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

April, 2024

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=J (Abated to D): Failed to provide adequate supervision to prevent 1 cognitively impaired resident who was IDd with elopement risk & with known hx of elopement, from leaving facility unsupervised & w/o staff knowledge

- *Facility last saw resident on 4-21 between 10pm & 11pm; at around 3am facility staff unable to locate resident; after searching & notifying Adm, Law Enforcement & resident's family, facility learned resident was with sibling in another state, over 5 hours away; resident stated used hammer to remove window braces, crawled out of window & walked over 100 feet to back gate area where family member picked resident up & drove resident out of state; lack of facility supervision for resident who displayed verbal expressions of wanting to leave placed resident in immediate jeopardy*
- *Abatement Plan:*
  - *Mandatory staff review of elopement policy & online education prior to shift work confirmed by sign-in sheet & verification on online education program*
  - *Counseling along with disciplinary action on staff involvement with follow up with DON to assure compliance*
  - *Room searched & resident's belongings searched for any additional tools & when resident returned to facility*
  - *Window cranks in areas where resident spends time were replaced & window braces were repaired & secured by maintenance staff; staff education r/t window repairs, cranks & tool removal*
  - *Resident on visual checks every 15 minutes upon returned in facility until re-assessment by DON & then visual checks every 30 minutes until next mental health visit which resulted in evaluation of frequency of visual checks; visual checks will be monitored on facility electronic charting via "tasks" program*
  - *LN meeting help to discuss elopement assessment values*

May, 2024

F550 Resident Rights/Exercise of Rights

SE: SS=D: Failed to ensure 1 resident received care in dignified manner during incontinent care when window blind was left open placing resident at risk for decreased psychosocial wellbeing

- Observed CNA & CMA complete incontinent care & staff failed to close window blinds when providing care to resident & resident's bed was directly in front of window & staff were able to see across yard to therapy room window 46 feet away & window faced street 150 feet away; failed to ensure 1 resident received care in dignified manner during incontinent care when window blind was left open placing resident at risk for decreased psychosocial wellbeing

NE: SS=D: Failed to ensure staff provided care in dignified manner for 2 residents placing residents at risk for decreased self-esteem & decreased self-worth

- Observed resident uncovered while in bed; failed to ensure staff maintained 1 resident's privacy while resident in bed placing resident at risk for decreased self-esteem & decreased self-worth
- Observed LN called resident "honey" & informed resident of results of blood sugar & that resident would receive insulin; staff confirmed staff call resident's "honey" & "darling" w/o thinking about it; failed to promote dignified experience for 1 resident placing resident at risk for decreased psychosocial wellbeing

F558 Reasonable Accommodations Needs/Preferences

NE: SS=E: Failed to ensure 4 resident's call lights were within reach; also failed to ensure 1 resident's w/c had necessary foot pedals attached while propelled by staff placing residents at risk of injury, delay in care & decline in physical wellbeing

- Failed to ensure resident's call light was within reach placing resident at risk for injury, delayed care & possible decline in physical wellbeing due to unmet care needs for multiple residents
- Failed to ensure resident had required equipment & assistance to support highest level of wellbeing placing resident at risk for impaired physical & mental wellbeing due to unmet needs
- Failed to ensure foot pedals were provided for 1 resident's w/c to prevent feet from dragging on floor placing resident at risk for injuries r/t unmet care needs

F565 Resident/Family Group & Response

SE: SS=Failed to ensure resident had a right to organize & participate in resident groups in facility, respond to written requests that resulted from group meetings, consider views of a resident or family group & act promptly upon grievances & recommendations of such groups concerning issues

of resident care & life in facility; additionally, facility failed to demonstrate their response & rationale for such response to residents' concerns voices in resident council

- Resident stated "food could be better" & noted facility would "run out of food" & food cold at times; facility did not always have cook for grill orders for alternates; a lot of changes in kitchen; resident stated had reported concerns to SSD & well as voiced concerns in Resident Council & that no one from facility would come back to council with action plan & just responded "working on it"
- During Resident Council meeting with staff present; resident voiced concerns over food; all residents unanimously voiced concerns about food temps, needing more variety & lack of ethnic choices such as Japanese/Chinese cuisine
- Resident Council meeting with resident stated had to eat what resident gave them & not what they asked for
- SSD confirmed facility failed to address all concerns expressed by residents r/t food
- Resident Council Meeting Minutes documented facility lacked evidence of Resident Council meeting &/or any associated concerns, grievances & follow up for 2-2023 thru 7-23, 11-23, 2-24 & 4-24; minutes for 8-23 thru 1-23 & 12-23 lacked any plan of action or follow up &/or timely response to residents r/t facility's actions to resolve grievances expressed by residents in Resident Council meeting; failed to ensure resident's rights to organize & participate in resident groups in facility, respond to written requests that resulted from group meetings, consider views of resident or family groups & ac promptly upon grievances & recommendations of such groups concerning issues of resident care & life in facility; additionally failed to demonstrate response & rationale for such response to residents' concerns voiced in resident council

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

- Review of Resident Council meeting notes documented multiple concerns & all minutes lacked actions taken or outcomes for repeat concerns & residents stated issues had not been corrected or improved; failed to adequately address & resolve recurring issues reported by Resident Council placing residents at risk for decreased psychosocial wellbeing & impaired quality of life

F558 Reasonable Accommodations Needs/Preferences

SE: SS=D: Failed to ensure staff assessed 1 resident for positioning devices in timely manner

- Resident with OA with touch assist to total dependence with ADLs; Baseline CP revealed bedrails not indicated for resident; CP instructed staff resident required supervision of touch with bed mobility; observed resident & resident stated would prefer to have positioning rails on side of bed to aide in movements & had mentioned request to multiple staff members & staff stated rails were available but no one had placed them on bed; failed to assess resident's need for positioning devices to decrease pain when repositioning & to increase independence

F567 Protection/Management of Personal Funds

Failed to provide 1 resident with accurate accounting of personal funds when facility over-charged resident's personal funds account by $51

- Review of trust fund documented closing balance of $11.01; family member stated resident should have money in account but facility staff told resident, that resident did not have money; document showed $51 overcharge dated 5-6-24 which showed balance of $11.01 & Adm stated facility would request refund from accounts receivable to return funds to maintain trust balance of no less than $62; CMA stated most staff unaware about resident money if requested & would just give money to any resident that requested money; failed to provide 1 resident with correct amount of money in trust fund

F568 Accounting & Records of Personal Funds

SE: SS=E: Failed to provide quarterly statements for all residents in facility with trust fund; further failed to establish & maintain a system that assured full complete & separate accounting, according to generally accepted accounting principles of each resident's personal funds entrusted to facility on resident's behalf

- Review of trust transaction history of all 31 residents IDd that there were no copies of quarterly statement available to review; staff unable to locate any copies of quarterly statements for any of 31 residents that had trust funds managed by facility; failed to establish & maintain system that assured full & complete & separate accounting, according to generally accepted accounting principles of each resident's personal funds entrusted to facility on residents' behalf

F569 Notice & Conveyance of Personal Funds

SE: SS=D: Failed to ensure conveyance of personal funds within 30 days of discharge for 1 resident & within 30 days of death for 1 resident

- Failed to convey personal funds within 30 days of discharge for 1 resident & within 30 days of death for 1 resident

F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive

SE: SS=D: Failed resident by having a guardian sign a completed DNR

- CP documented resident had established an advance directive & had selected DNR; POS for DNR; EMR with signed DNR by resident's guardian, witnessed by SSD & provider; EMR with uploaded document, a signed guardianship by District Court but lacked direction on advance directives; failed resident by having guardian sign a completed DNR without court permission

F582 Medicaid/Medicare Coverage/Liability Notice

NE: SS=D: Failed to ensure facility issued CMA form 10055 for 2 residents placing residents at risk of uninformed treatment decisions & unexpected costs

- Failed to issue 2 residents with ABN form CMS-10055 placing residents at risk of uninformed treatment decisions & unexpected costs

F584 Safe/Clean/Comfortable/Homelike Environment

SE: SS=E: Failed to maintain a clean, comfortable & homelike environment to residents that resided in facility

- Observed frayed carpeting in multiple areas; floor sewer cleanout cap loose & able to be lifted easily; divider wall in shower with broken tiles with jagged exposed edges; transition between floor to wall in shower with black substance between tiles

NE: SS=E: Failed to ensure safe, clean & homelike environment provided for residents placing residents at risk of infection, decreased psychosocial wellbeing & impaired safety & comfort

- Observed rolling cart with dirty, leftover plates & covers from meal night before & soiled drink cups left on tables & food crumbs all over floor in DR; area near ice machine with strong, foul odor; heavy urine smell in & near DR; resident room with liquid on floor & room heavily scratched up at w/c height & floor with dry but sticky residue; resident room with dried coffee-like stains & candy wrapper on floor; resident room with smell of urine & hallway; observed 4 residents wheeled into DR & left in DR w/o TV or entertainment for 40 minutes

F585 Grievances

SE: SS=E: Failed to ensure residents had a right to voice grievances with respect to care & treatment, behavior of staff, other residents, & other concerns r/t long-term care stay; additionally, facility failed to make prompt efforts resolve grievances resident shad & provide written decision r/t his/her grievance

- Cited findings noted in F565 r/t food issues & issues raised during Resident Council; review of Grievance Logs from 2-23 thru 5-24 revealed lack of tracking & action plans for residents' recurring grievances noted in Resident Council meetings & lacked documentation of action plans & reviewed with residents; concerns r/t food dissatisfaction lacked any indication issues were addressed throughout logs; failed to ensure residents had right to voice grievances with respect to care & treatment, behavior of staff, other residents, & other concerns r/t long-term care stay; additionally, facility failed to make prompt efforts resolve grievances residents had & provide a written decision r/t his/her grievance

F600 Free from Abuse and Neglect

NE: SS=D: Failed to ensure 1 resident remained free from staff-to-resident abuse &/or mistreatment from direct care staff placing resident at risk for impaired psychosocial wellbeing, pain & fear

- Incident Report documented resident reported to Adm Nurse that resident had witnessed CNA provide rough care & almost pushed another resident off bed & resident instructed CNA to stop pushing resident but CNA continued to push harder & CNA suspended pending investigation for allegations of abuse; Adm nurse stated CNA had been terminated & was unavailable for interview due to incarceration for unrelated domestic violence allegation; failed to ensure 1 resident remained free from staff-to-resident abuse & mistreatment when staff were intentionally rough with care to resident placing resident at risk for impaired psychosocial wellbeing, pain & fear

NW: SS=D: Failed to protect 1 resident from intimidation & abuse placing resident at risk for impaired psychosocial wellbeing & ongoing abuse

- *Resident with dementia with behaviors; incident report documented Adm nurse received text from SSD who reported LN had pulled resident down in chair "super hard"; during investigation SSD stated LN had "slammed resident down in chair"; 2 Adm nurses entered building, had LN fill out witness statement then took over LN's shift & LN escorted out of building; assessment revealed no signs of injury; sheriff's office notified & officer arrived & reviewed camera footage & witness statements & stated it did not appear anything criminal happened; notifications made; Ombudsman notified & resident interviews completed; records revealed LN had been educated on ANE; investigation abuse allegation unsubstantiated & found LN needed dementia training & safe handling of residents; LN was agency nurse & put on "do not return" list; CNA witness statement documented LN stated "I'm not going to put up with resident all night because it would drive her crazy"; LN told CNA did not like dementia patients because "they were dumb" & "could not have a conversation with them"; failed to protect resident from intimidation & abuse placing resident at risk for impaired psychosocial wellbeing & ongoing abuse*

