for 2 resident's ongoing PRN antianxiety placing residents at risk for unintended effects r/t psychotropic drug meds

- Cited findings noted in F756; failed to ensure 1 resident did not receive antipsychotic medication w/o appropriate indication or required documentation for its use placing resident at risk for adverse side effects
- Failed to ensure 1 resident did not receive antipsychotic med w/o appropriate indication or required documentation for its use & failed to ensure resident's Ativan had 14-day stop date or specified duration placing resident at risk for adverse side effects

- Failed to ensure 1 resident did not receive antipsychotic med w/o appropriate indications for or required documentation for its use & failed to ensure resident's PRN Ativan had 14-day stop date or specific duration placing resident at risk for adverse side effects
- Failed to ensure 1 resident did not receive antipsychotic med w/o appropriate indications or required documentation for its use & failed to provide rationale for lack of GDR placing resident at risk for adverse side effects r/t psychotropic med use

NW: SS=D: Failed to ensure appropriate indication for use of antipsychotic or required physician documentation for 2/5 residents reviewed for unnecessary meds placing residents at risk for unnecessary psychotropic meds

- CP documented staff to monitor resident for drug-related complications from Seroquel r/t behavior management; POS for Seroquel 25mg q hs r/t depression; EMR lacked evidence of nondrug behavioral interventions that were tried & failed before starting antipsychotic med & lacked physician-documented rationale including risk vs benefits for continued use of Seroquel; failed to ensure appropriate indication for use, or required physician documentation for resident's Seroquel placing resident at risk for unnecessary psychotropic meds
- Resident with dementia; POS for Clonazepam 0.5mg in afternoon for dementia with agitation; POS for Seroquel 75mg BID for dementia with agitation; POS for Seroquel 50mg in AM for dementia with agitation; POS for Clonazepam 1mg in AM for dementia with agitation; EMR lacked physician documentation of interventions that were attempted & failed prior to starting antipsychotic & lacked physician documentation of risks vs benefits for continued use of Seroquel; failed to ensure appropriate indication for use or required physician documentation for ongoing use of antipsychotic meds for 1 resident placing resident at risk for unnecessary psychotropic meds

F759 Free of Medication Error Rates 5% or More

NW: SS=E: Failed to ensure med error rate of less than 5% placing 1 resident at risk for significant med errors & resulted in facility med error rate of 7.69% placing all residents receiving medication at risk for med errors

- Cited findings noted in F756 & F757 r/t administration of meds outside physician-ordered parameters; failed to administer meds with less than 5% error rate placing resident at risk for significant med errors & resulting in 7.69% error rate placing all residents who received meds at risk for complications r/t med errors

F761 Label/Store Drugs & Biologicals

NW: SS=D: Failed to record open or discard date on residents' insulin vials when opened a new, multi-use insulin vial placing 2 residents at risk for ineffective insulin medication

- Observed med cart with opened & partially used insulin Glargine vial for 1 resident & was note dated & 1 insulin Glargine vial for another resident had been opened & was not dated; failed to date 2 residents' multi-use insulin vials when opened, placing residents at risk for ineffective insulin

F801 Qualified Dietary Staff

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

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

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=F: Failed to store, prepare & serve food in sanitary manner to prevent possible foodborne illnesses to residents of facility

- Observed opened food items w/o open date; multiple undated food items or expiration dates; open garbage can full with garbage near food prep station; top oven with bubbled burned food debris on bottom of inside; fry pan with multiple scratches in cooking surface; cutting board with multiple scratches & gouges on both sides of board; rubber spatulas with cracks & chips

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

- Observed open undated food items, unsealed food items; fridge with liquids w/o open date; frying pans with scratches; cutting boards with scratches; 2 ovens with burnt substance on bottom; freezer with ice cream w/o lids & with freezer burn

F835 Administration

SW: SS=F: Failed to put in place effective administration who ensured facility was administered in manner that enabled it to use its resources effectively & efficiently to attain or maintain highest practicable physical, mental, & psychosocial wellbeing of each resident residing in facility placing residents at risk for decreased quality of care, quality of treatment, & sense of wellbeing

- Cited all 15 other deficiencies including 4 IJ tags; failed to have effective administration to ID & develop corrective action plans for potential quality deficiencies as found on current survey placing residents at risk for decreased quality of care, quality of treatment, & sense of wellbeing

F849 Hospice Services

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

- CP lacked instruction on services provided by hospice including hospice staff visits, supplies & medical equipment provided by hospice & meds covered by hospice; failed to coordinate care between facility & hospice provider for 1 resident who received hospice services placing resident at risk for inappropriate end-of-life care

F851 Payroll Based Journal

SE: SS=F: Failed to accurately report 24 hr/day LN coverage on 16 dates between 4-1-23 & 3-31-24

- PBJ revealed lack of LN 24hr/7 days/wk on 16 dates; failed to electronically submit to CMS with complete & accurate direct staffing information based on payroll & other verifiable & auditable data in uniform format according to specifications established by CMS, PBJ r/t LNs when facility failed to accurately report 24 hr/day LN coverage on 16 dates between 4-1-23 & 3-31-24

NW: SS=F: Failed to submit complete & accurate information to PBJ when facility failed to submit accurate staffing hour date for all diret care personnel as required placing residents at risk for unidentified issues with inadequate staffing

- PBJ report for 1 quarter documented 13 dates facility did not have LN coverage; review of nursing schedule & timesheet payroll revealed LN & RN coverage; Adm verified inaccurate entries into PBJ & verified had not made submission deadline for 1 quarter; failed to submit accurate information to CMS PBJ placing residents at risk for unidentified issues with inadequate staffing

F851 Payroll Based Journal

SW: SS=F: Failed to electronically submit to CMS complete & accurate direct care staffing information including information for agency & contract staff based on payroll & other verifiable & auditable data in a uniform format according to PBJ r/t LN coverage 24 hrs/day & excessively low weekend staffing

- Review of daily staffing sheets from May 2023 thru March 2024 revealed equal staffing on weekend as during week; Adm Nurse confirmed inaccurate staff hours reported on PBJ for 3rd quarter, 2023 & inaccurate excessive low weekend staffing reported to PBJ

F867 QAPI/QAA Improvement Activities

SW: SS=F: Failed to demonstrate effective QAPI program affecting all residents of facility & placing residents at risk for decreased quality of life, decreased quality of care, & continued resident abuse

- Cited 15 other deficiencies including 4 IJ deficiencies r/t quality of care

F880 Infection Prevention & Control

NW: SS=F: Failed to follow infection prevention standards r/t disinfecting shared equipment & O2 tubing storage & failed to place appropriate isolation signage outside of resident's room after resident tested positive for COVID-19; further failed to assess, ID risks, & create plan to address risk for Legionella disease or other opportunistic waterborne pathogens placing residents at risk for infectious diseases

- EMR documented order for isolation for 10 days starting 7-21 for positive COVID; O2 concentrator with O2 tubing placed in handle instead of bag; room with isolation cart outside of it but no signage on door to alert staff & visitors of TBP or PPE required
- Obtained LN placed glucometer on top of med cart w/o clean barrier, went to room & did not disinfect glucometer before use & placed glucometer on top of dresser, & when finished returned to med cart & placed glucometer in drawer w/o disinfecting glucometer
- Adm staff stated facility did not have Legionella testing procedure in place reaching out a company to set that up; failed to follow infection prevention standards r/t disinfecting shared equipment & O2 tubing storage & failed to place appropriate isolation signage outside of 1 resident's room after resident tested positive for COVID-19; further failed to assess, ID risks, & create a plan to address risk for Legionella disease or other opportunistic waterborne pathogens placing residents at risk for infectious diseases

