July, 2025 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

January, 2025

F689 Free of Accident Hazards/Supervision/Devices

NW: SS=J (Past Non-Compliance): Failed to provide a safe environment free from preventable accidents for 1 resident placing resident at risk for death, injury, pain & decreased in daily function

- *On 01/15/25 at approximately 09:20 AM, 2 CNAs transferred resident from w/c to recliner using a Hoyer lift. CNAs used the lift to suspend resident into the air due to limited space in resident's room. 1 CNA turned around to position resident's recliner for resident to sit in, turned back around to assist resident into the recliner, and the right top lift sling strap dislodged & resident slid out of the lift sling onto the floor. Resident hit the right side of head & came to rest on right side. The facility transferred resident to the hospital where hospital diagnosed resident with a fractured neck. This deficient practice placed resident at risk for death, injury, pain, and a decrease in daily function*
- *Plan of Removal:*
  - *Hoyer lift removed from use & unable to be accessed by staff*
  - *New lift rented from medical equipment company*
  - *Education provided to current nursing staff on how to use the new lift*
  - *Educated current staff on need to notify administration when equipment not working properly*
  - *Mechanical Lift competency completed for all current nursing staff*

February, 2025

F550 Resident Rights/Exercise of Rights

SE: SS=D: Failed to provide a dignified care environment for 2 residents placing residents at risk for impaired dignity & quality of life

- Observed multiple staff standing over residents while assisting with meals on multiple occasions

F558 Reasonable Accommodations Needs/Preferences

SE: SS=D: Failed to provide w/c foot pedals for 1 resident's w/c while pushing resident in hallway placing resident at increased risk for preventable falls & injuries

- Observed resident on multiple occasions was pushed by different staff members w/o foot pedals & staff instructed resident to hold feet up; failed to provide w/c foot pedals for 1 resident's w/c while pushing resident in hallway placing resident at increased risk for preventable falls & injuries

F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directives

SE: SS=D: Failed to clearly identify the expressed choices to initiate or withhold resuscitative measures by maintaining a DNR advance directive for 1 resident placing resident at risk of wishes not being honored

- CP documented resident signed Full Code; EMR with POS for Full Code; EMR revealed signed DNR; EMR documented resident a Full Code; resident's nameplate indicated resident a Full Code; hospice communication book documented resident a DNR; failed to clearly ID expressed choices to initiate or withhold resuscitative measures by maintaining DNR in resident's EMR placing resident at risk of wishes not being honored

F582 Medicaid/Medicare Coverage/Liability Notice

SE: SS=D: Failed to provide 2/3 residents/representatives CMS SNF ABN form 10055; failed to provide 2 resident contact phone numbers on NOMNC which informed beneficiary of right to expedited review by QIO placing residents at risk of uninformed decisions about skilled services

- Failed to provide 2 resident QIO contact number for appealing Medicare Part A decision & CMS approved 10055 ABN form placing 2 residents at risk of uninformed decisions about skilled services

F607 Develop/Implement Abuse/Neglect Policies

SE: SS=E: Failed to conduct a criminal background check as required for three agency licensed nurses. The employees were allowed access to residents without knowing if they had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. This deficient practice placed the affected residents at risk for abuse, neglect, misappropriation, or mistreatment

- Facility was unable to provide evidence a criminal background check had been completed or a license verification had been completed by the facility for3 LNs (agency nurses), who had worked at the facility; failed to conduct a criminal background check as required for 3 agency licensed nurses. The employees were allowed access to residents without knowing if they had been found

guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law. This deficient practice placed the affected residents at risk for abuse, neglect, misappropriation, or mistreatment

F623 Notice Requirements Before Transfer/Discharge

SE: SS=D: Failed to provide written notification of the reason and location for the facility-initiated transfer for 1 resident placing resident at risk of delayed care or uncommunicated care needs

- Failed to provide written notification of reason & location for facility-initiated transfer for 1 resident placing resident at risk for delayed care or uncommunicated care needs

SE: SS=D: Failed to notify LTC Ombudsman of discharges for 2 residents placing 2 residents at risk for uninformed care choices

- Facility lacked proof facility had sent notice to ombudsman r/t 1 resident's discharge to hospital; SSD stated facility only sent a "Continuation of Stay" form to KDADS offices monthly, listing all residents & if they were still in facility or had moved somewhere else & facility did not have ombudsman & did not send information to them r/t hospitalizations; failed to send notice to LTCO office r/t resident's discharge to hospital placing residents at risk for uninformed decision making for 2 residents

F625 Notice of Bed Hold Policy Before/Upon Transfer

SE: SS=D: Failed to provide a copy of the facility bed hold policy to 1 resident and/or representative, with a written notice specifying the duration and cost of the bed hold, at the time of resident's transfer to the hospital placing resident at risk for impaired rights

- Failed to provide a bed hold policy for 1 resident/representative r/t hospitalization on 1-11-25

F641 Accuracy of Assessments

SE: SS=D: Failed to complete accurate MDS for 1 resident's status r/t admission to hospice services placing resident at risk for inappropriate care planning & care needs

- Sig Change MDS lacked indication resident received hospice services during observation period; failed to accurately document resident's status on MDS for admission to hospice services placing resident at risk for inappropriate care planning & care needs

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to ensure staff assisted1 resident with grooming and face shaving placing resident at risk for impaired dignity, comfort, and a further decline in ADLs

- Observed female resident in hallway & hair matted to right side of head, shirt with food on front & resident's face had long gray whiskers on multiple occasions

F679 Activities Meet Interest/Needs Each Resident

SE: SS=E: Failed to develop and implement individualized activities programming based on resident preferences for the residents on Weekends placing the affected residents at risk for decreased psychosocial well-being, boredom, and isolation

- Resident Council reported activities on weekends inconsistent compared to weekdays & council reported facility lacked staff-led activities on Saturdays & Sundays when direct care staff got busy & w/o activities, weekends were "slow" & staff would often turn on TV for residents on weekend when staff-led activities not held

F684 Quality of Care

SE: SS=D: Failed to follow a physician's order for weekly weights to monitor 1resident for fluid overload placing resident at risk for delay in treatment related to fluid overload and untreated illness

- CP instructed staff to weigh resident weekly; POS for weekly weights along with diuretic daily; MAR lacked evidence staff measured & recorded resident's weight on 6 occasions from 12-19 thru 2-20; record lacked documentation of physician notification weekly weights not obtained & lacked evidence resident refused to be weighed; failed to follow a physician's order for weekly weights to monitor 1 resident for fluid overload placing resident at risk for a delay in treatment related to fluid overload and untreated illness

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

SE: SS=D: Failed to ensure 1 resident's low air-loss mattress was set to the appropriate weight settings per current weight placing at risk for complications related to skin breakdown and PUs

- CP lacked guidance r/t low air-loss mattress settings; POS w/o guidance r/t low air-loss mattress; resident weight 288#'s; observed mattress control panel locked at 400#'s

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=D: Failed to ensure safe care environment r/t 3 residents placing residents at risk for preventable accidents & injuries

- CP documented resident with non-injury fall from bed & was to have perimeter mattress; observed bed lacked perimeter mattress
- CP instructed staff to keep Dycem mat in w/c r/t unwitnessed fall; observed resident in Broda w/o Dycem under resident
- Observed resident with hx of falls w/o call light within reach & w/o foot pedals while being pushed & feet slid on floor as staff pushed resident

F690 Bowel/Bladder Incontinence, Catheter, UTI

SE: SS=D: Failed to assess & maintain urine continence for 1 resident placing resident at risk of embarrassment & complications from incontinence

- MDS documented resident occasionally incontinent of urine with no trial of toileting program or current toileting & always continent of bowel; bladder continency review revealed resident had incontinence 18/30 days; observed resident carrying bag of linens down hallway & bed had large wet area in center of bed; failed to assess causation factors & maintain resident's urinary incontinence placing resident at risk for continued embarrassment & complications of urinary incontinence

F692 Nutrition/Hydration Status Maintenance

SE: SS=D: Failed to address 1 resident's food preferences & dislikes with continued weight loss resulting in significant weight loss of 11.3% in 6 months

- Resident with schizoaffective d/o, bipolar, autistic d/o, insomnia due to other mental d/o's, EPS; 8-23-24 MDS documented resident weighted 165#'s with weight loss & on mechanical soft diet; 11-23-24 MDS indicated resident weighed 159#'s; nutritional assessment documented resident with low BMI & recent weight loss; resident edentulous & reported being "picky eater" at times & assessment lacked food likes & dislikes; CP lacked specific food preferences; EMR intake review documented resident refused breakfast meal 17/20 days, lunch 3/30 days & supper 1/30 days; resident stated does not feel food was appealed to resident but agreed to supplement; failed to assess 1 resident's preferences of diet to address continued weight loss placing resident at risk for continued significant weight loss

F695 Respiratory/Tracheostomy Care & Suctioning

SE: SS=D: Failed to ensure 1 resident's nebulizer mask & nasal cannula were stored in a sanitary manner placing resident at an increased risk for respiratory infection and complications

- Observed resident's nebulizer mask laid directly on bedside table; at bottom of resident's bed sat O2 tank on stand & nasal cannula wrapped around handle; mask & cannula not stored in sanitary manner

F700 Bedrails

SE: SS=D: Failed to assess actual rail being used to assure safety for 2 residents placing residents at risk for accident or injury due to unidentified risks associated with side rail use

- On 02/20/25 at 08:25 AM, observation revealed a half-circle side rail on the upper right and left side of resident's bed with an opening approximately 13 inches wide by 20 inches high. Continued observation and examination revealed the side rail had a piece of canvas material covering 1⁄2 of the height of the rail, however, it was torn and easily movable to allow for a larger opening. The rail was unstable, able to be moved up and down, and back and forth a few inches with slight pressure on the rail; failed to adequately assess 1 resident's actual rail in use to ensure safe openings & failed to assess for the safe use of a side rail prior to placing the side rail on resident's bed placing resident at risk for accident or injury due to unidentified risks associated with side rail use for 2 residents with side rails

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

SE: SS=F: Failed to ensure 1/5 CNAs reviewed had yearly performance evals completed placing residents at risk for inadequate care

- CNA hired 3-6-23 w/o yearly performance eval in record

SE: SS=E: Failed to ensure required annual performance review was completed for 2/5 staff reviewed placing residents at risk of receiving impaired care

- Failed to ensure CNA performance reviewed r/t special needs of resident population as ID'd from facility assessment based on outcome of review placing residents at risk of receiving impaired care

F732 Posted Nurse Staffing Information

SE: SS=C: Failed to maintain posted daily nurse staffing data for required 18 months

- Review of posted staffing sheets from 8-20-23 to 1-02-24 not provided

F744 Treatment/Service for Dementia

SE: SS=D: Failed to provide dementia-related care services for 1 resident to promote resident's highest practicable level of wellbeing placing resident at risk for decreased quality of life, isolation & impaired dignity

- Resident with dementia admitted to memory care unit; observed resident went into other resident's room & dug thru personal items; observed resident left unsupervised close to patio exit doors & upon hearing facility's fire alarm, resident attempted multiple times to open patio door w/o staff supervision; observed resident seated near patio doors w/o staff supervision; observed resident attempted to push thru DR exit doors

F755 Pharmacy Services/Procedures/Pharmacist/Records

SE: SS=E: Failed to ensure controlled substances were accounted for & reconciled between shifts placing residents at risk for misappropriation &/or diversion of controlled substances

- Review of Narcotic Count Sheet on 3 hallways revealed missing signatures for "on" on 19 occasion from 1-1 thru 2-23; & missing signatures for "off" on 33 occasions

F760 Residents are Free of Significant Med Errors

SE: SS=D: Failed to ensure correct use of subcutaneous injection of insulin during observation of administration placing resident at risk of receiving less than ordered dose

- Observed LN administer insulin; LN had dialed pen to 5 units then injected insulin into lower lt abdomen w/o priming pen; LN stated usually primed insulin with 2 units of waste insulin before administration but was nervous & failed to at time of observation;

F761 Label/Store Drugs & Biologicals

SE: SS=E: Failed to appropriately store meds & biologicals when staff ailed to ensure TB test serum was dated after vial opened placing residents at risk for adverse outcomes or ineffective medication regimens

- Failed to ensure TB test serum dated when vials opened placing residents at risk for adverse outcomes of ineffective med regimens

SE: SS=D: Failed to label 3 resident's insulin flex pens with date opened & discard date on 2 med carts placing affected residents at risk for ineffective meds

- Failed to date insulin flex pens when opened & expiration dates placing residents at risk for ineffective medication

F801 Qualified Dietary Staff

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

- Adm reported facility currently w/o CDM

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=F: Failed to follow sanitary dietary standards r/t storage, preparation & meal service placing residents at risk for foodborne illnesses & food safety concerns

- DR closed off to resident r/t construction; observed DR ceiling fixtures hung from ceiling with dust covering tables & floor of DR; no barriers in place between construction area & food prep areas; from 7am to 4pm door between DR leading directly into kitchen's cooking area remained propped open during meal prep for meal prep
- Memory care unit kitchen with opened, undated ice cream
- Observed CNA failed to complete hand hygiene during entire meal service or during assistive feeding

SE: SS=F: Failed to store, prepare & serve food at required serving temps placing residents at risk of unpalatable food & foodborne illness

- Observed dietary staff prepared to serve noon meal & took serving temps revealing pureed turkey at 110 degrees & pureed corn at 115 degrees & staff unaware what holding/serving temps of hot food was; failed to store, prepare & serve food at required temp placing residents at risk unpalatable food & foodborne illnesses

F849 Hospice Services

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

- Failed to ensure coordinated CP which coordinated care & services provided by facility with care provided by hospice placing resident at risk for inappropriate end-of-life care when staff unaware of what care & services hospice provided

F868 QAA Committee

SE: SS=F: Failed to retain evidence of the required Quality Assessment and Assurance (QAA) and Quality Assurance Performance Improvement (QAPI) members attended meetings at least quarterly, placing residents at risk of unidentified quality care services placing residents who resided in the facility at risk for decreased quality of care

- Facility failed to provide QAPI meeting attendance sheets for past year; stated could not find QAA or QAPI meeting sign-in sheets from 2024; failed to retain evidence required QAA & QAPI members attended meetings at least quarterly placing residents at risk of unidentified quality care services

F880 Infection Prevention & Control

SE: SS=E: Failed to ensure the linen cart was covered, and wash clothes were not stuffed in the guard rails outside of resident's rooms, and further failed to ensure all oxygen cannulas and nebulizer masks were stored in a sanitary manner placing residents at risk for infectious diseases

- Observed wash cloths placed in handrails outside resident rooms on 3 hallway
- Observed linen cart with towels, washcloths & bedding left uncovered
- Observed nebulizer mask laid directly on resident's bedside table & nasal cannula & mask unbagged & unlabeled

F882 Infection Preventionist Qualifications/Role

SE: SS=F: Failed to ensure the staff member designated as the Infection Preventionist, who was responsible for the facility's Infection Prevention and Control Program, completed the specialized training in infection prevention and control placing the residents at risk for lack of identification and treatment of infections

- Adm Nurse stated responsible for IPCP but lacked certification as IP & IP starting at facility in a week but presently assumed job & lacked certification

F883 Influenza & Pneumococcal Immunizations

SE: SS=D: Failed to administer, after receiving a signed consent or obtaining informed declinations PCV20 vaccination for 1 resident placing residents at risk for complications r/t pneumonia

- Failed to offer PCV20 after receiving signed consent or obtaining informed declination for 1 resident placing resident at increased risk for complications r/t pneumonia

F941 Communication Training

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

- Facility unable to provide documentation 3 LNs agency staff had completed communication training

F942 Resident Rights Training

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

- Facility unable to provide documentation 3 LNs agency staff completed resident rights training

F943 Abuse, Neglect & Exploitation Training

SE: SS=F: Failed to ensure agency staff receiving required ANE training placing residents at risk for impaired care & decreased quality of life

- Facility unable to provide documentation 3 LNs agency staff completed ANE training

