March, 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

October, 2024

F550 Resident Rights/Exercise of Rights

SW: SS=D: Failed to treat residents in dignified manner when it charted in record that resident placed at "feeder table"; facility did not honor resident's rights r/t personal food preferences & food choices for 1 resident placing resident at risk for decreased psychosocial wellbeing

- Failed to provide 1 resident care in dignified manner when it referred to table where resident was placed as "feeder table" in electronic charting placing resident at risk for decreased psychosocial wellbeing
- Failed to honor 1 resident's rights r/t personal food preferences & food choices

F565 Resident/Family Group & Response

SE: SS=E: Failed to address & resolve recurring issues reported by Resident Council placing resident at risk for decreased psychosocial wellbeing

- Resident Council minutes documented multiple months with concerns about food temps; minutes lacked actions taken or outcomes for repeat concerns; SSD unable to produce Grievance Forms r/t food temps; failed to address & resolve recurring issues reported by Resident Council placing residents at risk for decreased psychosocial wellbeing & impaired quality of life

F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directives

SE: SS=D: Failed to ensure 1 resident's advance directives were thoroughly completed; 1 resident with DNR which was only signed by physician

- Failed to ensure 1 resident had fully completed advance directive with potential to lead to uncommunicated needs specifically to end-of-life care

SW: SS=E: Failed to ensure 5 residents' advance directives were thoroughly completed

- Observed 2 resident records lacked documentation of DPOA paperwork who had signed the DNR forms for residents
- 1 resident record lacked DNR order & lacked uploaded DNR form
- 1 resident record lacked order for DNR
- 1 resident had no code order or scanned advance directive documents but was ID'd as DNR
- CP's for 4 residents lacked advance directive information for each resident; 4 residents lacked physician orders for advance directives
- Failed to ensure 5 residents had accurate advance directives completed with potential to lead to uncommunicated needs r/t residents' choice in end-of-life care

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

SE: SS=D: Failed to ensure 1 resident/representative right to be informed with resident had new order for antipsychotic med dosage change

- POS for Seroquel 25mg q hs for delusions; NN documented verbal order to decrease Seroquel for GDR; NN lacked evidence staff notified resident's representative of med change; failed to ensure resident/representative right to be informed when resident had new order for antipsychotic med dosage change

F584 Safe/Clean/Comfortable/Homelike Environment

SW: SS=E: Failed to promote clean homelike environment for 5 residents; 1 resident with chair seat repaired with duct tape, 1 resident with bureau drawer which had lacked part of veneer on drawer facing & remaining veneer loose & brittle; 4 residents with fall mats which were cracked & had worn down surfaces all that were ID'd as non-cleanable surfaces & non-homelike environment with potential to spread possible infections to residents in facility

- Failed to promote clean homelike environment for 5 residents with potential to spread possible infections to residents in facility & had potential to lead to negative psychosocial effects r/t non-home-like environment

F623 Notice Requirements Before Transfer/Discharge

SW: SS=E: Failed to provide written notice to resident/representative for facility-initiated transfers for 3 residents when residents transferred to hospital; also failed to send copy of notice to LTC Ombudsman for 3 resident discharges placing residents at risk for uninformed care choices

- Resident discharged to hospital & EMR lacked documentation r/t written notification of resident/representative or to state LTC Ombudsman r/t discharge/transfer for 3 residents

F625 Notice of Bed Hold Policy Before/Upon Transfer

SE: SS=D: Failed to provide 3 residents/representatives with written notice of bed hold policy at time of residents' transfers to hospital placing residents at risk to not be allowed to return to former rooms at facility

- Failed to provide written bed hold notice to 3 residents for hospitalization placing residents at risk to not be allowed to return to former room at facility

SW: SS=E: Failed to provide written bd hold policy notice to 3 residents/representatives when transferred to hospital with risk of impaired ability to return to facility & to previous room for 3 residents

- Resident transferred to hospital & EMR lacked documentation r/t written notification of resident/representative or notification of LTC Ombudsman r/t discharge/transfer for 3 residents

F636 Comprehensive Assessments & Timing

SW: SS=F: Failed to develop and implement a person-centered comprehensive care plan for three residents, 1 resident related to psychotropic medication use, opioid medication use, diuretic
medication use and nebulized medication use; 1 resident's Care plan lacked interventions related to the performance (or lack thereof) for activities of daily living, psychotropic medication use, visual function, abnormal behaviors, nutritional status, and pain; 1 resident's care plan lacked interventions to mitigate the risk for falls with a known history of falls; with potential to lead to uncommunicated needs which would negatively impact the physical and psychosocial wellbeing of residents; Failed to complete CAAs that addressed individual underlying causes contributing factors & risk factors for 6 residents who had incomplete or no CAAS

- Failed to accurately complete CAAs for 6 residents r/t several CAAs triggered placing residents at risk for uncommunicated care needs

F641 Accuracy of Assessments

SE: SS=D: Failed to accurately complete MDS for 3 residents: 1 resident for falls & injections; 1 residents for use of Foley catheter & O2 & 1 resident r/t falls placing residents at risk for uncommunicated care needs

- Failed to accurately complete MDS r/t falls & insulin injections placing resident at risk for uncommunicated care needs
- Failed to accurately completed MDS r/t catheter & O2 placing resident at risk for uncommunicated care needs
- Failed to accurately capture fall with potential to create inaccurate or uncommunicated care needs & place resident at risk for continued & ongoing risk for falls which had potential to negatively impact resident's physical & psychosocial wellbeing

F638 Quarterly Assessment at Least Every 3 Months

SW: SS=E: Failed to complete a quarterly MDS in timely manner for 8 residents placing residents at risk for unmet care needs & inaccurate assessments

- Failed to complete quarterly MDS assessment in timely manner for 8 residents placing residents at risk for unmet care needs & inaccurate assessments

F640 Encoding/Transmitting Resident Assessments

SW: SS=E: Failed to complete a comprehensive MDS assessment in timely manner for 10 residents placing residents at risk for unmet care needs & inaccurate assessments

- Failed to complete comprehensive MDS assessment in timely manner for 10 resident placing residents at risk for unmet care needs & inaccurate assessments

F641 Accuracy of Assessments

SW: SS=F: Failed to accurately completed MDS for 7 resident: 5 residents r/t falls; 1 resident r/t antipsychotic med; 1 resident r/t chair alarm; 1 resident r/t antidepressant med; 1 resident r/t antiplatelet med placing residents at risk for uncommunicated care needs

- Failed to accurately complete CMS for 1 resident r/t falls & antipsychotic meds placing resident at risk for uncommunicated care needs
- Failed to accurately complete MDS for 1 resident r/t falls & chair alarm placing resident at risk for uncommunicated care needs
- Failed to accurately complete MDS for 1 resident r/o documentation of psychotropic & opioid med use when resident did not utilize those meds during lookback period placing resident at risk for uncommunicated care needs
- Failed to accurately completed MDS for 1 resident r/t falls & antipsychotic meds placing resident at risk for uncommunicated care needs
- Failed to accurately complete MDS for 1 resident r/t antiplatelet meds placing resident at risk for uncommunicated care needs
- Failed to accurately completed MDS for 1 resident r/t falls & antibiotic meds placing resident at risk for uncommunicated care needs
- Failed to accurately complete MDS for 1 resident r/t falls placing resident at risk for uncommunicated care needs

F655 Baseline Care Plan

SE: SS=D: Failed to develop a person-centered baseline CP for 1 resident with potential to lead to uncommunicated needs & accidents

- Failed to provide environment that remained free from accident hazards for 1 resident when facility failed to complete baseline CP interventions for hx of falls

SW: SS=D: Failed to develop a person-centered baseline CP for 2 residents with potential to lead to uncommunicated needs

- Failed to complete baseline CP for 2 residents with potential to lead to uncommunicated needs

F656 Develop/Implement Comprehensive Care Plan

SE: SS=D: Failed to develop a comprehensive CP with interventions to address EBP for 1 resident's wounds to ensure infection control precautions which placed other residents at risk

- Failed to develop comprehensive CP with interventions to address EBP for 1 resident's wounds to ensure infection control precautions placing other residents at risk

SW: SS=D: Failed to develop & implement person-centered comprehensive CP for 3 residents: 1 r/t psychotropic med use, opioid med use, diuretic med use & nebulized med use; 1 lacked interventions r/t performance of ADLs, psychotropic med use, visual function, abnormal behaviors, nutritional status & pain; 1 Cp lacked interventions to mitigate risk for falls with known hx of fall with potential to lead to uncommunicated needs which would negatively impact physical & psychosocial wellbeing of residents

- Failed to develop & implement person-centered comprehensive CP for multiple residents cited in findings statement with potential to lead to uncommunicated needs which had potential to negatively affect physical & psychosocial wellbeing of residents

F657 Care Plan Timing & Revision

SE: SS=D: Failed to review & revise comprehensive CP for 2 residents r/t falls & accident hazards with potential to lead to uncommunicated needs that would negatively affect physical & psychosocial wellbeing of residents

- Failed to review & revise permanent CP to include interventions to mitigate risk for additional falls after fall on 6-21-24 placing resident at risk for uncommunicated needs as well as continued & on-going risk for falls with potential to negatively impact resident's physical & psychosocial wellbeing
- Failed to revise 1 resident's CP after fall in timely manner when staff did not add fall intervention to CP until 10 days after resident's fall placing resident at risk for uncommunicated care needs & at risk for further falls

SW: SS=E: Failed to review & revise CPs with appropriate interventions for 8 residents

