May, 2022 Survey Findings

**October, 2021**

**F550 Resident Rights/Exercise of Rights**

NW: SS=D: Failed to promote care in a manner to maintain and enhance dignity and respect, when staff applied a patch to 1 resident's right shoulder at the dining room table, with 5 residents in full view

- Failed to promote care for 1 resident in a manner to maintain & enhance dignity & respect

**F584 Safe/Clean/Comfortable/Homelike Environment**

NW: SS=E: Failed to provide comfortable sound levels to allow for privacy & unwanted noise for overhead intercom paging system placing all residents at risk for unwanted noise/sound levels in facility

- Observed/heard on multiple occasions, office staff made generalized announcements on overhead paging system that started off as shrill noise followed by announcement that pertained to staff & not residents; failed to provide a comfortable sound level intercom paging system which allowed staff to communicate with other staff in building placing residents at risk for excess noise & an uncomfortable home like environment

**F677 ADL Care Provided for Dependent Residents**

NW: SS=D: Failed to provide staff assistance with eating to 1 resident, who required assistance of 1 staff for eating and who had a recent weight loss

- Observed resident in w/c at DR table & resident with full plate of food; observed resident did not eat any of meal independently & staff did not come over to table to assist resident with eating meal; 50 minutes later, CNA sat down to assist resident with cold food; after meal heated at surveyor request, resident ate 20% meal; resident with documented weight loss; Failed to provide staff assistance with eating for 1 resident at risk for weight loss

**F686 Treatment/Services to Prevent/Heal Pressure Ulcer**

NW: SS=D: Failed to evaluate resident's PUs on buttocks & toes each week for 3 month period

- Failed to evaluate/assess condition of resident's PUs to determine what further treatment was needed placing resident at risk for continued wounds

**F688 Increase/Prevent Decrease in ROM/Mobility**

NW: SS=D: Failed to prevent a decline in functional ability for 1 resident when facility failed to implement a restorative program

- Resident with hemiplegia & hemiparesis; PT note documented resident DCd from skilled PT/OT & start RA program to continue with exercises; record lacked evidence resident received restorative services after discharge from PT/OT services; failed to implement a restorative therapy program following PT/OT skilled services to maintain resident's level of function placing resident at risk for ADL decline

**F692 Nutrition/Hydration Status Maintenance**

NW: SS=D: Failed to develop & implement effective nutritional interventions to prevent weight loss for 1/5 residents who had weight loss

- ADL CP documented resident needed limited assist of 1 staff with meals; weight records revealed resident lost 9.8 pounds over 5 week period; meal intake log documented resident's oral intake at meals approx. 40% & resident with regular diet; observed resident with full meal in front of resident but no staff assist for 50 minutes & food was cold; at surveyor's request, new plate of food served & resident ate 20% meal; failed to implement timely & effective interventions to prevent weight loss for 1 resident who had weight loss which placed resident at risk for further weight loss

NW: SS=D: Failed to develop & implement effective nutritional interventions to prevent weight loss for 1/5 residents who had weight loss

- Resident with documented 7.4 pound weight loss in 1 month & 13.8 pound weight loss in 6 week period; facility lacked meal intake log to document oral dietary intake; failed to implement timely & effective interventions to prevent weight loss for 1 resident who had weight loss which placed resident at risk for further weight loss

**F698 Dialysis**

NW: SS=D: Failed to collaborate care consistently with treatment dialysis facility for 1 resident

- POS directed staff to weigh & take BP before & after dialysis & send results to dialysis appointment twice a day 3x/wk; correspondence to dialysis center for 8 months lacked documentation of BPs & weights on all days resident went to dialysis; failed to send or obtain collaborative information r/t resident's medical condition prior to or following dialysis treatment placing resident at risk for health concerns of ESRD treatment

**F755 Pharmacy Services/Procedures/Pharmacist/Records**

NW: SS=D: Failed to provide physician ordered medications for 1/5 residents

- Resident with major depressive d/o; POS documented staff to administer KCl ER 20 mEq BID & MAR revealed facility did not have medication available to administer for 30 occasions in 1 month; Chlorpromazine HCl 5mg on 11 occasions; Metronidazole 500mg BID on 22 occasions; staff reported medications not available due to VA status; failed to provide 1 resident with physician ordered medications placing resident at risk for ineffective medication management

**F756 Drug Regimen Review, Report Irregular, Act On**

NW: SS=D: Failed to ensure the facility's consulting pharmacist (CP) identified and reported irregularities to the Director of Nursing, physician and medical director when the facility failed to obtain a physician ordered lab for 1 resident placing resident at increased risk of medication complications and side effects

- Failed to ensure facility's CP IDd & reported to DON, physician & medical director a missing BMP for 1 resident placing resident at risk for adverse outcomes & complications r/t medications

NW: SS=E: Consultant Pharmacist (CP) failed to notify DON, medical director or residents' physicians r/t 6/6 residents' PRN psychotropic medications lacked a required stop date

- CP's reviews in multiple months requested a risk versus benefit statement for continued use of Ativan but did not request a stop date; CP failed to notify DON, medical director or physician of lack of required stop date for resident's PRN Ativan for multiple residents
- CP failed to notify DON, medical director or physician of lack of required stop date for resident's PRN Xanax placing resident at risk for receiving unnecessary psychotropic medication for multiple residents

NW: SS=D: CP failed to notify DON, physician or medical director of 3/5 residents' medication irregularities; 1 resident with BPs lower than physician ordered parameters w/o physician notification; 1 resident with physician order for Lorazepam PRN w/o required stop date; 1 resident with inappropriate diagnosis for use of Seroquel

- CP failed to notify DON, physician & medical director of BPs less than physician ordered parameters for notification for resident placing resident at risk for adverse clinical effects of low BPs
- CP failed to ID & notify DON, physician & medical director of lack of stop date for use of Lorazepam for 1 resident
- CP failed to ID & report to DON, facility medical director & physician, an inappropriate diagnosis for use of Seroquel for 1 resident placing resident at risk for inappropriate use of antipsychotic medication

**F757 Drug Regimen is Free from Unnecessary Drugs**

NW: SS=D: Failed to obtain an ordered lab test for 1 resident placing resident at increased risk of medication complications & side effects

- Cited findings noted in F756 r/t BMP not obtained as ordered; failed to obtain a BMP for 1 resident placing resident at risk for adverse outcomes & complications r/t medications

NW: SS=D: Failed to notify physician in timely manner of resident's BPs which were lower than physician ordered parameters

- Cited findings noted in F756 r/t low BPs not reported; failed to notify physician of BPs less than physician ordered parameters for notification for 1 resident placing resident at risk for adverse clinical effects of low BPs

**F758 Free from Unnecessary Psychotropic Meds/PRN Use**

NW: SS=E: Failed to ensure 6/6 residents' PRN psychotropic medications had required stop date

- Cited findings noted in F756 r/t lack of stop date for PRN Ativan & PRN Xanax

NW: SS=D: Failed to obtain a required stop date for PRN Lorazepam for 1 resident & failed to obtain an appropriate diagnosis for use of Seroquel for 1 resident

- Cited findings noted in F756 r/t no stop date for PRN Lorazepam and inappropriate diagnosis for Seroquel; failed to obtain a stop date for use of PRN Lorazepam for 1 resident placing resident at risk for receiving unnecessary psychotropic medications
- Failed to ensure appropriate diagnosis for use of antipsychotic medication, Seroquel for 1 resident placing resident at risk for adverse side effects

**F761 Label/Store Drugs & Biologicals**

NW: SS=D: Failed to label & dispense medication appropriately for 3 residents

- Observed med cart with multiple dose insulin pens undated when opened for 3 residents; failed to date 3 residents' insulin pens when opened which placed residents at risk for medication ineffectiveness & complications r/t insulin use

**F801 Qualified Dietary Staff**

NW: SS=C: Failed to employ a full time CDM for all residents who resided in facility & received meals from facility kitchen

- Staff verified had completed CDM course & had not passed test; failed to employ a full time CDM for all residents who resided in facility & received meals from facility kitchen placing residents at risk for receiving inadequate nutrition

**F804 Nutritive Value/Appear, Palatable/Prefer Temp**

NW: SS=D: Failed to correctly prepare a pureed diet for 2 residents

- Observed staff prepared pureed diet; failed to measure additions; failed to follow recipe; staff stated only worked at facility for 5 days & was unaware of recipes for pureed foods; failed to prepare 2 pureed diets using professional standards for food service safety for 2 residents, placing residents at risk for choking

**F812 Food Procurement, Store/Prepare/Serve-Sanitary**

NW: SS=F: Failed to store, prepare & serve foods in a sanitary kitchen for all residents of facility

- Observed: ice machine with slimy substance on inside surface; plate-holder cart with food crumbs; wall knife holder with dust & food crumbs on top where knives slide in; 3/8 overhead fluorescent lights with cracked plastic covers & 1 with visible lint on surface, utensil drawers under steam oven with dried food or liquid spills inside drawer

NW: SS=F: Failed to prepare, store, distribute & serve food under sanitary conditions for all residents in facility who received meals from facility kitchen

- Observed: air vents with rust stains noted on grill; fluorescent light with part of cover missing & fluorescent bulbs exposed; stove hood with sprinkler spigots with gray fuzzy substance covering spigot top, side & pipes connecting system; per documentation missed scheduled cleaning 3 months prior

**F865 QAPI Program/Plan, Disclosure/Good Faith Attempt**

NW: SS=F: Failed to develop a QAPI plan

- Review of QAPI plan as provided by DON revealed a blank plan; failed to develop a QAPI plan which had ability to affect all residents in facility

**F880 Infection Prevention & Control**

NW: SS=E: Failed to provide a safe, sanitary & comfortable environment to help prevent development & transmission of disease & infection for 6 residents when staff failed to store O2 tubing per standards of care to reduce contamination; failed to sanitize contact precaution isolation room for 1 resident's room to prevent spread of infection

- Observed O2 cannula & tubing unbagged & wrapped in handle of O2 concentrator on multiple occasions; observed O2 cannula & tubing unbagged & lying of floor; failed to ensure 6 resident's O2 tubing & nasal cannula was properly stored in plastic bag placing residents at risk for infection
- Observed housekeeper cleaned resident's room with MRSA in urine; failed to clean w/c or vinyl recliner; mopped contact precaution room floor then mopped shared toilet floor with same mop head; failed to provide an environment to prevent transmission of infectious disease process placing residents at risk for infection

**November, 2021**

**F585 Grievances**

SW: SS=D: Failed to investigate & follow-up on reported grievances

- Resident reported an incident (about a week prior) in which she pushed her call light at 02:00 AM and waited two hours for assistance from Licensed Nurse (LN), who finally provided assistance; Resident reported the CNA came in multiple times stating there was no one available (to provide assistance); CNA told resident no one was in the building and when resident needed to use the restroom before meals, staff told resident to "hold it: conclusion documented the DON would investigate incident, however, the facility did not provide an investigation or documentation of follow-up for this incident
- Resident reported "nurse aid is mean", & resident's family member also reported staff member "mean" & both resident & family member preferred CNA did not provide care for resident; conclusion was that DON would investigate situation but facility did not provide investigation or documentation of follow-up for incident
- Failed to investigate & follow-p on grievance reported by 2 residents

**F600 Free from Abuse & Neglect**

SW: SS=J (Abated to D): Failed to ensure an environment free of physical/verbal abuse when CMA verbally & physically abused cognitively impaired & dependent resident during cares; CMA roughly handled 1 residents & verbally berated, cursed at6 & made demeaning & hateful statements to resident in front of 2 CNA students; after incident, facility failed to remove CMA from floor which allowed CMA to continue to provide resident care & pass medications to cognitively impaired, dependent resident where 5 CNA students witnessed CMA smack resident on bottom & then forcefully attempted to administer resident's medications, refusing to let resident spit them out; both residents became physically & verbally upset with CMA & no facility staff intervened to stop incidents placing residents at risk for psychosocial, mental & physical harm which constituted immediate jeopardy

- Failed to ensure an environment free of physical/verbal abuse when CMA verbally & physically abused cognitively impaired & dependent resident during cares; CMA roughly handled resident & verbally berated, cursed at, & made demeaning & hateful statements to resident in front of 3 CNA students; after incident facility failed to remove CMA from floor; resident became physically & verbally upset with CMA & no facility staff intervened to stop the incidents placing resident at risk for psychosocial, mental & physical harm which constituted immediate jeopardy
    - Abatement plan:
        - Facility filed a police report for the abuse incidents
        - Facility contacted Attorney General's office & referred to KDADS
        - Both residents' family's & physician were updated on abuse investigation & each resident would be evaluated for psychosocial monitoring for 5 days then weekly for 1 month
        - Facility contacted all contracted staffing agencies & requested vetting processes including all staff training completed through agency, background checks, certification/license checks, & all requested documentation must be in facility's possession before agency staff's first shift
        - Facility revised & implemented a new ANE policy for staff, agency staff & CNA students with a competency checklist/quiz that required completion before working any further shifts in facility
        - Facility implemented new investigating elder abuse/neglect procedure which all licensed nurses would review & sign before next scheduled shift
        - An emergency QAPI meeting with current Medical Director was held to address incidents, revised ANE policy & IJ infractions with plan for medical director's approval
- Facility failed to ensure an environment free of physical/verbal abuse after facility failed to remove CMA from floor after an allegation of abuse, CMA was allowed to continue to provide resident care & passed medications to resident resulting in CMA smacking resident on bottom & forcefully attempting to administer resident's medications; resident was cognitively impaired/dependent & became physically & verbally upset with CMA & no staff intervened to stop incident leaving residents at risk for psychosocial, mental, & physical harm which constituted immediate jeopardy

- Abatement plan:
  - Facility filed a police report for the abuse incidents
  - Facility contacted Attorney General's office & referred to KDADS
  - Both residents' family's & physician were updated on abuse investigation & each resident would be evaluated for psychosocial monitoring for 5 days then weekly for 1 month
  - Facility contacted all contracted staffing agencies & requested vetting processes including all staff training completed through agency, background checks, certification/license checks, & all requested documentation must be in facility's possession before agency staff's first shift
  - Facility revised & implemented a new ANE policy for staff, agency staff & CNA students with a competency checklist/quiz that required completion before working any further shifts in facility
  - Facility implemented new investigating elder abuse/neglect procedure which all licensed nurses would review & sign before next scheduled shift
  - An emergency QAPI meeting with current Medical Director was held to address incidents, revised ANE policy & IJ infractions with plan for medical director's approval

**F607 Develop/Implement Abuse/Neglect Policies**

SW: SS=F: Failed to ensure implementation of facility ANE policy when facility failed to ensure CNA students & agency staff were trained on facility ANE policy to ensure prompt reporting & ID of ANE incidents

- Failed to ensure implementation of facility ANE policy when facility failed to ensure CNA students & agency staff were trained on facility ANE policy to ensure prompt reporting & ID of ANE incidents

