## November, 2022 Survey Findings

**July, 2022**

**F550 Resident Rights/Exercise of Rights**

NE: SS=E: Failed to maintain dignified care practices for 4 residents placing residents at risk for unnecessary embarrassment & decreased psychosocial well-being

- Observed staff transported 1 resident through main TV area uncovered & wearing only a loosely draped hospital gown in facility's shower seat
- Observed staff transported 1 resident to room after taking a shower; door to room failed to latch upon being closed & resident was observed from hallway sitting in shower chair wearing only an incontinence brief & privacy curtain was not utilized & resident was in full view of roommate as well
- Observed resident sat in communal TV area & confused resident sitting to left grabbed side of Broda chair & began shaking it; resident appeared startled & began making grunting noises & staff did not intervene until 9 minutes later when LN moved peer resident
- Observed resident sitting in communal TV area & placed hands down pants & handled genital area in front of 4 other resident & behavior continued for 12 minutes & staff did not intervene
- Observed 2 CNAs prepared 1 resident for shower using Hoyer lift in room & resident undressed from waist down; staff did not cover resident's groin area or legs upon lifting resident from bed & transferred resident in full view of roommate to shower chair positioned in direct view of roommate; resident's shower chair was positioned within 3 feet of roommate with no barrier or privacy curtain to protect either's privacy
- Resident stated each time staff prepare roommate for breakfast, they leave door open which causes resident to have to get dressed with door open or call staff to close it & could not easily close door self; failed to maintain dignified care practices for 4 residents

**F557 Respect, Dignity/Right to have Personal Property**

SE: SS=E: Failed to secure personal belongings for 4/4 residents with failure to return 1 resident's personal vaping device, failure to locate 1 resident's personal w/c; failure to locate missing clothing for 2 residents

- Resident stated Adm took "Vape" & took it to police station to analyze it for marijuana & "vape" did not contain marijuana & never got device back & resident wanted facility to reimburse resident for cost of device since facility took it from resident; Adm reported device came from internet site specializing in marijuana paraphernalia so Adm took to local law enforcement & device was broken at police station; Adm stated facility did not reimburse resident for "vape"; failed to return/reimburse resident for "vape" device which was resident's personal property
- Resident lacked documentation of resident's clothing; resident with wet pants & no pants hanging in closet & staff reported resident admitted with at least 3 pair of pants; failed to ensure resident had clean pants to wear following soiling of pants to enhance feeling of wellbeing & dignity & failed to complete inventory of resident's clothing to determine resident's clothing needs
- Failed to ensure dependent resident had his clothing returned to room & failed to ensure resident had appropriate clothing to wear
- Resident brought w/c from home when admitted; LN moved w/c out of resident's room into hall & staff unable to find w/c since that time & have looked for w/c & have been unable to find it; Failed to ensure dependent resident's personal property was returned to resident when staff moved resident's w/c out of room & failed to return it to resident

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

SE: SS=E: Failed to provide housekeeping services necessary to maintain a sanitary, orderly & comfortable interior in 18/25 resident rooms, DR, 1/3 shower rooms & therapy room for resident in these areas

- Observed: DR: handwashing sink in DR with discolored stains & sink cabinet with chipped paint on outsides; insides of cabinet door with unknown substance of dark yellow splatters with drips; bottom of cabinet with discolored splatters & brown debris in bottom; floor lacked tile next to cabinet; tiles that were present with brown discoloration build-up all around & between them
- Therapy room: wall by door with multiple various areas of chipped off paint
- Hallway: resident rooms floor dirty under bed & in corners of bathroom; scraped paint to closet doors & cracked tiles; 2 overbed tables with chipped off laminate finish & rust colored areas over legs; darkened ring on floor around toilet brush holder in BR; floor dirty & edges of BR flooring lacked caulking; base of toilet dirty at front & with rusty color to caulking around toilet; resident room's entire floor dirty; BR sink discolored rust at drain area; peeling paint; loose floor tiles; missing caulking; ceiling vent with rust; soiled utility room with hopper dirty & carts discolored; shower room discolored & with visible rust; missing sheet rock & missing paint
- Hallway: Missing caulking; splintered door; stained sink drain
- Hallway: paint scrapes & soiled BR floor; discolored on light switch plate; soiled floors; loose floor tiles; soiled floor; failed to provide housekeeping services necessary to maintain sanitary, orderly, & comfortable interior of identified multiple resident areas of facility