NW: SS=J (Abated to G): Failed to 1 resident remained free from neglect when facility failed to provide necessary care & services including supervision required by resident to promote resident's safety & wellbeing

- On 4-14 at approx. 2pm CNA assisted resident into courtyard off DR then left for day while resident remained outside with no ability to contact facility or get back inside; around supper time, staff noted resident's absence & CNA found resident outside & resident unresponsive; staff brought resident inside & facility assessed vital signs & resident's body temp was 104.9 degrees F with pulse of 144 bpm; staff began cooling measures & resident became more responsive; resident sent to ER where received IV fluids to rehydrate; failed to ensure resident received care & services including supervision to promote safety & wellbeing placing resident in immediate jeopardy
- Abatement Plan:
    - Facility will no longer employ nurse on duty that day
    - Trained all current staff & will train all future employees including agency staff on outdoor safety & neglect
    - Re-training to all staff on ANE
    - Created procedure specific to incident that all staff trained on
    - Administration will monitor outdoor times & safety on ongoing basis
    - Staff ensure residents outside received adequate visual checks & adequate hydration

F602 Free from Misappropriation/Exploitation

NE: SS=D: Failed to ensure 1 resident remained free from misappropriation when staff took possession of debit cards resulting in unauthorized charges placing resident at risk for impaired psychosocial wellbeing

- Incident Report documented resident reported $577.50 worth of transactions were charged to debit card & resident reported to SS staff; report documented resident gave debit card to 2 different staff on 2 occasions so staff could purchase items from facility's vending machines & documented 2 CNAs immediately suspended & local police notified & facility reimbursed resident's $577.50 & educated staff not to handle resident money; failed to ensure 1 resident remained free from misappropriation when staff used 1 resident's use of debit card resulting in unauthorized charges placing resident at risk for decreased psychosocial wellbeing

F609 Reporting of Alleged Violations

NW: SS=D: Failed to report incident of neglect for 1 resident to State Agency as required placing resident at risk for ongoing neglect

- Cited findings noted in F600 r/t resident with unsupervised outdoor exposure; EMR lacked evidence investigation including witness statements & analysis of causative factors done r/t event & unable to provide investigation r/t event; failed to report incident of neglect of 1 resident to state agency as required placing resident at risk for ongoing neglect

F610 Investigate/Prevent/Correct Alleged Violation

NW: SS=D: Failed to thoroughly investigate incident of neglect for 1 resident placing resident at risk for unidentified and ongoing neglect

- Cited findings noted in F600 & F609 r/t resident with unsupervised outdoor exposure; failed to thoroughly investigate incident of neglect for 1 resident placing resident at risk for unidentified & ongoing neglect

F641 Accuracy of Assessments

SE: SS=D: Failed to accurately complete MDS for 2 residents: 1 r/t O2 use & 1 r/t completion of sections C & D placing residents at risk for uncommunicated care needs

- CP documented resident had been on O2 but documented as resolved; POS lacked active orders r/t O2; MAR & TAR lacked documentation r/t O2; progress notes lacked documentation r/t O2; observed resident's room revealed no O2 equipment in room; MDS documented resident on O2; Adm nurse confirmed regional staff completed MDS & entry "clerical error"; failed to accurately complete MDS for 1 resident r/t O2 placing resident at risk for uncommunicated care needs
- CP lacked documentation of cognitive loss/dementia; POS for hospice; Section C & D on MDS not completed prior to ARD; failed to accurately complete MDS for 1 resident r/t cognition & depression placing resident at risk for uncommunicated care needs

SE: SS=D: Failed to complete accurate MDS for 1 resident r/t opioid meds

- Resident with dx of pain & received PRN meds; MDS inaccurately documented resident did not receive opioid meds when CAA documented resident received Fentanyl q 72 hours; failed to complete 2 accurate MDSs for dependent resident who received opioid medication; MDS staff confirmed annual MDS & quarterly MDS inaccurately coded as resident had received opioid med during lookback period; failed to complete 2 accurate MDSs for dependent resident who received opioid medication

F656 Develop/Implement Comprehensive Care Plan

SE: SS=D: Failed to complete a comprehensive CP for 1 resident r/t use of O2

- CP lacked staff instruction r/t care of O2 tank or supplies; failed to complete a comprehensive CP with staff instructions for dependent resident who uses O2

SE: SS=E: Failed to develop comprehensive CP for 1 resident's PU; further failed to develop CP for 1 resident's care & maintenance of respiratory equipment; further failed to develop CP for 1 resident's dysphagia; further failed to develop CP's for 1 resident's monitoring of behaviors for psychotropic meds placing residents at risk for inadequate care & services

- CP lacked dysphagia, pureed diet & recommended speech therapy interventions; failed to develop CP for 1 resident's dysphagia placing resident at risk for inadequate care & services
- CP lacked guidance to staff r/t PUs; resident with 2 blisters on coccyx; failed to develop comprehensive CP for 1 resident's PU placing residents at risk for inadequate care & services
- POS for Ativan, Cymbalta & Remeron; CP with no interventions planned to monitor behaviors/mood r/t use of antidepressant & antianxiety meds; failed to develop comprehensive CP to include interventions to monitor behaviors r/t use of psychotropic meds for resident that required med for depression & anxiety
- CP lacked documentation r/t nebulized med use or care & maintenance of nebulizer equipment; failed to accurately completed a comprehensive CP for 1 resident r/ nebulizer tx's with potential to lead to uncommunicated need for care & services to meet resident's needs

NE: SS=D: Failed to ensure that 1 resident's CP was developed to address interventions for ADLs & enteral feeding placing resident at risk of impaired care due to uncommunicated care needs

- CP lacked staff direction r/t ADL care & enteral feeding; failed to ensure that 1 resident's comprehensive CP was developed to address interventions for ADLs & enteral feeding enteral feeding placing resident at risk for impaired care due to uncommunicated care needs

F657 Care Plan Timing & Revision

SE: SS=D: Failed to review & revise person-centered CP for 1 resident r/t use, care & maintenance of nebulizer equipment with potential to place resident at risk for not receiving appropriate cares & treatments

- CP lacked documentation r/t nebulized medication use or care & maintenance of nebulizer equipment; failed to review & revise comprehensive CP for 1 resident to include nebulizer treatments with potential to lead to uncommunicated need for care & services to meet resident's needs

NE: SS=E: Failed to revise 2 resident's CP to reflect smoking interventions; additionally failed to revise CP to include 1 resident's side rails, 1 resident's choices for ADLs & 1 resident's preferred name of "grandpa" placing residents at risk for impaired care due to uncommunicated care needs

- CP lacked interventions r/t smoking assessment or safe smoking practices; failed to revised CPs to include safe smoking interventions for resident placing resident at risk for impaired care due to uncommunicated care needs for multiple residents
- Failed to revise CPs to include 1 resident's name preferences placing resident at risk for impaired care due to uncommunicated care needs
- Failed to revise 1 resident's CP to include side rails that had been installed on resident's bed placing resident at risk of impaired care due to uncommunicated care needs
- Failed to revise 1 resident's CP to include direction to staff for necessary assistance with personal hygiene placing resident at risk for impaired care due to uncommunicated care needs

NW: SS=D: Failed to review & revise 1 resident's CP with interventions for care of resident's stasis ulcers in leg on shins placing resident at risk for decreased quality of care due to uncommunicated care needs

- CP lacked section r/t skin integrity with instructions to staff on how to care for 1 resident's bilateral lower legs; failed to update 1 resident's CP with information r/t venous ulcers on bilateral lower legs placing residents at risk for decreased quality of care due to uncommunicated care needs

F677 ADL Care Provided for Dependent Residents

SE: SS=E: Failed to provide appropriate & timely ADL cares to 4 residents: 3 r/t untrimmed facial hair 1 r/t untrimmed facial hair & long fingernails

- Observed resident with long facial hair on multiple occasions including immediately after shower; resident stated facial hair bothers resident but staff do not shave resident & resident requested daughter bring razor so could have facial hair shaved; failed to provide appropriate & timely ADL cares for dependent resident r/t facial shaving
- EMR revealed resident did not receive scheduled shower on 3 days in April; observed resident with long, unshaven facial hair; failed to provide appropriate & timely ADL cares for dependent resident, r/t facial shaving
- EMR documented resident received shower on 5-7 & on same day observed resident with ½-inch long facial hair; & again 6 days later observed resident with long facial hair; failed to provide appropriate & timely ADL cares for 1 resident when staff did not provide facial shaving to meet resident's preference
- Observed resident on multiple occasions with long, jagged fingernails & long facial hair; failed to provide appropriate & timely ADL cares for dependent resident r/t facial shaving

SE: SS=D: Failed to ensure 1 resident received care for removal of facial hair placing resident at risk for decreased psychosocial wellbeing

- CP lacked direction for staff on bathing assist & removal of facial hair; observed resident with facial hair above & below lips, several approximate length of ¼ inch whiskers on multiple occasions & resident stated cannot see them & it bothered her that she had facial hair; failed to ensure 1 resident received care for removal of facial hair placing resident at risk for decreased psychosocial wellbeing

NE: SS=D: Failed to provide necessary assistance with personal hygiene for 1 resident placing resident at risk for poor hygiene, decreased self-esteem & impaired dignity

- CP lacked direction to staff for resident's choices for personal hygiene & shaving; observed resident with facial hair & resident stated had not been shaved every day & needed assist with shaving; failed to ensure 1 resident received assist with trimming facial hair placing resident at risk for poor hygiene, decreased self-esteem & impaired dignity

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

SE: SS=G: Failed to assess & provide treatment to prevent a pressure injury for 1 resident; on 5-8-24 staff observed 2 intact blisters on resident's coccyx; staff failed to notify provider until 5-14, 6 days later when the 2 areas developed into stage 2 PUs placing resident at risk to worsen PUs & delayed healing

- POS lacked orders for resident's 2 opened, stage 2 PUs; during interview CNA revealed barrier cream not applied every time incontinent care provided & staff confirmed it should have been applied; failed to assess & provide treatment to resident's coccyx area that opened in timely manner placing resident at risk to worsen current PU or develop more skin issues

NE: SS=D: Failed to ensure 1 resident's low air loss mattress was set at appropriate setting for resident's weight who was prone to pressure-related injury placing resident at increased risk for development of PUs & development of new PUs

- CP documented every nursing shift would check to ensure low-loss air mattress was plugged in & inflated; CP documented redness of left gluteal area with tx orders; CP did not indicate setting for low-air loss mattress; resident weight 140.5 pounds; mattress set at 210 pounds; failed to ensure low air loss mattress was set at appropriate setting for resident's weight who was prone to pressure-related injury placing resident at increased risk for development of PUs & development of new PUs

NE: SS=D: Failed to ensure 1 resident received PU care consistent with standards of practice when facility failed to ensure resident consistently received ordered treatments & failed to ensure dressing orders were in place to be followed; further failed to ensure resident's low air loss mattress was set at accurate weight setting for resident; additionally failed to ensure 1 resident's heels were floated as ordered placing residents at risk for complications r/t skin breakdown & PUs

- Failed to ensure staff obtained & consistently followed orders & provided treatment for 1 resident's stage 4 PU placing resident at risk for delayed healing &/or wound worsening
- Failed to ensure pressure-reducing measures were implemented for 1 resident who was at risk for pressure injuries placing resident at increased risk for PUs & pressure/skin injuries

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=G: Failed to ensure a safe environment for 1 cognitively impaired resident when staff failed to check temperature of bowl of soup before serving it to resident; resident suffered burns that developed blisters on 2 fingers of hand when resident placed them in the hot bowl of soup during mealtime