NW: SS=F: Failed to follow sanitary infection control standards r/t handling of soiled laundry, hand hygiene, storage of O2 tubing while not in use, & disinfecting of shared equipment placing residents at risk for infectious diseases

- Observed electric razor with brown shavings on EBP cart outside of resident's room & soiled razor not in container
- Observed CNA pushed Hoyer lift from resident's room into another resident's room w/o sanitizing Hoyer lift & CNA did not perform hand hygiene upon leaving resident's room & before entering other resident's room
- Observed O2 cannula wrapped around w/c & not in sanitary container
- Observed soiled linens directly on floor while CNA changing bed & resident on EBP & CNA did not sanitize floor immediately after soiled linens were picked up
- Observed 2 commercial washers left from 10pm to 12am shift & no PPE available in laundry room
- Observed CAN pushed resident down hallway & CNA had dirty unbagged hospital gown in hand
- Observed 2 CNAs donned 2 pairs of gloves each & donned gloves & resident on contact precautions & removed gloves w/o hand hygiene; failed to follow sanitary infection control standards r/t handling of soiled laundry, hand hygiene, storge of O2 tubing while not in use, & disinfecting of shared equipment placing residents at risk for infectious diseases

F881 Antibiotic Stewardship Program

NW: SS=D: Failed to implement antibiotic use protocols to avoid unnecessary &/or inappropriate ABT to reduce risk of adverse events, including antibiotic resistance when facility failed to monitor effectiveness & evaluate appropriateness for extended administration of prophylactic ABT for 2 residents placing resident at risk for complications r/t antibiotic use including development of antibiotic-resistant organisms

- POS for Macrodantin for chronic UTIs; Record documented resident wtih2 UTIs while being administered Macrodantin prophylactic; EMR lacked physician rationale & benefits statement r/t ongoing use of antibiotics or concurrent use with other antibiotics for same issue; failed to ID & address ongoing use of antibiotics for 1 resident placing resident at risk for adverse effects & antibiotic resistance
- POS for Nitrofurantoin for urinary health; 2 UAs resulted in no active infection or reason for cultures; EMR lacked physician rationale & benefits statement r/t ongoing use of antibiotics w/o symptoms or infection present; failed to ID & address ongoing use of antibiotics for resident placing resident at risk for adverse effects & antibiotic resistance

F883 Influenza & Pneumococcal Immunizations

NE: SS=D: Failed to offer or obtain a signed declination for Prevnar 20 pneumococcal vaccination for 1 resident placing resident at risk of acquiring, spreading, & experiencing complications from pneumococcal disease

- Failed to obtain a signed consent or declination of pneumococcal vaccination for 1 resident placing resident at risk of acquiring, spreading & experiencing complications from pneumococcal disease

F921 Safe/Functional/Sanitary/Comfortable Environment

SE: SS=D: Failed to provide sanitary environment when staff stored unlined trash can in soiled utility room on 1 hallway

- Observed trash can in soiled utility room lacked liner & lid; failed to provide sanitary environment when staff stored unlined trash can in soiled utility room of 1 hallway

NW: SS=E: Failed to provide safe environment in facility kitchen placing residents & staff at risk for impaired safety

- Observed 4 2-foot x 4-foot fluorescent lights between food prep area & stove that lacked plastic light diffuser (cover); each fixture had 2 glass light bulbs per fixture; 5 2-foot x 4-foot fluorescent light, located above dishwasher area lacked plastic light cover & each fixture with 2 fluorescent tube glass light bulbs per fixture; failed to provide a safe environment for facility kitchen placing residents & staff at risk

F947 Required In-Service Training for Nurse Aides

NW: SS=F: Failed to ensure staff completed required 12-hour in-service education for 2 CNAs who were all employed by facility for at least 1 year placing residents at risk for decreased quality of care

- Review of facility's 12-hour annual in-service documentation for 2/5 CNAs/CMAs who had been employed at facility for at least 1 year including: CMA lacked dementia care training; CNA had only 3/required 12 in-service hours; failed to ensure required topics & 12-hours in-service education for 1 CMA & 1 CNA placing residents at risk for decreased quality of care

S948 Laundry Services

SW: SS=F: Failed to obtain & log water temps for laundry equipment in facility; further failed to ensure soiled linen hampers were clean

- Observed water temps not written down on temp log sheet & soiled linen hamper with crumbs in bottom of hamper; staff reported checked temps but did not write them down on logs; & stated soiled linen hampers were cleaned when had a chance; failed to obtain & log water temps for laundry equipment in facility

August, 2024

F550 Resident Rights/Exercise of Rights

SW: SS=E: Failed to protect privacy & dignity of residents that were dependent of staff assistance for eating when staff labeled residents as "feeders" with potential to lead to negative psychosocial effects r/t dignity

- Observed CNA referring to residents who required feeding assistance as "feeders"; failed to protect dignity of residents of facility that were dependent on assistance of facility staff to eat when staff labeled residents as "feeders"

F553 Right to Participate in Planning Care

SW: SS=D: Failed to include 1 resident for development & continued planning of resident's CP quarterly with potential to lead to negative psychosocial effects r/t safety & uncommunicated needs

- Documented that SS had invited family members & hospice to CP meeting; resident stated had never been invited to CP meeting with staff; SS reported no attendance sign in sheet when CP meetings completed & no progress note that CP meeting had occurred; failed to include resident to CP meetings placing residents at risk for inadequate care & services with potential to lead to negative psychosocial effects r/t safety & uncommunicated needs

F567 Protection/Management of Personal Funds

NE: SS=D: Failed to hold, safeguard & manager 1 resident's trust fund as required when facility failed to obtain appropriate authorization to disperse or use monies from 1 resident's trust fund placing resident at risk for impaired rights & potential misappropriation

- *Resident with severely impaired cognition; Resident statement revealed personal need items debit of $124.61 dated 7-15-24; $300 dated 7-18-24; receipt indicated handwritten note indicating resident unable to sign receipt but resident's DPOA approved; document included scanned copy of Walmart receipt listing multiple items purchased & indicated attempt to purchase debit card & load with $300 which was denied & voided & trust account check with noted "would not allow to purchase debit card"; then receipt including resident's signature & note "to buy a debit card so she can order on line w/assist; DPOA stated unaware of purchase of debit card & had not authorized debit card purchase of amount of $300 & there was no way resident could sign for anything or use a debit card to order anything; failed to hold, safeguard, & manage resident's trust fund as required when facility failed to obtain appropriate authorization to disperse or use monies from resident's trust fund placing resident at risk for impaired rights & potential misappropriation*

F568 Accounting & Records of Personal Funds

NE: SS=E: Failed to distribute quarterly statements to all residents that held trust fund accounts in facility placing residents at risk for uninformed decisions r/t trust fund & misappropriation

- *Review of "Trial Balance" revealed 30 total accounts with balance of $63,621.38 & resident with current trust fund balance of $3705.47; resident's representative & DPOA-F stated had never received a quarterly statement r/t resident's trust account & had made inquiries into*

any remaining balances from resident's trust account since resident discharged on 3-24 & had not received any answers or account balances; Adm staff confirmed had never sent out any quarterly statements for any of trust accounts & had nt received training r/t quarterly statements; failed to distribute quarterly statements to all residents that held trust fund accounts in facility placing residents at risk for uninformed decisions r/t trust fund & misappropriation

F569 Notice & Conveyance of Personal Funds

NE: SS=E: Failed to ensure conveyance of personal funds within 30 days of discharge &/or death for 5 residents placing residents at risk for impaired rights & misappropriation