F945 Infection Control Training

SE: SS=F: Failed to ensure agency staff receiving required Infection Control training placing residents at risk for impaired care & decreased quality of life

- Facility unable to provide documentation 3 LNs agency staff completed Infection Control training

F947 Required In-Service Training for Nurse Aides

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

- Records revealed 5/5 CNAs had not completed required in-services in past 12 months

F949 Behavioral Health Training

SE: SS=F: Failed to ensure agency direct care staff had receiving required behavioral health training placing residents at risk for impaired care & decreased quality of life

- Facility unable to provide documentation 3 LNs agency staff completed behavioral health training

March & April, 2025

F550 Resident Rights/Exercise of Rights

SE: SS=D: Failed to show respect & dignity to 1 resident when 2 staff members entered resident's room during cares placing resident at risk for impaired dignity & embarrassment

- Observed 2 CNAs were doing morning cares with resident & resident laid on top of bed, uncovered while staff providing peri-care; privacy curtain in room not pulled; another CNA knocked on resident's door to which CNA in room responded "resident care" & other CNA opened door to resident's room & spoke to staff with door open leaving resident visible to residents or staff in hallway

NE: SS=D: Failed to provide dignified toileting care by leaving curtains and window blinds open for 2 residents during toileting activities, and 1 resident during suprapubic care placing residents at risk for impaired dignity and decreased psychosocial well-being

- Observed 2 CNAs provided incontinent care & brief change w/o drawing curtain or blinds to window which looked out to patio & exit walkway
- Observed 2 CNAs provide toileting assist in BR with BR door open & in visual line of exterior window through which exit & walkway to courtyard; staff failed to close window drapes or window shades
- Observed 2 CNAs positioned resident for catheter care while window blinds ½ up & with visualization of 1 hallway rooms/windows

NE: SS=D: Failed to ensure staff assisted 1 resident with cutting her whiskers per resident's preference placing resident at risk for impaired dignity & decreased psychosocial wellbeing

- Observed resident on multiple occasions with long grey hairs on chin; resident stated does not like chin to have long whiskers; CP lacked direction to staff on assisting with cutting whiskers during bathing

NW: SS=D: Failed to promote dignity for 1 resident whose pajamas were soiled with urine from waist down to back of knees; further failed to promote dignity for 1 resident by taking resident out into common area & into activity in pajamas placing resident at risk for impaired dignity

- Observed resident in bed & CNA swung legs over side of bed; resident w/o socks & bare feet placed on footplate of sit-to-stand mechanical lift; after transfer resident's bed had "chuck" that was heavily soiled with urine & resident's back of PJs soiled with urine clear down to back of knees; after putting on clean brief & clean PJ pants, pushed resident into area by nurses' station for extended period of time; AD asked resident if wanted to participate in music activity & pushed resident into common area with heels dragging on floor & resident lacked any protection on feet; at 12 noon nursing staff entered activity room & took resident to lunch in PJs & resident stated, "but I'm not dressed"; when CNA questioned why resident didn't receive bath as resident had been told, CNA stated "because coworker is lazy"; failed to promote care for 1 resident in manner & environment that maintains & enhances each resident's dignity & respect in full recognition of resident's individuality

NW: SS=D: Failed to provide assist in privacy for 2 residents who wore incontinent briefs, which were visible from hallway to visitors, staff & other residents placing 2 residents at risk for impaired dignity & decreased psychosocial wellbeing

- Observed resident with coughing & gagging into basin in morning, placing leg off bed, had lower portion of body uncovered with brief & legs visible from doorway & hall as staff & visitors walked by; no staff assist until midday meal brought to room & resident not assisted with positioning for meal & resident remained in bed with HOB only raised 30 degrees; continued with leg off mattress & hanging, not touching floor or covered from waist down exposing incontinence brief; observed this exposure on multiple occasions; observed resident with call light not within reach
- Observed resident in bed, covered with blanket, clothing lying on floor & room smelled of urine; observed resident standing with walker wearing only blue incontinent brief & after staff left room, resident walked around room with only incontinent brief & staff & visitors could observed resident wearing only brief as they passed in hallway

F558 Reasonable Accommodations Needs/Preferences

SE: SS=D: Failed to ensure adequate bariatric equipment was available to provide necessary care & promote resident's highest practicable level of function & quality of life for 1 resident; also failed to ensure 1 resident had foot pedals in use on w/c & call light available within reach placing residents at risk for impaired quality f life & health complications r/t unmet needs

- LN stated facility unable to obtain weights for 1 bariatric resident because facility did not have mechanical lift with scale that could accommodate resident's weight; LN stated if staff needed to get resident out of bed & out of room or facility, staff would have to use some sort of gurney but facility did not have one readily available; CNA stated resident receives bed baths twice weekly but resident usually refused; Adm nurse stated when hallway flooded, facility called EMS to get resident moved; failed to ensure adequate adaptive equipment including suitable mechanical lift, & w/c available to provide resident necessary care & promote resident's highest practicable level of function & quality of life placing resident at risk for decreased quality of life & health complications due to unmet needs
- Observed resident's call light clipped to wall in middle of room on multiple occasions; observed CNA pushed resident w/o foot pedals into DR on multiple occasions; failed to ensure 1 resident's call light was within reach & further failed to ensure resident had foot pedals on w/c if staff were pushing resident leaving resident vulnerable to unmet care needs due to inability to call for staff assist & possible injury from falls

NE: SS=D: Failed to ensure 2 residents had a way to communicate needs due to call lights being left out of reach placing residents at risk for preventable accidents & injuries

- Observed resident in bed & call light on floor to side of bed
- Observed resident slept in bed & call light pinned to pillow on recliner across room from bed & out of reach

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

SE: SS=D: Failed to verify 1 resident's advance directives ; additionally, facility failed to ensure resident's DNR was signed by resident with potential to lead to uncommunicated needs specifically to end-of-life care

- CP documented hospice care started with terminal dx; CP documented resident DNR; hospice certificate listed resident as "full code"; POS revealed order for DNR & date unreadable; scanned documented revealed DNR directive signed by physician but not signed by resident or representative; resident stated wanted to be DNR

SE: SS=D: Failed to notify physician when resident had weight gain in 24 hours while on diuretic placing resident at risk for delayed physician involvement & treatment options

- Resident with CHF; CP documented resident's weight monitored daily; POS for daily weight; EMR documented resident gained 4-7 #'s on 5 occasions from 1-21 to 3-31; EMR lacked documentation of physician notification for dates with weight gain noted

NE: SS=D: Failed to notify 1 resident's representative of plan of care changes placing resident at risk of miscommunication between resident/representative & facility

- *Resident with G-tube & anoxic brain damage; POS for ABT for bacterial infection; NN documented resident's abdomen distended & tender; POS instructed staff to hold tube feeding; NN documented resident had swollen abdomen with "huge" palpable mass around PEG tube & area inflamed, warm & tender to touch with pus noted from PEG tube site; physician noted documented resident with persistent vegetative state with total care for PEG tube & cellulitis surrounding PEG with low-grade fever with no evidence of abscess & noted order for ABT; record lacked evidence facility notified representative of new ABT; failed to notify resident's representative of plan of care changes with risk of miscommunication between resident, representative & facility*

NE: SS=D: Failed to notify resident's guardian of discharge & transfer of resident to another facility until after resident's discharge from facility placing resident at risk for further decline & impaired health & wellbeing

- Resident with court-appointed guardian; resident on VA contract; NN documented VA contract would be cancelled on 9-1-25; Guardian gave permission for facility to search for alternate placement; SS staff stated contacted resident's guardian via phone, not email so could not provide documentation; guardian stated would prefer resident go to facility in KC area but SS stated found closer facility that accepted resident on 4-10 but did not notify guardian until 4-14

F582 Medicaid/Medicare Coverage/Liability Notice

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

- ABN form staff provided for 3 residents was CMS-R-131 when residents' skilled services ended

NW: SS=D: Failed to provide 3 residents/representatives the completed CMS ABN Form 10055 placing residents at risk of uninformed decisions about skilled services

- ABN form lacked estimated cost of continued service & resident received wrong form as received CMS-R-131 instead of CMS Form 10055 for multiple residents; failed to provide 3 residents/representatives correct 10055 form which included estimated cost of continued services when discharged from skilled care placing residents at risk of uninformed decisions about services & continuation of skilled services

NW: SS=D: Failed to provide the resident/representative a fully completed ABN Form 10055 for skilled services for 2 residents, which included the estimated cost of services placing residents at risk for uninformed care decisions

- Facility provided CMS Form 10124 to resident instead of 10055 for 2 residents; Adm stated facility stopped using 10055 due to direction from corporate

F584 Safe/Clean/Comfortable/Homelike Environment

NW: SS=E: Failed to provide a safe, functional, sanitary, and comfortable environment for residents who ate in the dining room placing residents who ate in the main dining room at risk for unhomelike, unsanitary conditions

- Observed 2-3 feet of mopboard on 1 end of DR coming away from wall & 6 inches of mopboard lying on floor

F585 Grievances

NE: SS=E: Failed to implement a system to allow residents/representative to file grievances anonymously placing residents at risk for decreased psychosocial wellbeing & unresolved grievance & concerns

- Facility revealed no designated grievance drop boxes or system available in areas accessible to residents & visitors of facility; Resident Council members reported unaware if facility provided a way to complete anonymous grievances & must take grievance to a staff member & staff helped residents fill out grievances & residents could also talk to SS person; AD stated not an anonymous grievance box & residents able to call facility hotline & leave anonymous reports; Adm nurse stated facility w/o anonymous reporting box but had hotline

F600 Free from Abuse & Neglect

NE: SS=J (Removed to G): Failed to prevent the neglect of 1 resident when staff did not provide adequate monitoring and timely care and attention to resident's PEG site, which became infected, resident's abdomen became swollen and inflamed, and right lower abdomen developed darkening, which staff documented as bruising. On 02/18/25 at 05:34 AM, resident had a swollen abdomen and a large palpable mass around the PEG tube, with pus noted coming from the site. Staff notified physician, who assessed resident, and a note at 08:40 AM documented resident had cellulitis surrounding resident's PEG tube site with the skin indurated and erythematous . Six days later, on 02/24/25 at 12:13 PM, LN documented resident's PEG tube balloon appeared displaced and noted bruising around resident's right lower abdomen. LN documented a new PEG tube was placed with a KUB x-ray ordered. LN documented leaving a message for Consultant with the KUB results. On 02/25/25 at 05:59 AM, LN documented resident continued on an antibiotic for bacterial infection, Resident's right side of her abdomen remained very swollen, inflamed, had blisters, the PEG tube stoma size increased and the inflated balloon was visible. At 06:52 AM, LN notified Consultant that no new orders were received. On 02/25/25 at 10:15 AM, LN documented resident's PEG site was very inflamed with bruising noted from the PEG tube site across resident's left breast and down her left side to her hip. LN notified Consultant & received an order to send resident out to the hospital. Resident died at the hospital the same day. The facility's failure to ensure resident remained free from neglect placed resident in Immediate Jeopardy.

- *Failed to provide necessary monitoring & treatment for 1 resident's PEG tube complications which included abdominal distention, redness & swelling at PEG tube site & discoloration of resident's abdomen; resident transferred to hospital where resident died same day placing resident in immediate jeopardy*
- *Plan of Removal:*
  - *Educated all LN in in-service provided by Adm nurse prior to next scheduled shift on PEG tubes, notification or changes & ANE*
  - *Adm Nurse rounded on all 23 residents with PEG tubes to ensure proper placement*
  - *Adm Nurse/designee rounded daily using "PEG Tube Nursing Audit Tool"*
  - *Adm Nurse reviewed information from audits & reported findings to QAA Committee quarterly*

F602 Free from Misappropriation/Exploitation

SS=E: Failed to ensure residents with trust accounts managed by the facility remained free from misappropriation when Administrative Staff misappropriated funds from the resident trust fund account placing all residents with trust accounts managed by the facility at risk for misappropriation, financial instability, and impaired rights

- *Facility's undated Resident Funds Management Systems Investigation documented facility initiated investigation after finding credit card fraud on company credit card attributed to Adm staff (not Administrator of facility); facility noted several large checks from resident funds account written to Adm staff member with withdrawals not matching up with written checks; Corporate staff conducted audit of fund account & ID'd several withdrawals from 3 resident accounts w/o receipts signed by residents; also noted several checks written out of trust fund account not attached to any specific resident; Adm staff came to facility to give account of discrepancies & unable to remember details but stated money was accounted for; facility placed staff member on suspension pending further investigation; Adm staff member resigned from facility effective immediately; facility reimbursed missing funds to resident trust account & notified law enforcement & SA; failed to prevent misappropriation of resident trust funds from resident trust account & from 3 residents' trust accounts placing all residents with trust accounts managed by facility at risk for misappropriation, financial instability & impaired rights*

F607 Develop/Implement Abuse/Neglect Policies

NW: SS=D: Failed to conduct a criminal background check as required for one facility employee. The employee was allowed access to residents without knowing if they had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law placing affected residents at risk for abuse, neglect, misappropriation, or mistreatment

- Facility unable to provide evidence CBC completed for maintenance staff who had worked at facility since 5-21-2020; failed to conduct a criminal background check as required for 1 Maintenance Staff prior to employment at the facility. The employee was allowed access to residents without knowing if they had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law placing affected residents at risk for abuse, neglect, misappropriation, or mistreatment

NW: SS=E: Failed to conduct a criminal background check as required for one facility employee. The employee was allowed access to residents without knowing if they had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law placing affected residents at risk for abuse, neglect, misappropriation, or mistreatment

- Facility unable to provide evidence CBC completed for 1 CMA who worked at facility since 8-29-24

F609 Reporting of Alleged Violations

NE: SS=D: Failed to report the suspicion of misappropriation of resident funds to the State Agency (SA) and law enforcement within the required timeframe placing all residents with trust accounts managed by the facility at risk for unidentified and ongoing misappropriation

- *Cited findings noted in F602 r/t misappropriation of resident funds r/t administrative staff member; Adm started investigation on 12-11-24 & had corporate staff help with investigation who started investigation on 12-17-24; facility started writing new policies on 12-19-24; alleged perpetrator quit on 12-30-24; ; on 2-27-25 Adm stated after audit facility reported incident to SA; failed to report suspicion of misappropriation of resident funds to SA & law enforcement within required timeframe placing all residents with trust accounts managed by facility at risk for unidentified & ongoing misappropriation*

NW: SS=D: Failed to immediately report to the nurse in charge an incident between 2 residents placing 1 resident at risk for ongoing abuse and/or mistreatment and a lack of adequate supervision

- Resident with moderately impaired cognitive function with extensive assist with ADLs with no behaviors & received antidepressants, antipsychotics & opioids; resident with supervised smoking breaks & staff assisted with smoking & wore smoking apron; NN documented CMA reported to charge nurse that another resident made contact with open hand to resident's shoulder just prior to smoke break in attempt to move resident out of way; CMA separated residents; no assessed injuries; Adm stated on 3-14-25 at 8pm resident was hit on shoulder by another resident & CMA stated residents were friends so though it was "no big deal" & CMA failed to report it until 9:45 pm; Adm stated CMA failed to report incident to nurse in charge immediately

F623 Notice Requirements Before Transfer/Discharge

SE: SS=D: Failed to ensure that written notification of transfer provided to 1 resident included required information; failed to ensure staff provided written notification of transfer as soon as practicable to resident's representative placing resident at risk for uninformed care choices

- "Notice of Resident Transfer/Discharge to Alternate Healthcare Setting" not provided to resident/representative for discharge from 7-22-24 to 7-27-24; "Notice of Resident Transfer/Discharge to Alternate Healthcare Setting" form dated 8-1-24 lacked reason for transfer or discharge & notice not mailed & provided to resident's representative as required; "Notice of Resident Transfer/Discharge to Alternate Healthcare Setting" dated 9-6-24 lacked reason for transfer or discharge & not mailed & provided to resident's representative as required; "Notice of Resident Transfer/Discharge to Alternate Healthcare Setting" dated 3-1-25 lacked reason for transfer or discharge & not mailed & provided to resident's representative as required; failed to ensure that written notification of transfer provided to 1 resident included reason for transfer; failed to ensure staff provided written notification of transfer as soon as practicable to representative placing resident at risk for uninformed care choices