- CP documented resident with dementia could communicate by "tapping"; resident could feed self but had tremors & might need staff assist at times; NN documented resident placed fingers in hot soup at dining table & received burn; assessment documented resident with intact fluid blister, round in shape; observed another resident requested bowl of soup & dietary staff opened can of soup, poured soup into bowl & place bowl into microwave & when microwave shut off removed soup, covered bowl with plastic wrap & put it on tray for resident w/o checking for temperature & upon request measured temp of soup at 154 degrees F; failed to ensure safe environment for 1 resident reviewed for accidents by failure to check temp of bowl of soup before serving to cognitively impaired resident allowing resident to suffer burns that developed into blisters on 2 fingers placing fingers in hot bowl of soup during evening meal

SE: SS=D: Failed to ensure fall interventions were maintained for 1 resident placing resident at increased risk for further falls, injury, & pain

- Resident with Huntington's disease; CP instructed staff to ensure nonskid strips in BR in front of toilet & by recliner & ensure fall mats in place; observed strips in front of toilet & 1 strip with worn area approx. 10 inches in length x 2 inches wide; failed to ensure 1 resident's BR with nonskid strips in good working order to decrease risk of falls as CPd

NE: SS=E: Failed to ensure environment free from potential hazards r/t resident's bedrails; failed to ensure 1 resident was safe to use electronic recliner; failed to follow CP'd fall interventions for 2 residents placing residents at risk for preventable accidents & injuries

- Failed to ensure environment free from potential hazards r/t resident's bedrails & CP'd portable urinal placing resident at risk for preventable accidents & injuries
- Failed to assess 1 resident's ability to safely operate resident's electric reclining chair placing resident at risk for preventable falls & injuries
- Failed to ensure staff provided visual cues such as signs in resident's BR & bedroom walls to prompt resident to use call light per CP to prevent fall placing resident at risk for falls
- Failed to ensure resident's bed remained in lowest position to prevent falls per CP placing resident at risk for falls

NW: SS=E: Failed to ensure environment free from accident hazards with staff left gallon chemical bottle in unlocked bottom cabinet in 1/3 kitchenettes placing 12 cognitively impaired, independently mobile residents at risk for preventable accidents or injuries

- Observed unlocked cabinet under skin in kitchenette, located off family DR containing Attack Myer Enzyme odor digester, drain opener & maintainer with warning label; failed to ensure environment free from accident hazards when staff stored harmful chemicals in unlocked cabinet placing 12 cognitively impaired independently mobile residents at risk for preventable accidents or injuries

F692 Nutrition/Hydration Status Maintenance

SE: SS=G: Failed to ensure pertinent & timely interventions were implemented as ordered to prevent 1 resident's significant weight loss of 25.11% in 141 days; facility did not weight resident monthly & did not ID & assess resident when meal intake consistently declined between 10-23 & 2-24 & failure resulted in resident losing 29.4 pounds/25.11% body weight in 141 days; additionally, failed to monitor resident for effectiveness of treatment plan which resulted in additional weight loss of 11.2 pounds in additional 42 days which was total of 40.6 pounds/29.64% over 182 days & placed resident at risk for continued decline in nutritional status & at risk for development of life-threatening symptoms which could negatively affect mental, physical, & psychosocial wellbeing of resident

- EMR Weights documented weights in 10-23, 2-24, 3-24, 4-24, 5-24; EMR with no lab results or physician orders for lab work since 11-30-23 to monitor resident's nutritional status; observed resident ate 25%-50% of meal & tray removed & no alternative foods offered; failed to ensure pertinent & timely interventions were implemented as ordered to prevent resident's significant weight loss was a total of 40.6 pounds/29.64% over 182 days & placed resident at risk for continued decline in nutritional status & at risk for development of life-threatening symptoms which could negatively affect mental, physical & psychosocial wellbeing of 1 resident

F695 Respiratory/Tracheostomy Care & Suctioning

SE: SS=D: Failed to store O2 tubing in clean & sanitary manner for 1 resident

- CP lacked staff instruction r/t care of O2 tank or supplies; observed O2 tubing hung over O2 concentrator, uncovered; failed to store dependent resident's O2 tubing in clean & sanitary manner when not in use by resident

SE: SS=E: Failed to properly clean & store nebulizer for 2 residents; additionally failed to properly store CPAP for 1 resident; furthermore, failed to provide tracheostomy care for 1 resident in accordance with professional standards of practice with potential to have negative impact on resident's physical & psychosocial wellbeing

- CP lacked documentation r/t nebulized med use or care & maintenance of nebulizer equipment; POS lacked documentation r/t care & maintenance of nebulizer equipment; progress notes lacked documentation r/t nebulized medication use; observed resident's room with nebulizer, sitting on nebulizer machine on over bed table with clear residue noted in atomizer chamber; on multiple occasions; resident stated staff do not clean or disassemble nebulizer but change it every 6 weeks; resident stated able to self-administer meds but was not aware if nebulizer needed to be cleaned between uses & had not been trained on cleaning procedures r/t nebulizer; failed to properly clean & store nebulizer for 1 resident in accordance with professional standards of care
- CP lacked documentation r/t nebulized medication use or care & maintenance of nebulizer equipment; POS lacked documentation r/t care & maintenance of nebulizer equipment; progress notes lacked documentation r/t nebulized med use; observed nebulizer with attached mask inside top drawer on clear plastic bedside table with unknown clear liquid in atomizer chamber on multiple occasions; failed to properly clean & store nebulizer for 1 resident in accordance with professional standards of care

- Resident with old trach with POS orders for size & care; NN documented resident reported feeling short of air & lung bases very diminished to absent; resident to ER; observed LN performed trach care; no extra trach in room & room lacked suction machine; failed to ensure trach care & equipment was available for emergency care for resident with trach to prevent respiratory emergencies if trach was dislodged or resident had copious secretions, consistent with professional standards of practice
- Observe CPAP mask on nightstand over other personal items on multiple occasions; failed to properly store resident's CPAP in accordance with professional standards of care to prevent possible respiratory illness

NE: SS=D: Failed to ensure 1 resident's CPAP mask was stored in sanitary manner to decrease exposure & contamination placing resident at increased risk of developing respiratory infection

- Observed CPAP mask laid directly on bedside table unbagged on multiple occasions; failed to ensure 1 resident's CPAP mask was stored in sanitary manner to decreased exposure & contamination placing resident at increased risk of developing respiratory infection

NE: SS=D: Failed to administer 1 resident's supplemental O2 per physician's order; additionally failed to store 1 resident's O2 nebulizer mask in sanitary manner placing both residents at risk for respiratory complications

- Failed to administer resident's supplemental O2 per physician order placing resident at risk for complications r/t shortness of breath
- Failed to ensure 1 resident's nebulizer was stored in sanitary manner to decrease exposure & contamination placing resident at increased risk of developing respiratory infection

F700 Bedrails

NE: SS=D: Failed to ID resident's individual risks on resident's side rail assessment; additionally failed to assess 1 resident's side rails for safety prior to use placing residents at risk for siderail-related injuries & accidents due to unidentified risks

- "Side Rail/Device Consent Form" did not acknowledge resident's pressure-reducing mattress or bolstered overlay; observed 5-6 inch gap between wall & bed rail with 5-6 inch gap between mattress & bed; failed to ID resident's pressure-reducing mattress & bolstered overlay as possible risks on resident's side rail assessment placing resident at risk for preventable accidents r/t use of side rails
- CP lacked direction to staff for siderails; failed to ensure resident had documented risk assessment, a consent for use of siderails & failed to ensure resident/representative were advised of risks &/or benefits of use of side rails placing resident at risk for uninformed decisions & impaired safety related to risks associated with use of siderails

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

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

- Review of January 2023-December 2023, nursing schedule revealed no RN for 8 consecutive hours on more than 50 days; Adm staff verified facility did not employ a full time RN as DON & verified lack of RN coverage on dates reviewed & stated had not been able to get an RN for 8 consecutive hours & unable to get RN except every once in awhile from agency; failed to employ a full time DON & failed to have RN coverage for 8 consecutive hours daily placing all residents at risk for inadequate care

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

NE: SS=F: Failed to ensure 2/5 CNA staff reviewed had required yearly performance evaluations completed placing residents at risk for inadequate care

- 2 CNAs had no yearly performance evaluations upon request; failed to ensure 2/5 CNAs reviewed had required yearly performance evals completed placing residents at risk for inadequate care

F732 Posted Nurse Staffing Information

SE: SS=C: Failed to ensure staff recorded resident census on "Daily Staff Postings"

- Review of Daily Staff Posting for 2-24, 3-24, & 4-24 revealed lack of documentation of resident census for each day; failed to document daily resident census on "Daily Staff Posting"

NE: SS=C: Failed to retain daily posted nursing staffing data for 18 months as required

- Review of daily posted nursing staffing data provided by facility lacked any posted nursing staffing data for December 2023 (31 days); failed to retain daily posted nursing staffing data for 18 months as required

NE: SS=C: Failed to ensure that posted nursing hours included required information for residents or visitors

- Failed to include required posted nursing staffing information that included daily census & nursing hours

F744 Treatment/Service for Dementia

NE: SS=D: Failed to implement effective person-centered dementia care interventions r/t resident's wandering behaviors placing resident at risk for unmet care needs & inability to maintain highest practicable level of functioning

- Documentation described behaviors but lacked interventions attempted outside redirection on multiple occasions; failed to implement effective person-centered dementia interventions r/t resident's wandering behaviors which provided staff with information on techniques to divert & redirect specific to resident's current or hx of interests placing resident at risk for unmet care needs to maintain highest practicable level of functioning

F756 Drug Regimen Review, Report Irregularities, Act On

SE: SS=E: Failed to reply in timely manner & act on Consultant Pharmacist (CP) of MRR & GDR recommendations for 5 residents placing residents at risk for receiving unnecessary meds

- MRR on 12-3 with recommendations r/t timing of meds & facility did not respond for 36 days later; MRR for Bactroban & blank form of MRR lacked provider signature or nurse signature & 3 post it notes taped on MRR; multiple MRR lacked dates; failed to prevent use of unnecessary meds for 1 resident when facility failed to respond to pharmacist recommendations in timely manner consistent with facility policy placing resident at risk for receiving unnecessary meds
- Failed to follow up with pharmacist recommendations for 1 resident in timely manner for multiple residents
- Failed to prevent use of unnecessary meds for 1 resident when facility failed to respond to pharmacist recommendations in timely manner consistent with facility policy placing resident at risk for receiving unnecessary meds for multiple residents

NW: SS=D: Failed to ensure physician acknowledged & responded to Consultant Pharmacist (CP) for required stop date for 1 resident's PRN antianxiety placing resident at risk for unintended effects r/t psychotropic drug medications

- MDS documented resident with antianxiety & antidepressant; CP documented resident with trouble sleeping & behavior problems & received Lorazepam; POS for Lorazepam PRN for anxiety & order lacked stop date; EMR lacked evidence of physician-o0rdered duration which included rationale for extended use of PRN Lorazepam; MRR of 3-8-24 with pharmacist recommendation for stop date; record lacked evidence physician responded to recommendation; failed to ensure physician acknowledged & responded to CP's recommendation for 1 resident placing resident at risk for unnecessary psychotropic med side effects

F757 Drug Regimen is Free from Unnecessary Drugs

SE: SS=D: Failed to ensure 1 resident remained free from unnecessary meds r/t failure to administer PRN meds for lack of BMs for longer than 3 days

- POS for Colace, Lactulose, MOM, Bisacodyl, Fleets Enema; EMR revealed resident w/o BM for 6 days & staff failed to administer PRN BM med or enter NN documenting resident's refusal for bowel management intervention on multiple occasions; 4 days repeated; failed to keep dependent resident free from unnecessary meds by failing to administer PRN meds for lack of BMs

