April, 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

**December, 2024**

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

*SE: SS=G: Failed to protect 1 dependent Resident from harm, when staff did not follow the resident's care plan, which instructed nursing staff to utilize a slide board to transfer the resident. On 10/18/24 at approximately 12:00 PM, LN requested assistance from CMA when the resident requested to use the restroom. CMA entered resident's room and observed the resident sitting in her wheelchair. CMA offered to transfer resident from wheelchair to the bed to use the bed pan per CP, but the resident requested to use the toilet in the bathroom. CMA propelled the resident to the bathroom, placed a gait belt around the resident's body, wrapped arms around the resident, and completed a stand and pivot transfer from resident's w/c to toilet while LN removed resident's pants and brief. This failure resulted in broken bones in resident's lower leg.*

- *During stand & pivot transfers staff heard a "pop" sound; LN completed assessment while resident on toilet & did not visualize any issue; staff transferred resident off toilet with stand & pivot maneuver; when back in bed LN assessed resident's leg & ankle & observed bump with bruising to lower extremity; LN got order for x-ray then before mobile x-ray arrived resident transferred to ER & upon return, findings of visit resulted in "closed, comminuted non-displaced tibial fx & distal fibular fx of rt lower extremity"; resident returned with posterior splint on extremity; failed to protect resident from harm when nursing staff did not use appropriate transfer equipment to safely meet needs of resident that caused oblique acute, nondisplaced fx of mid tibial shaft; resident also obtained acute fx of distal fibular shaft*

**January, 2025**

**F550 Resident Rights/Exercise of Rights**

SE: SS=D: Failed to ensure staff respected 1 resident's privacy & dignity while in bed placing resident at risk of decreased self-esteem & decreased self-worth

- Observed resident laying in bed with door open & 1 leg & brief visible from doorway; failed to ensure staff respected resident's privacy & dignity while in bed placing resident at risk of decreased self-esteem & decreased self-worth

**F558 Reasonable Accommodations Needs/Preferences**

SE: SS=D: Failed to utilize & ensure appropriate use of foot pedals during w/c transports for 2 residents; additionally failed to ensure that 3 residents' call lights remained within reach placing residents at risk for preventable accidents & injuries

- EMR documented resident with fall out of w/c while being pushed in hallway w/o foot pedals resulting in multiple skin tears
- Observed resident being pushed down hallway & w/c lacked foot pedals & staff had to remind resident several times to pick up feet
- Observed 1 resident in w/c & stated cold but could not get to call light & call light observed on bed across room
- Observed resident on bed & call light pinned to cord on wall at foot of bed & pancake call light pinned to recliner at foot of bed out of reach
- Observed resident in bed & call light stuck between mattress & bed cane out of reach
- Failed to utilize & ensure appropriate use of foot pedals during w/c transports for 2 residents & additionally failed to ensure 3 residents call lights remained within reach placing resident at risk for preventable accidents & injuries

**F623 Notice Requirements Before Transfer/Discharge**

SE: SS=D: Failed to provide written notification of transfer to 1 resident/representative for facility-initiated discharge placing resident at risk for uninformed care choices

- MDS documented multiple unplanned discharges to acute hospital with return anticipated; facility provided appropriate bed holds for 6 discharges to hospital; failed to provide required written notification of transfer to resident/representative for all 6 discharges; SS stated unaware of form to provided about discharge & facility called representative; failed to provide written notification of transfer to 1 resident/representative for facility-initiated transfers placing resident at risk for uninformed care choices

**F686 Treatment/Services to Prevent/Heal PU**

SE: SS=D: Failed to ensure 1 resident's low air-loss mattress was set to appropriate weight settings per current weight; additionally failed to ensure resident's w/c had pressure-reducing cushion in place per CP placing both residents at risk for complications r/t skin breakdown & PUs

- Resident's weight 135.4# on 1-15-25; observed low air-loss mattress setting locked at 200 #'s; failed to ensure resident's low air-loss mattress set to appropriate weight setting per current weight placing resident at risk for complications r/t skin breakdown & PUs