NE: SS=E: Failed to maintain a clean, safe, homelike environment when it failed to ensure unused medical equipment was stored out of resident's way & in a manner which did not impede residents' use of personal & common space; further failed to ensure facility carpet was clean & free of stains in residents' communal area placing residents at risk for impaired comfort & decreased homelike environment

- Observed main TV with very large oblong stain on carpet approx. 2ftx2ft; 3 hallways leading to residents' rooms with Hoyer lifts, medication carts & Broda chairs stored on both sides of hallway; hallway leading to dining area with several large stains on carpet; observed staff left Hoyer lift on resident's side of room after using it to transfer resident's roommate; observed hallway blocked by Hoyer lift & empty Broda chair; resident stated often had difficulty maneuvering around chairs & lifts left in hallways & common areas & carpets

were really stained where residents watch TV; failed to maintain a clean, safe, homelike environment when it failed to ensure unused medical equipment was stored out of residents' way & in manner which did not impede residents' use of personal & common space; further failed to ensure facility carpet was clean & free of stains in resident use areas placing residents at risk for impaired comfort & decreased homelike environment

**F656 Develop/Implement Comprehensive Care Plan**

SE: SS=D: Failed to develop comprehensive care plan for 1 resident r/t bowel & bladder incontinence & instructions for TED hose with edema

- Resident with occasional incontinence of bladder; CP lacked individualized toilet plan for resident's incontinence & lacked staff instruction for use of physician ordered TED hose; EMR lacked voiding diary or toileting plan; failed to develop a comprehensive CP for dependent resident r/t individualized toileting needs & placement of physician ordered TED hose for edema

**F657 Care Plan Timing & Revision**

SE: SS=D: Failed to review & revise CP for 1 resident r/t individualized toileting plan to maintain or restore as much normal bladder function as possible for incontinent resident

- CP lacked staff instruction on toileting times for individualized toileting plan for incontinent resident; failed to review & revise incontinent resident's CP with individualized toileting plan to maintain or restore as much normal bladder function as possible

NE: SS=D: Failed to revise CP to include resident-centered fall interventions for 1 resident placing resident at risk for future falls & uncommunicated care needs

- CP directed staff to reposition resident when resident sat on edge of w/c; CP lacked further fall interventions to prevent falls; Prior to date of CP, Fall Investigation revealed resident with unwitnessed fall in room & investigation updated to reflect multiple fall prevention interventions including PT & walking program not included on CP; further unwitnessed fall in DR, resident stated slid out of w/c while passed food to another resident & investigation updated to reflect staff should intervene & reposition as needed but not included on CP; resident with another unwitnessed fall in DR & resident hit head during fall & investigation updated to reflect staff were to redirect & remind resident when resident was anxious about family not coming to visit to prevent resident from falling & getting hurt; failed to ensure 1 resident's CP was updated with appropriate, resident-centered interventions to prevent future falls for 1 resident placing resident at increased risk for injury r/t falls

**F677 ADL Care Provided for Dependent Residents**

SE: SS=D: Failed to provide adequate assistance to ensure 2/4 residents had appropriate personal hygiene r/t long, dirty fingernails

- Resident with BIMS 11 & required limited assist with personal hygiene; CP lacked staff instruction for caring for resident's fingernails; observed resident with long fingernails with dark brown substance under them on multiple occasions; failed to provide adequate assist to ensure dependent resident received appropriate personal hygiene r/t clean fingernails
- Failed to provide adequate assist to ensure dependent resident received appropriate personal hygiene r/t clean fingernails

NE: SS=D: Failed to ensure bathing & personal hygiene was provided for 2 residents who required assist from staff to complete care placing 2 residents at risk for potential skin breakdown &/or complications from not maintaining good personal hygiene & bathing practices

- Resident with dementia & anxiety; BIMS 8 with extensive assist of 2; MDS documented bathing activity did not occur during look back period; documentation for bathing reviewed for 46 days & resident received 2 baths/showers & bathing documented "not applicable" 6 times & "resident refused documented 1 time; observed resident at DR table & hair uncombed; failed to ensure shower/bath was provided for 1 resident who required assist with ADLs with potential to cause skin breakdown &/or complications due to poor personal hygiene & impaired psychosocial wellbeing
- Bathing records reviewed for 102 days & resident received 6 baths/showers; failed to ensure shower/bath was provided for 1 resident who required assist with ADLs with potential to cause skin breakdown &/or skin complications due to poor personal hygiene & impaired psychosocial wellbeing

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

NE: SS=E: Failed to provide weekend activities placing residents in facility at risk for boredom & decreased socialization