F758 Free from Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure nonpharmacological interventions were attempted & documented prior to administration of antipsychotic med for 1 resident with dx of dementia placing resident at risk for unnecessary psychotropic meds & related complications

- Resident with dementia, Parkinson's with Lewy Body's neurocognitive d/o, psychotic d/o & HTN; POS for Seroquel psychotic d/o with delusions; EMR lacked documentation or evidence of nonpharmacological symptom management interventions that were implemented & failed before starting Seroquel; failed to ensure nonpharmacological interventions were attempted prior to administration of antipsychotic med for resident with dx of dementia placing resident at risk for unnecessary psychotropic meds & related complications

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

- Cited findings noted in F756 r/t no stop date for Lorazepam; failed to ensure 1 resident's Lorazepam had 14-day stop date or physician-ordered specified duration with rationale placing resident at risk for adverse psychotropic medication side effects

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to properly label & store meds in 2/4 med carts placing residents at risk for adverse outcomes or ineffective medication regimens

- Observed med cart with opened, undated insulin pens; observed med cart unlocked & unattended; failed to properly store & label meds which could potentially cause adverse consequences or ineffective treatment to affected residents

NW: SS=D: Failed to store meds appropriately when staff did not label 1 resident's insulin flex pens with date opened & discard date on 1 treatment cart placing affected resident at risk for ineffective meds

- Observed tx cart with 1 resident's Basaglar flex pen lacked open & discard date; failed to label & date 1 resident's flex pens with date opened & discard dates placing residents at risk for ineffective medication

F775 Lab Reports in Record-Lab Name/Address

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

- Failed to ensure current physician-ordered lab test results for 1 resident were included in clinical record with potential to result in unnecessary tests & delayed treatment

F801 Qualified Dietary Staff

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

- Failed to ensure director of food & nutritional services had required qualifications of CDM placing residents at risk for unmet dietary & nutritional needs

F802 Sufficient Dietary Support Personnel

NE: SS=F: Failed to ensure facility had sufficient staff with appropriate competencies & skill sets to carry out functions of Food & Nutrition Services resulting in residents' meal service being delayed & potentially impaired nutrition

- Observed 1 Dietary Staff only dietary staff in kitchen & stated cook was sick or at hospital & dietary manager would not get to facility until later in morning; Adm nurse & dietary staff & 2 unidentified staff in kitchen area preparing biscuits & gravy for residents; Adm nurse stated dietary staffing was low & no extra staff available to help cover call-ins; first breakfast trays served at 9:03am; lunch trays served at

1:21pm; failed to ensure sufficient dietary staff available to carry out functions of Food & Nutritional Services placing residents at risk for delayed meal service & potentially impaired nutrition

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NE: SS=D: Failed to ensure dietary staff prepared food that conserved nutritive value, flavor & appearance when preparing pureed foods placing 2 residents at risk of decreased nutritional food value & quality of food

- Observed pureed foods; failed to measure food quantities; staff reported no recipes for pureed foods; observed pureed foods with lumps; failed to ensure dietary staff prepared food that conserved nutritive value, flavor & appearance when preparing pureed foods placing residents at risk for decreased nutritional food value & quality of food

F805 Food in Form to Meet Individual Needs

NE: SS=D: Failed to ensure 1 resident was provided with appropriate textured diet placing resident at risk for aspiration

- CP documented resident on regular, mechanical soft with thin liquids; observed resident in bed with HOB elevated; tray included pork cutlet & cutlet uncut & not ground; failed to provide required mechanical soft-textured diet for 1 resident placing resident at risk for aspiration or other adverse consequences

F812 Food Procurement, Store/Prepare/Serve-Sanitary

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

- Observed: hand-washing sink trashcan lacked cover; multiple food items unlabeled; food items not properly covered; 3 racks in fridge with dried-on food substances & rust; outside dumpster with garbage bags & not closed; container of flour with grime on top of lid; dried mild grime on top of lid; failed to prepare & serve food under sanitary conditions to residents of facility
- Observed dietary staff serving foods with front hair on temples & forehead not covered & hung loosely during serving; dietary staff wore same pair of blue gloves as served plates touched eating surfaces of plates & staff touched food placed on several plates with thumb then served plate to residents

SE: SS=F: Failed to store foods safely & under sanitary conditions to residents of facility to prevent potential for foodborne bacteria by staff's failure to date & reseal open food items in fridges & freezer & failure to clean thermometer between food items while taking food temps prior to serving with potential to affect all residents receiving meals from main kitchen

- Observed: fridge with opened, undated food items; freezer with undated w/o lid ice cream; meat items in open bag, open to air; cheese open & lacked opened date
- Observed dietary staff took thermometer out of sheath & turned on & cleaned with alcohol prop pad then placed into multiple food items w/o cleaning between food items & when done with last food item wiped with alcohol pad & replaced sheath
- Observed dietary staff failed to take temp of soup heated in microwave

SE: SS=E: Failed to ensure sanitary food storage in therapy room fridge & failed to maintain microwave in sanitary manner

- Observed maintenance staff with unlabeled, undated hamburger patties in therapy room fridge freezer & freezer also contained 2 medical devices for cold therapy & multiple cold packs & lower shelf of freezer contained purple sticky substance
- Observed undated open container of almond milk expired, yogurt expired; sack of various foods undated & unmarked Styrofoam containers with expired date; 32-ounce container of chicken broth w/o open date
- Microwave in therapy room with rusted surfaces along perimeter of interior & splatters; failed to ensure staff maintained therapy room fridge, freezer & microwave in sanitary manner & failed to ensure food items did not exceed "use by" date to prevent foodborne illness amongst residents

NE: SS=F: Failed to ensure staff stored, prepared & served food items with professional standards for food service safety placing residents at risk for foodborne illness & cross-contamination

- Observed kitchen floor dirty with food debris; piles of dirty dishes & kitchen equipment from previous day that had not been washed; walk-in fridge area with large plastic container with 90 bowls of food/fruit with lids w/o labels or dates; freezer condenser iced over; dish machine log lacked temps on multiple occasions on multiple occasions; clean plates stored on cart face up; fridge with undated food items & produce brown; observed staff holding cup from top, touching drinking surface; observed dietary staff w/o beard net; walls with visible holes; door frame at wash station with missing trim pieces close to floor with bits of plaster pieces on floor; water holding tank leaking water into dishwashing area floor & metal containment rusted; glass bowls stored face up; cooler door not latched & floor wet & ice chunk formed around bottom part of door; ice crystals on condenser & ice on vents & icicle formation on condenser pipes where fluids were dripping; expired foods; plates stored face up in plate rack; dietary staff failed to perform hand hygiene prior to starting food prep of pureed foods

F849 Hospice Services

NE: SS=D: Failed to ensure a communication process was implemented which included how communication would be documented between facility & hospice provider creating a risk for missed or delayed services & impaired care for 1 resident

- Hospice communication binder lacked CP for resident & physician-signed terminal dx for admission to hospice & last documentation of hospice dated 5-2-24 on 5-8; failed to ensure communication process was implemented which included how communication would be documented between facility & hospice provider creating a risk for missed or delayed services & impaired care for 1 resident

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

- Failed to ensure collaboration between facility & hospice provider & failed to develop CP for both by hospice & facility that included description of services, medication & equipment provided to resident by facility placing resident at risk for delayed services or impaired end-of-life care

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

- CP lacked any information r/t resident's hospice services & lacked evidence of coordination of care between hospice & facility; facility did not have communication book or external document; failed to coordinate care between facility & hospice provider for 1 resident who received hospice services placing resident at risk for inappropriate end-of-life care

F880 Infection Prevention & Control

SE: SS=F: Failed to ensure staff performed hand hygiene during meals, failed to ensure sanitary storage of O2 concentrators with tubing, failed to ensure staff performed hand hygiene during dressing change, failed to ensure sanitary glucometer cleaning for 2 glucometers used by 3 residents & failed to ensure staff provided EBP for 2 residents with use of urinary catheters

- Observed staff touched foot pedals on w/c then w/o hand hygiene assisted 2 residents with eating & repositioning
- Observed O2 concentrators with tubing & cannula not stored in sanitary manner & 1 cannula rested directly on floor
- Observed CNA assisted 2 residents & failed to perform hand hygiene between 2 residents; CNA manipulated glasses, scratched nose, coughed into hand & failed to perform hand hygiene
- Observed CNA picked up glass of juice by top rim then failed to perform hand hygiene
- Observed LN provided wound care & did not perform hand hygiene after removing gloves & donning new gloves during dressing change
- Observed LN obtained accu-check & did not sanitize hands & used alcohol wipe to sanitize glucometer & facility had Sani-wipes to sanitize glucometer but LN did not find them on cart on multiple occasions; failed to ensure staff sanitized glucometer used by multiple residents to prevent spread of bloodborne pathogens
- Observed staff drained urine from collection bag & CNA unaware of what EBP were or what PPE needed for resident's urine on multiple occasions; failed to ensure staff provided EBP for 2 residents with urinary catheters to prevent spread of infection as required

SE: SS=F: Failed to maintain effective infection control program with failure to implement & staff to follow EBP as required for 3 residents in facility: 1 r/t PU, 2 r/t urinary catheter & 1 r/t trach; additionally failed to appropriately clean & store nebulizer for 2 residents; furthermore failed to appropriately store mask of CPAP with potential to spread potentially infectious organisms to vulnerable residents

- Failed to maintain effective infection control program with failure of facility to implement & staff to follow EBP as required for 3 residents in facility with potential to spread potentially infectious organisms to vulnerable residents
- Failed to maintain effective infection control program r/t improper cleaning of respiratory equipment of resident's CPAP in accordance with professional standards of care to prevent possible respiratory illness for multiple residents

NE: SS=E: Failed to follow sanitary infection control standards r/ following EBP, hand hygiene, cleaning medical equipment, supplemental O2 equipment storage, & indwelling catheter maintenance; additionally failed to handle soiled trash in sanitary manner placing residents at risk for infectious diseases

- Observed trash bags filled with soiled incontinence products sat directly on floor outside 3 resident rooms on multiple occasions
- Observed O2 nebulizer mask sat on top of bedside table & no clean storage bag present in multiple rooms
- Observed LN checked blood glucose with glucometer & placed glucometer on chair w/o clean barrier, & after obtaining result placed glucometer on floor then administered injection then gathered supplies & left room wearing same soiled gloves & placed glucometer & med pen back in resident's kit bag w/o sanitizing it then wearing same soiled gloves opened drawer & place kit inside cart then shut drawer, opened another drawer then promptly shut drawer, shut drawer, removed soiled gloves & performed hand hygiene
- Observed urinary catheter bag & drainage port lay directly on floor under w/c as propelled down hall
- Observed ice machine with tape on lip of service area & tape tattered & lifting in areas with adhesive side showing & tape had collected debris & dirt & appeared black & dirty & surface would not wipe clean after attempts made
- Observed LN failed to wear protective gown for EBP for resident with tube feed

NW: SS=F: Failed to implement a water management program for Legionella disease & other waterborne pathogens placing residents in facility at risk for infectious disease

- Maintenance staff verified unaware of any routine facility water management checks & verified 1 hallway presently not in use & stated staff do not flush water in unoccupied room but did occasionally use shower room on hallway for 1 resident of facility; Adm staff verified city checked water monthly but Adm did not have any records of monthly checks; failed to implement water management program to test & manage waterborne pathogens placing residents who reside in facility at risk for contracting Legionella pneumonia

F883 Influenza & Pneumococcal Immunizations

NE: SS=D: Failed to obtain a signed consent or declination for pneumococcal Prevnar 20 for 3 residents placing residents at risk of acquiring, spreading & experiencing complications from pneumococcal disease