**Investigate/Prevent/Correct Alleged Violation**

SW: SS=D: Failed to ensure protection of residents from abuse; CMA verbally & physically abused cognitively impaired & dependent resident during cares, roughly handling resident & verbally berating by making fun of incontinence, physical appearance, spouse, resident odor; cursed at & made demeaning & hateful statements to resident in front of student CNAs; after incidence of abuse, facility failed to prevent further resident abuse when staff did not remove CMA from floor, allowing CMA to continue to provide care & pass medication to cognitively impaired, dependent resident; CMA smacked another resident on bottom & forcefully attempted to administer resident's medications, refusing to let resident spit them out; both cognitively impaired & dependent residents became physically & verbally upset with CMA & no facility staff or CNA students intervened to stop the abusive incidents or remove CMA form floor in timely manner to ensure all facility residents' safety; also failed to ensure appropriate screening of contracted staff prior to resident care in facility & did not file a police report at the time of the incident

- Failed to protect facility residents from physical & verbal abuse to 1 resident during cares then further failed to protect facility residents when staff allowed CMA to continue to provide cares & pass medication to another resident; both cognitively impaired/dependent residents became physically & verbally upset with CMA & no facility staff or CNA students intervened to stop abusive incidents or remove CMA from floor in timely manner to protect residents of facility; also failed to ensure appropriate screening of contracted staff prior to resident care in facility & did not file a police report at time of incident

**F689 Free of Accident Hazards/Supervision/Devices**

SW: SS=J (Past Non-Compliance): Failed to ensure an environment free of accident hazards when 1 CNAs did not correctly secure sling during a full mechanical lift transfer & cognitively impaired, dependent resident fell out of sling during transfer placing resident in immediate jeopardy

- Failed to ensure CNA staff correctly secured the sling resulting in a fall of 3-4 feet to floor for 1 resident during a transfer with a full mechanical lift placing resident in immediate jeopardy
  - Abatement Plan
    - Staff re-education for lift/sling use/policies for safe resident transfers
    - Random competency screens 3x/wk for 1 month, 1 time/wk for 1 month then as needed
    - Yearly competency check offs for all current employees & new employees/agency staff
    - Emergency QAPI meeting when medical director is available

**F726 Competent Nursing Staff**

SW: SS=D: Failed to ensure competency of nursing staff to provide nursing services & ensure resident safety when facility did not provide competency in use of mechanical lifts for nursing staff; direct care staff inaccurately attached/secured a sling to mechanical lift during a transfer in which resident fell out of sling onto floor (a fall of 3-4 feet)

- Failed to provide competent nursing staff r/t safe/competent use of mechanical lifts for residents of facility

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

SW: SS=E: Failed to ensure CNA received 12 hours of in-service education per year for 4/5 staff reviewed to ensure care provided to residents for highest practicable level of well-being

- Review of 5 CNA records revealed lack of documentation of 12 hours of in-service for 4/5 with 1 with 9 hours, 3 with hours & 1 with 11 hours recorded; Failed to provide 12 hours of in-services to 4/5 CNAs reviewed to ensure highest practicable level of well-being for each resident

**December, 2021**

**F584 Safe/Clean/Comfortable/Homelike Environment**

SE: SS=D: Failed to ensure 1 resident had hot, running water in personal BR

- Observed resident's hot water faucet in BR ran for approximately 5 minutes & hot water temp was 56 degrees F; maintenance checked with temp of 45 degrees F; failed to ensure resident had hot, running water to personal BR

**F656 Develop/Implement Comprehensive Care Plan**

SE: SS=D: Failed to develop comprehensive CPs for 3 residents: 1 resident for behaviors & use of Seroquel; 1 resident for pai n & 1 resident for fall interventions

- Failed to provide a comprehensive CP for resident's use of Quetiapine & behavior management to enhance resident's sense of we ll-being
- Failed to complete an individualized comprehensive CP for dependent resident who experienced pain
- Failed to complete an individualized comprehensive CP for dependent resident who experiences pain & preventing further falls for resident with hx of falls

**F657 Care Plan Timing & Revision**

SE: SS=D: Failed to review & revise CP for 2 residents for fall interventions

- Failed to provide a fall intervention after a fall & resident sustained a similar fall 4 days later
- Failed to revise CP r/t resident's falls

**F677 ADL Care Provided for Dependent Residents**

SE: SS=D: Failed to ensure 3 residents had appropriate grooming needs met r/t facial shaving

- Failed to ensure dependent resident had grooming needs met r/t shaving resident
- Failed to provide shaving assistance for resident who required assistance with personal hygiene to maintain grooming per resi dent's preference
- Failed to provide resident with adequate grooming services as indicated by resident's unshaven appearance & dirty fingernails

**F689 Free of Accident Hazards/Supervision/Devices**

*SE: SS=G: Failed to ensure staff transferred 1/3 residents as CPd with a mechanical lift for 1 resident when staff directed resident to stand holding onto a grab bar in shower room which resulted in staff assisting resident to floor & staff also failed to use mechani cal lift to move resident off of floor; resident sustained bilateral distal femur fx's that required surgical intervention*

- *Resident with low back pain, chronic pain & OA; Record revealed resident with osteopenia; CAA lacked summary note r/t ADL assistance; CP directed staff to transfer resident w ith total assist of 2 using Hoyer lift & resident non-ambulatory; NN documented resident in shoer room in shower chair & staff member asked co-worker to reposition sling behind resident in shower chair & as staff assisted resident to feet to stand at handicap bar, legs gave out & resident lowered to floor by 2 staff; note lacked description of how staff transferred resident off floor; resident later documented with pain; resident developed moments of unresponsiveness; re sident transferred to ER; X-ray revealed bilateral femur fx's; CNA stated when staff tried to get resident off floor attempted to place sling under resident but resident uncooperative & resident would not move legs or sit up to get resident to chair from floor & neither staff had ahold of resident under legs when getting resident up off floor; failed to ensure staff transferred resident appropriately with a mechanical lift when standing resident at a grab bar in shower room which resulted in staff assisting resident to floor & failed to use mechanical lift to move resident off floor who later was diagnosed with bilateral distal femur fx's that required surgical interve ntion*

SE: SS=D: Failed to safely transfer 1 resident & failed to provide appropriate fall interventions for 3 residents

- Failed to ensure safe transfer for resident with 1 sided weakness & failed to provide a fall intervention after 1 fall then resident sustained a similar fall 4 days later
- Failed to implement an appropriate fall intervention following resident's fall
- Failed to provide a fall intervention after a fall & resident sustained a similar fall 1 month later

**F697 Pain Management**

SE: SS=G: Failed to implement effective pain management for 1 resident with moderate to severe pain r/t facility not having a ccess to resident's pain medication for 2 days

- Failed to have access to resident's PRN hydrocodone renewal order for 2 days over a weekend & pharmacy reported waiting on script from physician, causing resident to experience severe pain & tearfulness; staff administered PRN acetami nophen

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

SE: SS=E: Failed to provide direct care staff annual evaluations for 2/5 staff reviewed to determine strengths & weaknesses i n providing resident care & lacked a system to ensure staff received 12 hours of education annually for 5/5 residents reviewed

- Failed to ensure direct care staff received annual evaluations to determine strengths & weaknesses to guide 12 hour of educat ional opportunities & failed to ensure staff completed 12 hours of education annually as required

**F732 Posted Nurse Staffing Information**

SE: SS=C: Failed to display accurate, publicly accessible & identifiable staffing information on a daily basis on a "Daily Nurse Staffing" with actual hours worked as required, for all residents that reside in facility

- Review of daily staff postings lacked completion of actual hours worked on multiple days in multiple months; failed to comple te daily nurse staffing sheets with actual hours worked as required for residents of facility

**F744 Treatment/Services for Dementia**

SE: SS=D: Failed to provide dementia care to 1 resident

- Review of MAR revealed a category for behaviors of yelling & becoming angry with interventions for staff to utilize & record lacked recording of behaviors or interventions; observed resident yelling "hey" continuously at passing staff, residents & visitors & resident had no diversional activity on multiple occasions; failed to monitor resident's behaviors & develop individualized interventions to enhance resident's wellbeing

**F880 Infection Prevention & Control**

SE: SS=F: Facility IDd 2 residents quarantined on isolation precautions for new admission status; failed to ensure water temp erature in laundry remained a minimum of 160 degrees F to ensure sanitary laundry processing for residents of facility

- Observed temp log in laundry room with undated monthly temp logs & log recorded temps of 161=163 degrees F but failed to record temp for 21 days in current month of survey; observed maintenance staff tested water for hot water line that supplied noncommercial washing machine & temps fluctuated between 110-151 degrees F; hot water heater set at 180 degrees F per staff; water temp failed to reach required 160 degrees F to process residents' laundry; failed to ensure infection prevention due to failing to ensure water temperature in laundry remained at least 160 degrees F to ensure sanitary laundry processing for residents of facility that included 2 residents in isolation precautions

**January, 2022**

**F558 Reasonable Accommodations Needs/Preferences**

NE: SS=D: Failed to provide an alternate method which relayed directly to nursing staff for 1 resident to summon staff for assistance during a call light system failure placing resident at risk for a delay in care or assistance

- Failed to provide an alternate method, which relayed directly to nursing staff for resident to summon staff for assistance during a call light system failure placing resident at risk for a delay in care assistance

**F567 Protection/Management of Personal Funds**

SE: SS=E: Failed to establish a system for residents of the facility with personal fund trust accounts to ensure residents received interest-bearing account; failed to distribute interest for pooled account to residents with qualifying accounts greater than $50.00, as required

- Failed to ensure a system in place to distribute interest for resident accounts as required

**F584 Safe/Clean/Comfortable/Homelike Environment**

SE: SS=E: Failed to maintain windows in resident's rooms, residents' quiet room & common sitting area in a safe, clean & homelike manner

- Observed windows contained a buildup of dead bugs, cobwebs & holes of various sizes in screens that measured approximately 1-2 inches in diameter; window screen edges were loose & did not make full contact with window frame; failed to maintain ad3quate maintenance & housekeeping services to windows in facility to ensure a safe, clean, & homelike manner for resident areas of f acility

**F609 Reporting of Alleged Violations**

SE: SS=D: Failed to complete an investigation for 1 resident when facility railed to administer 4 days of Zosyn (ABT) IV resulting in medication error; facility also failed to administer ordered STATE IV fluids to another resident as ordered by physician, resulting in f luids being administered over 24 hours later & creating an error in following physician orders; facility then failed to report these 2 incidents of neglect with failure to follow physician orders to State Survey Agency within 5 working days of missed doses of IV ABTs & late admini stration of IV fluids

- Facility lacked documentation of any investigation started or completed r/t 4 days of missing ABT & medication error; Failed to complete an investigation of neglect when facility staff neglected to administer physician-ordered IV Zosyn for 4 days; facility also failed to report incident of neglect to State Survey Agency within 5 working days of incident taking place
- Resident with physician order for stat IV fluids; EMR lacked indication staff notified ordering provider that facility did no t have NaCl solution & resident did not receive the fluids as ordered; Failed to report incident of neglect when staff failed to administer IV fluids for dehydrated resident as ordered by physician to SA within 5 working days of incident taking place

**F636 Comprehensive Assessments & Timing**

SE: SS=E: Failed to develop CAAs for psychotropic medications for 3 residents & 1 resident for falls & 1 resident for ADLs & 1 resident for functional/rehab potential

- Failed to develop psychotropic medication CAA for resident on multiple psychotropic medications to develop a person-centered care plan for 1 resident
- Failed to develop the ADL Functional/Rehab Potential CAA for 1 resident
- Failed to complete triggered areas of MDS for multiple residents

**F655 Baseline Care Plan**

NE: SS=D: Failed to implement a person-centered care plan that included minimum information necessary to properly care for 1 resident who required off-site dialysis services, & failed to implement a baseline CP for 1 resident who required use of pressure reducing devices which had potential for 2 resident to have unmet care needs

- Failed to ensure that resident's baseline CP included minimum healthcare information necessary to properly care for resident immediately upon admission that addressed resident-specific goals & interventions (time, days, location of dialysis; monitoring weight, monitoring fluid intake, documentation pre- and post-dialysis) needed for dialysis services which placed resident at risk for decline & possible unwarranted adverse side effect & ineffective dialysis treatment
- Failed to develop a person-centered baseline CP that included pressure reducing devices ordered for 1 resident (Bunny Boots) placing resident at risk of development & worsening PUs

**F657 Care Plan Timing & Revision**

SE: SS=D: Failed to review & revise CPs for 2 residents including 1 resident r/t use of Eliquis & 1 resident r/t fall interventions

- Failed to update CP with new fall interventions following resident's 2 non-injury falls
- Failed to review & revise resident's CP to include use of Xarelto to monitor for adverse effects of this medication & left lower extremity blood clot complications

**F661 Discharge Summary**

SE: SS=D: Failed to complete a discharge summary 1 resident at the time of discharge from the facility

- EMR lacked a discharge summary; failed to complete a discharge summary for resident who discharged to another nursing home

**F677 ADL Care Provided for Dependent Residents**

*SE: SS=E: Failed to provide scheduled baths in accordance with residents' planned shower schedule to ensure necessary services to maintain good personal hygiene for 19 dependent residents*

- *Resident stated facility needed more staff & resident was not getting a shower every other day like she preferred & was "lucky to get one bath a week"; multiple residents reported facility needed more staff & residents were not getting showers/bath as requested; failed to provide scheduled baths in accordance with residents' planned shower schedule to ensure necessary services to maintain personal hygiene for 19 dependent residents*

SE: SS=D: Failed to provide necessary services to maintain good personal hygiene for 1 resident r/t nail care

- Failed to provide necessary services to maintain good personal hygiene for 1 resident r/t trimming of nails

**F684 Quality of Care**

*SE: SS=D: Failed to complete a skin assessment when staff found a 23x4 cm bruise on resident's arm day after staff found resident on floor to ensure resolution of bruising w/o complications*

- *Resident with large bruise & resident stated had fallen out of bed the previous weekend & staff assisted back to bed but not post-fall assessment completed at time of incident; failed to complete an accurate skin assessment with continued follow up monitoring, when staff found 23x4 cm bruise on resident's arm to ensure resolution*

SE: SS=G: Failed to order & provide 4 days of continued IV ABT treatment as ordered for 1 resident who was continuing post-surgical recovery for osteomyelitis & gangrene treatment to foot; Infectious Disease Provider prescribed Zosyn IV TID for additional 2 weeks; interruption of IV ABT treatment resulted in worsening of wound & potential for regrowth of infection, osteomyelitis & gangrene; furthermore, facility failed to ensure necessary treatment & care in accordance to professional standards of practice for 1 resident who had multiple wounds

- DON received verbal order from IFD team to continue IV ABT but DON did not place order into resident's chart but told LN to place order in chart but LN stated because DON received verbal order, LN did not feel comfortable placing order for medication another nurse verbally received from physician; failed to provide ordered ANT tx for 1 resident for 4 days & resident's surgical wound revealed worsening with decline
- Failed to provide necessary treatment & care to ensure proper monitoring & promote healing for resident with multiple wounds r/t lack of consistent wound evaluations weekly

**F686 Treatment/Services to Prevent/Heal PU**

SE: SS=D: Failed to provide necessary treatment & services to promote healing for 2/5 residents with PUs

- Failed to provide necessary treatment & services to ensure proper monitoring & promote healing of resident's PU of coccyx r/t lack of weekly wound monitoring & documentation for multiple residents

NE: SS=D: Failed to ensure pressure reducing measures were placed on 1 resident's bilateral lower extremities to prevent PUs placing resident at increased risk for PU development

- Failed to implement pressure reducing measures for 1 resident who was at risk for pressure injuries placing resident at increased risk for pressure/skin injuries