- MDS documented resident to have pressure-reducing devices on bed & in chair; CP documented pressure-reducing mattress & pressure-reducing cushion in w/c; resident developed PU with onset on 11-26-24 to buttocks; observed resident's w/c w/o pressure-reducing cushion in w/c; & w/c lacked Dycem or cushion; failed to ensure pressure-reducing heel cushion in place for resident who had hx of pressure injury to buttocks placing resident at risk for complications r/t skin breakdown & development for further PUs

**F688 Increase/Prevent Decrease in ROM/Mobility**

SE: SS=D: Failed to ensure 1 resident was provided services & tx to prevent worsening of contractures in hand placing resident at risk for discomfort & decreased ROM

- Resident with limited RON in upper & lower extremity, 1 side; CP documented supportive devices & staff to use washcloth in hand to prevent further contracture formation & staff may use weighted puppy stuffed animal on forearm for comfort & resident could wear hand splint for up to 1 hour at a time up to 3x/day as tolerated; EMR from 12-1-24 to 1-29-25 lacked documentation of resident's supportive devices applied or refused; observed resident lacked any type of contracture prevention device in palms of hands on multiple occasions; failed to ensure resident received services & tx for contractures to prevent avoidable reduction of ROM leaving resident at risk for further decline & discomfort

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

SE: SS=D: Failed to secure electrical furnace closet out of reach of 30 cognitively impaired/independently mobile residents; additionally failed to ensure 1 resident's CP'd fall interventions were in place placing identified residents at risk for preventable injuries & accidents

- Observed furnace closet next to resident room & closet double doors locked but easily pulled open due to damage to door's frame; closet contained numerous electrical boxes containing warning; door fixed by maintenance within 30 minutes of observation; failed to secure electrical furnace closet out of reach of 30 cognitively impaired independently mobile residents placing identified residents at risk for preventable injuries & accidents
- CP documented Dycem placed in 1 resident's w/c to reduce fall risk from sliding out of w/c; observed resident's w/c at foot of recliner & lacked Dycem or pressure-reducing cushion; observed resident in w/c lacking Dycem; failed to ensure Dycem in w/c or recliner as CP'd for 1 resident with hx of multiple falls placing resident at further risk for injuries r/t falls

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

SE: SS=D: Failed to provide appropriate tx for 1 resident with indwelling catheter when facility failed to prevent catheter drainage bag from resting on floor placing resident at risk for catheter-related complications

- Resident with urinary catheter for BPH & admitted with catheter; observed resident in recliner & catheter bag & tubing rested directly on floor under recliner on multiple occasions; failed to ensure standard of care provided for 1 resident's catheter bag which rested directly on floor placing resident at risk of catheter-related complications

**F695 Respiratory/Tracheostomy Care & Suctioning**

SE: SS=D: Failed to ensure 1 resident had physician-ordered supplemental O2 on as ordered; failed to ensure resident's nasal cannula was appropriate stored when not used placing resident at risk for respiratory complications & possible infection

- Resident with continuous supplemental O2 & BiPAP at night; observed nasal cannula not stored in storage bag; failed to ensure 1 resident had physician-ordered supplemental O2 was on as ordered; failed to ensure resident's nasal cannula was properly stored when not in use placing resident at risk for respiratory complications & possible infection

**F726 Competent Nursing Staff**

SE: SS=D: Failed to ensure staff possessed appropriate skills & knowledge to order 1 resident's physician-ordered eyedrops placing resident at risk for impaired quality of care

- POS for Refresh Plus Ophthalmic Solution 1 gtt rt eye qid for dry eyes; NN documented staff received medication on 1-7-25 & instructions from representative to contact resident's outside medical provider; NN documented resident's eyedrops never added to orders or administered; facility never followed up on call to outside medical provider; eyedrops had to be re-ordered from pharmacy on 1-14-25 & were delivered on 1-15-25; resident's representative stated facility failed to administer prescribed resident's eyedrops ordered by eye doctor; failed to ensure staff possessed appropriate skills & knowledge to ensure resident's physician-ordered eyedrops were ordered & administered placing resident at risk for impaired quality of care