- Record documented resident received Prevnar 13 & Pneumovax 23; record lacked evidence resident received Prevnar 20 or signed declination for Prevnar 20 for 3 residents; failed to obtain signed consent or declination for PCV 20 for 3 residents placing residents at risk for acquiring, spreading & experiencing complications for pneumococcal disease

NW: SS=D: Failed to obtain resident/DPOA signed consent to receive influenza immunizations for 3 residents placing residents at risk for influenza infection & related complications

- Failed to offer or obtain informed declinations for flu vaccination placing residents at risk of acquiring, spreading & experiencing complications from influenza

F919 Resident Call System

NE: SS=D: Failed to provide resident with functioning call light system to convey needs to staff placing resident at risk for delayed care & decreased psychosocial wellbeing

- Observed 1 resident's call light not working in room & call box taped with medical tape & wires hanging out of call light box; failed to provide resident with functioning call light system to convey needs to staff placing resident at risk for delayed care & decreased psychosocial wellbeing

F921 Safe/Functional/Sanitary/Comfortable Environment

SE: SS=F: Failed to provide sanitary environment by failure to have lids on linen cans in shower rooms, failure to have a lid on biohazard container in soiled utility room & failure to maintain appropriate flooring in laundry area with potential to be unsanitary environment which would affect all residents in facility

- Failed to provide sanitary environment by failure to have lids or covers on soiled linen cans in soiled utility rooms, failure to have lid on biohazard container in soiled utility room & failure to maintain appropriate flooring in laundry area with potential to be an unsanitary environment which would affect all residents in facility

F941 Communication Training

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

- Review of training provided by facility for 3 agency CNAs lacked documented training completed for communication; failed to ensure completion of required communication training for all staff who provided care in facility placing residents at risk for impaired care & decreased quality of life

F942 Resident Rights Training

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

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

F943 Abuse, Neglect & Exploitation Training

NE: SS=F: Failed to ensure all direct care staff had received required ANE training placing residents at risk for abuse, neglect & exploitation

- Failed to ensure completion of required ANE training for staff who provided care in facility placing residents at risk for ANE

F945 Infection Control Training

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

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

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F550 Resident Rights/Exercise of Rights

NE: SS=D: Failed to provide a dignified care environment for 3 residents placing residents at risk for impaired dignity & quality of life

- Observed clear box attached to wall in hallway behind activity room ; observed grievance form from representative placed in clear box with details of grievance visibly displayed
- Observed catheter collection bag w/o dignity bag hanging from w/c in DR & other occasions
- Failed to provide dignified care environment for 3 residents placing residents at risk for impaired dignity & quality of life

F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to ensure resident had foot pedals on w/c while being pushed leaving resident vulnerable to preventable accidents & injuries due to unmet care needs

- Failed to provide foot pedals for 1 resident's w/c leaving resident vulnerable to preventable accidents & injuries due to unmet care needs

F585 Grievances

NE: SS=E: Failed to implement a system to allow residents & representatives to file grievances anonymously placing residents at risk for decreased psychosocial wellbeing & with potential to affect all residents

- Observed suggestion box inside walkway that required a door code to access & no labeled grievance boxes in place; Resident Council unaware of how to file a grievance or if facility provided way to file anonymous grievance & turned in complaints to SS or would have family member contact SS; failed to implement system to allow residents/representatives to file grievances anonymously placing all residents at risk for decreased psychosocial wellbeing

F600 Free from Abuse & Neglect

NE: SS=J (Abated to G): Failed to ensure 1 resident remained free from neglect when staff failed to ensure 1 resident received adequate care & services required to prevent harm or injury to physical & psychosocial wellbeing

- *Resident who had colostomy & indwelling urinary catheter, was legally blind & dependent on staff for hygiene was outside w/o staff for extended periods of time with no brief or underwear & with urinary catheter tubing exposed; resident complained of burning sensation to genital area & staff took resident to room for assessment & discovered maggots in resident's genital area & vagina; resident sent to hospital for eval of infestation of genital area; facility's failure to ID risks associated with resident behaviors & activity & implement interventions or strategies to mitigate risks as well as failure to provide adequate hygiene & catheter care to prevent maggot infestation placing resident in immediate jeopardy*
- *Abatement Plan:*
  - *Staff cleaned resident & resident room completely*
  - *In-services nursing staff for notification of resident refusals, changes in resident preferences, refusal of resident cares, refusal of peri-care, residents who go outside w/o wearing a brief; staff were signing that care was completed when resident refused or did not want to come in from being outside; staff in-serviced on what to do in event a resident refused care & to notify nurse then reattempt to go & render care as necessary*
  - *Provided on-going in-services to staff r/t documenting only cares that are completed & charting refusals as refusals; thorough & complete catheter & peri-care for all nursing staff; how neglecting is harmful to resident psychologically & physically & that it is neglectful treatment*
  - *DON provided education to resident on importance of always wearing a brief, especially need to wear brief & spending most of day outside & necessity of sanitary care of peri-area & catheter care given to residents*
  - *DON & ADOIN complete frequent checks on resident weekly to ensure care provided & no recurrence of issue*
  - *Audit of all residents who were potentially affected to ensure appropriate peri-care & catheter care*
  - *Ongoing audits on appropriate peri-care, catheter care & monitoring for correct documentation by nursing staff & complete nursing in-services quarterly to ensure correct peri-care & catheter care per doctor's orders*
  - *Monitor to ensure on-going compliance by following up monthly in QAPI for 3 months with review of all audits completed & changes made as needed; ED to ensure ANE discussed in next 3 all-staff meetings*

F623 Notice Requirements Before Transfer/Discharge

NE: SS=D: Failed to ensure required information was provided on involuntary notification of discharge to resident/representative placing resident at risk for inappropriate discharge & impaired resident rights

- *Resident with dementia with behavioral disturbances; required 1:1 supervision; NN documented resident hit employee with fist & continued to be agitated then walked around, spit on people & cursed; police called & arrived & took statements then left; resident continued to be aggressive & hit staff member & police called again & resident started cursing & police cuffed resident & took resident to jail & nurse attempted to call representative but had to leave message; record documented resident tout of facility & was arrested for warrant & order obtained for emergency discharge due to violence against staff & arrest to protect other residents who were fearful of resident; facility provided 3-page Notice of Transfer or Discharge; notice did not provide appropriate agency for resident/representative to contact for appeal on transfer or discharge; representative stated notice was 2 pages with 2nd page blank & did not include statement of resident/representative's appeal rights; failed to ensure required information was provided on involuntary notification of discharge to 1 resident/representative placing resident at risk for inappropriate discharge & impaired resident rights*

NE: SS=D: Failed to provide written notification of transfer to 1 resident/representative with risk for miscommunication between facility & resident/representative & possible missed opportunities for healthcare services

- *Resident admitted on 5-14-24 & discharged to hospital on 6-11-24 & readmitted to facility on 6-13-24; resident with dementia, bipolar; NN documented resident pacing & showed signs of agitation & anxiety while voicing wanted to leave; facility unable to provide written notification of transfer for resident's facility-initiated transfer; failed to provide written notification of transfer to 1 resident/representative with risk for miscommunication between facility & resident/representative & possible missed opportunities for healthcare services*

F625 Notice of Bed Hold Policy Before/Upon Transfer

NE: SS=D: Failed to provide bed hold policy notice to 1 resident/representative when resident was transferred to hospital with risk of impaired ability to return to facility & to previous room for 1 resident

- *Cited findings noted in F623; facility unable to provide bed hold notice to resident/representative for resident's facility-initiated transfer; failed to provide bed hold policy notice to 1 resident/representative when resident transferred to hospital with risk of impaired ability to return to facility & to previous room for 1 resident*

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

- Record lacked evidence facility provided resident/representative with bed hold policy upon transfer to hospital; failed to provide 2 resident/representative with bed hold policy when 1 resident was transferred to hospital placing resident at risk for not being permitted to return & resume residence in nursing facility

F655 Baseline Care Plan

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

- Baseline CP lacked dialysis provider, days of week & times for dialysis; failed to develop baseline CP for 1 resident to include physician orders for hemodialysis provider, days of week & time for dialysis placing resident at risk of impaired care r/t uncommunicated care needs

F656 Develop/Implement Comprehensive CP

NE: SS=D: Failed to ensure 1 resident's comprehensive CP was updated to include staff direction on collaboration between dialysis clinic & facility; failed to ensure CP was updated with interventions to direct staff on days, times, location, & contact numbers of resident's dialysis treatment clinic placing resident at risk for complications r/t dialysis due to uncommunicated care needs

- Failed to ensure resident's comprehensive CP updated with interventions to direct staff on days, times & location & contact number of resident's dialysis treatment clinic; failed to ensure resident's comprehensive CP updated to include staff direction on collaboration between dialysis placing resident at risk for complications r/t dialysis due to uncommunicated care needs

F657 Care Plan Timing & Revision

SE: SS=D: Failed to review & revise 1 dependent resident's CP to include non-pharmacological interventions for pain

- Resident with dx of pain & OA; Pain CAA did not trigger; CP for pain instructed staff resident had moderate leg pain & received Acetaminophen; CP lacked staff instruction on non-pharmacological interventions for pain; failed to include non-medical interventions for pain for 1 resident's CP

F661 Discharge Summary

NW: SS=D: Failed to complete a discharge summary for 1 resident which included recapitulation summary of resident's stay in facility placing resident at risk for unidentified & unmet care needs

- CP documented resident wanted to return to live in community; POS for discharge back to apartment with same medication orders; EMR lacked recapitulation of resident's stay; staff verified discharge summary lacked recapitulation of resident's stay; failed to develop a recapitulation of resident's stay for 1 resident placing resident at risk for unidentified & unmet care needs

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to ensure 1 resident received grooming per usual preference

- CP documented resident baths Monday & Wednesday on evening shift; observed resident in recliner with several days of facial hair & family stated resident preferred clean-shaven appearance & did not recall when resident last received shave; failed to ensure staff provided grooming opportunities for dependent resident with decline in condition & decline in resistive behaviors

F684 Quality of Care

NE: SS=J (Abated to G): Failed to ensure 1 resident received care consistent with standards of practice when staff failed to notify & obtain physician involvement r/t resident's multiple medication refusals including meds used to control seizures

- *Resident refused all morning doses for BID Keppra from 5-1-24 thru 5-8-24; record lacked evidence staff reported refusals to physician for medical evaluation; on 5-8-24 resident had seizure activity; seizure progressed for 14 minutes when staff called EMS & resident transported to hospital; resident admitted to hospital & later died 4 days later; failure to provide nursing care within standards of practice including notification & involvement for medical oversight for repeated & ongoing seizure medication refusals placed resident in immediate jeopardy*
- *Abatement Plan:*
    - *Educated CMA & nurses in facility on medication refusals & notifications following medication refusals*
    - *Audited all missed meds form 6-17-24 & physician notified during Ad Hoc QAPI meeting on 6-17*

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

NE: SS=D: Failed to ensure staff followed intervention in place for pressure-reducing boots for 1 resident to prevent possible development of PU placing resident at risk for complications associated with skin breakdown

- MDS documented resident at risk for PUs/injuries & resident needed pressure-reducing device for chair, bed, turning & repositioning program & ointments or medications; CP documented skin would be checked q day; toileting plan for repositioning; pressure-reducing cushion for w/c & resident would wear heel protector boots when in bed & heel-up cushion; observed resident with heels directly on mattress & w/o heel-up cushion or boots in place & heels directly on mattress; failed to implement pressure-reducing interventions for 1 resident's heels placing resident at risk for complications associated with skin breakdown

