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

July, 2024

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=G: Failed to ensure 1 resident's safety during a transfer when CNA & LN used Hoyer lift to transfer resident form bed to w/c; during transfer, lift tipped & resident hit back of head on dresser & as result resident sustained laceration to back of head that required staples & sutures to close placing resident at risk for pain & other avoidable injuries

- *Fall note documented CNA & LN used Hoyer lift to transfer resident from bed to w/c & Hoyer lift tipped in middle of transfer & CNA & LN lowered resident to floor & on way down, back of resident's head hit corner of dresser; resident suffered laceration to back of head r/t fall & transported to ER; ER note documented resident required 7 staples & 3 sutures to back of head; Adm nurse stated unsure if staff completed Hoyer lift training prior to resident's fall from lift; LN stated unsure what caused lift to tip; failed to ensure resident's safety during transfer when CNA & LN used Hoyer lift to transfer resident from bed to w/c & during transfer lift tipped & resident hit back of head on dresser & as result resident sustained laceration to back of head that required staples & sutures to close placing resident at risk for pain & other avoidable injuries*

NE: SS=D: Failed to ensure 1 resident received adequate supervision & appropriate interventions to prevent resident from exiting facility placing resident at risk for accidents or injuries

- *CP documented resident with hx of attempting to leave facility; Record lacked any documentation of resident's elopement incident; LN documented notified of resident outside with CMA & door alarm sounding; resident brought back into building & returned to assigned unit; observed gate in courtyard with no locking mechanism on gate; failed to ensure 1 resident received adequate supervision & appropriate interventions to prevent resident from exiting building w/o staff knowledge & w/o staff placing resident at risk for accidents or injuries*

August, 2024

F550 Resident Rights/Exercise of Rights

SE: SS=D: Failed to show respect & dignity to 2 residents by failing to cover resident's bare lap leaving silicone portion of indwelling urinary catheter visible to others while in DR & for 1 resident for failure to use dignity cover for collection leg bag of resident's indwelling urinary catheter while in DR & common area

- Failed to use dignity cover for dependent resident's catheter bag, making bag, containing urine, visible to others in DR & common area of facility
- Failed to ensure staff maintained resident's dignity when resident unknowingly exposed self & urinary catheter in common living areas

NE: SS=D: Failed to promote a dignified care environment for 1 resident during mealtime placing resident at risk for impaired dignity & decreased psychosocial wellbeing

- Observed resident in dining area & gown open in back exposing backside, excluding buttocks to peers & visitors on multiple occasions; failed to promote a dignified care environment for resident during mealtimes placing resident at risk for impaired dignity & decreased psychosocial wellbeing

NE: SS=D: Failed to ensure 1 resident's urinary catheter drainage bag was placed in privacy bag placing resident at risk for impaired dignity & decreased psychosocial wellbeing

- Failed to ensure 1 resident's urinary catheter drainage bag was placed in privacy bag placing resident at risk for impaired dignity & decreased psychosocial wellbeing

NW: SS=D: Failed to promote dignity for 1 resident when staff called resident "honey" multiple times instead of addressing resident by proper name placing resident at risk for undignified care & services

- CP lacked evidence resident preferred to be called "honey"; failed to promote dignity for 1 resident when staff called resident "honey" multiple times instead of addressing resident by proper name placing resident at risk for undignified care & services

F553 Right to Participate in Planning Care

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

- Resident reported had never been given opportunity to participate in CP & felt it was important to be in on CP; failed to include resident in development & planning of resident's CP quarterly placing resident at risk of impaired care & autonomy

F557 Respect, Dignity/Right to Have Personal Property

SW: SS=D: Failed to ensure resident's right to retain & use personal possessions for resident r/t motorized w/c & 1 resident's missing coat

- Resident verbalized wanted to use electric w/c & staff would not allow resident to have electric w/c; staff confirmed that resident could not have access to electric w/c; Failed to ensure resident right to retain & use personal possessions r/t motorized w/c
- Resident reported topcoat missing; failed to ensure resident received personal property back in timely manner placing resident at risk for decreased psychosocial wellbeing

F558 Reasonable Accommodations Needs/Preferences

SE: SS=D: Failed to ensure reasonable accommodation of resident's needs when facility failed to follow up on recommendations for different w/c which would meet resident's physical needs & preference to maintain independence

- Resident with MS, contractures & anxiety d/o; CP documented resident uses electric w/c; 17 months prior OT eval & treat documentation included resident & clinician to participate in seating & positioning assessment to determine resident's w/c needs; resident's current electric w/c donated to resident years ago; record lacked documentation or follow up r/t assessment recommendation for specific w/c for seating & positioning; representative stated had contacted facility Adm multiple times r/t resident obtaining electric w/c to meet resident's needs; therapist stated tried to get resident new w/c in March 2023 which would benefit resident; failed to ensure reasonable accommodation of resident's needs when facility failed to follow up on recommendations for different w/c which would meet resident's physical needs & preference to maintain independence

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

- Failed to ensure 1 resident's call light was within reach leaving resident at risk for unmet care needs

F559 Choose/Be Notified of Room/Roommate Change

NE: SS=E: Failed to inform 9 residents in writing of impending room change in order to create a hall to group skilled residents placing residents at risk for impaired resident rights & decreased psychosocial wellbeing

- *Failed to inform 9 residents in writing of impending room change to create a hall to group skilled residents placing residents at risk for impaired resident rights & decreased psychosocial wellbeing*

F561 Self-Determination

SW: SS=E: Failed to provide choices r/t resident's bathing preferences for 4 residents r/t bathing

- Failed to provide choices & accommodate resident's preferences/choices r/t bathing r/t staff assigned bathing times by master bathing schedule for multiple residents; multiple residents stated didn't get scheduled showers
- Failed to provide choices & accommodate residents' preferences r/t resident's bathing, grooming & personal hygiene
- Failed to provide resident with preference choices for bath days & times of bathing

F580 Notify of Changes (Injury/Decline/Room, etc)

SE: SS=D: Failed to notify physician timely r/t lack of monthly catheter changes & failed to assess, document, & notify physician with change in condition when staff alerted LN of swelling & redness to resident's penis & scrotum on 8-14-24 at 9pm; on 8-15-24 at 3:52pm, over 18 hours later; resident required emergency medical transport for further evaluation & treatment

- *NN lacked notification to physician r/t catheter change not administered after resident "refused" catheter change for 3 months & as of 8-7-24, last catheter change was 4-15-24 & facility failed to notify physician catheter not changed each month; failed to notify physician timely r/t lack of monthly catheter changes for 3 months; failed to assess resident & notify physician of resident's condition changes timely on 8-14-24 then went over 18 hours at which time resident required emergency medical transport for further evaluation & treatment*

SE: SS=D: Failed to notify resident's chosen representative when resident required new form of treatment, r/t resident's newly diagnosed scabies infestation

- Failed to notify resident's representative when need to commence new form of treatment r/t resident's newly diagnosed scabies infestation

F582 Medicaid/Medicare Coverage/Liability Notice

SW: SS=D: Failed to notify 1 resident ABN or NOMNC as required

- Failed to provide 1 resident forms on ABN & NOMNC 3 days before discharge as required

NW: SS=D: Failed to provide correct CMS Form 10055 SNF ABN which included estimated cost to continue services for skilled services to resident/representative for 3 residents placing all 3 residents at risk for uninformed decisions r/t skilled services

- Observed facility ABN form provided was CMS-R-131; failed to provide 3 residents correct SNF ABN form CMS 10055 as required placing all 3 residents at risk for uninformed decisions r/t skilled services

F584 Safe/Clean/Comfortable/Homelike Environment

SW: SS=E: Failed to provide a safe, functional, sanitary & comfortable environment for all residents that smoked in 3/3 designated smoking areas & service hallway residents had to travel thru to 1 smoking area that needed cleaning & /or repairs

- Observed stale, musty odor prevalent odor throughout facility during initial tour; observed 1 smoke area with ashtray/tower bent over & cracked & cigarette butts discarded on ground
- Resident stated had to use w/c to navigate hallway to smoking area & could not use feet to self-propel w/c to smoking area & had to use hands to propel w/c & long way from room to smoke area & resident reported smoking area not clean or maintained although staff provided supervision at each smoke break
- Observed smoke area with strong smoke odor in hallway; area by vending machines lacked floor tiles in front of drink machines; missing pain & unsealed chair rails; cracked ceilings; chair rails chipped & exposed raw wood; missing floor tiles & garbage on floor & floor with black grime build up; failed to provide safe, functional, sanitary & comfortable environment for all residents that smoked in 3/3 smoking areas & service hallway leading to smoke area

NW: SS=D: Failed to perform weekly skin assessments & follow up documentation of non-pressure related skin issues found for 1 resident placing resident at risk for further skin issues

- EMR with no follow up note or assessment of skin issue noted on 7-1-24 r/t open wound on lower leg below knee & site oozing clear fluid & nurse covered with 2x2 gauze & band aid; EMR w/o follow up on future assessments; failed to perform weekly skin assessments & follow up documentation of skin issues found on 1 resident placing resident at risk for further skin issues due to lack of routine skin assessments & follow up of ID'd skin issues

F600 Free from Abuse & Neglect

SE: SS=D: Failed to ensure dependent & cognitively impaired resident who had dx of dysphagia, oropharyngeal phage & ileus remained free from neglect when CMA continued to administer resident's morning meds despite resident's request to slow down because resident was having a difficult time swallowing; when CMA left room, CMA told resident, "There you're done now you CNA quit your crying"

- *Failed to ensure dependent & cognitively impaired resident remained free from neglect when CMA continued to administer meds in applesauce, despite resident's request to slow down because resident was having a difficult time swallowing, witnessed by housekeeping aide, CNA & outside resource staff & when CMA left room CMA told resident "there, you're done now you CNA quit your crying"*

SW: SS=J (Past Non-Compliance): Failed to prevent neglect of cognitively impaired resident who had mental health d/o, anger r/t living in facility & hx of exit seeking

- Staff did not respond to suicidal ideation statements after elopement; on 6-29-24 resident eloped from facility; when staff returned resident to facility placed WanderGuard on resident & resident reported would "never eat again"; on 6-30-24 resident made statements such as "give me a gun so I CNA shoot myself"; at 10pm resident reported was being held against wishes; on 7-3-24 resident reported would to eat until someone came back to talk about him being dismissed; on 7-8-24 staff assessed resident for exit seeking behaviors & continued 15-minute checks for 24 hours; on 7-15, new orders to increase Seroquel to TID; on 7-22-24 at 3:30pm staff found resident had hung self in room with TV cable on closet door frame placing resident in immediate jeopardy; failed to prevent neglect of cognitively impaired resident with known mental illness & anger r/t placement in facility when staff failed to respond to suicidal ideation comments after elopement placing resident in immediate jeopardy & resident hung self with cable cord from closet door
- Past Non-Compliance Plan:
    - Ad Hoc QAPI meeting held by IDT
    - Adm notified Medical Director
    - VP of Clinical Operations re-educated Adm & DON on community process for recognizing signs/symptoms of suicide
    - Corp Director of Clinical Reimbursement educated Adm, SS, DON r/t community process of SS comprehensive assessment & trauma informed care assessment; education included intended scheduled, psychosocial CP
    - Current associates will be re-educated by community by Adm/designee or prior to working next scheduled shift in community; trauma informed care process with specific focus on ID of suicidal symptoms & suicidal ideation, required notifications & immediate actions
    - SS comprehensive assessments completed on admission, annually & with significant change; assessment documented in record
    - Residents IDd with need for trauma preventative services will have trauma informed assessment at admission, annually & with ID'd significant change in condition; assessments will be documented in record; CP updated as indicated
    - Routine angle rounds completed by assigned IDT members routinely & will include staff members interviews to validate understanding of resident suicide awareness & notification requirements; results of angel rounds reported during routine morning stand up meetings
    - Weekly risk meetings review clinical record of newly admitted residents or residents IDd change in condition to validate completion of required SS assessments &/or trauma informed care evals & review documented in record
    - Adm/designee routinely review sampled selected residents x next 60 days to validate compliance of: completion of SS assessment, completion of trauma informed care assessments, psychosocial CP present including resident specific interventions based on assessment findings; & any noted suicidal ideation as indicated
    - Monthly review weekly risk review & angle rounds results & trends completed by Adm/designee & reported to QAPI committed for next 3 months then re-evaluated to determine if further monitoring indicated

F604 Right to be Free from Physical Restraints

NE: SS=D: Failed to ensure resident was free of physical restraints when staff placed resident in recliner & raised footrest though resident unable to lower the footrest on own placing resident in supine position in recliner & impeded resident's freedom of movement & mobility placing resident at risk for impaired mobility, impaired resident rights & autonomy & increased risk for restraint-related accidents

- Failed to ensure 1 resident was free of physical restraints placing resident at risk for impaired mobility, impaired resident rights & autonomy & increased risk for restraint-related accidents

F609 Reporting of Alleged Violations

SE: SS=D: Failed to ensure dependent & cognitively impaired resident who had dx of dysphagia, oropharyngeal phage & ileus remained free from neglect when CMA continued to administer resident's morning meds despite resident's request to slow down because resident was having a difficult time swallowing; when CMA left room, CMA told resident, "there you're done now you CNA quit your crying"

- *Cited findings noted in F600 r/t med administration; failed to ensure dependent & cognitively impaired resident with dx of dysphagia, ileus & oropharyngeal phase remained free from neglect when housekeeping staff & outside resource staff failed to report to Adm staff that CMA continued to administered resident's morning meds despite resident's request to slow down because resident had difficult time swallowing; when CMA left room CMA told resident "there you're done now you CNA quit your crying"*