**F744 Treatment/Service for Dementia**

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

- Resident with Alzheimer's disease, dysphagia, cognitive-communication d/o & hx of falls; EMR w/o documentation r/t attempted use of fidget devices or resident's refusal to use devices; resident with multiple documented falls; failed to provide dementia-related behavioral services for 1 resident to promote highest practicable level of wellbeing, resulting in numerous non-injury falls placing resident at risk for decreased quality of life, isolation & impaired dignity

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

SE: SS=D: Failed to ensure physician parameters were followed for hypertensive medication for 1 resident with potential of unnecessary medication administration thus leading to possible harmful side effects

- POS for Carvedilol for HTN with holding parameters; MAR documented 7 occasions in January when record lacked documentation of resident's BP; failed to ensure staff followed physician-ordered parameter for monitoring 1 resident's Carvedilol with potential of unnecessary medication administration thus leading to possible harmful side effects

**F758 Free from Unnecessary Psychotropic Meds/PRN Use**

SE: SS=D: Failed to ensure 1 resident had adequate CMS approved indication of use of antipsychotic medication placing resident at risk for unnecessary medication administration & related complications

- Resident with Alzheimer's disease; POS for Seroquel for Alzheimer's dementia with behavioral disturbance target behavior of agitation; pharmacy review had not been conducted by pharmacist yet; LN could not say for certain what appropriate dx was for use of Seroquel; failed to ensure resident had adequate CMS-approved indication for use of Seroquel placing resident at risk for unnecessary medication administration & related complications

**F761 Label/Store Drugs & Biologicals**

SE: SS=E: Failed to properly store meds in 2/4 med carts; also failed to label med in 1/2 med carts placing residents at risk for adverse outcomes or ineffective med regimens

- Observed med cart on 1 hallway unlocked & unattended in hallway; observed 2nd med cart on same hallway unlocked & unattended; observed 1 med cart with 2 opened, undated insulin pens; failed to properly label & store meds with potential to cause adverse consequences or ineffective treatment to affected residents

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

SE: SS=F: Failed to ensure food was properly stored; failed to ensure freezer was in proper working condition; failed to ensure freezer temps remained at required temps; failed to ensure food temps were logged to ensure appropriate temps were reached before serving

- Observed cottage cheese opened & lacked open date on outside of container; bread rack with 3 opened loaves of bread & buns unsealed, undated & unlabeled; bag of macaroni & bag of pasta shells opened & unsealed, undated & unlabeled; walk-in freezer with opened potato patties unsealed, undated & unlabeled; meat items opened, unsealed, undated, unlabeled; breadsticks opened, unsealed, undated, unlabeled; no food temp logs provided; fridge/freezer temp log with multiple holes

**F880 Infection Prevention & Control**

SE: SS=D: Failed to follow sanitary infection control practices r/t O2 equipment storage & Foley catheter care placing residents at risk for infectious diseases

- Cited findings noted in F695 & F690 r/t unbagged O2 cannula when not in use; foley tubing & bag directly on floor

**February, 2025**

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

SW: SS=D: Failed to notify physician of episodes of syncope & lightheadedness of 1 resident placing resident at risk for further decline & delay in treatment

- NN documented resident was sat up in lift & became light-headed & staff sat resident down & resident started to "feel strange"; EMR lacked documentation physician notified of episode; NN documented transfer in lift & resident eyes rolled into back of head & stated "put me down" & resident lowered back into w/c & resident stated "I just saw stars"; EMR lacked documentation physician notified of episode; NN documented resident unhappy with use of full mechanical lift; staff reported no more episodes of passing out since changed from toileting sling to regular sling; failed to notify 1 resident's physician of episodes of syncope & lightheadedness placing resident at risk for further decline & delay in treatment

**F623 Notice Requirements Before Transfer/Discharge**

NE: SS=D: Failed to provide a written notice of transfer as soon as practicable to 1 resident/representative with risk of miscommunication between facility & resident/family & possible missed opportunities for healthcare service