- *Adm staff stated not entirely certain what she was supposed to do with residents' trust funds when resident died & typically called family & asked what funeral home & wrote a check to funeral home & closed out account & had not been trained on what to do with past accounts; failed to ensure conveyance of personal funds within 30 days of discharge &/or death for 5 residents placing residents at risk for impaired rights & misappropriation*

F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive

SW: SS=D: Failed to verify 1 resident's advance directives; additionally failed to obtain proper authorization for DNR for 1 resident when facility allowed resident's guardian to consent with potential to lead to uncommunicated needs specifically to end-of-life

- CP documented resident full code; POS for full code; document in EMR revealed un-rescinded DNR order signed by resident; staff reported lanyards in med room which documented resident's code status but upon inspection were found to be empty; failed to verify resident's advance directives & code status with potential to lead to uncommunicated needs specifically to end-of-life care
- CP documented resident had established advance directive & had selected DNR; CP lacked documentation that resident had guardian; POS for DNR; documented indicated DNR by verbal consent from resident's guardian & signed by LN & DON; EMR contained signed guardianship by Court but lacked direction of advance directives; DON stated unaware guardian could not sign DNR; failed to obtain proper authorization for DNR for resident when facility allowed guardian to consent with potential to lead to uncommunicated needs specifically to end-of-life care

F600 Free from Abuse & Neglect

NE: SS=D: Failed to ensure 1 resident remained free from staff to resident verbal abuse placing resident at risk for further abuse & decline in psychosocial wellbeing

- *Resident with schizoaffective d/o & borderline personality d/o; LN witness statement on 8-13-24 documented on 8-12-24 early in shift, N heard resident & CNA talking in resident's room & CNA asked resident how doing & resident responded by telling CNA to just leave as CNA was making a fool out of self; CNA left room w/o incident; upon request CNA delivered cup of ice then LN heard yelling coming from resident & CNA; resident appeared noticeable upset after CNA exited room & stated CNA threw cup of ice & LN observed water & ice on floor & around rom; CNA was upset A& stated resident called racial slurs & resident & CNA continued to call each other inappropriate names & make comments towards each other; LN notified Adm Nurse & local law enforcement & facility asked CNA to leave building; CNA unavailable for interview & resident refused to discuss incident; failed to ensure resident remained free from verbal abuse placing resident at risk for further abuse & decline in psychosocial wellbeing*

F602 Free from Misappropriation/Exploitation

NW: SS=E: Failed to ensure 1 resident remained free from misappropriation when LN on 2-11-24 at 6:57pm emptied resident's Promethazine with codeine liquid into water bottle & put it in LN's purse then left facility with water bottle placing resident at risk for missed medications & further misappropriation of meds

- *Resident with chronic pain, shortness of breath & constipation; POS for Promethazine-Codeine 5 mL q 4 hours PRN cough; MAR for 1-15-24 thru 3-31-24 revealed resident med on 1 day, 3-1-24; LN witness statement documented on 2-11-24 LN & other LN performed narcotic cunt & after count other LN asked LN for keys to med room so could get into petty cash box; LN stated handed other LN keys & after short while, other LN brought keys back to LN; LN documented check of med count did not match count sheet & seal broken & resident did not report cough; investigation documented LN noted broken seal on resident's Promethazine-Codeine bottle & volume of bottle did not match count sheet; documentation did not support that staff gave dose to resident; LN denied giving any doses & did not notice discrepancy when started shift; investigation started; camera footage in med room revealed confirmation about LN asking for keys to med room & LN entered med room & removed 2 medication bottles & emptied med into water bottle & filled water bottle up with water from sink then placed med bottles back into narc cabinet & exited med room then household then placed water bottle filled with liquid med in purse & returned keys to LN then grabbed purse & left; Adm Nurse relieved other LN of duty & brought into office for questioning & obtained statement; upon being presented with camera footage, other LN stated "she was sick"; facility terminated other LN & escorted other LN out of building; Facility failed to compete ANE education after incident but did complete controlled substance education; failed to ensure resident remained free from misappropriation of medication of meds placing resident at risk for missed meds & further misappropriation of meds*

F625 Notice of Bed Hold Policy Before/Upon Transfer

SW: SS=E: Failed to provide 4 residents/representatives with written notice specifying duration & cost of bed hold policy at time residents transferred to hospital placing residents at risk to not be allowed to return to former rooms at facility

- Failed to provide written bed-hold notice for hospitalization placing resident at risk to not be allowed to return to former rooms at facility for multiple residents

- Failed to provide written bed-hold notice to resident/representative specifying duration & cost of bed hold policy at time of resident's transfer to hospital

F636 Comprehensive Assessments & Timing

SE: SS=E: Failed to complete an analysis of findings for MDS triggered CAAs to complete a comprehensive assessment & develop a CP for 4/14 residents selected for review including 1 resident for delirium, cognitive loss/dementia, psychotropic drug use & pain; 1 resident for delirium, cognitive loss/dementia, psychotropic drug use, psychosocial wellbeing, pain, mood state, fall, urinary incontinence & indwelling catheter; 1 resident for cognitive loss/dementia, mood state, psychotropic drug use & behavioral symptoms & 1 resident for urinary incontinence & indwelling catheter, ADL functional/rehab potential, pain & return to community to develop comprehensive CPs as required with potential to lead to uncommunicated care needs

- CAAs not developed for MDS triggered for cognitive loss/dementia, mood state, psychotropic drug use & behavioral symptoms; failed to develop MDS triggered CAAs to complete comprehensive assessment for resident to develop a comprehensive CP as required with potential to lead to uncommunicated care needs
- CAAs for urinary incontinence & indwelling catheter, ADL functional/rehab potential, pain & return to community not developed; failed to develop MDS triggered CAAs to complete comprehensive assessment for resident to develop comprehensive CP as required with potential to lead to uncommunicated care needs
- CAAs triggered but lacked analysis for delirium, cognitive loss/dementia, psychotropic drug use & pain; failed to accurately complete significant change MDS CAA for dependent resident with potential to lead to uncommunicated needs
- CAAs triggered but lacked analysis of findings for delirium, cognitive loss/dementia, psychotropic drug use, psychosocial wellbeing, pain, mood state, falls & urinary incontinence & indwelling catheter; failed to accurately complete significant change MDS for dependent resident with potential to lead to uncommunicated needs

F655 Baseline Care Plan

SW: SS=D: Failed to develop a person-centered baseline CP for 1 resident with potential to lead to uncommunicated needs

- Baseline CP lacked any information or directions except resident requested a mesh stop sign to be put on door; observed baseline CP incomplete & failed to address: resident's initial goals, preferred name, representative name, communication risk, dietary preferences, dietary risks, dietary interventions, therapy/restorative services, functional interventions social/psychosocial services, special treatments/procedures, alarms/restraints, skin concerns, other conditions/concerns, resident life hx/daily routine preferences/cultural & ethnic preferences, discharge plans/goals, resident/caregiver education needs &/or hospice/outside coordination needs; additionally baseline CP unsigned & undated by IDT; failed to complete baseline CP for 1 resident with potential to lead to uncommunicated needs

F656 Develop/Implement Comprehensive Care Plan

SE: SS=D: Failed to complete a comprehensive CP for 1 resident r/t use of CPAP for 1 resident

- CP lacked staff instruction on use & care of resident's CPAP; EMR lacked POS & indication for CPAP; failed to complete a comprehensive CP for resident who utilized CPAP machine

SW: SS=D: Failed to develop a comprehensive person-centered CP for 1 resident r/t O2 delivery or nebulized medication administration with potential to lead to uncommunicated needs which could lead to negative impacts on resident's physical wellbeing