NE: SS=D: Failed to notify State LTC Ombudsman of facility-initiated transfers or discharge for 1 resident with risk of miscommunication between facility & resident or representative & possible missed opportunities for healthcare services for 1 resident & placed resident at risk for impaired rights

- Facility lacked documentation LTC Ombudsman had been notified of resident's discharge or transfer on 1-9-25 to hospital

NE: SS=E: Failed to provide written notice for a facility-initiated transfer for 4 residents/representatives when residents were transferred to hospital; facility also failed to notify Office of LTC Ombudsman of 4 residents placing residents at risk for uninformed care choices & impaired rights

- Record lacked evidence resident/representative was provided a written notice or LTCO was notified of hospital transfer; SS stated had not provided resident/representative with notice of transfer & had not notified LTCO of hospital transfer for 4 residents

NW: SS=D: Failed to notify LTC Ombudsman (LTCO) for 2 residents' facility-initiated discharge to hospital placing both residents at risk for impaired rights

- Record lacked documentation that staff notified LTCO of resident's discharge from facility; Adm stated unaware needed to send information to LTCO; failed to notify LTCO of 2 residents' facility-initiated discharge to hospital placing resident at risk for impaired rights
- Failed to provide required written notification of transfer to 1 resident/representative for facility-initiated discharges on 12-12-24 & 1-12-25 including reason for transfer; effective date of transfer, specific location of transfer, explanation of right to appeal transfer to state; name, address & telephone number of state entity which receives appeal requests; name, address & phone number of LTCO & notice must be provided to resident & representative as soon as possible

NW: SS=D: Failed to notify the Office of the Long-Term Care Ombudsman (LTCO) of 1 resident's discharge placing residents at risk for uninformed care choices

- NN documented resident admitted to hospital; record lacked evidence LTCO notified of resident's hospital transfer

NW: SS=D: Failed to notify State LTCO of 1 resident's discharge to hospital placing resident at risk for impaired rights

- NN documented resident hospitalized for fall to out-of-town hospital after dx'd with fx'd hip; Record lacked documentation/evidence staff notified LTCO of resident's discharge from hospital

F625 Notice of Bed Hold Policy Before/Upon Transfer

NE: SS=E: Failed to provide 1 resident a Bed Hold notice when he was hospitalized placing resident at risk of not being permitted to return & resume residence in nursing facility

- Record lacked Bed Hold notice for resident's hospitalization

NE: SS=E: Failed to provide 4 residents with written information r/t facility bed hold policy when residents were transferred to hospital placing residents at risk for not being permitted to return & resume residence in nursing facility

- Record lacked evidence copy of bed hold policy was provided to resident/representative when resident transferred to hospital for 4 residents; SS stated had not provided residents/representatives with written bed hold notice when resident went to hospital

NW: SS=D: Failed to provide 2 residents with written information r/t the facility bed hold policy when residents were transferred to the hospital placing resident at risk of not being permitted to return and resume residence in the nursing facility

- Facility lacked evidence of signed bed hold policy notice that had been verbally acknowledged, provided or signed by resident/representative when residents admitted to hospital; failed to provide 2 residents/representatives with copy of facility bed hold policy when residents transferred to hospital placing resident at risk of not being permitted to return & resume residence in nursing facility

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

- Record lacked evidence copy of bed hold policy was provided to resident/representative when resident transferred to hospital

NW: SS=E: Failed to provide 4 residents a Bed Hold notice when the residents were hospitalized placing 4 residents at risk of not being permitted to return and resume residence in the nursing facility

- SSD verified facility had not provided Bed Hold Notice to residents/representatives upon discharge to hospital & only provided Bed Hold Notice upon admission to facility for 4 residents

NW: SS=D: Failed to provide 2 residents with written information r/t facility bed hold policy when resident transferred to hospital placing residents at risk of not being permitted to return & resume residence in nursing facility

- Record lacked bed hold policy for 2 residents when residents hospitalized

F636 Comprehensive Assessments & Timing

SE: SS=E: Failed to complete comprehensive MDS for 6/6 residents when staff failed to ensure triggered CAAs were completed as requires placing residents at risk for unmet care needs & inaccurate assessments

- 6 residents' MDS lacked completion of triggered CAA as required

F641 Accuracy of Assessments

SE: SS=D: Failed to complete MDS for 1 resident within required timeframes placing resident at risk for unidentified care needs & inadequate CP

- EMR documented resident with schizoaffective d/o & mood d/o, irritability & anger, seizure d/o, PTSD, anxiety, insomnia & depressive d/o; Admission MDS with PHQ-9 with score of 1 indicating no depression; no behaviors documented; resident took antidepressant & anticonvulsant; quarterly MDS not completed

F655 Baseline Care Plan

SE: SS=D: Failed to address catheter care on 1 resident's baseline CP with risk for adverse outcomes & complications for resident due to uncommunicated care needs

- Baseline CP lacked documentation that resident had catheter or instructions on catheter care

SE: SS=D: Failed to address necessary dialysis assessments, care & services on 1 resident's baseline CP with risk of adverse outcomes & dialysis complications for 1 resident due to uncommunicated care needs

- Baseline CP lacked documentation that resident received dialysis or any direction for dialysis care & services

F656 Develop/Implement Comprehensive Care Plan

SE: SS=D: Failed to develop a comprehensive care plan for 1 resident which included individualized, person-centered interventions for her trauma-based care. The facility also failed to develop a comprehensive care plan for 1 resident which included individualized person-centered intervention for his activities placing residents at risk for impaired care due to uncommunicated care needs

- Resident with PTSD; CP lacked individualized triggered-specific interventions that ID'd ways to decrease exposure to triggers which could re-traumatize resident; staff unaware resident had PTSD; SS staff stated last Trauma Informed Care assessment completed 2-26-20; staff reported resident frequently yelled out; failed to develop a comprehensive CP for 1 resident which included individualized person-centered interventions for resident's PTSD placing resident at risk for impaired care due to uncommunicated care needs and re-traumatization
- CP lacked person-centered activities for 1 resident; Activity Participation lacked documentation of any activity participation; failed to ID & create person-centered comprehensive CP that included meaningful activities for 1 resident placing resident at risk for decline in physical, mental & psychosocial wellbeing & independence

SE: SS=D: Failed to complete a comprehensive CP for 1 resident sampled to include staff instruction for use of foot pedals while propelling resident in w/c

- CP lacked instruction to staff on applying foot pedals when being propelled; quarterly MDS documented resident with no impairment in functional ROM & was independent with w/c for locomotion; observed resident being pushed by SS staff

NE: SS=D: Failed to develop a plan of care, & implement skin care interventions for 1 resident who developed a Stage 2 PU placing 1 resident at risk for pain, complications, and possible infection associated with PUs

- CP lacked care area for skin care & PU prevention; CP not revised with interventions after development of Stage 2 PU; documentation indicated resident developed facility-acquired stage 2 PU

NE: SS=D: Failed to develop a comprehensive CP with resident-centered interventions to prevent PUs for 1 resident placing resident at risk for unmet care needs & skin breakdown

- Resident at risk for skin breakdown; POS for heel protectors; resident with wound treated by wound clinic; CP lacked care area with interventions for skin breakdown

F657 Care Plan Timing & Revision

SE: SS=D: Failed to revise 1 resident's CP to reflect visitation requirements & 1 resident's fall interventions placing residents at risk for impaired care due to uncommunicated care needs

- CP failed to reflect incident when visitor was physically aggressive with resident then placed on restricted visitation then resident requested visitor not allowed to visit; failed to revise 1 resident's CP to reflect visitation requirements placing resident at risk for impaired quality of life & safety concerns

NW: SS=D: Failed to implement effective CP interventions for 1 resident from falling & sustaining major injuries placing resident at risk for continued falls & injuries

- 4-9-24 NN documented resident found in room, lying on side on floor with walker parked against BR door & resident c/o hip pain & with skin tear to elbow; resident sent to ER; CT revealed displaced fx's of superior & inferior pubic ramus; 6-28-24 NN documented resident found on side with bleeding to hand which required stitches in 2 fingers & intervention was to remind resident to call for assist when getting up & X-ray revealed hand with nondisplaced fx at base of 4th digit & questionable non-displaced fx at base on 3rd digit; resident with multiple other falls resulting in injury; failed to implement effective CP interventions for 1 resident from falling placing resident at risk for continued falls & injuries

NW: SS=D: Failed to revise 1 resident's CP to include physician-ordered fluid restriction placing resident at risk of fluid overload & unmet care needs

- CP lacked physician-ordered fluid restriction

F676 Activities of Daily Living (ADLs)/Maintain Abilities

SE: SS=D: Failed to ensure 1 resident was provided a touch pad call light placing resident at risk of unmet care needs & inability to call for assist if needed

- Resident with cerebral palsy; dependent on staff for ADLs; CP documented staff would provide resident with mechanical pad call light; observed resident's bed elevated with rails up bilaterally & push button call light attached to bed rail & hung off bed out of resident's reach & resident's bilateral hands clenched tightly closed with no palm grippers in place & resident's low air-loss mattress unplugged from wall & not working; staff stated resident could not operate push call light; failed to ensure resident had touch pad call light placing resident at risk of uncommunicated needs & ability to call for assist

NW: SS=D: Failed to provide meal assist for 1 resident who required assistance placing resident at risk for further weight loss

- CP documented resident may need assist of 1 staff with eating depending on how resident felt that day & directed staff to offer assist if resident had trouble unwrapping food & drinks & monitor weight closely for gain or loss; EMR lacked documentation of how often to weight resident; resident with 12.07% weight loss in 30 days; EMR lacked documentation RD notified of continued weight loss; MAR lacked documentation that supplement provided to resident; resident admitted to hospice; observed resident in DR leaning causing resident to be lower than table; resident tried to adjust to get closer to table then CDM cut up resident's meat as resident continued to lean & resident reached for food but it was out of reach then tablemate assisted resident to reach food items; resident unable to pick up drink; next day resident in room with room tray & stated to surveyor could not reach food items; failed to provide meal assist for 1 resident who required assist placing resident at risk for further weight loss

F677 ADL Care Provided for Dependent Residents

SE: SS=E: Failed to ensure staff provided consistent bathing to 4 dependent residents per preferred preferences

- CP lacked staff direction on preferred bath/shower days; resident stated got bed baths or shower at least once weekly but sometimes it was longer in between them & resident stated knew that facility was short of staff & would not always get bath cone as resident required more help bathing than some other residents; failed to ensure staff provided consistent bathing to dependent resident per resident's preferred bathing preferences placing resident at risk for skin breakdown & possible injury/infection
- Failed to provide consistent bathing opportunities for 1 resident placing resident at risk for impaired psycho-social wellbeing & skin breakdown
- Observed resident in bed with hair greasy & wore hospital gown with food stains on front of gown; failed to provide consistent bathing for 1 resident who required assistance with bathing placing resident at risk for complications r/t poor hygiene & impaired dignity
- 1 resident's record lacked evidence resident offered or refused care during 82 days reviewed; observed resident with hair oily & resident with body odor noted & bilateral hands clenched tightly closed w/o any type of contracture prevention device; failed to provide consistent bathing for 1 resident who was dependent on staff for bathing placing resident at risk for poor hygiene, skin breakdown, decreased self-esteem & dignity

SE: SS=D: Failed to recognize, assess & implement interventions consistent with 1 resident's current level &/or mode of assistance required for transfers placing resident at risk for injury & further ADL decline

- EMR lacked staff documentation of assistance required to transfer resident; observed 2 CNAs transferred resident from w/c to recliner using gait belt & transferred resident with total assist of both staff as resident unable to bear weight on either leg during transfer & feet not flat on floor

SE: SS=E: Failed to provide necessary ADL cares for 4 sampled residents as 1 resident was not shaven, 1 resident had dirty clothes, 1 resident did not get showered, and 1 resident received no feeding assistance. This deficient practice placed the affected residents at risk for impaired quality of life, weight loss and poor hygiene

- Record revealed resident with 4 showers with no other opportunities documented; observed resident unshaven in DR; LN stated twice weekly showers but this had not been happening due to not enough staff
- Observed resident at activity & resident with large wet area on front of shirt for prolonged period
- Observed resident unshaven & hair greasy & dirty
- Resident with maximal assist with eating; observed resident no staff assisted resident with meal at multiple meals

NW: SS=D: Failed to provide ADL support for 2 residents who required assist from staff placing residents at risk for ongoing unmet needs & care

- On 04/21/25 at 02:33 PM, ongoing observations revealed resident had coughing & gagging into a basin in the morning, placing left leg off the bed, had the lower portion of her body uncovered with a brief, & legs visible from the doorway & hall as staff and visitors walked by; no staff assistance until the midday meal was brought to her room; resident was not assisted with positioning for the meal, resident remained with the head of the bed, & was only raised 30 degrees; resident's plate & drinks were uncovered & left on the overbed table; resident lacked assistance with positioning in bed, remained with head of the bed lowered, ate a few bites, and coughed; at 03:01 PM, R44 continued with left leg off the mattress & hanging, not touching floor or covered from the waist down, exposing incontinent brief, which was visualized from the hallway; staff entered room and told resident her leg was hanging, & assisted resident in putting leg into the bed & covered resident; at 03:45 PM, resident had left leg off side of the bed & lower body, & an incontinent brief was exposed to staff, visitors, & other residents from the hallway; resident called out for assistance; resident stated could not find call light and needed O2 canula; SSD entered room, found resident's call light, which had been off to the right side of bed, not within reach of resident & provided resident with O2 tubing; similar incidents occurred multiple occasions; cited findings noted in F550
- CP lacked physician-ordered fluid restriction; observed resident in bed, covered with blanket, clothing ling on floor & room smelled of urine; cited findings noted in F550

F678 Cardio-Pulmonary Resuscitation (CPR)

NE: SS=E: Failed to establish and maintain a system to ensure nursing staff maintained current CPR certification for healthcare providers placing residents who desired CPR if needed at risk for inadequate resuscitative measures

- Facility unable to provide verification of CPR certification for staff members on evening & night shifts as requested

F679 Activities Meet Interest/Needs Each Resident

SS=E: Failed to provide consistent weekend activities placing affected residents at risk for decreased psychosocial wellbeing

- Review of 3 months' activity calendars revealed weekend activities of movie matinee & residents' choice; Resident Council reported activities rarely occurred on weekends & movie matinees upstairs on AL floor & residents would like activities on weekends with interactive groups & would like to have staff lead activities; failed to provide consistent activities for residents during weekends placing affected residents at risk for decreased psychosocial wellbeing

F684 Quality of Care

SE: SS=D: Failed to ensure 1 resident had adequate care when facility did not monitor resident's weights & notify provider of weight fluctuations as ordered placing resident at risk for health complications

- CP instructed staff to notify physician of 3# weight gain in 1 day or 5#'s in 3 days; EMR documented resident with 6 occasions when weight outside parameters w/o physician notification from 2-1-25 thru 4-14-25; observed resident with edema in both legs & wore compression socks

NE: SS=D: Failed to ensure physician order followed for daily weights for 1 resident to monitor for CHF; failed to ensure physician order was followed to wrap 1 resident's bilateral lower extremities placing residents at risk for delayed treatment & untreated illness

- POS for 2-gm sodium diet & 2000 ml fluid restriction due to CHF; EMR lacked documentation or monitoring of fluid restriction; Adm nurse stated new diet & fluid restriction order entered into EMR incorrectly & overlooked
- Resident with CHF, dementia; resident with indwelling catheter; POS for daily weight with notification parameters & 2 diuretic meds ordered; during 103 day period, record lacked evidence staff measured weights as ordered; record lacked evidence physician notification daily weights not obtained or refused
- Resident with lymphedema, DM, anxiety, edema; POS for heel protector boots when in w/c or bed; pressure-reducing device while in chair/bed; compression socks or tube grips on legs; observed resident in w/c w/o tubi-grips applied to legs but had ace wraps on legs…not as physician ordered tubi-grips