- Resident stated that facility never offered activities on weekends & resident would like to attend activities on weekends if they were provided; review of 4 months of activity calendars revealed activities had been scheduled for Monday-Friday but not offered on weekends; staff reported Activity Director left & currently staff were supposed to provide activities until new director found; failed to provide activity program for Saturdays & Sundays placing residents in facility at risk for increased boredom, loneliness & decreased socialization by not providing activities that promote self-esteem, pleasure, comfort, education, creativity, success & independence

**F684 Quality of Care**

SE: SS=D: Failed to ensure staff provided assist with application of physician ordered compression sock treatments for 2/2 residents with facility failure to also ensure staff applied a dressing cover to 1 resident's open wound on leg

- CP instructed staff to apply sock or slipper to resident's foot for protection; POS instructed staff to apply TED hose to resident's lower extremity in mornings & remove at night; observed resident sitting on side of bed & open area uncovered & resident w/o TED hose or dressing as ordered to cover open wound; observed flies in room landing on resident's bed & Styrofoam cup; observed no TED hose or covering over wound on multiple occasions; failed to ensure staff applied a dressing over resident's open wound on lower extremity & failed to apply TED hose as ordered by physician

- CP lacked instruction to staff on applying resident's compression stockings in mornings & removing at night; observed resident w/o TED hose on multiple occasions; failed to ensure dependent resident received assist & wore TED hose each day as directed by physician for treatment for feet/legs edema

NE: SS=D: Failed to implement a physician order for daily weights to monitor for CHF for 1 resident & failed to follow up &/or implement a physician order for Hospice services for 1 resident placing residents at risk for delayed treatment & untreated illness

- EMR with POS to weight daily per physician order every day shift for CHF with notification parameters; TAR for 1 month revealed 6 day period that resident's weight obtained only once; failed to follow physician order for daily weights to monitor weight gain for CHF for 1 resident placing resident at increased risk of adverse side effects for complications r/t CHF
- CP lacked documentation r/t hospice referral; POS with order for hospice to eval & treat as indicated; record lacked further documentation r/t hospice services; record lacked evidence facility discussed with resident or representative r/t delaying hospice services, treatment options or choices r/t hospice services; record lacked hospice evaluation; record lacked evidence resident's physician was notified that resident was never placed on hospice services; failed to follow physician order & DPOA preference for hospice eval & treatment for 1 resident placing resident at risk for decreased quality of life & increased discomfort by delaying hospice services

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

SE: SS=D: Failed to provide a pressure relieving w/c cushion for 1/3 residents to prevent further decline in resident's chronic PU

- Resident with buttock PU present on admission; POS with order for ROHO seat cushion in w/c at all times; POS with order to apply collagen dressing & non-adherent dressing to resident's PU 3x/wk; observed resident w/o ROHO cushion in w/c; CNA unaware of kind of cushion resident to have; DON revealed resident did have a ROHO & refused it; failed to ensure resident's w/c contained a pressure relieving cushion as ordered by physician to prevent worsening of resident's chronic pressure injury

NE: SS=D: Failed to implement interventions to prevent pressure injuries for 2 residents placing residents at increased risk for skin breakdown

- Resident with risk for skin impairment; observed resident remained in same position w/o staff repositioning for 3 hours 7 minutes; failed to reposition 1 resident to prevent skin breakdown placing resident at increased risk for pressure injuries
- Resident with PU risk; CP directed staff to place pressure reducing cushion in w/c to prevent skin breakdown; observed resident in w/c w/o pressure reducing cushion; failed to ensure pressure reducing cushion was in resident's w/c which placed resident at increased risk of development of pressure injuries

**F687 Foot Care**

NW: SS=G: Failed to provide appropriate foot care in accordance with professional standards of practice, to prevent complications from conditions such as diabetes, when CNA filed resident's callous on big toe causing a wound; as a result resident's wound became infected, required medical treatment including antibiotics & continued to cause resident pain

- Resident with DM with BIMS of 14; required supervision with transfers, independent with ADLs & with infection of foot; CP instructed staff to provide diabetic foot checks on resident twice weekly; CP documented resident received added protein in meals TID for wound healing & MVI & Vitamin C for wound healing; CP recorded tow with no dressing & instructed nurses to monitor wound twice weekly with baths; wound note documented resident stated CNA riled callous on resident's last bath day & resident reported pain since that time; wound documentation documented wound as pressure ulcer; wound culture report documented wound with staph & enterococcus; resident started on IV Vancomycin for wound infection; wound required debridement at hospital; LN stated CNAs provided resident foot care, including diabetic resident on bath day; failed to ensure 1 resident received appropriate footcare in accordance with professional standards of practice when CNA filed 1 resident's callous, causing resident pain, infection & surgery