- CAA lacked documentation r/t O2 use or nebulized meds; CP lacked documentation r/t O2 use or nebulized meds; failed to develop comprehensive person-centered Cp for 1 resident r/t O2 use or nebulized med use with potential to lead to uncommunicated needs that would negatively affect physical wellbeing

F657 Care Plan Timing & Revision

SW: SS=D: Failed to accurately revise 2 resident CPs after 2 resident had falls placing residents at risk for uncommunicated care needs

- Failed to revise 1 resident's CP after fall to prevent possible further falls placing resident at risk for uncommunicated care needs with potential to have negative effect on overall physical & psychosocial wellbeing of resident in facility
- CP lacked guidance or staff instruction r/t hip fx precautions for weight bearing status; failed to revise resident's CP after fall with ordered weight bearing status placing resident at risk for uncommunicated care needs with potential to have negative effect on overall physical & psychosocial wellbeing of resident in facility

NE: SS=G: Failed to ensure staff provided safe ADL care to 1 resident consistent with level of need resulting in fx across rt distal femur for 1 resident

- *Resident with dementia & cerebral infarction & total assist of staff for ADLs with Hoyer lift & non-weight bearing; Witness statement by CNA documented CNA entered resident's room & noticed bruise on rt knee & assumed it happened over weekend; CNA documented CNA transferred resident 1:1 with right hand around resident's shoulders & lt hand under resident's knees; investigation documented resident assisted up for lunch & noted purple bruise to rt knee measuring 18 cm x 12 cm with swelling & pain with touch; x-ray indicated fx across rt distal femur; CNA indicated CNA transferred resident alone & w/o Hoyer lift; facility placed CNA on "do not return" list; failed to ensure resident received safe & appropriate ADL assist consistent with level of need resulting in fx across resident's ft distal femur*

F658 Services Provided Meet Professional Standards

SW: SS=D: Failed to provide services to meet professional standards of care r/t unsanitary manner meds administered when CMA dropped resident's meds, picked them up from floor & med cart & administered meds to resident

- Failed to provide services to meet professional standards of care r/t unsanitary manner meds administered when CMA dropped meds, picked them up from floor & med carts, & administered meds to resident

F677 ADL Care Provided for Dependent Residents

SW: SS=D: Failed to ensure 1 resident who was dependent on staff received care for removal of facial hair; failed to ensure resident, who was dependent on staff, received care for removal of facial hair & oral care placing residents at risk for decreased psychosocial wellbeing

- CP lacked documentation for facial hair removal; NN lacked documentation r/t personal hygiene care; observed resident in DR & chin had several approx. ¼ inch length facial whiskers on multiple occasions; family stated resident would be bothered that she had facial hair on chin & had removed facial hair when visited; failed to ensure dependent resident received care for removal of facial hair placing resident at risk for decreased psychosocial wellbeing
- Observed resident' chin had several approx. ¼ inch length facial whiskers & had dried scaly lips with few small cracks & upper front teeth with dried brown substance covering teeth; failed to ensure dependent resident received care for removal of facial hair & adequate oral care placing resident at risk for decreased psychosocial wellbeing & possible illness due to improper oral care

F684 Quality of Care

SE: SS=D: Failed to ensure appropriate positioning for 1 resident while in specialized w/c

- Resident with dementia with severe cognitive impairment & dependent on staff for mobility in w/c; observed resident in DR in w/c with feet dangling above footrest of w/c approximately 8 inches then CNA propelled resident from spa room to table in living room with feet dangling above footrest of w/c approximately 8 inches; CNA stated resident's feet did not always reach the footrest of the w/c; failed to ensure dependent resident was positioned properly in w/c

NE: SS=J (Abated to G): Failed to immediately respond to change in health status & failed to obtain physician involvement when resident had critical lab result & subsequently developed abnormal BP, lower than physician ordered parameter; further failed to immediately act on resident &/or representative's request to seek acute care for treatment of declining health situation

- *On 8-13-24 resident fell from full body lift during transfer; on 8-14 resident complained of intermittent back pain & shakiness; on 8-15 lab tech notified LN of resident's critical creatinine level & LN entered late entry note on 8-16 indicating LN called Consultant who gave orders on 8-15 to increase fluids 1-2 liters & recheck labs on following Monday; LN entered increased fluid order into EMR but staff did not keep track of increased fluid intake; LN continued neuro assessments r/t fall & noted resident spoke like he had "thick tongue" & could not grip with lt hand & resident's BP 88/64 & facility did not notify resident's physician of low BP; BP dropped further to 72/65 & representative called LN & requested staff send resident to hospital; LN stated to representative that if they sent resident to hospital & they did not admit him, facility would have difficulty transporting resident back to facility; representative contacted PACE & PACE called facility & instructed staff to send resident to hospital; EMS reported resident's BP as 60/40; & administered fluids during transport; resident admitted to hospital with dx of acute kidney injury & dehydration & resident remained in ICU; facility's failure to respond immediately to critical lab value & decline in health status including abnormally low BPs & failure to notify & inform physician of resident's changing status placed resident in immediate jeopardy*
- *Abatement Plan:*
  - *All current nurses, CMAs & CNAs & applicable agency staff educated on following:*
    - *How to ID & respond to changes in condition*
    - *Honoring resident/representative's right to direct own healthcare*
    - *Notification of changes to resident, responsible party & physician*
    - *How to respond, according to standard, r/t critical labs*
    - *BP parameters & when to notify or act*
  - *All current residents had chart review no later than 8-22 to ensure BP parameters were noted within clinical record supervised by DON with oversight by Regional Nurse Consultant*
  - *All current resident who had clinical order for fluid monitoring would have additional task added to record-to-record fluid intake*
  - *All current residents had chart reviews completed by 8-22 to ensure currently ordered labs were in clinical record & full assessment to ID labs were drawn, report was received, & resident, representative & physician were notified*

NE: SS=J (Abated to G): Failed to ensure 1 resident received care consistent with standards of practice when staff failed to report abnormal x-ray findings & obtain physician involvement for tx; on 6-4-24, resident had fall in facility's van; on 6-6 resident c/o right shoulder pain & staff obtained order for x-ray; x-ray showed medial subluxation (dislocation) of right glenohumeral joint; staff ailed to notify resident's physician of results; on 6-27 after continued c/o right shoulder pain affecting resident's ADLs, staff obtained order for referral to orthopedic doctor; staff called to schedule appointment but did not follow up or ensure appointment was made for resident until 7-18-24 when staff received call from orthopedic physician's office for scheduled appointment on 7-31-24; at 7-31-24 appointment, orthopedic physician noted resident had anterior subluxation of humeral head with probably impaction fx of humeral head on right side & would required surgical repair; facility's failure to report abnormal x-ray findings to physician & delay in physician involvement in resident's injury placed resident in immediate jeopardy

- *EMR lacked evidence facility followed up with orthopedic office to schedule appointment for referral from 6-28-24 to 7-17-24; EMR lacked evidence facility followed up with pulmonologist's office to schedule appointment for referral from 8-6-24 to 8-14-24;*
- *Abatement Plan:*
  - *LN educated on physician recommendations & order follow-ups including appointments & all LNs educated prior to next shift*
  - *LNs educated on post-incident follow-up & all LN's education prior to next shift*
  - *LNs educated on pain management & observation &all LNs educated prior to next shift*

- *LNs educated on physician notifications to include abnormal diagnostic testing & all LNs educated prior to next shift*
- *All current staff educated on ANE*
- *Staff notified resident's physician to review pain meds to ensure pain control for resident*
- *Ad-hoc QAPI meeting with facility's medical director occurred*

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

SW: SS=D: Failed to use effective infection control practices when providing wound care to 1 resident who admitted with PU with potential to inhibit wound healing

