January, 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

NW: SS=D: Failed to provide care per resident's preferences & to promote dignity for 1 resident who required extensive staff assist for dressing & hygiene resulting in 1 resident exposing breast in DR placing resident at risk for impaired dignity

- *CP documented resident preferred to have bra on; observed resident at table in DR & resident (who had cognitive impairment) lifted shirt & used shirt to wipe nose & mouth & resident w/o bra on & when lifted shirt bare breast exposed; failed to provide care per resident's preferences & to promote dignity for 1 resident when staff failed to put bra on resident per resident's specific preferences resulting in resident exposing breast in DR placing resident at risk for impaired dignity*

NW: SS=D: Failed to provide care for 2 residents in manner that protected & promoted resident dignity placing residents t risk for impaired psychosocial wellbeing

- Observed LN obtained 1 resident's blood sugar right outside med room in common hall then announced reading to resident within hearing distance of anyone in hallway then LN lifted resident's shirt & administered insulin in resident's abdomen; failed to promote care for resident in manner to maintain & enhance dignity & respect placing resident at risk for impaired psychosocial wellbeing
- Observed 1 resident with hair disheveled & greasy & with dried food on sweatshirt on multiple occasions; failed to promote dignity for 1 resident when staff did not adequately provide grooming assist before bringing resident out to common area placing resident at risk for impaired dignity

F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to ensure that 1 resident had foot pedals on w/c while being pushed leaving resident vulnerable to accidents & injuries due to unmet care needs

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

F575 Required Postings

NE: SS=F: Failed to post required information including a list of names, addresses (mailing & email) & telephone numbers of all pertinent State Agencies & advocacy groups placing all residents at risk for impaired resident rights

- Failed to post required information of list of names, addresses (mailing e-mail) & telephone numbers of all pertinent State agencies & advocacy groups placing all residents at risk for miscommunication of resident rights & impaired resident rights

F577 Right to Survey Results/Advocate Agency Info

NE: SS=C: Failed to post, in a place readily accessible to residents, family members, or legal representatives, the results of most recent survey of facility; failed to have last 3 years of survey results available; & failed to post a notice of availability of such reports in areas of facility that were prominent & accessible to public placing residents at risk for impaired resident rights

- Failed to post in a place readily accessible to residents, family members or legal representatives, the results of most recent survey of facility; failed to have last 3 years of survey results available; & failed to post a notice of availability of such reports in areas of facility that were prominent & accessible to public placing residents at risk for impaired resident rights

F582 Medicaid/Medicare Coverage/Liability Notice

NW: SS=D: Failed to provide 3 residents/representatives completed CMS 10055 placing resident at risk for uninformed decisions about skilled services

- Failed to provide 3 residents/representatives correct ABN CMS-10055 form which included estimated cost of continued services when discharged from skilled care & remaining in facility placing residents at risk of uninformed decisions about services & continuation of skilled services

F585 Grievances

NE: SS=F: Failed to implement a system to allow residents/representatives to file grievances anonymously placing residents at risk for decreased psychosocial wellbeing

- Failed to implement a system to allow residents/representatives to file grievances anonymously placing residents at risk for decreased psychosocial wellbeing

F607 Develop/Implement Abuse/Neglect Policies

NE: SS=E: Failed to implement policy that prohibited hiring employees found guilty of ANE, misappropriation of property or mistreatment by a court of law when facility failed to conduct background screening on 2 employees placing affected residents at risk for ANE, misappropriation or mistreatment

- Employee file for LN hired 8-30-23 w/o evidence CBC completed by facility for LN
- Employee file for housekeeping staff hired on 6-6-24 w/o evidence of CBC completed by facility for staff member; failed to conduct CBC as required for 2 employees; employees allowed access to residents w/o knowing if they had been found guilty of ANE, misappropriation of property, or mistreatment by court of law placing affected residents at risk for ANE, misappropriation or mistreatment

F620 Admissions Policy

NE: SS=F: Failed to establish & implement an admissions agreement that protected residents' right to personal property with risk of loss of personal property, including property of monetary &/or sentimental value, & loss of dignity & personal right to property for residents admitted to facility

- Admission agreement under section title "Personal Belongings" stated, "All personal belongings not placed in safe were solely the resident's responsibility & the facility wound not be liable for any resulting loss or damage of such property; failed to establish & implement an admission agreement that protected residents' right to personal property with risk of loss of personal property, including property of monetary & or sentimental value & loss of dignity & personal right to property for residents admitted to facility

F622 Transfer & Discharge Requirements

NE: SS=D: Failed to ensure that 1 resident's transfer or discharge was documented in resident's medical record & appropriate information was communicated to receiving healthcare institution or provider placing resident at risk for delayed treatment & impaired continuity of care

- Record lacked any change of condition assessment r/t resident's change of condition including physician notification, mode of transport & destination; record lacked evidence appropriate health information was communicated to receiving provider or healthcare destination; failed to ensure that 1 resident's transfer or discharge was documented in resident's medical record & appropriate information was communicated to receiving healthcare institution or provider placing resident at risk for delayed treatment & impaired continuity of care

F623 Notice Requirements Before Transfer/Discharge

NE: SS=D: Failed to provide written notification of transfer to 2 residents/representatives for facility-initiated transfers with risk of miscommunication between facility & resident/family & impaired rights of 2 residents

- Record lacked evidence resident was provided written notice when resident transferred to hospital; facility unable to provide evidence as requested; failed to provide resident or representative written notification of facility-initiated transfer placing resident at risk of impaired rights for multiple residents

NW: SS=D: Failed to notify State LTC Ombudsman of 1 resident's facility-initiated discharge to hospital placing resident at risk for impaired rights

- Staff observed resident trying to sharpen shaving razor with red door hanger & CNA alerted LN who asked resident if wanted to hurt self & resident stated "why not"; & staff notified PCP & sent resident to ER then returned when resident denied wanting to hurt self; resident transported to behavioral health hospital for inpatient stay; record lacked documentation staff notified LTCO of resident's discharge from facility; failed to notify LTCO of resident's facility-initiated discharge to hospital placing resident at risk for impaired rights

NE: SS=D: Failed to provide written notification within a practical timeframe of a facility-initiated transfer to resident/representative; further failed to notify the State LTC Ombudsman of facility-initiated transfers/discharges for resident with risk of miscommunication between facility & resident/representative & possible missed opportunities for healthcare services for 1 resident placing resident at risk for impaired rights