F623 Notice Requirements Before Transfer/Discharge

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

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

NE: SS=D; Failed to provide a written notice of transfer as soon as practicable to resident/representative of facility-initiated transfers with risk of miscommunication between facility & resident/family & possible missed opportunity for healthcare services for resident

- EMR & facility lacked written notification of transfer or discharge for resident's facility-initiated transfer provided; failed to provide written notice of transfer as soon as practicable to resident/representative for facility-initiated transfer with risk for miscommunication between facility & resident/family & possible missed opportunity for healthcare service for 1 resident

NW: SS=D: Failed to provide a written notice for facility-initiated transfer for 3 residents/representative when residents transferred to hospital; facility also failed to notify LTC Ombudsman of discharges placing residents at risk for uninformed care choices

- Documentation revealed resident transferred to hospital & record lacked evidence resident/representative provided written notice; SS unaware required to notify LTCO when resident went to hospital & unaware of written notification required to resident/representative but did provide bed hold policy; failed to provide resident/representative written notice r/t resident's transfer to hospital & failed to notify state LTCO placing resident/representative at risk of uninformed care choices
- Failed to provide resident/representative written notice r/t resident's facility-initiated transfer placing resident at risk of uninformed transfer placing resident at risk of uninformed care choices for multiple residents

F625 Notice of Bed Hold Policy Before/Upon Transfer

NE: SS=D: Failed to provide a bed hold notice to resident/representative when resident transferred to hospital placing resident at risk for impaired ability to return to facility or same room

- Failed to provide bed hold notice to resident/representative when resident transferred to hospital placing resident at risk for impaired ability to return to facility or resident's same room

F641 Accuracy of Assessments

SW: SS=E: Failed to accurately complete MDS for 5 residents including: 2 resident r/t inaccurate documentation of meds; 3 residents r/t inaccurate documentation of falls with potential to lead to uncommunicated need for care & services to meet each resident's needs

- Failed to complete accurate assessment when MDS documented resident received hypoglycemic med & no order for hypoglycemic med
- Failed to complete accurate MDS for resident r/t order for Trazadone for depression but med ordered for sleep
- MDS documented resident w/o falls but NN documented resident with multiple falls for multiple residents

F657 Care Plan Timing & Revision

SE: SS=E: Failed to review & revise CPs for 4 residents: 2 for scabies; 1 for use of urine collection leg bag device & 1 for self-removal of anchoring device & alternative catheter stabilizing devices

- Failed to review & revise resident's CP to include 1 resident's initial & recurrent infection with scabies
- Failed to review & revise CP to include 1 resident's CP to include alternatives for urinary catheter device & resident's behavior of removing anchoring device to ensure catheter remained sanitary & in proper position
- Failed to review & revise dependent resident's CP to include leg bag for urinary catheter & need for dignity bag
- Failed to review & revise 1 resident's CP to reflect new acute diagnosis of scabies infestation & its prescribed treatment for resident

SE: SS=D: Failed to revise 1 resident's CP to reflect interventions r/t resident's personal hygiene

- *Resident with dementia; CP lacked revision to include notification of family when resident refused to bathe; bathing sheets documented resident w/o bath x 24 days; POS for bath daily; failed to revise CP to reflect interventions r/t resident's personal hygiene*

SW: SS=E: Failed to review & revise CP for 4 residents r/t bathing preferences/choices & 2 residents r/t accidents/falls to prevent further falls

- CP lacked direction to staff r/t resident's bathing schedule &/or preferences including bathing preferences/choices r/t frequency, schedule & type of bath for multiple residents
- Failed to revise resident's CP r/t preferred bath days & preferred times
- Failed to implement CP interventions for resident who had falls placing resident at risk for preventable falls & injuries

NE: SS=D: Failed to ensure resident's CP revised with interventions to direct staff on dialysis access port location, care & monitoring placing resident at risk for impaired care due to uncommunicated care needs

- CP lacked direction or interventions r/t dialysis fistula & assessing for thrill or bruit & restrictions for that extremity r/t BP & lab; failed to ensure resident's CP revised to direct staff on dialysis AV fistula access site type location, & monitoring placing resident at risk for impaired care due to uncommunicated care needs

NE: SS=D: Failed to ensure staff revised 1 resident's CP with staff direction for safe transfers; failed to ensure staff revised 1 resident's CP with interventions after fall placing 2 residents at risk for impaired care due to uncommunicated care needs

- Failed to ensure staff revised resident's CP with appropriate staff direction for safe transfers placing resident at risk for impaired care due to uncommunicated care needs

NW: SS=D: Failed to revise CP for 1 resident to include use of protective sleeves to prevent skin injury placing resident at risk for further skin injury due to uncommunicated care needs

- CP lacked direction for 1 resident's Dermasaver sleeves; observed resident with & without sleeves; failed to revise CP for resident to include Dermasaver sleeves to prevent skin injury placing resident at risk for further injury due to uncommunicated care needs

F661 Discharge Summary

NW: SS=D: Failed to complete a recapitulation of 1 resident's stay in facility placing resident at risk of unmet care needs

- Adm nurse reported nurses, SS & therapy each do discharge summaries but had not done a recapitulation of resident's stay; failed to complete a recapitulation of resident's stay in facility placing resident at risk of unmet care needs

F676 ADLs/Maintain Abilities

SE: SS=D: Failed to ensure staff provided resident necessary bathing services to maintain good grooming & personal hygiene

- *Bathing sheets documented resident did not receive bath in 24 days & POS for daily bath; failed to provide resident with necessary bathing services to maintain good grooming & personal hygiene*

F677 ADL Care Provided for Dependent Residents

SW: SS=E: Failed to ensure necessary services to maintain good personal hygiene for 5 residents r/t bathing, nail care, hair care &/or unwanted facial hair

- Failed to ensure necessary services to maintain good personal hygiene r/t bathing for resident
- Failed to ensure necessary services to maintain good personal hygiene r/t bathing & nail care for residents of facility for multiple residents
- Failed to provide resident with preferences for type, frequency & time of bathing
- Failed to ensure resident received care for removal of facial hair placing resident at risk for decreased psychosocial wellbeing

F679 Activities Meet Interest/Needs Each Resident

SW: SS=D: Failed to provide consistent activities for 2 residents; residents observed not to have received activities on Memory Care Unit placing residents at risk for complications r/t decreased psychosocial wellbeing

- Failed to provide consistent activities placing residents at risk for complications r/t decreased psychosocial wellbeing for multiple residents

F684 Quality of Care

NW: SS=D: Failed to ensure 1 resident, who received anticoagulant received care as required to prevent skin injuries including Dermasaver sleeves & sheepskin surface padding placing resident at risk for further skin injury

- POS for Eliquis for a-fib; observed resident with & without protective sleeves & w/c arms did not have sheepskin; failed to ensure 1 resident received necessary interventions including Dermasaver sleeves & sheepskin surface padding to prevent skin injuries placing resident at risk for further skin injury

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

NW: SS=J (Abated to G): Failed to ID & provide appropriate interventions consistent with standards of care to prevent PUs from developing & worsening for 1 resident

- *On 3-11-24 resident developed 2 facility-acquired stage 2 PUs to bilateral buttocks; on 5-16-24 wound specialists IDd diffuse pressure & redness to entire intergluteal cleft area; facility did not implement further preventative measures to address offloading or positioning until 7-11-24; further failed to assess resident's pressure wounds weekly to determine effectiveness of treatments; on 8-7-24 resident transferred to acute care hospital where IDd arrived with unstageable PU to coccyx with necrosis & slough in wound bed, stage 3 PU to buttock, stage 3 PU to other buttock, & DTI to heel, DTI to lt trochanter; failure to ID & implement interventions consistent with standards of care to prevent development of further pressure injuries & to promote healing of existing facility-acquired PUs placing resident in immediate jeopardy*
- *Abatement Plan:*
    - *Staff re-educated on PU/wound prevention & appropriate documentation*
    - *Ad Hoc QAPI held*
    - *Facility-wide skin sweep*
    - *Staff reviewed & updated skin assessment & CPs as applicable*

NW: SS=D: Failed to implement interventions to prevent development & promote healing of PUs for 1 resident who had stage 4 PU when staff did not reposition resident per CP placing resident at risk for development of new pressure injuries or delayed healing of existing PU

- CP instructed staff to reposition resident q hour while in chair 12x/day; observed resident remained in same position in same place w/o staff assisting resident to stand or encourage resident o lie down in bed & resident remained in same position in chair w/o staff assisting resident to stand, reposition, or encourage resident o lie down in bed on multiple occasions; failed to implement interventions to prevent development & promote healing of PUs for resident with stage 4 PU when staff did not reposition resident per CP placing resident at risk for development of new pressure injuries or delayed healing of existing PU

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to ensure 1 resident had interventions in place to avoid a further decrease in ROM placing resident at risk for decreased mobility & impaired quality of life

- Failed to ensure that staff had interventions in place for staff direction r/t resident's ROM & positioning to avoid further decreased ROM & functionality placing resident at risk for further decline & decreased ROM

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=D: Failed to ensure staff provided safe transfers for 1/3 residents reviewed

- Observed CNA transported resident & aligned w/c perpendicular to bed & instructed resident to grab side rail & transfer self into bed; resident leaned forward & grabbed w/c & chair moved due to resident weight still in seated position in chair but reaching for siderail; CNA then locked brakes on w/c & resident attempted to stand but had difficulty to bring self to standing position; CNA then obtained gait belt to assist resident to stand; failed to ensure staff provided safe transfer techniques for resident at risk for falls with weakness & balance deficits

SE: SS=D: Failed to investigate a fall on 7-16-24, conduct a complete assessment & implement a new intervention following for 1 resident that had pervious falls in facility; on 7-17-24 resident had additional fall, which facility failed to complete assessment & implement new intervention following fall; additionally, facility failed to notify responsible party & physician following falls on 7-16-24 & 7-17-24

- *On 08/20/24 at 02:10 PM, R1's family member stated the staff informed her of the fall in the dining room and the next day when she came in R1 told her he had stumbled on the bed on his way back from the bathroom a little after 03:00 AM. The family member stated two days later the same thing happened during the night, R1 had tripped fell towards the side of the bed and when*
- *he was talking, she noticed he did not have his bottom plate in and the big tooth on the top plate was broken. R1's family member stated she was not made aware of those falls and when addressed with Administrative Nurse D why the staff did not notify her, Administrative Nurse D responded probably because it was the middle of the night. R1's family member stated she had told the facility to call her or text, she had her phone with her 24 hours a day, seven days a week. R1's family member stated it was that day she informed the facility she was going to take him home and did the following day as she felt the facility had neglected resident; failed to investigate a fall on 7-16-24, conduct a complete assessment & implement a new intervention following fall for resident that had previous falls in facility; on 7-17-24 resident had additional fall, which facility failed to complete assessment & implement a new intervention following fall; additionally, failed to notify responsible party & physician following falls on 7-16-24 & 7-17-24*

SW: SS=J (Past Non-Compliance): Failed to provide adequate supervision to cognitively impaired, independently mobile resident, IDd as high risk for elopement

- On 6-29-24 at 7:25am staff unable to locate resident in facility & at 8:30am located resident 2 miles away from facility; resident walked down busy residential areas with 35 mph speed limit & would have crossed 20 cross walks & crossed over 2 river bridges placing resident in immediate jeopardy; further more facility failed to keep resident safe r/t fall hazards in room; resident with hx of elopement & wanting to leave facility & felt being kept at facility against resident's desires; failed to provide adequate supervision to cognitively impaired, independently mobile resident ID's as high risk for elopement; resident found 5 minutes after being ID'd as not on property placing resident in immediate jeopardy
- Past Non-Compliance Plan:
    - The Community Interdisciplinary Team completed a review of the community with four additional residents identified as being at risk for elopement and placed in wander guard alarms.
    - An Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting held by interdisciplinary team
    - The Administrator notified the Medical Director

- Current clinical associates were re-educated by the Director of Nursing or designee or prior to working next scheduled shift on the Community Elopement policy and Community Elopement Evaluation process.
    - Education included identification of at -risk residents, and courtyard oversight requirements.
- Residents with a new risk for elopement or change in elopement risk will be reviewed by clinical interdisciplinary team during routine clinical huddle to verify elopement risk assessment accuracy, physician notification and preventative interventions in place as indicated. If discrepancies identified, immediate corrective action will be completed, and one on one education completed as indicated.
- Residents identified with a change in elopement risk or who have had an actual elopement attempt will be reviewed during routine risk meeting by clinical interdisciplinary team. Review will be documented in the resident electronic medical record
- Routine elopement drills scheduled per community policy on varying shifts to confirm staff competency.
- Findings of elopement drills are to be reported to the community Administrator and reviewed at the following morning meeting. If discrepancies are identified immediate correction will be completed and one on one education provided as indicated

NE: SS=E: Failed to secure hazardous materials & rooms from 9 cognitively impaired ambulatory mobile residents placing residents at risk for preventable accidents & injuries

- Observed 1 floor's electrical rooms unsecured; failed to secure hazardous materials & rooms from 9 cognitively impaired ambulatory mobile residents placing residents at risk for preventable accidents & injuries

NE: SS=D: Failed to ensure meaningful interventions were implemented for resident after falls placing resident at risk for future falls & possible injuries

- Failed to ensure meaningful fall interventions were implemented & applied to resident to prevent future falls placing resident at risk for future falls & possible further injuries

NW: SS=D: Failed to ensure staff followed CP to prevent accidents when staff failed to place resident's alarm under resident when resident in bed per CP resulting in fall placing resident at risk for injuries from falls