- Failed to update CP with fall prevention interventions to prevent falls for cognitively impaired resident who had hx of falls & several falls at facility placing resident at risk for further falls with injury for multiple residents
- Failed to review & revise person-centered comprehensive CP for 1 resident including interventions r/t inclusion of EBP r/t chronic wound & urinary catheter care with potential for uncommunicated needs that could negatively impact resident's physical & psychosocial wellbeing
- Failed to revise CP with fall prevention interventions for cognitively impaired resident with repeated falls
- Failed to implement effective fall prevention interventions to prevent falls for cognitively resident; resident fell at facility with no new interventions in CP placing resident at risk for further falls

F684 Quality of Care

SE: SS=D: Failed to assess & address skin issues including open areas to bilateral legs & edema for 1 resident with potential to place resident at increased risk for development of additional medical problems

- Failed to assess & address skin issues for 1 resident with potential to place resident at increased risk for development of additional medical problems

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=G: Failed to provide environment free from accident hazards for 5 residents; failed to include fall prevention interventions on CP for 1 resident who fell & sustained deep lacerations to face requiring transfer to ER & sutures/stitches & glue as treatment; further failed to implement new CP interventions to prevent further falls for 1 resident & failed to investigate fall experienced by resident; also failed to ensure staff did not leave resident unattended in BR, attached to sit to stand mechanical lift & staff also did not provide adequate supervision to 1 resident when staff left resident unattended in room & resident attempted to self-transfer from w/c with potential to result in injury

- Baseline CP documented with fall hx but lacked interventions to prevent falls; failed to provide environment that remained free from accident hazards for 1 resident with hx of falls when facility failed to include fall prevention interventions on CP & resident fell & sustained deep lacerations to face requiring transfer to ER & sutures/stitches & glue as tx
- Failed to provide environment remaining free from accident hazards for 1 resident when failed to place effective interventions in place for resident with hx of falls
- Failed to complete fall investigation & develop immediate & permanent CP interventions to mitigate risk for additional falls after 1 fall placing resident at continued & on-going risk for falls with potential to negatively impact resident's physical & psychosocial wellbeing
- Failed to provide environment free of accident hazards when staff left 1 resident unattended in w/c in room after multiple assessments that documented resident a high fall risk placing resident at continued & ongoing risk for accident hazards with potential to negatively impact resident's physical & psychosocial wellbeing
- Failed to provide environment free of accident hazards when staff left 1 resident with multiple assessments of high risk for falls, unattended in BR while attached to mechanical lift placing resident at continued & ongoing risk for accident hazards with potential to negatively impact resident's physical & psychosocial wellbeing

SW: SS=G: Failed to ID, implement & re-evaluate fall prevention interventions to prevent falls for 6 residents; 1 resident experienced fall resulting in multiple sinus fx's & 1 resident's fall resulted in hip fx which required hospitalization & surgery; additionally, facility failed to implement new interventions to prevent falls for 4 residents placing residents at risk for falls with injury

- Failed to implement effective fall prevention interventions to prevent falls for cognitively impaired resident who had hx of falls & resident fell at facility & fx'd facial bones & facility did not update CP with further fall prevention interventions until 12 days after fall with major injury placing resident at risk for further falls with injury
- Failed to implement effective fall prevention interventions to prevent falls for cognitively impaired resident with hx of falls & several falls at facility placing resident at risk for further falls with injury
- Failed to implement fall prevention interventions after multiple falls for cognitively impaired & dependent resident with known hx of repeated fall; resident with injury fall on 4-22-24, non-injury fall on 6-15 & injury fall on 7-25 with no fall prevention interventions ID'd & implemented to prevent further falls resulting in actual injuries to resident to physical & psychosocial wellbeing of 1 resident

F692 Nutrition/Hydration Status Maintenance

SW: SS=D: Failed to accurately assess nutritional status of cognitively impaired resident on admission placing resident at risk for nutritional deficits

- Resident admitted on 9-16-24; RD confirmed had not seen resident on 10-24 & did not know resident admitted to facility & should have received information from dietary staff; additionally RD reported concerned as resident's preferences & nutritional needs were unknown & RD expected to have assessment completed within 3 days of admission; failed to accurately assess resident's nutritional status on admission placing resident at risk for uncommunicated care needs & potential nutritional deficits

F695 Respiratory/Tracheostomy Care & Suctioning

SE: SS=D: Failed to properly clean & store nebulizer for 1 resident & failed to properly store O2 cannula for 2 residents placing residents at risk for respiratory complications

- Failed to appropriate clean & store nebulizer & nebulizer equipment for 1 resident with potential to result in respiratory complications
- Failed to ensure physician order to reflect resident's O2 use
- Failed to appropriately store O2 tubing for 1 resident with potential to result in respiratory complications

SW: SS=E: Failed to provide respiratory care consistent with professional standards for 4 residents; failed to ensure staff properly cleaned & stored nebulizer for 3 residents; failed to ensure 1 resident's room remained free of used nebulizer equipment not required for resident's care; facility to ensure nasal cannula were stored appropriately, sanitarily when not in use for 2 resident with potential to have negative impact on resident's physical wellbeing & at risk of respiratory infection

- Failed to properly clean & store nebulizer for 3 residents; failed to ensure 1 resident's room remained free of used nebulizer equipment not required for resident's care & failed to ensure that nasal cannulas were stored appropriately when not in use for 2 residents with potential to have negative impact on residents' physical wellbeing & at risk for respiratory infections

F712 Physician Visits-Frequency/Timeliness/Alt NPP

SW: SS=D: Failed to ensure physician documented & conducted in-person admission visit as required for 1 resident

- EMR revealed resident admitted to facility on 9-16-24 & lacked physician visit noted as of 12-21-24**;** Adm nurse confirmed resident had not been seen by physician since admission; failed to ensure physician visits were conducted in person & documented as required for 1 resident for admission placing resident at risk for uncommunicated care needs

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

SW: SS=F: Failed to provide RN coverage 8 hrs/day/wk, placing all residents who reside at facility at risk of lack of assessments & inappropriate care

- PBJ report documented lack of consecutive 8-hr RN coverage for 39 days from 7-1-23 thru 6-30-24; failed to provide RN coverage 8 consecutive hr/day, 7 days/wk placing residents who resided in facility at risk for lack of assessment & inappropriate care

F732 Posted Nurse Staffing Information

SW: SS=C: Failed to ensure posted daily nurse staffing sheets included daily census & nursing hours as required

- Observed daily staffing sheets on back wall of nurses' station & form lacked total number or actual hours worked by licensed & unlicensed staff along with daily resident census on multiple occasions; failed to ensure posted daily nurse staffing sheets included daily census & nursing hours as required

F744 Treatment/Service for Dementia

SW: SS=D: Failed to support 2 residents & implement CP'd interventions to address dementia care needs placing residents at risk for impaired ability to achieve &/or maintain highest practicable level of functioning & wellbeing; failed to implement individualized interventions as well as revise CP accordingly to address individualized interventions r/t residents' symptomology & rate of progression as evidenced by observation, record review &/or interview

- CP lacked documentation of individualized interventions & measurable outcomes or monitoring of effectiveness of interventions r/t resident's Alzheimer's dx; failed to ensure 1 resident provided individualized care approaches & failed to provide documentation of non-pharmacological interventions attempts; failed to implement individualized interventions as well as revise CP accordingly

to address individualized interventions r/t residents symptomology & rate of progression; facility did not provide documentation of interventions performed or Cp being reviewed or revised with individualized goals & interventions to attain or maintain resident's highest practicable wellbeing placing resident at risk for impaired ability to achieve &/or maintain highest practicable level of functioning & wellbeing

- CP lacked documentation of individualized interventions & measurable goals r/t resident's behaviors; CP lacked 1 resident administered antipsychotic & antidepressant meds; failed to ensure 1 resident provided individualized care approaches & failed to provide documentation of non-pharmacological interventions attempted; failed to implement individualized interventions to address individualized interventions r/t resident's symptomology & rate of progressing placing resident at risk for impaired ability to achieve &/or maintain highest practicable level of functioning & wellbeing

F756 Drug Regimen Review, Report Irregularities, Act On

SW: SS=D: Failed to act on pharmacist's MRR for 1 resident with potential to lead to residents receiving unnecessary meds

- POS for Sertraline 150mg qd for depression; hydrocodone/acet q 8 hrs PRN hip pain; EMR lacked documentation r/t non-pharmacological interventions attempted by staff; failed to ensure 1 resident was free of unnecessary psychotropic meds & failed to provide documentation of non-pharmacological interventions attempted, further facility did not provide documentation of required MRR & attempted GDR of unknown med with potential to lead to 1 resident receiving unnecessary meds

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SW: SS=D: Failed to ensure 1 resident's medication regimen remained free of PRN psychotropic med that lacked required 14-day stop date or clinical rationale for continued use beyond initial 14 days with potential to lead resident receiving unnecessary psychotropic meds

- POS for Ativan 0.5mg, q 8 hrs PRN anxiety & order lacked stop date or rationale for continued use of medication; failed to ensure 14-day stop date or physician rationale for continued use beyond 14 days for 1 resident's PRN psychotropic med, Ativan with potential for resident to receive unnecessary psychotropic med

F761 Label/Store Drugs & Biologicals

SE: SS=E: Failed to ensure 1/4 med carts were locked while unattended with potential to affect 14 residents located on main campus

- Failed to ensure 1/4 med carts observed were locked while unattended with potential to have negative effect on overall physical & psychosocial wellbeing on resident in facility

SW: SS=E: Failed to ensure staff secured storage of resident meds when observation onsite revealed unlocked & unattended med cart, not in line of vision of attending staff, containing oral, topical & inhaled meds placing 9 cognitively impaired, independently mobile residents at risk