**F689 Free of Accident Hazards/Supervision/Devices**

SE: SS=E: Failed to initiate appropriate interventions for 1 resident following falls; failed to provide a safe shower chair for residents of facility with an approximately 7-inch crack/split in shower chair seat & facility IDd possibility of all residents had access to shower chair in shower chair

- Failed to initiate new interventions for resident following un-witnessed falls in room
- Failed to maintain shower chair potentially used by all residents in a safe working order to ensure residents were free from accidents or skin issues

**F694 Parenteral/IV Fluids**

SE: SS=D: Failed to administer IV fluids in accordance with physician orders for 1 resident when physician ordered IV fluids given "stat" & staff failed to implement IV fluids for over 24 hours for resident's dehydration

- Failed to administer resident's IV fluids as ordered by physician to prevent further dehydration

**F695 Respiratory/Tracheostomy Care Suctioning**

SE: SS=D: Failed to provide appropriate respiratory care r/t maintaining respiratory equipment to prevent spread of infection, consistent with standard of practice & person-centered care plan for 2 residents r/t storage of O2/nebulizer tubing & cannula when not in use & changing O2 concentrator humidifier bottle & tubing cannula

- Failed to provide appropriate respiratory care r/t maintaining respiratory equipment to prevent spread of infection, consiste nt with standard of practice for multiple residents

**F698 Dialysis**

SE: SS=D: Failed to ensure an appropriate system for monitoring fluid intake for 1 resident r/t resident's fluid restriction

- Resident on dialysis; CP instructed staff that dialysis recommended resident have 32 ounces but no more than 42-48 oz daily; POS revealed order for staff to encourage resident to limit fluid to 1000mL/day, TID; Dietary staff stated unaware of how many oz's of fluids resident could be served at each meal but was to have at least 2 drinks; failed to effectively mo nitor resident with a fluid restriction, actual fluid intake, as ordered, to ensure resident had no adverse effects of dialysis

NE: SS=D: Failed to ensure there was ongoing communication & collaboration with dialysis facility r/t dialysis care & service s & failed to monitor 1 resident's dialysis access port daily which had potential for unwarranted & unidentified physical complications r/t dialysis

- Failed to retain dialysis communication sheets & failed to monitor 1 resident's dialysis access port daily, wh ich had potential for adverse outcomes & unwarranted physical complications r/t to dialysis

**F725 Sufficient Nursing Staff**

*SE: SS=F: Failed to provide adequate sufficient nursing staff to provide nursing-related services of adequate bathing/hygiene, to maintain highest practicable physical, mental & psychosocial well-being for at least 19 residents*

- *Cited findings noted in F677 r/t lack of bathing/showers per residents' preferences & schedules; multiple residents reported facility lacked enough staff; failed to provide adequate sufficient nursing staff to provide nursing-related services of adequate bathing/hygiene to maintain highest practicable physical, mental, & psychosocial well-being of at least 19 residents*

**F757 Drug Regimen is Free from Unnecessary Drugs**

NE: SS=D: Failed to ensure antihypertensive medications were administered as ordered & physician notification for blood sugar outside ordered parameters for 1 resident placing resident at risk for unnecessary medication use & unwarranted side effects

- Failed to ensure that physician was notified when blood sugar was >350 & failed to ensure antihypertensive medication was hel d as ordered for 1 resident with potential for unnecessary medication use & possible unwarranted side effects

**F804 Nutritive Value/Appear, Palatable/Prefer Temp**

NE: SS=E: Failed to serve food at an appetizing temperature to 5 residents placing residents at risk for decreased nutrition & a delay in recovery

- Resident stated that every time food arrived to room, it arrived cold & resident would have to ask staff to reheat it but most of the time resident just did not feel like eating it; temp inspection of food revealed food temps in kitchen to be at or above acce ptable temp range for dining service; failed to serve food at an appetizing temperature to multiple resident placing residents at risk for decreased nutrition & a delay in recovery from rehab services

**F806 Resident Allergies, Preferences, Substitutes**

NE: SS=D: Failed to provide 1 resident with food ordered on dietary me nu & did not notify of changes or substitutions to meal placing resident at risk for malnutrition & impaired quality of life

- Failed to provide 1 resident with food ordered on dietary menu & did not notify of changes or substitutions to meal placing r esident at risk for malnutrition & impaired quality of life

**F807 Drinks Available to Meet Needs/Preferences/Hydration**

NE: SS=D: Failed to provide 1 resident with drinks during meal service placing resident at risk for dehydration & health comp lications

- Failed to provide 1 resident with drinks on a room tray as promoted in resident's CP during meal service placing resident at risk for dehydration & further health complications

**F812 Food Procurement, Store/Prepare/Serve-Sanitary**

SE: SS=F: Failed to store & serve food under sanitary conditions to prevent spread of food borne illnesses to residents of facility

- Observed: freezer with food debris & outside of freezer heavily soiled with food debris; fridge with food debris & outside of fridge was heavily soiled with food debris; fridge with undated bag of bananas which had turned brown; inside of microwave with heavy build up of food debris on all sides, bottom & top; can opener with dried, red substance on part which punctured can; opened, undated container of condiment in fridge; freezer with food debris on bottom & outside heavily soiled with food debris; containers covered with sticky, dirty substance

NE: SS=E: Failed to ensure sanitary food services & failed to document daily cleaning & sanitation process placing residents at risk for food borne illnesses & food safety concerns

- Observed sanitation log with missing documentation on multiple occasions in previous month; observed grease covering top surfaces of main oven & fryer area; spice rack with dust & spice particles; trash can lid in oven area with red sauce dried on it; sink area with pan of food uncovered & unattended for more than 10 minutes

**F842 Resident Records-Identifiable Information**

SE: SS=D: Failed to maintain medical records in accordance with accepted professional standards & practices for 2/21 residents that were completed & accurately documented when resident discharged from facility to hospital & attending nurse failed to update & com plete resident's medical record with these changes in condition; facility failed to document a request in medical record from 1 resident r/t obtaining a mammogram

- Failed to maintain an accurate complete medical record for resident who experienced a sudden change in condition which resulted in hospitalization
- Failed to maintain medical records on concerned resident that were complete & accurately documented to address test for possible further breast cancer

**F880 Infection Prevention & Control**

SE: SS=F: Failed to provide sanitary glucometer cleaning for 4 residents; failed to provide sanitary cleaning of nebulizer components for 2 residents & failed to ensure proper cleaning techniques of a resident BR to prevent spread of infection

- Observed LN obtained blood glucose with multi-resident use glucometer from resident & following completion of obtaining specimen, LN obtained a PDI Easy Screen wipe from treatment cart & wiped glucometer with it & placed glucometer back in cart; failed to follow "wet time"; manufacturer info revealed product did not sanitize glucometer for multiple residents; failed to ensure staff properly disinfected glucometer used for 4 residents to prevent spread of blood-borne infection
- Failed to ensure staff cleaned resident BR fixtures (handrails), toilet seat & outer area of toilet in sanitary manner & failed to perform hand sanitization after removal of gloves to prevent spread of infection
- Failed to properly clean mouthpiece of nebulizer for resident to prevent possible respiratory infections for multiple residents

SE: SS=F: Failed to ensure visitors to facility were screened appropriately for COVID upon entry to facility; failed to ensure staff wore face masks in effective manner & failed to quarantine unvaccinated residents timely following an outbreak of COVID in staff

- Observed CMA opened facility door for surveyors but did not screen surveyors on multiple days of survey; review of temps on entrance log lacked multiple visitor temps; failed to ensure screening of visitors for COVID upon entry to facility to prevent spread of infection
- Record review revealed 3 residents declined COVID vaccination; facility currently in outbreak testing due to 4 staff testing positive; observed the 3 unvaccinated residents ambulated in facility w/o mask & ate meals in common DR with other residents; multiple residents stated they had been told today they would have to stay in room (4 days after staff tested positive); failed to quarantine for 4 days, 3 unvaccinated residents with exposure to positive COVID staff to prevent spread of infection
- Observed dietary staff wearing face mask under chin, dietary staff wearing face mask over mouth only with nose exposed; failed to ensure staff wore face masks effectively to prevent spread of infection

NE: SS=E: Failed to ensure staff did appropriate hand hygiene in-between cares for residents & proper disinfecting of equipment used in between resident cares placing residents at risk for increased infection & transmission of communicable disease

- Observed CMA failed to do hand hygiene between resident rooms & used vital machine in both rooms w/o disinfecting BP cuff or pulse oximeter after use; observed staff removed lift from 1 resident room & placed in another resident room w/o disinfecting equipment; failed to ensure staff demonstrated proper use of hand sanitizer/hand washing in between residents while providing services to residents & failed to ensure staff properly sanitized shared equipment in between residents after use with potential to increase risk for infection & disease to residents in facility

**F881 Antibiotic Stewardship**

SE: SS=F: Failed to ensure principles of antibiotic stewardship would be followed by nursing staff to ensure antibiotics used in a safe & effective manner to prevent unnecessary side effects of antibiotics & antibiotic resistance in an ongoing, proactive manner

- Infection Control Logs missing for 4 months in previous year; logs lacked complete data for analysis of adherence with an evidenced-based surveillance criterion to define infections & effectiveness of facility's antibiotic stewardship program; logs lacked completed documentation of culture results of organism ID for monitoring trends in infections; failed to proactively apply principles of antibiotic stewardship for residents for 1 year period to ensure antibiotics administered in a safe & effective manner to prevent unnecessary side effects of antibiotics & antibiotic resistance

**F885 Reporting-Residents, Representatives & Families**

SE: SS=E: Failed to notify all residents, representatives & families by 5:00pm next calendar day following the occurrence of 3 or more residents or staff with new onset of respiratory symptoms that occurred within 72 hours of each other, or by 5:00pm next calendar day each time a confirmed COVID infection IDd, as required

- Failed to notify responsible parties of outbreak of COVID until 4 days later within the timeframe required

**F921 Safe/Functional/Sanitary/Comfortable Environment**

SE: SS=E: Failed to provide maintenance services to ensure a safe & sanitary environment for residents & staff in facility laundry area

- Observed soiled linen room's ceiling contained a stain with peeling spackling; cement floor throughout laundry processing area as with multiple areas of missing paint & with chips in concrete; folding table had missing areas of luminant revealed raw wood; failed to maintain a safe & sanitary environment for resident & staff in facility laundry areas

SE: SS=F: Failed to provide a sanitary environment for residents & staff in kitchen

- Observed kitchen floor with build up of debris around parameter of kitchen especially in corner of kitchen by 3-part sink; failed to provide a sanitary environment for residents & staff in kitchen

**F923 Ventilation**

SE: SS=F: Failed to have adequate ventilation to control odors of unknown sources in residents' environment

- Observed strong malodorous odor in conference room to which surveyors were assigned; on 1 occasion odor became overwhelming causing those present to have watery eyes, nausea & headaches; failed to have adequate ventilation to control odors in the facility

**February, 2022**

**F550 Resident Rights/Exercise of Rights**

NE: SS=D: Failed to promote dignity when staff failed to provide a privacy bag for the indwelling urinary catheter drainage bag for 1 resident placing resident at risk for impaired dignity & psychosocial wellbeing

- Failed to promote dignity for 1 resident when staff did not provide a privacy bag for resident's indwelling catheter drainage bag while in bed

NE: SS=D: Failed to provide a dignified dining experience for 2 residents placing residents at risk for an undignified experience & impaired psychosocial well-being

- Observed resident at DR table in high back w/c & consultant stood next resident & assisted resident with fluids on multiple occasions; 5 minutes after first observations, consultant sat down & assisted resident with eating then moved all food & drinks out of resident's reach & resident reached for fluids but unable to reach them for extended period but no staff assisted resident with items resident was reaching for; resident yelled "hey" on multiple occasions in DR to assist resident & staff walked by until staff removed resident from DR; failed to provide dignified dining experience for 1 resident placing residents at risk for an undignified experience & impaired psychosocial well-being
- Observed resident slouched in w/c at DR table & staff approached resident from behind & reached under resident's arms & pulled resident up in w/c; staff did not speak to resident prior to act or explain what staff was going to do prior to moving resident up in w/c; failed to ensure that staff treated resident with dignity & respect when staff did not speak to resident to explain to resident that staff was going to pull resident up in chair prior to assisting resident up in w/c while at DR table placing resident at risk for decreased self-esteem & decreased self-worth

**F577 Right to Survey Results/Advocate Agency Info**

SW: SS=C: Failed to inform residents who attended resident council of location of state survey notebook & failed to inform residents of right to read survey results; notebook contained only 2 years of survey results in notebook

- Observed survey results not located & no signage posted to indicate location of survey results; failed to inform residents of location of "State Survey Book", right to read survey results, & lacked required 3 years of survey results

**F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive**

NE: SS=D: Failed to obtain & verify DPOA paperwork prior to allowing resident's representative sign a DNR; facility entered DNR status for resident though person lacked a lawful DNR signed by resident or DPOA placing resident at risk for miscommunication r/t preferences & incorrect actions r/t life-saving measures

- Record lacked evidence of DPOA paperwork for 1 resident; POS documented order for DNR; failed to obtain & verify DPOA paperwork & allowed 1 resident's representative to sign a DNR w/o verification of legal authority & entered a DNR status for resident though person lacked a lawful DNR signed by resident or a legal DPOA placing resident at risk for miscommunication r/t preferences & incorrect actions r/t life-saving measures

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

SW: SS=D: Failed to ensure staff notified 1 resident's representative of changes

- NN documented staff notified DON & provider of non-injury fall but lacked documentation of DPOA notification on multiple occasions; representative stated facility did not notify of fall but found out about fall when hospital notified representative; failed to notify DPOA or other representative when there was a change in resident's condition

NW: SS=D: Failed to notify resident's representative when staff ripped off loose toenail during a transfer placing resident at risk for uninformed treatment decisions &/or delayed wound care treatments

- EMR lacked documentation resident's representative was notified of incident; failed to notify resident's representative when staff ripped off toenail during a transfer placing resident at risk for uninformed treatment decisions &/or delayed wound care treatments

**F600 Free from Abuse & Neglect**

*NW: SS=D: Failed to provide an environment free of verbal abuse &/or intimidation for 1 resident placing resident at risk for psychosocial impairment*

- *LN stated had witnessed SS talk loudly at resident & SS stated if resident did not like facility, resident should call a cab & get out of there; resident stated SS yells at resident frequently & had come into resident's room & "backed" resident into a corner & had "gotten right up into resident's face" & told resident that resident did not deserve to be there & told resident that if resident did not like facility, resident should call a cab & get out; on another occasion, SS staff member was helping in kitchen & refused to give resident a snack "because resident did not need any food because there were other residents & resident needed to stop being so selfish"; other witnessed incidents documented; facility failed to provide an environment free of mistreatment & intimidation for 1 resident placing resident at risk for psychosocial well-being impairment*

**F604 Right to be Free from Physical Restraints**

*SE: SS=J: Failed to ensure 1 resident remained free from physical restraints when resident had escalating behaviors in memory care unit during medication administration, LN failed to appropriately respond to agitated state of resident, which resulted in a physical altercation; LN called for help from additional staff & response from multiple staff members caused a higher escalation in resident's behaviors which resulted in 5 staff members holding resident down on floor; DON attempted medication administration with a spoon as resident was being restrained on floor by LN & other staff members; resident yelled & screamed "NO!" & shook head back & forth placing resident at risk for serious physical injury & physical restraining of resident by 5 staff members placing resident at risk for psychosocial & physical harm placing resident in immediate jeopardy*