- Failed to provide a written notification of transfer to 1 resident/representative; further failed to notify the State LTCO of transfers/discharges for resident with risk of miscommunication between facility & resident/representative & possible missed opportunities for healthcare services for resident placing resident at risk for impaired rights

F625 Notice of Bed Hold Policy Before/Upon Transfer

NE: SS=D: Failed to provide 2 residents with appropriate bed hold policy as required placing residents at risk of being uninformed of bed hold requirements

- Record lacked evidence resident/representative received copy of bed hold notice at time of transfer/discharge; facility unable to provide evidence as requested; failed to provide resident with bed hold policy placing resident at risk of being uninformed of choices & impaired ability to return to same room for multiple residents

NE: SS=D: Failed to establish a bed hold policy & provide written notification of bed hold policy to 1 resident/representative with risk of impaired ability to return to facility & to previous room for 1 resident

- Failed to establish a bed hold policy & provide written notification of bed hold policy to 1 resident/representative with risk of impaired ability to return to facility & to previous room for 1 resident

NW: SS=D: Failed to provide 1 resident with bed hold policy as required placing resident at risk of being unable to return to facility in same room or bed

- Record lacked evidence resident/representative received copy of bed hold notice when resident sent to hospital; failed to provide 1 resident with bed hold policy placing resident at risk of being unable to return to facility in same room or bed

F641 Accuracy of Assessments

NE: SS=D: Failed to accurately assess & document that resident had terminal condition on MDS placing resident at risk for inaccurate CP & unmet care needs

- MDS lacked documentation resident had terminal condition & was on hospice; failed to accurately assess & record 1 resident's terminal condition on comprehensive MDS placing resident at risk for inaccurate CP & unmet care needs

F657 Care Plan Timing & Revision

NW: SS=D: Failed to revise CP to address toileting needs of 1 resident placing resident at risk for impaired care due to uncommunicated care needs

- MDS documented resident with frequent incontinence of bladder & occasional incontinence of bowel; next quarterly MDS documented resident frequently incontinent of bladder & bowel; ; B&B Assessment documented resident w/o decline in incontinence & was always incontinent of bowel & frequently incontinent of bladder; CP lacked direction to staff that resident required toileting after every meal; failed to revise 1 resident's CP with directions to staff on when to assist resident with toileting needs placing resident at risk for impaired care due to uncommunicated care needs

NW: SS=D: Failed to review & revise 1 resident's CP with resident-centered intervention to prevent 1 resident's falls & 1 resident's CP to prevent Pus placing 2 residents at risk for further falls & injuries r/t uncommunicated care needs

- Resident with multiple falls; CP lacked fall interventions based on causal factors ID'd in fall investigation when falls w/o investigations; failed to update 1 resident's CP with new interventions to prevent further falls placing resident at risk for further injuries due to uncommunicated care needs
- Record lacked evidence of fall investigation completed after 1 fall; failed to update 1 resident's CP with new interventions to prevent further falls placing resident at risk for further injuries due to uncommunicated care needs

NW: SS=D: Failed to revise CP for 1 resident who was on EBP placing resident at risk for impaired care due to uncommunicated care needs

- CP lacked any direction for staff r/t EBP care & precautions; failed to revise 1 resident's CP to include EBP placing resident at risk foe impaired care 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 implement strategies to allow & promote 1 resident who had primary language other than English to communicate wants, needs or feelings & promote socialization placing resident at risk for decreased quality of life, isolation & impaired dignity

- Resident documented as not speaking a lot of English & was able to use a few words & gestures; staff repeated when necessary & restated things or used gestures; observed resident did not communicate with resident during meal & on other occasions; observed resident seated in front of TV with English show on & no subtitles in resident's native language & resident with head down on multiple occasions; failed to implement strategies to facilitate person-centered communication & socialization for 1 resident placing resident at risk for decreased quality of life & isolation

F677 ADL Care Provided for Dependent Residents

NE: SS=E: Failed to provide consistent bathing for 4 residents placing residents at risk for poor hygiene & related complications

- Documentation revealed resident with multiple days w/o scheduled baths; failed to provide resident with consistent bathing placing resident at risk for poor hygiene for multiple residents;

NW: SS=D: Failed to provide necessary services to maintain good personal hygiene including bathing & toileting for 1 resident placing resident at risk for poor personal hygiene & related complications

- Cited findings noted in F657 r/t B/B incontinence; CP lacked direction to staff that resident required toileting after every meal; Bathing Record for October documented resident requested showers on Wednesday & Saturday & documented resident had not received bath/shower for 14 days & 16 days & resident refused shower on 3 scheduled occasions; observed resident with "very disheveled hair"; failed to provide cognitively impaired resident with consistent bathing opportunities & alternatives that incorporated resident's needs & preferences; further failed to assist resident with toileting after meals placing resident at risk for poor hygiene & related complications

F686 Treatment/Services to Prevent/Heal PU

NE: SS=D: Failed to ensure 1 resident's low air-loss mattress was set to appropriate weight settings per physician's order & current weight placing resident at risk for complications r/t skin breakdown & Pus

- Resident with pre-existing Stage 3 PU on sacrum; CP indicated low air-loss mattress was to be set on less than 250 lbs. mark; POS for low air-loss mattress with instructions to staff to set mattress's weight at less than 250 lbs; observed resident in bed with mattress control panel set to 500 lbs, 550 lbs; failed to ensure 1 resident's low air-loss mattress was set to appropriate weight settings per physician order & current weight placing resident at risk for complications r/t skin breakdown & PUs

NE: SS=D: Failed to ensure 1 resident received appropriate prompt treatment to promote healing & prevent worsening of stage 2 PUs; also failed to ensure 1 resident had nutritional measures & pressure reducing device for w/c in place placing 2 residents at risk for delayed healing &/or increased risk for PUs

- Failed to monitor & treat 1 resident's Stage 2 PU to buttocks promptly resulting in delay of treatment placing resident at risk for complications r/t skin breakdown & PUs
- Record lacked evidence RD evaluated 1 resident's nutritional status to promote wound healing; failed to provide pressure-reducing w/c cushion & nutritional support to promote healing for 1 resident with stage 2 PU upon admission placing resident at risk for further breakdown & delayed healing

NW: SS=D: Failed to provide interventions to prevent facility-acquired PU to 1 resident's heel upon significant change in mobility; further failed to ensure all interventions were implemented as directed to prevent wound worsening or promote healing placing resident at risk for complications r/t skin breakdown & wounds