- CP documented resident high fall risk & used bed & chair alarm & CP instructed staff to ensure alarm on at all times when resident in bed or w/c; NN documented resident with unwitnessed fall & LN noticed bed alarm in place but box missing; staff failed to place alarm under resident when resident in bed per CP & resident with fall placing resident at risk for injuries from fall

NW: SS=G (Past Non-Compliance): Failed to ensure environment free from accidents for 1 resident when staff serviced resident a hot beverage on abdomen causing 2nd degree burn & placed resident at risk for increased pain

- Resident with MS, dysphagia; "Hot Liquid Assessment" documented score of 3 & 2 indicating risk of spills from hot liquid; CP directed resident to have hot liquids in cup with lids; NN documented resident dropped Styrofoam cup of hot cocoa & lid came off causing cocoa to spill onto resident's abdomen; physician follow up ordered med for burned area; area with burn blisters; failed to provide resident with correct Kennedy cup to prevent hot liquid accidents resulting in resident spilling hot liquid on abdomen causing 2nd degree burn & placed resident at risk for increased pain

F690 Bowel/Bladder Incontinence, Catheter, UTI

SE: SS=D: Failed to analyze 1 resident's 3-day voiding diary to determine type of incontinence & pattern of incontinence to mitigate fall occurrences & provide sanitary urinary catheter care for 1/3 resident to prevent UTIs

- Observed resident in DR with 6 inches urine collection tubing lay directly on floor; observed resident in DR w/o lap robe to cover exposed thighs with 8 inches tubing directly on floor; observed CNA transported resident with 8 inches tubing on floor; Failed to ensure staff provided sanitary catheter care for resident with hx of UTIs
- Failed to interpret 3-day Voiding Trial data to determine 1 resident's toileting patterns to develop personalized CP

NE: SS=D: Failed to ensure 1 resident's suprapubic catheter was anchored on abdomen to prevent pulling & injury placing resident at risk for catheter-related complications

- CP lacked direction for placement of anchor to prevent pulling or injury for suprapubic catheter; failed to ensure standard of practice was followed for anchoring 1 resident's suprapubic catheter tubing to prevent pulling or injury placing resident at risk for catheter-related complications

F692 Nutrition/Hydration Status Maintenance

NE: SS=D: Failed to monitor effectiveness of weight loss interventions after significant weight loss for 1 resident placing resident at risk for further loss & malnutrition

- *Failed to consistently monitor effectiveness of interventions, including intake amounts for meals, snacks, & nutritional supplements after significant weight loss for resident placing resident at risk for continued weight loss & malnutrition*

NE: SS=D: Failed to ensure fluids were within reach for 1 resident & failed to ensure weight loss interventions were provided for 1 resident placing 2 residents at risk for further weight loss or malnutrition

- Failed to ensure 1 resident's water was within reach placing resident at risk for dehydration & adverse effects
- Failed to provide 1 resident's weight loss interventions when staff failed to provide milk at each meal & further failed to implement RD recommendations to change & increase resident's supplement to prevent further weight loss placing resident at risk for malnutrition & other negative outcomes

F695 Respiratory/Tracheostomy Care & Suctioning

SE: SS=D: Failed to ensure staff provided sanitary care to respiratory equipment & administration of aerosolized medication for 1 resident

- Observed resident in room with O2 cannula directly on floor; during care CMA washed hands but failed to don gloves to administer aerosol treatment; then after tx, failed to perform hand hygiene or don gloves, rinsed components with water then wiped with paper towel, then dropped on floor then re-rinsed components with tap water; failed to ensure staff provided respiratory care in sanitary manner to resident with compromised respiratory system to prevent spread of airborne infections

NW: SS=D: Failed to provide adequate respiratory care & services for 1 resident when staff did not provide O2 during meal & failed to store O2 tubing & cannula in sanitary manner when not in use placing resident at risk for respiratory complications

- POS for O2 continuously at 2 lpm to keep O2 sat above 90%; observed resident at DR table & did not have O2 concentrator in DR then staff took resident to living room & did not bring O2 to resident; observed CNA took O2 tubing & laid it over handles of w/c & cannula resting on resident's back; failed to provide adequate respiratory care & services for 1 resident when staff did not provide resident O2 during meal & in living room & failed to store O2 tubing & cannula in sanitary manner when not in use placing resident at risk for respiratory complications

F698 Dialysis

SW: SS=D: Failed to ensure staff obtained vital signs or dialysis site after resident received dialysis

- Failed to ensure staff obtained vital signs after resident returned from dialysis to ensure stability for adverse reactions to dialysis procedure

NE: SS=D: Failed to ensure ongoing communication & collaboration with dialysis facility r/t dialysis care & services r/t resident's health status with each procedure; failed to ensure staff ID'd & assessed resident's access type & location placing resident at risk for complications r/t dialysis

- TAR lacked documentation of monitoring of AV fistula shunt access site for thrill or bruit; failed to ensure ongoing communication & collaboration with dialysis facility r/t dialysis care & services r/t resident's health status with each procedure; failed to ensure staff ID'd & assessed resident's access type & location placing resident at risk for complications r/t dialysis

F700 Bedrails

NE: SS=D: Failed to assess risks of bedrail use r/t 1 resident's low air-loss mattress placing resident at risk for impaired safety r/t unidentified risks associated with use of bedrails

- CP lacked documentation r/t bed rails &/or assistive positioning devices; Air mattress manufacturer information documented "usage of bed rails should be appropriately assessed, monitored, & maintained to reduce risk of entrapment"; failed to assess risks of bed rail use r/t low air-loss mattress system for 1 resident placing resident at risk for impaired safety r/t unidentified risks associated with use of bedrails

NE: SS=D: Failed to attempt to use alternative measures prior to installing 1 resident's side rail & facility further failed to complete a side rail safety assessment that acknowledged presence of low air loss mattress & associated risks, prior to installation of side rails for resident placing resident at risk of injury due to unidentified risks for use of side rails

- Restraint Assessment lacked a side rail assessment that ID'd resident's low air loss mattress; EMR lacked evidence of risk vs benefits & education provided to resident/representative r/t risks associated with use of side rails; failed to attempt to use alternative measures prior to installing resident's side rail & further failed to complete side rail safety assessment that acknowledged presence of low air loss mattress & associated risks, prior to installation of side rails for resident placing resident at risk of injury due to unidentified risks from use of side rails

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

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

- Review of daily posted nursing hour sheets from 3-1-23 to 8-15-24 revealed multiple dates that did not list hours for RN; facility data report lacked evidence of 8 consecutive hours of RN coverage for 5 days from 3-14-24 thru 6-15-24; failed to provide RN coverage 8 consecutive hours a day, 7 days a week as required placing residents residing in facility at risk for lack of assessment & inappropriate care

NE: SS=F: Failed to provide RN coverage 8 consecutive hours a day/7 days a week placing all resident residing in facility at risk of lack of assessment & inappropriate care

- Nursing scheduled lacked evidence of RN coverage for 8 consecutive hours a day on 6 days from 1-1 thru 4-7; failed to provide RN coverage 8 consecutive hrs/day, 7 days/wk as required placing residents residing in facility at risk of lack of assessment & inappropriate care

NW: SS=F: Failed to provide RN coverage 8 consecutive hr/day, 7 days/wk placing all residents residing at facility at risk of decreased quality of care

- PBJ documented facility lacked 8 consecutive hrs of RN coverage for: 7 days in April, 2023, 7 days in May 2023, 6 days in June 2023, 8 days in July 2023, 6 days in August 2023, 6 days in Sept 2023, 8 days in October 2023, 4 days in Nov 2023, 4 days in Dec 2023, 4 days in March 2024, 4 days in April 2024, 4 days in May 2024, 8 days in June 2024, 8 days in July 2024 & 6 days in August 2024; Adm nurse confirmed dates; failed to provide RN coverage 8 consecutive hr/day, 7 days/wk placing all residents residing in facility at risk of lack of assessments & inappropriate care

F730 Nurse Aide Perform Review-12 Hr/yr In-Service

SW: SS=F: Failed to provide direct care staff annual evaluations/performance reviews for 5/5 CNAs sampled to determine strengths & weaknesses in providing resident care

- Personnel files for 5 CNAs lacked annual review; failed to provide direct care staff an annual eval to determine strengths & weaknesses

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

- Review of records revealed 5/5 CNAs w/o yearly performance evaluation; failed to ensure any of 5 CNA staff reviewed had required yearly performance evals completed placing residents at risk for inadequate care

F732 Posted Nurse Staffing Information

SE: SS=C: Failed to display accurate, publicly accessible, & identifiable staffing information on daily basis for all residents residing in facility

- Failed to properly complete daily staffing sheets for residents of facility

NE: SS=C: Failed to maintain posted daily nurse staffing data for required 18 months; failed to list daily census on provided daily staffing documentation

- Failed to maintain posted daily nurse staffing data for required 18 months; additionally failed to list daily census on provided daily staffing documentation

F742 Treatment/Services Mental/Psychosocial Concerns

SW: SS=J (Past Non-Compliance): Failed to ensure appropriate treatment & services to attain highest practicable mental & psychosocial wellbeing of cognitively impaired resident who had mental health d/o dx, portrayed anger r/t living in facility, hx of exit seeking & staff did not respond to suicidal ideation statements after elopement

- Staff did not respond to suicidal ideation statements after elopement; on 6-29-24 resident eloped from facility; when staff returned resident to facility placed WanderGuard on resident & resident reported would "never eat again"; on 6-30-24 resident made statements such as "give me a gun so I CNA shoot myself"; at 10pm resident reported was being held against wishes; on 7-3-24 resident reported would to eat until someone came back to talk about him being dismissed; on 7-8-24 staff assessed resident for exit seeking behaviors & continued 15-minute checks for 24 hours; on 7-15, new orders to increase Seroquel to TID; on 7-22-24 at 3:30pm staff found resident had hung self in room with TV cable on closet door frame placing resident in immediate jeopardy; failed to prevent neglect of cognitively impaired resident with known mental illness & anger r/t placement in facility when staff failed to respond to suicidal ideation comments after elopement placing resident in immediate jeopardy & resident hung self with cable cord from closet door; failed to ensure appropriate treatment & services to attain highest practicable mental & psychosocial wellbeing to cognitively impaired resident with known mental illness & anger r/t placement in facility when staff failed to respond to suicidal ideation comments after resident eloped from facility placing resident in immediate jeopardy & resident hung self with cable cord from closet door
- Past Non-Compliance Plan:
    - Ad Hoc QAPI meeting held by IDT
    - Adm notified Medical Director
    - VP of Clinical Operations re-educated Adm & DON on community process for recognizing signs/symptoms of suicide
    - Corp Director of Clinical Reimbursement educated Adm, SS, DON r/t community process of SS comprehensive assessment & trauma informed care assessment; education included intended scheduled, psychosocial CP
    - Current associates will be re-educated by community by Adm/designee or prior to working next scheduled shift in community; trauma informed care process with specific focus on ID of suicidal symptoms & suicidal ideation, required notifications & immediate actions
    - SS comprehensive assessments completed on admission, annually & with significant change; assessment documented in record
    - Residents IDd with need for trauma preventative services will have trauma informed assessment at admission, annually & with ID'd significant change in condition; assessments will be documented in record; CP updated as indicated
    - Routine angle rounds completed by assigned IDT members routinely & will include staff members interviews to validate understanding of resident suicide awareness & notification requirements; results of angel rounds reported during routine morning stand up meetings
    - Weekly risk meetings review clinical record of newly admitted residents or residents IDd change in condition to validate completion of required SS assessments &/or trauma informed care evals & review documented in record
    - Adm/designee routinely review sampled selected residents x next 60 days to validate compliance of: completion of SS assessment, completion of trauma informed care assessments, psychosocial CP present including resident specific interventions based on assessment findings; & any noted suicidal ideation as indicated
    - Monthly review weekly risk review & angle rounds results & trends completed by Adm/designee & reported to QAPI committed for next 3 months then re-evaluated to determine if further monitoring indicated

F744 Treatment/Service for Dementia

NW: SS=D: Failed to provide dementia care & services for 1 resident with dementia & behaviors placing resident at risk for abuse & decreased quality of life

- MDS documented resident with physical & verbal behaviors & rejected cares 4-6 days/wk; resident with antipsychotic & antidepressant meds; CP documented resident with physical aggressiveness & would hit, kick & attempt to bite during bedtime cares; POS for Quetiapine BID for dementia with psychotic disturbance, Divalproex sodium for agitation; Vilazodone (antidepressant) for depression, Remeron for appetite stimulant; NNs documented multiple physically aggressive behaviors; observed staff member repeatedly called resident "honey" & asked resident if wanted to watch specific TV program but failed to change channel after resident responded "yes" then resident yelled "help" multiple times; resident not provided O2 as ordered prior to aggressive behaviors; observed resident in DR yelling "help…I need to go to BR" & staff failed to respond; staff reported unaware of what interventions to offer when resident had behaviors; failed to provide dementia care & services for 1 resident in order to promote & maintain resident's highest practicable wellbeing placing resident at risk for abuse & decreased quality of life

F755 Pharmacy Services/Procedures/Pharmacist/Records

SW: SS=D: Failed to ensure 1 resident's medication was available for administration w/o missed doses placing resident at risk for unnecessary complications from not receiving medication as ordered by physician

- Failed to ensure resident's medication was available for administration w/o missed doses placing resident at risk for unnecessary complications from not receiving medication as ordered by physician

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=E: Failed to ensure Consultant Pharmacist (CP) ID'd & reported need for physician-documented rationale for non-approved CMS indications for use of antipsychotic meds for 4 residents placing residents at risk for adverse medication effects & med errors