- *Failed to ensure resident remained free from physical restraint when resident had escalating behaviors in memory care unit during medication administration; LN failed to appropriately respond to agitated state of 1 resident which resulted in a physical altercation; LN called for help from additional staff & response from multiple staff members caused a higher escalation in resident's behaviors which resulted in 5 staff members holding resident down on floor; DON attempted medication administration with a spoon as resident ws being restrained on floor by LN & other staff members including maintenance staff; resident yelled & screamed "NO!" & shook head back & forth placing resident at risk for serious physical injury & physical restraining of resident by 5 staff members placing resident at risk for psychosocial & physical harm placing resident in immediate jeopardy*
- *Abatement Plan:*
    - *Administrative staff began investigation interviews with facility staff involved in incident; along with interviews, dementia & behavior care education was provided verbally to staff*
    - *Final facility staff member completed mandatory education on:*
        - *"Caring for the Person with Dementia: Behaviors & Communication"*
        - *"Recognizing, Reporting & Preventing Abuse"*

**F609 Reporting of Alleged Violations**

*NW: SS=D: Failed to ensure staff reported alleged violations to facility administrative staff immediately placing resident at risk for ongoing abuse & impaired psychosocial well-being*

- *Cited findings noted in F600 r/t perceived abusive behavior of SS staff toward 1 resident; failed to ensure staff reported alleged violations of abuse or mistreatment to facility administrative staff immediately placing 1 resident at risk for ongoing abuse & impaired psychosocial well-being*

**F623 Notice Requirements Before Transfer/Discharge**

SW: SS=D: Failed to provide written notice to State Ombudsman of facility-initiated hospitalization transfer of 1 resident

- Failed to notify ombudsman of 1 resident's facility-initiated hospitalization transfer

SW: SS=D: Failed to provide written notice to State Ombudsman of facility-initiated hospitalization transfer of 1 resident

- Failed to notify Ombudsman when 1 resident was admitted to hospital

**F625 Notice of Bed Hold Policy Before/Upon Transfer**

SW: SS=D: Failed to provide 1 resident or representative with a bed hold policy upon transfer to hospital

- Failed to provide 1 resident or resident's representative with written notice concerning facility's bed hold policy when resident transferred to hospital

SW: SS=D: Failed to provide 1 resident or representative with a bed hold policy upon transfer to hospital

- Failed to provide 1 resident or representative with written notice concerning facility's bed hold policy when resident discharged to hospital

**F656 Develop/Implement Comprehensive Care Plan**

NE: SS=E: Failed to develop a person-centered comprehensive CP for 1 resident for prevention/increase of ROM/mobility, 1 resident for monitoring & treatment of skin/wounds, medication monitoring, ADLs, dementia care & monitoring of diagnosis; 1 resident for medication monitoring & ADLs & 1 resident for dementia care & ADLs placing residents at risk for inadequate cares due to miscommunication of needs

- Failed to incorporate new CP interventions to prevent development or worsening contractures, loss of ROM/mobility & independence for 1 resident placing resident at risk for ineffective treatment & decreased quality of care
- Failed to develop & implement an adequate comprehensive person-centered care plan for 1 resident to receive treatment & services to attain &/or maintain resident's practicable physical, mental & psychosocial wellbeing placing resident at risk of potential of unnecessary medication administration thus leading to possible harmful side effects, increased confusion, isolation, & lack of appropriate activities & interaction
- Failed to incorporate new CP interventions to address resident's decline of care due to increased dementia behaviors resulting in 85 missed medication administration opportunities & 28 bathing opportunities placing resident at risk for ineffective treatment & decreased quality of care
- Failed to incorporate new CP interventions to address resident's decline of care due to increased dementia behaviors resulting in missed medication administration opportunities & bathing opportunities placing resident at risk for ineffective treatment & decreased quality of care

**F657 Care Plan Timing & Revision**

SW: SS=D: Failed to revise CP to include use of O2 therapy & care of O2 equipment for 1 resident & failed to update CP to include new fall interventions to prevent further falls for 1 resident

- Current CP failed to include use of O2 per nasal cannula & maintenance of equipment; failed to revise CP to include use of O2 therapy & care of O2 equipment for 1 resident
- Fall incident report lacked ID of causal factors r/t fall & lacked new fall interventions; failed to revise CP for 1 resident to include information concerning a fall with interventions to help prevent future falls

**F676 Activities of Daily Living/Maintain Abilities**

NE: SS=D: Failed to ensure 1 resident received required assistance with eating & w/c mobility placing resident at risk for further physical decline & unmet needs

- Failed to ensure 1 resident received required assistance with eating & w/c mobility placing resident at risk for further physical decline & unmet needs

**F677 ADL Care Provided for Dependent Residents**

NE: SS=E: Failed to provide consistent bathing per residents' preferences & bathing schedules for 6 residents placing residents at risk for poor hygiene & decreased self-esteem

- Record revealed resident received 15 showers in 168 days; failed to provide consistent bathing per residents' preferences & bathing schedules for 1 resident placing resident at risk for poor hygiene & decreased self-esteem
- Record revealed resident received 12 showers in 168 days; failed to provide consistent bathing per residents' preferences & bathing schedules for 1 resident placing resident at risk for poor hygiene & decreased self-esteem
- Record revealed resident received 3 showers in 168 days period with 28 refusals & 8 "not applicable"; failed to provide consistent bathing per residents' preferences & bathing schedules for 1 resident placing resident at risk for poor hygiene & decreased self-esteem
- Record revealed resident received 6 baths/showers in 100-day period with 7 "not applicable" 2 refusals failed to provide consistent bathing per residents' preferences & bathing schedules for 1 resident placing resident at risk for poor hygiene & decreased self-esteem
- Record revealed resident received 5 baths/showers in 97 days with 5 "not applicable" & 8 refusals failed to provide consistent bathing per residents' preferences & bathing schedules for 1 resident placing resident at risk for poor hygiene & decreased self-esteem
- Record revealed resident received 6 baths/showers in 1 month, 4 baths/showers in 1 month, 3 baths/showers in 1 month, 2 baths/showers in 1 month, 1 bath/shower in 15-day period in 1 month; failed to provide consistent bathing per residents' preferences & bathing schedules for 1 resident placing resident at risk for poor hygiene & decreased self-esteem

**F678 Cardio-Pulmonary Resuscitation (CPR)**

SW: SS=J (Abated to G): Failed to initiate CPR on a full-code resident when LN & CNA found resident w/o respirations & was pulseless; staff thought resident was a DNR due to nursing report sheet did not list "FULL" beside resident's name to indicate resident's full code status; due to lack of an effective code system in place to ID full code & DNR residents, staff failed to follow resident's wishes to be resuscitated

- Due to lack of orientation for agency staff on facility code system to ID full code & DNR residents, staff failed to perform CPR on resident who desired resuscitation; Failed to have an effective code status system to ensure nursing staff correctly IDd code status of 1 resident when staff failed to initiate CPR when resident was not breathing & was pulseless placing resident in immediate jeopardy
- Abatement Plan:
  - Audit all residents to ensure they have a signed code status order & CP
  - Educated nurses on where to look & ID code status
  - Educate that as nurses in facilities we cannot decide not to do CPR-this must be physician only
  - Education on if there is no code status, residents are to be considered full code util otherwise IDd
  - Validate all code status were put into computer properly

**F679 Activities Meet Interest/Needs for Each Resident**

NE: SS=D: Failed to establish & implement a resident-specific activity program which included activities in resident's primary language in order to support resident's highest level of emotional well-being placing resident, who was primarily non-English speaking at risk for impaired psychosocial well-being & isolation

- CP lacked documentation of resident's preferred activities or directives to staff on how to accommodate &/or facilitate activities with regards to language barrier; failed to establish & implement a resident-specific activity program which included activities in resident's primary language in order to support resident's highest level of emotional well-being placing resident who was primarily non-English speaking at risk for impaired psychosocial well-being & isolation

**F684 Quality of Care**

*SE: SS=D: Failed to ensure necessary treatment & care in accordance with professional standards of practice for 1 resident who fell & c/o of shoulder pain & facility staff sent a fax to physician office r/t fall; 5 days later, physician ordered an x-ray completed on that day with results faxed to physician next day; x-ray revealed resident sustained a fx of clavicle; failed to follow up with physician for any orders until 11 days later when physician ordered a sling to resident's arm for comfort & to recheck x-ray in 1 month*

- *Failed to communicate with physician timely to ensure 1 resident received proper care & treatment following a fall where resident sustained fx'd clavicle*

NE: SS=D: Failed to prevent & treat moisture associated skin damage (MASD) for 1 resident which placed resident at risk for possible infection & worsening wounds

- Failed to prevent & treat a MASD wound for 1 resident placing resident at risk of worsening wounds, infection & pain r/t wounds/ulcers

**F686 Treatment/Services to Prevent/Heal Pressure Ulcer**

*SE: SS=D: Failed to provide necessary treatment & services to promote healing for 1/3 residents who had a PU in hip when LN failed to follow physician orders to order a wound vac for treatment of resident's hip*

- *Failed to follow physician order for application of a Negative Pressure Wound Treatment to promote healing of 1 resident's PU of hip for 9 days after receiving physician order for wound vac*

**F688 Increase/Prevent Decrease in ROM/Mobility**

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

- Record lacked documentation of implementation of a restorative program; failed to provide services to prevent a potential decrease in ROM/mobility &/or worsening of contractures for 1 resident placing resident at risk of loss of ability to perform ADLs & development of contractures

**F689 Free of Accident Hazards/Supervision/Devices**

*SE: SS=K (Past Non-Compliance): Failed to maintain a secure environment for residents IDd at high risk for elopement by facility; resident exited facility w/o staff knowledge after staff turned hall exit door alarm off resulting in exit alarm failure to sound when resident exited facility; resident seen by staff at *:32pm until 11:06pm when a staff member was leaving facility noted resident, w/o coat or shoes on ground in ditch near stop sign at end of facility driveway with a red abrasion to toe & slight abrasion to bilateral knees; resident outside in temperatures from 32-33 degress F for 2 hours & 34 minutes; staff failure to secure facility exit door placed resident & other residents at high risk for elopement in immediate jeopardy*

- *Failed to ensure 1 resident did not exit facility w/o staff knowledge after staff turned off exit door alarm allowing resident to elope from building in cold weather for 2-1/2 hours before a staff leaving facility happened to see resident on ground outside; facility failure also placed other residents at risk for elopement in immediate jeopardy*
- *Abatement Plan:*
  - *Alarm on exit door on hallway turned on to alert staff by maintenance staff*
  - *Door alarms checked for functionality by maintenance staff*
  - *Staff immediately notified physician for order to transport to ER for evaluation*
  - *Staff provided 15-minute safety checks for resident upon return from ER*
  - *Staff in-serviced on exit door alarms may not be turned off at any time, elopement, elopement drill, elopement risk when a resident is discovered missing who will be notified, assessment of resident & documentation, sign-out protocol*
  - *Facility notified medical director & conducted a QAPI meeting*

SW: SS=D: Failed to ID causal factors r/t fall experienced by 1 resident which resulted in hematoma to head & failed to implement new fall prevention intervention after fall

- Failed to ID causal factors r/t fall experienced by 1 resident & failed to implement new fall prevention interventions

NE: SS=D: Failed to ensure that adaptive equipment was properly installed to resident's w/c per resident's CP to ensure that resident's w/c stayed in place placing resident at risk for future falls or injury

- Observed resident in w/c with 1 anti-roll attachment on 1 side of w/c but other side lacked attachment; observed on multiple occasions; failed to ensure fall interventions in place for 1 resident were properly followed when resident's w/c was inappro priately equipped with only 1 anti-roll back attachment which placed resident at risk for future falls &/or injuries

NW: SS=E: Failed to maintain an environment free of accident hazards for 2/2 shower/w/p rooms when facility failed to adequat ely secure harmful chemicals placing cognitively impaired, independently mobile residents residing in facility at risk for harm or injury r/t avoidable hazards

- Observed multiple shower rooms with unlocked cabinet with hazardous labeled chemicals accessible; failed to adequately secure harmful chemicals in 2/2 shower/w/p rooms placing cognitively impaired independently mobile residents at risk for injury

**F690 Bowel/Bladder Incontinence, Catheter, UTI**

NE: SS=D: Failed to provide a safe, sanitary & hygienic catheter care by allowing resident's indwelling catheter drainage bag to touch the floor placing resident at risk for improper catheter care

- Observed resident in bed with an indwelling catheter drainage bag lying of floor under bed; failed to provide safe, sanitary & hygienic catheter care for 1 resident

**F692 Nutrition/Hydration Status Maintenance**

NE: SS=D: Failed to ensure 1 resident who was at risk for weight loss & had a recorded weight loss received chicken broth meant for nutritional supplement, failed to consistently record resident's intake for comparison & failed to offer resident preferred food it ems consistently & encourage increased intake placing resident at risk for physical decline & complications r/t impaired nutrition

- Failed to ensure 1 resident who was at risk for weight loss & had a recorded weight loss received chicken broth meant for nut ritional supplement, failed to consistently record resident's intake for comparison & failed to offer resident preferred food items consistently & encourage increased intake placing resident at risk for physical decline & complications r/t impaired nutriti on

**F695 Respiratory/Tracheostomy Care & Suctioning**

SW: SS=D: Failed to obtain physician orders prior to use of O2 therapy for 1 resident

- Failed to obtain physician orders prior to initiation of O2 therapy for 1 resident

NE: SS=D: Failed to provide safe & sanitary care for O2 tubing to help prevent development & transmission of diseases & infections for 1 resident placing resident at risk for infection

- Observed resident's O2 mask for nebulized medication sat with no barrier on countertop & O2 tubing laid on floor next to concentrator with no storage bag noted on concentrator; observed O2 mask for nebulized medication sat on rocking chair with n o barrier & with no bag for storage; failed to provide respiratory care consistent with professional standards of pr actice for 1 resident

**F698 Dialysis**

SW: SS=D: Failed to provide necessary care & service to attain or maintain a resident's highest practicable physical well-being r/t dialysis by failure of staff to document assessments of 1 resident's dialysis fistula site & post dialysis weights

- Failed to ensure nursing staff performed & documented post-dialysis assessments of resident's fistula site & weight

NE: SS=D: Failed to monitor 1 resident's dialysis treatments appropriately by not sending or collecting dialysis communication forms placing resident at risk for complications & health decline

- EMR lacked dialysis communication forms for 13 occasions in 60-day period; failed to prepare & collect dialysis communication forms for 1 resident as ordered

NE: SS=D: Failed to retain dialysis communication sheets & obtain or document vital signs &/or assessments before & after dialysis for 1 resident placing resident at risk for potential adverse outcomes & unwarranted physical complications r/t dialysis

- Failed to retain dialysis communication sheets, obtain or document vital signs &/or assessments before & after dialysis for 1 resident which had potential for adverse outcomes & unwarranted physical complications r/t dialysis