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

SE: SS=E: Failed to ensure environment in resident DR free of accident hazards with failure to keep hazardous chemical out of reach of multiple identified residents

- Observed DR with unlocked cabinet under sink with hazardous cleaning chemicals; failed to ensure DR area remained safe with 2 cleaning chemicals accessible to multiple self-mobile confused residents

NE: SS=D: Failed to implement fall interventions per CP for 1 resident & failed to develop & implement resident-centered fall interventions appropriate for 1 resident to prevent falls placing residents at risk for falls & injuries

- Resident with fall risk & seizure risk with fall mat CPd; observed fall mat not in place; Failed to implement fall interventions per CP for 1 resident placing resident at risk for falls & injuries
- CP directed staff to reposition resident when resident sat on edge of w/c w/o further fall prevention interventions; resident with multiple falls; failed to ensure appropriate resident-centered interventions were developed & implemented to prevent future falls for 1 resident placing resident at increased risk for injury r/t falls

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

SE: SS=E: Failed to ensure there were appropriate toileting programs for 3 residents to help residents restore or improve bladder function & prevent UTIs; failed to ensure 1 resident had appropriate incontinent products available & failed to ensure 1 resident received proper catheter care

- Failed to ensure incontinent, dependent resident had toileting program in place to help resident restore or improve bladder function
- Failed to ensure incontinent, dependent resident received an individualized toileting program to help resident restore or improve bladder function

- Observed resident in room in w/c; room smelled of urine & urine pooled under resident's w/c on floor; w/c cushion saturated with urine; CNA stated brief on backwards; CNA stated resident will notify staff when needs to be changed; DON stated resident often refused staff assist with toileting & refused incontinence care but unaware of reason for refusal; DON stated staff should dress resident with extra-large overnight briefs but could not find any in room or in supply room at the time; failed to ensure staff provided adequate incontinence care products to keep resident's clothing/chair/floor dry & to prevent UTIs, changes needed to provide individualized toileting program; also failed to complete adequate assessment of incontinent resident to plan & implement individualized toileting plan to maintain or restore as much normal bladder function as possible & prevent UTIs
- Observed urinal full of urine on bedside table next to 2 drinking cups with straws; observed resident's pants wet in groin area; resident stated emptied urine collection bag earlier & did not realize resident spilled urine on self but explained did not have another pair of pants to put on; observed resident with same wetness to pants but resident placed 2 work gloves over wet areas in groin area; CAN stated resident emptied urine collection bag into urinal & staff record amount; Failed to monitor resident's technique to empty urine collection bag & storage of used urinal to prevent UTIs & prevent spread of infection

**F744 Treatment/Services for Dementia**

NE: SS=D: Failed to provide dementia care & services to support 1 resident's highest practicable level of wellbeing placing resident at risk for decreased quality of life & impaired wellbeing r/t dementia

- Resident with dementia; MDS indicated no behavioral symptoms; resident with extensive assist of 2 for most ADLs; CAA revealed resident with hx of impulsive frequent outburst behaviors & made frequent grunting noises & outburst if touched by others; observed resident in communal TV area & resident sat next to resident & resident grabbed side of resident's chair & began shaking it; resident startled expression & began making grunting noises & staff did not intervene until LN moved other resident 9 minutes later; LN did not attempt to engage or comfort resident during or after encounter; observed resident sat in communal TV area & placed hands down pants & handled genital area in front of multiple other residents & behavior continued for 12 minutes & staff did not intervene; observed resident in Broda chair facing wall for 1 hour 45 minutes with no entertainment or social engagement; failed to provide dementia care & services to support resident's highest practicable level of wellbeing placing resident at risk for decreased quality of life & impaired wellbeing r/t dementia

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

SE: SS=D: Failed to ensure staff administered pain medications as instructed by physician for 1 resident

- Resident with scheduled pain meds & reported frequent pain rating of 10/10 in BKA stump; resident received 7 days of antipsychotic, antidepressant & opioid meds during 7-day look back period; resident with multiple pain meds: meloxicam, gabapentin, hydrocodone/acetaminophen (PRN), MS; eMAR revealed resident received dose of Hydrocodone-acet at 1:08pm & 2nd dose at 3:37pm; resident continued to report pain & DON administered another dose of hydrocodone-acet prior to leaving for resident's MRI; NN documented 2nd dose was administered at 2:40pm not 3:37 per eMAR; physician notified of medication error; failed to ensure staff administered meds as ordered by physician to prevent adverse effects