- Resident admitted with PU with orders for wound tx; observed LN donned gloves & pulled dressing off wound & resident incontinent of bowel; LN cleansed rectal area, removed gloves, used hand sanitizer, then replaced gloves, cleaned wound but before redressing resident continued to have BM & LN wiped BM from resident & without changing gloves & continued to provide wound care; failed to use infection control practices when providing wound care to resident that had PU

NE: SS=G: Failed to provide 1 resident with wound care consistent with standards of practice when staff failed to ensure physician involvement for wound status changes & appropriate treatment orders & failed to assess wound characteristics consistently & when treatment changes were made; failures resulted in deterioration of wound & worsening of infectious process & also placing resident at risk for increased pain & other wound-related complications

- *CP documented resident with stage 4 PU to sacrum with intervention with initiated date of 7-23-24 & resident with wound vac to sacral wound & staff to change wound vac 3x/wk & PRN; CP with wound assessment weekly with details of assessment reporting improvements & declines to physician & administered ordered treatments; & dressing assessment q shift with reporting parameters; resident developed infection of sacral wound; EMR lacked order or dressing instructions to staff in event wound vac malfunctioned or could not be placed; MAR/TAR lacked evidence dressing applied when initially ordered; MAR/TAR recorded dressing first applied 3 days after order & then DC'd 2 days later; EMR lacked evidence physician contacted or made aware of resident's complications r/t wound vac & new dressing change order on day wound vac was DC'd; weekly skin evals lacked required descriptive assessment information; resident with change in status with decline in alertness, BP dropped & pulse increased & resident refused to eat or drink & coccyx black in color with strong, foul smell & physician ordered ER eval & treat; ER documented possible sepsis; phone interview with nurse for physician stated reviewed all call logs & stated no logged calls on day of admission; hospital staff reported wound was "really bad" & showed signs of neglect & confirmed resident transferred to another hospital for higher level of care; failed to provide 1 resident wound care consistent with standards of practice when staff failed to ensure physician involvement for wound status changes & appropriate treatment orders, & failed to assess wound characteristics consistently & when tx changes were made resulting in deterioration of wound & worsening of infectious process placing resident at risk for increased pain & other wound-related complications*

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=D: Failed to provide safe transfers for 2 residents & failed to provide safe w/c transport for 1 resident

- Resident with dementia & required supervision to touching assist with chair to bed transfers; CP instructed staff resident required substantial assist of 2 staff for transfers & resident to wear non-skid socks during transfers; observed transfer & resident unable to bear weight during transfer & lacked non-skid footwear & resident's legs became twisted & feet slid on floor during transfer; LN confirmed staff should use full body mechanical lift for residents unable to bear weight during transfer; failed to safely transfer dependent resident
- Resident with dementia & MDS documented resident required substantial/maximal assist of staff for transfers & had no limitation in functional ROM; CP instructed staff resident required substantial assist of 2 staff for transfers & staff were to ensure resident wore non-skid footwear; observed 2 staff transferred resident from bed to specialized w/c with extensive assist; resident lacked nonskid footwear, was unable to bear weight & feet slid on floor during transfer & staff failed to use gait belt; failed to safely transfer dependent resident
- CP instructed staff to remove foot pedals from w/c when staff not propelling resident; EMR documented resident was dependent on staff for mobility in w/c; observed CNA propelled resident & foot pedals were in place but resident had shoed feet pulled back under w/c with tips of toes skimming floor on multiple occasions; failed to safely transport dependent resident in w/c

SW: SS=E: Failed to provide a secure door to maintenance shop area located in main hallway that led to resident units & sop contained multiple labeled hazardous chemicals; failed to provide environment that remained free from accident hazards for 1 resident when facility failed to appropriately place electric cord for resident's lamp & approx. 5-foot cord extended in front of resident's window on carpeted floor between resident's recliner & dresser that could have potential to result in injury, furthermore, resident had fall resulting in hip fx

- Failed to provide a secure door to maintenance shop area located in main hallway leading to resident units & failed to keep hazardous chemicals from confused, self-mobile residents of facility; further ore, facility failed to have functional alarm on unsecured door that led to outside with potential result in resident injury
- Failed to provide environment that remained free from accident hazards for 1 resident when facility was aware resident's furniture surfed & failed to appropriately place electric cord for resident's lamp where it would not be a fall hazard; approx. 5-foot cord extended in front of resident's window on carpeted floor between resident's recliner & dresser that could have potential to result in injury

NE: SS=G (Past Non-Compliance): Failed to ensure 1 resident remained free from preventable accidents during Hoyer lift transfer resulting in impaired psychosocial wellbeing & placed resident at risk for further complications

- *Resident with AKA & hemiplegia affecting right dominant side; CP documented resident required total assist with Hoyer lift to move between surfaces; CNA stated CNA & CMA hooked resident up to Hoyer lift & 1 of lift sling leads came unattached & thought it had ripped then resident fell out of sling & staff quickly got resident off Hoyer lift to make sure resident was okay & notified nurse & called EMS; investigation revealed staff put resident in lift & as started to turn around to resident in shower chair, 1 side of lift sling snapped & resident*

tipped while another sling loop slid off & resident fell to ground & back landed on lift & arm bled & resident c/o back pain but did not move resident until ambulance arrived; resident expressed fear of using lift in future; failed to ensure resident remained free from preventable accidents during Hoyer lift transfer resulting in impaired psychosocial wellbeing & placing resident at risk for further complications

- *Abatement Plan:*
  - *Updated resident's CP*
  - *Maintenance inspected Hoyer lift*
  - *PT evaluated resident*
  - *Direct care staff received mechanical lift, fall prevention & abuse education*

NE: SS=G: Failed to prevent accidents for 1 resident when on 6-4 during van transport to appointment, resident's seatbelt came unfastened & electric w/c tipped towards right to lift gate & resident hit right arm/shoulder on lift gate; resident complained of right shoulder pain on 6-6 & facility obtained x-ray resulting in medial subluxation of resident's right glenohumeral joint

- *Cited findings noted in F684; witness statement documented transportation aide anchored & buckled resident's chair in van to transport resident to appointment & when turned at stop sign, resident's chair tipped over, resulting in skin tear; transportation checked on resident & bandaged skin tear & had resident stand up so staff could get resident's w/c upright; Monthly Vehicle Inspection Report dated 8-19-24 documented safety belts/tether all worked but 1 "sticks" & staff had to make sure it clicked into place; failed to prevent accidents for 1 resident when on 6-4-24 during van transport to appointment, resident's seatbelt came unfastened; electric w/c tipped towards right to lift gate & resident hit right arm/shoulder on lift gate; resident c/o right shoulder pain on 6-6 & facility obtained x-ray resulting in medial subluxation of resident's right glenohumeral joint*

F690 Bowel/Bladder Incontinence, Catheter, UTI

SW: SS=D: Failed to provide proper care to prevent urinary infection for 1 resident when staff failed to properly handle urinary catheter collection bag to ensure bag remained below level of bladder to prevent urine backflow & development of UTI

- Failed to properly place urinary catheter below level of bladder to prevent backflow of urine into bladder & risk of causing UTI

NW: SS=D: Failed to provide adequate catheter care per standards of practice for 1 resident's urinary catheter placing resident at risk for UTI & other catheter-related complications

- Resident suprapubic catheter; with hospitalization r/t 2 UTIs; observed resident in recliner with catheter drainage bag on inside of trash can with multiple used tissues; Observed catheter care & CNA washed hands & gloved but did not don gown then CNA set urinal canister inside trash can on top of used tissues then CNA held catheter bag over canister & emptied it then wiped port with moist wipe then alcohol pad & after emptying cannister rinsed canister with water & stored it in cabinet; failed to provide adequate catheter care for 1 resident's urinary catheter placing resident at risk for further UTI & catheter-related complications