**F744 Treatment/Services for Dementia**

NE: SS=D: Failed to implement new dementia care interventions r/t behavioral refusals, social engagement documentation & dementia-specific care planning for 3 residents placing residents at risk for ineffective treatment & impaired psychosocial well-being due to increased dementia-related behaviors

- Resident with documented multiple refusals of medications; failed to implement ade3quate dementia care for 1 resident resulting refusal of ADL care, missed medication opportunities & lack of documentation showing promotion of cognitive & social engagement placing resident at risk for ineffective treatment & impaired psychosocial well-being due to increased dementia-related behaviors
- Failed to develop & revise a person-centered dementia care plan with interventions to address specific tasks & ways to divert resident to reduce resident's decline of care due to increased dementia behaviors which resulted in missed medication administration opportunities & bathing opportunities placing resident at risk for ineffective treatment & decreased quality of care
- Failed to develop & implement an adequate person-centered dementia care to receive treatment & services to attain &/or maintain practicable physical, mental & psychosocial well-being for 1 resident placing resident at risk of increased confusion, isolation & lack of appropriate activities & interaction

**F755 Pharmacy Services/Procedures/Pharmacist/Records**

NE: SS=D: Failed to ensure medications were available for administration for 1 resident who had an order for Nuplazid (antipsychotic) which is approved for treatment of Parkinson's disease psychosis placing resident at risk for complications & ineffective medication therapy

- POS in EMR revealed Nuplazid ordered on 12-24-21 for Parkinson's; December MAR revealed resident did not receive 1 dose of ordered Nuplazid & record lacked indication of reason or physician notification; MAR revealed resident did not receive drug 3 doses & record indicated drug "not available" & pharmacy would deliver when available; failed to ensure medications were available for administration for 1 resident who had an order for Nuplazid which was not administered in consistent manner due to availability placing resident at risk for complications & ineffective medication therapy

**F756 Drug Regimen Review, Report Irregular, Act On**

SW: SS=E: Failed to provide evidence of monthly monitoring of medication regimen by a licensed pharmacist for 4 residents

- Review of Consulting Pharmacist Monthly Medication Review revealed no monthly medication reviews for 4 months during review period for multiple residents; failed to provide evidence of monthly medication regimen reviews by a licensed pharmacist for multiple months for multiple residents

NE: SS=E: Failed to ensure Consulting Pharmacist (CP) IDd & reported administration of prescribed medication outside of ordered parameters for 6 residents placing residents at risk for ineffective treatment & further health concerns

- Failed to ensure CP IDd & reported inadequate monitoring of resident's BP medication being administered on 14 occasions outside of physician's ordered parameters placing resident at risk for ineffective treatment & further health concerns
- Failed to ensure CP IDd & reported inadequate monitoring of resident's PB medication when medication was administered on 7 occasions outside of physician's ordered parameters placing resident at risk for ineffective treatment & further health concerns
- Failed to ensure CP IDd & reported resident's hypertensive medication refusals & interruption of therapeutic medication regime placing resident at risk for ineffective treatment & further health concerns
- Failed to ensure CP IDd & reported irregularities for 1 resident for antihypertensive medications was administered outside physician ordered parameters & insulin was administered as ordered by physician placing resident at risk of unnecessary medication administration thus leading to possible harmful side effects for multiple residents
- Failed to ensure CP IDd & reported irregularities for 1 resident when Humalog insulin was administered outside physician ordered parameters with potential of unnecessary medication administration thus leading to possible harmful side effects

**F757 Drug Regimen is Free from Unnecessary Drugs**

SW: SS=E: Failed to ensure 2 residents were free of unnecessary medications by failure to check blood sugars & give medications as ordered

- Failed to accurately monitor accuchecks & insulin administration for multiple residents

NE: SS=E: Failed to ensure administration of prescribed medications within ordered parameters for 6 residents placing residents at risk for side effects & further health complications

- Cited findings noted in F756; facility administered resident's BP medication on 14 occasions outside physician's ordered parameters placing resident at risk for ineffective treatment & further health concerns
- Facility administered resident's BP medication on 7 occasions outside physician's ordered parameters placing resident at risk for ineffective treatment & further health concerns
- Failed to implement new CP intervention resulting in 85 missed medication administration opportunities of resident's ordered BP medication placing resident at risk for ineffective treatment & further health concerns

- Failed to ensure antihypertensive medications were not administered outside physician ordered parameters & insulin was administered as ordered by physician for 1 resident with potential for unnecessary medication administration thus leading to possible harmful effects
- Failed to ensure antihypertensive medications were held per physician ordered parameters & insulin was administered as ordered by physician for 1 resident with potential of unnecessary medication administration thus leading to possible harmful side effects
- Failed to ensure staff administered resident's Humalog within physician order parameters with potential of unnecessary medication administration thus leading to possible harmful side effects

**F758 Free from Unnecessary Psychotropic Meds/PRN Use**

SW: SS=D: Failed to ensure completion of targeted behavior monitoring for 1 resident & continued to administer 1 resident's PRN psychotropic medication longer than 14 days w/o a renewed physician order or reason provided by physician for continued administration of Lorazepam on a PRN basis

- Failed to complete targeted behavior monitoring for 1 resident who received psychotropic medications
- Facility continued to administer a PRN psychotropic medication longer than 14 days w/o a renewed physician order or reason provided by physician for continued administration for 1 resident

NE: SS=D: Failed to ensure 1 resident had an appropriate diagnosis with clinical rationale clearly recorded in medical chart which supported the continued use of an antipsychotic medication placing resident at risk for complications & adverse effects r/t antipsychotic use

- In response to DRR, consultant declined a request for a diagnosis clarification for Seroquel & resident needed to continue drug & would follow up with resident's representative r/t medication; record lacked evidence consultant followed up with resident's representative, reviewed risk & benefits of ongoing treatment; record further lacked evidence an appropriate diagnosis was assigned to antipsychotic medication; failed to ensure resident had an appropriate diagnosis with clinical rationale clearly recorded in medical chart which supported continued use of antipsychotic medication placing resident at risk for complications & adverse effects r/t to antipsychotic use

**F760 Residents are Free of Significant Med Errors**

NE: SS=Failed to ensure 1 resident was free from significant medications errors when a medication order was transcribed incorrectly which resulted in resident received wrong dose of methotrexate on at least separate occasions placing resident at risk for adverse medication side effects & unnecessary complications r/t medication errors

- Failed to ensure resident was free from significant medications errors when a medication order was transcribed incorrectly which resulted in resident received wrong dose of methotrexate placing resident at risk for adverse medication side effects & unnecessary complications r/t medication errors

**F761 Label/Store Drugs & Biologicals**

NE: SS=E: Failed to label & store medications within currently accepted professional principles on 1 cart placing affected residents at risk to receive ineffective or incorrect medications

- Observed unattended, unlocked medication/treatment cart in 1 hallway & observed plastic medication cup in top drawer of cart containing 9 white oval pills & had word cetirizine written on side; cup with no cover, no label, no dose, directions for use, open date or expiration date; unlocked cart also contained multiple stock supplements & medications & other medical supplies; failed to label & store medications within currently accepted professional principles on 1 cart placing affected residents at risk to receive ineffective or incorrect medications

**F804 Nutritive Value/Appear, Palatable/Prefer Temp**

NE: SS=D: Failed to serve food at a safe & appetizing temperature to 1 resident placing resident at risk for decreased nutrition, food borne illness & impaired psychosocial well-being

- Observed room tray of biscuits & gravy with temp in room of 106 degrees F & resident stated breakfast was "cold as usual"; failed to serve food at a safe & appetizing temperature to 1 resident placing resident at risk for decreased nutrition, food borne illness & impaired psychosocial well-being

**F812 Food Procurement, Store/Prepare/Serve-Sanitary**

SW: SS=E: Failed to ensure dishes & cookware were washed under sanitary conditions due to lack of accurate chemical monitoring

- Observed dietary staff demonstrated chemical sanitization test & dipped test strip in water reservoir for 15 seconds & test strip did not change color which indicated zero parts per million; CDM reported no sanitizer going through hose to dishwasher; failed to properly wash dishes & cookware under sanitary conditions

SW: SS=E: Failed to store, prepare, & serve food under sanitary conditions for all residents who resided in facility & received meals from facility kitchen placing residents at risk for foodborne illness

- Observed: multiple expired thickened drinks; expired gravy mix
- Observed dietary staff plating food & staff washed hands & donned gloves then touched multiple contaminated items then proceeded to plate food items including touching bread using soiled gloves
- Observed dietary staff wearing gloves & touched arm then with same gloves, placed lettuce & tomatoes on plate w/o changing gloves; also observed staff with gloved hands peeled banana, placed banana on cutting board used to prepare lettuce & tomatoes, then cut banana into bit size pieces into bowl w/o changing gloves between tasks
- Temp logs revealed no temps recorded for cold foods on multiple days; observed steam cooker & oven doors & handles with build up deposits of debris; QT testing strips expired

NE: SS=F: Failed to store food in accordance with professional standards for food service safety, when kitchen observation revealed numerous expired food items placing residents who received meals from facility kitchen at risk for foodborne illness

- Observed multiple items with expired dates; failed to store food in accordance with professional standards for food service safety when observations revealed expired food in facility kitchen

NE: SS=E: Failed to ensure staff members properly secured their hair in a hairnet when preparing & serving residents' food; failed to ensure hand soap, paper towels & hand sanitizer was available in kitchen prep & service area for staff to conduct hand hygiene; failed to ensure kitchen staff kept ice covered & scoop out of ice & stored in sanitary manner when not being used placing all residents who ate food from facility at risk for food borne illness

- Failed to ensure a safe food prep & servicing area when staff failed to wear proper head covering & left ice bucket uncovered with a spoon resting in ice & accessible to resident placing residents at risk for contamination & food borne illness

NW: SS=F: Failed to distribute & serve food in accordance with professional standards for food service safety in 1/1 facility kitchen placing residents who received food from facility kitchen at risk for foodborne illness

- Observed outer layer of wood peeling from 10 cupboards & drawers; shelf above stove with sticky gray substance; missing mopboard

**F868 QAA Committee**

SW: SS=F: Failed to ensure minimum required members attended QAPI meetings on at least a quarterly basis

- Review of sign in sheets lacked evidence of presence of medical director & DON on at least a quarterly basis; failed to ensure minimum required members attended QAPI meetings

**F880 Infection Prevention & Control**

SW: SS=D: Failed to perform blood sugar testing on 2 resident in a sanitary manner when LN failed to clean facility glucometer after using it on first resident &/or before testing 2nd resident

- Failed to perform blood sugar testing on 2 residents in a sanitary manner by failure to clean facility glucometer after using it & before testing a 2nd resident

NE: SS=E: Failed to ensure staff followed infection control standards of practice; failed to ensure staff properly used/wore PPE while in community areas; failed to practice proper hand hygiene while serving residents meals in DR as well as during medication administration pass; failed to provide a clean barrier under glucometer while obtaining blood glucose reading; failed to properly maintain a shared ice chest that residents had access for use of placing residents at risk for increased infection & transmission of communicable disease

- Failed to ensure staff practices hand hygiene while serving residents in DR & in between resident cares; failed to ensure staff properly wore masks when in community areas; failed to ensure staff cleaned &/or sanitized reusable BP monitoring equipment before being used on next resident; failed to ensure staff placed a barrier down on a surface before placing glucometer on table; failed to maintain & keep an ice chest & scoop clean & sanitized after each use leaving facility's residents vulnerable for potential spread of infection & disease to all residents of facility

**March, 2022**

**F550 Resident Rights/Exercise of Rights**

SW: SS=D: Failed to ensure dignity of 1 resident who used a urinary catheter by failing to place urinary drainage bag in dignity cover for 1 resident

- Failed to maintain dignity for 1 resident by not placing urinary catheter drainage bag inside a dignity cover

NE: SS=D: Failed to acknowledge & honor resident's right for self-determination to sleep undisturbed w/o feeling interference or reprisal from facility staff; further failed to ensure 2 resident's right to be treated with respect, dignity & care during meals placing residents at risk for negative psychosocial outcomes & decreased autonomy & dignity

- NN documented staff assisted resident to BR at 1:30am & noted documented resident requested not to be disturbed until 7:30am so resident could sleep undisturbed; resident refused routine tasks & q 2 hour checks & stated wanted to sleep; resident stated afraid to ask for things; failed to ensure staff recognized & honored resident's right for self-determination to sleep undisturbed w/o feeling interference or coercion from facility staff placing resident at risk for impaired dignity & decreased psychosocial well-being
- Failed to ensure dignified dining experience when staff stook over resident instead of sitting beside resident while assisting with meals placing resident at risk for impaired dignity & decreased psychosocial well-being for multiple residents

**F558 Reasonable Accommodations Needs/Preferences**

NE: SS=D: Failed to provide care & services to maintain 1 resident's highest level of function by not maintaining urostomy supplies placing resident at risk for physical discomfort & negative psychosocial impact

- Progress note documented night shift reported that resident removed urostomy bag wafer after being informed facility did not have any extras at this time; supply room searched to locate wafer that would fit & could not locate; staff notified DON who stated would get some ordered & overnighted to facility; staff notified resident & resident was upset that facility could not get them at that time; resident stated not having correct urostomy supplies made resident feel dirty & afraid of soiling self; DON stated facility had urostomy supplies available but resident had chosen not to use those supplies; failed to provide care & services r/t resident's urostomy supplies being unavailable for 6 days placing resident at risk for physical discomfort & negative psychosocial impact

**F561 Self-Determination**

SE: SS=D: Failed to ensure encouragement for 1 resident to voice preferences choices for beverages & food

- Record lacked indication of food preferences for resident; Observed resident in room with room tray & no beverages on meal tray; family member stated resident did not receive beverages on meal tray & preferred to have coffee in mornings; family member stated family brought in foods for resident to eat but did not know if facility determined what resident's preferences/choices were;

dietary staff stated computer system "down" & did not complete a dietary assessment to determine resident's preferences; failed to determine resident's preferences for food/beverages to enhance resident's appetite & eating experience before administering an appetite stimulant/antidepressant

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

NE: SS=D: Failed to notify physician of low BPs for 1 resident placing resident at risk for continued low BPs & adverse medication side effects

- Failed to notify physician of 1 resident's low BPs, placing resident at risk for continued low BPs & adverse medication side effects

*NW: SS=D: Failed to notify resident's physician & resident's DPOA of a decline in resident's condition placing resident at increased risk for delayed treatment & impaired decision-making ability by resident's DPOA due to lack of communication*

- *Resident with Foley catheter with order to change; nurse had difficulty removing catheter then unable to re-inflate balloon & physician notified; EMR lacked evidence of notification of DPOA r/t complication; EMR lacked any documentation r/t when catheter naturally dislodged from resident's bladder; EMR documented resident with low BP & EMR lacked any physician notification of low BP; EMR lacked any documentation r/t any kind of decline reported decline to resident's physician or reported to resident's representative; failed to notify resident's physician & failed to inform resident's DPOA of a decline in resident's condition placing resident at increased risk for delayed treatment & impaired decision-making ability by resident's DPOA due to lack of communication*

**F582 Medicaid/Medicare Coverage/Liability Notice**

NE: SS=D: Failed to provide 3 residents completed NOMNC Form 10123 & 1 resident with SNF ABN 10055