- Resident with skin risk; observed resident with air mattress on bed; observed resident w/o pillow behind legs on w/c pedals; failed to provide interventions to prevent facility-acquired PU to 1 resident's hell upon significant change in mobility; further failed to ensure all interventions implemented as directed to prevent worsening or promote healing placing resident at risk of complications r/t skin breakdown & wounds

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=G: Failed to ensure fall prevention interventions including floor mat were utilized for 1 resident; resident had fall resulting in femur non-displaced femoral neck fx; facility further failed to ensure 1 resident's WanderGuard was in place & functioning placing resident at risk of accidents & related injuries

- Failed to implement safety interventions for 1 resident r/t falls & subsequently resident fell resulting in femoral fx also placing resident at risk for future falls & injuries
- Failed to ensure 1 resident's WanderGuard was in place & functioning placing resident at risk of accidents & related injuries

NW: SS=G: Failed to provide adequate supervision & ID & implement interventions to prevent falls for 2 residents who had falls resulting in major injuries placing residents at risk of ongoing falls & injuries

- Resident with high fall risk; facility unable to provide investigation to ID causative factors for multiple falls with 1 resulting in hip fx; failed to investigate falls for causative factors & further failed to ID & implement interventions following falls to prevent further falls & as result resident fell & fx'd hip resulting in impaired mobility placing resident at risk for increased pain & further falls
- Failed to investigate & implement relevant interventions to prevent 1 resident from falling placing resident at risk for further falls & injuries

NW: SS=D: Failed to ID causative factors for falls & implement meaningful, resident-centered interventions including adequate supervision, to prevent falls for 1 resident who experienced repeated falls in past year; failed to assess interventions that were in place to ensure interventions were appropriate & to monitor effectiveness of interventions placing resident at risk for ongoing falls & injuries

- Resident with multiple falls in past year including falls that involved compliance with plan by spouse; Adm Nurse stated some of CP interventions in place ineffective; failed to ID causative factors for falls & failed to implement meaningful, resident-centered interventions including adequate supervision to prevent falls for resident; further failed to assess interventions that were in place to ensure interventions were appropriate & failed to monitor effectiveness of interventions placing resident at risk for ongoing falls & injuries

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to provide 1 resident with sanitary indwelling urinary catheter care placing resident at risk for UTIs & other catheter-related complications

- Observed CNA placed catheter bag directly on floor while emptying urine from catheter bag; Failed to provide 1 resident with sanitary indwelling urinary catheter care placing resident at risk for UTIs

F692 Nutrition/Hydration Status Maintenance

NW: SS=G: Failed to recognize 1 resident's weight loss & act on RD recommendations to prevent further loss resulting in significant unintended weight loss of 9.74% in 3 months & placed resident at risk for complications r/t continued weight loss

- Record lacked evidence facility implemented RD recommendation for 8-oz nutritional supplement in response to 4.11% loss; record lacked evidence facility implemented nutritional interventions recommended by RD on further dates; failed to recognize 1 resident's weight loss & act on RD's recommendation to prevent further loss resulting in significant unintended weight loss of 9.74% in 3 months placing resident at risk for complications r/t loss & continued weight loss

F693 Tube Feeding Management/Restore Eating Skills

NE: SS=D: Failed to ensure 1 resident had flush order for pre- & post-bolus via G-tube placing resident at risk for G-tube complications & adverse reactions including dehydration & fluid overload

- POS lacked order specifying amount for G-tube flush prior to & after administration of Glucerna bolus; observed LN administer Glucerna bolus & flushed tube prior to & after administration w/o physician order to do so; failed to ensure 1 resident had order for flush prior to & after administration of enteral bolus feeding placing resident at risk for G-tube complications & adverse effects including dehydration & fluid overload

F695 Respiratory/Tracheostomy Care & Suctioning

NE: SS=D: Failed to ensure 1 resident had physician orders for O2 therapy & failed to provide direction to staff for cleaning, storage, & dispensing of O2; failed to ensure resident had POS for O2 & further failed to store 2 residents' respiratory equipment in sanitary manner placing residents at risk for increased respiratory infections & other related complications

- EMR lacked physician order for O2 use; failed to obtain physician orders prior to administering resident's supplemental O2 & failed to store O2 tubing & cannula in sanitary manner when not in use placing resident at risk for respiratory complications & physical decline; failed to ensure 1 resident had physician's order in place for supplemental O2 use; failed to ensure staff appropriately changed, stored & labeled 1 resident's nebulizer mask, O2 tubing & cannula when not in use placing resident at risk of respiratory complications & infections
- Failed to maintain, change & label respiratory equipment for 1 resident placing resident at risk for respiratory infections

F697 Pain Management

NE: SS=D: Failed to ensure 1 resident had physician ordered Norco available for administration as scheduled for pain management resulting in 1 resident missing scheduled dialysis appointment placing resident at risk of complications r/t unmanaged pain

- Failed to ensure 1 resident had physician-ordered Norco available for administration as scheduled for pain management resulting in unmanaged pain placing resident at risk of complications r/t unmanaged pain

NW: SS=D: Failed to adequately respond to 1 resident's complaints of pain placing resident at risk for unresolved pain & discomfort

- POS for Tylenol 500mg q 4 hrs PRN pain; POS for Biofreeze to back q 8 hrs PRN for pain in thoracic spine; POS for Acetaminophen 650mg 2 tabs TID for pain & MAR documented Acet scheduled for 8a, 2pm, 8pm; observed resident in DR stating significant pain & CNA failed to inform LN or CMA of resident's back pain; failed to adequately respond to 1 resident's complaints of pain placing resident at risk for unresolved pain & discomfort

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=J (Abated to D): Failed to provide adequate supervision to prevent an elopement for cognitively impaired resident who required staff assistance for activities of daily living ADLs including safe ambulation with resident's walker and was at risk for falls