- Observed unlocked & unattended med cart in dining area & common area; failed to ensure safe & secure storage of resident med when observation onsite revealed unlocked & unattended med cart, not in line of vision of staff in resident hallway

F804 Nutritive Value/Appear, Palatable/Prefer Temp

SE: SS=F: Failed to ensure meals were served at safe & appetizing temperature; 2 residents c/o cold food temp at meals

- Cited findings noted in F565 r/t cold food; test tray with chicken at 122 degrees, cauliflower at 110 degrees, potatoes at 126 degrees & pears at 40 degrees & dietary staff unaware of appropriate food temps; failed to ensure meals; failed to ensure meals were served at safe & appetizing temps; residents c/o cold food temps at meals placing residents at risk for risks r/t impaired nutrition

F806 Resident Allergies, Preferences, Substitutes

SW: SS=D: Failed to accommodate resident's preferences r/t dietary preferences for 1 resident

- Cited findings noted in F550, F692; failed to assess dietary preferences of 1 resident in order to provide foods to meet resident's preferences

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=F: Failed to store, prepare & serve food in sanitary manner to prevent possible foodborne illness to residents of facility

- Observed multiple foods in multiple areas of facility with open, unlabeled & undated food items
- Observed kitchen with ovens with bubbled, burned food debris on bottom of inside of ovens; 3 fry pans with scratches in cooking surface; cutting boards with scratches & gouges

SW: SS=F: Failed to store, prepare & serve food in sanitary manner to prevent possible foodborne illness to residents of facility

- Observed kitchen & fridge storage area with multiple unsealed/uncovered, unlabeled, undated food items; observed fridge with temp of 42 degrees F; temp logs not maintained & temps documented out of range; failed to store, prepare & serve food in sanitary manner to prevent possible foodborne illness to residents of facility

F814 Dispose Garbage & Refuse Properly

SW: SS=F: Failed to maintain &/or dispose of garbage & refuse properly & in sanitary condition, ensuring lids were down to cover disposed waste & prevent potential harboring/feeding of pests

- Observed outside trash dumpsters & 7 dumpsters had lids in open position; failed to provide sanitary garbage & refuse containers that were maintained with lids closed or otherwise covered with potential to lead to harborage & feeding of pests

F835 Administration

SW: SS=F: Failed to provide administrative services in manner to effectively & efficiently use resources to attain/maintain each resident's highest physical, mental & psychosocial wellbeing for all residents residing in facility

- Cited: F550, F578, F584, F623, F625, F636, F638, F640, F641, F655, F656, F657, F689, F692, F695, F714, F727, F732, F744, F756, F758, F761, F806, F812, F814, F851, F867, F880, F882, F883, F947

F851 Payroll Based Journal

SW: SS=F: Failed to accurately complete PBJ reports for RN coverage 8 hrs/day, 7 days/wk & failed to accurately complete PBJ report for LN coverage 24 hrs/day placing all residents residing in facility at risk for lack of assessments & inappropriate care

- Failed to accurately complete PBJ report for 4 quarterly placing all residents who reside at facility at risk for lack of assessments & inappropriate care

F867 QAPI/QAA Improvement Activities

SW: SS=F: Failed to ensure QAA program conducted at least 1 PIP annually that focused on high-risk or problem prone areas, ID'd by facility thru data collection & analysis with potential to affect all residents

- Adm nurse reported no annual PIPs had been conducted for facility & stated, "It is a work in progress"; failed to conduct at least 1 PIP annually with potential to affect all residents of facility

F880 Infection Prevention & Control

SE: SS=F: Failed to maintain effective ICPC r/t maintaining sterile field with PICC line dressing change for 1 resident & dietary staff lacked proper hand hygiene during DR services; additionally , staff with improper hand hygiene with catheter care; failed to set up EBP; failed to provide respiratory care consistent with professional standards of care for 1 resident r/t use & cleaning of nebulizer equipment for 3 resident's O2 supplies not stored in clean manner with potential to spread possible infections to residents of facility

- Failed to maintain effective infection control program r/t improper cleaning & storage of respiratory equipment, lacked proper hand hygiene during DR service & after removal of soiled gloves, improper sterile technique during PICC dressing change & lacked placing resident on EBP with draining wounds to prevent cross contamination in facility

SW: SS=F: Failed to transport clean linens in a method to protect clean linens from dust or soiling when staff left the clean linen cart uncovered during transport. The facility further failed to maintain an effective infection control program related to the maintaining an annually reviewed Infection Prevention and Control Program (IPCP). The facility staff failed to utilize enhanced barrier precautions when providing catheter care and wound care on 1 resident. The facility failed to provide respiratory care consistent with professional standards of care for 3 residents regarding the use and cleaning of the nebulizer equipment and 1 resident's oxygen supplies were not stored in a clean manner with potential to spread possible infections to the residents in the facility.

- Cited findings noted in findings statement

F881 Antibiotic Stewardship Program

SE: SS=F: Failed to ensure staff adhered to principles of antibiotic stewardship thru monitoring for appropriate use of antibiotics prescribed for residents to prevent antibiotic resistance & spread of multidrug resistant organisms within facility

- Staff confirmed lack of completion of computerized infection monitoring system & lack of antibiotic stewardship for facility & confirmed some residents had prophylactic ABT prescribed & confirmed prescribing provider & medical director not updated with concerns; Failed to provide ongoing antibiotic stewardship to ensure appropriate antibiotic use for residents of facility to prevent antibiotic resistance & spread of multi drug resistant organisms

SW: SS=F: Failed to ensure staff adhered to principles of antibiotic stewardship thru monitoring for appropriate use of antibiotics prescribed for residents to prevent antibiotic resistance & spread of multidrug resistant organisms within facility

- Failed to provide ongoing antibiotic stewardship to ensure appropriate antibiotic use for residents of facility to prevent antibiotic resistance & spread of multidrug resistant organisms

F882 Infection Preventionist Qualifications/Role

SW: SS=F: Failed to designate a qualified IP who had completed specialized training in IPC to be responsible for facility's IPCP with potential to affect all residents

- Failed to designate a qualified IP who had completed specialized training in infection prevention & control to be responsible for facility's IPCP with potential to affect all residents

F883 Influenza & Pneumococcal Immunizations

SE: SS=D: Failed to provide pneumococcal vaccine declination form to 4/5 residents reviewed; failed to provide 1 resident with influenza vaccine declination form for 1/5 residents reviewed

- Failed to provide proof of declination of pneumococcal vaccine for 4 residents & proof of declination of influenza vaccine for 1 resident

SW: SS=E: Failed to provide pneumococcal vaccine consent/declination form to 5 residents reviewed; additionally facility failed to provide 2nd witness signature on 2 resident's influenza vaccine consent forms

- Failed to provide proof of declination or proof of immunization of pneumococcal vaccine for 5 residents & failed to receive witness signature for influenza vaccine for 2 residents

F947 Required In-Service Training for Nurse Aides

SW: SS=F: Failed to ensure 4/5 CNAs lacked required 12 hrs/year in-service training placing residents at risk for decreased quality of life &/or inadequate care

- Failed to ensure 4/5 CNAs received 12 hr/yr in-service training as required

November, 2024

F550 Resident Rights/Exercise of Rights

NE: SS=D: Failed to ensure dignified dining experience for 1 resident when staff stood over resident instead of sitting beside resident while assisting with eating placing resident at risk for impaired dignity

- Failed to ensure 1 resident was treated with dignity during dining placing resident at risk for impaired dignity

F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to ensure 1 resident had call light resident could functionally activate for staff assist; additionally failed to ensure 1 resident had foot pedals on w/c while being pushed placing both residents at risk for preventable accidents & injuries r/t unmet care needs

- Failed to ensure 1 resident had call light resident could functionally activate for staff assist placing resident at risk for preventable accidents & injuries due to unmet care needs
- Failed to ensure 1 resident's footrests were placed on w/c when staff pushed resident into DR then pushed resident into room placing resident at risk for impaired care due to unmet care needs

F561 Self-Determination

NE: SS=D: Failed to ensure staff allowed 1 resident who had smoking agreement in place at facility to remain at facility & continue to smoke after facility changed its policy to prohibit smoking; further failed to allow 1 resident to choose bathing times & preferences placing both residents at risk for decreased autonomy & impaired psychosocial wellbeing

- Observed "Memorandum for Resident of (name of another facility) dated 9-16-24 from Adm staff documenting that effective 30 calendar days from date of letter, facility would no longer be a smoking facility meaning that smoking would no longer be permitted anywhere on premises, including all indoor & outdoor areas; SS noted documented resident had been accepted to another facility & resident was eager to transfer; later NN documented resident stated "not sure" wanted to move from facility"; SS noted documented resident would be discharged; failed to ensure staff allowed resident who had smoking agreement in place at facility, to remain at facility & continue to smoke after facility changed policy to prohibit smoking placing resident at risk for decreased autonomy & impaired psychosocial wellbeing

F570 Surety Bond-Security of Personal Funds

NE: SS=E: Failed to have a surety bond that covered facility's resident trust funds placing 52 residents at risk for complications r/t financial loss

- Review of Trust Fund Account indicated current balance of $32,310.15 & 52 residents with active accounts managed by facility; Surety bond indicated bond covered $30,000; failed to have surety bond that covered facility's resident trust funds placing residents at risk for complications r/t financial loss

F583 Personal Privacy/Confidentiality of Records

NE: SS=D: Failed to ensure staff secured & protected privacy & confidentiality of 1 resident's medical record placing resident at risk for impaired right to confidentiality