- Failed to provide CMS form 10123 to resident's or representative when discharged from skilled care for 3 residents & failed to provide 1 resident the CMS form 10055 placing residents or representatives at risk to make uninformed decisions about continuation of skilled care

**F600 Free from Abuse & Neglect**

*NW: SS=J (Abated to D): Failed to ensure 1 resident remained free from abuse & neglect when facility failed to prevent an episode of staff to resident abuse, mistreatment, & neglect; LN & CNA witnessed CNA yank on resident's arm & roughly reposition resident in bed while resident pleaded for help & screamed for CNA to get out of room; as a result of occurrence, resident was inconsolable & was left alone in room where resident subsequently had a fall an hour later placing resident in immediate jeopardy*

- *CNA & LN witnessed incident around 6pm & reported to Adm at 10:30pm; When reported to DON, DON stated "abuse is a pretty big word"; Resident stated CNA had a "bad attitude" & left resident's room w/o helping resident on multiple occasions & resident stated CNA's actions & treatment made resident feel insignificant; CNAs unavailable for interview; LN unavailable for interview; failed to ensure resident remained free from abuse & neglect when facility failed to prevent an episode of staff to resident abuse & neglect placing resident in immediate jeopardy*
- *Abatement Plan*
  - *Resident assessed for physical &/or psychological injury*
  - *Adm staff/designee completed interview with current alert & oriented residents to determine that they have received needed supervision for resident safety & to prevent episodes of staff to resident abuse & neglect*
  - *Re-education was completed by Adm staff/designee to current staff on abuse & neglect prevention policy & procedures*
  - *All staff educated on AN policy prior to next shift*

**F609 Reporting of Alleged Violations**

*NW: SS=J (Abated to D): Failed to ensure staff IDd & immediately reported an allegation involved abuse, neglect or mistreatment; LN & CNA responded to cognitively impaired resident's screams for help; when LN & CNA entered resident's room, they witnessed CNA roughly yanking on resident's arm & roughly repositioning resident in bed while resident screamed out for help & yelled to CNA to get out of room; LN & CNA failed to immediately report witnessed abuse to Adm until 4.5 hours after event placing resident in immediate jeopardy*

- *Failed to ensure staff IDd & immediately reported an allegation involving abuse, neglect or mistreatment involving 1 resident placing resident in immediate jeopardy*
- *Abatement plan:*
  - *Adm re-educated LN on importance of IDing & reporting abuse & neglect to administrative team immediately; LN resigned effective immediately; CNA was agency aide whose contract ended on evening of incident*
  - *Adm staff/designee completed interview with current alert & oriented residents to determine that they have received needed supervision for resident safety & to prevent episodes of staff to resident abuse & neglect*
  - *Re-education completed by Adm/designee to current staff on abuse & neglect prevention policy & procedures*
  - *All educated on abuse & neglect policy prior to next shift*

**F610 Investigate/Prevent/Correct Alleged Violation**

*SE: SS=D: Failed to thoroughly investigate a resident's report to facility staff of a fall sustained by resident in facility to ensure no abuse or neglect to resident*

- *Resident fell while ambulating to sink with use of w/c instead of using walker & asking for assist from staff; resident stated no injury but resident with abrasion to scalp parietal area & normal ROM; resident's roommate reported resident fell during night days before & reported fall to staff & resident hit head during earlier fall; staff did not report fall to LN; failed to thoroughly investigate a resident reported fall sustained by resident in facility to ensure no abuse or neglect to resident*

*NW: SS=K (Abated to E): Failed to ensure 1 resident received necessary protective oversight to prevent ongoing abuse & neglect when facility administrative staff failed to respond to an allegation of staff to resident abuse; LN & CNA witnessed CNA yank on resident's arm & roughly reposition resident in bed while resident pleaded for help & screamed for CNA to get out of room; 4-1/2 hours later staff reported abuse to Adm; facility failed to implement protective measures after Adm learned of abuse allegation; CNA was allowed to remain in facility, providing*

*direct care to 1 resident & other residents for 12 hours after alleged abuse occurred & for 7.5 hours after Adm became aware of allegation placing resident & other residents in facility in immediate jeopardy*

- *Failed to ensure resident received necessary protective oversight to prevent ongoing abuse & neglect when facility failed to respond to allegation of staff to resident abuse placing resident in immediate jeopardy*
- *Abatement plan:*
  - *Adm staff re-educated on protecting residents when allegation is made*
  - *CNA suspended pending investigation*
  - *Adm staff/designee completed interview with current alert & oriented residents to determine that they have received needed supervision for resident safety & to prevent episodes of staff to resident abuse & neglect*
  - *Re-education completed by Adm/designee to current staff on abuse & neglect prevention policy & procedures*
  - *All staff educated on abuse & neglect policy prior to next shift*

**F623 Notice Requirements Before Transfer/Discharge**

SW: SS=D: Failed to send a copy of the facility-initiated hospitalization transfer/discharge notice to representative of Office of State Long-Term Care Ombudsman for 1 resident

- Facility failed to send copy of notice of facility-initiated hospitalization transfer/discharge to a representative of the Office of the State Long-Term Care Ombudsman when 1 resident transferred to hospital

SW: SS=D: Failed to provide written notice to State Ombudsman of 1 facility-initiated hospitalization transfer of 1 resident

- Failed to notify ombudsman of 1 resident's facility-initiated hospitalization transfer

NE: SS=D: Failed to provide written notice of discharge to resident's representative & the Ombudsman when resident was discharged to an acute care facility

- Failed to provide resident representative & Ombudsman with written notice of discharge as soon as practical when resident was sent to an emergency acute facility

**F625 Notice of Bed Hold Policy Before/Upon Transfer**

SW: SS=D: Failed to provide a copy of facility bed hold policy to 2 residents or representatives when they transferred out of facility to hospital

- Failed to provide a copy of facility bed hold policy to 1 resident or representatives when resident transferred to hospital
- Failed to provide 1 resident or representative with facility's bed hold policy within 24 hours after admission to hospital

**F641 Accuracy of Assessments**

NE: SS=D: Failed to ensure 1 resident received accurate MDS when facility incorrectly coded an antipsychotic as an antidepressant

- Failed to ensure accurate assessment & documentation of antipsychotic drug usage for 1 resident with risk for miscommunication in care planning process r/t antipsychotic medication side effects

**F645 PASARR Screening for MD & ID**

SW: SS=D: Failed to obtain a Care Assessment Screening for 1 resident upon admission

- Failed to obtain a Care Assessment screening PASARR for 1 resident upon admission

**F655 Baseline Care Plan**

NE: SS=D: Failed to develop a baseline CP for 1 resident upon admission placing resident at risk for inappropriate car

- Failed to develop a baseline CP for 1 resident, placing resident at risk for inappropriate care

NE: SS=D: Failed to develop a baseline CP which included fall interventions for 1 resident placing resident at risk for accidents & injury

- Failed to provide initial CP fall interventions for 1 resident placing resident at risk for accidents & injuries

**F656 Develop/Implement Comprehensive Care Plan**

NE: SS=D: Failed to develop a comprehensive care plan for 1 resident who had a fluid restriction r/t dialysis placing resident at risk of complications r/t fluid overload or dehydration

- Failed to develop a comprehensive CP r/t resident's fluid restriction placing resident at risk for possible fluid overload or dehydration

NE: SS=D: Failed to develop a comprehensive CP to include catheter & skin care prevention for 1 resident; further failed to ensure 1 resident's CP included vital information r/t dialysis placing residents at risk for complications r/t care delivery

- Failed to ensure resident's CP for dialysis was updated to include location, a contact phone number, time of each appointment & transportation information to/from each appointment placing resident at risk for not receiving appropriate cares or dialysis treatment needed
- Initial CP did not indicate or ID risks r/t stage 2 PUs; failed to develop a comprehensive CP which directed interventions aimed to prevent skin breakdown & direct catheter cares for 1 resident who was at risk for skin complications for existing pressure injuries

**F657 Care Plan Timing & Revision**

SE: SS=D: Failed to review & revise CP for 2/15 residents; 1 resident to prevent further bruising following a large bruise on hand & 1 resident with implementation of hospice services

- Failed to review & revise dependent resident's CP with interventions to prevent further bruising when resident sustained a large 8x8 cm brise with extension up fingers on hand
- Failed to review & revises CP to include hospice care for dependent resident who was admitted to hospice care

NE: SS=D: Failed to revie CP with interventions to prevent skin ears for 1 resident who received 2 skin tears during cares placing resident at risk for further injury

- Record lacked evidence of analysis of root cause for skin tears & lacked evidence preventative measures were evaluated & implemented; Failed to revise 1 resident's CP with interventions to prevent skin tears for 1 resident who had fragile skin & had obtained 2 skin tears placing resident at risk for further injury

NE: SS=D: Failed to revise comprehensive CP to include antipsychotic medication use & antibiotic therapy for aspiration pneumonia for 1 resident with potential for alteration of continuous care among nursing home staff that could result in adverse consequences r/t safety, adverse side effects or injury

- Failed to revise 1 resident's comprehensive CP to include psychotropic medication use & antibiotic therapy for aspiration pneumonia upon readmission from hospital which had potential for alteration of continuous care among nursing home staff, that could res ult in adverse consequences r/t safety, adverse side effects or injury

**F661 Discharge Summary**

SW: SS=D: Failed to document a recapitulation of resident's stay upon discharge for 1 resident

- Failed to document a discharge summary including recapitulation of resident's stay at facility upon discharge of 1 resident

SW: SS=D: Failed to develop a discharge summary which included a recapitulation of resident's stay, a final summary of reside nt's status, reconciliation of all pre- and post-discharge medications & develop a post-discharge plan of care including discharge instructions for 1 resident

- Failed to develop a discharge summary, recapitulation & discharge instructions for 1 resident

NE: SS=D: Failed to complete a discharge summary for 1 resident that included a recapitulation summary of resident's stay in facility placing resident at risk for miscommunication or interruptions in continuum of care after discharge

- Failed to develop a discharge summary that included a recapitulation summary of 1 resident's stay in facility

**F676 ADLs/Maintain Abilities**

NE: SS=D: Failed to use alternative communication methods for 1 resident who had a diagnosis of cognitive communication defic it placing resident at risk for ineffective communication & frustration

- Observed resident with communication deficit & observed staff did not use available communication board in room & continued to verbally ask resident what resident wanted & resident with frown on face & kept shaking head "no"; failed to effectively communicate with 1 resident by using resident's communication board placing resident at risk for ineffective communication

**F677 ADL Care Provided for Dependent Residents**

SE: SS=D: Failed to provide 1 resident with adequate bathing opportunities to maintain good personal hygiene

- Failed to provide adequate baths to dependent resident to maintain good personal hygiene as resident received 2 baths for 20 day period with noted greasy/dirty hair

*NE: SS=D: Failed to provide 1 resident with scheduled showers during last week at facility placing resident at risk for impaired skin integrity & impaired psychosocial well-being*

- *Failed to provide 1 resident with resident's 2 scheduled showers per resident's preference during last week at facility placing resident at risk for impaired skin integrity & impaired psychosocial well-being*

NE: SS=D: Failed to ensure bathing was provided for 1 resident who required assistance from staff to complete care placing re sident at risk for potential skin breakdown &/or skin complications from not maintaining good personal hygi ene & bathing practices

- Failed to ensure shower/bath was provided for 1 resident who required extensive assistance with ADLs which had potential to c ause skin breakdown &/or skin complications due to poor personal hygiene & impaired psychosocial wellbeing

NE: SS=D: Failed to provide consistent bathing per residents' preferences & bathing schedules for 2 residents placing residen ts at risk for poor hygiene & impaired psychosocial well-being

- Bathing logs documented "Not Applicable" on multiple days in multipl e months & record lacked documentation of refusals for bathing; observed resident with hair oily & resident stated felt "dirty & bad"; failed to ensure shower/bath was provided for 1 resident who required extensive assistance with ADLs with potential to cause skin breakdown &/or skin complications due to poor personal hygiene & impaired psychosocial wellbeing
- Failed to ensure a shower/bath was provided to 1 resident who required extensive assist with ADLs which had potential to caus e skin breakdown &/or skin complications due to poor personal hygiene & impaired psychosocial wellbeing

**F684 Quality of Care**

SE: SS=D: Failed to develop interventions to prevent bruising for 1/2 residents who had extensive bruising on top of hand tha t extended into fingers

- LN stated noticed bruise on hand & CNA reported that prior shift CNA reported bruise occurred during night when resident became restless & hit hand on wall; nurse stated did not develop interventions for protection based on root cause analysis; Failed t o thoroughly investigate & implement interventions to prevent further/repeated bruising for dependent resident with large bruise on top of hand;

NE: SS=D: Failed to implement interventions to prevent skin tears for 1 resident who received 2 skin tears during cares placing resident at risk for further injury

- Record lacked documentation how resident received kin tear to forearm; record lacked evidence of analysis of root cause for s kin tears & lacked evidence preventative measures were evaluated & implemented; failed to implement interventions to prevent skin tears for 1 resident who had fragile skin & had obtained 2 skin tears placing resident at risk for further injury

*NE: SS=D: Failed to provide consistent wound care for 1 resident with risk for prolonged wound hea ling & unwarranted physical complications*

- *Current month lacked evidence of administration for wound care for multiple orders for wound care on multiple occasions; failed to provide consistent would care for 1 resident with risk for prolonged wound healing & unwarranted physical complications*

*NE: SS=D: Failed to provide consistent wound care for 1 resident with risk for prolonged wound healing & unwarranted physical complications*

- *Resident with local infection of skin & subcutaneous tissue; physician orders with wound care orders; TAR lacked evidence of administration for wound care for multiple orders on multiple occasions; failed to provide consistent wound care for 1 resident with risk for prolonged wound healing & unwarranted physical complications*

*NE: SS=D: Failed to provide necessary wound care as ordered & failed to obtain staple removal order upon admission for 1 resident with risk for worsening wound condition & physical complications for 1 resident*

- *CP did not address surgical wound; TAR revealed blank documentation for 4/12 possible administrations for gauze & tape changed daily; record lacked evidence nursing staff notified physician about lack of orders r/t staple removal; failed to provide necessary wound care as ordered & failed to obtain staple removal order upon admission for 1 resident with risk for worsening wound condition & physical complications for 1 resident*

*NW: SS=D: Failed to provide necessary cares & services for 1 resident to prevent urosepsis & hospitalization from occurring when they failed to report, & take action in response to resident's significant clinical findings which included low BPs, decreased appetite & inability to conduct physician ordered UA placing resident at increased risk for delayed treatment & hospitalization*

- *Failed to provide quality care to 1 resident by not notifying physician of changes in resident's physical status & inability of lab to perform physician ordered UA*

**F686 Treatment/Services to Prevent/Heal Pressure Ulcer**

SE: SS=D: Failed to ensure staff implemented planned pressure reducing seat cushion to w/c for 1 resident who admitted with PUs & was at risk for further development of PUs

- Observed resident being wheeled in w/c with no type of pressure relieving seat device; failed to ensure implementation with staff placing a pressure reducing seat cushion in w/c for dependent resident to promote healing of PUs

*NE: SS=D: Failed to provide consistent PU wound care for 1 resident with risk for prolonged wound healing & unwarranted physical complications*

- *Failed to provide consistent PU wound care for 1 resident with risk for prolonged wound healing & unwarranted physical complications r/t multiple blank documentation of PU dressing changes*