NE: SS=E: Failed to ensure a system to promote an accurate reconciliation of controlled drugs at end of daily work shifts & maintain staff count sheets for controlled drugs placing residents at risk for misappropriation of medications by staff

- Observed med cart & staff had not counted or signed Controlled Drug Record on 5 occasions in 1 month; Adm Nurse stated facility unable to locate past Controlled Drug Record flow sheets to review & former staff had disposed of past Controlled Drug Record flow sheets; failed to ensure accurate reconciliation of controlled drugs at end of daily work shifts placing residents at risk for misappropriation of medications by staff

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

NE: SS=D: Failed to perform physician ordered weekly heart rate monitoring r/t medication use placing resident at risk for side effects of unnecessary medication or complications

- Resident with Donepezil for dementia with order to check heart rate 1x weekly due to risk of bradycardia; EMR revealed lacked 11 weeks of heart rate monitoring for bradycardia; failed to ensure consistent weekly heart rate monitoring to assess for bradycardia r/t medication use completed for 1 resident placing resident at risk for potential harm & adverse consequences r/t medications

**F761 Label/Store Drugs & Biologicals**

SE: SS=D: Failed to ensure staff safeguarded & secured narcotic pain medication in double locked storage drawer as required to prevent misappropriation of narcotic medications

- Findings irrelevant to findings statement

**F770 Laboratory Services**

SE: SS=D: Failed to obtain physician ordered laboratory tests for 1 resident who complained of chest tightness & abdomen pain in timely manner

- Resident with dx of iron deficiency anemia; POS with order to obtain lab tests including BNP, CBC & CMP; EMR lacked results of physician ordered lab tests & lacked documentation that staff drew blood for ordered tests; failed to obtain physician ordered lab in timely manner for physician to monitor/manage resident's reported conditions

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

SE: SS=F: Failed to maintain a kitchen environment to store, prepare & serve food under sanitary conditions for residents in facility

- Observed freezer in pantry area with thick heavy layer of frost/ice build up on insides; residents' snack fridge with soiled debris across bottom & metal type vent below door of fridge with discoloration of brown rust substance; freezer seal not secured around edges; missing paint on wood shelves; shelf above microwave with multiple spice containers with thick layer of dust/debris with grimy substance over containers; triple sink with slow drip; kitchen ceiling with crack in ceiling; metal vents with crown rusty colored substance; wall with metal scoop hanger with thick layer of dust/debris; cobweb in corner of pantry

NE: SS=E: Failed to maintain sanitary dining services r/t equipment cleaning, & safe food temps & storage during service placing residents at risk r/t food borne illnesses & food safety concerns

- Observed dish washing area with floor drain with trash & debris visible & obstructing drain holes; ice machine with food & trash items under unit; bug observed crawling under ice machine; dry good storage area with undated, opened bag of noodles; beverage cart transported to main dining for lunch with pitcher of ice & metal scoop used to serve ice left in ice pitcher; jug of milk on cart with no refrigeration or ice & jug temped at 50 degrees F

**F867 QAPI/QAA Improvement Activities**

SE: SS=F: Failed to maintain an effective quality assurance program that IDd , developed & implemented appropriate intervention plans of action to ensure residents received adequate needed services from facility

- Referenced: F557, F584, F677, F684, F686, F689, F690, F755, F761, F770, F812, F880, F887, F921, F925
- Failed to maintain QAA program to ID & develop appropriate plans of action to meet needs of residents of this facility; failed to proactively monitor effectiveness of plans for improvements in areas as well as other areas

NE: SS=F: Failed to maintain an effective QAA program to ID & develop corrective action plans & monitor to correct IDd quality deficiencies prior to survey placing residents at risk for ineffective care

- Referenced: F550, F677, F679, F684, F686, F689, F755, F812; failed to ID & develop corrective action plans for potential quality deficiencies through QAPI plan to correct IDd quality issues placing residents at risk for ineffective care

**F868 QAA Committee**

NW: SS=F: Facility QAA Committee failed to include Medical Director's presence at quarterly meetings placing residents at risk for lack of input from Consultant towards issues discussed in quarterly QAA meetings