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=G (Past Non-Compliance): Failed to ensure environment free from preventable accidents for 1 resident

- *On 4-30 CNA was providing incontinence care for 1 resident when CNA noticed resident was close to edge of bed; CNA moved hand to wipe resident's buttocks & resident rolled off bed onto floor; resident sent to ER for eval & treat where resident received 13 stiches for laceration to scalp because of fall placing resident at risk for increased pain & further decline in mobility*
- *Past Non-Compliance Plan:*
    - *Resident sent to ER for eval & treat*
    - *CP updated to include 2 staff for repositioning & turning in bed*
    - *Staff received education on safe transfers/fall prevention*

NE: SS=E: Failed to secure hazardous chemicals in safe, locked area & out of reach of 7 cognitively impaired, independently mobile residents placing affected residents at risk for preventable accidents

- Failed to secure chemicals in safe, locked area & out of reach of 7 cognitively impaired, independently mobile residents placing affected residents at risk for preventable accidents

NE: SS=D: Failed to ID & implement appropriate, resident-centered interventions to prevent falls for cognitively impaired resident placing resident at risk for additional falls & injuries

- CP documented resident at risk for falls; resident with multiple falls; NN documented multiple falls w/o injury; 1 with "continue CP" for multiple falls; Adm nurse stated did not feel fall interventions were person-centered; failed to ID & implement appropriate, resident-centered interventions to prevent falls for 1 resident who was cognitively impaired placing resident at risk for additional falls & injuries

NW: SS=J (Past Non-Compliance): Failed to ensure staff provided adequate supervision to prevent cognitively impaired resident from exiting facility w/o staff knowledge & supervision

- *On 06/13/24 at approximately 07:55 AM Resident, who was at risk for elopement, propelled his wheelchair from the dining room to the smoker's room on the south hall. Resident went into the smoker's room and said that it was his home. Housekeeping Staff removed resident from the smoker's room and told CNA what resident was doing. Resident reentered the smoker's room and CNA went in and tried to convince resident to leave but resident again stated it was his home. Since resident was not attempting to exit, CNA left him to go answer call lights. Both CNAs began assisting other residents. At 08:20 AM, Administrative Staff entered the parking lot and headed to the door of the facility. She heard someone say, "Good Morning." When she looked back to the east, she saw resident in the parking lot, sitting in his wheelchair. Administrative Staff approached resident and asked what he was doing outside, and he said, "I am going home to see my wife and brother." Administrative Staff called Administrative Nurse and she came to assist resident back into the facility. The investigation revealed the door alarm to the smoker's room sounded, but staff could not hear it. The facility's failure to provide adequate supervision to prevent resident from eloping placed resident in immediate jeopardy.*
- *Abatement Plan:*
    - *All nursing staff re-educated on wandering/elopement*
    - *Resident placed on 1:1 with staff until determined resident is not exit-seeking*
    - *Maintenance fixed smoke room door alarm so it would alarm not only in room & outside but at the alarm panel to alert staff*
    - *Maintenance staff & manager on duty on weekends checking all door alarms twice daily*
    - *CPs of residents at risk for elopement reviewed & new elopement risk evals completed on all residents*

NW: SS=J (Abated to D): Failed to provide adequate supervision to ensure environment free from accident hazards placing resident in immediate jeopardy

- *At approx. 10:07am, dietary staff let 1 resident out exit door by main DR which led to patio then returned to dietary tasks w/o ensuring additional supervision for 1 resident; patio area contained gate that was unlocked & resident exited patio area through unlocked gate; at approx. 10:39am maintenance staff saw resident on bench by front door reading newspaper & when went out door, resident walked back inside facility; at approx. 1:12pm another resident asked staff to go outside & dietary staff stated would have to check with charge nurse to see if resident could go outside & when dietary staff asked charge nurse, dietary staff mentioned letting resident outside earlier; staff did not know first resident was outside w/o staff supervision until approx. 3.5 hours later; staff found resident in room in recliner as resident had made way back to room; failure to provide adequate supervision to ensure environment free from accident hazards placed resident in immediate jeopardy*
- *Abatement Plan:*
    - *Updated Elopement & Elopement Risk Policies*
    - *Started sign-off sheet to include charge nurses' verification that resident able to go outside facility w/o staff or family member*
    - *Staff participated in elopement drill*
    - *Resident's CP updated*
    - *Initiated daily maintenance checks of patio gates to ensure secured*
    - *Resident on 15-minute checks*
    - *Updated resident's wander/elopement risk assessment to show moderate risk for elopement*
- *Resident with multiple falls; CP lacked intervention r/t multiple falls & some repeated interventions; failed to adequately prevent 1 resident's fall due to lack of preventative interventions for 5/11 falls experienced placing resident at risk for injuries due to falling*

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to provide necessary care & services r/t incontinence care for 1 resident with hx of UTIs & failed to provide necessary care & services r/t indwelling catheters for 1 resident placing 2 residents at risk for UTIs & related complications

- Resident with urinary & bowel incontinence frequently; review of urine C&S revealed resident with multiple E coli infections; observed staff provided incontinence care; during care staff failed to perform hand hygiene prior to donning new gloves on multiple occasions

during care; used 1 wipes for 4 swipes, then 1 wipe for 3 swipes; failed to provide necessary care & services to 1 resident who had risk for UTIs & unwarranted physical complications for 1 resident

- Resident with Foley catheter; observed staff perform catheter care; LN exited room to obtain isolation gown from bin outside room then returned to room, closed door & donned isolation gown; failed to doff gloves & perform hand hygiene & apply clean gloves then obtained leg bag from BR & laid bag on foot of resident's bed & failed to perform hand hygiene & change gloves prior to cleaning tip of urinary leg bag then disconnected dependent drainage bag form resident's catheter & attached bag to resident's catheter then rinsed drainage bag & placed it in plastic bag in BR then doffed gloves & done new glove but failed to perform hand hygiene between gloves; failed to ensure standard of care provide during catheter care for 1 resident for resident who was being treated for UTI placing resident at risk for catheter-related complications & further UTIs

F695 Respiratory/Tracheostomy Care & Suctioning

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

- POS for O2 at 2 lpm & O2 sats BID; observed nasal cannula laying directly on floor next to resident's bed; failed to ensure 1 resident's O2 tubing was stored in sanitary manner to decrease exposure & contamination placing resident at increased risk for respiratory infection & complications

F698 Dialysis

NE: SS=D: Failed to obtain communication from dialysis center & assess pre-dialysis & post-dialysis status for 1 resident placing resident at risk of potential adverse outcomes & physical complications r/t dialysis

- Failed to obtain communication from dialysis center & failed to assess pre-dialysis & post-dialysis clinical status for 1 resident placing resident at risk for potential adverse outcomes & physical complications r/t dialysis

F699 Trauma Informed Care

NW: SS=D: Failed to assess 1 resident for trauma-informed care needs to eliminate or mitigate triggers that may cause re-traumatization of resident placing resident at risk for impaired quality of life

- EMR lacked evidence facility assessed resident for hx of trauma to ID potential mental health needs; resident with behavioral health stay but continued to have behaviors following re-admission; staff confirmed had not done trauma assessment; failed to assess 1 resident for trauma-informed care needs to eliminate or mitigate triggers that may cause re-traumatization of resident placing resident at risk for unmet care emotional & psychosocial needs

F700 Bedrails

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

- EMR lacked evidence of safety assessment for side rails, prior to installation of side rails; facility unable to provide risk assessment for side rails for resident; observed resident in bed with bed canes in place on each side of bed; failed to ensure that resident had documented risk assessment, a consent for use of side rails & failed to ensure resident/representative were advised of risks/benefits of use of side rails placing resident at risk for uninformed decisions & impaired safety related to risks associated with use of side rails

F732 Posted Nurse Staffing Information

NE: SS=C: Failed to ensure nurse staffing data was posted daily

- Observed staffing data posted from 4 days earlier; failed to ensure daily nurse staffing data was posted as required

F756 Drug Regimen Review, Report Irregular, Act On

NW: SS=E: Failed to ensure Consultant Pharmacist (CP) IDd & reported unapproved indication for use, lack of target behaviors & side effect monitoring & lack of patient-specific rational describing why GDR was contraindicated for use of psychotropic meds for 4 residents

- POS for Lexapro, Norco, Olanzapine, Lorazepam; CP lacked resident-specific targeted behaviors & monitoring related side effects from use of high-alert meds; MRR documented recommendation for GDR for Lexapro & Zyprexa & GDR for Lorazepam MRR lacked evidence CP IDd & reported lack of side effects & targeted behaviors monitoring & lacked evidence CP reported unapproved indication & associated risk for Zyprexa; record lacked evidence physician documented specific benefits vs risks for resident's continuation of antipsychotic med; failed to ensure CP IDd & reported lack of approved indication for use of antipsychotic as well as inadequate monitoring &/or rationale for continued use of psychotropic meds for 1 resident placing resident at risk of unnecessary psychotropic meds & related side effects
- Failed to ensure CP IDd & reported inadequate monitoring &or rationale for continued use of psychotropic meds for 1 resident placing resident at risk of unnecessary psychotropic meds & related side effects
- Failed to ensure CP IDd & reported lack of approved indication for use of antipsychotic for 1 resident placing resident at risk of unnecessary psychotropic meds & related side effects
- CP failed to ID & report unapproved indication for use of 1 resident's Seroquel & inadequate monitoring of targeted behaviors for 1 resident's psychotropic meds placing resident at risk for unnecessary psychotropic meds & related side effects

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to follow orders r/t medication monitoring when facility administered resident's anti-hypertensive beta blocker on multiple occasions outside physician ordered parameters w/o physician notification placing resident at increased risk for unnecessary medication & side effects

- POS for Metoprolol 50mg BID with holding parameters; MAR documented from 3-31 thru 6-11 (72 days) indicated med given outside parameters on 7 occasions; failed to follow orders r/t medication monitoring when facility administered 1 resident's anti-hypertensive beta blocker on multiple occasions outside physician-ordered parameters w/o physician notification placing resident at risk for unnecessary medication & side effects

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure GDR was attempted or addressed by physician for 1 resident's antipsychotic medication who had dx of dementia placing resident at risk for medications & related complications

- POS for Risperidone 0.5 mg 2 tabs daily for major depressive d/o with psychosis; Risperdal 0.5mg q AM & 2 tabs q evening for major depression d/o with psychosis; June 2023 MMR documented recommendation for GDR & physician marked "no"; 9-23 consult with physician documentation that med ordered for persistent behaviors; June 2024 MMR did not ID attempts at GDR & lacked evidence physician documented justification for not attempting GDR; failed to ensure GDR was attempted for 1 resident's antipsychotic medication who had dx of dementia placing resident at risk for unnecessary psychotropic meds & related complications

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

- Resident with Alzheimer's disease, anxiety, dementia & depression; MDS documented resident received antipsychotic, antianxiety & antidepressant meds; POS for Trazodone, Mirtazapine; Sertraline; Lorazepam, Risperidone for Alzheimer's; record lacked physician-documented rationale which included multiple unsuccessful attempts for nonpharmacological interventions & risk vs benefits for continued use of antipsychotic med for resident with dementia; failed to provide physician-documented rationale which included multiple unsuccessful attempts for nonpharmacological interventions & risk vs benefits for continued use of antipsychotic med for 1 resident placing resident at risk for unnecessary psychotropic med & related complications
- Resident with vascular dementia; POS for Risperdal for vascular dementia with psychotic disturbances; record lacked physician-documented rationale which included nonpharmacological interventions & risk vs benefits for continued use of antipsychotic medication; failed to ensure nonpharmacological interventions & risk vs benefits were attempted prior to administration of antipsychotic med for 1 resident who had dx of dementia placing resident at risk for unnecessary psychotropic meds & related complications