*NE: SS=D: Failed to provide consistent PU wound care for 1 resident with risk for prolonged wound healing & unwarranted physical complications*

- *Cited findings noted in F684 r/t blanks in TAR in ordered PU treatments on multiple occasions; failed to provide consistent PU wound care for 1 resident with risk for prolonged wound healing & unwarranted physical complications*

**F688 Increase/Prevent Decrease in ROM/Mobility**

NE: SS=D: Failed to ensure staff applied 1 resident's splint & brace as ordered by physician placing resident at risk for further decrease in ROM

- Resident with hemiplegia & hemiparesis following CVA & required total assist; POS with order for foot brace while in bed for 1-2 hours a day BID for foot/ankle contracture; POS with restorative nursing order to wear hand splint/brace 6-8 hours/day to prevent further contracture; apply bean bags to palm & elevate arm; observed resident w/o ordered heel protectors, ankle brace of hand brace on multiple occasions; staff unaware of restorative nursing program or a brace; failed to ensure that staff provided treatment/services & failed to apply ordered braces &/or splints to help prevent further avoidable reduction of ROM & maintain or improve ROM in resident's extremities

**F689 Free of Accident Hazards/Supervision/Devices**

*SE: SS=D: Failed to ensure 1/3 residents remained free from accident hazards when staff failed to provide appropriate air mattress settings according to resident's weight; air mattress settings were for a resident weighing 400 pounds & resident weighed 191 pounds at time of an unwitnessed fall; inappropriate settings caused over inflation of mattress & contributed to fall*

- *Facility lacked policy addressing air mattress settings; failed to ensure 1 resident remained free from accident hazards when staff failed to provide appropriate air mattress settings according to resident's weight; air mattress settings were for a resident weighing 400 pounds & resident weighed 191 pounds at time of an unwitnessed fall causing over inflation of mattress & contributed to fall*

NE: SS=D: Failed to implement appropriate interventions aimed at preventing falls for 1 resident who was IDd as a high fall risk; resident, in 4 month period had 7 fall occurrences with resulted in minor injury 5/7 occurrences placing resident at risk for injuries r/t falls

- Failed to ensure interventions determined by IDT to be helpful in preventing future falls for 1 resident were implemented by staff & added to CP to assist in preventing possible major injury from falls

*NE: SS=J (Past Non-Compliance): Failed to provide adequate supervision to prevent elopement for 1 resident who was independently mobile & cognitively impaired; resident was at high risk for elopement, wore a Wanderguard & had a recent hx of agitation, exit seeking & behaviors; resident exited unit through an unattended door left slightly ajar from a visitor; resident's Wanderguard triggered safety alarm as resident exited; staff responded to alarm but canceled alarm w/o assessing presence of all residents at risk & w/o reviewing display which notified staff which Wanderguard triggered alarm; as a result, resident exited facility w/o staff knowledge or supervision & facility staff observed resident outside 10 minutes later placing resident in immediate jeopardy*

- *Failed to ensure resident received necessary supervision to prevent elopement & failed to ensure staff responded to safety alarms appropriately when staff canceled alarm w/o assessing presence of all residents at risk & w/o reviewing display which notified staff which Wanderguard triggered alarm; resident was able to exit facility w/o supervision which presented likelihood of serious harm or impairment*
- *Abatement plan:*

- *Education to all facility staff reiterating that anytime an alarm went off on roam alert system, staff should always check to ensure resident was safe prior to cleaning alarm; education included direction to staff to never clear alarm prior to IDing resident's location*
- *Elopement drill performed & completed within 2 minutes*
- *LN received written reprimand which indicated no roam alerts were to be cleared until LN confirmed resident was safe inside facility; if unsure of resident, LN needed to view photo in book with pictures of all residents that have a Wanderguad*
- *CMA received written reprimand was suspended & received written reprimand; CMA was educated with demonstrated understanding & return demonstration on how to look up roam alert numbers, review profile book with residents that have a Wanderguard & view resident names on roam alert computer*

NE: SS=D: Failed to ensure staff utilized CPd interventions for 1 resident to prevent falls & failed to implement appropriate interventions aimed at preventing fall for 1 resident who was IDd as high fall risk; failed to implement preventative fall measures upon admission as well as appropriate fall interventions immediately after a fall for 1 resident who was at risk for falls placing residents at risk for injury r/t falls

- Failed to ensure interventions determined by DON to be helpful in preventing future falls for 1 resident were implemented by staff placing resident at risk of possible major injury from falls
- Failed to develop & implement appropriate interventions to prevent falls for 1 resident who had multiple falls placing resident at increased risk for major injuries r/t falls
- Failed to implement preventative fall measures upon admission as well as appropriate fall interventions immediately after a fall for 1 resident who was at risk for falls placing resident at risk for fall related injury

*NW: SS=G (Past Non-Compliance): Failed to ensure 1 resident remained free from accidents & hazards when CNA prepared a hot pack & placed it to resident's hip w/o consulting nurse on duty & w/o assessment actual temperature of hot pact; as result, resident sustained 2 second degree burns to hip*

- *Resident with hemiplegia affecting non dominant side; NN documented physician at facility on rounds & wrote order to apply heat to hip for pain which directed staff to apply warm compress to hip for pain & directed nurse to monitor temp of warm pack for 15 minutes or less at a time & to assess skin after each application; order directed nursing to dampen washcloth with warm water, place in plastic zip bag, seal & wrap plastic bag with towel before placing on resident; investigation revealed resident asked for warm pack & told CNA to give warm pack which was hot; resident reported did not alert any other staff about warm pack & reported when staff came back to retrieve pack & stated did not have pain; LN unaware resident received warm pack; resident received 2 blisters; failed to ensure resident was free from accidents or hazards when CNA prepared a hot pack & placed it to resident's hip w/o consulting nurse on duty & w/o assessing actual temperature of hot pack & as result resident sustained 2 second degree burns to hip, placing resident at risk for impaired healing & infection*
- *Correction plan:*
  - *Education to all staff reiterating that all medical interventions must be physician ordered & administered under supervision of a LN or physician*
  - *Education provided to nursing staff on safe use of warm compresses*
  - *CNA suspended during investigation & educated*

*NW: SS=G (Past Non-Compliance): Failed to implement safety protocols while using a w/p lift chair to prevent falls; as result, resident fell out of w/p lift chair & sustained a hip fx*

- *Post Fall Huddle documented resident fell out of w/p chair lift because resident felt unsafe due to safety bars not being down; CNA did not have safety bars down on w/p lift chair while CNA moved lift out of w/p bath; CNA documented CNA pulled resident out of bath on lift & resident grabbed tub door in front of resident as CNA moving lift out of tub & resident fell forward; failed to ensure use of safety bars while resident was in w/p lift chair that resulted in fall, causing hip fx*
- *Correction plan:*
  - *Provided CNA with "Teachable Moment" to re-educate CNA that safety bars on w/p chair needed to be down while chair moving; safety arms could be up while chair was locked & in down position*
  - *CNA completed competency checklist r/t w/p bathing*
  - *Facility ensured all relevant staff re-trained on operating bath lift*

**F690 Bowel/Bladder Incontinence, Catheter, UTI**

SE: SS=D: Failed to properly anchor catheter tubing & keep catheter tubing from coming into direct contact with floor for 2/3 residents

- Failed to ensure proper anchoring devices were in place for dependent resident with urinary catheter; failed to ensure tubing for urinary catheters did not come into direct contact with floor to prevent urinary tract infections for resident
- Failed to ensure resident's tubing did not have direct contact with floor & had an anchor in place to prevent possible catheter associated infection & trauma from occurring

NE: SS=D: Failed to follow resident's toileting schedule resulting in increased episodes of overnight incontinence placing resident at risk for increased incontinence, impaired psychosocial well-being & skin breakdown

- Failed to follow 1 resident's scheduled toileting schedule resulting in increased episodes of overnight incontinence placing resident at risk for increased incontinence, impaired psychosocial well-being, & skin breakdown

*NE: SS=D: Failed to provide 1 resident with toileting assistance resulting in bowel incontinence placing resident at risk for impaired skin integrity, increased bowel incontinence & impaired psychosocial well-being*

- *Failed to provide 1 resident with toileting assistance resulting in bowel incontinence placing resident at risk for impaired skin integrity, increased bowel incontinence & impaired psychosocial well-being*

**F691 Colostomy, Urostomy, or Ileostomy Care**

NE: SS=D: Failed to ensure a physician's order for ileostomy care & appropriate application of necessary cares leaving 1 resident at risk for complications r/t ileostomy such as infection & skin breakdown

- Resident stated that since resident was admitted & staff had not been able to get a good seal on skin for ileostomy so it had been leaking & needed to be changed numerous times; MAR & TAR lacked evidence of ileostomy care (when to change, how often to change & monitoring) provided; resident stated had to wear a hospital gown all the time because the bag was always leaking; failed to ensure staff gave necessary care & services r/t ileostomy care for 1 resident placing resident at risk for ostomy related complications

**F693 Tube Feeding Management/Restore Eating Skills**

*NE: SS=D: Failed to provide consistent tube feeding administrations for 2 residents with risk for unwarranted physical complications r/t decreased nourishment, dehydration & potential weight loss*

- *TAR revealed 11/56 possible administrations for enteral feed q 4 hours flush with 150 mL H2O & 5/37 possible administrations for enteral feed q 6 hours 250 mL per PEG tube; failed to consistently provide tube feedings administrations for 1 resident with risk for unwarranted physical complications r/t decreased nourishment, dehydration, & potential weight loss*
- *MAR revealed blank documentation for 7/119 possible administrations for Osmolyte tube feedings; failed to consistently provide tube feedings administrations for 1 resident with risk for unwarranted physical complications r/t decreased nourishment, dehydration & potential weight loss*

*NE: SS=D: Failed to provide consistent tube feeding administrations for 2 residents with risk for unwarranted physical complications r/t decreased nourishment, dehydration & potential weight loss*

- *TAR revealed missing administrations 11/56 administrations for enteral feed every 4 hours flush with 150 mL of water & 5/37 possible administrations for enteral feed every 6 hours 250 mL per PEG tube; failed to consistently provide tube feedings administration for 1 resident with risk for unwarranted physical complications r/t decreased nourishment, dehydration, & potential weight loss*
- *Failed to consistently provide tube feedings administrations for 1 resident with risk for unwarranted physical complications r/t decreased nourishment, dehydration & potential weight loss*

**F695 Respiratory/Tracheostomy Care & Suctioning**

NE: SS=D: Failed to ensure staff provided necessary respiratory care & services when staff failed to properly change, date & store O2 tubing when not in use for 2 residents which left residents at risk for unwarranted respiratory complications

- Observed O2 tubing not stored in bag when not in use; failed to ensure staff properly dated & stored O2 tubing & failed to ensure tracked when O2 tubing was changed for 1 resident leaving resident vulnerable for respiratory complications
- Failed to properly date & store 1 resident's O2 tubing in a hygienic manner placing resident at risk for complications r/t respiratory therapy

**F698 Dialysis**

NE: SS=D: Failed to implement a physician ordered fluid restriction for 1 resident who had dialysis treatment placing resident at risk of complications r/t fluid overload or dehydration

- Failed to incorporate a fluid restriction for 1 resident who had dialysis treatments placing resident at risk for complications r/t fluid overload or dehydration

NE: SS=D: Failed to ensure 1 resident had a physician's order for dialysis & failed to ensure critical information such as name, location of dialysis center, a contact number, time of treatment & transportation to/from dialysis clinic was documented on resident's clinical record leaving resident at risk for improper care & treatment

- Failed to ensure that a physician's order for dialysis treatment & failed to ensure resident's record contained information that included address of facility providing dialysis service, a contact phone number, & time of each appointment placing resident at irks for inappropriate cares r/t dialysis treatment

**F756 Drug Regimen Review, Report Irregular, Act On**

NE: SS=D: Failed to ensure physician documented clinical indication for antipsychotic medication use as recommended by Consultant Pharmacist (CP) for 1 resident which had potential of unnecessary psychotropic medication administration thus leading to possible harmful side effects

- Resident with Risperidone q hs for psychosis; record lacked physician documentation of clinical indication & rationale for use of antipsychotic w/o an appropriate diagnosis; failed to ensure physician documented a clinical justification for use of antipsychotic medication for 1 resident as recommended by CP which had potential of unnecessary psychotropic medication administration thus leading to possible harmful side effects

**F757 Drug Regimen is Free from Unnecessary Drugs**

*SE: SS=D: Failed to ensure ¾ residents remained free of unnecessary medications when facility staff failed to monitor blood sugars & administer diabetic medications as ordered by physician to ensure no unnecessary medication usage*

- *Review of TAR revealed 1 month with lack of documentation for evening insulin administration on 1 occasion, lack of documentation for bedtime insulin administration on 1 occasion & lack of accu-check documentation on 1 occasion at bedtime; review of next month revealed lack of documentation for insulin administration on 7 occasions at various times & lack of accu-check documentation on 6 occasions; failed to ensure 1 resident received adequate monitoring of blood sugars & appropriate administration of antidiabetic medication to ensure no unnecessary medication usage*
- *Failed to ensure 1 resident received adequate monitoring of blood sugar results to ensure no unnecessary medication usage*
- *Failed to ensure 1 resident received adequate monitoring of blood sugars & appropriate administration of antidiabetic medication to ensure no unnecessary medication usage*

*NE: SS=D: Failed to consistently provide medications as ordered by a physician for 1 resident with risk for unnecessary medication use & unwarranted physical complications*

- *Failed to consistently provide medications as ordered by physician for 1 resident r/t multiple blanks in eMAR for multiple medications with risk for unnecessary medication use & ineffective medication therapy*

*NE: SS=D: Failed to consistently provide medications as ordered by physician for 1 resident with risk for unnecessary medication use & unwarranted physical complications*

- *MAR revealed multiple medications lacked evidence medication was administered; failed to consistently provide medications as ordered by physician for 1 resident with risk for unnecessary medication use & ineffective medication therapy*

**F760 Residents are Free of Significant Med Errors**

SE: SS=D: Failed to obtain physician ordered lab tests to monitor PT/INR to ensure 2/6 residents had no adverse effects of medications of Coumadin for 2 residents

- Failed to obtain physician ordered lab tests to monitor resident's PT/INR to ensure resident had no adverse effects of medication
- Failed to obtain resident's INR as ordered by physician to prevent possible adverse reactions to unnecessary medications as resident received Coumadin medication

NE: SS=D: Failed to ensure medication was administered per physician orders for 1 resident placing resident at risk for decreased well-being & ineffective medication regimen

- Failed to order resident's Aricept medication as ordered upon admission to facility for 9 days placing resident at risk for physical & psychosocial decline

NE: SS=D: Failed to ensure an appropriate diagnosis for antipsychotic medication for 1 resident which had potential of unnecessary psychotropic medication administration thus leading to possible harmful side effects

- Failed to ensure an appropriate diagnosis for antipsychotic medication for 1 resident which had potential of unnecessary psychotropic medication administration thus leading to possible harmful side effects

**F761 Label/Store Drugs & Biologicals**

*NE: SS=E: Failed to properly date & store insulin pens & insulin vials; failed to discard insulin pens with an unreadable open date, & failed to secure a medication cart with risk of unwarranted physical complications & ineffective treatment for affected residents*