F694 Parenteral/IV Fluids

NE: J (Abated to D): Failed to provide appropriate treatment & care for 1 resident's PICC including monitoring resident's status for complications & providing a sterile dressing change per standards of care for PICC at least every 7 days

- *Resident admitted to facility on 7-12-24 with PICC line in place for administration of IV ABT; record lacked evidence that staff had changed resident's PICC dressing while in facility; on 8-19-24 resident went to hospital for possible sepsis; hospital staff ID'd resident's PICC dressing was 38 days old; staff's failure to provide ongoing monitoring of dressing status, failure to ID lack of dressing orders as well as failure to provide sterile dressing change for over 5 weeks placed resident in immediate jeopardy; CP lacked evidence of dressing changes r/t PICC line; EMR lacked evidence of order to change resident's PICC line dressing; MAR lacked evidence 250cc NS administered as initially ordered; MAR lacked evidence PICC flush administered as ordered on 2 occasions*
- *Abatement Plan:*
  - *Halted admission immediately of any resident who would require a PICC line or other IV as part of care until re-education with all current LNs completed & return competency demonstrated with responsibility assigned to DON/designee with Regional Consultant Nurse ensuring competency of DON prior to educating staff*

F695 Respiratory/Tracheostomy Care & Suctioning

SE: SS=D: Failed to obtain physician's order for use of CPAP for 1 resident

- CP lacked staff instruction on use & care of resident's CPAP; EMR lacked physician order & indication for CPAP; observed resident in room & CPAP mask inside plastic bag on table next to resident's recliner & mask with dried white substance & remained connected to hose of machine; failed to obtain physician order for use of CPAP machine for dependent resident with dx of sleep apnea & failed to ensure mask was clean/changed according to professional standards to prevent possible respiratory illness

SW: SS=D: Failed to properly clean & store nebulizer for 1 resident; additionally failed to obtain physician's order to administer O2 to 1 resident & replace contaminated cannula for resident with potential to have negative impact on residents' physical & psychosocial wellbeing

- POS lacked documentation r/t administration of O2; failed to obtain physician order to administer O2 to resident & replace contaminated cannula for resident with potential to have negative impact on resident's physical & psychosocial wellbeing
- CP lacked documentation r/t O2 use or nebulized medication; failed to date O2 & nebulizer tubing changes

F699 Trauma Informed Care

NW: SS=D: Failed to ensure 1 resident received trauma-informed care to eliminate or mitigate triggers that may result in re-traumatization placing resident at risk for unmet mental healthcare needs & impaired psychosocial well-being

- Resident with PTSD, generalized anxiety d/o, major depressive d/o, urinary retention & cardiac murmur; POS for antipsychotic, antidepressant; POS for Clonazepam for verbal expressions of anxiety, religious doubts & isolation r/t PTSD; CAN unaware of resident's PTSD dx or what triggers were; LN unaware of triggers; CP lacked trauma triggers; failed to ensure resident received trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization placing resident at risk for unmet mental healthcare needs

F755 Pharmacy Services/Procedures/Pharmacist/Records

SW: SS=E: Failed to ensure 12/20 residents received meds from 7-21-24 from 6pm to 7-22-24 at 6am when LN failed to administer meds as ordered by physician

- Investigation report revealed facility employed LN from agency to work 7-21-24 from 6p to 7-22-24 6am in 1/3 houses for 20 residents; found many meds not administered to residents during shift & LN had "weird behavior" review found med & tx errors for 15/20 residents residing in house; failed to ensure 15/20 residents received meds as ordered for 1 12 hour shift when LN failed to administer meds as ordered by physician

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NW: SS=D: Failed to ensure approved indication for use or required physician documentation as well as ongoing monitoring for effectiveness & ongoing necessity for use of antipsychotic drugs & psychotropic drugs for 1 resident & failed to ensure a stop date for PRN Lorazepam placing 2 residents at risk for unnecessary antipsychotic & psychotropic drugs & related side effects

- POS for Quetiapine q hs with "dx pending"; POS for Sertraline ad for "dx pending"; behavior monitoring lacked specific targeted behaviors for use of antipsychotic & sertraline & documented no behaviors observed since admission; failed to ensure 1 resident had CMS-approved indication for use of Quetiapine or required physician documentation & failed to monitor for targeted behaviors to determine effectiveness & ongoing necessity of psychoactive meds placing resident at risk of receiving unnecessary antipsychotic & psychotropic drugs
- Resident with anxiety & dementia; POS for Lorazepam oral concentrate q 2 hrs PRN for anxiety & order lacked stop date; EMR lacked evidence of specified duration including rationale for extended use; MRR lacked physician response for recommended stop date; failed to ensure 1 resident's Lorazepam had 14-day stop date or specified duration placing resident at risk for adverse side effects

F759 Free of Medication Error Rates 5% or More

SW: SS=E: Failed to ensure 1 resident during med administration remained free of med errors; 25 med opportunities observed with 12 med errors placing resident at risk for adverse reactions from meds & resulted in med error rate of 48%

- Observed CMA prepared meds; CMA performed hand hygiene & verified all meds as prepared them; CMA spilled med cup that contained all resident's p.o. meds except for Oxycodone; 6 landed on floor & 4 landed on med cart top; CMA picked up all meds & placed them back in med cup & administered meds to resident; during administration CMA administered nasal spray which caused coughing & CMA administered w/o gloves & resident requested cough medication so CMA walked back to med cart & w/o hand hygiene prepared cough med liquid & administered to resident then went back to cart & started preparing another resident's meds w/o hand hygiene; failed to ensure 1 resident's meds were in sanitary manner; failed to ensure overall med error rate was below 5% with potential to have negative effect on overall physical & psychosocial wellbeing of residents in facility

F761 Label/Store Drugs & Biologicals

SW: SS=D: Failed to store meds properly for 3 residents, all of whom had over-the-counter meds stored in individual bedrooms; failed to screen residents for safety related med storage & safe self-medication administration

- Failed to provide proper storage of residents' meds in safe manner & failed to complete self-administration assessment for meds left in residents' rooms with potential to have negative effect on overall physical & psychosocial wellbeing of multiple residents in facility

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SW: SS=F: Failed to store, prepare, & serve food under sanitary conditions for residents of facility placing affected residents at risk for decreased palatability of food & foodborne illness

- Observed: dietary staff unable to locate thermometers in fridge & freezer; stand-alone fridge with foods lacking date, expiration dates or label of contents; freezer with foods open to air; freezer with undated, unlabeled foods/liquids; dry storage with items unlabeled, opened areas
- Observed fridge with 46 degrees F & staff stated temp should be 41 degrees F; freezer with unlabeled, undated items; open to air items; fridge with unknown, loaf of discolored lunch meat w/o open date, expiration date or label on contents;

F851 Payroll Based Journal

SE: SS=F: Failed to electronically submit to CMA with complete & accurate direct staffing information based on payroll & other verifiable & auditable data in uniform format according to specification established by PBJ r/t LN'ing staffing information when facility failed to accurately report 24 hr/day LN coverage on 8 dates between 4-1-23 & 6-30-23 & 5 days between 10-1-23 & 12-31-23

- Failed to electronically submit to CMA with complete & accurate direct staffing information based on payroll & other verifiable & auditable data in uniform format according to specification established by PBJ r/t LN'ing staffing information when facility failed to accurately report 24 hr/day LN coverage on 8 dates between 4-1-23 & 6-30-23 & 5 days between 10-1-23 & 12-31-23