- Review of multiple sign in sheets revealed Medical Director did not attend QAA meeting in person & reports were emailed to Medical Director; failed to ensure Consultant Medical Director attended quarterly QAA meetings placing residents at risk for lack of input from Medical Director r/t QAA issues

**F880 Infection Prevention & Control**

SE: SS=F: Failed to maintain effective infection control procedures to ensure staff processed resident laundry in a sanitary manner & failed to ensure personal care items were stored in sanitary manner to prevent spread of infection amongst residents of facility

- Observed resident room with variety of packaged food items stacked on plastic container with used soiled sheets rolled up on top beside fridge & recliner; urinal full of urine on bedside table next to 2 drinking cups with straws; used urinal positioned on top of opened box of gloves; failed to ensure procedures to monitor for sanitary storage of resident personal care items & soiled/used laundry to prevent spread of infections amongst residents
- Observed laundry area with large washer running & area lacked any staff present with concerns: multiple bags & trash bags of clothes/linens directly on floor in soiled laundry area; soiled barrels lacking lid & linens stacked up above level of barrel; sink with numerous items in sink; staff reported did not have designated laundry staff; multiple further laundry area observations; unbagged linens on top of lid of barrel; resident seat cushion lying directly on floor; small washer with hairs & dirt on surface & rust present around top opening of washer; dust on large washer & water heater; floor with wet substance present where buckets of chemical sat; latch broken on dryer; cabinet with missing paint; totes with layer of lint; tablecloths stacked on top of tote in cabinet; on top of cabinet, linens in direct contact with surface & basket of clothing protectors on top uncovered; failed to ensure ongoing effective infection control program in facility laundry areas to prevent spread of infections amongst residents of facility
- Observed resident rooms with plastic wash basins sitting directly on BR floor; toilet scrub brush & disposable gloves directly on floor; plastic bag directly on floor; bed pan directly on floor; urinal directly on floor; unlabeled brushes with hairs in them; multiple unlabeled personal items; failed to maintain effective infection control program when failed to ensure items not stored directly on floor & failed to ensure sanitary laundry environment to prevent spread of infections amongst residents of facility

*NE: SS=D: Failed to ensure staff perform appropriate hand hygiene to prevent cross-contamination during peri-care for 1 resident with risk to spread infection to resident*

- *Observed 2 CNAs transfer resident from w/c to bed using Hoyer lift, removed lift sling & pants by rolling resident in bed; CNA used wipes to perform peri-care, cleaned BM off buttocks & did not doff gloves, perform hand hygiene & don new gloves when moving from dirty to clean areas; did not remove soiled gloves, perform hand hygiene & don new gloves before touching resident's body; 1 CNA doffed 1 hand glove & did not perform hand hygiene & don new glove before touching resident's bedding & personal belongings. 1 CNA did not perform hand hygiene after doffing gloves & before touching resident's personal belongings; failed to ensure staff performed appropriate hand hygiene to prevent cross-contamination during peri-care for 1 resident with risk to spread infection for resident*

NW: SS=F: Failed to monitor & adhere to use of facial masks as directed in core principles of infection control to mitigate spread of COVID-19 placing residents at increased risk for COVID-19 infection

- Observed desk set up inside facility entrance with plastic covered sheet with instructions for visitors saying "please wear a mask while in facility"; observed box on desk with surgical masks; observed SS staff walked down hall w/o mask; Adm Nurse reported facility had nurse test positive that morning when reported to work; observed LN administered medications to resident with surgical mask below nose; observed dietary staff with surgical mask below chin; observed housekeeping staff in DR sweeping floor with surgical mask below chin; observed family visitor passed screening desk w/o screening in & went to dining area w/o mask & another visitor advised visitor to don mask & visitor complied; failed to enforce infection control measures to mitigate spread of COVID-19 by allowing visitors & staff not to wear a mask or to wear facial mask inappropriately placing residents at increased risk for COVID-19

**F887 COVID-19 Immunization**

SE: SS=F: Failed to ensure 6 residents were offered 2nd vaccine booster which became available on May 20, 2022 in a timely manner as required &/or failed to monitor residents' vaccine status for possible booster administration

- Staff reported no clinics since February & facility did not monitor what residents needed/requested a booster or arrange for 2nd booster; failed to monitor vaccine status of residents in proactive manner to ensure residents received full protection of vaccines to prevent spread of COVID-19 & failed to offer vaccines timely when available

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

SE: SS=E: Failed to maintain a sanitary environment in kitchen areas for staff & residents of facility