- Observed laptop showing MAR left unattended on 1 med cart; failed to ensure staff secured & protected privacy & confidentiality for 1 resident's record placing resident at risk for impaired right to confidentiality

F602 Free from Misappropriation/Exploitation

NW: SS=D: Failed to ensure 1 resident remained free from misappropriation of property placing resident at risk for ongoing misappropriation & impaired psychosocial wellbeing

- *Inventory Sheet documented resident had gold diamond ring; Investigation documented staff reported to Adm Nurse that resident's wedding ring missing from finger; resident (with cognitive impairment) reported that someone sprayed something on finger & took ring & finger had hurt for a few days; resident unable to remember who or when occurred; after search, ring not located; staff stated when resident first admitted, staff asked family to take ring home, but several family members could not get ring off finger so left it on finger; facility implemented policy for exploitation completely in response to incident; failed to protect 1 resident from misappropriation of resident property after staff failed to safeguard resident's wedding ring which had to be physically removed, went missing placing resident at risk for further loss of property & psychosocial decline*

F609 Reporting of Alleged Violations

NE: SS=D: Failed to ID fx of unknown origin for 1 resident as potential abuse or neglect & report to State Agency (SA) as required placing resident at risk for unidentified & ongoing abuse, neglect or mistreatment

- Cited findings noted in F610; dated 09/26/24; NN at 03:56 documented the CNA assigned to resident was assisting resident with cleaning up bowel movement, resident had a bowel movement all over her body, the floor, and toilet. When the CNA stepped out of the room briefly to put resident's dirty laundry in a bag and get a second CNA to help with resident. Resident was observed sitting on the floor next to the toilet stool. Resident had bowel movements on her fingers, hands, and hips, and resident was trying to pull her panties and jeans off her. Resident had nonskid socks on her feet. The Nurse assigned to resident did a head-to-toe assessment; resident eventually dx'd with hip fx per F610; failed to ID fx of unknown origin for 1 resident as potential abuse or neglect & report to SA as required placing resident at risk for unidentified & ongoing abuse, neglect of mistreatment

F610 Investigate/Prevent/Correct Alleged Violation

NE: SS=J (Removed to D): Failed to implement protective measures to prevent ongoing abuse while investigation was conducted placing resident in immediate jeopardy

- Resident was cognitively impaired, had a diagnosis of aphasia and had wandering behaviors. Resident's clinical record documented a non-injury fall on 09/26/24 with multiple assessments following which reported resident ambulated and wandered in the facility with no apparent injury. On 11/11/24 staff noted resident lying in bed, with her incontinence brief half off. The staff took resident to the shower and observed she was limping, and her right knee appeared swollen. Staff notified the provider and obtained orders for an X-ray of resident's right knee. On 11/12/24 the right knee X-ray was completed with no remarkable findings. On 11/13/24, resident's pain became intense, and staff obtained an order for a right hip X-ray, which indicated a fracture. Resident went to the hospital where she was diagnosed with a broken hip where the bone at the sub-capital region comminuted . Upon learning of the fracture, the facility failed to identify the serious injury of unknown origin as a potential abuse or neglect situation and failed to initiate an investigation to determine the cause of the fracture. The facility failed to implement protective measures to prevent ongoing abuse while an investigation was conducted. This deficient practice placed resident in immediate jeopardy
- Plan of Removal
    - Resident is being monitored every shift using the appropriate pain scale.
    - Staff conducted an immediate observation of resident for identification of any current injuries as appropriate, and ongoing monitoring of resident and other residents at risk, including conducting unannounced management visits at different times and shifts.
    - Administrator will notify any alleged violations to the appropriate agency or law enforcement authority as applicable.
    - An immediate assessment would be conducted on any resident with cognitive deficit issues if any signs of pain, discomfort, or alteration in the skin such as bruising, or discoloration are identified. If any of the above is identified, then a formal investigation will be initiated by the DON/ and or designee.
    - Conduct interviews with cognitively intact residents to ensure residents are free of abuse, neglect, and exploitation. The facility enhanced its internal incident reporting and escalation program, by creating a real-time notification system for staff, visitors, or residents to utilize.
    - Enhanced reporting program includes a focus for falls, abuse, and unusual occurrences/injuries of unknown source.
    - Upon immediate completion of the incident report, automated notification will be provided to facility leadership including but not limited to the Administrator and DON.
    - The facility created an informational flyer displaying the internal incident reporting program and provides a QR code that can be scanned for immediate reporting/escalation.

F623 Notice Requirements Before Transfer/Discharge

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

- Notice sent lacked location & reason for transfer/discharge; Failed to send written notification of facility-initiated transfer for 1 resident which included reason for transfer & location of transfer placing resident at risk for miscommunication between facility & resident/representative & impaired rights

F636 Comprehensive Assessments & Timing

NE: SS=D: Failed to complete CAA analysis of findings, r/t MDS for 2 residents in order to address underlying cause, risk factors & other contributing factors to ensure resident received care based on individual needs placing residents at risk for impaired care & decreased quality of life due to unidentified care needs

- Sig change MDS with all triggered CAAs lacing completion with analysis of findings for 2 residents; failed to complete Comprehensive MDS including CAAs for 2 residents as required placing residents at risk for impaired care & decreased quality of life due to unidentified care needs

F656 Develop/Implement Comprehensive Care Plan

NE: SS=D: Failed to develop a comprehensive CP for 1 resident which included individualized person-centered interventions for Trilogy ventilator placing resident at risk for impaired care due to uncommunicated care needs

- CP lacked direction to nursing staff for care & application of Trilogy mask; failed to develop a comprehensive CP for 1 resident which included individualized person-centered interventions for Trilogy ventilator placing resident at risk for impaired care due to uncommunicated care needs

F657 Care Plan Timing & Revision

NE: SS=D: Failed to ensure 1 resident's CP with revised interventions to direct staff on care r/t stage 1 pressure wound placing resident at risk for delayed healing & increased risk for PUs due to uncommunicated care needs

- Failed to ensure 1 resident's CP was updated with interventions to direct staff on care r/t stage 1 pressure wound placing resident at risk for delayed healing & increased risk for PUs due to uncommunicated care needs

F676 Activities of Daily Living (ADLs)/Maintain Abilities

NE: SS=D: Failed to ensure 1 resident received supportive care & services to promote & maintain quality of life when facility did not use communication cards per CP to allow resident who had aphasia to communicated wants, needs or feelings placing resident at risk for decreased quality of life, isolation & impaired dignity

- Observed resident in room & reaching out hand, attempting to communicate with staff & staff did not use communication sheet or pictures but picture sheets were under containers of cereal, jelly & water flavor packs on bedside table; observed resident attempting to communicate with staff & staff did not use communication sheets; failed to ensure resident received supportive care & services to promote & maintain quality of life when facility did not use communication cards to allow resident to communicate wants, needs, or feelings placing resident at risk for decreased quality of life, isolation & impaired dignity

F677 ADL Care Provided for Dependent Residents

NE: SS=E: Failed to provide personal hygiene or bathing for 3 residents placing residents at risk for decline in ADLs

- Observed resident unable to activate call light when needed assistance when began choking on meal; CNA acknowledged that resident supposed to be in more upright position during meals; failed to provide ADL care & services to 1 resident r/t eating placing resident at risk for impaired nutrition, aspiration & general decrease in ADL ability
- ADL sheets documented in 51 days resident received 5 baths but scheduled 2x/wk; documentation with no refusals or attempts to offer alternatives; failed to provide consistent bathing for 1 resident with risk for poor hygiene & decreased self-esteem & dignity
- Failed to ensure 1 resident had proper nail care to maintain cleanliness placing resident at risk for decreased quality of life & impaired dignity
- Failed to ID & implement interventions to ensure 1 resident received required staff assist for toileting placing resident at risk of impaired ADLs & unmet care needs

F679 Activities Meet Interest/Needs Each Resident

NE: SS=E: Failed to provide directed, interaction activities based on resident preferences for residents on weekends placing affected residents at risk for decreased psychosocial wellbeing, boredom, & isolation

- Resident Council reported staff-led activities did not occur as scheduled every weekend & some scheduled activities did not occur; failed to provide consistent activities on weekends which reflected residents' interests & preferences placing affected residents at risk for boredom, isolation, & decreased quality of life

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

NE: SS=D: Failed to provide ongoing wound assessment for 1 resident's pressure injury & failed to ensure 1 resident's offloading boots were applied placing 2 residents at risk for delayed healing & increased risk for PUs

- Record lacked evidence staff assessed, measured, & recorded wound status for stage 1 PU at least weekly; Failed to ensure 1 resident's stage 1 pressure wounds were assessed & measured at least weekly placing resident at risk for delayed healing & increased risk for PUs
- Observed resident in room w/o ordered heel boots on multiple occasions; failed to ensure 1 resident's offloading boots were applied to both heels to prevent PUs placing resident at increased risk for worsening PUs & developing PUs

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=G: Failed to ensure 1 resident was monitored & provided a safe environment free of accident hazards when resident's bed was left in high upright position which contributed to fall resulting in fx; failed to ensure safe care environment r/t resident's positioning during meals; failed to provide safe care environment r/t appropriate usage of w/c foot pedals during transport; failed to ensure 1 resident's call light was within reach & further failed to ensure resident's bed was in low position & fall mat in place beside bed; failed to ID & respond to 1 resident's increased need for assist & failed to ensure staff were present to ensure safety during toileting & ADL care for 1 resident; failed to investigate 1 resident's falls on 9-16 & 9-26 to determine causative factors & implement relevant interventions to prevent falls; failed to ensure safe environment free from accident hazards with 1 resident's bed was left in high position placing 6 residents at risk for falls & related injuries