F842 Resident Rights-Identifiable Information

SW: SS=E: Failed to maintain medical records on each resident that were complete, accurately documented, readily accessible for 7 residents when LN failed to document meds/treatments/assessments from 7-21-24 at 6pm to 7-22-24 at 6am

- Cited findings noted in F755 r/t agency nurse failed to administer meds or perform treatments during shift; failed to maintain medical records on each resident that were complete, accurately documented, readily accessible for 8 residents when LN failed to document meds/treatments/assessments during shift

F880 Infection Prevention & Control

SW: SS=E: Failed to maintain effective infection control program r/t sanitary manner meds administered & lacked proper hand hygiene during med administration with potential to spread possible infections to residents in facility

- Cited findings noted in F658, & F759 r/t CMA dropping meds & picking up & administering contaminated meds; failed to ensure resident's meds were administered in sanitary manner with potential to have negative effect on overall physical & psychosocial wellbeing of resident in facility

NW: SS=F: Failed to implement a water management program for Legionella disease & other waterborne pathogens; further failed to implement EBP when providing high-contact care to 1 resident placing residents at risk for infectious diseases

- Maintenance staff verified unaware of any routine facility water management checks & verified facility had some rooms presently unoccupied & did not flush water in unoccupied rooms; Adm nurse verified facility lacked system to check r/t standing water & potential growth inside facility & lacked system to mitigate risk of Legionella; failed to implement water management program to test & manage waterborne pathogens placing residents who resided in facility at risk for contacting Legionella disease
- Cited findings in F690 r/t lack of EBP during suprapubic catheter care; failed to provide adequate infection prevention during care for 1 resident's urinary catheter placing resident at risk for infection

F941 Communication Training

NE: SS=F: Failed to ensure CNA received required effective communication education placing residents at risk for impaired care

- *Cited findings noted in F600 r/t staff to resident abuse incident of throwing ice & yelling after resident made racial slurs to CNA; facility unable to provide documentation that CNA completed education on effective communication from facility as required; failed to ensure CNA received required effective communication education placing residents at risk for impaired care*

September, 2024

F550 Resident Rights/Exercise of Rights

SW: SS=D: Failed to provide 1 resident care in dignified manner during colostomy care

- Resident lying in bed for 40 minutes with door open, undressed waist up & no colostomy bag covered stoma placing resident at risk for decreased psychosocial wellbeing; failed to provide 1 resident care in dignified manner during colostomy care when resident was left lying in bed for 40 minutes with door open, undressed waist up & no colostomy bag covered stoma placing resident at risk for decreased psychosocial wellbeing

F553 Right to Participate in Planning Care

SW: SS=D: Failed to include 1 resident for development & continued planning of resident's CP quarterly placing resident at risk for impaired care & services with potential to lead to negative psychosocial effects r/t safety & uncommunicated needs

- Notes lacked documentation r/t resident's CP meeting or if resident had been invited to or attended a meeting; resident with BIMS 15 stated had never been invited to CP meeting or attended a CP meeting since admission; failed to include resident to CP meetings placing resident at risk for inadequate care & services with potential to lead to negative psychosocial effects r/t safety & uncommunicated needs

F567 Protection/Management of Personal Funds

SW: SS=D: Failed to ensure 1 resident received monthly benefits when requested funds

- Resident stated requested monthly benefits of $62 prior to him leaving facility for dialysis appointment & when returned, facility there was no check waiting for him & Adm staff gone for day; CMA, LN, SSD reported unaware of any money for residents to have available when business office was closed; failed to ensure resident received monthly benefit in timely manner with potential to have negative effect on overall physical & psychosocial wellbeing of resident in facility

F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive

SW: SS=E: Failed to ensure 4 residents had accurately completed advance directives; 1 resident had DNR in event of cardiac only signed by physician; 1 resident had 2 DNRs, 1 signed by guardian only & other signed only by physician; 1 DNR not signed by witness & 1 resident's DNR only signed by physician

- Failed to ensure resident had accurately completed advance directive with potential to lead to uncommunicated needs specifically to end-of-life care for multiple residents

F582 Medicaid/Medicare Coverage/Liability Notice

SW: SS=D: Failed to ensure correct & complete Beneficiary Protection Notification forms were issued to 1/3 residents reviewed

- Review of SNF ABN & NOMNC both lacked resident's signature before discharge home; option 3 checked to reflect "I don't want the care listed above…"box was marked off with "X" with handwritten comment on both forms "Resident discharged from facility before signature

was received"; forms only signed by SSD; failed to ensure correct & complete Beneficiary Protection Notification forms were issued to resident as required

F623 Notice Requirements Before Transfer/Discharge

SW: SS=E: Failed to provide written notification to representatives of 5 residents; additionally, facility also failed to notify LTC Ombudsman placing residents at risk for impaired rights & uninformed care choices & had potential to lead to uncommunicated needs r/t continuity of care across healthcare spectrum

- Failed to provide written notification to representatives & LTC Ombudsman when resident required hospitalization placing resident at risk for impaired rights & uninformed care choices & had potential to lead to uncommunicated needs r/t continuity of care across healthcare spectrum for multiple residents

F625 Notice of Bed Hold Policy Before/Upon Transfer

SW: SS=E: Failed to provide a bed hold notice to 4 residents &/or representatives with written notice specifying duration of bed-hold policy at time of residents' transfer to hospital

- Failed to provide a bed hold notice to residents/representatives specifying duration of bed hold policy at time of resident's transfer to hospital for multiple residents; failed to provide bed hold notice to multiple residents/representatives specifying duration of bed hold policy at time of residents' transfer to hospital for multiple residents

F636 Comprehensive Assessments & Timing

SW: SS=E: Failed to complete CAAs that addressed individual underlying causes, contributing factors & risk factors for 5 residents; 2 residents had incomplete & repetitive documentation; additionally, 1 resident, all CAA notes documented resident was deceased when resident was still a resident in facility; 1 resident had no CAA notes for 2 triggered categories

- Failed to accurately complete CAAs fro1 resident r/t functional abilities, urinary incontinence, nutritional status & pressure ulcer/injury placing resident at risk for uncommunicated care needs
- Failed to accurately complete CAAs for resident r/t functional abilities, urinary incontinence, nutritional status & pressure ulcer/injury placing resident at risk for uncommunicated care needs
- Failed to accurately complete CAAs for resident r/t functional abilities, urinary incontinence, nutritional status & pressure ulcer/injury placing resident at risk for uncommunicated care needs
- Failed to accurately complete CAAs for resident r/t cognitive/dementia, visual function, communication, urinary incontinence & indwelling catheter, psychosocial wellbeing, behavioral symptoms, PU/injury, psychotropic drug use or pain placing resident at risk for uncommunicated care needs

F641 Accuracy of Assessments

SW: SS=D: Failed to accurately complete MDS for 2 resident r/t falls; additionally, 1 resident for dentition placing residents at risk for uncommunicated care needs

- Failed to accurately complete MDS for 1 resident r/t falls & dentition placing resident at risk for uncommunicated care needs
- Failed to accurately complete MDS for 1 resident r/t falls placing resident at risk for uncommunicated care needs

F657 Care Plan Timing & Revision

SW: SS=D: Failed to review & revise CPs with appropriate interventions for 4 residents;1 resident r/t physician ordered intervention, 1 resident r/t treatment of area of PU/injury; 2 residents r/t development & implementation of appropriate interventions to prevent multiple falls for resident r/t continued use of power lift chair or develop any new interventions for 1 resident resulting in uncommunicated care needs