- *On 10/17/24 between 04:00 AM and 04:30 AM, CNA heard resident's toilet flush, entered resident's BR and asked resident if resident needed anything. Resident responded "No" and CNA left to assist another resident without assisting resident back to bed as CNA assumed the resident would go back to bed. At approximately 04:40 AM, per camera footage, resident ambulated to elevator, took the elevator to the first floor, walked to a set of double doors, passed through them into the main lobby area, and proceeded to exit the main entrance doors of the facility without staff knowledge or supervision. At approximately 05:30 AM, LN received a call informing her that Law Enforcement was with resident at a nearby gas station. LN confirmed resident was a resident of the facility and at 05:22 AM LE returned resident to facility. Staff assessed resident and noted resident temperature to be 97.5 degrees F and oxygen saturation was 94 percent (%) on room air. Resident wore pajamas, shoes, and a jacket. The temperature outside on 10/17/24 was 36 degrees F at 04:53 AM and 34 degrees F at 05:53 AM. The lack of supervision allowed resident to exit facility without staff knowledge or supervision placing resident in immediate jeopardy.*
- *Abatement Plan:*
  - *WanderGuard was placed on resident with orders to monitor and document function each shift.*
  - *Resident's care plan was updated to include an intervention and monitoring for resident's WanderGuard.*
  - *Staff completed an updated Elopement screening on resident to reflect resident's new risk and behavior.*
  - *Facility contacted maintenance and the facility door contractor to inspect the unit door's locking systems to ensure there was no other point of failure.*
  - *Facility ordered parts to have a set of double doors resident went through on 10/17/24 coded with a keypad lock to prevent future elopements through those doors.*
  - *Administrative Nurse was in the process of providing education for all staff related to elopement, wandering, and missing residents.*

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

- Observed restorative room unlocked & unsupervised with multiple multi-purpose cleaners in unlocked cabinet under sink; failed to secure potentially hazardous cleaning chemicals in safe, locked area & out of reach of 7 cognitively impaired independently mobile residents placing affected residents at risk for preventable accidents & injuries

F698 Dialysis

NE: SS=D: Failed to ensure consistent communication between facility & resident's dialysis center placing resident at risk for potential adverse outcomes & physical complications r/t dialysis

- Failed to ensure consistent communication between facility & resident's dialysis center placing resident at risk for potential adverse outcomes & physical complications r/t dialysis

NE: SS=D: Failed to ensure ongoing communication & collaboration with dialysis facility r/t dialysis care & services r/t resident's health status with each procedure placing resident at risk for complications r/t dialysis

- Failed to ensure ongoing communication & collaboration with dialysis facility r/t dialysis care & services r/t resident's health status with each procedure placing resident at risk for complications r/t dialysis

F700 Bedrails

NE: SS=E: Failed to ensure that 1 resident's bedrails were removed as indicated per resident's most current side rail assessment; additionally failed to ensure that 3 residents had safety assessments for use of side rails that acknowledged risks from low air-loss mattresses, risk for entrapment, consent for use of side rails & failed to ensure resident/representative were advised of risks &/or benefits of use of side rails placing residents at risk for uninformed decisions & impaired safety r/t risks associated with use of side rails

- Assessment indicated side rails, grab bars or transfer bars will not be used currently due to assessment findings & evaluation did not acknowledge use of resident's low air-loss mattress; mattress manual indicated use of bed rails with air mattress should be assessed based on risk of entrapment; EMR lacked safety assessment for use of bed cane addressing risk for entrapment between device & mattress, consent for use & failed to ensure resident/representative were advised of risks &/or benefits of use of bed canes; failed to ensure that R24's bed rails were removed as indicated per her most current side rail assessment and further failed to ensure safety assessments acknowledged the risks when used with a low air loss mattress. This placed resident at risk for impaired safety related to the risks associated with the use of side rails
- Failed to ensure that 1 resident had a safety assessment for the use of side rails that acknowledged the risks from use with the low air-loss mattress, consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails placing resident at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails for multiple residents

F726 Competent Nursing Staff

NW: SS=F: Failed to ensure 1 nurse aide had appropriate skills, competencies & active certification & failed to ensure LN staff had knowledge & skills to safely pass meds to residents placing residents at risk for impaired quality of care

- 1 CNA certification on the Registry Certification and Credentialing site revealed CAN had an Aide ID issued on 12/18/19 and certification was marked inactive on 12/18/21. CNA had been employed at the facility since 07/12/22. Failed to ensure 1 CNA had active certification placing residents who resided in facility at risk of receiving impaired Quality of Care
- Observed LN stood at counter in nurse workroom & 5 residents' med cups, 4 with initials, 2 w/o writing with assorted pills in each cup; LN verified had set meds up that morning in locked cabinets in residents' rooms; failed to provide LN with adequate competency & skills to safely administer meds for all residents currently residing in facility placing resident at risk for med errors

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

NE: SS=F: Failed to provide RN coverage 8 consecutive hrs/day, 7 days/wk placing all residents residing at facility at risk of decreased quality of care

- Per PBJ report facility lacked RN coverage for 8 hours for 57 days in 10 months; failed to provide RN coverage 8 consecutive hrs/day, 7 days/wk placing all residents residing at facility at risk of decreased quality of care

F732 Posted Nurse Staffing Information

NW: SS=C: Failed to display current daily nursing staff hours

- Failed to display current daily nursing hour information as required

F742 Treatment/Services Mental/Psychosocial Concerns

NE: SS=D: Failed to immediately involve physician & provide supportive mental health services to attain 1 resident's highest practicable mental & psychosocial wellbeing after resident made statements of self-harm placing resident at risk for unmet mental health care needs & related complications

- NN documented resident voiced to self & staff resident wanted to leave & kill self & had nothing to live for anymore & just wanted to die; record lacked documentation physician notified & lacked documentation of staff monitoring after resident made self-harm statements; failed to immediately involve physician & provide supportive services to attain highest practicable mental & psychosocial wellbeing for 1 resident who made statements of self-harm placing resident at risk for unmet mental health care needs

F755 Pharmacy Services/Procedures/Pharmacist/Records

NE: SS=E: Failed to ensure accurate reconciliation of controlled meds was completed placing residents at risk of medication misappropriation & diversion

- Failed to ensure accurate reconciliation of controlled meds was completed consistently placing residents at risk of medication misappropriation & diversion

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported that staff failed to follow physician's orders to administer insulin to 1 resident placing resident at risk for physical decline & ineffective med regimen

- Failed to ensure CP ID'd & reported that staff failed to follow physician's orders to administer insulin to 1 resident placing resident at risk for physical decline & ineffective med regimen

NW: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported lack of appropriate indication or required physician documentation for 1 resident's antipsychotic medication; further failed to ensure CP ID'd & reported irregularities in 1 resident's blood sugar monitoring placing residents at risk for physical decline, ineffective medication regimen, & side effects from necessary medication