- Failed to ensure 1 resident was monitored & provided a safe environment free from accident hazards when bed was left in high position & resident had fall resulting in fx placing resident at risk for increased pain & preventable injuries
- Failed to ensure safe care environment r/t resident's positioning during meals placing resident at risk for choking or complications r/t aspiration

- Failed to provide safe care environment r/t appropriate usage of w/c foot pedals during transport for 1 resident placing resident at risk for preventable falls & injuries
- Failed to ensure 1 resident's call light was within reach & further failed to ensure resident's bed was in low position & fall mat in place beside bed placing resident at risk for falls & related injuries
- Failed to ID resident's increased need for assist & failed to ensure staff were present to ensure safety during toileting & ADL care for 1 resident; failed to investigate falls on 2 occasions to determine causative factors & implement relevant interventions to prevent falls placing resident at risk for falls with potential injuries, pain & increased risk for more falls
- Failed to ensure safe environment free from accident hazards when 1 resident's bed was left in high position placing resident at risk for possible injury from falls

F695 Respiratory/Tracheostomy Care & Suctioning

NE: SS=D: Failed to ensure 1 resident's Trilogy ventilator mask was stored in sanitary manner to decrease exposure & contamination; resident on ABT for chronic respiratory failure placing resident at increased risk of developing a respiratory infection or other respiratory complications

- Observed respiratory mask stored unbagged; Failed to ensure 1 resident's Trilogy mask was stored in sanitary manner placing resident at increased risk for further respiratory infections & complications

F698 Dialysis

NE: SS=D: Failed to monitor 1 resident's access site for complications at least daily placing resident at risk of adverse outcomes & physical complications r/t dialysis

- Failed to monitor resident's dialysis access site for signs of infection, bleeding & status of dressing in place placing resident at risk of potential adverse outcomes & physical complications r/t dialysis

F726 Competent Nursing Staff

NE: SS=D: Failed to ensure nursing staff demonstrated appropriate competencies & skill sets to provide nursing services to care for resident's needs when staff failed to transcribe correct dosage amount from hospital discharge order to MAR for IV Daptomycin for 1 resident then failed to check order in MAR against actual med dose being administered placing resident at risk for medication errors & potential adverse side effects

- Failed to ensure staff were competent when staff failed to check order in MAR against actual med dose being administered & failed to transcribe correct dosage amount from hospital discharge order to MAR for 1 resident's Daptomycin placing resident at risk for unnecessary medication administration & possible adverse side effects

F732 Posted Nurse Staffing Information

NE: SS=C: Failed to include census on daily posted nurse staffing hours

- Post daily nurse hours lacked census on daily posted nurse staffing hours

F755 Pharmacy Services/Procedures/Pharmacist/Records

NE: SS=D: Failed to provide adequate pharmaceutical services to ensure 1 resident had prescribed meds available in timely manner for administration placing resident at risk of delayed treatment which could have adverse consequences

- Pharmacy failed to deliver 1 resident's antianxiety medications in timely manner r/t resident's insurance failure to pay pharmacy bill until facility agreed to pay pharmacy for med; Failed to provide adequate pharmaceutical services to ensure 1 resident received prescribed medication placing resident at risk of delayed treatment which could have adverse consequences

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure CP Idd & reported irregularities for 1 resident r/t antipsychotic med & antianxiety med not administered as ordered by physician placing 1 resident at risk for unnecessary med use, side effects & physical complications

- Record lacked evidence 8-22-24 dose of Invega was ever administered or rescheduled & lacked evidence physician notified that medication was not administered as ordered; Sept MAR documented Invega was administered on 9-14-24 which was 44 days since last administration of Invega on 8-1-24; failed to ensure CP ID'd & reported irregularities with 1 resident's antipsychotic & antianxiety med not administered per physician orders placing resident at risk for unnecessary med administration, ineffective benefits of med & possible adverse side effects

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure documented physician rationale, nonpharmacological attempts & risk vs benefits with Informed Consent PRIOR TO starting antidepressant for 1 resident; further failed to ensure appropriate indication of use or documented physician rationale & risk vs benefits for continued use of antipsychotic for 1 resident & further failed to ensure 1 resident had signed consent for Caplyta placing residents at risk for adverse med effects & unnecessary meds

- Failed to ensure documented physician rationale, risk vs benefits including informed consent & non-pharmacological interventions prior to starting a psychotropic med for 1 resident placing resident at risk for unnecessary medication effects
- Failed to ensure documented physician rationale, risk vs benefits including informed consent for antipsychotic med for 1 resident placing resident at risk for unnecessary med side effects

- Failed to ensure documented risk vs benefits including informed consent for psychotropic med for 1 resident placing resident at risk for unnecessary med side effects

F760 Residents are Free of Significant Med Errors

NE: SS=G: Failed to ensure 1 resident remained free of significant med errors when staff failed to administer antipsychotic med as ordered resulting in increased auditory & visual hallucinations for 1 resident which caused significant psychosocial distress & additional psychotropic meds were prescribed placing resident at increased risk for adverse med effects

- Record lacked evidence 8-22-24, 9-12-24 dose of Invega was ever administered or rescheduled & lacked evidence physician was notified that med was not administered as ordered; Medication order indicated required Invega monthly; failed to ensure 1 resident remained free of significant med errors causing resident significant psychosocial harm as evidenced by resident having increased auditory & visual hallucinations causing resident significant distress & risk of unnecessary meds

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to ensure appropriate storage of meds &/or biologicals placing residents at risk for unnecessary medication & administration errors & medication diversions

- Observed unlocked & unsupervised med cart with unsecured prescription meds, diabetic treatment supplies & medicated ointments in drawers & controlled substance drawer remained locked; observed unlocked treatment cart ; observed medicine cup with resident's name left unsupervised on top of med cart ; failed to ensure appropriate storage of meds &/or biologicals placing residents at risk for unnecessary med & administration errors & med diversions

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 with potential to affect all residents residing in facility

- Assessment failed to ID specific staffing levels needed for each unit & ID number of RNs, LPNs, CMAs, CNAs needed for each unit, patient acuity & census; assessment lacked staffing levels required for each shift to include evenings & weekends; assessment lacked informed contingency plans for events that do not require activation of facility's emergency plan but have potential to impact resident care; failed to conduct thorough updated facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations & emergencies with potential to affect all residents residing in facility

F867 QAPI/QAA Improvement Activities

NE: SS=F: Failed to maintain effective QAA program to develop action plans & monitor them to correct quality deficiencies prior to survey placing residents at risk for inadequate care

- Cited: F558, F570, F609, F610, F623, F636, F676, F677, F679, F686, F689, F726, F755, F758, F760, F761, F941, F942, F945, failed to ID & develop corrective action plans for potential quality deficiencies thru QAPI plan to correct ID"d quality issues placing residents at risk for inadequate care

F880 Infection Prevention & Control

NE: SS=E: Failed to ensure 1 resident's ventilator mask was stored in sanitary manner, failed to implement adequate hand hygiene & further failed to ensure sit-to-stand lift was sanitized after resident use placing residents at risk for infectious diseases

- Failed to ensure 1 resident's ventilator mask was stored in sanitary manner, failed to implement adequate hand hygiene & further failed to ensure sit-to-stand lift was sanitized after resident use placing residents at risk for infectious diseases

NW: SS=D: Failed to ensure adequate infection control measures for 1 resident during wound care when staff did not change gloves after cleansed wound placing resident at risk for continued wound infection & complications

- *Failed to ensure adequate infection control measures during wound care for 1 resident who had recent infection in foot wound placing resident at risk for continued infection & complications*

F941 Communication Training

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

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

F942 Resident Rights Training

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

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

F945 Infection Control Training

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

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

December, 2024

F550 Resident Rights/Exercise of Rights

SW: SS=D: Failed to protect privacy & dignity of 1 resident who stood in room partially dressed in pants & undergarment when staff walked by resident's room, looked into room & continued to walk down hallway w/o intervening with potential to lead to negative psychosocial effects r/t dignity

- Failed to protect privacy & dignity of 1 resident who stood in room wearing pants & undergarment & staff member walked by resident's room, looked into resident's room & continued to walk down hallway w/o intervening with potential to lead to negative psychosocial effects r/t dignity

NE: SS=D: Failed to provide services in a dignified manner for 1 resident when staff stood over resident while feeding resident a pudding cup placing resident at risk for impaired dignity & decreased psychosocial wellbeing

- Observed resident in Broda chair in DR while LN stood over resident & fed resident a pudding cup; failed to ensure 1 resident's dignity when staff stood while feeding resident pudding cup placing resident at risk for impaired dignity & decreased psychosocial wellbeing

F558 Reasonable Accommodations Needs/Preferences

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

- Observed resident in bed with call light dangling off bed on floor & not within reach; observed resident in bed with call light clipped to room dividing curtain & not within reach; failed to ensure resident's call light was within reach leaving resident vulnerable to unmet care needs due to inability to call for staff assist

F582 Medicaid/Medicare Coverage/Liability Notice

NE: SS=D: Failed to ensure CMS form 10055 SNF ABN form was provided to 1 resident placing resident at risk of uninformed treatment decisions & unexpected costs

- Resident's Part A began 10-1-24 & ended on 10-9-24 & resident remained in facility & provided NOMNC but was not issued SNF ABN as required; SS stated had been issuing ABNs except for residents on managed care as insurance directed care & would send documents & as SS understood ANB not mandatory until 10-31-24; failed to ensure CMS SNF ABN form was provided to 1 resident placing resident at risk for uninformed treatment decisions & unexpected costs