NW: SS=G: Failed to ensure 1 resident received treatments and care in accordance with professional standards of practice. On 03/22/25 at 10:30 AM, CMA assisted resident in undressing in the bath spa and noted extensive purple/black bruising to resident's bilateral axilla, bilateral arms, torso, and back. CMA reported LN, who assessed resident & documented the extensive bruising. LN then reported the findings to the nurse manager on duty; neither LN reported resident's extensive bruising to resident's primary care physician even though resident was on Coumadin for anticoagulation and per facility protocol, staff were to notify the primary care physician of any resident who was on an anticoagulant of signs of excessive bruising before the next scheduled dose of Coumadin would be given. Facility staff gave resident 3 more doses of Coumadin 5 milligrams (mg) on 03/22/25 at 05:00 PM, 03/23/25 at 05:00 PM, and 03/24/25 at 05:00 PM. This deficient practice placed resident at risk for complications for bleeding, falls with injury, and possible death

- *Failed to ensure 1 resident received treatments & care in accordance with professional standards of practice placing resident at risk for complications for bleeding, falls with injury & possible death*

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

SE: SS=D: Failed to ensure staff set the appropriate weight for 1 resident's low air-loss mattresses and failed to ensure 1 resident's low air-loss mattress was plugged in and functioning placing both residents at risk for complications r/t skin breakdown & PUs

- Resident's low air-loss mattress set to 400#'s on multiple occasions
- CP documented low air-loss mattress placed on resident's bed; record lacked documentation of monitoring mattress function; observed bed 3 ft off floor & low air-loss mattress unplugged from wall & not functioning

NE: SS=G: Failed to act upon an identified risk for PUs and implement preventative interventions for 1 resident who had edema in leg and required staff assistance with ADLs. Subsequently, resident developed a Stage 3 PU right heel. The facility then failed to involve the RD for nutritional recommendations to promote wound healing, and also placed the resident at risk for delayed healing or worsened wounds

- MDS indicated resident not on turning or repositioning program & w/o skin breakdown on admission MDS; resident at risk for skin breakdown r/t incontinence & bed mobility; resident with severely impaired cognition; on 4-8-25 sig change MDS documented stage 3 PU; CP continued to lack interventions to prevent skin breakdown; resident referred to wound clinic; POS for heel protectors; EMR lacked documentation RD notified after resident developed skin breakdown & record lacked evidence of RD evaluation or recommendation from 3-20-25 thru 4-15-25; observed resident w/o protective boots on

NE: SS=E: Failed to follow preventative wound care practices related to 2 residents' low air-loss mattress settings. The facility additionally failed to float 2 residents' heels per their wound care interventions. This deficient practice placed both residents at risk for complications related to skin breakdown and pressure ulcers

- CP lacked documentation r/t low air-loss mattress setting or care instructions; resident weighed 190.2# & mattress pump set to 450# on multiple occasions
- CP lacked instructions for low air-loss mattress setting or care instructions; Resident weight documented at 130.4# & observed mattress setting on multiple occasions at 350#
- POS for pressure-reducing boots bilaterally while in bed; observed resident in bed with HOB elevated & mattress slid forward & was bending back toward resident & resident's bilateral heels pressed against bent portion of mattress w/o any pressure-reducing devices

- POS for wound treatment to foot incision from toe amputation & pressure-reducing device to bilateral extremities while in chair or bed & to offload bilateral extremities or apply soft boots to bilateral extremities for pressure relief; observed resident in bed lying directly on mattress & heels not offloaded & resident w/o soft boots to feet on multiple occasions

NE: SS=G: Failed to identify timely and prevent PU for dependent resident who developed a sacral wound which was not identified until 4 days after admission placing resident at risk for harm, including pain, potential infection & worsening of overall condition

**Resident with hemiplegia, hemiparesis following CVA, Parkinson's disease, seizures, dementia; BIMS of 5; incontinent of bowel & bladder, dependent on staff for ADLs; MDS documented 1 stage 3 PU; CP lacked documentation of any specific information &/or tx for resident's stage 3 sacral wound or other skin disruptions; Admission Assessment documented resident with excoriation to groin & abdominal fold, chest surgical incision & sheering to inner buttock; Admission Assessment lacked any detailed information r/t groin excoriation, chest surgical incision &/or inner buttock sheering; eval did not record stage 3 sacral wound; POS for Zinc barrier cream on 2-14-25 then revised on 2-18 after wound care team's evaluation on 2-18 to include cleansing sacral wound with wound cleanser, patting dry & applying zinc barrier cream q day & night shift; NN from admission on 2-14 thru 2-18 lacked documentation of assessment &/or care provided for resident's stage 3 sacral PU; Wound notes on 2-18 documented active stage 3 PU with descriptions; skin observation on 2-28 documented "no skin issues"; no Braden scores before 3-7-25; Adm nurse unaware of delayed assessment for resident; failed to timely identify & prevent a PU for 1 resident who was admitted to facility on 2-14 with cognitive & mobility deficits; subsequent wound assessment on 2-18 revealed resident with stage 3 sacral PU & surrounding deep tissue injury placing resident at risk for pain, infection, & complications r/t skin breakdown*

NE: SS=D: Failed to recognize or address the potential for developing a pressure ulcer; failed to ID risks, develop a CP, & failed to implement interventions when 1 resident developed at Stage PU placing resident at risk for pain, complications, & possible infection associated with PUs

- Resident with DM, schizoaffective d/o, COPD; independent with ADLs; with pressure-reducing device for bed; POS for tx orders for PU & nutritional supplements for wound healing

NW: SS=D: Failed to prevent the development of a Stage 3 PU for 1 resident who had edema in legs; also failed to implement interventions to prevent further breakdown and follow the CP to wear pressure-relieving boots at all times, placing resident at risk for further breakdown

- NN documented resident developed blister then eschar on heel with physician note that resident in bed more recently causing breakdown; wound care notes with wound treatment including get cushion to foot; EMR lacked documentation that order implemented; observed staff transfer resident with mechanical lift w/o foot protection; failed to prevent development of stage 3 for resident with edema in legs; also failed to implement interventions to prevent further breakdown & follow CP to wear pressure-relieving boots at all times placing resident at risk for further breakdown

F688 Increase/Prevent Decrease in ROM/Mobility

SE: SS=D: Failed to ensure 1 resident was provided services and treatment to prevent worsening of contractures in resident's left hand placing resident at risk for discomfort and decreased range of motion

- CP instructed staff to apply palm grips on bilateral hands & resident to wear palm grips 4-6 hrs/day, 7 days/wk; CP instructed staff to monitor skin integrity, pain & circulation & staff to provide passive ROM to UEs with stretching, flexion & extension of digits, wrists & shoulders with restorative program up to 15 minutes per day up to 7 days/wk; EMR lacked documentation of nursing restorative program & application of palm grippers; observed resident in bed with bilateral hands clenched tightly closed w/o any type of contracture prevention device on multiple occasions; staff stated therapy would apply palm grippers

SE: SS=D: Failed to perform restorative cares for 3 residents & failed to properly position 1 resident while in Ger-chair

- CP instructed staff to perform restorative cares with specific exercises & times; EMR from 2-1-25 thru 4-22-25 revealed restorative cares had not been completed; observed resident in DR in Geri-chair & bilateral feet dangled above DR floor by several inches w/o support
- Resident with restorative nursing plan in CP; EMR from 2-1-25 thru 4-22-25 revealed resident received restorative cares for 12 days in Feb, 8 days in March & 1 day in April; on other restorative cares documented; staff stated resident was to receive daily restorative cares but was not getting it daily
- Resident with restorative plan in CP; EMR revealed resident had not received restorative cares

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=D: Failed to ID & implement interventions to prevent falls for 1 resident placing resident at risk for ongoing falls & injuries

- EMR & CP lacked updated interventions to prevent further falls for multiple falls; facility failed to provide fall management program policy

SE: SS=D: Failed to ensure safe environment free from accident hazards for 1 resident when staff failed to have foot pedals in place when staff propelled resident in chair placing resident at risk for avoidable accidents

- Cited findings noted in F656 r/t lack of foot pedals on 1 resident's w/c & observed staff pushing resident in w/c w/o foot pedals

NE: SS=D: Failed to ensure environment free from chemicals & hazards for 4 cognitively impaired, independently mobile residents who resided in facility

- Observed unlocked housekeeping room on 1 hallway with accessible hazardous chemicals

NE: SS=D: Failed to ensure safe care environment free from potential hazards r/t following 3 resident's implemented fall interventions placing residents at risk for preventable falls & injuries

- Resident at high risk for falls; CP intervention included for Dycem under w/c cushion & anti-rollback device on w/c; observed resident in w/c with no anti-rollback device & no Dycem on multiple occasions
- Resident with hx of falls with CP interventions including fall mat; observed resident in bed with fall mat propped up against wall by dresser on multiple occasions
- Resident with hx of falls with CP interventions including keeping bed in low position; observed resident with bed elevated & not in low position on multiple occasions

NE: SS=G: Failed to investigate, determine causative factors, and implement relevant interventions to prevent further falls for 1 resident, after resident was found lying face down on the floor, at the bedside, on 11/08/24. Subsequently, resident had another fall from the bed on 04/10/25, which resulted in a left femur fracture and placed the resident at risk for further injuries and related pain

- *Resident with Lewy body dementia, benign brain neoplasm, malignant neoplasm of parietal lobe; restless leg syndrome; high fall risk & hx of falls; CP lacked evidence of additional fall interventions r/t fall that occurred on 11-8-24 which resulted in femur fx except for admission to hospice; resident with another fall on 4-10-25 resulting in resident sent to ER per hospice order & returned next day with dx of lt femur fx & blood clots; facility unable to provide investigation r/t resident's fall on 11-8-24*

NW: SS=D: Failed to prevent 1 resident from falling & sustaining major injuries with ineffective interventions placing resident at risk for continued falls & injuries

- Cited findings noted in F657 r/t resident with multiple falls with major injuries; resident with multiple falls, multiple resulting in fx's; failed to prevent 1 resident's falls which resulted in pelvic & finger fx's with ineffective repeated interventions placing resident at risk for continued falls & injuries

NW: SS=D: Failed to thoroughly investigate the causative factor to prevent further falls for 1 Resident after resident slid out of w/c placing resident at risk for injuries related to falls. The facility failed to promote environment free of hazards for 1 resident who smoked cigarettes but lacked smoking assessment since admission to facility placing resident at risk for avoidable injuries & fire-related hazards

- Resident with IDD, epilepsy, anxiety, restless leg syndrome; risk for falls with hourly safety checks; NN documented resident in w/c & 2 staff found resident face down on floor with w/c beside resident; Risk Evaluation documented resident's fall but lacked witness statement & lacked viewing of camera footage to see if anyone walked into room when resident had fall; failed to provide information & investigations that addressed causative factor to prevent further falls for resident after resident slid out of manual transport w/c placing resident at risk for injuries r/t falls
- Resident with CVA, nicotine dependence & generalized muscle weakness; CP documented resident with contractures of rt hand; smoking CP documented resident independent with tobacco products & would sign self out of building, off property through back door & smoke 5x/day; CP documented resident's cigarettes kept a nurses' station; Adm nurse verified resident admitted to facility in April 2024 & previous DON allowed resident to go outside & smoke & verified facility was smoke-free facility & resident had to go off premises to smoke & resident would go smoke behind facility where shed located or next door at city park; staff verified resident w/o smoking assessment completed until first day of survey 3-3-25; failed to assess & promote safe environment for 1 resident & all residents residing in facility placing residents at risk for smoke or fire

NW: SS=G (Past Non-compliance): Failed to ensure an environment free from accident hazards when staff left an unlocked shower door open on 1 hallway and 1 resident entered, fell, and sustained a fractured wrist placing residents at risk for preventable accidents or injuries

- NN documented resident asked for a bath on a day hospice not present to give bath & nurse told resident staff were busy at the time, but would get someone to assist resident when things were "less busy"; at 10pm nurse walked down hall & heard someone calling out from shower room; nurse entered shower room & observed resident sitting on buttocks, naked on floor with legs crossed; resident told nurse "this wrist is broken" & wrist was swollen & deformed; resident stated "I just opened the door"; resident transported to hospital due to fx'd wrist; investigation revealed shower door not completely closed & resident able to enter on own; Adm verified did investigation but did not report to state due to resident able to state what happened
- Plan of Removal:
    - Education r/t shower room doors: assuring shower room doors closed & locked at all times for resident safety
    - Added self-locking number pad lock to shower doors, added self-closure to shower door, added self-closure springs to door hinges as added security & back up & purchased & attached self-closures to utilize in place of hinge springs for added protection & back up & was completed

F690 Bowel/Bladder Incontinence, Catheter, UTI

SE: SS=D: Failed to provide timely incontinent care to 1 resident to prevent an incontinence episode during the lunchtime meal in the DR, which left a puddle of urine on the floor by the resident. This failure placed the resident at risk for potential negative psychosocial well-being, due to embarrassment and frustration. The facility staff also failed to ensure they educated 1 resident regarding keeping the urinary catheter bag below the level of the bladder, in order to prevent the potential infection control issue, which could lead to urinary tract infections

- Observed resident in bed asleep with catheter collection bag on side of bed above level of bladder & urine pooled in tubing of catheter; observed resident in w/c in hallway & catheter bag off armrest on side of w/c & urine pooled in tubing; observed resident in w/c in hallway & catheter bag hung off side of handrail of w/c above bladder level until resident returned to bed to rest after meal
- Observed resident sat in DR & incontinence left puddle of urine on floor in area where other residents were eating meal; CNA stated resident should be toileted before meals

NE: SS=D: Failed to ensure the standard of care was provided for 1 resident who had a history of UTI when resident's catheter drainage bag laid directly on the floor. This deficient practice placed resident at risk of catheter-related complications and further UTIs

- Resident with indwelling catheter for neuromuscular dysfunction of bladder; recent hx of UTI tx'd with ABTs; observed resident in recliner with catheter bag laid directly on floor under footrest of recliner & bag lacked privacy bag

NW: SS=D: Failed to provide urinary catheter care in manner to prevent UTIs for 1 resident placing resident at risk for infections & catheter-related complications

- Resident with 18 French catheter; observed resident in DR with catheter bag in privacy bag hung to dependent drainage under w/c with 4 inches tubing resting on floor when foot was on floor on multiple occasions

F692 Nutrition/Hydration Status Maintenance

NE: SS=D: Failed to provide care and services to maintain acceptable parameters of nutritional status by failing to properly follow the plan of care for 1 resident. Also, the facility failed to properly assess nutritional status for 1 resident. This deficient practice had the potential to negatively affect the residents physical well-being and nutritional status

- EMR documented resident with 7.87% from 2-4-25 thru 4-8-25 & 5.99% from 3-10-25 thru 4-8-25; observed resident sitting at table, already assisted with biscuits & gravy but then with fork in hand & staring at uneaten eggs then rested with head hanging down & staff walked by resident & did not say a word & then resident roused & did not complete eating eggs; observed staff assisted resident with meal but not health shake & staff encouraged resident to drink but did not assist; observed resident at 11:38am delivered food & did not assist until 11:57am; observed lack of assist on multiple occasions
- Baseline CP lacked documentation resident received dialysis; resident on regular diet; order for daily weight; EMR lacked weights on 2 occasions

NW: SS=D: Failed to monitor 1 resident's physician order for fluid restriction placing resident at risk of complications r/t hydration status due to resident's cardiac status

- CP lacked physician-ordered fluid restriction; POS for 3000cc fluid restriction with dietary to provide 1500 cc & nursing 270cc; evening dietary provides 800cc & nursing 270cc; night shift 160cc; staff reported unaware of fluid restriction; LN aware of restriction but could not recall amount; observed 600cc ice water mug on bedside stand