- POS for Seroquel BID for major depressive d/o; EMR lacked documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management & risk vs benefits for continued Seroquel use; MRR lacked evidence of recommendation for appropriate indication for continued use of Seroquel; failed to ensure CP ID'd & reported inappropriate indication for continued use of antipsychotic med Seroquel placing resident at risk for unnecessary antipsychotic med with side effects
- Resident with DM; POS for Novolog insulin ac with notification parameters & order DC'd 9-12-24; August documentation indicated blood sugar outside of parameters x 5 occasions when physician not notified; with multiple further months with lack of notification; MRR failed to indicate lack of physician notification; failed to ensure CP ID'd & reported irregularities in resident's blood sugar monitoring placing resident at risk for physical decline, ineffective medication regimen, & side effects from unnecessary medication

NW: SS=D: Failed to ensure CP ID'd & reported that resident lacked stop date as required by CMS for continued use of PRN Ativan placing resident at risk for complications r/t psychotropic med use beyond 14 days

- Failed to ensure CP ID'd & reported that resident lacked stop date as required for continued use of PRN Ativan placing resident at risk for co9mplications r/t psychotropic med use beyond 14 days

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to follow physician ordered parameters r/t blood glucose monitoring for 2 residents placing residents at risk for delayed treatment of hyperglycemia, hypoglycemia & unnecessary med complications

- Resident with DM; POS for Glargine insulin q hs with holding & notification parameters of blood sugars; Novolog Flex-Pen with holding & notification parameters; EMR documented with documentation insulin was administered on 8 occasions when blood sugar below ordered parameters from 8-9-24 thru 10-15-24; failed to hold 1 resident's insulin for blood glucose levels outside ordered parameters placing resident at risk for complications r/t hypoglycemia & unnecessary meds
- Failed to follow physicians' ordered parameters r/t blood glucose monitoring for 1 resident placing resident at risk for complications r/t meds

NE: SS=D: Failed to ensure 1 resident's PRN antihypertensive med hydralazine was given per physician-ordered parameters; failed to ensure 1 resident's insulin administered as directed placing residents at risk of medication-related complications & possible adverse reactions

- MAR documented 43/124 opportunities for resident's BP above order parameters & resident should have received PRN hydralazine; failed to ensure staff administered resident's PRN hydralazine as physician-ordered when SBP reading was greater than 160 mmHg placing resident at risk of complications & adverse reactions
- POS for Insulin Glargine q hs; Sept MAR lacked documentation resident received ordered insulin on 3 occasions; failed to administer insulin as ordered for 1 resident placing resident at risk for physical decline

NW: SS=D: Failed to monitor & provide interventions for bowel management for 1 resident & failed to notify physician of blood sugars outside of physician-ordered parameters for 1 resident placing resident at risk for physical decline & other related complications

- Failed to monitor & provide ordered interventions for bowel management for 1 resident placing resident at risk for impaction & physical decline
- Failed to notify physician when resident's blood sugar was out of physician-ordered parameters placing resident at risk for unnecessary medication side effects & other related complications

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NW: SS=D: Failed to ensure appropriate indication or documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management & risk vs benefits for continued use of 1 resident's antipsychotic Seroquel placing resident at risk for unintended effects r/t psychotropic drug meds

- Cited findings noted in F756 r/t inappropriate dx for Seroquel; failed to ensure 1 resident did not receive antipsychotic med w/o appropriate indication or required physician documentation for use placing resident at risk for adverse side effects

NW: SS=D: Failed to obtain stop date from physician for continued use of PRN Ativan for 2 residents placing residents at risk for complications r/t psychotropic meds & unnecessary meds

- Failed to obtain 14-day stop date or physician rationale for continued use of PRN Ativan with specified duration placing resident at risk for unnecessary psychotropic medication for multiple residents

NW: SS=D: Failed to ensure an appropriate indication for use of antipsychotic or required physician documentation for 2/5 residents reviewed for unnecessary medications placing residents at risk for unnecessary psychotropic medications

- POS for Seroquel for agitation & restlessness; MRR advised of inappropriate dx but physician failed to address recommendations; record lacked evidence of physician documentation which included rationale & risks vs benefits for resident's continued use of Seroquel; Adm Nurse stated facility had tried to get physicians "on board" with proper documentation for antipsychotic meds; failed to ensure appropriate indication for use or required physician documentation for resident's Seroquel placing resident at risk for unnecessary psychotropic meds

- POS for Seroquel for unspecified dementia w/o behavioral disturbance, psychotic disturbance, mood disturbance & anxiety; Pharmacist recommended physician review of indication; record lacked physician documentation which included rationale & risk vs benefit for continued Seroquel use; failed to ensure appropriate indication for use or required physician documentation for resident's Seroquel placing resident at risk for unnecessary psychotropic meds

F761 Label/Store Drugs & Biologicals

NW: SS=D: Failed to label 3 resident's insulin flex pens with opened & discard dates placing affected residents at risk for ineffective meds

- Observed tx cart with 3 resident's insulin flex pens unlabeled with open or discard date; failed to date insulin flex pens with opened & discard dates placing residents at risk for ineffective meds

F801 Qualified Dietary Staff

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

- Dietary manager stated schedule to take test on 11-16-24; Failed to ensure director of food & nutrition services had required qualifications of CDM placing residents at risk for unmet dietary & nutritional needs

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

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

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

- Failed to employ a full time CDM to evaluate residents' nutritional concerns & oversee ordering, preparing & storage of food for all residents in facility placing residents at risk for inadequate nutrition

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NE: SS=D: Failed to hold food at safe temp for 1 resident's room tray placing resident at risk for foodborne illness

- Failed to maintain safe food temps for 1 resident's room tray placing resident at risk for foodborne illness

NW: SS=D: Failed to correctly prepare a pureed diet for 3 residents that retained both nutritive value & palatability placing affected residents at risk for impaired nutrition or decreased quality of life

- During pureed meal prep staff did not puree rolls or biscuit with milk; failed to provide food prepared by methods that conserve nutritive value & flavor while preparing a pureed diet for 3 residents placing affected residents at risk for impaired nutrition

F805 Food in Form to Meet Individual Needs

NE: SS=D: Failed to ensure 1 resident received thickened liquids per physician orders placing resident at risk of complications of aspiration