F677 ADL Care Provided for Dependent Residents

NE: SS=D: Failed to ensure staff assisted 1 resident with grooming & failed to ensure resident's fingernails were cut short & kept clean placing resident at risk for impaired dignity, comfort & further decline in ADLs

- Resident dependent on staff for ADLs; observed resident with fingernails not trimmed short & resident with dark substance under nails & hair greasy & uncombed on multiple occasions; failed to ensure staff assisted resident with grooming & failed to ensure fingernails were cut short & clean placing resident at risk for impaired dignity & further decline in ADLs

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

SW: SS=D: Failed to provide pressure reducing device on bed to prevent pressure injury for 1 resident; additionally, facility utilized incorrect size fully body sling when transferring resident in & out of bed with mechanical lift

- Failed to place interventions to prevent pressure injuries for 1 resident who developed 1 preventable, facility-acquired, unstageable pressure injury placing resident at risk to worsen current PU or develop more skin issues
- Failed to implement effective fall prevention interventions to prevent falls for cognitively impaired resident who had repeated falls
- Resident with skin risk & chair w/o pressure relieving cushion & observed that resident w/o repositioning for extended period of time; Failed to provide treatment & care in accordance with professional standards of practice & comprehensive person-centered CP for 1 resident

NE: SS=E: Failed to ensure 1 resident's low air-loss mattress was set to appropriate weight settings for pressure reduction placing resident at risk for complications r/t skin breakdown & PUs

- Resident weight 202 #'s; & on hospice; CP documented to offload heels while in bed; Observed bed set to 350#'s & set to "static" setting; observed low air-loss mattress set 125-150#'s; failed to ensure 1 resident's low air-loss mattress system set to appropriate weight placing resident at risk for complications r/t skin breakdown & PUs

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to ensure 1 resident's washcloth was applied to hands placing resident at risk for discomfort & decreased ROM

- CP documented resident with passive ROM to wrist & wrist presented with contracture & staff to apply clean washcloth to hand to prevent contracture daily & washcloth was acceptable to use in place of splint; observed resident on multiple occasions w/o

washcloth in hand & resident with fist tightly closed; failed to ensure 1 resident's washcloth was applied to hands to treat contracture placing resident at risk for discomfort & decreased ROM

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=D: Failed to provide environment that remained free from accident hazards for 5 residents; failed to use appropriate size full body lift sling for transfers with mechanical lift for 1 resident; failed to follow 1 resident's CP & left resident unattended in BR & connected to mechanical lift resulting in non-injury fall; additionally, resident who had lower extremity weakness, facility to apply foot pedals to w/c resulting in non-injury fall with potential to result in injury

- Failed to use appropriate size full body lift sling for transfers with mechanical lift with potential to contribute to PU; placing resident at risk to worsen current PU or develop more skin issue
- Failed to provide environment free of accident hazards when staff pushed resident in w/c w/o foot pedals & resident's feet caught on floor causing resident to experience fall w/o injury with potential to lead to additional falls with potential for injury or actual harm
- Failed to implement effective fall prevention interventions to prevent falls for 1 cognitively impaired resident who had repeated falls

NE: SS=E: Failed to secure areas containing hazardous materials to keep them out of reach of 28 cognitively impaired, independently mobile residents placing affected residents at risk for preventable injuries & accidents

- Observed unlocked closets in sitting area with purple disinfectant wipe containers & tile cleaner spray bottles containing warning labels; 1 hallway with spray bottle of window cleaner with warning in sink; unlocked lift storage area with disinfectant with warning labels accessible; unlocked electrical panel room with PPE; failed to secure rooms containing hazardous materials out of reach of 28 cognitively impaired, independently mobile residents placing affected residents at risk for preventable injuries & accidents

F692 Nutrition/Hydration Status Maintenance

NW: SS=G: Failed to obtain consistent weights to establish a baseline, failed to ID & respond to progressive weight loss with intervention & increased assistance & failed to follow RD recommendations to provide nutritional support for 1 resident; subsequently, resident had significant weight loss placing resident at risk for decreased nourishment & delayed wound healing

- *Record with missing weekly weights & holes in meal %'s & low intake on some documentation w/o interventions; failed to obtain consistent weight to establish a baseline, failed to ID & respond to progressive weight loss with interventions & increased assistance & failed to follow RD's recommendations to provide nutritional support for resident; subsequently resident had 19.5% significant weight loss in 95 days from admission placing resident at risk for decreased nourishment & delayed wound healing*

F744 Treatment/Service for Dementia

NE: SS=D: Failed to develop an individualized dementia treatment plan to address 1 resident's dementia-related behaviors to promote his highest practicable quality of life & wellbeing placing resident at risk for impaired psychosocial wellbeing & impaired quality of life

- *Resident with metabolic encephalopathy, Parkinsonism, anxiety, restlessness & agitation; BIMS of 6; CP lacked information r/t resident's dementia care or observed behaviors; documentation revealed resident wandered into another resident's room; multiple documentation notes documented resident with "behaviors" w/o description of behaviors or what staff did in response to behaviors & to prevent further episodes; failed to develop individualized dementia treatment plan to address resident's dementia-related behaviors to promote highest practicable quality of life & wellbeing placing resident at risk for impaired psychosocial wellbeing & impaired quality of life*

F761 Label/Store Drugs & Biologicals

SW: SS=F: Failed to provide safe environment for 7 residents, ID'd as cognitively impaired & independently mobile by failure to ensure med storage room door remained closed & secured when not in use with potential to lead to accidental ingestion of prescription & non-prescription meds that could be harmful to residents

- Observed door to med room propped open by trash can with no staff present & remained open for 9 minutes; failed to provide safe environment for 7 residents by failure to ensure med storage room door remained closed & secured when not in use with potential to lead to accidental ingestion of prescription & non-prescription meds that could be harmful to residents

NW: SS=E: Failed to store & label meds in accordance with professional standards of practice placing residents at risk of med error

- Observed med cart with 6 med cups with numerous pills in each cup sitting in top drawer; cups labeled with various residents' names; LN stated placed cups for administration & would recheck them when delivered meds to residents; staff confirmed meds should not be prepared until time of delivery to residents; failed to ensure storage & delivery of meds in accordance with professional standards of practice placing residents at risk of med errors

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SW: SS=F: Failed to store, prepare & serve food in sanitary manner to prevent possible foodborne illness to residents of facility

- Observed floor storage, expired foods, frozen foods with ice growing on them; unlabeled, undated food items

F849 Hospice Services

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

- Failed to ensure collaboration between nursing home & hospice services to ID hospice-provided services & medication for 1 resident placing 2 residents at risk for delayed services & uncommunicated care needs

F880 Infection Prevention & Control

SW: SS=F: Failed to transport clean & distribute clean laundry to residents of facility when staff failed to perform hand hygiene between resident room contacts; further failed to maintain effective infection control program r/t EBP when providing catheter care for 1 resident wound care for 1 resident & peri-care for 1 resident; additionally failed to provide respiratory care consistent with professional standards of care for 1 resident r/t use & storage of O2 supplies that were not stored in clean manner or changed when appropriate with potential to spread infections to residents in facility

- Failed to transport clean & distribute clean laundry to residents of facility
- Failed to maintain effective ICPC r/t EBP when providing catheter care, wound care, peri-care
- Failed to provide respiratory care consistent with professional standards of care r/t use & storage of O2 supplies that were not stored in clean manner or changed when appropriate

NE: SS=F: Failed to ensure BP cuff, pulse monitor & O2 saturation equipment were sanitized after each resident's use & further failed to ensure all 2 cannulas & nebulizer masks were stored in sanitary manner placing residents at risk for infectious diseases

- Observed 1 resident's nebulizer mask laid directly on dresser on box next to bed & rolled-up nasal cannula laid directly on bedside table
- Observed laundry room with wet linens left in washer overnight
- Observed O2 nasal cannula over canister next to bed unbagged
- Observed CMA obtained resident vital signs & did not sanitize BP cuff, pulse monitor & O2 saturation equipment before or after residents' vital signs obtained
- Observed 1 resident's nasal tubing thrown over nightstand & unbagged

NW: SS=E: Failed to ensure ice was maintained in sanitary manner & failed to implement EBP for 2 residents with indwelling urinary catheter placing residents at risk of contracting or spreading infectious processes

- Observed resident ambulated to unlocked ice machine, opened lid, took scoop off side of ice machine, placed used Styrofoam cup over ice & scooped ice into cup; observed 2 residents walked into DR & went to drink center, went to unlocked ice machine, placed cup over ice machine bin & scooped ice into water container, overfilling it; ice spilled from cup back into ice machine bin then retrieved other resident's water container, placed in over ice bin & filled water container with ice; failed to provide safe & sanitary environment when 2 residents filled used drinking containers over ice in DR ice machine contaminating ice placing residents who received ice from ice machine at risk of acquiring infectious disease
- Observed 2 CNAs provide perineal care & catheter car & did not gown before providing care; observed 1 CNA providing catheter care & used gloves & did not don gown; failed to implement EBP for 2 residents with indwelling catheter placing residents at risk for contracting or spreading infectious processes

NW: SS=D: Failed to ensure staff implemented targeted gown & glove use during high-contact care of resident with wound infection during dressing change placing resident at risk for infectious diseases

- *Observed LN & CNA did not don gown for dressing change on multiple occasions; failed to ensure staff wore gown during high-contact care of resident with wound infection during dressing change placing resident at risk for infectious diseases*

January, 2025

F550 Resident Rights/Exercise of Rights

NE: SS=D: Failed to ensure 1 resident's right to be treated with respect & dignity when resident's privacy curtain or door was closed when resident uncovered & exposed from waist down placing resident at risk for negative psychosocial outcomes & decreased dignity