F698 Dialysis

NE: SS=D: Failed to provide necessary dialysis assessment, care & services for 1 resident with risk for adverse outcomes & dialysis complications

- Facility unable to provide any completed dialysis communication forms before & after dialysis

F693 Tube Feeding Management/Restore Eating Skills

SE: SS=E: Failed to ensure safe enteral nutritional feedings for 4 residents placing residents at risk for malnutrition and complications related to enteral feedings

- Observed resident in bed with bed almost flat with low air-loss mattress pump set to firm with unlabeled/undated bag of tube feeding for multiple observations
- Observed resident in bed sleeping flat with low air-loss mattress set to 400#s & tube feeding running; unlabeled/undated bag of unknown supplement being administered on multiple occasions
- Observed resident in bed sleeping flat with tube feeding running with clear unlabeled/undated bag of unknown supplement for multiple residents

F695 Respiratory/Tracheostomy Care & Suctioning

SE: SS=D: Failed to ensure 1 resident's CPAP mask was stored appropriately when not in use. This deficient practice placed 2 residents at risk of respiratory complications and possible infection

- Observed resident on bed with CPAP laid in windowsill & not stored in sanitary manner & staff stated resident would not have been able to place the mask in windowsill

F699 Trauma Informed Care

SE: SS=D: Failed to identify trauma-based triggers related to 1 resident's PTSD & failed to implement individualized interventions to prevent re-traumatization placing resident at risk for decreased psychosocial well-being and ineffective treatment

- CP lacked individualized triggered-specific interventions that ID'd ways to decrease exposure to triggers which could re-traumatize resident; staff unaware of resident's dx of PTSD; SS staff stated last Trauma Informed Assessment completed on 2-26-20

NE: SS=D: Failed to ID trauma-based triggers related to 2 residents' PTSD & failed to implement individualized interventions to prevent re-traumatization placing residents at risk for decreased psychosocial well-being & ineffective treatment

- Resident with HTN; PTSD, schizoaffective d/o & insomnia; BIM of 15; CP lacked what trauma had caused PTSD or what might have caused resident to be retraumatized; CP lacked personalized interventions to assist resident with coping with PTSD; assessment documented no PTSD issues reported
- Resident with schizoaffective d/o, bipolar d/o & PTSD; CP lacked staff direction that addressed triggers or interventions to prevent further re-traumatization; multiple PTSD Screens lacked specific trauma or possible triggers for 1 resident

NE: SS=D: Failed to identify trauma-based triggers related to 1 resident's PTSD & failed to implement individualized interventions to prevent re-traumatization. These deficient practices placed resident at risk for decreased psychosocial well-being and ineffective treatment.

- Resident with PTSD, schizoaffective d/o & anxiety; CAA documented resident received multiple psychotropic meds to help control mood & behaviors; CP lacked what trauma had caused resident's PTSD or what might possible cause resident to be re-traumatized & lacked personalized interventions to assist resident with coping with PTSD; no trauma based assessment completed at time of admission; last assessment dated 4-19-24 with triggers identified w/o personalized interventions

F700 Bedrails

SE: SS=D: Failed to ensure that 2 residents had a safety assessment for the use of side rails that acknowledged the risks of their low air-loss Mattress placing both residents at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails

- Resident with low air-loss mattress with CP note that resident with bed rails to aid in mobility after evaluation; assessment lacked risk assessment for low air-loss mattress; record with no documentation showing ID'd risks r/t use of low air-loss mattress in conjunction with bedrails; failed to ensure that resident had safety assessment for use of side rails that acknowledged risks from low air-loss mattress, consent fo ruse of side rails, & failed to ensure resident/representative were advised of risks &/or benefits of use of side rails placing resident at risk for uninformed decisions & impaired safety related to risks associated with use of side rails for 2 residents

F726 Competent Nursing Staff

NW: SS=F (Past Non-Compliance): Failed to ensure nursing staff possessed current licensure as required placing all residents residing in facility at risk for not attaining or maintaining highest practicable physical, mental & psychosocial wellbeing

- *Kansas State Board of Nursing License Verification printed on 5-24-23 documented LN's LPN license expired on 11-30-24; Working Scheduled documented LN worked 8/23 days as LN after license had expired; LN suspended & taken off schedule until license reinstated*
    - *Plan of Removal:*
        - *Facility's BOM will run monthly report to ensure staff renew licensed on timely basis*
        - *No employee will be allowed to work in registered, licensed or certified position w/o proof of active license status*

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

SE: SS=F: Failed to have RN coverage for at least 8 consecutive hrs as required placing residents in facility at risk for unsupervised nursing care & services

- Daily Staff Posting from 5-1-24 thru 7-30-24 revealed facility did not have required 8 consecutive hrs of RN coverage on 9 occasions; Adm Nurse unable to verify facility had RN for 8 consecutive hrs on mentioned dates

NE: SS=F: Failed to provide RN coverage for 8 consecutive hrs/day, 7 days/wk placing all residents at risk of lack of assessment & inappropriate care

- June 2024 & March 2025 nursing schedules revealed that no RN was on duty on 3 occasions

NE: SS=F: Failed to provide RN for at least 8 consecutive hours/day 7 days/wk placing residents at risk of decreased quality of care

- PBJ report indicated 74 days in FY 2024, facility did not have RN for 8 consecutive hours for each 24 hours; time clock information & payroll data revealed facility did not have 8 consecutive hours of RN coverage for 44/182 days

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

SE: SS=F: Failed to ensure 1/5 CNA staff reviewed had yearly performance evaluations completed placing residents at risk for inadequate care

- Personnel file revealed 1 CNA had no yearly performance evaluation

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

- Employee files reviewed for staff working more than 1 year & 3 CMAs & 2 CNAs had no yearly performance evals upon request

NE: SS=F: Failed to ensure required annual performance reviews were completed for 5/5 staff members reviewed placing residents at risk of receiving impaired care

- Review of performance evals revealed 1 LN, 1 CMA & 3 CNAs who worked at facility over 1 year lacked annual review

F732 Posted Nurse Staffing Information

SE: SS=C: Failed to maintain posted daily nurse staffing data for required 18 months

- Review of staffing sheets from 9-24-23 to 3-24-25 revealed facility unable to provide posted staffing documentation for 29 dates; 12 days lacked resident census; 8 days lacked total number of nursing hours

SE: SS=C: Failed to post daily nurse staffing data as required

- Daily Staffing Sheets for past 30 days revealed actual hours worked not completed; Adm nurse unaware postings needed to include actual hours worked

F744 Treatment/Services for Dementia

NE: SS=D: Failed to provide 1 resident who had dx of dementia & aggressive behavior toward others, with supervision, treatment & services to attain or maintain highest practicable physical, mental & psychosocial wellbeing placing resident at risk for unmet behavioral & psychosocial wellbeing needs

- CP documented resident with behaviors of outbursts, yelling, spitting & refusing cares & instructed staff to redirect; resident with kissing behaviors with another resident in DR

F745 Provision of Medically Related Social Service

SE: SS=D: Failed to ID & provide medically related social services to attain or maintain highest practicable physical, mental & psychosocial wellbeing for 1 resident how had hx of PTSD placing resident at risk for further decline of emotional & mental wellbeing

- Cited findings previously cited in F656 & F699 r/t lack of current trauma assessment or individualized CP interventions based on ID'd triggers

F755 Pharmacy Services/Procedures/Pharmacist/Records

NE: SS=F: Failed to have a system to account for controlled meds' receipt & disposition in sufficient detail to enable accurate reconciliation & conduct a periodic reconciliation to account for controlled meds in order to prevent loss or diversion

- Observed unlocked Adm Nurse office & no staff present on multiple occasions; E-kit for narcotic meds kept in that office; DON stated when E-kit was received at facility 1/3 drawers not closed & therefore unlocked; observed unlocked drawer held Fentanyl patches, MS Tramadol & stated had contacted pharmacy & informed them of problem at least 2x's but pharmacy had not come to facility & corrected problem; E-kit w/o list of numbers of narcotic meds & facility unable to access other 2 drawers

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=F: Failed to provide services of Consultant Pharmacist (CP) to review & ID irregularities in 30 residents' DRR during December 2024 placing 30 residents at risk for adverse consequences r/t med therapy to extent possible form lack of oversight by licensed pharmacist & further placed 1 resident at risk for adverse consequences from meds

- Facility failed to provide CP report for August, Sept, Oct, Nov & Dec 2024; Adm Nurse stated facility had changed pharmacy in Nov 2024 & unable to locate MRRs

NE: SS=D: Failed to ensure that the physician responded to the recommendations made by the Consultant Pharmacist (CP) to ensure that 1 resident's antipsychotic medication Seroquel had an appropriate CMS indication for use. These deficient practices placed resident at risk of unnecessary medication administration and related complications

- MRR documented CP's recommendation that resident received antipsychotic but lacked allowable dx to support use & physician failed to respond to CP recommendation; Adm nurse stated Adm staff had noticed that in past previous physician had not been addressing CP recommendation as should have been & staff working with physicians & pharmacy to ensure recommendations were being addressed promptly

NW: SS=D: Failed to ensure that 1 resident's antipsychotic medication had an approved indication for use and that 1 resident's PRN antianxiety medication had an end-of-use date placing residents at risk of receiving unnecessary psychotropic medications

- POS for Aripiprazole 2mg po q hs for insomnia; POS for Sertraline 25 mg po q am r/t depression; POS for Alprazolam 0.5mg po q hs r/t anxiety d/o; POS for Norco 5-325 mg PRN pain TID r/t pain; MRRs from 4-24- thru 2-25 lacked documentation r/t unapproved indication or risk vs benefit for continued use of Aripiprazole for insomnia; failed to ensure that 1 resident's antipsychotic medication had approved indication for use placing resident at risk of receiving unnecessary psychotropic medication
- Failed to obtain required stop date for 1 resident's PRN Alprazolam placing resident at risk of receiving unnecessary psychotropic medication

NW: SS=D: Consultant Pharmacist (CP) failed to obtain approved indication for use for Seroquel for 2 Residents and Zyprexa for 1 resident placing 3 residents at risk to receive unnecessary antipsychotic drugs

- POS for Seroquel for depression; MRR did not request approved dx or indication for use of Seroquel; CP failed to obtain approved indication or thorough rationale from physician of why Seroquel was necessary to treat 1 resident placing resident at risk of receiving unnecessary antipsychotic drug for 2 residents
- POS for Zyprexa for psychosis r/t to major depressive d/o; MRR lacked recommendation to physician for CMS-appropriate indication for use of Zyprexa; failed to ensure CP ID'd & reported 1 resident's Zyprexa failed to have adequate CMS-approved indication for antipsychotic medication

F757 Drug Regimen is Free from Unnecessary Drugs

SE: SS=D: Failed to ensure BP monitoring was conducted r/t use of Midodrine for 1 resident placing resident at risk of complications r/t abnormal BP

- Dx of hypotension; POS for Midodrine q 8 hrs PRN for hypotension; with administration parameters; EMR documented resident with BP's outside parameters & med not administered & physician not notified

NE: SS=D: Failed to notify the physician of blood sugars outside of ordered parameters for 1 resident & failed to hold insulin when the medication was out of the physician ordered parameters placing residents at risk for adverse effects related to medication

- POS for accu-checks with notification parameters; MAR documented 5 occasions when blood sugar was out of physician-ordered parameters & physician not notified from 2-15-25 thru 4-23-25; 1 day in March MAR; POS for Lantus based on blood sugar parameters & 2 occasions when insulin administered when blood sugar outside parameters

NE: SS=D: Failed to hold BP meds per physician-ordered parameters for 2 residents placing resident at risk for physical decline & other related complications

- POS for Losartan 100mg daily for HTN with holding parameters; Amlodipine for HTN with holding parameters; Coreg for HTN with holding parameters; MAR documented resident received Losartan 5 occasions when pulse below parameters & med administered from 3-14-25 thru 4-15-25; Amlodipine 7 occasions administered outside parameters; Coreg 6 occasions administered outside

parameters; observed CMA took BP & pulse & administered all meds & repeated parameters & heart rate was 55 despite parameters & CMA stated had not realized should have held BP meds due to low pulse

- POS for Metoprolol BID for HTN with holding parameters; March MAR documented 5 occasions med administered outside ordered parameters; April with 5 occasions administered outside parameters

NE: SS=D: Failed to ensure staff notified the physician when 1 resident's physician ordered insulin was refused or held. This deficient practice placed resident at risk of unnecessary medication administration and related complications

- Resident with DM with notification parameters for blood sugar levels; insulin orders lacked parameters to hold or notify; MAR documented 90 opportunities for administration of scheduled insulin & resident refused administration 3/90 opportunities & staff held insulin due to vitals being outside parameters for administration on 3/90 opportunities; NN lacked documentation that physician notified of insulin being held or resident refusals; multiple other months with same results

NE: SS=D: Failed to ensure dosing instructions for Voltaren gel for 1 resident placing resident at risk for unnecessary medication use & physical complications for affected resident

- POS for Voltaren external get to knee & shoulder topically q 12 hours PRN pain; order lacked dose

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SE: SS=D: Failed to properly inform families of risks & benefits associated with psychotropic meds for 2 residents; also failed to properly monitor for adverse reactions & behaviors r/t antipsychotic medication for 1 resident placing affected residents at risk for adverse effects associated with use of psychotropic meds

- CP lacked information r/t Latuda & lacked non-pharmacological interventions for behaviors; POS for Clonazepam, Duloxetine, Trazodone, Latuda; POS did not address BBW for Latuda; NN lacked documentation of monitoring of side effects r/t Latuda
- Resident with schizoaffective d/o, mood d/o; panic d/o, irritability & anger, seizer d/o, PTSD, anxiety, insomnia & depressive d/o; POS for Citalopram; observed resident in bed & resident not aroused when staff talked in room or called resident's name

NE: SS=D: Failed to ensure an appropriate diagnosis or a physician's statement of the risk versus benefit for the continued use of Seroquel; These deficient practices placed resident at risk of unnecessary medication administration

- Cited findings noted in F756 r/t Seroquel ordered despite CP recommendation r/t appropriate dx; POS for Quetiapine q hs for mood management

NW: SS=D: Failed to ensure that 1 resident's antipsychotic medication had an approved indication for use and that 1 resident's PRN antianxiety medication had an end-of-use date, placing residents at risk of receiving unnecessary psychotropic medication

- Cited findings noted in F756 r/t psychoactive medications; failed to ensure 1 resident's antipsychotic medication had approved indication for use placing resident at risk for receiving unnecessary psychotropic medication
- Failed to obtain required stop date for 1 resident's PRN Alprazolam placing resident at risk for receiving unnecessary psychotropic medication

NW: SS=D: Failed to obtain an approved indication for use for Seroquel for 2 residents, and Zyprexa for 1 resident placing 3 residents to receive unnecessary antipsychotic drugs

- Cited findings noted in F756 r/t 2 residents with Seroquel & 1 resident with Zyprexa orders w/o appropriate indications

NW: SS=D: Failed to obtain an appropriate indication or the required physician documentation for the continued use of antipsychotic med for 1 resident placing resident at risk for unnecessary psychotropic meds & potential adverse effects

- POS for Zyprexa for depression; staff verified Zyprexa not approved by CMS for depression

F760 Residents are Free of Significant Med Errors

NE: SS=D: Failed to ensure 1 resident remained free for significant med error when staff failed to administer resident 7 physician ordered meds for 3 days in a row placing resident at risk for unalleviated pain, decreased ability to participate in rehab, inability to sleep & psychosocial impairment

- Hospital Discharge Order for Xarelto, Levofloxacin, Allopurinol, Divalproex, HCTZ, Seroquel, Cyanocobalamin; MAR documented resident did not receive physician ordered meds on 3-28, 3-29 or 3-30-25; resident stated facility had not administered 5 of his meds for few days when first admitted & some of meds with psychoactive & should not be stopped abruptly

NE: SS=D: Failed to prevent medication administration errors for 1 resident whose heart rate was out of physician-ordered parameters & resident received 4 BP meds placing resident at risk for physical decline & other related complications