- Observed pipes & wall under dishwashing table with rust colored substance; cove base bubbling & loose from wall in DR & kitchen; kitchen with noted chipped tiles around drain hole & drain hole laced cover; failed to maintain a sanitary environment in residents' kitchen areas

**F925 Maintains Effective Pest Control Program**

SE: SS=E: Failed to maintain an effective pest control program so facility resident areas were free of bed bugs &/or flies

- Observed multiple areas with flies including fly landing on open area during wound care on multiple occasions; failed to maintain an effective pest control program to ensure resident rooms were as free from flies
- Maintenance staff stated facility has had bed bugs the day of interview & pest control had been notified after nurses saw live adult bed bugs & facility had another bed bug infestation 3-4 months ago; failed to ensure an effective pest control system in facility when they failed to conduct planned routine monitoring of mattresses & other harborage locations for bed bugs

**October, 2022**

**F600 Free from Abuse and Neglect**

*SE: SS=J (Abated to G): Facility neglected to ensure cognitively impaired resident's safety while resident remained outside of facility, unsupervised for 1 hour 50 minutes, in temperatures of about 97 degrees F; further failed to check on resident's wellbeing or provide fluids; failure resulted in resident having an altered mental status, a body temperature of 102.5 degrees F, required emergency medical services response & resident transferred/admitted to local hospital placing resident in immediate jeopardy*

- *NN documented resident sat on porch in sun; when LN attempted to assist resident inside facility for supper, resident had difficulty with ambulation; LN placed gait belt around resident's waist & assisted resident to stand but resident unable to move legs & placed in w/c & brought into building; LN noted resident with altered mental status & was not responding well; resident's temp on temporal thermometer measured 102.5 degrees F; ice packs placed under each of resident's arms & cold wash cloths placed on head & neck; LN placed call to physician & obtained order to send resident to ER; NN documented hospital called facility to inform that resident was being kept overnight for fluids & oral potassium; hospital record documented resident admitted with heat exhaustion, dehydration & acute kidney failure; failed to ensure resident's safety while sat outside of facility on porch for minimum of 1.25 hours in extreme heat of 97 degrees F & was transferred to ER with temp of 102.5 degrees F & altered mental status*
- *Abatement plan:*
  - *All staff educated on routine resident checks*
  - *Established monitoring log on residents sitting outside*
  - *Placed thermometer at front entrance & gazebo*
  - *Implemented administrative staff conducting random routine resident checks daily each shift for 7 days then weekly x 4 weeks results of audits forwarded to QAA committee for review*

**F609 Reporting of Alleged Violations**

*SE: SS=D: Failed to report an injury accident/fall for 1/3 residents to state agency within 5 days of occurrence as required*

- *Resident with unwitnessed fall in room; assessment revealed golf ball sized red area to back of resident's head; resident's cognition declined, slower to respond with eyes closed & would only speak when staff stated name; LN notified physician & obtained order to transfer to ER; NN documented LN received call from ER with results of CT scan revealed subdural hematoma; LN reported CNA informed LN that resident fell in unoccupied, unsecured room; LN reported unsecured door fell against BR wall & was being removed from unoccupied room by staff when LN arrived; maintenance man reported placing door in unsecured room; failed to report severely confused resident's injury fall to state agency within 5 days of occurrences as required*

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

*SE: SS=J (Abated to G): Failed to provide an environment as free as possible of accident hazards for 1/3 residents, cognitively impaired resident when facility staff removed BR door from residents' room & placed BR door in another room just across hall, that was unsecured & unoccupied; CNA observed resident not in room & CNA observed door to unsecured & unoccupied room entrance door stood open & removed BR door stood open & removed BR door stood leaning against BR wall that was previously leaning against wall across from BR; failures placed resident in immediate jeopardy & placed other 9 resident of memory care unit at risk for harm or injury*

- *Failed to provide an environment as free of accidental hazards as possible for 10 cognitively impaired residents residing in memory care unit including 1 resident when staff removed BR door from residents' room & placed BR door in an unsecured & unoccupied room next to resident's room on Memory Care Unit; CNA observed 1 resident not in room & observed door to unsecured & unoccupied room entrance door was opened & BR door from resident's room was leaned against BR wall that was previously leaning against wall adjacent from BR; staff observed resident in unsecured room hying on back with knees upward holding head & with golf ball sized red circle to back of head; resident sent to ER & was found to have subdural hematoma & fractured skull placing resident in immediate jeopardy*
- *Abatement plan:*
  - *Unsecured door removed*
  - *Maintenance educated on "Removal of Unsecured Door"*
  - *Unoccupied room in Memory Care secured*
  - *All staff educated on "Need to Ensure Environment Free of Accident Hazard" & "Appropriate Supervision for Cognitively Impaired Residents"*
  - *Staff members who had not had education educated prior to working next shift*
  - *New hires educated on hire*
  - *Complete Full House Environmental Round on Memory Care Unit*