- Failed to provide speech therapy eval or tx; POS for nectar consistency liquids; water pitcher with thin liquids at bedside; failed to provide 1 resident with nectar-thick liquids per orders placing resident at risk of complications r/t aspiration of liquids

F812 Food Procurement, Store/Prepare/Serve-Sanitary

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

- Observed coffee station table with dry, brown-tinged towel in front of coffee maker; dishwasher area with trays of dishes left from previous night that had not been washed & area with musty odor; fridge with unlabeled, undated liquids; tray with filled drinking glasses lacing cover, label or date; covered fruit cups & other trays lacked label or date

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

- Observed: unlabeled, undated food items, unsealed items;

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

- Observed air vent grill covered with brown grease/sticky substance & gray fuzzy substance blowing directly on food prep area; multiple fluorescent light fixtures with missing & exposed fluorescent bulb & other cover partially affixed to light fixture; other fixtures with fuzzy substance affixed to chains

NW: SS=D: Failed to prepare food in sanitary manner for 2 residents who requested lettuce salad at mealtime placing residents at risk for foodborne illness

- Observed dietary staff donned gloves & took head of lettuce out of fridge, unwrapped plastic wrap & loose leaves then lifted trash can lid & threw away discarded lettuce then failed to change gloves prepared salad then CDM covered bowls of salad & placed in fridge & stated they would be served at mealtime; failed to prepare food in sanitary manner for 2 residents who requested lettuce salad at mealtime placing residents at risk for foodborne illness

F838 Facility Assessment

NE: SS=F: Failed to develop a facility assessment that accurately reflected required sections of facility assessment including services provided, staff required, staff competencies & religious practices placing residents at risk for unidentified care needs & inadequate care & services

- Failed to develop a facility assessment that accurately reflected required sections of facility assessment including services provided, staff required, staff competencies, & religious practices placing residents at risk for unidentified care needs & inadequate care & services

F849 Hospice Services

NW: SS=D: Failed to ensure coordinated CP which coordinated care & services provided by hospice was developed & available for 2 residents placing residents at risk for inadequate end-of-life care

- Staff confirmed CP lacked information for staff r/t hospice service contact information, visit frequency, medications & supplies hospice would supply; failed to ensure coordinated CP which coordinated care & services provided by facility & hospice provider for 1 resident placing resident at risk for inadequate end-of-life care for 2 residents

F851 Payroll Based Journal

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

- Failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

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

- Failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

F868 QAA Committee

NW: SS=F: Facility lacked evidence required committee members, including Medical Director attended QAPI meetings quarterly placing residents residing at facility at risk for decreased quality of care

- Sign-in sheets lacked evidence of medical director's attendance from May thru Sept 2024; staff confirmed medical director did not attend a QAPI meeting in 3rd quarter of 2024

F880 Infection Prevention & Control

NE: SS=E: Failed to implement EBP for 1 resident's indwelling catheter, 1 resident's G-tube & 1 resident's wound care; failed to ensure 1 resident's eye med was administered using adequate infection control standards & failed to ensure 1 resident's O2 equipment was changed & stored in sanitary manner placing residents at risk for infectious processes

- Failed to ensure staff followed EBP for 3 residents & failed to use standard infection control practices during eye drop administration & for sanitary storage of respiratory tubing placing resident at risk for increased infections

NW: SS=D: Failed to adhere to infection control for EBP for 1 resident with urinary catheter placing resident at risk for infection

- Observed CNA entered resident who had urinary catheter room & ambulated resident to BR; CNA donned gloves but no gown; failed to adhere to infection control standards & policies for 1 resident who required EBP placing resident at risk for possible exposure to illness

NW: SS=D: Failed to ensure staff followed appropriate infection control standards r/t urinary catheter care for 1 resident placing resident at increased risk for infections

- Observed CMA & CAN performed catheter care; resident in low bed & catheter bag laid directly on bare floor; CMA applied new gloves, wiped resident's bottom 1 more time, then emptied catheter bag wearing same contaminated gloves; failed to provide proper infection control practices during urinary catheter care for 1 resident placing resident at risk for infection

F883 Influenza & Pneumococcal Immunizations

NE: SS=D: Failed to administer a pneumococcal vaccination to 1 resident after resident consented to receive it on 9-26-24 placing resident at risk of acquiring, spreading, & experiencing complications from pneumococcal disease

- Failed to administer pneumococcal vaccination to 1 resident after resident consented to receiving it placing resident at risk of acquiring, spreading, & experiencing complications from pneumococcal disease

F908 Essential Equipment, Safe Operating Condition

NE: SS=C: Failed to ensure kitchen stand-up freezer & plate warmer were in safe operating condition

- Observed stand-up freezer not in working order; plate warmer located by stove unplugged & no plates present in it; failed to ensure kitchen stand-up freezer & plate warmer were in safe operating condition

November, 2024

F550 Resident Rights/Exercise of Rights

SW: SS=D: Failed to protect privacy & dignity of 3 residents: 1 resident when med was administered via PEG with left breast exposed & door to room stood open; failed to explain procedures to 1 resident when providing cares & further failed to provide privacy to when staff transported 1 resident from shower room to room with buttocks exposed with potential to lead to negative psychosocial effects r/t dignity

- Failed to protect dignity of 1 resident when door to resident's room was left open when med was administered via PEG tube with PEG tube exposed 7 resident's breast partially exposed with potential to lead to negative psychosocial effects r/t dignity
- Failed to protect resident's dignity when staff transported resident from shower room to room with buttocks exposed with potential to lead to negative psychosocial effects r/t dignity
- Failed to protect resident's dignity when staff provided care w/o explaining procedure with potential to lead to negative psychosocial effects r/t dignity

NE: SS=D: Failed to provide care & services that promoted resident dignity for 1 resident placing resident & other residents in vicinity at risk for impaired dignity & decreased quality of life

- *Incident report documented 2 CNAs asked resident if resident wanted shower & resident refused & asked staff to leave & threatened to call police; CNAs left room; later resident told another resident that "didn't like that little (expletive)"; 1 CNA then told resident "You cannot call me that" with further verbal altercation & resident CNA raised voice & told resident "unacceptable" & "could not speak to her like that"; "bickering" continued until CMA & SSD stepped in; observed CNA in DR & CNA stated to resident "You cannot call me a black (expletive), I will not allow you to disrespect me like that, That is not my name. My name is (CNA name). If you call me that again I am going to take you to your room". Loud exchange drew attention of staff & other residents until SSD intervened; Resident stated to surveyor "I don't like people"; failed to provide care & services that promoted resident dignity for resident placing resident & other residents in vicinity at risk for impaired dignity & decreased quality of life*