- Cited findings noted in F757 r/t multiple staff on multiple occasions administering BP meds outside physician-ordered parameters

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to properly label & store meds in the med room, & further failed to secure med carts containing residents' insulin pens & needles placing residents at risk for adverse outcomes or ineffective med regimens

- Observed med cart in DR unlocked & unattended with insulin pen laying on top of cart & multiple insulin pens in unlocked med cart; med fridge with opened, undated vials of TB serum; observed 2nd med cart in common area unlocked & unattended

NE: SS=E: Failed to remove expired meds from potential use placing residents at risk of receiving expired or ineffective meds

- Observed med room with multiple expired stock meds

NE: SS=E: Failed to secure 1/4 med carts placing residents at risk for unnecessary medication & administration errors

- Observed unsecured med cart next to O2 storage room on 1 wing

NW: SS=E: Failed to store meds securely & dispose of expired meds timely placing residents of facility at risk for ineffective meds & unsafe access to meds

- Observed treatment cart with expired stock meds & 1 undated insulin pen; med cart with expired stock meds; med room with expired stock meds
- Observed treatment cart unlocked & no licensed staff in sight of cart for 2 minutes until surveyor asked aide whose cart it was & LN came around corner

NW: SS=D: Failed to label 2 residents' insulin flex pens with started/opened date or use by date placing affected residents at risk for ineffective medications

- Observed med cart with 1 resident's Tresiba not labeled with open or expired date; 1 resident's Tresiba flex pen not labeled with open or expired date

F801 Qualified Dietary Staff

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

- Staff member stated was manager & was not a CDM & had not enrolled in certification course at this time & RD came monthly & was available by phone for consult

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

- Dietary staff verified not CDM

F808 Therapeutic Diet Prescribed by Physician

NE: SS=D: Failed to implement a therapeutic diet as ordered by the physician order for 1 resident who had a diagnosis of CHF. This deficient practice placed resident at risk of adverse side effects from unnecessary medication or complications r/t CHF

- Cited findings noted in F684 r/t lack of 2gm low sodium diet & 2000cc fluid restriction order r/t CHF that was never implemented; diet meal card listed diet as regular; Adm nurse stated resident's new diet & fluid restriction order had been entered into EMR incorrectly & was overlooked

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=F: Failed to follow sanitary dietary standards r/t storage, preparation, & meal service placing residents at risk r/t foodborne illnesses & food safety concerns

- Observed: cereal bins lacked dates opened for cereals; plates stored upward with no barrier to prevent contamination of eating surfaces; DR with trash & food debris under ice machine & condiment counter; drain cleaner in cabinet under sink, unlocked & accessible

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

- Observed staff stated residents requested over easy & sunny-side up eggs & unable to verify that eggs in fridge were pasteurized; back door entrance to kitchen unable to reach ground & outside light visible; window with bags of bread with layer of dust on window seal; handwashing sink with dirt throughout handles, sink edges & on eyewash bottle; carts with dirty, linty, greasy material on all wheels; ceiling tiles with staining; front of oven, oven handles & stainless-steel fridge door with food debris; stove/grill drip pans with dried food remnants; shelf with grey lint; fluorescent light with dead insects; container with dust; chemical testing strips with expired date; ice machine lacked 2-inch air gap; baseboards throughout kitchen with missing or coming unattached from walls

NW: SS=F: Failed to store, prepare, distribute & serve food by professional standards for food service safety in 1/1 facility kitchen placing residents who received meals from facility's kitchen at risk for foodborne illness

- Observed: shelving unit for clean pans with rust with sheet pans stored on it & all shelves with chipped paint; clean steam table pans with dried, stuck on pieces of plastic wrap used when food first cooked
- Food prep table bottom shelf with numerous dried food crumbs
- Flour & sugar gins with scoops in bins
- Metal knife holder with dust & crumbs
- AC unit blowing toward stovetop with gummy lint in grate
- Can opener with soiled, dried food particles

NW; SS=F: Failed to store food by professional standards for food service safety in the nourishment refrigerator located in the south hall. The facility failed to cover two fluorescent light fixtures in one of one dining room. This placed the residents, who received their food items from the south nourishment refrigerator/freezer, at risk for foodborne illness. This also placed the residents who ate in the facility's dining room at risk of getting foreign objects in meals

- Observed: expired frozen foods; undated food items; unlabeled, undated containers with meat; undated/expiration dates missing from foods
- 2 overhead fluorescent light fixtures with 2 light bulbs in each fixture directly above 2 tables in DR & covers missing & exposed fluorescent bulbs

NW: SS=F: Failed to measure & record food temps for food items at mealtime & daily fridge & freezer temps for evening shift; further failed to record chemical ppm of sanitizing solution on Sanitizer Bucket Log 3x/day placing residents at risk for foodborne illness

- Observed holes in daily temp log for fridge & freezer on multiple days; observed dietary staff obtained temps of noon meal & documented in Temp Log & logs for current month lacked documentation of daily food temps for multiple meals, primarily on dinner meals
- Observed dietary staff found multiple plates with dried food particles on them; dietary staff aware of resident complaints of dirty dishes
- Observed multiple holes on Sanitizer Bucket Log

F835 Administration

NW: SS=F (Past Non-Compliance): Failed to ensure adequate administrative oversight when the facility failed to monitor and ensure all nurses practicing in the facility maintained active license as required to provide the residents residing in the facility with the care they needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being placing the residents residing in the facility at risk for lack of quality nursing care

- *Cited findings noted in F726 r/t facility allowing LN to work 8 shifts after license had expired*

F838 Facility Assessment

NE: SS=F: Failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during day-to-day operations and emergencies with potential to affect all residents currently residing in facility

- Assessment failed to ID specific staffing needs by shifts for weekends; PBJ revealed excessively low weekend staffing triggered for all 4 quarters; Adm stated facility assessment did not differentiate between weekdays & weekends but weekends staffed differently from normal nursing hours due to increased staff presence during weekdays

NE: SS=F: Failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents during both day-to-day operations and emergencies. This failure affected all residents in the facility

- Assessment failed to identify the specific staffing levels needed for each unit and identify the number of RNs, LPNs, CMAs & CNAs needed for each unit, patient acuity, and census. The assessment further lacked the staffing levels required for each shift. The assessment failed to identify the means of input gathered from the residents and their representatives when the assessment data was formulated

F849 Hospice Services

NE: SS=D: Failed to ensure a communication process between the hospice provider and the facility for 2 residents, which included a plan of care and a description of the services provided which included visit frequency, medications, and medical equipment. This placed the residents at risk of not receiving needed care

- CP lacked contact number for hospice & what supplies, equipment, & medications hospice would provide CP lacked when hospice staff would be in building & what care they would provide for multiple residents

NW: SS=D: Failed to include hospice service visit frequency, medications, medical equipment & resident representative's preference for 1 resident placing resident at risk of not receiving resident-directed end-of-life care

- CP lacked specifics r/t delegation of hospice staff services, visit frequency, medication, medical equipment & resident representative preferences

NW: SS=D: Failed to ensure coordinated care & services provided by facility with care & services provided by hospice for 1 resident placing residents at risk for inadequate end-of-life care

- Lacked specific information on facility CP that coordinated with hospice CP

NW: SS=D: Failed to ensure a communication process between the hospice provider and the facility for 1 resident who admitted to hospice on 02/25/25, which included a plan of care & a description of the services provided, such as contact information, visit frequency, medications, & medical equipment placing resident at risk of not receiving needed care

- CP lacked instructions on services provided by hospice, including frequency & type of support visits, supplies, & medical equipment provided by hospice, meds covered by hospice & hospice contact information

F851 Payroll Based Journal

NE: SS=F: Failed to submit completed & accurate staffing information to PBJ placing residents at risk for impaired care due to unidentified staffing issues

- PBJ indicated excessively low weekend staffing in all 4 quarters submitted to PBJ; Adm nurse stated weekend staffing was not low & stated "must be an error in reporting of hours"

NE: SS=F: Failed to submit complete and accurate staffing information through PBJ as required placing residents at risk for unidentified and ongoing inadequate nurse staffing

- PBJ report indicated facility had excessively low weekend staffing in 2 quarters; review of facility's weekend nursing schedules revealed facility had adequate staffing; Adm nurse verified facility had not submitted correct information for weekend nursing staffing & stated Adm responsible for submitting PBJ information

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

- PBJ report indicated no LN coverage on 9 dates for 1 quarter, 6 days on 1 quarter & 11 days in 1 quarter; Payroll data revealed LN was on duty for 24 hrs/day/7 days/wk; failed to submit complete & accurate staffing information thru PBJ as required placing residents at risk for inadequate nurse staff

NE: SS=F: Failed to submit accurate staffing information to PBJ when facility failed to submit accurate RN coverage hours

- PBJ report document for multiple quarters w/o any RN hours & facility failed to have information for RN clock in & out times for staff hours on multiple occasions

NE: SS=F: Failed to submit accurate staffing information to PBJ when facility failed to submit accurate weekend staffing hours placing residents at risk for unidentified & ongoing inadequate staffing

- PBJ report indicated facility triggered for low weekend staffing for multiple quarters; review of working schedule revealed no missed coverage or gaps

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

- PBJ reported indicated excessively low weekend nurse staffing; review of nurse schedules revealed facility had adequate staffing

F867 QAPI/QAA Improvement Activities

NE: SS=F: Failed to prioritize improvement, develop & implement action plans, conduct at least 1 PIP annually & regularly review, analyze & act on data collected placing all residents of facility at risk for lack of quality improvement activities in facility

- Facility failed to provide documentation of any PIPs done in 2024 & 2025

F868 QAA Committee

NE: SS=F: Failed to have a Quality Assessment and Assurance (QAA) committee of the required membership which met at least quarterly and received reports from the Infection Control Preventionist (ICP). This deficient practice placed the 30 residents of the facility at risk for impaired care and services that met accepted standards of quality, identification of problems, and opportunities for improvement

- QAA committee sign-in sheets for 3-13-25 & 4-10-25 but no others; sign-in sheets lacked attendance for medical director/representative, Adm or consultant pharmacist; no documentation of any QAA meeting for 2024

NE: SS=F: Failed to maintain QAA that met quarterly & had required membership in attendance; failed to maintain QAA Committed that met quarterly & had required membership in attendance

- Adm failed to provide sign-in sheets for all QAA meetings & only provided sign-in sheet for 9-11-24; stated had a meeting on 4-20-25 but w/o sign-in sheet

F880 Infection Prevention & Control

SE: SS=E: Failed to cover all linen & store pillows in sanitary manner; further failed to ensure 1 resident's urine bag not dragging floor; failed to ensure staff perform hand hygiene during wound dressing changes & urinary catheter care placing residents at risk for infections

- Cited findings listed in findings statement: linen cart uncovered & pillow laid on top of cabinets uncovered; w/p had "Do Not Use" sign which contained stack of bedspreads in middle of shower room; observed catheter bag drug on floor under w/c in DR; CPAP laid in windowsill; during wound care LN failed to perform hand hygiene or wash hands prior to entering resident's room; during wound care LN threw cleansing wipe in trash can beside bed; failed to doff dirty gloves before opened & cleaned resident's 2nd wound; LN failed to perform hand hygiene between glove changes during catheter care; LN did not perform hand hygiene between glove changes during feeding tube dressing change

SE: SS=D: Failed to implement adequate & acceptable infection control practices for 1 resident whose O2 tubing was allowed to drag floor as resident wheeled self thru facility placing resident at risk of infections

- Observed resident in DR wearing O2 nasal cannula & O2 tubing wrapped around part of w/c & dragging on floor on multiple occasions

SE: SS=D: Failed to implement EBP for 1 resident with Foley catheter & 1 resident receiving tube feeding & wound care; failed to implement EBP for urostomy with potential to spread possible infections to residents in facility

- Observed resident with no EBP PPE or signage for resident with open wounds to arm, buttock & back
- Observed staff did not use gowns for resident with tube feeding
- Resident with Foley & no EBP, PPE or signage

NE: SS=E: Failed to implement signage or indicators within the physical environment to alert staff & visitors of the required EBP & PPE for 2 residents; additionally failed to cover linens in hallways & further failed to ensure dirty laundry sorting area was equipped with a gown & Mask placing residents at risk of infectious diseases

- Observed room with no EBP indicator signage to inform visitors or staff for multiple rooms
- Observed laundry staff pushing cart of blankets down hallway & cart uncovered;
- Laundry room with no PPE to sort dirty laundry & staff unaware of need to use PPE to sort dirty laundry

NE: SS=E: Failed to adhere to infection control procedures for 1 resident who had EBP, and failed to adhere to personal cares & change gloves for 1 resident who had a suprapubic catheter & failed to adhere to infection control procedures when dietary staff placed a rubber dish tub on the table with dirty dishes while the residents were still eating their meal placing residents at increased risk for infection

- Observed 2 CNAs provide care for resident on EBP & donned gowns & gloves to perform suprapubic catheter care; 1 CNA removed gloves & washed hands; then transferred resident from bed to shower chair with mechanical lift; resident stated just had BM & CNA removed brief & cleansed resident with peri wipes then lowered resident onto shower chair & 1 CNA continued to wear same

gloves cleaned residents with & opened closet doors & retrieved clothing then opened BR door with same gloves & got clean brief then removed gloves & used hand sanitizer & transported resident to shower room

- Following incontinent care staff failed to remove gown until returned to utility room
- Observed dietary staff placed plastic tub of dirty dishes on table where residents were eating meal & continued to place dirty dishes in pan from other tables then left dirty dishpan on table & asked residents who entered DR what they would like to drink; CDM stated staff could place dirty dishpan on table if it was only ½ full

NW: SS=D: Failed to ensure a sanitary & comfortable environment to help prevent the development & transmission of communicable diseases & infections when staff failed to ensure 1 resident's urinary catheter tubing & uncovered bag off the floor

- Cited findings noted in F690 r/t catheter tubing directly on floor

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

- Maintenance staff stated had attended training a couple of months ago to learn about Legionella prevention but had not developed surveillance system yet

NE: SS=E: Failed to store 3 residents' respiratory equipment in a sanitary manner; additionally failed to store clean linens in a sanitary manner and further failed to ensure 1 resident's Foley catheter remained off the floor placing residents at risk for infectious diseases

- Observed multiple residents' O2 nasal tubing w/o sanitary storage present; nebulizer mask w/o sanitary storage present
- Observed resident with Foley with drainage bag laid directly on floor & bag w/o privacy cover
- Observed clean lines placed on EBP cart outside 1 resident's room

NW: SS=D: Failed to maintain standardized infection control practices during dressing change for 1 resident placing resident at increased risk of wound infection

- Resident with stage 3 PU to sacrum & buttock which was present on admission; Observed Consultant & LN donned PPE removed outer dressing (Duoderm) then skin replacement then cleansed wound with moistened gauze, took measurements, treated it with silver nitrate on edge of wound, applied skin replacement then covered wound with Duoderm; consultant failed to change gloves following cleansing wound & performing treatment

F881 Antibiotic Stewardship Program

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

- Surveillance log from 1-24 thru 3-25 lacked evidence of organism ID, duration of ABT prescribed & infections treatment for 6 months

F882 Infection Preventionist Qualifications/Roles

NE: SS=F: Failed to ensure staff member designated as Infection Preventionist who was responsible for facility's IPCP completed specialized training in infection prevention & control placing residents at risk for lack of ID & treatment of infections

- Upon request, facility did not provide documentation of current certified Infection Preventionist employed in facility

F883 Influenza & Pneumococcal Immunizations

NE: SS=E: Failed to assess 2 residents for eligibility to receive further pneumococcal vaccination; failed to offer, or obtain informed declination or physician-documented contraindication for PCV20 vaccination per latest guidance for CDC placing residents at risk for pneumococcal infection & related complications

- 2 resident records lacked evidence facility, resident/representative received or signed consent to receive or informed declinations for PCV20; immunizations noted no pneumococcal vaccination was given historically had been offered or declined

NW: SS=E: Failed to ensure that 5 residents were offered and educated regarding the Prevnar 20 (PCV20) pneumococcal vaccination or assessed and deemed contraindicated as recommended by the CDC placing residents at risk of acquiring, transmitting, or experiencing complications from pneumococcal disease

- Review of "Long Term Care Resident and Staff Annual Vaccination Acknowledgement Consent/Declination Form" signed by 1 resident's DPOA declining to be vaccinated for pneumonia; form lacked distinction of all pneumococcal vaccinations offered
- Record revealed PCV20 had been offered to 1 resident but was refused & facility unable to provide documentation that resident had been offered & declined specifically PCV20 vaccination; resident had received the PCV23 on 10-11-08
- Record lacked documentation that resident had been offered nor had declined PCV20 vaccination for multiple residents; failed to offer PCV20 vaccination as recommended by CDC to 5 residents placing facility residents at risk of acquiring, transmitting or experiencing complications from pneumococcal disease

NW: SS=D: Failed to offer pneumococcal PCV20 immunizations for 3 residents per the guidance from the CDC placing residents at risk for pneumococcal infections

- Adm nurse unaware of CDC guidance r/t PCV20 immunizations; records revealed 2 residents had previously been immunized with Prevar 13 but lacked documentation of resident being offered or refused any further pneumococcal vaccinations; 1 record lacked pneumococcal information if resident was offered or refused any pneumococcal vaccinations

NW: SS=E: Failed to follow latest guidelines from CDC when failed to offer & administer or obtain informed declination or physician-documented contraindication for 5 residents for pneumococcal PCV20 vaccination placing residents at risk of acquiring, spreading & experiencing complications from pneumococcal disease

- 5 records reviewed lacked evidence of physician-documented contraindication for use of PCV20 & lacked evidence resident/representative received or signed consent or informed declination for current pneumococcal vaccine PCV20

NW: SS=E: Failed to offer, or obtain an informed declination or a physician-documented contraindication for the pneumococcal PCV20 vaccination per the latest guidance from the CDC. This placed the residents at risk for pneumococcal infection and related complications.