NW: SS=E: Failed to ensure 4 residents had approved indications & adequate monitoring for use of psychotropic meds placing residents at risk for receiving unnecessary psychotropic meds

- Cited findings noted in F656; Failed to ensure 1 resident had approved indication for use of antipsychotic as well as adequate monitoring &/or rationale for continued use of psychotropic meds for 1 resident placing resident at risk of unnecessary psychotropic meds & related side effects
- Failed to ensure 1 resident had adequate monitoring &/or rationale for continued use of psychotropic meds placing resident at risk of unnecessary psychotropic meds & related side effects
- Failed to ensure 1 resident had approved indication for use of antipsychotic placing resident at risk of unnecessary psychotropic meds & related side effects
- Failed to ensure approved indication for use of 1 resident's Seroquel & adequate monitoring of targeted behaviors for 1 resident's psychotropic meds placing resident at risk for unnecessary psychotropic meds & related side effects

F804 Nutritive Value/Appear, Palatable/Prefer Temp

SE: SS=D: Failed to prepare food consistent with required recipes to ensure nutritional value & preservation of vitamins for 3 residents IDd to receive pureed diets

- Observed dietary staff prepare pureed foods; staff stated did not have recipes to follow to puree residents' foods & would add water, gravy or butter till got food right consistency & stated did not know how much to add; failed to prepare food consistent with required recipes for 3 residents that received pureed diets

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=F: Failed to prepare food under sanitary conditions for residents of facility r/t appropriate use of hair restraints, beard restraints & cross contamination following handwashing

- Observed dietary staff walked thru food prep area with hair unrestrained & exposed outside of ball cap on multiple occasions; observed staff with facial beard & lacked beard guard; observed staff washed hands at kitchen handwashing sink, dry hands with paper towels, walk to large, covered trash barrel in food prep area, lifted lid with used paper towel, throw towel in barrel then slid lid with bare hand then prepared pureed foods; did not use trash can lid with foot operation; failed to prepare food under sanitary conditions for residents of facility r/t appropriate use of hair restraints, beard restraints, cross contamination following hand washing

NE: SS=F: Failed to ensure staff stored & prepared food items in accordance with professional standards for food service safety placing residents at risk for foodborne illnesses

- Observed freezer with multiple opened, not closed, labeled or dated; freezer with unlabeled & undated food items; fridge with rolling cart with uncovered, unlabeled & undated food items; cooler with unlabeled & undated food items; cooler with numerous uncovered desserts; cooler with undated food items; cooler with unlabeled, undated food items & milk container; clean dish storage with bowls & ramekins uncovered or inverted; fridge with box of produce leaking & some with visible mold; dry storage with opened pack of pecans undated & unsealed

NW; SS=F: Failed to store foods & ensure proper dishwashing in manner to prevent foodborne illness placing residents at risk for foodborne illness

- Observed fridge with freezer lacked thermometer in fridge section; freezer with opened, unsealed unlabeled bags of frozen foods & thermometer on door shelf not working; freezer with floor storage of food items; fridge with multiple containers of expired frozen product; freezer lacked independent backup thermometer; dishwashing machine used detergent pellets & sensors for heating & amounts of chemicals to disperse & dishwashing logs documented excessive high temps & holes in temp logs & holed in sanitizer or temp logs

F814 Dispose Garbage & Refuse Properly

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

- Observed 3 compartment outside dumpster with open lids; failed to maintain &/or dispose of garbage & refuse properly in sanitary condition to prevent harborage & feeding of pests

F849 Hospice Services

NE: SS=D: Failed to ensure consistent method of communication process including how communication would be documented between facility & hospice provider to ensure needs of resident were addressed & met 24 hours/day for 1 resident placing resident at risk for decline &/or from maintaining highest practicable physical, mental & psychosocial wellbeing

- CP lacked direction to staff for collaboration of care & services with hospice provider which included services, frequency of visits, medications & equipment provided by hospice; EMR lacked documentation of collaboration of care for 1 resident from January 2024 thru 5-24; failed to ensure collaboration between facility & hospice provider & failed to develop a CP by facility that included description of services, medication & equipment provided to resident by facility placing resident at risk for delayed services which could affect resident's mental, & psychosocial wellbeing

F880 Infection Prevention & Control

NE: SS=E: Failed to follow sanitary infection control standards r/t EBP, wound care, disinfection of mechanical lifts & maintaining O2 therapy equipment placing residents at risk for infectious diseases

- Observed resident's room with O2 tubing with no clean bag or storage device in room to store O2 equipment when not in use for multiple residents; observed O2 tubing laying on floor next to resident's recliner; resident's room with no EBP signage or PPE posted in or around room for wound care
- 1 resident's room with no EBP for PPE in or around room r/t dialysis & resident's nebulizer mask sat directly on room's recliner & no clean bag or storage device in room to store O2 equipment when not in use
- Observed resident's room with no EBP signage or PPE posted in or around room for wound care
- Observed resident's O2 tubing & nasal cannula on top of used incontinent pad & nebulizer mask sat on nebulizer mask & no clean bag or storage device in room
- Observed staff pushed Hoyer lift transfer resident & upon exiting staff did not sanitize machine before parking it
- Failed to follow sanitary infection control standards r/t EBP, sanitary wound care, disinfection of mechanical lifts & maintaining O2 therapy equipment placing residents at risk for infectious diseases

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

- Observed 1 resident's nasal cannula laid directly on floor next to resident's bed & pile of soiled linen was laid directly on side of bed
- Observed 1 resident's catheter tubing & drainage bag touching floor on multiple occasions
- Observed LN failed to perform hand hygiene prior to donning clean gloves during catheter care
- Observed CNA staff failed to perform appropriate peri care when used wipes for multiple swipes & failed to perform hand hygiene prior to donning clean gloves
- Facility unable to provide a plan, facility-based risk assessment or procedures & monitoring r/t Legionella prevention
- Failed to ensure proper infection control standards were followed r/t implantation of procedure or plan to monitor & prevent Legionella disease or other opportunistic waterborne pathogens, hand hygiene during catheter care & peri care, storage of O2 equipment, proper placement of soiled linen, & catheter bags resting on floor placing residents at risk for complications r/t infectious diseases

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

- Observed documentation w/o Legionella preventative measures including ID of risk areas & actions taken to mitigate risk; maintenance staff verified facility lacked map of water distribution & dead-end or little used faucets despite 1 whole resident hall not used; failed to implement water management program to manage waterborne pathogens placing residents residing in facility at risk of contracting Legionella pneumonia

F883 Influenza & Pneumococcal Immunizations

NE: SS=D: Failed to obtain consent or declinations for Pneumococcal (PCV20) vaccinations or administration information for 2 residents placing residents at increased risk for complications r/t pneumonia

- Failed to obtain PCV20 consents, declinations or administration information for 2 residents who were eligible to receive vaccination placing residents at increased risk for acquiring, transmitting or experiencing complications from pneumococcal disease

NW: SS=E: Failed to offer pneumococcal immunizations for 4/6 residents sampled for immunizations placing residents at risk for complications r/t pneumococcal pneumonia

- Failed to offer 4 residents physician ordered pneumococcal immunization placing residents at risk for complications r/t pneumococcal pneumonia

July, 2024

F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to provide 1 resident foot pedals for w/c placing resident who was vulnerable to possible injury due to unmet care needs

- Observed resident rolled self to meal then CMA offered to push resident & instructed resident to raise legs which resident did & resident's foot hit floor 2x's while CNA propelled w/c; failed to provide resident with w/c pedals for w/c when staff pushing w/c leaving resident vulnerable to possible injury due to unmet care needs

F600 Free from Abuse & Neglect

NE: SS=D: Failed to ensure that residents were free from resident-to-resident abuse when 1 resident threw hot coffee on another resident placing resident & other residents on 1 hallway at risk of possible harm & or injury & impaired quality of life

- Resident with hemiplegia & hemiparesis, DM, HTN & PVD; resident with BIMS of 15, used motorized w/c & independent of functional abilities & received antidepressant, hypnotic & opioid meds; CP documented resident would get upset easily & felt that other residents impeded resident's "prayer group" time & staff was to remind resident that common area was for everyone & staff would redirect resident back to own room if resident became verbally aggressive; Investigation documented Adm staff notified that nursing staff had reported that resident had spilled coffee on another resident & summary of investigation documented resident had disagreement with another resident in DR & resident became upset when other resident would not move from certain spot & began to yell at other resident to move then grabbed a cup of coffee & threw it on other resident, hitting other resident's abdomen & thighs then went back to resident's room stating that resident would throw coffee in other resident's face; LN assessed other resident with no injury with no redness or blistering; when asked resident stated incident was "accident"; when interviewed, resident stated incident was accident & did not want to talk about it anymore; during interview LN stated assessed other resident next day & noted scabs to skin but had not ever noted any blisters in area; failed to ensure residents were free from abuse when resident threw hot coffee on other resident placing residents at risk of possible harm &/or injuries & impaired quality of life

F609 Reporting of Alleged Violations

NE: SS=D: Failed to report allegation of abuse between staff & 1 resident & injury of unknown origin for 1 resident to State Agency (SA) as required placing resident at risk for unidentified & ongoing abuse

- *Witness statement of CNA stated CNA checked on resident to see if resident wanted to get up for breakfast & resident declined; around 10am resident's hospice nurse reported 2 large bruises on resident's arm & asked if staff aware of source; CNA told hospice that at times another CNA "could be rough when transferring and rolling residents"; LN assessed resident with 2 large bruises with many smaller bruises present; investigation revealed that reporting CNA stated "having a bad day & spouted off" to hospice nurse but had not witnessed other CNA being rough; investigation lacked evidence facility reported allegation of abuse to SA; failed to report allegation of abuse & injury of unknown origin for 1 resident to SA placing resident at risk for unresolved & ongoing abuse*

F610 Investigate/Prevent/Correct Alleged Violation

NE: SS=D: Failed to ensure resident-to-resident altercation was fully investigated & interventions implemented to prevent further abuse after resident threw hot coffee on other resident placing residents on 1 hallway at risk of possible harm &/or injury & impaired quality of life

- Cited findings noted in F600 r/t 1 resident throwing hot coffee on another resident; Adm Nurse stated present in facility when incident occurred & had talked with resident in room after incident & resident had said it was accident & no further action was taken at the time as resident spent most time in room & did not feel resident would be a threat to any other residents & did notify Adm immediately of incident; failed to ensure resident-to-resident incident was fully investigated & inappropriate interventions put in place to ensure residents were free from abuse placing residents at risk of possible harm & /or injuries

F684 Quality of Care

NE: SS=D: Failed to ensure staff obtained physician-ordered labs for 1 resident & failed to notify physician of delay in resident's labs being obtained placing resident at risk of delayed care & related complications

- CP documented staff to monitor & document for s/sx of UTI & staff to monitor, document & report s/sx of dehydration & staff directed to obtain & monitor lab & diagnostic work as ordered & report results to physician & follow as indicated; NN documented resident with sx of altered mental status & diaphoresis & POS for UA, CMP, CBC with differential; straight cath completed for UA with thick off-white sediment-like discharge noted; lab order placed online with note for lab to report results STAT & request return phone call; NN

documented staff called lab for STAT lab draw & lab company called again requesting STAT lab draw & orders changed in lab system to STAT; NN documented resident w/o voiding during shift & straight cath completed with 800 mL of urine; new sample collected for UA; POS for IM ABT & provider notified of possible allergy; EMR & NN lacked documentation any further monitoring of condition & s/sx from 7-5 to 7-9; On 7-10 resident did not eat breakfast; failed to ensure 1 resident received appropriate care & services when staff failed to ensure that STAT physician ab orders were obtained when ordered causing a delay in resident's care & treatment for UTI & placed resident at risk for further complications