- Failed to provide copy of any signed "Written Notification of Transfer or Discharge" for 2 hospitalizations; failed to provide a written notice of transfer as soon as practicable to 1 resident/representative with risk of miscommunication between facility & resident/family & possible missed opportunities for healthcare services

**F625 Notice of Bed Hold Policy Before/Upon Transfer**

NE: SS=D: Failed to provide bed hold with required information for 1 resident/representative when resident transferred to hospital placing resident at risk for impaired ability to return to facility or same room

- Failed to provide evidence a bed hold notification was provided to legal representative when resident transferred to hospital for 2 hospitalizations; failed to provide bed hold with required information to resident & family representative when resident transferred to hospital placing resident at risk for impaired ability to return to facility or same room

**F657 Care Plan Timing & Revision**

SE: SS=D: Failed to revise 1 resident's CP with individualized person-centered interventions for dementia; further failed to monitor & document resident's behaviors as directed in CP placing resident at risk for decreased quality of life due to uncommunicated care needs

- Failed to revise resident's CP with individualized person-centered interventions for dementia care & failed to follow CP to monitor & document behaviors placing resident at risk for uncommunicated care needs

SW: SS=D: Failed to revise CP with direction to staff for interventions when 1 resident had periods of syncope & lightheadedness placing resident at risk for decline

- Cited findings noted in F580 r/t episodes of syncope & lightheadedness; CP lacked direction to staff if resident should become lightheaded or have syncope episode during transfers; failed to revise 1 resident's CP with direction to staff when resident had periods of lightheadedness & syncope placing resident at risk for decline

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

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

- Review of Activity Calendar for December, January, February revealed religious services 2x on Saturdays but lacked staff-led activities; & devotional group on Sundays but lacked staff-led activity groups; council reported weekends slow w/o activities; failed to provide consistent activities on weekends which reflected residents' interests & preferences placing affected residents at risk for boredom, isolation & decreased quality of life

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

SW: SS=D: Failed to evaluate effectiveness of fall interventions & change or modify ineffective interventions at preventing falls for 1 resident placing resident at risk for further falls & injury

- Resident with high fall risk with multiple documented falls; failed to evaluate effectiveness of fall interventions & change or modify interventions that were ineffective at preventing falls for 1 resident placing resident at risk for further falls & injury

NE: SS=E: Failed to secure 15 pressurized medical O2 tanks in safe, locked area, & out of reach of 9 cognitively impaired independently mobile residents placing residents at risk for preventable accidents & injuries

- Observed O2 storage room door not secured; failed to secure 15 pressurized medical O2 tanks in safe, locked area & out of reach of 9 cognitively impaired independently mobile residents placing residents at risk for preventable accidents & injuries

**F744 Treatment/Services for Dementia**

SE: SS=D: Failed to develop & implement individualized dementia treatment plan that used non-pharmacological approaches to care for 1 resident placing resident at risk for abuse & decreased quality of life

- Cited findings noted in F657 r/t resident with dementia's behaviors; POS for Sertraline & Quetiapine Fumarate for Alzheimer's disease then increased 1 month later; then increased again 1-16-25 for major depressive d/o; NN documented resident constantly got up during night & wander; EMR lacked consistent documentation of resident's behaviors & stated staff should document any behaviors & what interventions were provided in response to behaviors; staff reported family requested increase in quetiapine for wandering at night; documentation initialed every shift to confirm monitoring of behaviors but nothing specifically to state what behavior was; failed to adequately meet 1 resident's mental health needs by failing to ensure pharmacological interventions were only used when non-pharmacological interventions were ineffective or when clinically indicated placing resident at risk for decreased quality of life

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

- Resident with dementia & Parkinson's disease; CP lacked interventions r/t resident's wandering & sun-downing behaviors; observed resident in DR confused & repeating question about visitor parking lot because needed to leave then continued to wheel around common area; staff failed to offer diversion & did not attempt to re-orient resident during episode; observed resident in DR & was not provided plate divider per CP & resident failed to eat any of food offered & was left in DR past dining times & attempted multiple time to move but unable because w/c stuck on table leg for extended period then fell asleep in chair until next meal when again no plate guard provided; failed to provide dementia-related care services for 1 resident to promote residents' 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: CP failed to ID & report out-of-parameter BPs for 1 resident placing resident at risk for physical decline & medication related complications