- Failed to ensure CP ID'd & reported non-approved CMS indication for use of antipsychotic meds placing resident at risk for unnecessary meds & related complications
- Failed to ensure CP ID'd & reported non-approved CMS indication for use of antipsychotic med for resident; also failed to ensure physician provided documented rationale or risk vs benefit of continued use of resident's psychotropic meds w/o GDRs placing resident at risk for unnecessary meds & adverse side effects
- Failed to ensure CP ID'd & reported non-approved CMS indication for use of antipsychotic med for resident placing resident at risk for unnecessary med administration & possible adverse side effects for multiple residents

NW: SS=D: Failed to ensure Consultant Pharmacist (CP) IDd & reported to facility administration lack of documented physician rationale which included multiple unsuccessful attempts for non-pharmacological symptom management & risk vs benefits for continued use of antipsychotic &/or for not attempted GDR for psychotropic meds & that staff had not administered physician ordered PRN blood pressure medication when BP was out of parameters placing resident at risk for further issues r/t uncontrolled BPs & for receiving unnecessary psychotropic meds

- Failed to ensure Consultant Pharmacist (CP) IDd & reported to facility administration lack of documented physician rationale which included multiple unsuccessful attempts for non-pharmacological symptom management & risk vs benefits for continued use of antipsychotic &/or for not attempted GDR for psychotropic meds & that staff had not administered physician ordered PRN blood pressure medication when BP was out of parameters placing resident at risk for further issues r/t uncontrolled BPs & for receiving unnecessary psychotropic meds

F757 Drug Regimen is Free from Unnecessary Drugs

SE: SS=D: Failed to ensure 2 residents remained free from unnecessary meds r/t failure to administer PRN meds for BMs

- Failed to use PRN meds for dependent resident with constipation for multiple residents

NW: SS=D: Failed to administer 2 BP meds based on BP monitoring per physician orders for 1 resident placing resident at risk for unnecessary medication resulting from abnormal BP

- Failed to administer BP meds as physician ordered placing resident at risk for high or low BP effects

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure 1 resident's PRN Hydroxyzine had 14-day stop date or documentation of physician rationale & specific duration of use placing resident at increased risk for unnecessary psychotropic med & related side effects

- POS for Hydroxyzine 50mg before dressing changes & q 6 hours PRN anxiety & order lacked stop date; failed to ensure resident's PRN Hydroxyzine had 14-day stop date or documented physician rationale & specified duration placing resident at increased risk for unnecessary psychotropic med & side effects

NE: SS=E: Failed to ensure 4 residents had approved CMS indication or required physician documentation for antipsychotic meds; failed to ensure documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk vs benefits for continued use or GDR placing affected residents at risk for unnecessary psychotropic med & possible adverse side effects

- Cited findings noted in F756 r/t inappropriate indications for antipsychotic meds & lack of GDRs or physician rationale for psychotropic meds; failed to ensure 1 resident had appropriate CMS-approved indication for use of antipsychotic med placing resident at risk for unnecessary med administration & possible adverse side effects for multiple residents
- Failed to ensure resident had CMS-approved indication for use of antipsychotic or required physician documentation; further failed to ensure GDR was attempted or documented as contraindicated by physician with supporting rationale placing resident at risk for unnecessary meds & adverse side effects for multiple residents

NW: SS=D: Failed to obtain a written risk vs benefit rationale from physician for continued use of 4 psychotropic for 1 resident placing resident at risk for unnecessary psychotropic meds & related side effects

- POS for Risperidone, Clonazepam, Trazodone & Zoloft; failed to obtain written risk vs benefit rationale from physician for continued use of 4 psychotropic drugs for 1 resident placing resident at risk for unnecessary psychotropic meds & related side effects

F761 Label/Store Drugs & Biologicals

SE: SS=E: Failed to provide a safe environment for 9 residents by failure to ensure nurse treatment cart that contained insulin remained locked when not in direct line of vision of nurse

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

NE: SS=E: Failed to store meds securely to limit access when staff failed to lock 3 med carts placing residents at risk for unsafe medication practices & misappropriation

- Failed to store meds securely to limit access when staff failed to lock 3 med carts placing residents at risk for unsafe med practices & misappropriation

NW: SS=D: Failed to label & date 1 vial of insulin for 1 resident placing resident at risk for receiving expired or ineffective insulin

- Observed med room with 1 Fiasp insulin vial that had been accessed but undated when accessed; failed to date 1 resident's vial of insulin when opened placing resident at risk for receiving ineffective insulin

F801 Qualified Dietary Staff

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

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

NW: SS=F: Failed to employ a full time CDM for all residents residing in facility & receiving meals from facility's kitchens placing residents at risk for inadequate nutrition

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

F804 Nutritive Value/Appear, Palatable/Prefer Temp

SE: SS=D: Failed to ensure pureed foods were prepared to ensure nutritional & flavor compatibility with menu to enhance dining experience for 2 residents

- Observed staff prepared pureed foods & made substitutions w/o nutritionally equivalent substitute guide for rice or corn for pureed diets; failed to provide pureed food substitutes nutritionally & with flavor compatibility with menu to enhance dining experience for 2 residents requiring a pureed diet

SW: SS=E: Failed to serve food that is palatable, & at safe & appetizing temp for residents of facility

- Observed open metal carts with 10 plus meal trays being served on each of 5 units; plate lacked insulated covers, nor served in closed insulated food service cart; multiple residents sated food is not right temp…hot foods are cold & cold foods are warm; temps of foods outside acceptable parameters; failed to serve food that is palatable & at safe & appetizing temp for residents of facility

NW: SS=D: Failed to provide food prepared by methods that conserve nutritive value, flavor & appearance when dietary staff failed to prepare all food items on noon menu while prepared 2 residents' pureed diets placing residents at risk for impaired nutrition

- Observed dietary staff prepare pureed meals for 2 resident & failed to measure food & thinners; staff stated would not prepare bread, asparagus or fruit crisp for resident on pureed diet but residents would receive protein ice cream as dessert & CNA of V8 juice; staff failed to puree all food items on menu in 1/3 kitchenettes placing 2 residents at risk for impaired nutrition

F806 Resident Allergies, Preferences, Substitutes

SW: SS=D: Failed to honor a food preference for 1 resident; staff served resident pork when documented on meal ticket as "no pork" placing resident at risk for inadequate care & services

- Failed to honor food preference for resident; resident served food item that was recorded as a "no pork" on meal ticket placing residents at risk for inadequate care & services

F812 Food Procurement, Store/Prepare/Serve-Sanitary

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

- Observed room trays & temps failed to meet recommended parameters
- Observed air vents & ceiling with black substance over multiple areas; wooden cabinet drawers with peeling varnish & liquid stain; serving items with brown/black substance in surface groove; cabinet with worn varnish & inside shelves; shelf with grime & debris; omelet pan with black surface; ice machine drain laid directly in sewer drain in basement w/o 2-inch air gap

NE: SS=E: Failed to ensure food items were appropriately labeled & stored after original package had been opened placing residents at risk for foodborne illnesses & food safety concerns

- Observed fridge with multiple unlabeled & undated food items; sugar granules on counter; water & ice machine with water deposit stains around dispenser spout

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

- Observed dietary staff touching multiple items after applying gloves then touched beef while cutting it up then continued to serve residents plates of food; then with same soiled gloves, took baked potato out of oven & placed it on plates then held onto it while cutting it then with same soiled gloves, wiped gloved hand across nose then serviced dessert & after serving desserts removed & discarded gloves then applied new gloves & touched multiple contaminated items then touched bread from toaster then placed beef on bread
- One kitchenette with missing documentation for multiple temps & dishwasher PPM tests for multiple days
- Observed staff prepare purred food & used soiled blender to puree multiple food items then delivered plates/bowls uncovered
- Observed dry storage fridge that lacked thermometers in fridge & freezer

F849 Hospice Services

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

- Failed to ensure communication process was implemented which included how communication would be documented between facility & hospice provider & failed to provide description of services, medication & equipment provided to resident by hospice creating a risk of missed or delayed services & inadequate end-of-life care for 1 resident

F851 Payroll Based Journal

SE: SS=F: Failed to electronically submit complete & accurate staffing information to PBJ when failed to accurately submit hourly staffing data for all nursing personnel

- PBJ data indicated facility failed to have LN 24 hrs/day o 5 days; schedule & payroll data revealed adequate hours to account for 24-hour nursing coverage; failed to submit complete & accurate staffing information to PBJ when facility failed to accurately submit hourly staffing data for all nursing personnel

SE: SS=F: Failed to electronically submit to CMS complete & accurate direct staffing information based on payroll & other verifiable & auditable data in unform format according to specifications established by CMS on PBJ r/t LN staffing information when facility failed to accurately report weekend staffing for 4 quarters

- Adm stated DON worked most weekends & since DON was salaried, hours were not show on timesheets; failed to accurately report weekend staffing on PBJ for 4 quarters

NE: SS=F: Failed to submit accurate RN coverage hours placing residents at risk for unidentified & ongoing inadequate staff

- Facility unable to provide RN punch times for staff on 8 days from 1-20-24 thru 4-7-24; failed to ensure accurate staffing hour information was submitted to Federal regulatory agency thru PBJ when facility failed to submit accurate RN coverage hours placing residents at risk for unidentified & ongoing inadequate staff

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

- Multiple PBJ reports documented no LN 24 hrs/day but payroll data revealed LN 24 hrs/day 7 days/wk; Adm stated PBJ submitted off-CMApus & unaware that there were submission problems; failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

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

- PBJ report documented 1 quarter with no LN on 13 days but payroll data revealed LN on duty 24 hr/day 7 days/wk; failed to submit accurate PBJ data which placed residents at risk for unidentified & ongoing inadequate staffing

F880 Infection Prevention & Control

NE: SS=F: Failed to follow sanitary infection control standards r/t use of PPE for EBP; further failed to implement water management program to address & mitigate risk of Legionella disease & other waterborne pathogens placing residents at increased risk for infectious diseases

- Observed LN entered room labeled as EBP w/o wearing gown as directed by EBP & changed resident's wound dressing
- Facility unable to provide risk assessment & water management program for Legionella & other waterborne pathogens; failed to follow sanitary infection control standards r/t use of PPE for EBP; further failed to implement water management program to address & mitigate risk of Legionella & other waterborne pathogens placing residents at increased risk for infectious diseases

NE: SS=E: Failed to post clear signage for TBP room & failed to implement EBP for all residents requiring EBP placing residents at risk for infectious diseases

- Failed to post clear signage for TBP room & failed to implement EBP for all residents requiring EBP placing residents at risk for infectious diseases

F883 Influenza & Pneumococcal Immunizations

NE: SS=D: Failed to provide 1 resident with PCV 20-vaccination as consented placing resident at increased risk for complications r/t pneumonia

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

NW: SS=D: Failed to offer or obtain informed declination or physician-documented contraindication for PCV20 vaccination to 1 resident per latest guidance from CDC placing resident at risk for pneumococcal infection & related complications

- Failed to offer 1 resident PCV20 pneumococcal vaccination placing resident at risk of acquiring, spreading, & experiencing complications from pneumonia

F923 Ventilation

SW: SS=E: Failed to provide adequate ventilation in beauty shop; facility lacked ventilation to outside by means of a window, mechanical vent or combination of to promote good air circulation as required

- Failed to provide policy r/t beauty shop ventilation in beauty shop to promote good air circulation as required

F942 Resident Rights Training

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

- Facility unable to provide training records for agency LN; failed to ensure agency staff received required resident rights training placing residents at risk for impaired care & decreased quality of life

F943 Abuse, Neglect, & Exploitation Training

NE: SS=E: Failed to ensure agency staff received required ANE training placing residents at risk for ANE

- Failed to ensure agency staff received required ANE training placing residents at risk for ANE

F945 Infection Control Training

NE: SS=E: Failed to ensure agency staff received required infection control training placing residents at increased risk for infections

- Failed to ensure completion of required infection control training for staff who provided care in facility placing residents at increased risk for infections

F947 Required In-Service Training for Nurse Aides

SW: SS=F: Failed to develop, implement & maintain in-service training program to ensure staff completed required 12-hr in-service education for 5/5 CNAs sampled who were employed by facility for at least 1 year placing residents at risk of decreased quality of care

- Failed to develop, implement & maintain in-service training program to ensure staff completed required 12-hr in-service education for 5/5 CNAs sampled who were employed by facility for at least 1 year placing residents at risk of decreased quality of care

NE: SS=F: Failed to ensure 3/5 CNA staff reviewed had required 12 hours of in-service education placing residents at risk for decreased quality of life &/or inadequate care

- 3/5 CNA files revealed staff had not completed required yearly in-services in past 12 months as required placing residents at risk for decreased quality of life &/or inadequate care

F949 Behavioral Health Training

SW: SS=F: Failed to develop, implement & maintain effective training program for all staff which included, at a minimum, training on behavioral health care & services that was appropriate & effective placing all residents at risk of not reaching highest practicable wellbeing

- Failed to develop, implement & maintain effective training program for all staff, which included, at a minimum, training on behavioral healthcare & services that was appropriate & effective placing all residents at risk of not reaching highest practicable wellbeing

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F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to ensure 1 resident's built-up utensils & divided plate was provided leaving resident vulnerable to unmet care needs due to inability to feed self

- Failed to ensure 1 resident's divided plate & built-up utensils were provided leaving resident vulnerable to unmet care needs due to inability to feel self