- Resident with multiple falls; Resident with fall intervention but lacked evidence of implementation of intervention r/t smaller recliner with more appropriate fit; CP intervention to provide frequent rounding but facility lacked evidence of implement of intervention; some falls w/o immediate interventions; failed to review & revise & implement appropriate interventions after multiple falls to provide environment free of accident hazards for dependent resident with severely impaired cognition & known hx of repeated falls; resident fell 2x & was injured, fell again multiple times with injury & some w/o injury
- Failed to revise 1 resident's CP after physician ordered CAM boot or post-op shoe placing resident at risk for uncommunicated care needs with potential to have negative effect on overall physical & psychosocial wellbeing of resident in facility
- Failed to revise 1 resident's CP with PU tx's & changes of PU placing resident at risk for uncommunicated care needs with potential to have a negative effect on overall physical & psychosocial wellbeing of resident in facility

F660 Discharge Planning Process

SW: SS=D: Failed to implement a discharge plan for 1 resident being discharged from facility; discharge planner failed to involve resident with discharge planning process

- Failed to implement a discharge plan for 1 resident being discharged from facility; discharge planner failed to involve resident with discharge planning process placing resident at risk for decreased psychosocial wellbeing & uncommunicated needs

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

SW: SS=G: Failed to provide a pressure reducing device on bed to prevent a pressure injury for 1 resident; on 7-11-24 facility noted resident's previous pressure injuries were all closed; on 7-12-24 resident moved to different room & facility failed to move air mattress for bed to new room; on 7-24-24 resident's heel pressure injury re-opened & was IDd as stage 3 pressure injury placing resident at risk to worsen PUs & delayed healing

- Failed to place interventions to prevent pressure injuries for 1 resident who developed 2 preventable, facility-acquired stage 3 pressure injuries placing resident at risk to worsen current PU or develop more skin issues

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=G: Failed to provide an environment free of accident hazards for residents of facility when facility failed to properly store chemical in unlocked cabinet in an unlocked room & when facility stored chemicals along rail in hallway; additionally, failed to ensure 1 resident who as ID by facility as confused & independently mobile with aggressive & wandering behaviors remained free of accident hazards when resident put scissors in pocket & wandered inside facility; furthermore, facility failed to ensure 2 residents remained free of accident hazards r/t falls when facility failed to appropriately investigate, develop & implement appropriately investigate, develop & implement appropriate interventions to prevent multiple falls for 1 resident r/t continued use of powered lift chair or develop any new interventions for 1 resident resulting in resident falling & sustaining fx humerus 4th rib which required hospitalization

- Failed to implement interventions after multiple falls to provide environment free of accident hazards for dependent resident with severely impaired cognition & known hx of repeated falls; resident fell 8x's resulting in actual harm to physical & psychosocial wellbeing of resident
- Failed to provide environment free of accident hazards when facility failed to appropriately store hazardous chemicals
- Failed to ensure resident, a resident facility IDd as confused & independently mobile with aggressive & wandering behaviors when resident put scissors in pocket & wandered inside facility placing resident at risk for self-injury as well as residents of facility at risk for potential of harm r/t unsecured sharp objects
- Failed to assess if resident was safe to use a power lift chair & failed to thoroughly investigate to determine contributing factors & causes of falls to ensure appropriate interventions to prevent further falls for resident with repeated falls

F695 Respiratory/Tracheostomy Care & Suctioning

SW: SS=E: Failed to properly clean, label & store nebulizer for 1 resident in accordance with standards of care & failed to follo up on BiPAP physician order; in addition, facility failed to date O2 tubing for 5 residents

- Failed to provide respiratory care consistent with professional standards of care for 1 resident r/t use & cleaning of nebulizer equipment & O2 supplies were not labeled
- Failed to provide respiratory care consistent with professional standards of care for 1 resident r/t use & cleaning of CPAP equipment & O2 supplies not labeled
- Failed to provide respiratory care consistent with professional standards of care for 1 resident r/t use of O2 supplies that were unlabeled
- Failed to provide respiratory care consistent with professional standards of care for 1 resident r/t O2 supplies that were not labeled

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

SW: SS=F: Failed to complete annual performance review at least 1x q 12 months for 5 CNAs reviewed to ensure adequate appropriate cares & services provided to residents of facility

- Review of employee files revealed lack of performance evals signed by management for 5/5 CNAs that had been employed over 1 year; Adm stated unaware that annual performance evals for CNA staff was a requirement; failed to complete annual performance review at least once every 12 months for 5 CNAs reviewed to ensure adequate appropriate care & services provide to resident of facility with potential to negatively affect physical & psychosocial wellbeing of all residents in facility

F732 Posted Nurse Staffing Information

SW: SS=C: Failed to display accurate & identifiable staffing information daily for all residents in facility

- Observed daily staffing sheets on wall & nurse staff information lacked facility name & daily resident census; failed to display accurate & identifiable staffing information daily for all residents in facility

F761 Label/Store Drugs & Biologicals

SW: SS=F: Failed to provide a safe environment by failure to ensure nurse tx cart containing insulin, topical ointments & creams & narcotics that were in locked box within nurses' tx cart remained locked when not in direct line of vision of nurse, in area where residents could access it

- Failed to provide safe environment for residents by failure to ensure tx cart remained locked when not in direct line of vision of LN passing meds from carts

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SW: SS=F: Failed to provide sanitary conditions for food storage & dishes to prevent spread of foodborne illness to residents of facility

- Observed: stacks of bowls/plates stored in upright position that had potential to be exposed to splash, dust or other contamination; dry storage area multiple food items opened & undated; fridge with food open to air; dietary manager unable to provide current sanitation documentation & produce pack of testing strips & when tested water did not change color indicating insufficient amount of sanitizer
- Kitchen with 2 cutting boards with deep gouges & uncleanable surface
- Fridge measured 50 degrees F with milk, eggs, raw chicken, lunch meats & other foods

- Fridge temp logs with 26/124 holes, 35/124 temps above required temps; lacked temp log for fridge at 50 degrees F

F814 Dispose Garbage & Refuse Properly

SW: SS=F: Failed to maintain &/or dispose of garbage & refuse properly in sanitary condition to prevent harborage & feeding of pests

- Observed trash dumpsters with lids open & trash debris stuck out of dumpster; both lids broken & failed to completely cover trash cans; failed to provide sanitary garbage & refuse containers that were maintained with lids closed or otherwise covered with potential to lead to harborage & feeding of pest animals

F835 Administration

SW: SS=F: Failed to put in place effective administration who ensured facility was administered in manner that enabled it to use its resources effectively & efficiently to attain or maintain highest practicable physical, mental, & psychosocial wellbeing of each resident residing at facility

- Cited all other 22 deficiencies in survey

F880 Infection Prevention & Control

SW: SS=E: Failed to use EBP for 1 resident during wound care & 1 resident during urinary catheter care placing residents at risk for infection

- Failed to utilize proper PPE for EBP for 1 resident with hx of MDRO during wound care
- Failed to utilize proper PPE for EBP for resident with hx of MRSA during catheter care

F883 Influenza & Pneumococcal Immunizations

SW: SS=D: Failed to provide proper documentation of vaccination or declination of vaccines for COVID-19 or pneumococcal vaccines for 1/5 residents reviewed

- Failed to provide proof of vaccination of declination of vaccines for 1 resident

F908 Essential Equipment, Safe Operating Condition

SW: SS=F: Failed to ensure kitchen's double-door oven was in safe operating condition

- Failed to maintain mechanical equipment in safe operating condition

F947 Required In-Service Training for Nurse Aides

SW: SS=F: Failed to develop, implement & permanently maintain an in-service training program for CNAs with required training topics; 2/5 CNAs sampled lacked required 12 hours per year of in-service training

- Failed to develop, implement & permanently maintain in-service training program for CNAs with required topic & no less than 12 in-service training hours per year