- POS for Metoprolol Succinate ER with a-fib with holding parameters; MAR documented 10 occasions in December 2024 administered below ordered holding parameters; 3 occasions in January 2025, February with 2 occasions; failed to ensure CP ID'd & reported that 1 resident's Metoprolol was administered outside physician-ordered parameters placing resident at risk for physical decline &medication related complications

SW: SS=D: Consulting Pharmacist failed to request approved indication for use of Seroquel & required physician-written clinical rationale for continued use of Seroquel for 1 resident placing resident at risk of receiving unnecessary antipsychotic drugs

- POS of 5-24-24 directed staff to administer Seroquel 25mg po q hs for severe anxiety; MRR recommended GDR for Seroquel & physician declined & failed to provide written clinical rationale for use of antipsychotic for anxiety; Adm nurse verified CP had not

continued to request written thorough clinical rationale for use of antipsychotic for anxiety; facility's pharmacist failed to request approved indication for use of Seroquel & required physician-written clinical rationale for continued use of Seroquel for 1 resident placing resident at risk of receiving unnecessary antipsychotic meds

NE: SS=E: Failed to ensure Consultant Pharmacist (CP) recommendations were acknowledged &/or acted on for 3 residents; failed to ensure CP ID'd & reported non-approved indication for 1 resident's antipsychotic med placing residents at risk for unnecessary med use & physical complications

- MDS lacked documentation MRR completed during observation period for 1 resident; MDS lacked indication of physician documentation that GDR clinically contraindicated for resident; MDS lacked documentation MRR completed during observation period for resident; resident with Zoloft for anxiety with depression; failed to ensure physician reviewed & addressed CP recommendations for 1 resident placing resident at risk for unnecessary medication use, side effects & physical complications
- EMR lacked documentation physician addressed resident's Quetiapine; failed to ensure physician addressed CP recommendations placing resident at risk for unnecessary med use, side effects & physical complications
- Facility's CP failed to ID & report inappropriate indication for 1 resident's Olanzapine med placing resident at risk for unnecessary psychotropic meds & related complications

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

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

- Cited findings noted in F756 r/t Metoprolol administered below physician's holding parameters; failed to hold BP meds for 1 resident when BP was out of physician-ordered parameters placing resident at risk for physical decline & other related complications

**F758 Free from Unnecessary Psychotropic Meds/PRN Use**

SE: SS=D: Failed to ensure appropriate indication or documented physician rationale which included unsuccessful attempts for non-pharmacological symptom management & risk versus benefit for continued use for 1 resident's antipsychotic placing resident at risk for unintended side effects related to psychotropic drug medication

- Cited findings noted in F657, F744 r/t to resident with psychotropic meds r/t Alzheimer's disease; POS for Sertraline HCl for depression; Quetiapine Fumarate for Alzheimer's disease with increase then change in indication to major depressive d/o with additional increase; EMR lacked physician rationale including unsuccessful attempts for non-pharmacological symptom management & risk vs benefits for quetiapine fumarate use; failed to ensure 1 resident did not receive antipsychotic medication w/o appropriate indication or required physician documentation for use placing resident at risk for adverse side effects

SW: SS=D: Failed to obtain approved indication for use of Seroquel & required physician-written clinical rationale for why any attempted GDR would be likely to impair resident's function or cause psychiatric instability for 1 resident placing resident at risk for receiving unnecessary antipsychotic drugs

- Cited findings noted in F756 r/t use of Seroquel w/o GDR or physician documented rationale; failed to obtain approved indication for use of Seroquel or required physician-written clinical rationale placing resident at risk of receiving unnecessary antipsychotic drugs