F576 Right to Forms of Communication with Privacy

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

- Resident Council members reported facility did not provide mail services for residents on Saturdays & that mail was stored over weekend at nurses' station & distributed following Monday & that weekend activity staff that used to pass it out stopped coming; failed to provide mail delivery on Saturdays

F580 Notify of Changes (Injury/Decline/Room, etc)

NW: SS=D: Failed to notify physician of changes in status or condition for 1 resident who made statements of self-harm placing resident at risk of delayed treatment due to delay in physician involvement

- NNs documented resident with increased "behaviors"; NN documented resident with suicidal ideation when resident stated wanted to be dead & made a "shot to the head" gesture; stated resident was going to fail everyone & thought resident might as well be dead; resident placed on 15 minute checks & staff directed to keep resident occupied; note lacked evidence physician notified; EMR lacked documentation physician notified & any further documentation r/t resident's suicidal ideation; failed to notify physician of resident's statements of self-harm placing resident at risk for delayed treatment due to delay in physician involvement

F582 Medicaid/Medicare Coverage/Liability Notice

NE: SS=D: Failed to provide CMS-10055, SNF ABN which included estimated cost for continued services for skilled services to resident/representative for 3 residents placing residents at risk for uninformed decisions

- SS state ABN form facility had instructed to use was different from form MDS-R-131 & DON had provided updated CMS 10055; failed to issue 3 residents correct SNF ABN form CMS-10055 that included cost to resident for continued skilled therapy placing 3 residents at risk for uninformed decisions

F585 Grievances

NW: SS=D: Failed to log & promptly resolve 1 resident's grievance when resident reported to staff that resident had missing clothing items placing resident at risk for unresolved grievances & decreased quality of life

- CP documented resident with mood swings; Grievance Log lacked documentation of resident's grievance r/t missing clothing items; record lacked documentation r/t resident's missing clothing; resident stated missing multiple clothing items since Feb 2024; CNA stated resident had reported some missing clothing & notified laundry supervisor & SSD; CNA stated new laundry staff & "a lot of residents' clothes were mixed up, so staff were looking for them" & had found some missing clothes; failed to log & promptly resolve 1 resident's grievances & decreased quality of life

F600 Free from Abuse & Neglect

SE: SS=J (Abated to G): Failed to prevent neglect of cognitively impaired resident who displayed recent increase in behaviors

- *On 8-26-24 at 10:12pm LN completed skin assessment on resident & documented skin as clean, dry, intact & w/o new skin conditions; on 8-27-24 at 10:45am staff observed blood on tissue after wiping resident & failed to notify LN in charge of resident's care; on 8-27 at 11:15am SS & Adm took resident out of town to senior behavioral unit; upon arrival to ER, resident expressed need to use BR & when assisted by staff, resident's brief had 2 dime-size spots of blood in it & had blood at front of peri-area; on 8-27-24 at 2:45pm hospital staff began skin assessment after arrived at behavioral intake area from ER & assessment revealed resident with multiple areas of bruising, bleeding, & genital trauma (possible indicators of sexual assault); on 8-27-24 at 8:30pm staff performed sexual assault exam which revealed resident had possible sexual & genital trauma, was having bloody discharge, had evidence of abrasions to major & minor labia, evidence of possible penetration & vaginal edema; prior to 8-27-24 resident had increased behaviors but multiple areas of bruising, bleeding & genital trauma not discovered until observed by hospital staff, 1 day after LN documented no skin issues placing resident in immediate jeopardy for neglect & negative psychosocial impact to resident's sense of safety, protection, health & wellbeing*
- *Abatement Plan:*
  - *Resident admitted to hospital*
  - *Resident's responsible party contacted & had already been made aware by police dept*
  - *Facility contacted physician*
  - *Facility began interviewing staff & residents for any indications of abuse & neglect*
  - *Staff in-service on ANE & education completed*
  - *Facility held QAPI meeting*
  - *Facility educated staff to provide care in pairs for all residents until further notice & initiated immediately*
  - *Skin sweep for all resident in building initiated with CPs revised & physician & representative notified with any findings from assessments*
  - *Resident representative informed facility that resident would not be returning*
  - *Facility had resident council meeting to review ANE*

NE: SS=G: Failed to provide adequate supervision to ensure residents remained free from resident-to-resident abuse when 1 resident threw a ceramic mug at another resident during an unsupervised altercation in DR resulting in broken nose for other resident & placing resident at risk for pain, impaired psychosocial wellbeing & ongoing abuse

- *Resident with hx of physical aggression to other residents; failed to ensure residents received needed supervision to ensure resident safety & to prevent episodes of resident-to-resident abuse when resident threw ceramic mug at another resident & fx'd other resident's nose*

NW: J (Past Non-Compliance): Failed to ensure 1 resident remained free from neglect

- *On 08/16/24 at 07:00 AM Certified Nurse Aide (CNA) M entered R1's room, asked if he wanted to get up and when R1 did not answer, CNA M lifted the covers, patted the front of R1's brief, and left the room without ensuring R1 had his call light in reach. At 08:32 AM, CNA M entered R1's room and placed his food tray on the bedside table but did not raise the head of the bed or unwrap*

R1's silverware. R1 proceeded to eat breakfast lying flat, using his left hand, and dropping food all over the front of his shirt. At 09:18 AM R1 reached into his brief and pulled out feces. R1 still did not have a call light in reach to call for staff assistance. At 09:28 AM R1 removed a large ball of feces from his brief and placed it on the bedside table. At 09:39 AM, R1 pulled himself to a seated position on the side of the bed, and at 09:41 AM Certified Medication Aid (CMA) R entered the room and gave R1, who sat on the side of the bed, his medications. R1 picked up the ball of feces from the table and showed it to the CMA. CMA R walked out of the room without assisting the resident, leaving R1 sitting on the side of the bed, with no call light in reach, and the wheelchair pushed to R1's far right, out of his reach. Four minutes later, at 09:45 AM, R1 tried to pull the bed pad, which was covered with feces, out from underneath him using his left hand. During this action, R1 fell to the right side but due to his hemiplegia was unable to break his fall and fell to the right, hitting his head on the floor. R1 lay on the floor yelling and staff entered the room at 09:48 AM. Licensed Nurse (LN) G assessed his blood pressure, and then all staff left the room to get linens, leaving R1 on the floor yelling. The staff did not place a pillow or padding underneath R1's head. Staff returned and began cleaning the area and removing the soiled linens from R1's bed. When staff removed the bed pad, there was a soiled, soaked area under the bed pad as well. During this cleanup procedure, R1 remained on the floor, moaning and yelling. Staff did not close the privacy curtain until the cleanup was done and they assisted R1 from the floor. The facility failed to ensure R1 received the care and service he required when staff failed to ensure R1 had a call light in his reach to call for staff assistance and failed to provide assistance after R1 gestured and communicated the need for help by showing staff a ball of feces. The facility further failed to provide basic toileting and incontinent care when staff failed to thoroughly check the resident for incontinence early in the morning, also evidenced by the bed pad and linens soaked and covered with feces. The facility failed to ensure the resident's dignity was protected and failed to provide comfort measures when staff left the resident on the floor, stepping around and over him without providing padding or a pillow. This series of failures resulted in R1 falling from the bed, hitting his head, and having an acute hemorrhagic brain bleed (an emergency condition in which a ruptured blood vessel causes bleeding inside the brain). The facility's neglect placed R1 in immediate jeopardy. The facility's failure to identify the resident's risks and implement immediate basic safety interventions and staff assistance to prevent a fall placed R1 in immediate jeopardy. The facility's failure to ensure R1 received adequate care consistent with the standards of care after a fall for a resident taking blood thinners placed R1 in immediate jeopardy.

- *Past Non-Compliance Plan:*
    - *All nursing staff were re-educated on policies including Quality Care Documentation, Notifying Primary Care Physician (PCP) and Family, Neurological Assessments and Vital Signs, Change in Condition, Gait Belt Use, Falls, Using a Lift, Abuse, Neglect, and Exploitation] Recognition and reporting.*
    - *The facility implemented a Quality Assurance and Performance Improvement (QAPI) review of the incidents.*
    - *The facility conducted one-on-one disciplinary counseling with direct care staff on duty.*
    - *The involved nurses were terminated.*
    - *Audits were completed to identify residents at risk and to ensure all appropriate actions/interventions were implemented.*

F609 Reporting of Alleged Violations

SE: SS=D (Past Non-Compliance): Failed to report an allegation of staff to resident verbal abuse r/t calling resident "lazy" in presence of another resident

- Review of self-report to State documented on 6-29-24 CMA & CNA witnessed another CNA verbally insult resident while in DR in presence of other resident; event described included as CNA propelled resident to room CNA "yelling at him, calling names, such as lazy and telling him he could do it himself"; CNA stated did not care if "got wrote up again"; witnessing CNA did not report incident to facility staff until gave resignation on 7-8-24; CMA failed to report incident but confirmed it had happened; resident did not recall incident; failed to report allegation of staff to resident verbal abuse to resident

NE: SS=D: Failed to ID elopement for 1 resident as potential neglect & report to State Agency (SA) as required placing resident at risk for unidentified & ongoing neglect

- *Failed to ID elopement for 1 resident as potential neglect & failed to report to SA as required placing resident at risk for unidentified & ongoing neglect*

NW: SS=D: Failed to ID injury of unknown origin as potential abuse & report immediately to Adm for 1 resident who had bilateral upper arm bruises placing resident at risk for further injury & unidentified abuse or mistreatment

- NN documented resident received shower & had bilateral upper arm bruises; Shower Sheet documented resident with bilateral deltoid bruises; EMR lacked documentation further assessment completed r/t status of bruises or how injuries obtained; Adm unaware of bruises; failed to ID resident's injury of unknown origin as potential abuse & report it to administration staff immediately placing resident at risk for further injury & unidentified abuse or treatment

F623 Notice Requirements Before Transfer/Discharge

NE: SS=D: Failed to provide written notice of transfer/discharge as soon as practicable for 1 resident's facility-initiated transfer placing resident at risk of uninformed choices & miscommunication r/t care needs

- NN documented resident hospitalized on multiple occasions; facility unable to provide evidence written notice of transfer or discharge notification provided to resident/representative when resident transferred to hospital on multiple occasions; SS staff stated had not ever sent any written notification to resident/representative r/t transfer & admission to hospital; failed to provide written notice of transfer/discharge as soon as practicable for 1 resident's facility-initiated transfers placing resident at risk of uninformed choices & miscommunication r/t care needs

NW: SS=D: Failed to provide a written notice for facility-initiated transfer for 1 resident/representative as soon as practicable when resident transferred to hospital; also failed to notify Office of Long-Term Care Ombudsman of resident's discharge placing resident at risk for impaired rights & uninformed care choices

- Record lacked evidence resident/representative provided written notice when resident transferred to hospital on dates; SSD stated unaware required to provide resident/representative with written notice when transferred to hospital or that was to notify LTCO when residents were discharged; failed to provide resident/representative written notice r/t resident's transfers to hospital as soon as practicable; also failed to notify LTCO when resident discharged placing resident &/or representative at risk of impaired rights & uninformed care choices

F625 Notice of Bed Hold Policy Before/Upon Transfer

NW: SS=D: Failed to provide 1 resident/representative with written information r/t facility bed hold policy when resident transferred to hospital placing resident at risk for impaired ability to return & resume residence in facility

- Failed to provide 1 resident/representative with bed hold policy upon transfer to hospital placing resident at risk for impaired ability to return & resume residence in facility

F638 Quarterly Assessment at Least Every 3 Months

NE: SS=D: Failed to complete a quarterly MDS no more than 92 days from last MDS for 2 residents placing residents at risk for unidentified & unmet care needs

- EMR indicated Quarterly MDS started on 7-26-24 but never completed & was "in progress" but none completed & accepted since 4-30-24; failed to complete Quarterly MDS assessments for 2 residents within required 92-day timeframe placing 2 residents at risk for unidentified & unmet care needs

F661 Discharge Summary

NW: SS=D: Failed to complete recapitulation post-discharge for 1 resident who had self-initiated discharge from facility placing resident at risk of unidentified & unmet care needs

- Record lacked evidence of recapitulation of resident's stay in facility; failed to complete recapitulation post-discharge for 1 resident placing resident at risk of unidentified & unmet care needs

F677 ADL Care Provided for Dependent Residents

NE: SS=D: Failed to ensure bathing was provided for 1 resident who required assist from staff to complete care placing resident at risk for complications r/t poor hygiene & impaired dignity

- Resident Bath Sheet documented no bathing from 8-31-24 thru 9-10-24; observed resident with greasy hair & long fingernails on 1 hand on multiple occasions; resident stated had been told by staff there was no hot water & resident would have to wait & does not like it when she does not get a bath because it "makes her itch"; failed to provide consistent bathing for 1 resident who required assist with bathing placing resident at risk for complications r/t poor hygiene & impaired dignity

F679 Activities Meet Interest/Needs Each Resident

NE: SS=E: Failed to provide activities on weekends that met residents' interests, social needs & preferences placing residents at risk for boredom, isolation & decreased quality of life

- Review of Activity Calendar for July, August, September, 2024 revealed residents only offered self-led activities in August & September on Saturdays & Sundays & no structured or group activity opportunities on weekends; Resident Council reported no available staff to direct or assist with activities on weekends; failed to provide activities on weekends that met residents' interests, social needs & preferences placing residents at risk for boredom, isolation & decreased quality of life

F684 Quality of Care

SE: SS=D: Failed to complete a thorough investigation to determine causes & contributing factors r/t skin tear & failed to implement appropriate immediate interventions to prevent further skin tear for 1 resident