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to ensure 1 resident's leg/ankle brace was applied to leg when resident was out of bed to prevent contractures from worsening placing resident at risk for further decline & decreased ROM or mobility

- Resident with hemiplegia & hemiparesis; CP documented resident with contracture to upper & lower extremity & POS for leg brace on foot/ankle when resident out of bed every shift; record with no refusals to splint; observed resident w/o leg or ankle brace & CNA stated did not know how to put leg brace on; failed to apply 1 resident's leg/ankle brace to leg when resident out of bed placing resident at risk for worsening of contractures & decreased mobility

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=D: Failed to provide a safe environment for 1 resident by failure to implement interventions to prevent repeated falls with major injury for 1 resident who had fall that resulted in fx'd wrist

- *No change of condition assessment done to reflect residents current status including multiple falls with fx to arm; Resident with hx of falls & recent admit to hospice; fall CP documented fall prevention interventions but lacked guidance r/t incontinence; resident with multiple falls; NN documented resident fell to buttocks in room & family picked resident up themselves from floor & family reported resident did not hit head; resident denied pain or discomfort & ROM within normal limits & NN lacked root cause of fall to implement intervention that caused resident's fall; another fall investigation lacked root cause analysis & intervention for fall; further fall investigation documented root cause was resident non-compliant & received medication that heavily medicated resident & resident removed O2 at times & NN documented resident returned to facility with wrist fx; resident with multiple further falls; observed resident up in room walking around by self barefooted & was confused; Adm nurse reported no toileting program & thought toileting program would put staff in resident's room more often; failed to provide safe environment for cognitively impaired resident with hx of multiple falls & low vision to prevent repeated falls with 1 fall that resulted in fx'd wrist*

NE: SS=J (Past Non-Compliance): Failed to provide adequate supervision to prevent 1 resident, a cognitively impaired resident with hx of making comments about leaving & was at risk for falls from eloping facility

- *On 7-15 housekeeping staff notified LN that resident made statement that wanted to go home; LN retrieved vital sign machine then went to resident's room to obtain vital signs & noted resident was not in room; LN asked other staff if had seen resident, but had not; LN informed Adm nurse that resident missing & elopement code was called to inform staff of missing resident & resident count began while facility searched; Adm nurse & SS exited 2nd floor stairwell & exited facility to parking lot & resident found sitting on grass between 2 parked cars holding water glass 10 minutes after went missing; door alarm for stairs did not alarm because alarm had been turned off for unknown reasons placing resident in immediate jeopardy*
- *Past Non-Compliance Plan:*
  - *Placed resident on 1:1 supervision immediately*
  - *Updated CP to include resident's risk for elopement*
  - *Ad-Hoc QAPI meeting held on same day*
  - *Maintenance audited exit doors & alarms with continued audits planned*
  - *Key-access-only box placed over keypad for 2nd floor stairwell door*
  - *Staff education on elopement completed*
  - *Elopement drill completed*
  - *Residents with BIMS of 12 or below were audited*
  - *Residents at risk for elopement audited with CPs updated accordingly*

NE: SS=E: Failed to ensure safe environment free from potential hazards out of reach of 5 cognitively impaired, independently mobile residents; additionally failed to follow fall prevention interventions CP'd for 2 residents; additionally failed to ensure 1 resident's room was free from physical hazards placing residents at risk for preventable accidents & injuries

- Observed kitchenette with hazardous cleaning chemicals accessible with warning label; & pressurized CO2 sat unsecured in cabinet under sink; Observed unlocked O2 storage room & room with 4 large pressurized canisters & 2 small pressurized canisters in room; DR with large leak in front of drink station covered with soiled wet towels on floor & no "Wet Floor" sign in place for leading on floor; Observed 1 resident's room revealed unsecured pressurized supplemental O2 cannister sitting directly on floor next to w/c; Failed to ensure safe environment free from potential hazards out of reach of 5 cognitively impaired, independently mobile residents placing residents at risk for preventable accidents & injuries
- Observed resident's low air loss mattress with pump set at 350 pounds; failed to ensure 1 resident's fall interventions were followed r/t low air-loss mattress placing residents at risk for preventable accidents & injuries
- Failed to ensure safe transfer of 1 resident during shower care placing resident at risk for preventable falls & injuries r/t CP to keep bed in low position & observed resident's bed not in low position

- Failed to ensure safe environment free from accident hazards when staff left O2 canister unsecured & free-standing in resident's room placing resident at risk for injuries

NW: SS=G (Past Non-Compliance): Failed to provide a safe environment for 1 resident during a transfer; on 7-4 CNA transferred resident by self with sit-to-stand lift; resident's ankle buckled & resident fell out of lift sling & sustained broken thumb placing resident at risk for falls, injury & pain

- *CP directed staff required 2 staff assist for ADLs; & CP directed staff to use 2 staff assist using sit-to-stand lift to transfer resident; resident high risk for falls; NN documented LN called to resident' room for fall to floor; CNA used sit-to-stand lift alone & resident's ankle buckled sideways & resident slipped to floor; fall witnessed & resident w/o head injury; LN noted hand swollen & bruised between thumb & index finger & physician notified & ordered mobile X-ray; NN documented X-ray revealed irregular lucency at base of thumb r/t non-displaced fx; physician ordered spika splint & ordered staff not to use sit-to-stand lift for transfers & non-weight bearing to hand; failed to provide safe environment for resident during transfer & as result resident fell & sustained broken thumb placing resident at risk for falls, injury & pain*
- *Past Non-Compliance Plan:*
  - *CNA retrained on proper mechanical lift protocol & placed on performance improvement plan*
  - *In-service completed for all employees r/t when using any mechanical lift 2 staff members must be present per facility policy & failure to do so could result in immediate suspension &/or termination*

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to ensure standard of care was provided for 1 resident who had hx of UTIs placing resident at risk of complications & further UTIs

- Observed resident sitting in doorway & stated waiting on staff to come & assist resident to BR; 16 minutes later observed resident standing in BR, holding onto handrail & staff present & after resident had BM, staff wiped bottom then wiped front peri area & doffed gloves & donned 2nd pair of gloves w/o performing hand hygiene then wiped front peri care, doffed gloves, assisted with re-dressing w/o hand hygiene first; failed to ensure standard of care was provided during peri care for 1 resident placing resident at risk of further UTIs

F692 Nutrition/Hydration Status Maintenance

NE: SS=G: Failed to monitor weights consistently in order to ID loss & immediately involve RD & physician to evaluate if nutritional needs were met for 1 resident's enteral nutrition regimen to prevent significant, unplanned weight loss of 11.74% within 2 months

- Resident with aphasia, dysphagia, hemiplegia/hemiparesis & CVA; POS for PEG tube feedings; RD documentation revealed visit by RD in 6-24; Physician progress noted documented physician had met with resident & representative r/t 5# weight loss & family concern about resident's nutritional intake & weight loss; EMR lacked follow up documentation from provider; POS for weights weekly x 4 weeks & DC'd 7-2-24 with no other orders for weight monitoring; POS for Jevity 1.5 L BID & water flushes q 4 hours then DC'd & reentered with no nutritional changes; Weight History documented resident with 7.35% since admission to facility (8 days) then 8.13% (17 days); EMR lacked documentation showing provider or RD notified on continued weight loss; then 11.74% in 37 days; failed to monitor weights & adjust resident's enteral nutrition regimen before significant weight loss occurred & as result of deficient practices, resident had significant unplanned weight loss of 11.74% within 2 months

F698 Dialysis

NE: SS=D: Failed to consistently communicate resident's medical condition prior to & post-hemodialysis placing resident at risk of potential adverse outcomes & physical complications r/t dialysis

- Failed to consistently communicate 1 resident's medical condition prior to hemodialysis & post-hemodialysis placing resident at risk of potential adverse outcomes & physical complications r/t dialysis

F732 Posted Nurse Staffing Information

NE: SS=C: Failed to ensure nurse staffing data was posted daily with required information & failed to ensure facility retained posted daily staffing data as required

- Failed to ensure nurse staffing data was posted daily with required information & failed to ensure facility retained posted daily staffing data as required

F740 Behavioral Health Services

NE: SS=D: Failed to adequately meet 1 resident's behavioral health needs r/t utilizing non-pharmacological care approaches resulting in repeated behavioral episodes placing resident at risk for continued behavioral episodes & unmet care needs

- MDS documented BIMS of 9 & resident with verbal & physical aggressive behaviors 1-3 days; CAA documented resident with hx of verbal & physical aggression; NN documented resident still aggressive & verbally abusive to staff & refused meds & treatments frequently & note lacked documentation of what interventions were offered or attempted to calm resident down & note lacked evidence medical provider notified of behaviors; NN with multiple entries r/t resident's aggressive behaviors; Failed to adequately meet 1 resident's behavioral health needs r/t utilizing non-pharmacological care approaches resulting in repeated behavioral episodes placing resident at risk for continued behavioral episodes & unmet care needs

F744 Treatment/Service for Dementia

NE: SS=D: Failed to ID a pattern of dementia-related behaviors for 1 resident & failed to implement meaningful interventions to promote quality of life placing resident at risk for preventable injuries & inability to maintain resident's highest practicable level of functioning

- Resident with BIMS of 9; Observed resident in DR & threw plate on floor upon receiving food & then started eating replacement food & began chewing & spitting food down shirt; observed resident started mocking nurses; observed resident ordered grilled cheese sandwich

& shoved entire sandwich down shirt & began screaming for help; observed resident poured hot eggs down shirt & had bright red burn area on upper breast; failed to ID pattern of dementia-related behaviors for 1 resident placing resident at risk for preventable injuries & inability to maintain highest practicable level of functioning

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to ensure staff followed physician-ordered parameters for 1 resident's antihypertensive medication monitoring placing resident at risk of unnecessary medication administration & possible adverse side effects

- Failed to ensure 1 resident's BP & pulse were monitored as physician ordered prior to administration of Metoprolol placing resident at risk for unnecessary medication administration & possible adverse side effects

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to secure its medication & treatment carts placing residents at risk for unnecessary medication & administration errors

- Observed unlocked skin treatment cart containing multiple medication lotions with warning labels; observed unsecured med cart; failed to secure its medication & treatment carts placing residents at risk for unnecessary medication & administration errors

F880 Infection Prevention & Control

NE: SS=E: Failed to follow sanitary infection control standards r/t handling of soiled laundry, medication administration & disposal of PPE placing residents risk for infectious diseases

- Observed soiled towels on ground for large leak in front of drink station
- Observed soiled glove & broken facemask left on top of EBP cart outside resident room
- Observed pile of bed linen on floor in resident room
- Observed soiled damp towels & clothing on floor in resident room
- Observed CMA failed to complete hand hygiene while preparing & administering meds
- Observed used PPE on floor in resident room
- Observed CMA failed to complete hand hygiene after touching multiple surfaces during med administration for 1 resident
- Cited findings noted in F690 r/t CNA failure to perform hand hygiene between glove changes

F941 Communication Training

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

- CNA facility-provided credentialing file lacked evidence training was completed for communication training for multiple agency CNAs; failed to ensure agency direct care staff had received communication training placing residents at risk for impaired care & decreased quality of life

F942 Resident Rights Training

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

- Failed to ensure agency direct care staff had received resident rights training placing residents at risk for impaired care & decreased quality of life

F947 Required In-Service Training for Nurse Aides

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

- Failed to ensure agency direct care staff had received required in-service for nurse aide training placing residents at risk for impaired care & decreased quality of life