- Observed resident on bed uncovered from waist down & incontinence brief pulled to side & groin area visible from open doorway & privacy curtain not pulled to provide privacy; failed to ensure 1 resident's right to be treated with respect & dignity when door left open to hallway when resident uncovered & exposed with risk for negative psychosocial outcomes & decreased dignity

F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to utilize w/c foot pedals for 3 residents placing residents at risk for preventable accidents & injuries

- Failed to utilize w/c foot pedals for 3 residents placing residents at risk for preventable accidents & injuries

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

NE: SS=D: Failed to notify 1 resident's physician with refused daily weights placing resident at risk for unmet needs

- Resident with multiple dx's including CHF; POS for daily weight & diuretic order; record lacked documentation physician informed of refused weights; failed to notify 1 resident's physician with refused daily weights placing resident at risk for unmet needs

F600 Free from Abuse & Neglect

NE: SS=J (Removal Plan to Past Non-Compliance): Failed to ensure 1 resident remained free from neglect

- *On 01/15/25 between 08:00 PM and 09:00 PM, resident propelled himself in his wheelchair to the bathroom. He reached for the grab bar beside the toilet and the momentum of that action caused him to slip from his wheelchair and fall to the right, into the walk-in shower. Resident laid on the floor, unable to move or reach the call light beside the toilet. Resident remained on the floor until LN discovered him on 01/16/25 at approximately 05:10 AM when she entered his room to empty his catheter bag. Resident stated he hit his head and he complained of right rib pain. The facility sent resident to the hospital for evaluation where the hospital*

found no acute injuries. Upon investigation, the facility discovered CNA failed to complete two-hour rounding on all of her assigned residents. This deficient practice placed R1 in immediate jeopardy.

- *Plan of Removal:*
  - *The facility placed CNA on the do not return list on 01/16/25.*
  - *LN received a final written warning for not completing rounding on 01/17/25.*
  - *The facility started two-hour rounding check sheets at night on 01/16/25.*
  - *The facility started two-hour rounding check sheets all day on 01/18/25*
  - *The facility updated resident's care plan to include a call-light pendant on 01/20/25.*
  - *The facility completed staff education on rounding, agency education, and abuse/neglect/exploitation by 01/20/25.*

F622 Transfer & Discharge Requirements

SE: SS=D: Failed to ensure staff had documented when, where & why 1 resident was transferred to acute hospital placing resident at risk for uninformed care choices

- Failed to document when, where & why 1 resident was transferred to hospital for further care placing resident at risk for uninformed care choices

F623 Notice Requirements Before Transfer/Discharge

SE: SS=D: Failed to provide written notification of transfer to 2 residents for facility-initiated transfers placing 2 residents at risk for uninformed care choices

- Failed to provide written notification of transfer to 2 residents for facility-initiated transfers placing resident at risk for uninformed care choices for multiple residents

F641 Accuracy of Assessments

SE: SS=D: Failed to accurately code MDS for 1 resident who lacked need of specialized services & 1 resident to include dx of PTSD placing residents at risk for inappropriate comprehensive care

- MDS indicated resident received dialysis, hospice, IV & with trach/ventilator & resident w/o any of those services; failed to accurately submit 1 resident's DMS placing resident at risk for accurate comprehensive care
- MDS lacked indication of dx of PTSD; failed to ensure 1 resident's admission & quarterly MDS section PTSD was accurately coded as required by RAI Manual placing resident at risk for inaccurate CP & unmet care needs

F656 Develop/Implement Comprehensive Care Plan

SE: SS=D: Failed to develop a comprehensive CP for 2 residents which included individualized person-centered interventions for trauma-based care placing residents at risk for impaired care due to uncommunicated care needs

- Failed to develop comprehensive CP for 1 resident which included individualized person-centered interventions for PTSD placing resident at risk for impaired care due to uncommunicated care needs & re-traumatization
- Failed to implement individualized CP to address 1 resident's PTSD & behaviors with person-centered interventions to prevent re-traumatization & known triggers for behaviors placing resident at risk for decreased psychosocial wellbeing & ineffective treatment

F657 Care Plan Timing & Revision

SE: SS=D: Failed to revise 1 resident's CP to reflect ID'd care needs r/t incontinence, ADLs, & behaviors placing resident at risk for impaired care due to uncommunicated care needs

- Failed to revise 1 resident's CP to reflect ID'd care needs r/t incontinence, ADLs & behaviors placing resident at risk for impaired care due to uncommunicated care needs

F686 Treatment/Services to Prevent/Heal PU

NE: SS=D: Failed to ensure pressure reducing heel supportive device in place for 1 resident who had pressure-related injury on buttocks placing resident at risk for complications r/t further skin breakdown

- CP instructed staff to elevate heels on supportive device when in bed; observed resident in bed with bilateral heels resting directly on bed on multiple occasions; failed to ensure pressure reducing heel supportive device in place for 1 resident who had pressure injury on buttocks placing resident at risk for complications r/t skin breakdown & development of PUs

F688 Increase/Prevent Decrease in ROM/Mobility

SE: SS=D: Failed to implement ROM program to help maintain & prevent a potential decreased in ROM/mobility for 1 resident placing resident at risk of loss of ability to perform ADLS & worsening or development of contractures

- EMR lacked evidence ROM or restorative care provided to resident; failed to implement a ROM program to help maintain & prevent potential decrease in ROM/mobility for 1 resident placing resident at risk of loss of ability to perform ADL & worsening or development of contractures

NE: SS=D: Failed to ensure 1 resident's orthotic was in place placing resident at risk for discomfort & decreased ROM

- Observed resident in Broda chair & hand curled at wrist toward chest on multiple occasions; CNA stated CNAs do not apply splints & therapy applies splints then nursing takes splints off & stated had not seen splint for resident "for a few months"; Adm Nurse

stated facility had restorative aide who applied splints & did ROM but restorative aide on maternity leave & had not been replaced; failed to ensure 1 resident's orthotic was in place placing resident at risk for discomfort & decreased ROM

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=J (Removal Plan of Past Non-Compliance): Failed to provide adequate supervision to prevent the elopement of cognitively impaired resident

- *Review of facility camera footage revealed resident pushed on the door at the end of the hallway, opened it, and exited the building on 01/23/25 at 04:58 PM. Resident wore a wander guard bracelet for safety, but the maglock failed to sound due to loose wiring. As a result, resident exited the facility without staff knowledge or supervision. The facility did not know resident was missing until approximately 43 minutes later, in 22 degrees Fahrenheit weather, when the local Police Department returned the resident to the facility. This deficient practice placed resident in Immediate Jeopardy.*
- *Plan of Removal:*
    - *Staff conducted a headcount ensuring the safety of all residents in the facility.*
    - *Camera footage was reviewed, identified the malfunction, and effected immediate repairs on the faulty exit door.*
    - *Audited all doors and windows to ensure no similar situations existed.*
    - *Reported the issue to the state agency, physician et al.*
    - *Conducted all staff in-service "How to check Doors for Lock function" on 01/23/25, 01/24/25, and 01/25/25.*
    - *Conducted an Ad Hoc QAPI meeting with the Executive Director, (ED) Director of Nursing (DON), and Medical Director (MD). The Medical Director was requested for feedback and had nothing further to add or suggest.*

NE: SS=E: Failed to secure areas containing hazardous materials out of reach of 7 cognitively impaired/independently mobile residents in secured unit placing affected residents at risk for preventable injuries & accidents

- Observed nursing station with alcohol-based disinfectant container & wipes on outside counter of nurses' station; shelf next to sensory room with 2 more disinfectant containers on top shelf all with hazardous warnings; observed cognitively impaired resident wandering around unit; later in day, products no longer accessible on unit; failed to secure areas containing hazardous materials out of reach of 7 cognitively impaired/independently mobile residents in secured unit placing affected residents at risk for preventable injuries & accidents

F690 Bowel/Bladder Incontinence, Catheter, UTI

SE: SS=D: Failed to implement individualized toileting interventions to improve/maintain 1 resident's bowel/bladder incontinence based on incontinence evaluations placing resident at risk for complications r/t incontinence

- EMR revealed no bowel/bladder training that resident was on toileting program to improve incontinence; failed to implement individualized toileting interventions to improve/maintain resident's bowel & bladder incontinence based on incontinence evaluations placing resident at risk for complications r/t incontinence

F692 Nutrition/Hydration Status Maintenance

SE: SS=G: Failed to ID & implement nutritional interventions r/t 1 resident's significant weight loss between 1-1-24 to 6-7-24; additionally failed to implement alternative nutritional interventions for 1 resident's ongoing significant weight loss between 8-1-24 & 1-1-25; as result of deficient practice resident had significant unplanned weight loss of 19.52% & 16.84% within 2 3-month periods placing resident at risk for malnourishment-related complications

- EMR documented resident with regular diet with regular consistency & texture; EMR lacked documentation on prescribed weight loss program; EMR lacked documentation no orders for dietary supplementation between 3-11-22 thru 11-20-24; EMR lacked dietitian-related documentation from 12-1-23 thru 8-1-24; failed to ID & implement nutritional interventions r/t 1 resident's significant weight loss between 1-1-24 thru 6-7-24; additionally failed to implement alternative nutritional interventions for resident's ongoing significant weight loss between 8-1-24 thru 1-1-25; as result of deficient practice, resident had significant unplanned weight loss of 19.52% & 16.84% within 2 3-month periods placing resident at risk for malnourishment-related complications