- Observed resident in high back reclining chair hand with bordered foam dressing in place dated that day; resident with dementia with psychotic behaviors & did not know what happened to hand; LN stated resident wheeled self down hall & would hit hand against wall & doorway; no order r/t resident's hand skin tear; staff confirmed resident's hand skin tear lacked thorough investigation to determine cause or contributing factors as well as lacked immediate intervention to prevent further injuries for dependent resident; failed to complete thorough investigation to determine causes & contributing factors r/t skin tear & failed to implement appropriate immediate interventions to prevent further skin tear for 1 resident

NW: SS=J (Past Non-Compliance): Failed to ensure 1 resident received adequate post-fall treatment consistent with standards of practice

- *Cited findings noted in F600 r/t fall from bed; On 08/16/24 at 09:45 AM R1 fell from a seated position out of bed, onto the floor. R1 fell to the right, hitting his head on the floor. R1 remained on the floor, yelling until staff entered the room at 09:48 AM. Licensed Nurse (LN) G entered the room, assessed his blood pressure with a wrist cuff then all staff left the room to get linens, leaving R1 on the floor yelling. Staff returned and began cleaning the area and preparing R1's bed. During this time, R1 remained on the floor, moaning and yelling. Certified Nurse's Aide M and Licensed Nurse (LN) G started to assist R1 off the floor. Without LN G assessing for fractures or other injuries, CNA M tried to bend R1's legs and R1 yelled out in obvious pain. LN G, CNA M, and Certified Nurse Aide (CNA) N picked R1 up using an underarm method, not using a gait belt, and placed R1 back in bed. LN G wiped the right side of*

R1's face but made no other assessment of his face or head though R1 had visible redness on the right side of his face and received Plavix (medication used to prevent blood from clotting) daily. LN G assessed a wrist blood pressure but did not perform a neurological assessment on R1. LN G asked R1 if he was in pain but R1 did not answer, and LN G took no further action at that time. At 10:36 AM, LN G entered R1's room again and assessed wrist blood pressure but did not perform a neurological exam. At 11:52 AM CNA M assisted R1 out to lunch and at 12:26 PM R1 self-propelled into his room and transferred himself back to bed. Staff did not reenter R1's room until 05:21 PM when staff found R1 lethargic and with vomit on his bed. R1 was transferred emergently to the acute hospital where he was diagnosed with an acute hemorrhagic brain bleed and subsequently died on 08/18/24. The facility's failure to ensure R1 received adequate care consistent with the standards of care after a fall for a resident taking blood thinners placed R1 in immediate jeopardy.

- *Past Non-compliance Plan:*
  - *All nursing staff were re-educated on policies including Quality Care Documentation, Notifying Primary Care Physician (PCP) and Family, Neurological Assessments and Vital Signs, Change in Condition, Gait Belt Use, Falls, Using a Lift, Abuse, Neglect, and Exploitation] Recognition and reporting.*
  - *The facility implemented a Quality Assurance and Performance Improvement (QAPI) review of the incidents. The facility conducted one-on-one disciplinary counseling with direct care staff on duty. The involved nurses were terminated.*
  - *Audits were completed to identify residents at risk and to ensure all appropriate actions/interventions were implemented.*

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

SE: SS=D: Failed to ensure pressure relieving device was in working order for 1/4 residents reviewed for Pus

- Resident with documented PU stage 2 & 2 venous stasis ulcers & MDS indicated resident with pressure reducing device for chair & bed & received PU care; CP instructed staff to ensure low air loss mattress on resident's bed & cushion in chair; observed resident sitting on 2 cushions; observed cushion in recliner with multiple areas of malfunctioning air cells & were deflated; failed to monitor status of 1 resident's ROHO cushion to ensure optimal functioning to provide pressure reduction for resident's stage 2 sacral PU

NE: SS=D: Failed to ensure 1 resident & 1 resident's low air-loss mattress pump, used to prevent Pus was set & functioning for adequate pressure relief placing resident at risk for complications r/t skin breakdown & Pus

- CP indicated resident with low air-loss mattress on bed & CP lacked guidance r/t weight & comfort settings of low air-loss mattress; POS lacked documentation r/t low air-loss mattress; observed bordered mattress & bed CNAs (a side rail device attached to bed to improve bed mobility) on both sides of bed & manufacturer recommendations indication use of bed rails with air mattress system should be assessed based on risk or entrapment; observed mattress set at 350 lbs; failed to ensure 1 resident's low air-loss mattress pump was appropriately set to current weight or indicate weigh settings could be altered per preferences & indicate those preferences placing resident at risk for complications r/t skin breakdown & Pus
- Resident with Huntington's disease; CP lacked direction r/t use of low air-loss mattress & appropriate weight or comfort settings; resident with documented weight of 107.2 lbs; observed resident in bed & low air-loss mattress not plugged in & was deflated & mattress set at 350 lbs; failed to ensure 1 resident's low air-loss mattress was plugged in & further failed to set it at correct weight to provide adequate pressure relief placing resident at increased risk for PU development

NW: SS=D: Failed to ensure pressure-reducing devices functioned correctly to prevent worsening of PU/injury for 1 resident's coccyx wound placing resident at risk for delayed healing or worsening of existing PU

- Documentation of resident with 1 new stage 1 PU & 1 stage 3 PU with new onset of urinary incontinence; resident with ROHO cushion in w/c & recliner; resident verified resident slept in recliner r/t bed uncomfortable & resident stated staff had instructed resident to change positions; observed ROHO cushion in seat of recliner had lost air & gone flat; failed to ensure 1 resident's pressure-reducing cushion functioned correctly placing resident at risk for delayed healing or worsening of existing PU

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to ensure 3 residents were provided services & treatment to prevent worsening of contractures placing residents at risk for discomfort & decreased ROM

- DON stated facility did not have restorative program & PT assessed each resident every quarter & if decline noted staff would get a physician order to treat & if resident didn't qualify for therapy facility would give resident 4 free days; Failed to ensure 1 resident received services & treatment for contractures to prevent further loss of ROM & to promote comfort
- CP indicated restorative program would address & provide rehab/restorative plan; TAR for August & September revealed no passive or active ROM exercises listed or documented; failed to provide services to maintain or improve resident's ROM & ADL abilities while waiting for therapy to begin placing resident at risk for decline in ROM & development of contractures
- POS for palm guard splint to hand for 5-8 hours; TAR documented splint had not been applied on 4 days in current month & documented "splint not available"; observed resident on multiple occasions w/o splint; failed to ensure staff applied resident's palm guard splint as ordered placing resident at risk for decreased mobility & impaired quality of life

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=D: Failed to complete safe transfer for dependent resident using sit to stand lift r/t lack of use of sling's safety belt to ensure resident's safe transfer

- Observed 2 CNAs transferred resident, positioned sling under resident's back & hooked it to lift but failed to secure safety belt prior to lifting resident from chair with lift; staff reported safety belt was broken & was not able to secure Velcro around resident & had

been broken for over 1 week but continued to use it & stated had not reported safety belt as broken; failed to complete safe transfer for dependent resident using sit to stand lift r/t lack of use of sling's safety belt to ensure resident's safe transfer

SW: SS=G: Failed to provide adequate supervision to ensure a safe environment for 1 resident after fall while outside alone; as result resident had 2nd fall while outside alone resulting in abrasions & laceration to palm that required sutures as well as rib fx's; also failed to evaluate 1 resident for ability to safely handle hot liquids to ID risk & implement interventions & education to prevent accidents & subsequently resident spilled coffee & sustained multiple burns including 2nd degree burn placing residents at risk for increased pain

- *Resident with hx of falls with CP interventions; Fall investigation documented resident self-propelled self outside in w/c & was going too fast causing resident to fall forward onto knees & resident sustained abrasions to knee; staff assisted resident to w/c & took resident to room; resident with another fall outside resulting in "deep laceration across palm"; resident with another fall outside when wheels went off sidewalk causing resident to fall from w/c resulting in sutures to hand & rib fx's; failed to provide adequate safety interventions & supervision for 1 resident in order to promote safe environment free from accident hazards after resident had fall while outside & as result resident had 2nd fall while outside resulting in palm laceration requiring sutures as well as ID of multiple rib fx's placing resident at risk for increased pain & decreased mobility*
- *Record lacked evidence facility assessed resident's ability to safely handle hot liquids; Investigation documented CNA gave resident coffee & walked out of room then heard noise, went back into room & noted resident had spilled coffee; failed to assess 1 resident's ability to handle hot liquids to ID risks & implement safety intervention including education for resident r/t potential hazards & as result resident spilled coffee & sustained 2nd degree burns placing resident at risk for increased pain*

NE: J (Abated to D): Failed to provide adequate staff response to door alarms to prevent cognitively impaired & independently mobile resident from eloping from facility

- *On 09/11/24 at 07:26 AM resident pressed the release bar on an emergency exit door for 15 seconds, opened the door, and exited the facility. The door alarm sounded but no staff responded, therefore, staff were unaware resident exited the facility. Resident wheeled self down the sidewalk of the rear parking lot. Therapy Consultant arrived for work around 07:32 AM and observed resident outside near the facility dumpsters on the side of the building and alerted facility staff. Staff assisted resident back inside the facility and assessed for injuries though none were noted. The failure of facility staff to respond to the door alarms in order to ensure resident's safety and prevent cognitively impaired resident from exiting the facility without staff supervision or knowledge, placed resident in immediate jeopardy.*
- *Abatement Plan:*
  - *Resident's CP updated to include current status of resident's exit seeking*
  - *Staff placed Wander Guard on resident*
  - *Full in-service given to staff to discuss resident & procedure for answering door alarms*
  - *Maintenance director assessed door, door alarms & added louder door alarm to emergency exit door*
  - *Nursing staff educated on answering alarms immediately*
  - *Any resident suspected of exit seeking would be assessed by IDT & protective action taken immediately*
  - *All-staff in-service on elopement prevention & response to door alarms scheduled*

NE: SS=G: Failed to ensure 1 resident remained free from avoidable accident hazards when staff failed to provide safe transfers using required number of staff & required equipment per resident's CP; subsequently resident sustained fx's to both ankles/lower legs also placing resident at risk for increased pain & impaired wellbeing

- *CP documented resident used sit-to-stand lift with extensive assist of 2 staff members for transfers; Incident report documented CNA entered room & resident with legs dangling over side of bed & CNA stated resident adamant about getting up; investigation documented 2 CNAs transferred resident from bed to w/c at resident's request & resident reported bilateral ankle pain; investigation lacked ID of any other staff who assisted resident's transfer; Adm nurse reported only interviewed 1 CNA even after it was reported that transfer was done with 2 staff members; no other CNAs or CMAs reported assisting CNA with transfer; failed to ensure 1 resident remained free from avoidable accidents resulting in bilateral ankle &/or lower leg fx's also placing resident at risk for increased pain & impaired wellbeing*

NW: SS=J: (Past Non-compliance): Failed to implement safety interventions to ensure Resident (R) 1 remained free from falls

- *On 08/16/24, R1, laid flat in his bed around 07:00 AM. The bed was not in the lowest position and R1 did not have his call light within reach. Certified Nurse Aide (CNA) M entered R1's room, asked if R1 wanted to get up and when R1 did not answer, CNA M lifted the covers, patted the front of R1's brief and left the room without ensuring R1 had his flat call light in reach. At 08:32 AM, another staff entered R1's room, placed a food tray on the bedside table but did not ensure R1 had his call light. At 09:39 AM, R1 pulled himself to a seated position on the side of the bed. At 09:41 AM Certified Medication Aid (CMA) R entered the room and gave R1, who sat on the side of the bed, his medications. CMA R walked out of the room leaving R1 sitting on the side of the bed, with no call light in reach. Four minutes later, at 09:45 AM, R1 pulled the bed pad, which was covered with feces out from underneath him using his left hand. During this action, R1 fell to the right side but due to his hemiplegia was unable to break his fall. R1 fell to the floor from a seated position, hitting his head on the floor. As a result of the fall, R1 suffered a hemorrhagic brain bleed and subsequently died. The facility's failure to identify the resident's risks and implement immediate basic safety interventions and staff assistance to prevent a fall placed R1 in immediate jeopardy.*
- *Past Non-Compliance Plan:*
  - *All nursing staff were re-educated on policies including Quality Care Documentation, Notifying Primary Care Physician (PCP) and Family, Neurological Assessments and Vital Signs, Change in Condition, Gait Belt Use, Falls, Using a Lift, Abuse, Neglect, and Exploitation] Recognition and reporting.*

- *The facility implemented a Quality Assurance and Performance Improvement (QAPI) review of the incidents. The facility conducted one-on-one disciplinary counseling with direct care staff on duty. The involved nurses were terminated.*
- *Audits were completed to identify residents at risk and to ensure all appropriate actions/interventions were implemented.*

F698 Dialysis

NE: SS=D: Failed to ensure ongoing communication & collaboration with dialysis facility for dialysis care & services r/t resident's health status with each procedure; additionally failed to weigh resident before dialysis appointments on 8 occasions placing resident at risk for complications r/t end-stage renal failure

- Failed to ensure ongoing communication & collaboration with dialysis facility r/t resident's health status with each procedure; additionally failed to weigh resident before dialysis appointments on 8 occasions placing resident at risk for complications r/t end-stage renal failure

F700 Bedrails

NE: SS=D: Failed to ensure 1 resident had safety assessment for use of side rails, consent for use of side rails & failed to ensure resident/representative were advised of risks &/or benefits of use of side rails placing resident at risk for uninformed decisions & impaired safety r/t risks associated with use of side rails