F609 Reporting of Alleged Violations

NW; SS=D: Failed to ensure staff ID'd allegation of rough care as potential abuse & reported immediately to Adm; further failed to report allegation of abuse to State Agency (SA) as required placing resident at risk for ongoing abuse & mistreatment

- *NN documented resident hollered out with care; observed 2 CMAs explained to residents that staff were going to assist resident onto mechanical lift & take to BR & staff proceeded to provide care; resident yelled "Ouch" & "stop"; 2 CMAs reported it was common for resident to yell out especially when cares involved something wet like wipes & showers; Adm reported CMA suspended pending investigation of alleged physical abuse; Adm stated Adm Nurse aware of allegation on day of incident & should have reported incident to Adm on that day; CMA stated told by CNA that CNA had witnessed CMA squeezing resident's arm while resident was yelling out & being assisted with lift transfer; CMA reported had inquired about status of investigation r/t incident & Adm Nurse stated it had been "taken care of"; failed to ensure staff ID'd allegation of rough care as potential abuse & reported it immediately to Adm; further failed to report allegation of abuse to SA as required placing resident at risk for ongoing abuse & mistreatment*

F610 Investigate/Prevent/Correct Alleged Violation

NW: SS=D: Failed to initiate protective measures & fully investigate allegation of abuse for 1 resident placing resident at risk for ongoing abuse

- *Cited findings noted in F609 r/t allegation of CMA squeezing resident's arm & resident reported "rough treatment"; failed to fully investigate & initiate protective measures for 1 resident after allegation of abuse placing resident at risk for continued abuse*

F623 Notice Requirements Before Transfer/Discharge

SW: SS=D: Failed to provide written notification within a practicable timeframe of facility-initiated transfer to 2 residents; further failed to notify stated LTC Ombudsman of facility-initiated transfers/discharges for 2 resident placing residents at risk of uninformed care choices & impaired rights

- Failed to provide written notification of transfer to 1 resident as soon as practicable; further failed to notify state LTCO of transfer/discharges for resident placing resident at risk for uninformed care choices & impaired rights for 2 residents

SW: SS=D: Failed to provide written notice for facility-initiated transfers for 3 residents/representatives when residents were transferred to hospital

- EMR lacked documentation r/t written notification of resident or representative r/t discharges/transfers; failed to provide written notification of facility-initiated discharges/transfers to residents/representatives

F625 Notice of Bed Hold Policy Before/Upon Transfer

SW: SS=D: Failed to provide 2 residents with written information r/t facility bed hold policy when residents were transferred to hospital placing residents at risk for not being permitted to return & resume residence in facility & in same room

- Failed to provide 1 resident with copy of facility bed hold policy when resident was transferred to hospital placing resident at risk of not being permitted to return & resume residence in facility & in same room for multiple residents

F657 Care Plan Timing & Revision

SW: SS=D: Failed to review & revise CPs with appropriate interventions for 2 residents: 1 resident r/t development & implementation of appropriate interventions to prevent additional falls &1 resident r/t storage of CPAP equipment when not in use resulting in uncommunicated care needs

- Failed to review & revise 1 resident's comprehensive person-centered CP to include interventions to place 1 resident's CPAP mask in sanitary bag when not in use placing resident at risk for uncommunicated care needs
- Failed to revise CP for 1 resident after fall to prevent further falls with potential to negatively affect resident's physical wellbeing r/t ongoing risk of falls

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

SW: SS=D: Failed to initiate interventions to mitigate risk for development of PUs for 1 resident who developed 2 facility-acquired pressure injuries placing resident at risk for further pressure-related injury & related complications

- CP lacked interventions to prevent development of PU prior to development of PU; failed to respond to 1 resident's risk factors for pressure injuries with interventions to prevent development of PU for 1 resident placing resident at risk for further pressure-related injury & related complications

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=D: Failed to provide environment free from accident hazards when staff failed to use Hoyer lift to facilitate safe transfer for 1 resident whose admission note indicated resident required Hoyer lift for transfers placing resident at risk for falls & potential injury

- Failed to provide environment free from accident hazards when staff failed to use Hoyer lift to facilitate a safe transfer for 1 resident whose admission note indicated resident required a Hoyer for transfers placing resident at risk for falls & potential injury

SW: SS=D: Failed to ID fall, investigate causal factors & implement fall prevention interventions for 1 resident to prevent further falls

- Failed to ID fall, investigate causal factors & implement fall prevention interventions for resident to prevent further falls with potential to negatively affect resident's physical wellbeing r/t ongoing risk of falls

F690 Bowel/Bladder Incontinence, Catheter, UTI

SW: SS=D: Failed to provide adequate catheter care & services within standards of care for 1 resident placing resident at risk for UTI & other catheter-related complications

- LN failed to don gloves when touching catheter tubing & failed to anchor catheter tubing to prevent injury; failed to provide adequate catheter care & services within standards of care for 1 resident placing resident at risk for UTI & other catheter-related complications

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

SS=F: Failed to conduct annual performance reviews for 5/5 CNAs employed with facility over a year

- Failed to conduct annual performance reviews for 5/5 sampled CNAs employed with facility over a year who provided care for all residents of facility

F761 Label/Store Drugs & Biologicals

SW: SS=E: Failed to store & label biologicals adequately when staff failed to date 4 insulin pens when opened & failed to remove or dispose of 4 expired bottles of stock meds placing 4 residents at risk of receiving expired, ineffective insulin & other residents at risk of receiving expired ineffective stock meds

- Failed to date insulin pens when opened &/or add a discard date for 4 resident & failed to remove or dispose of expired stock meds placing residents at risk of receiving expired or ineffective meds

F812 Food Procurement, Store/Prepare/Serve-Sanitary

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

- Observed multiple uncovered, unlabeled & undated Styrofoam bowls of ice cream; ice cream with lid opened & not closed securely; uncovered, unlabeled, opened & unsealed food items
- Observed flour & sugar containers with numerous discolored areas around lids; observed light fixtures with bugs & debris inside cover

F851 Payroll Based Journal

SW: SS=F: Failed to electronically submit complete & accurate staffing information to PBJ when facility failed to accurately submit hourly staffing data for all nursing personnel