- *Observed med cart unlocked & unattended with no staff member within sight & drawers were able to be pulled open & revealed medications unsecured & revealed multiple medication concerns; observed multiple insulin pens opened & undated; observed insulin vial opened & undated; failed to properly date & store insulin pens; failed to ID & discard insulin pens that had no resident name; failed to ensure medication cart was secured when staff was out of line of sight from cart with risk for unwarranted physical complications & ineffective treatment for affected residents*

**F812 Food Procurement, Store/Prepare/Serve-Sanitary**

SE: SS=F: Failed to provide sanitary food preparation, storage & serving to prevent spread of food borne illness to residents of facility

- Opened, undated food items; expired food items; bottles of salad dressing lacked caps to cover open tops of bottles; freezer with thick build up of ice around perimeter of walls of freezer; thickener with scoop inside container directly on thickener; spilled substance on fridge door & on shelves; food fridge with "Active Ice" packs; dish racks with gray/brown substance over outside surfaces & over grated bottom surface; flour, sugar & bread crumb bines with crumbs & debris over tops of lids; plate storage cart with crumb & grime; vents above stove with grime & buildup of yellow substance; metal drawers with cooking utensils with debris along upper inner edges; staff unaware of how to verify machine low temp dishwasher functioned appropriately to sanitize dishes

SW: SS=F: Failed to prepare & serve food in sanitary manner by failure to change gloves when handling ready to eat food items & failure to maintain clean cooking equipment that worked properly to prepare meals

- Observed food items in oven not done cooking & was checked multiple times & at noon staff removed pan from oven though they could not be served due to not setting up or baked fully & staff served alternate of ice cream; at 12:10 staff removed souffle from oven & middle of souffle was not set up & center was runny so staff stirred it all together & served it for meal; staff reported sometimes oven worked fine & other times it won't cook food; failed to have cooking equipment in good, working order condition when preparing food for lunch meal
- Observed dietary staff donned clean gloves & reached into bag of bread to make sandwich then used tongs for meat & cheese & while wearing same gloves, dietary staff took sandwich plate to serving line, put food item on plate & handed it off to be served, then handled multiple meal tickets & while wearing same gloves reached into bread bag & retrieved bread for 2nd sandwich & used tongs for meat & cheese & wore same gloves throughout observation of making sandwiches; failed to prepare & serve food in sanitary manner when dietary staff did not change gloves between handling of ready to eat food items
- Observed oven with thick burned debris in oven with burned spilled food in bottom of oven & oven with thick, black, burnt buildup of food on grates; failed to have kitchen upright oven in clean sanitary condition

NE: SS=F: Failed to provide a backflow device or a 2-inch air gap for drainage system of kitchen ice machine used by all residents residing in facility placing affected residents at risk to receive contaminated ice

- Failed to provide a backflow device or 2-inch air gap for drainage system of kitchen ice machine placing all residents who resided in facility at risk for contaminated ice

NE: SS=E: Failed to perform required cooking equipment checks, store food in a sanitary manner & ensure kitchen appliances are wiped down daily placing residents at risk r/t food borne illnesses & food safety concerns

- Holes in dishwasher sanitation logs on multiple days in multiple months; fridge logs with holes for multiple days in multiple months; freezer log with holes on multiple days in multiple months; juice machine with dust & debris; fridge with undated, unlabeled food

belonging to staff stored in same area as food served to residents; produce stored open w/o barrier from other boxes or items stored on shelf;

**F849 Hospice Services**

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

- Failed to coordinate care between themselves & hospice services for 1 resident who received hospice services, placing resident at risk for inappropriate end of life care

**F880 Infection Prevention & Control**

SW: SS=D: Failed to perform blood sugar testing in a sanitary manner when LN failed to clean facility glucometer after using it on a resident &/or before using it to test another resident; failed to ensure staff handled resident's urinary catheter in a sanitary manner

- Observed LN took resident to room & proceeded to use same glucometer used on another resident w/o cleaning glucometer between residents on multiple occasions; failed to cleanse glucometer used for multiple residents in between residents
- Observed urinary catheter drainage bag laid on floor in full contact with carpet; failed to ensure handling of 1 resident's urinary catheter bag & tubing

NE: SS=F: Failed to handle linens appropriate in order to reduce transmission of infectious diseases when facility failed to cover clean laundry while delivering to resident rooms & wear protective equipment (gown) when sorting soiled linens; facility further failed to ensure appropriate use of cleaning products & techniques for disinfection of C-diff rooms which placed residents & staff at increased risk of infection

- Failed to handle linens appropriately in order to reduce transmission of infectious diseases when facility failed to cover clean laundry while delivering to resident rooms & wear protective equipment (gown) when handling soiled linens; further failed to ensure appropriate use of cleaning products & techniques for disinfection of C-diff rooms which placed residents & staff at increased risk for infection

NE: SS=D: Failed to ID & implement transmission-based precautions & PPE for 2 residents & failed to ensure adequate hand hygiene during peri-care for 1 resident placing residents at risk for complications r/t infectious pathogens

- Resident's lab report indicated urine culture + for MRSA on multiple cultures; failed to provide an isolation cart or sign outside room directing staff & visitors to check with nursing before entering due to presence of MRSA; area w/o biohazard bags for waste or laundry; no PPE available in room for staff to wear; bedside urinal emptied but not sanitized; observed staff failed to use PPE while providing peri-care; failed to ID & implement transmission-based precautions for 2 residents placing residents at risk for complications r/t infectious pathogens

NE: SS=E: Failed to ensure appropriate hand hygiene during dining service; failed to store respiratory equipment in a sanitary manner; failed to maintain sanitary handling of clean linen placing residents at increased risk for infections

- Observed O2 tubing & nasal cannula lying on top of soiled bed pad on bed; concentrator had no bag for storing cannula or date indicating how long tubing had been in use; dirty bed linen, heel floats & soiled pillow placed directly on top of recliner in room; floor with 2 bloody cotton balls & used diabetic blood glucose test strip on floor next to resident's bed
- Observed multiple staff members touching residents, w/c's & environment w/o completing hand hygiene between assists; during meal distribution observed multiple staff passing out meals & drinks w/o completing hand hygiene in between each serving; staff observed touching residents, dining environment & w/c's w/o completing hand hygiene between assists; failed to ensure appropriate hand hygiene during dining service; failed to prevent contamination of resident's medical equipment & care environment; failed to maintain sanitary handling of clean linen

*NW: SS=D: Failed to follow infection control practices while performing perineal hygiene care for 1 resident placing resident at risk for infections*

- *Observed peri care & staff failed to change gloves & perform hand hygiene between soiled & clean areas; CNA stated did not understand difference between soiled & clean gloves; failed to provide perineal hygiene care in a sanitary manner for 1 resident placing resident at risk for development of infections*

**F881 Antibiotic Stewardship Program**

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

- Record lacked evidence of signs & symptoms which met professionally accepted criteria for testing & treatment of UTI & resident was ordered ABT for UTI; failed to implement core components of antibiotic stewardship program to promote correct use of ABTs or prevent incorrect or unnecessary ABT placing residents at risk for worsening infection & antibiotic resistance

**April, 2022**

**F550 Resident Rights/Exercise of Rights**

NE: SS=D: Failed to treat 2 residents with dignity when staff failed to cover urinary catheters with a privacy bag leaving urine collection bag visible to other residents & guests in the facility placing residents at risk for impaired psychosocial well-being

- Staff reported that catheter bag needed to be covered when resident out of room, but not when in room; failed to treat 1 residents with dignity, when staff failed to cover urinary catheter bag with a privacy bag when it was visible to others placing resident at risk for impaired psychosocial well-being
- Failed to cover resident's urinary catheter bag placing resident at risk for embarrassment & an undignified living environment

**F600 Free from Abuse & Neglect**

*NW: SS=J (Past Non-Compliance): Failed to ensure staff provided 1 resident the necessary care & services resident required to promote resident's highest level of physical comfort & psychosocial well-being from approximately 9:15pm until resident's death around 4:10am the next day; resident, who was COVID positive & had pneumonia, readmitted to facility's isolation unit on comfort cares; LN failed to monitor resident's respiratory status & respond to low O2 saturations & shortness of breath as directed by physician; LN failed to respond to resident's pain after IDing resident's pain medication was ineffective; LN failed to obtain & administer Lorazepam for resident which physician ordered to alleviate resident's anxiety & shortness of breath; LN failed to respond to resident's change in status & declined to call resident's son, though resident repeatedly called out for resident's son; LN failed to assess resident despite multiple alerts from CNAs who reported resident's discomfort, agitation & inability to breath; LN further failed to respond to an alert from CNA that resident was unresponsive & was not breathing; 7 hours after last administration of pain medication, resident died placing resident in immediate jeopardy*

- *Failed to ensure staff provided 1 resident necessary care & services resident required to promote highest level of physical comfort & psychosocial well-being form 7 hours until resident's death placing resident in immediate jeopardy*
- *Abatement plan:*
    - *LN suspended & occurrence referred to Board of Nursing & appropriate State Agencies*
    - *Staff education on responding to changes in status, assessment of resident's health status, ordering medication, pain management & staff responsibility to deliver necessary care to residents*

**F689 Free of Accident Hazards/Supervision/Devices**

*SW: SS=J (Past Non-Compliance): Failed to provide adequate supervision for 1 resident with a history of exit seeking behaviors (including removing a window screen 6 months previously) & who exited facility through a window; facility staff did not know of this until 2 off-duty facility staff members called facility & reported resident was at local convenience store (located 6 minutes north of facility & within 500 feet of a major US highway) & resident was found scared & tearful placing resident in immediate jeopardy*

- *Failed to provide adequate supervision, allowed resident to leave facility through a window & walk approximately 6 minutes to local convenience store placing resident in immediate jeopardy*
- *Abatement plan:*
    - *Immediately initiated 15-minute safety checks for resident & hourly rounding on all elopement risk residents*
    - *All residents at risk for elopement were re-evaluated & assessments updated*
    - *Wander Guard was placed on resident's ankle*
    - *All window screens were screwed in place & window cranks were removed from all windows*
    - *Facility IDd need for staff education on elopement policy, drills & plan of action & completed an in-service with all facility staff; all staff members not in attendance must complete education with either Adm or DON/RN prior to working floor of next shift*
    - *Elopement drills were completed & are on-going with staff*
    - *PIP committee created for elopement prevention & response*

*NW: SS=G (Past Non-Compliance): Failed to ensure that a Hoyer lift full body sling strap was fully attached to hook on lift arm of lift; as result, resident slipped from sling & was lowered to floor which resulted in a fractured 7th rib & complications r/t internal injuries*

- *Resident with disease of spinal cord; required transfers with total lift; documentation revealed resident fell from lift sheet during transfer & staff assisted resident to ground & resident did not hit head; resulted in skin tear to elbow & pain in ribcage area & physician ordered mobile X-ray resulting in nondisplaced fx of rib; later resident vomited black emesis & transferred to hospital; radiology report revealed traumatic grade 3 liver injury with parenchymal laceration & subcapsular hematoma; radiology report revealed mildly displaced fx's of 2 ribs with small pneumothorax & lower lobe contusion & small pulmonary laceration; CNAs reported resident in Hoyer lift & began to move around & shifted weight to one side & lift sling came unhooked on 1 corner of lift; failed to ensure safe transfer of resident with use of Hoyer lift & sling when staff members failed to securely attach sling strap to lift arm hook resulting in avoidable accident when resident slipped out of sling which resulted in fx to rib cage & lacerated liver*
- *Correction Plan:*
    - *Staff re-educated on Hoyer lift usage, proper placement of slings when doing a transfer, how to properly apply sling to lift hooks & return demonstration of correct way to transfer a resident from bed to w/c & back*
    - *Education also given about importance of always watching sling while resident is on lift & making sure resident is only focus at the time*

**F690 Bowel/Bladder Incontinence, Catheter, UTI**

SE: SS=D: Failed to care for urinary catheter in clean manner to prevent UTIs for 1 resident

- Observed staff emptied catheter bag into urinal & emptied it into toilet then failed to cleanse nozzle tip with alcohol swab before reinserting nozzle tip back into catheter collection bag connection device; staff stated had not been trained to cleanse nozzle; failed to properly cleanse drain nozzle of catheter tubing after emptying urine from catheter bag for 1 resident with hx of UTIs

**F756 Drug Regimen Review, Report Irregular, Act On**

NE: SS=D: Facility's consultant pharmacist (CP) failed to notify DON, medical director or physician about an inappropriate diagnosis for use of an antipsychotic medication & facility failed to act on pharmacist recommendations for 2 residents placing residents at risk to receive unnecessary antipsychotic medications & have adverse side effects

- Resident with Seroquel BID for dementia with behaviors; Pharmacist reviews for 2 months lacked documentation pharmacist addressed inappropriate diagnosis of dementia with behaviors for resident's use of Seroquel; Pharmacy recommendation for 1 month documented inappropriate dx for use of Seroquel & recommended GDR or provide a risk benefit statement & physician did not address inappropriate dx & refused GDR; record lacked documentation facility acted on pharmacist's recommendation; CP failed to notify DON, medical director or physician about resident's inappropriate dx fo ruse of antipsychotic medication &/or facility failed to act on pharmacist recommendation placing resident at risk to receive unnecessary antipsychotic medications & have adverse side effects
- Resident with Zyprexa for anxiety; Physician failed to address CP's recommendation for appropriate dx for Zyprexa; failed to ensure physician responded to CP request to document an acceptable reason for continuing or an appropriate dx for use of an antipsychotic medication for 1 resident placing resident at risk to receive unnecessary antipsychotic medications & have adverse medication side effects

**F758 Free from Unnecessary Psychotropic Medications/PRN Use**

NE: SS=D: Failed to ensure an appropriate diagnosis for use of an antipsychotic medication for 2 residents placing residents at risk to receive unnecessary antipsychotic medications & have adverse medication side effects

- Cited findings noted in F756 r/t antipsychotics ordered for dementia with behaviors & anxiety; failed to ensure appropriate dx for use of an antipsychotic medication for 1 resident placing resident at risk to receive unnecessary antipsychotic medication & have adverse medication side effects
- Failed to ensure an acceptable reason for continuing or an appropriate dx for use of antipsychotic for 1 resident placing resident at risk to receive unnecessary antipsychotic medications & have adverse medication side effects

**F812 Food Procurement, Store/Prepare/Serve-Sanitary**

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

- Observed ceiling air vent grills/registers, located above food prep area covered with brownish-gray, fuzzy substance; ceiling air vent grills/registers, located above dishwasher area covered with brownish-gray fuzzy substance

**F881 Antibiotic Stewardship**

SE: SS=F: Failed to ensure ongoing antibiotic stewardship to ensure appropriate antibiotic use

- Review of Infection Control Surveillance Log revealed 1 month with resident with urine culture with no reported causative organism & resident treated with multiple antibiotics; multiple months with multiple residents with UTIs & of those with UTIs, multiple residents w/o causative organisms documented; failed to perform ongoing antibiotic stewardship to ensure appropriate ABT use & determine trends & tracking of infections in facility
- Resident with deep tissue wound infection treated by wound consultant; record revealed conflicting ABT orders; failed to perform ongoing ABT stewardship to ensure appropriate ABT use for resident with MRSA in heel wound