- CP ID'd resident with low air-loss mattress but lacked documentation of bilateral bed cane-style side rails; POS lacked documentation r/t bed canes; EMR lacked documented safety assessment for use of side rails & consent for use of side rails; EMR lacked evidence resident/representative advised of risks &/or benefits of use of side rails; failed to ensure resident had safety assessment for use of side rails that acknowledged risks from low air-loss mattress, a consent for use of side rails, & failed to ensure resident/representative were advised of risks &/or benefits of use of side rails placing resident at risk for uninformed decisions & impaired safety r/t risks associated with use of side rails

NW: SS=D: Failed to ensure bed rail that met safety requirements & addressed risks for entrapment for 1 resident placing resident at risk for accident or injury due to unidentified risks associated with side rail use

- Side rail assessment did not document rail's openings or address space between side rail/hoop & mattress; EMR lacked evidence therapy evaluated type of rail & its usage; failed to adequately assess resident's actual rail in use to ensure safe openings & failed to assess for safe use of side rail prior to placing it on resident's bed placing resident at risk for accident or injury due to unidentified risks associated with side rail use

F745 Provision of Medically Related Social Service

NW: SS=D: Failed to provide medically related social services to attain or maintain highest practicable physical, mental, & psychosocial wellbeing of 1 resident who made statements of self-harm placing resident at risk for further decline in emotional & mental wellbeing

- Resident with dementia, bipolar d/o, TBI, depression & newly dx'd with suicidal ideation; NN documented resident wandering halls, asking staff repeatedly when resident could leave & calling family several times; resident with multiple psychoactive meds; EMR lacked documentation physician notified of further documentation r/t resident's suicidal ideation; NN documented resident with multiple self-harm statements; record lacked evidence of social work follow up to address resident's suicidal verbalizations, feelings of sadness & potential spiritual crisis; SS verified had not discussed with resident suicidal ideation because did not want to bring it up & that did not document visits with residents; failed to provide medically related SS to attain or maintain highest practicable physical, mental & psychosocial wellbeing for 1 resident placing resident at risk for further decline in emotional & mental wellbeing

F756 Drug Regimen Review, Report Irregular Act On

NE: SS=E: Failed to ensure a medication regimen review (MRR) was completed at least monthly for 5 residents; further failed to ensure the Consultant Pharmacist (CP) identified and made recommendations for a CMS approved indication or a GDR for antipsychotic medications for 2 residents; failed to ensure the CP identified and reported 2 resident's diclofenac lacked a dosage; facility failed to ensure the CP identified and reported 1 resident's antihypertensive medication was given outside of the physician-ordered parameters placing resident at risk for unnecessary medication effects.

- EMRs for 5 residents lacked evidence MRR completed from October 2023 thru Dec 2023; failed to ensure MRR completed at least monthly placing affected residents at risk for unnecessary medications & related complications
- Failed to ensure CP ID'd & reported that resident lacked CMS-approved indication or required physician documentation for use of antipsychotic meds w/o GDR attempts placing resident at risk for unnecessary medication administration & possible adverse side effects
- Failed to ensure CP ID'd & reported lack of CMS-approved indication or required physician documentation for use of antipsychotic meds e/o GDR attempts & failed to ID & report lack of dosing instructions for Voltaren placing resident at risk for unnecessary med administration & possible adverse side effects
- Failed to ensure CP ID'd & reported irregularities for lack of dosing instructions for Voltaren gel & further failed to ID & recommend GDR & CMS-approved indication for 1 resident's Quetiapine placing resident at risk for unnecessary med use, side effects & physical complications
- Failed to ensure CP ID'd & reported irregularities for meds given outside physician-ordered parameters for 1 resident placing resident at risk for unnecessary med use, side effects & physical complications

NW: SS=D: Failed to ensure CP ID'd & reported that staff failed to follow physician orders to administer insulin & meds to treat Parkinson's disease placing resident at risk for physical decline & ineffective medication regimen

- POS for Sinemet for Parkinson's MAR lacked documentation that staff administered Sinemet on 2 doses in July, 1 dose in August; POS for Novolog TID for DM; TAR lacked documentation insulin administered 2 doses in July; POS for insulin Glargine BID & TAR lacked documentation insulin administered on 2 doses in August & 1 dose in Sept; MRRs for July, August, & Sept lacked evidence CP ID'd & reported resident had not been administered ordered meds & insulin; failed to ensure CP ID'd & reported that staff failed to follow physician's orders to administer insulin & med to treat Parkinson's disease placing resident at risk for physical decline & ineffective med regimen

NW: SS=D: Failed to ensure CP ID'd reported lack of 14-day stop date or specified duration for 1 resident's PRN antianxiety med placing resident at risk for unintended effects r/t psychotropic drug meds

- EMR lacked evidence of specified duration which included physician's rationale for extended use of PRN Lorazepam; CP's MRR lacked evidence Cp Idd PRN Lorazepam with no stop date; failed to ensure CP ID'd & reported lack of 14-day stop date for use of PRN Lorazepam for 1 resident placing resident at risk for unnecessary psychotropic med

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to ensure antihypertensive med was administered per physician-ordered parameters for 1 resident & failed to ensure dosing instructions for Voltaren for 2 residents placing residents at risk for unnecessary medication use, side effects & physical complications

- Cited findings noted in F756; Failed to ensure staff followed physician orders for 1 resident's antihypertensive meds placing resident at risk of adverse side effects & unnecessary meds r/t hypertension
- Failed to ensure dosing instructions for Voltaren gel for 1 resident placing resident at risk for unnecessary med use, side effects & physical complications
- Failed to ensure 1 resident's physician-ordered Voltarin had indicated dosage for application placing resident at risk of unnecessary med administration & possible adverse side effects

NW: SS=D: Failed to administer meds as ordered by physician for 1 resident who received insulin & meds to treat Parkinson's placing resident at risk for unnecessary med side effects & ineffective med regimen

- Cited findings noted in F756 r/t lack of multiple documentation of administration of Sinemet & insulin; failed to administer meds as ordered by physician for 1 resident who received insulin & Parkinson's disease meds placing resident at risk for unnecessary med side effects & ineffective med regimen

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure 3 residents had CMS-approved indication for use of antipsychotic or required physician documentation; further failed to ensure GDR attempted or documented as contraindicated by physician with supporting rationale placing residents at risk for unnecessary meds & adverse side effects

- Cited findings noted in F756; Failed to ensure 1 resident had CMS-approved indication or required physician documentation for use for antipsychotic meds w/o GDR attempts placing resident at risk for unnecessary med administration & possible adverse side effects for multiple residents

NW: SS=D: Failed to ensure 14-day stop date or specified duration with rationale for 1 resident's ongoing PRN antianxiety med placing resident at risk for unintended effects r/t psychotropic drug meds

- Failed to ensure 1 resident free of unnecessary psychotropic drugs when failed to obtain stop date for use of PRN Lorazepam placing resident at risk for adverse side effects from continued use of psychotropic med

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

- CP lacked interventions r/t use of antipsychotics, behavioral interventions & drug information including side effects & warnings; POS for Trazodone, Zyprexa; EMR lacked documentation of any hx of, or ongoing hallucinations or behaviors; failed to ensure appropriate CMS approved indication or required physician documentation for continued use of 1 resident's antipsychotic placing resident at risk for unnecessary psychotropic meds & adverse side effects

F761 Label/Store Drugs & Biologicals

NW: SS=E: Failed to store biologicals as required when staff failed to discard or destroy expired meds & vaccines placing residents of facility at risk of receiving ineffective meds

- Observed med cart with MVI with minerals with no expiration date; med room with multiple biologicals with expired dates & multiple vaccines with expired dates; failed to discard or destroy expired meds & vaccines placing residents of facility at risk of receiving ineffective meds

NW: SS=D: Failed to place open &/or discard dates on 1 resident's Admelog & Tresiba flex pen placing resident at risk of receiving expired or ineffective dose of insulin

- Observed med cart with 1 resident's Admelog & Tresiba flex pens w/o open date or discard date

F801 Qualified Dietary Staff

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

- Failed to employ a full time director of food & nutrition services who had required qualifications &/or CDM placing residents at risk for unmet dietary & nutritional needs

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

- Failed to employ a full time CDM for all residents residing in facility placing residents at risk of inadequate nutrition

NW: SS=F: Failed to employ a full time CDM to supervise preparation of meals & sanitation in facility's kitchen placing all residents of facility at risk for inadequate nutrition

- Failed to employ a full time CDM to supervise preparation of meals & sanitation in facility's kitchen placing all residents of facility at risk for inadequate nutrition

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NW: SS=E: Failed to provide food prepared by methods that conserve nutritive value, flavor & appearance when dietary staff failed to measure & provide proper amounts of food for 4 residents with pureed diet placing 4 residents at risk for impaired nutrition

- Failed to provide food prepared by methods that conserve nutritive value, flavor & appearance while preparing pureed diet placing affected residents at risk for impaired nutrition

NW: SS=E: Failed to serve palatable food during meal for 2 resident in facility receiving ground meat from facility kitchen placing residents at risk for foodborne illness & decreased quality of life

- Observed dietary staff prepare ground meat then scooped out portion of ground hamburger, placed it on bun & scooped out portion of beans on same plate along with lettuce, tomato & onion x 2 resident meals; staff had not checked ground meat temp after taken out of oven; meat temped at 132 degrees F; staff unaware of required temp; failed to ensure holding temps of ground meat was at or above 140 degrees F to ensure appropriate palatability as well as inhibit growth of bacteria placing residents at risk for foodborne illness & decreased quality of life

F812 Food Procurement, Store/Prepare/Serve-Sanitary

NE: SS=F: Failed to ensure staff stored food items in accordance with professional standards for food service safety; failed to ensure high-temp dishwasher was in proper working condition to wash & sanitize kitchenware & dishes placing residents at risk of foodborne illness & cross-contamination

- Observed area of kitchen with 15x4 feet area missing floor with cement flooring exposed underneath; freezer temp logs with missing temp logs; clean plates stored in plate service cart w/o cover over plates; walk-in fridge & freezer with unlabeled, undated food items; staff reported main dishwashing machine not reaching optimal temp during rinse cycle

F814 Dispose of Garbage & Refuse Properly

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

- Observed 2/4 compartments dumpster open with exposed trash & garbage; additionally discarded building supplies surrounded dumpster with grass grown over edges; failed to maintain &/or dispose of garbage & refuse properly in sanitary condition to prevent harborage & feeding of pests

F838 Facility Assessment

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

- The assessment did not identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census. The assessment lacked the staffing levels required for each shift. The assessment did not identify staffing-specific skill sets for each resident unit based on the resident population assessed of that unit. The assessment lacked an informed contingency plan for events that do not require activation of the facility's emergency plan but have the potential to impact resident care. The assessment lacked a plan to maximize recruitment and retention of direct care staff. The assessment did not identify the means of input gathered from the residents and their representatives when formulating the assessment data; failed to conduct a thorough updated facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations & emergencies placing all residents residing in facility at risk for impaired care

F849 Hospice Services

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

- Failed to ensure collaboration between facility & hospice provider placing resident at risk of missed or delayed services & inadequate end-of-life care

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

- 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 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 staffing information when facility failed to accurately report 24 hr per day LN coverage on 12 dates between 7-1-23 thru 9-30-23 & 10 days between 1-1-24 thru 3-31-24

- 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 staffing information when facility failed to accurately report 24 hr per day LN coverage on 12 dates between 7-1-23 thru 9-30-23 & 10 days between 1-1-24 thru 3-31-24

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

- PBJ for 3 quarters of FY 2023 documented facility w/o LN coverage 24 hrs/days y7 days wk on multiple days; payroll records documented LN on duty 24 hr/day/7 days/wk; failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

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

- Records documented LN present 24 hrs/day, 7 days/wk; Adm stated had noted some of LN hours not input into computer so didn't get reported; Failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

F880 Infection Prevention & Control

NE: SS=F: Failed to implement signage or indicators within physical environment to alert staff & visitors of required EBP; further failed to provide a Legionella water management program to assess & mitigate risk of Legionella & failed to maintain water temps to effectively clean & disinfect laundry; further failed to ensure staff performed adequate hand hygiene, respiratory equipment was stored in sanitary manner & failed to transport linens in sanitary manner placing residents at risk for infectious diseases

- Failed to implement signage or indicators within physical environment to alert staff & visitors of required EBP; further failed to provide a Legionella water management program to assess & mitigate risk of Legionella & failed to maintain water temps to effectively clean & disinfect laundry; further failed to ensure staff performed adequate hand hygiene, respiratory equipment was stored in sanitary manner & failed to transport linens in sanitary manner placing residents at risk for infectious diseases

NW: SS=D: Failed to ensure EBP used for 1 resident with ongoing PU & dressing change placing resident at risk for infectious disease processes

- Observed LN provided dressing change to resident & forgot to bring dressing & left room & upon returning failed to don gown while assisting resident to BR & during dressing change; failed to ensure staff use EBP while caring for resident with ongoing PU & dressing change placing resident at risk for facility-acquired infections

F882 Infection Preventionist Qualifications/Role

NW: SS=F: Failed to ensure staff person designated as IP who was responsible for facility's IPCP completed specialized training for infection prevention & control placing all residents in facility at risk for lack of identification & tx of infections

- IPCP in process of taking class but not certified; failed to ensure staff person designated as IP possessed required certification placing residents at increased risk for infections

F883 Influenza & Pneumococcal Immunizations

NW: SS=E: Failed to follow latest guidance from CDC when failed to offer & administer or obtain informed declination a physician-documented contraindication for 5 residents for pneumococcal PCV 20 vaccination placing residents at risk of acquiring, spreading & experiencing complications from pneumococcal disease

- Records for 5 residents lacked evidence facility/representative received or signed consent or informed declination for current PCV20; records lacked evidence of physician-documented contraindication; failed to offer pneumococcal PCV 20 vaccinations per CDC recommendations placing residents at risk of acquiring, spreading, & experiencing complications from pneumococcal disease

F941 Communication Training

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

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

F942 Resident Rights Training

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

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

F945 Infection Control Training

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

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

October, 2024

F550 Resident Rights/Exercise of Rights

NW: SS=D: Failed to protect 1 resident's dignity when resident put on call light because had to have BM & CNA came into room turned off call light, stated would be right back & did not return to resident's room for 2 hours; resident incontinent of bowel in bed placing resident at risk for impaired dignity & psychosocial impairment

- *CP lacked any direction r/t resident's ADLs; observed resident in w/c with overgrowth of beard & shirt unclean with dander all over front; resident stated had been humiliated at facility because 1 day used call light to call for help because had to have BM & staff came in, turned call light off & said would be right back then did not come back for 2 hours & resident pooped his pants & was humiliated; resident stated was a grown man & sit in refuse really made him very angry because pain good money to get care needed; CMA stated staff not taking care of residents way supposed to & lack of staffing for reason for lack of care; CNA stated "sick about how residents in facility being treated; CNA stated lack of staffing & more residents requiring 2 assistants cause of lack of care; LN stated glad "the state" was in building so hopefully something would be done about lack of care residents were receiving & lack of staffing reason care not being completed; failed to provide care in manner that promoted resident's dignity placing resident at risk for impaired dignity & psychosocial impairment*

F582 Medicaid/Medicare Coverage/Liability Notice

NW: SS=D: Failed to provide 2 residents complete information on NOMNC which informed beneficiary of right to expedited review by QIO placing residents at risk of uninformed decisions about skilled services & inability to appeal

- Failed to provide complete information on NOMNC which informed beneficiary of right to expedited review by QIO placing residents at risk of uninformed decisions about skilled services & inability to appeal

F600 Free from Abuse & Neglect

NE: SS=J (Past Non-Compliance): Failed to ensure cognitively impaired Resident remained free from physical abuse.