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

NE: SS=D: Failed to assess & ID services & assistance necessary to promote bladder continence for 2 residents placing residents at risk for decreased psychosocial wellbeing & increased incontinence

- MDS noted no toileting program had been attempted on admission & resident frequently incontinent of both bowel & bladder with no toileting program; record lacked evidence facility assessed type of incontinence or resident's voiding patterns; CP directed staff to toilet resident every 2-3 hours & resident required 1 assist with ADLs; staff reported family had recently purchased a Purewick device but had not brought it to facility; failed to assess & ID services & assistance necessary to promote bladder & bowel continence for 1 resident placing resident at risk from decreased psychosocial wellbeing & increased incontinence
- MDS indicated resident frequently incontinent with no toileting program; CP directed staff to toilet resident every 2-3 hours & as necessary; record lacked evidence resident was assessed for type of urinary incontinence, suitability for bladder retraining program or voiding patterns for personalized toileting schedule; failed to ID & develop an individualized toileting program &/or bladder retraining for 1 resident to promote continence & maintain dignity & wellbeing

**F697 Pain Management**

NE: SS=D: Failed to address & treat 1 resident's pain when providing care placing resident at risk of ongoing pain, impaired psychosocial wellbeing & diminished quality of life

- Resident with HTN, depression & abdominal pain; BIMS 10; MDS revealed resident with pain & had not received any non-mediation intervention or opioid medication during look back period; MDS documented resident with injury from fall; POS with order for Acetaminophen 650 q 4 hours PRN for general discomfort not to exceed 3gms in 24 hour period; MS .25mL po q 3 hours PRN pain & SOB; Norco 5-325 q 6 hrs PRN pain NTE 3gms in 24 hour period; observed 2 CNAs provided dressing & morning care; CNA asked resident if had pain & resident stated "yes"; staff continued to provide pericare & dressing as resident moaned & cried during cares; with transfer resident cried out; staff reported resident "always cried out that way"; failed to address & treat 1 resident's pain placing resident at risk of untreated pain, impaired psychosocial wellbeing & diminished quality of life

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

*SE: SS=E (Past Non-Compliance): Failed to ensure 1 resident was free of significant medication errors when facility staff prepared 2 different residents' medications & placed crushed medications in nurse's cart; staff entered resident's room & administered wrong medications to resident that included phenobarbital, Kepra, Bumex; staff removed cup of combined crushed medications in 1 med cup marked for other resident & administered medications to 1st resident; medication error resulted in significant medication error*

- *2 resident with PEG tubes; Med error report documented LN prepared medications for residents at 1PM & administered wrong med to 1st resident then observed med cup labeled with another resident's name when went to administer 2nd resident's meds; staff administered 1st resident's meds that were prescribed for 2nd resident including: guaifenesin, baclofen, dantrium, reglan, Keppra, phenobarbital; physician extender instructed staff to contact Poison Control & follow Poison Control's recommendations r/t staff administration of meds that 1st resident received; LN reported to surveyor that both residents' meds were prepared at same time while in med room; failed to ensure resident was free of any significant medication errors when facility staff set up 2 different residents' medication crushed meds & mixed/cocktailed meds & placed medication in nurse's cart drawer then entered 1st resident's room & administered wrong meds to 1st resident then removed combined crushed meds in 1 med cup marked for 2nd resident & administered meds to 1st resident in error resulting in significant medication error*

- *Past Non-Compliance Plan:*
    - *Staff member received 1:1 education & LN provided return demonstration of correct & safe administration of PEG tube meds*
    - *Education of all nurses with 100% LN staff education including review of facility policy entitled "Administration of Medications Via Gastrostomy Tube*

**F761 Label/Store Drugs & Biologicals**

NE: SS=E: Failed to date 1 insulin pen & failed to discard 1 expired insulin pen in 1/3 medication carts leaving residents at risk for adverse consequences or ineffective medication treatment

- Observed 1 insulin flex pen opened & undated & 1 insulin pen opened with expired date; failed to ensure that nursing staff properly dated resident's insulin pens when opened & failed to ensure expired medications were disposed of with potential to cause adverse consequences or ineffective treatment to residents