- Review of 5 resident records lacked evidence resident or resident/representative received or signed consent to receive or informed declination for PCV20

F909 Resident Bed

SE: SS=D: Failed to inspect 1 resident's bed frame & mattress as part of regular maintenance program to ID areas of possible entrapment placing resident at risk for injuries

- Observed resident bed with gap of approximately 6 inches from top to mattress to HOB with multiple observations

F947 Required In-Service Training for Nurse Aides

NE: SS=F: Failed to maintain in-service training program for nurse aides that was appropriate & effective as determined by nurse aide performance reviews & facility assessment as specific to needs of resident population placing residents at risk of inappropriate care & services

- 3 CNA/CMA files lacked required 12-hour in-service training

May, 2025

F550 Resident Rights/Exercise of Rights

NE: SS=D: Failed to ensure that residents ' rights and dignity were respected by staff when staff failed to provide a dignity bag for 1 resident's indwelling catheter bag placing resident at risk for decreased self-esteem and decreased self-worth

- Observed resident in bed with catheter collection bag hung on side of bed & visible from hallway & bag lacked dignity bag on multiple occasions

F602 Free from Misappropriation/Exploitation

NE: SS=D (Past Non-Compliance): Failed to ensure 2 residents remained free from misappropriation of medications when during a random controlled substance audit it was discovered 3/9 entries from 03/01/25 to 03/26/25 for 1 resident and 3/6 entries from 03/24/25 to 03/26/25 for other resident were signed out on the count sheet by 1 LN but were not documented on the eMAR. Further investigation by the facility revealed LN signed out medications as being destroyed using another nurse's initials and initials that were identified as not belonging to any member of the licensed facility staff. This deficient practice placed residents at risk for missed medications and further misappropriation of medications

- *Consultant conducted monthly on-site visit including med documentation review & controlled substance audit & results indicated missing entries on 2/4 residents selected thru random controlled substances audit; cited findings noted in findings statement; audit consisted of comparison of controlled med count sheet to each eMAR for each resident with scheduled & PRN controlled med orders with results cited; Adm Nurse reached out to LN to discuss findings & unable to make immediate contact & 2nd nurse involved in disposal of meds who stated had not destroyed any controlled meds with other LN & found initials were not correct*
- *Plan of Removal:*
    - *Controlled substance audit conducted, meds replaced*
    - *LN interviews conducted*
    - *Alleged Perpetrator (AP) interviewed, suspended & terminated & law enforcement notified*
    - *Impromptu QAPI meeting conducted*
    - *ANE education conducted*
    - *LN training conducted r/t following policies & procedures on: controlled med reconciliation, controlled med inventory, controlled med shift count sheet & 8 rights of med administration, controlled med individual reconciliation, disposal of meds, controlled med storage, documentation requirements & controlled substances*

F605 Right to be Free from Chemical Restraints

NE: SS=D: Failed to ensure 2 residents remained free from unnecessary psychotropic medications and chemical restraint placing both residents at risk for sedation and chemical restraint

- MDS noted no psychiatric or mood d/o's & did not take antianxiety or antipsychotic meds; CAA documented resident took psychotropic meds & antipsychotic drugs; POS for Seroquel via G-tube for depression & record documented resident had medication at time of admission on 1-28-25; POS for Lorazepam PRN for anxiety & order lacked stop date; MRR ID'd requirement of 14 day stop date & physician ordered 30-day duration with no orders to extend; MRR revealed pharmacist notified facility that Seroquel could not be used for depression & provider noted a failed GDR; MRR did not acknowledge that depression was not an accepted CMS indication for antipsychotic medication
- MDS documented resident with antipsychotic meds used to tx major mental conditions; POS for Diazepam (Valium) PRN for muscle spasms & lacked 14-day stop date or physician-ordered duration; Quetiapine (Seroquel) for insomnia; MRR with recommendation for clinical rationale documentation for Valium with physician response was chronic spasticity para status &

duration was “lifetime”; physician response for indication for Seroquel was psychosis & facility unable to provide physician documentation for use of antipsychotic with non-approved indication upon request

NE: SS=D: Failed to ensure 1 resident had a time limit of 14-days for PRN antianxiety medication order for Ativan & further failed to ensure 1 resident had time limit of 14 days for PRN Ativan with physician indication of use placing 2 residents for potentially unnecessary psychotropic med administration

- POS for Ativan q 8 hrs PRN for anxiety lacked 14-day DC date
- POS for Ativan 0.5mg for anxiety at bedtime PRN lacing 14-day stop date

F609 Reporting of Alleged Violations

NE: SS=D: Failed to report to State Agency (SA) as required when 1 resident had fall that resulted in major injury placing resident at risk for ongoing neglect & abuse

- Resident with hemiplegia & hemiparesis, major depressive d/o, displaced closed fx & hx of falling; BIMS of 15; CP lacked new intervention initiated post-fall on 12-20-24; NN documented CNA stated resident reported to LN resident fell; resident on floor with legs facing bed; resident hit head as fell to floor; fall occurred while being transferred from bed to w/c & resident grabbed armrest of w/c & when stood up, lost balance attempting to pivot around into w/c; CNA lowered resident to floor; post fall interview resident stated did not hit head when fell but leg with pain then resident reported did hit head during transfer; resident transported to hospital & ER reported resident being admitted for hip fx; CP previous to fall instructed staff to provide “cares in pairs”; incident report documented resident insisted on being transferred by 1 staff member even though CNA not confident about transferring resident by self; facility failed to report fall with major injury to SA; resident stated CNA did not use gait belt while transferred resident; Adm stated incident not reported to SA because resident able to tell facility exactly what happened & situation that occurred causing fall

F628 Discharge Process

NE: SS=D: Failed to provide a Bed Hold Notice to 1 resident/representative, upon transfer and admission to a hospital placing resident at risk for not being permitted to return and resume residence in the nursing facility. The facility further failed to provide a written notification of transfer to 1 resident/representative as soon as practicable, which included the required information

- Facility lacked documentation resident/representative were provided bed hold policy or notice for any of multiple hospitalizations
- Failed to provide required written notification of transfer to resident/representative for facility-initiated discharge on multiple hospitalizations

F636 Comprehensive Assessments & Timing

NE: SS=D: Failed to complete the CAA analysis of findings, related to a Comprehensive MDS for 2 residents in order to address the underlying cause, risk factors, and other contributing factors to ensure the residents received care based on their individual needs placing these residents at risk for impaired care & decreased quality of life due to unidentified care needs

- Triggered CAAs for functional abilities, urinary incontinence & indwelling catheter, PU & nutritional status lacked completion with analysis of findings
- Triggered CAAs for functional abilities, urinary incontinence & indwelling catheter, PU, psychotropic drug use, falls & nutritional status lacked completion with analysis of findings

F656 Develop/Implement Comprehensive Care Plan

NE: SS=D: Failed to ensure staff developed & implemented comprehensive CP for 1 resident that included staff direction for ADLs placing resident at risk of impaired care due to uncommunicated care needs

- Resident with CVA, trach, G-tube; CP lacked staff direction for resident’s ADLs & functional ability assistance; CNA stated did not have access to CP; DON stated after falls, team meets weekly & put in interventions at that time

F657 Care Plan Timing & Revision

NE: SS=D: Failed to revise comprehensive CP to include interventions for falls for 1 resident placing resident at increased risk for future falls

- Resident with multiple falls; CP lacked intervention for 3 falls & repeated previously CP’d interventions on multiple falls; CNA stated did not have access CP

F679 Activities Meet Interest/Needs Each Resident

NE: SS=E: Failed to provide consistent weekend activities placing affected residents at risk for decreased psychosocial wellbeing

- Resident Council members reported that activities rarely occurred on weekends & never a variety of activities on weekdays; council reported residents watched TV or read; council reported would like activities on weekends & would like to have staff lead activities; AD stated lets residents “do their own thing” on weekends; CNAs reported did not do activities on weekend when worked

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

NW: SS=G: Failed to provide necessary care, consistent with professional standards of practice, to prevent pressure ulcers including offloading for 1 resident who developed a facility-acquired on her left heel. This deficient practice also placed resident at risk for infection and pain. unstageable pressure ulcer

- *Resident admitted with stage 2 PU, 1 to each buttock & 1 stage 3 PU to coccyx; CP dated 2-10-25 lacked interventions r/t repositioning & lacked interventions r/t offloading until 3-27-25; Braden indicated resident at low risk for PU development; on 3-15-25 LN documented CNA reported resident with blood by lt heel & LN found resident with facility-acquired 5cm x 3cm stage 3 PU on lt heel; EMR lacked evidence of culture results ordered; 4-21-25 skin note documented resident with large injury to lt leg from obtaining laceration to lt inner calf during transfer with Hoyer lift caused by resident's leg rubbing on back of foot pedal & staff sent resident to ER for suture placement; wound required 9 sutures & documented laceration caused by resident's leg grazing back of foot pedals on w/c & hospital with concerns about resident's heel wound due to malodorous smell & X-ray done indicating calcaneus with soft tissue swelling, osseous destruction of heel bone cortex adjacent to wound consistent with acute osteomyelitis; resident transferred to higher level hospital for surgical evaluation; staff unsure if resident provided heel protection boots prior to development of wound*

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to assess or provide a restorative range of motion for 1 resident placing resident at risk for discomfort, stiffness, and the possibility of forming contracture

- Resident with CVA with functional limitations r/t stroke resulting in hemiparesis; Resident stated had never had ROM for hand & had never had therapy since coming to facility & would like to have some kind of therapy; staff reported currently facility did not have anyone specific for restorative therapy; CNAs reported did not do any ROM or exercises with residents; Adm nurse stated facility w/o restorative aide & did not have restorative therapy program

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=G: Failed to ensure safe environment free from accident hazards for 1 resident when staff transferred resident with assist of 1 staff instead of 2 & failed to use gait belt resulting in fall that caused fx; also failed to implement new fall interventions for 1 resident placing 2 residents at risk for preventable falls & related injuries

- Cited findings noted in F609 r/t resident fall with fx during transfer that CNA failed to follow resident's CP despite resident insisting on being transfer with 1 staff instead of 2 staff & CNA failed to use gait belt to assist in transfer
- Cited findings noted in F657 r/t resident with multiple falls without new interventions based on ID'd causal factors & use of repeat interventions

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

NE: SS=F: Failed to provide consistent RN coverage for 8 consecutive hrs/day/7 days/wk placing all residents residing in facility at risk of lack of assessment & inappropriate care

- PBJ information submitted for 4-1-24 thru 3-31-25 indicated facility triggered for no RN coverage on 12 occasions; working schedules & daily posted staffing revealed that no accounted RN for 8/12 days triggered; facility unable to provide documentation for 8 missing days of RN coverage

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

NE: SS=E: Failed to complete required nurse aide performance review at least once every 12 months placing residents at risk for inadequate care

- Personnel records revealed 4 CNAs & 1 CMA lacked evidence that performance review had been completed in last 12 months

F732 Posted Nurse Staffing Information

NE: SS=C: Failed to update its daily posted staffing form to provide accurate daily staffing information

- On 5-4-25 observed posted staffing documentation dated 4-29-25; on 5-5-25 posted staffing dated 4-29-25; Adm stated had been off since last week & unable to update forms

NE: SS=D: Failed to ensure daily posted nurse staffing data included facility census

- Observed daily posted staffing sheets & reviewed from 1-1-24 thru 3-31-25 & all lacked daily facility census number

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure the Consultant Pharmacist's (CP) recommended a CMS approved indication related to 1 resident's antipsychotic med placing resident at risk of unnecessary med administration and related complications

- Cited findings noted in F605 r/t dx of Seroquel for insomnia

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to ensure physician was notified of blood sugars outside the physician ordered parameters for 1 resident and the facility failed to ensure antihypertensive med was administered per physician ordered parameters for 1 resident placing residents at risk for unnecessary med administration & possible adverse reactions

- POS for blood glucose monitoring qid for DM with notification parameters & sliding scale insulin ordered based on blood glucose monitoring; MAR revealed blood sugar outside physician ordered parameters on 12 dates & record lacked documentation of physician notification
- POS for Metoprolol with holding parameters; MAR revealed drug given outside ordered parameters on 10 occasions & record lacked documentation showing why medication given outside parameters

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

- POS for Atenolol with holding parameters; MAR for April 2025 documented 5 occasions when med was administered outside ordered parameters

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to ensure safe medication storage with 3/5 med carts placing residents at risk for diversion & ineffective med regimen

- During inspection, observed 3 unlocked & unsupervised med carts on 1 hallway; LN stated only away from cart for 5 minutes

NE: SS=E: Failed to date 3 insulin pens when opened, ensure meds were secure when unattended & failed to remove expired med from use placing residents who may have received those meds at risk for ineffective meds

- Observed carts with 3 opened, undated insulin pens for 3 different residents
- Observed tx cart unlocked & unattended by licensed staff
- Med room fridge with expired Prevnar 23 syringes & 3 vials of COVID vaccine expired; med fridge temp logs lacked documentation for May 2025

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NE: SS=D: Failed to follow nutritionally approved recipes during prep of facility's puree-based meals placing 1 resident at risk for complications r/t nutritional impairment

- Observed staff preparing pureed meal for 1 resident w/o following recipe & stated "did not follow recipes because he had prepared altered diets for a long time"; staff thinned all foods with unmeasured amount of water then added unmeasured amount of thickener

F812 Food Procurement, Store/Prepare/Serve-Sanitary

NW: SS=F: Failed to store food by professional standards for food service safety in 1 kitchen placing residents who received meals from facility's kitchens at risk for foodborne illness

- Observed opened, unsealed food items; fridge with unlabeled, undated plastic bag with shredded produce

F838 Facility Assessment

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

- Assessment identified the required staffing needs per day but failed to identify the specific staffing needs for days, nights, and weekend shifts; PBJ revealed excessively low weekend staffing triggered in all 4 quarters; Adm nurse stated facility assessment did not separate hours required by shift but just showed required hours as a total

F849 Hospice Services

NE: SS=D: Failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider creating risk for missed or delayed services and impaired care for 2 residents