- PBJ report documented 8 days in May & June 2024 w/o 8 hrs of LN staffing; payroll records indicated appropriate staffing; failed to submit complete & accurate staffing information to PBJ when facility failed to accurately submit hourly staffing data for all nursing personnel

F880 Infection Prevention & Control

SW: SS=D: Failed to adhere to infection control for EBP for 1 resident who had PICC line & 1 resident with urinary catheter placing residents at increased risk for infection

- Failed to ensure staff used EBP as required for 2 residents placing residents at increased risk for infection

SW: SS=F: Failed to ensure sanitary environment to prevent potential spread of infectious organisms; facility did not ensure sanitary storage of respiratory equipment to include nasal cannulas & O2 tubing for 3 resident; facility did not ensure appropriate use of PPE r/t EBP for resident with catheter; staff wore PPE throughout 1/3 hallways of facility; failed to clean/sanitize full body lift between use for multiple residents

- CP lacked directions to staff for storage of O2 cannulas when not in use; failed to provide sanitary & safe environment to prevent cross contamination 7 infection r/t available storage of nasal cannulas & O2 tubing when not in use
- Failed to ensure 1 resident's CPAP equipment was stowed appropriately to prevent spread of illness with potential to lead to respiratory illnesses that would negatively impact resident's physical & psychosocial wellbeing
- Failed to ensure staff donned appropriate PPE while providing catheter care for 1 resident who was on EBP precautions with potential to lead to cross contamination that would negatively impact resident's physical & psychosocial wellbeing
- Failed to ensure 1 resident's CPAP equipment was stowed appropriately to prevent spread of illnesses

F921 Safe/Functional/Sanitary/Comfortable Environment

SW: SS=E: Failed to provide a sanitary environment in 1/3 DRs placing residents who ate in main DR at risk for impaired health & wellbeing

- Observed main DR with wall near kitchen entrance door with numerous stained areas; failed to provide sanitary environment in main DR when staff filed to clean wall by entrance door to kitchen placing residents who ate in DR at risk for impaired health & wellbeing

December, 2024

F550 Resident Rights/Exercise of Rights

NW: SS=G: Failed to facility failed to promote 1 resident's right to choose, failed to respect resident's wishes, and failed to treat resident with dignity and respect.

- *On 12/05/24 at approximately 09:30 PM, resident sat in his room in his wheelchair. CNA heard another CNA say resident did not want to go to bed. 2 CNAs went into resident's room and made resident go to bed despite his protest. Resident became resistant to the transfer from his wheelchair to the bed and started hitting and kicking out at 2 CNAs & yelled, "No, no, no, no," and "Get out of here." Another CNA entered resident's room and observed resident lying on his bed with his arms and legs up in a defensive position. Other CNA the 2 CNAs they could not force resident to go to bed. This deficient practice created psychosocial impairment and placed resident at risk for injury, impaired dignity, and decreased quality of life. Resident's representative stated came to facility & was "very concerned" when saw all the bruising & was told that forced transfer caused the bruising; failed to promote resident's right to choose, failed to respect resident's wishes & failed to treat resident with dignity & respect creating psychosocial impairment & placed resident at risk for injury, impaired dignity & decreased quality of life*

F625 Notice of Bed Hold Policy Before/Upon Transfer

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

- Failed to provide 1 resident with a copy of facility bed hold policy when resident was transferred to hospital placing resident at risk for not being permitted to return & resume residence in nursing facility

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=D: Failed to ensure a safe environment, free from preventable accidents for 1/4 residents sampled for falls placing resident at risk for accidents & related injuries & complications

- *Resident with multiple falls; CP revised on 11-14-24 resident with non-injury fall & recorded bilateral fall mats at beside when resident in bed & provide 2-person assist with checks & changes; APRN documented wound care follow up due to abrasion to resident's forehead post fall; Adm staff stated fall not reported to State Agency (SA) as it was witnessed fall w/o significant injury; failed to ensure 1 resident remained free from preventable accidents when staff attempted to provide incontinence cares with personal w/o required 2 person per resident's CP resulting in resident fell out of bed & hit head placing resident at risk for accidents & related injuries & complications*

NW: SS=G (Past Non-Compliance): Failed to ID risk for burns & provide adequate supervision to prevent accidental hot liquid burns for 2 residents

- *On 10-7-24 at 12:30pm resident ate lunch in DR; resident required staff assist with eating & drinking; resident took plastic wrap off coffee on tray, lifted it towards mouth & lost control of coffee cup, spilling hot coffee on thigh; resident sustained 2nd degree burn to thigh; failed to ID risk & implement appropriate interventions & assistance with eating to prevent a hot liquid spill & further failed to assess temp of hot liquid prior to serving to ensure safe temps resulting in 2nd degree burn for resident placing resident at risk for pain & prolonged healing*

- *On 12-3-24 at 5:30pm Student CNA took another resident's supper tray to resident's room & placed tray on bedside table; Student CNA attempted to adjust height of bedside table & instead pressed latch that tilted bedside table, causing hot tomato soup & hot coffee to land on resident's thigh causing burn to resident's thigh; failed to provide adequate supervision & failed to assess temp of hot liquids prior to serving to ensure safe temps to prevent resident from sustaining hot liquid burn resulting in burn which caused excruciating pain which impacted resident's ability to sleep & placed resident at risk for ongoing pain & impaired psychosocial wellbeing*
- *Past Non-Compliance Plan:*
    - *Resident assessed for safety with hot liquids & updated resident's CP to ensure always received lid on hot beverages*
    - *Dietary staff assessed temp of coffee carafes to ensure temps were in appropriate range*
    - *Microwaves removed from DRs & staff required to take all food & beverages to dietary staff for reheating so temps can be assessed & ensured in appropriate range*
    - *For 2nd residents, tray table switched out then later returned at resident's request & marked for increased staff awareness r/t tilt function & staff received education on new processes & accident prevention*

F880 Infection Prevention & Control

NE: SS=F: Failed to handle all soiled linen as contaminated & use appropriate barriers while sorting soiled laundry to prevent contamination of clean linens placing residents at increased risk for infectious diseases

- Observed laundry area & soiled side had washing machine & clean side had dryer & folding areas; staff reported only used gloves to sort soiled laundry & did not don a gown or apron; failed to handle all soiled linens as contaminated & use appropriate barriers while sorting soiled laundry placing residents at risk for infectious diseases