F695 Respiratory/Tracheostomy Care & Suctioning

NE: SS=D: Failed to ensure 1 resident's CPAP mask was stored in sanitary manner placing resident at increased risk for respiratory infection & complications

- Observed resident's CPAP mask laid directly on outside of CPAP bag on multiple occasions; Failed to ensure 1 resident's CPAP mask was stored in sanitary manner placing resident at increased risk for respiratory infection & complications

F699 Trauma Informed Care

SE: SS=D: Failed to ID trauma-based triggers r/t 3 resident's PTSD & failed to implement individualized interventions to prevent re-traumatization interventions to prevent re-traumatization placing 3 residents at risk for decreased psychosocial wellbeing & ineffective treatment

- Failed to ID trauma-based triggers r/t resident's hx of trauma & implement individualized interventions to prevent re-traumatization placing residents at risk for decreased psychosocial wellbeing & ineffective treatment for 3 residents

F700 Bedrails

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

- Bed rail assessment did not acknowledge use of resident's low air-loss mattress r/t bedrails; EMR lacked safety assessment for use of side rials addressing risk of entrapment between device & mattress, consent for use & lacked evidence resident/representative were advised on risks &/or benefits of use of side rails

F712 Physician Visits-Frequency/Timeliness/Alt NPP

NE: SS=D: Failed to ensure attending physician conducted required visits for 1 resident placing resident at risk for unrealized changes in condition leading to unnecessary complications in wellbeing

- Record revealed no Physician Progress Notes for past 6 months & w/o any documentation of attending physician visits; staff reported NP at facility Monday-Fri weekly & unsure when physician made rounds; failed to ensure resident seen by attending physician as required in past 6 months placing resident at risk of potential for unrealized changes in condition leading to unnecessary complications in wellbeing

F740 Behavioral Health Services

SE: SS=D: Failed to implement individualized behavioral care intervention for 3 residents placing residents at risk for continued behavioral episodes & unmet care needs

- Failed to implement individualized behavioral care interventions for resident placing resident at risk for continued behavioral episodes & unmet care needs for 3 residents
- Failed to provide person-centered care & have individualized interventions in place to address resident's behavioral dx of anxiety, depression & bipolar d/o placing resident at risk for decreased psychosocial wellbeing & ineffective treatment

F744 Treatment/Service for Dementia

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

- Resident with dementia with multiple documented falls; observed resident wandering about unit in presence of hazardous materials; observed resident wheeled to DR w/o foot pedals & feet lid on ground as resident pushed; failed to provide dementia-related behavioral 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

F756 Drug Regimen Review, Report Irregular, Act On

SE: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported 2 resident's physician ordered Diclofenac lacked specified dosage; CP further failed to ID & report when 1 resident's pulse was outside physician-ordered parameters placing 2 residents at risk for unnecessary meds & related complications

- POS for Diclofenac external topical gel to be applied to knee topically q 4 hrs PRN for knee pain; order lacked dosage amount to be applied; Failed to ensure CP ID'd & reported 1 resident's physician ordered Dicofenac had indicated dosage placing resident at risk for unnecessary meds & related complications
- POS for Lisinopril 5mg q day for HTN with notification parameters; POS for multiple lab testing & record lacked evidence of results of physician-ordered lab tests; failed to ensure CP ID'd & reported physician-ordered lab tests for medication monitoring was not obtained as ordered; also failed to ensure CP had ID'd & reported resident's heart rate was outside physician orders placing resident at risk for unnecessary meds & related complications

F757 Drug Regimen is Free from Unnecessary Drugs

SE: SS=D: Failed to ensure physician order was followed for 1 resident's lab tests to monitor for high-risk meds & that physician was notified of values outside physician-ordered parameters; also failed to ensure dosing instructions for Voltaren gel for 2 residents placing residents at risk for unnecessary medication use & physical complications for affected resident

- Cited findings noted in F756 r/t Voltaren orders & ordered notification parameters for antihypertensive & failure to obtain physician-ordered lab results; The facility failed to ensure the physician's order was followed for R19's laboratory tests to monitor for high-risk medications. The facility also failed to ensure the physician was notified heart rate was outside the ordered parameter These deficit practices placed R19 at risk of adverse side effects and unnecessary medications
- Failed to ensure dosing instructions for Voltaren gel for resident placing resident at risk for unnecessary med use, side effects & physical complications
- Failed to ensure 1 resident's physician ordered Diclofenac had indicated dosage placing resident at risk for unnecessary meds & related complications

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SE: SS=D: Failed to ensure PRN psychotropic med had 14-day stop date or specified duration with supporting physician documentation for 2 resident's PRN psychotropic meds placing residents at risk for unnecessary med administration & possible adverse side effects

- POS for Hydroxyzine PRN for PTSD & lacked 14-day stop date; Seroquel q 12 hrs PRN for anxiety lacked 14-day stop date; Haldol PRN for paranoia r/t schizoaffective d/o lacked 14-day stop date; failed to ensure 1 resident's PRN Haldol, Seroquel, & Hydroxyzine had stop date or physician ordered specified duration for administration placing resident at risk for unnecessary med administration & possible adverse side effects
- Failed to ensure 1 resident's PRN Trazodone had stop date or physician ordered specified duration for administration placing resident at risk for unnecessary med administration & possible adverse side effects

F801 Qualified Dietary Staff

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

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

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=F: Failed to ensure dietary staff safely thawed meat to prevent bacterial growth placing residents at risk for foodborne illnesses

- Observed kitchen with pork loin in 3-bin wash sink thawing & meat did not have water running over it; failed to ensure dietary staff safely thawed meat to prevent bacterial growth placing residents at risk for foodborne illnesses

F880 Infection Prevention & Control

NE: SS=D: Failed to ensure 1 resident's CPAP mask was stored appropriately when not in use; failed to ensure 1 resident's tracheal tubing was stored appropriately when not in use; failed to ensure 1 resident's nasal cannula was appropriately stored when not in use placing 3 residents at risk of infection development & possible respiratory complications

- Failed to ensure that 1 resident's CPAP mask was stored appropriately when not in use
- Failed to ensure 1 resident's tracheal tubing was stored appropriately when not in use
- Failed to ensure 1 resident's nasal cannula was stored appropriately when not in use placing 3 residents at risk of infection development & possible respiratory complications

F883 Influenza & Pneumococcal Immunizations

SE: SS=E: Failed to offer or obtain informed declinations, consent, or a physician-documented contraindication for the influenza vaccination for 4 residents; also failed to offer or obtain informed declinations, consent, or a physician-documented contraindication for the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial infections) pneumococcal vaccination for 4 residents placing residents at an increased risk for influenza, pneumonia, and related complications

- Failed to obtain influenza & pneumococcal vaccination consents, declinations or administration information for 5 residents placing residents at increased risk for influenza, pneumonia & related complications

F887 COVID-19 Immunization

SE: SS=D: Failed to offer or obtain informed declinations or a physician-documented contraindication for the COVID-19 vaccinations for 2 residents placing residents at increased risk for COVID-19.

- Failed to offer & obtain signed consents or declinations for COVID-19 vaccinations for 2 residents placing residents at risk for COVID-19 & related complications

February, 2025

F600 Free from Abuse & Neglect

NW: SS=G (Past Non-Compliance): Failed to prevent staff from physically forcing 1 resident to take her medications when she refused to take her medications. On 12/15/24 at approximately 07:20 AM, LN attempted to administer medications to resident; resident swatted LN's hand away indicating resident did not want to take the medications. LN pushed resident's hands away into her lap, removed resident's coffee cup as resident attempted to grab it and replaced it with a cup of water. LN then held resident's shoulders and attempted to spoon the medications into resident's mouth; resident spit out the medications and LN placed the medications that were spit out back on the spoon and attempted to administer the medications again. LN grabbed the back of resident's head, pushed her head forward, lifted the water cup up to resident's mouth, and poured water into resident's mouth; resident attempted to spit the medications back out; CNA intervened, sat beside resident, and encouraged resident to take her medications; resident accepted direction from CNA and swallowed her medications; based on the reasonable person concept, this deficient practice resulted in feelings of fear for resident and placed resident at risk for further psychosocial harm, intimidation, and neglect

- *Failed to prevent staff from physically forcing 1 resident to take meds; based on reasonable person concept deficient practice resulted in feelings of fear for resident placing resident at risk for further psychosocial harm, intimidation & neglect*
- *Plan of Removal:*
  - *LN immediately suspended pending investigation*
  - *All notifications completed*
  - *Thorough investigation conducted*
  - *All staff re-educated on ANE*

- *Twice daily skin assessments implemented to monitor for potential injuries with no concerns noted throughout monitoring period & report made to KSBN r/t investigation & findings involving LN*

F700 Bedrails

NW: SS=D: Failed to provide bed rails with gaps less than 4-3/4 inches per FDA guidelines for safety placing 2 residents at risk for injury

- CP lacked directions for bedrails; staff stated only measured height of gaps & not length of gaps; failed to provide bedrails with gaps less than 4-3/4 inches wide placing resident at risk for injury
- Failed to adequately assess 1 resident's actual rail in use to ensure safe openings & failed to assess for safe use a side rail prior to placing on resident's bed placing resident at risk for preventable entrapment, accident or injury

F882 Infection Preventionist Qualifications/Role

NW: SS=E: Failed to ensure staff person designated as Infection Preventionist who was responsible for facility's Infection Prevention & Control Program completed specialized training in infection Prevention & control placing residents at risk for lack of ID & treatment of infections

- Adm nurse stated responsible for IPCP & lacked certification as IP & had enrolled in program & completed training modules but had not received the certification; failed to ensure person designated as IP completed required certification placing residents at risk for lack of ID & tx of infections