- *On 10/09/24 at approximately 08:25 AM, LN overheard CNA tell resident she could not have any sugar because she was diabetic and resident became upset. LN turned around and observed resident hit CNA stomach. LN observed CNA to resident by making a fist and punching resident in the left upper arm. LN immediately notified Administrative Nurse who removed CNA from the building and suspended her pending investigation. Resident complained of left upper arm pain. Staff assessed the area and identified resident had a blue bruise on her left upper arm. Resident continued to complain of left upper arm pain and required PRN pain medication. The facility's failure to ensure resident remained free from staff-to-resident physical abuse placed resident in immediate jeopardy.*
- *Abatement Plan:*
  - *Suspended CNA immediately pending investigation*
  - *Completed skin assessment which revealed bruise to upper arm*
  - *Notified SA & law enforcement & law enforcement obtained witness statements at facility & provided case number*
  - *Provider saw resident following incident*
  - *Completed X-ray with no positive findings*
  - *Completed skin assessments on all resident on that unit*
  - *Interviewed all resident on that unit with BIMS of 10 or higher for safety & abuse*
  - *Staff received abuse education*
  - *SS visited resident daily x 3 days*
  - *Terminated CNA & banned from returning*

F623 Notice Requirements Before Transfer/Discharge

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

- EMR lacked documentation showing that written notification of transfer was provided to resident/representative; failed to send written notification of facility-initiated transfer for 1 resident placing resident at risk for miscommunication between resident/representative & possible missed opportunities for healthcare services

F625 Notice of Bed Hold Policy Before/Upon Transfer

NE: SS=D: Failed to provide a copy of bed hold policy to 1resident/representative when resident transferred to hospital placing resident at risk for impaired right to return to facility to same room

- Record lacked evidence facility sent a bed hold notice to 1 resident/representative for transfer to hospital; failed to provide copy of bed hold policy for transfer to hospital for 1 resident/representative placing resident at risk for impaired right to return to facility to same room

F677 ADL Care Provided for Dependent Residents

NW: SS=D: Failed to ensure staff provided consistent bathing &/or showers for 3 residents placing residents at risk for impaired dignity, infection, & alteration in skin integrity

- *CP lacked direction r/t resident's ADLs; EMR documented resident had 4 showers from 9-3 thru 10-2; observed resident with overgrowth of beard & shirt unclean with white dander all over front; resident stated had not been getting showers as scheduled & felt dirty & unclean & had to wait 10-14 days for shower not acceptable;*
- *CP lacked directions to staff r/t bathing/showering; EMR documented resident had 4 showers from 9-3 thru 10-2; observed resident with unkempt hair with white specks of dandruff thru hair & resident stated had not been showers as scheduled & felt dirty & smelly & stated staff did not have enough time to get in shower for bathing*
- *CP directed staff to bath resident 2x/wk & record documented had 3 showers from 9-3 thru 10-2 observed resident with oily hair & distinct odor of urine; multiple staff reported residents not being cared for & resident lucky to get showers 1 every 10 days; cited findings noted in F550 r/t ADL cares; failed to ensure staff provided consistent bathing &/or showers for 3 residents placing residents at risk for impaired dignity, infection & alteration in skin integrity*

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

NE: SS=D: Failed to ensure 2 resident's pressure-reducing interventions were implemented correctly when low-air-loss mattress pumps were set at an inappropriate weight for each resident placing all affected residents at risk for complications r/t skin breakdown & Pus

- CP noted resident with pressure-reducing mattress in place but CP lacked guidance on low air-loss mattress settings; manufacturer guidance indicated pump & mattress intended firmness adjusted based on recommendations of healthcare professional & patient's weight; observed mattress set to 550 pounds & mattress labeled by hospice services; failed to ensure 1 resident's low air-loss mattress system set to appropriate weight placing all affected residents at risk for complications r/t skin breakdown & Pus
- Resident's weight 197 pounds; LN stated nursing would ensure low air loss mattress working & would not adjust settings; observed mattress set at 300 pounds; observed during wound care heel slid across sheets on multiple occasions contrary to CP; during wound care observed LN doffed gloves & donned new gloves w/o performing hand hygiene, then wearing soiled gloves, opened Santyl & placed ointment on dry dressing then placed dressing onto wound; failed to ensure 1 resident's pressure-reducing interventions were adequate implemented placing resident at risk for complications r/t skin breakdown & worsening PUs

NW; SS=G: Failed to prevent a facility-acquired deep tissue injury (DTI) for 1 resident who sustained a DTI to buttock when staff placed bed pan under resident backward & left it under resident for too long; further failed to remove mechanical lift sling from 1 resident & resident sustained reddened area on buttocks placing resident at risk for further skin injury & breakdown

- NN documented resident with blanchable area from bedpan that was placed under resident backward; physician notified & ordered skin prep; observed staff transferred to w/c by mechanical lift & stated did not feel right & was not comfortable & staff attempted to reposition resident by pulling on sling that was left under resident after transfer; resident continued to state not comfortable & staff left sling under resident despite question from survey team about if sling might be bunched up under resident; observed later with sling still under resident in w/c; failed to prevent facility-acquired pressure injury for 1 resident who obtained DTI to buttock when staff placed incorrectly sized bed pan backward under resident & left it under resident for too long; further failed to remove mechanical lift sling from under resident resulting in reddened area on buttocks placing resident at risk for further skin injury & breakdown

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=J (Past Non-Compliance): Failed to provide adequate supervision to prevent elopement for 1 resident who was cognitively impaired, at high risk for elopement, and had a recent history of exit-seeking.

- *The facility placed a WanderGuard on resident on 10/04/24 due to resident's exit-seeking behaviors and setting off door alarms. Resident wandered the halls and into other residents' rooms almost daily from 10/06/24 through, and including, 10/11/24. On 10/12/24 resident ambulated past staff, from the dining room to the great room. Staff observed resident in the lobby area around the hall after he left the dining room, but did not accompany or redirect him to a safe place. Resident ambulated to the facility's great room, and pushed on the locked door, causing the door to release after 15 seconds. According to staff, the door alarmed, but staff were too far away to hear it. Resident then ambulated unsupervised through the courtyard, opened the gate, and walked around the side of the building on the sidewalk. Staff noted resident had exited the building unattended when staff observed resident outside at the front of the facility and at that time staff also acknowledged the sounding door alarm. The lack of supervision and response to a sounding door alarm allowed resident to exit the facility without staff knowledge or supervision and placed resident in immediate jeopardy.*
- *Abatement Plan:*

- *Resident assessed & placed under 1:1 staff supervision*
- *Resident's physician & family notified*
- *Resident's CP updated with interventions to address resident's desire to go outside & experience the weather*
- *Implemented daily behavioral audits in clinical meeting to review & follow up on any new behaviors from 24-hour report*
- *Staff received education on elopement policies & procedures*

NW: SS=D: Failed to prevent accidents for 1 resident when staff transported resident in w/c w/o footrests & resident fell forward onto floor & hit head placing resident at risk for injuries & increased pain; further failed to ensure environment free from accidents when staff failed to secure hazardous chemicals placing all confused, independently mobile residents at risk for accidental ingestion

- Fall Investigation documented staff transported resident in w/c to obtain weight w/o foot pedals & as staff started to push resident up incline, resident plated feet on ground, fell forward out of w/c & hit head on floor & sustained large hematoma & required ER by ambulance; failed to ensure 1 resident's environment remained free from accident hazards when failed to put w/c pedals on resident's w/c placing resident at risk for increased pain & further falls with injury
- Observed elevator with button to deactivate door alarm; observed maintenance shop accessible through unlocked double door; failed to ensure hazardous chemical were not accessible to confused, independently mobile residents

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to ensure 1 resident had physician-ordered indication for indwelling catheter & failed to provide adequate catheter care within standards of care placing resident at risk of catheter-related complications & UTIs

- POS for Foley catheter but lacked indication for catheter; observed CNA provide peri-/catheter care & cleaned rectal area then w/o performing hand hygiene, donned another pair of gloves then performed catheter care using multiple wipes with same wipe then wearing same soiled gloves transferred resident into w/c & placed drainage bag back into privacy bag; failed to ensure 1 resident had appropriate indication for indwelling catheter & failed to ensure standard of care provided during catheter care placing resident at risk of catheter-related complications & further UTIs

F692 Nutrition/Hydration Status Maintenance

NE: SS=G: Failed to provide nutritional interventions to prevent 1 resident's ID'd & continued slow weight loss; as result of deficient practice, resident had significant unplanned weight loss of 13.06% within 3 months placing resident at risk for malnourishment r/t complications

- Failed to provide nutritional interventions & failed to involve RD when initial weight loss for 1 resident & as result of deficient practices resident had significant unplanned weight loss of 13.06% within 3 months placing resident at risk for malnourishment r/t complications

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

NE: SS=F: Failed to ensure 1/5 reviewed CNAs were reviewed for yearly performance evals & in-service training placing residents at risk for inadequate care

- Failed to ensure 1/5 CNAs reviewed had required yearly performance evals completed placing residents at risk for inadequate care

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure PRN psychotropic med had 14-day stop date or specified duration with supporting physician documentation for 1 resident's PRN psychotropic meds placing resident at risk for unnecessary med administration & possible adverse side effects

- Failed to ensure 1 resident's PRN Lorazepam had stop date or physician-ordered specified duration for administration placing resident at risk for unnecessary med administration & possible adverse side effects

F761 Label/Store Drugs & Biologicals

NW: SS=E: Failed to ID & dispose of expired meds appropriately placing residents at risk for ineffective meds

- Observed multiple expired stock meds; failed to ID & dispose of expired meds appropriately placing residents at risk of receiving ineffective medication

F812 Food Procurement, Store/Prepare/Serve-Sanitary

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

- Observed: fridge with opened, unlabeled food/fluid items; kitchenette with unlabeled, undated food items; drink station with opened undated items & expired foods;

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

- Observed: wooden cupboards with numerous different-sized scrapes on outer surface; cupboards & drawers with scrapes on outer surface; fans with gray debris on blades; door frame missing piece of trim; trash CNA with streaks of substance around sides of it & on lid; wooden cupboards with scrapes on outer wood; mop board with gray substance

F849 Hospice Services

NE: SS=D: Failed to ensure collaboration between nursing home & hospice services to ID hospice-supplied services, supplies, medication & equipment for 1 resident placing resident at risk for delayed services & uncommunicated care needs

- CP lacked documentation r/t hospice contact information, equipment, medications, services & scheduled visits from hospice staff; failed to ensure collaboration between facility & hospice services to ID hospice-supplied services, supplies, medication & equipment for 1 resident placing resident at risk for delayed services & uncommunicated care needs

NW: SS=D: Failed to ensure communication process between hospice provider & facility for 1/2 residents reviewed for hospice placing resident at risk for not receiving adequate end-of-life care

- CP lacked mention of resident's hospice admission & guidance for staff r/t hospice services; failed to ensure communication process between hospice provide & facility for 1 resident including CP from hospice & description of services provided, noting visit frequency, meds & medical equipment placing resident at risk of not receiving adequate end-of-life care

F880 Infection Prevention & Control

NE: SS=E: Failed to ensure proper infection control standards were followed r/t hand hygiene & disinfecting shared equipment between each resident placing residents at risk for complications r/t infectious diseases

- Cited findings noted in F690 r/t observation of catheter care; observed staff failed to disinfect sit-to-stand lift; cited findings noted in F692 r/t inappropriate wound care r/t hand hygiene; failed to ensure proper infection control standards were followed r/t hand hygiene & disinfecting shared equipment between each resident placing residents at risk for complications r/t infectious diseases