- Hospice CP lacked collaboration of care with facility & hospice provider for 2 residents

F851 Payroll Based Journal

NE: SS=F: Failed to submit accurate staffing information to the PBJ, when the facility failed to submit accurate weekend staffing coverage hours placing residents at risk for unidentified and ongoing inadequate staffing

- PBJ data from 4-1-24 thru 3-31-25 indicated facility triggered for excessively low weekend staffing for 4 quarters; review of working schedule, time sheets/punches & posted staffing hours indicated no gaps or loss of hours & documented weekend call-offs documented with Administrative nurse coverage

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

- PBJ for 1 quarter indicated no RN for 4 days in October 2024 & 2 days in November 2024; review of staffing & RN hours of days revealed RN coverage

F880 Infection Prevention & Control

SW: SS=D: Failed to maintain an effective infection control program that included Enhanced Barrier Precautions (EBP) & failed to implement adequate infection control & hand hygiene measures during wound care for 1 resident in the facility placing resident at risk for wound infection and related complications

- *Observed LN entered 1 resident's room to perform wound care; LN donned gloves but did not don gown & 1 time during procedure removed gloves & applied clean gloves w/o performing hand hygiene; & observed LN initiated tx to a separate wound before completion of initial wound*

NW: SS=E: Failed to use appropriate barriers while sorting soiled laundry placing residents at risk of infectious diseases

- Observed laundry & staff stated soiled laundry sorted by laundry using only gloves; unless obvious visual soilage then gown would be worn

F881 Antibiotic Stewardship Program

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

- Infection Control Log lacked evidence of tracking & ID of possible infection outbreaks at facility & lacked ID of facility-acquired infections

June, 2025

F550 Resident Rights/Exercise of Rights

NE: SS=D: Failed to ensure a dignified care environment for 1 resident placing resident at risk for impaired dignity & unmet care needs

- CP lacked interventions r/t resident's preferences or behaviors r/t undressing; NN documented resident found standing in BR with no clothes on next to toilet; NN documented resident removed clothing for entire night & refused to allow staff to provide cares; NN documented resident found naked in bed with no sheets or blanket covering; observed resident in bed naked & exposed for prolonged period of time

F582 Medicaid/Medicare Coverage/Liability Notice

NE: SS=D: Failed to ensure SNF ABN & NOMNC provided to 1 resident placing resident at risk for uninformed treatment decisions & unexpected costs

- Upon request, 10055 & 10123 not provided; SS staff stated a change in staff & discovered that ABN & NOMNC forms not issued to residents as should have been & residents now receive forms

F600 Free from Abuse & Neglect

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

- *On 05/18/25 2 CNAs attempted to transfer resident from a shower chair to resident's wheelchair without using the full-body mechanical lift as required in resident's CP. Resident could not bear weight so CNAs lowered resident to the floor. The staff*
- *attempted to lift resident off the floor w/o using the mechanical lift but were unsuccessful, so they obtained the full-body mechanical lift, and both CNAs lifted resident into her wheelchair. CNAs did not report the incident to LN and only reported resident bent her leg during a transfer and complained of pain. In the early morning hours of 05/19/25, 2 other CNAs reported to LN that resident complained of leg. LN assessed resident's left knee, which was slightly larger than the right. X-ray results showed resident had a distal left femur fracture and a distal right fibula fracture. On 05/19/25 at approximately 02:00 PM, original CNA told other CNA she dropped resident on the previous shift and asked CNA what to do. Other CNA advised CNA to report the incident to the nursing staff. Administrative staff were not informed of the incident leading to the fractures until 05/19/25 at approximately 08:50 PM when other CNA asked Administrative nurse if original CNA had reported that resident was dropped; failed to use life per resident's CP & accurately report occurrence for follow-up care placing resident in immediate jeopardy*
- *Plan of Removal:*
    - *CNA M was suspended from 05/19/25 to 05/21/25 and terminated on 05/21/25.*
    - *Other CNAs were suspended from 05/19/25 to 05/21/25 and received final written warnings for violating policies on 05/21/25.*
    - *All staff received education related to ANE and immediately reporting suspected ANE events, proper use of the Kardex, following the resident's care planned interventions as well as safe lift usage, completed 05/20/25 at 08:00 PM.*
    - *The facility completed pain assessments on all residents for 72 hours to ensure no additional residents were affected.*
    - *The facility performed random mechanical lift performance audits.*
    - *The facility held an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting related to the occurrence.*

NW: SS=G (Past Non-Compliance): Failed to ensure 2 residents remained free from verbal and mental abuse placing residents at risk for continued abuse, embarrassment, humiliation, and decreased quality of life due to impaired psychosocial well-being.

- *"Facility Incident Report," dated 05/28/25, documented on 05/26/25, resident was scheduled to have a bath. CNA had 2 orientee CNAs go with her to resident's room to train them on how to transfer & bathe resident. The report documented CNA orientee reported while they assisted resident in his bed, resident was incontinent of stool, which was normal for him. The report documented CNA stated to resident, "You are going to clean my shoes, you are going to buy me new shoes, you need to stop pooping so we can get you in the shower chair," and "Oh, that ' s great. You' re still pooping". The report documented resident apologized repeatedly. The report noted after resident's shower, the CNAs transferred resident back to his room in the shower chair, CNA stopped at the nurse ' s desk and told the staff present resident "pooped" in the bathhouse, and it needed to be cleaned up. The report recorded resident was interviewed and stated he felt embarrassed by what CNA said to him. The report documented after questioning, CNA admitted she said some of the things reported, but she was joking, and said she felt resident knew she was joking. The report documented the facility terminated CNA from employment.*
- *Resident with Alzheimer's disease, anxiety, restlessness & agitation with BIMS of 3; CP documented resident could have behaviors of cussing & hitting typically during baths & BMs; "Facility Incident Report," dated 05/05/25, documented on 05/01/25 at approximately 07:00 PM, 2 CNAs provided peri-care and bedtime care for resident. The report noted resident became agitated, and 1 CNA attempted to calm resident by assuring her cares were almost done. The report documented that other CNA stated, "No , I'm going to make this take longer just to [expletive] you off." The report documented other CNA reported the occurrence to LN at 07:15*

PM and LN reported the incident to Administrative Nurse D. The facility told CNA to immediately exit the facility. The report documented CNA refused to write a statement and was terminated from employment on 5-2-25

- *Plan of removal:*
  - *2 CNAs involved in incidents terminated*
  - *All nursing staff re-educated on recognizing & reporting ANE*

F605 Right to be Free from Chemical Restraints

NE: SS=D: Failed to ensure an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic for 2 residents who had a diagnosis of dementia placing resident at risk for unnecessary psychotropic medications and related complications placing resident at risk for unnecessary medication use & unwarranted side effects

- POC for Olanzapine for "psychosis"; MMR from May 2024 thur April 2025 revealed pharmacist ID'd & reported irregularities to non-approved indication for use of antipsychotic med; Olanzapine for resident with dx of dementia & Alzheimer's disease; no physician documentation r/t risk vs benefit for drug
- Resident with Alzheimer's disease POS for Quetiapine fumarate for severe dementia with agitation; EMR w/o physician-documented rationale for continued use of antipsychotic & unable to provide risk vs benefit for continued use of Quetiapine

F677 ADL Care Provided for Dependent Residents

NE: SS=D: Failed to provide 1 resident with consistent assist & supervision during mealtime placing resident at risk for potential risk r/t impaired nutrition & weight loss

- POS for Ensure 30 minutes after each meal for protein-calorie malnutrition; assessment indicated resident required supervision during meals; observed resident in bed with bedside table positioning over chest & resident flat on back with shoulders & neck propped up with meal uncovered & Ensure left with meal, not 30 minutes after as ordered; 26 minutes later resident asleep in same position & call light under bed & meal remained untouched; observed another meal & resident consumed Ensure during meal

F678 Cardio-Pulmonary Resuscitation (CPR)

NW: SS=K (Past Non-Compliance): Failed to ensure staff provided CPR to 1 resident who desired resuscitative measures as indicated by full code status

- *Around 09:00 PM on 05/24/25, CNA saw 1 resident's representative leave his room. At 09:50 PM, CNA entered resident's room & noted the resident was purple and lacked a pulse. CNA called on the radio he needed a nurse STAT & then stepped out of resident's room and shut the door. CNA was not aware resident was a full code status. LN entered resident's room at 09:55 PM, assessed resident, & noted he was cool, cyanotic & lacked vital signs. LN G knew resident's full code status but determined resident was "out of the window" for CPR & decided starting resuscitative measures would do more damage than it would help. The facility's failure to initiate resuscitative measures for 1 resident placed resident & all residents with full code status in immediate jeopardy*
- *Plan of Removal:*
  - *All nursing staff re-educated r/t CPR & full-code status*
  - *Mock codes performed on all shifts*

F684 Quality of Care

NE: SS=D: Failed to follow physician order for daily weights to monitor for CHF placing resident at risk for delay in tx r/t fluid overload & untreated illness

- POS for daily weight before breakfast, with notification parameters; MAR & TAR lacked evidence staff measured & recorded resident's weight on 9 days from 3-4-25 thru 5-8-25 with 1 refusal noted on TAR; record lacked documentation of physician notification of daily weight not obtained as ordered

F686 Treatment/Services to Prevent/Heal PU

NE: SS=D: Failed to ensure 1 resident's pressure-reducing interventions were implemented correctly when 1 resident's low air-loss mattress pumps were not set within resident's current weight range placing resident at risk for complications r/t skin breakdown & PUs

- MDS indicated resident weighed 122 #s; CP lacked guidance or instructions r/t low air-loss mattress setting; observed bed setting at 200#'s on multiple occasions

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=G (Past Non-Compliance): Failed to ensure environment free from accident hazards for 1 resident who required staff assistance & mechanical lift for safe transfers; as result resident sustained humerus fx placing resident at risk for pain & impaired independence

- *CP documented resident unable to reposition self & needed Hoyer lift for transfer though resident often declined use of Hoyer & if resident declined Hoyer staff to use 2 staff & gait belt; CP note documented resident fell at home with fx'd ribs; Transfer to Hospital Summary documented staff assisted resident to shower with 2-person assist as resident declined use of Hoyer lift; resident & 2 CNAs stated resident needed to scoot back in shower chair by CNAs placing arms under resident's shoulders & assisted resident to scoot back in shower chair & all heard popping noise & alerted nurse; during assessment resident cried & stated pain 10/10 in right upper arm & appeared to be a bump between resident's shoulder & elbow; staff stabilized resident's arm so it did not shirt &*

resident adamant resident wanted to stand up to transfer & not use lift; resident's doctor on site & assessed resident & ordered resident to ER & resident agreed where fx ID'd humerus fx requiring surgical repair with open reduction & internal fixation

- *Plan of Removal prior to surveyor on site:*
    - *Education to staff on safe transfers & using necessary equipment to facilitate safe transfers*

NE: SS=E: Failed to secure pressurized supplemental oxygen tanks in a safe, locked area, and out of reach of the 11 cognitively impaired independently mobile residents; additionally failed to provide 1 resident with consistent supervision during her meals and ensure call light remained within reach placing residents at risk for preventable accidents and injuries

- Observed unlocked supply closet in dining area with 13 fully pressurized supplemental O2 cylinders stored in floor rack & storage closet next to supply closet with unsecured cleaning chemicals
- Resident with Alzheimer's disease, insomnia, anxiety, speech/language deficits; CP documented to keep call light within reach while in bed or chair; Observed call light under bed next to wall & low air-loss mattress set at 200 #'s when resident's weight was 122 #'s

NE: SS=D (Past Non-Compliance): Failed to provide adequate supervision for 1 resident resulting in elopement from facility placing resident at risk for preventable accidents & injuries

- *NN documented resident followed someone out door before door's lock could engage; Wanderguard alarm system activated alerting staff to elopement & staff found resident resting against brick wall outside main entry to facility; resident w/o injuries & resident redirected back into facility*
- *Plan of removal:*
    - *Resident immediately assessed*
    - *Facility emailed all DPOAs education r/t checking with staff before allowing residents to exit facility & placed signage*
    - *ID'd all at-risk residents with potential elopement risks*
    - *Completed audit of all residents with Wanderguard bracelets*
    - *Staff training & education provided r/t wandering & elopement risks*
    - *Med review completed for resident*

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to address the CP recommendations for 1 resident's Midodrine; facility also failed to ensure the physician had documented rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of a non-approved indication use of an medication for 2 residents with a diagnosis of Alzheimer's disease and dementia placing 2 residents at risk for unnecessary psychotropic medications & related complications

- POS for Midodrine TID for hypotension PRN with administration parameters; MAR documented 67 days when BP was within physician-ordered parameters for administration (50 opportunities) & record lacked documentation physician notified & med administered on 1 day; MMR documented CP ID'd & reported irregularities r/t lack of administration of resident's PRN Midodrine as ordered
- Resident with POS for Olanzapine for psychosis; MMR ID'd & reported irregularities for non-approved indication for use of antipsychotic for dx of dementia & Alzheimer's disease; facility unable to provide physician documentation for risk vs benefits upon request
- POS for Quetiapine fumarate for dementia with agitation; facility unable to provide risk vs benefit for use of Quetiapine for dementia with agitation

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to ensure POS for 1 resident's hypotension was administered placing resident at risk for unnecessary meds & adverse side effects

- Cited findings noted in F756 r/t facility's failure to administer PRN Midodrine for hypotension under physician's parameters

F760 Residents are Free of Significant Med Errors

NE: SS=D: Failed to ensure 1 resident was free from significant med error by not following physician-ordered parameter for administration of Midodrine placing resident at risk for increased complications, untreated complications & falls with possible injuries

- Cited findings noted in F756 & F757 r/t facility's failure to administer PRN Midodrine for hypotension per physician-ordered parameters on 50 opportunities

F761 Label/Store Drugs & Biologicals

NE: SS=D: Failed to appropriately store meds & biologicals when staff failed to ensure med carts were locked when cart was not within nurses' view placing residents at risk for adverse outcomes or ineffective med regimens

- Observed treatment cart unlocked

F808 Therapeutic Diet Prescribed by Physician

NE: SS=D: Failed to follow resident's physician orders to provide Ensure supplementation 30 minutes after meals placing resident at risk for potential risk r/t impaired nutrition & weight loss

- Cited findings noted in F677 r/t facility serving Ensure with resident meals rather than as physician ordered 30 minutes after meal

F812 Food Procurement, Store/Prepare/Serve-Sanitary

NE: SS=F: Failed to ensure that opened packages of frozen foods were stored in a sealed bag with a label and an open date. The facility failed to ensure staff wore a hairnet when in the kitchen food preparation and serving areas. The facility failed to ensure staff delivered plates of food in a sanitary manner. The facility failed to ensure staff performed hand hygiene after serving residents their plates and or drinks. This placed residents at risk of food-borne illnesses.

- Cited findings listed in findings' statement above

F880 Infection Prevention & Control

NE: SS=E: Failed to perform hand hygiene before performing glucose checks & before performing IV administration; further failed to sanitize Hoyer lift between residents placing residents at risk for infections

- Observed LN performed blood glucose checks for 1 resident & cleaned glucometer with alcohol wipes then wiped resident's finger with same alcohol wipe then wiped hub of insulin pen & LN did not perform hand hygiene before preparing glucometer
- Observed LN administered IV meds & did not perform hand hygiene before going to resident's room, then placed IV supplies on bed & opened alcohol wipe & removed cap from IV port hub then cleaned hub with alcohol wipe & primed IV med & did not perform hand hygiene before attaching IV med to hub
- Observed CNA used Hoyer lift in 1 resident's room & when finished pushed lift into hallway & walked away from lift & did not sanitize lift

F947 Required In-Service Training for Nurse Aides

NE: SS=D: Failed to ensure direct care staff had received required in-service education for nurse aide training placing residents at risk for impaired care & decreased quality of life

- Review of in-service trainings documented file lacked evidence of required 12 hours of nurse aid training for cited staff members