NE: SS=D: Failed to ensure a gradual dose reduction (GDR) was attempted or documented as contraindicated by the physician with a supporting rationale for risk versus benefit 2 residents' antipsychotic medication. The facility also failed to ensure 1 resident's antipsychotic medication had a Centers for Medicare and Medicaid (CMS) approved indication or the required risk versus benefit physician documentation. These deficient practices placed these residents at risk for unnecessary medications and adverse side effects

- Failed to ensure GDR attempted or documented as contraindicated by physician with supporting rationale with risk vs benefits for antipsychotic medication
- Failed to ensure appropriate indication or documented physician rationale for 1 resident's Seroquel med or a risk vs benefit placing resident at risk for unnecessary psychotropic meds & related complications
- Failed to ensure appropriate indication or documented physician rationale for 1 resident's Olanzapine med placing resident at risk for unnecessary psychotropic med use & related consequences

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

SW: SS=D: Failed to administer correct physician-ordered dose of Ativan at scheduled time for 1 resident placing resident at risk for adverse effects resulting from incorrect dose

- Resident with dementia & anxiety; POS for Ativan 0.5mg BID for restlessness on 8-2-24; POS for Ativan 0.5mg q hs for anxiety d/o & Ativan 0.5 ½ tab BID for anxiety & restlessness on 11-7-24; POS on 12-4-24 for Ativan 0.5mg daily q hs for anxiety d/o, Ativan 0.5mg ½ tab BID q AM &4PM for anxiety & restlessness & Ativan 0.5mg under tongue q 4 hrs PRN for anxiety or restlessness x 6 months; NN documented CMA alerted nurse that resident's noon dose of Ativan not administered prior day by error; NN documented CMA alerted nurse of finding med error of resident receiving 0.25mg previous night & resident with increased restlessness; NN documented resident had not received scheduled dose of Ativan; NN documented CMA reported narc book showed resident received Ativan 1.0 at bedtime instead of scheduled 0.5mg; NN documented incorrect dose on 2 days in December; then again in February; failed to administer correct physician-ordered dose of Ativan at scheduled time for 1 resident placing resident at risk for adverse effects resulting from incorrect dose

**F801 Qualified Dietary Staff**

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

- Failed to employ a fulltime CDM for residents residing at facility placing all residents at risk of inadequate nutrition

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

SE: SS=E: Failed to prepare & store food in sanitary manner for all residents receiving meals from kitchen placing residents at risk for foodborne illness

- Observed fridge with meat stored directly above gallons of mild & bowl of pudding & unpasteurized eggs stored on same shelf; fluorescent light over food prep area cracked thru; window AC above freezer with gray/blackish lint material on air outlet levers

**F849 Hospice Services**

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

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

**F880 Infection Prevention & Control**

SW: SS=F: Failed to implement water management program for Legionella disease placing residents at risk of contracting infectious processes

- Maintenance staff stated unaware of who managed waterborne pathogen prevention program including prevention of Legionella disease; Adm reported unaware of further monitoring programs for Legionella disease & facility had not mapped water system for possible dead-end water sources; failed to provide policy; failed to implement water management program to test & manage waterborne pathogens placing residents at facility at risk of contracting Legionella pneumonia

NE: SS=E: Failed to implement adequate hand hygiene placing residents at risk for infectious diseases

- Observed CMA failed to perform hand hygiene & don pair of gloved when CMA removed 1 resident's hearing aids from med cart & changed battery in 1 aide then placing aids in each ear of resident at DR table; CMA then doffed gloves & failed to perform hand hygiene then pushed resident to common area & failed to perform hand hygiene & donned gloves from uniform pocket & administered resident's inhalation med by assisting resident with 1 puff into each nostril; failed to perform hand hygiene or change gloves when then instilled resident's eye drops while holding resident's eye open & then instilled drop into each eye

**March 2025**

**F550 Resident Rights/Exercise of Rights**

SW: SS=E: Failed to protect the dignity of 1 resident when staff transferred resident from room to shower room with buttocks exposed; failed to honor dignity of residents in DR when observation revealed container in DR for soiled clothing protectors was labeled "bibs only, no trash" & was visible to all residents & guests in area with potential to negatively impact each residents' dignity & psychosocial wellbeing

- Observed staff transported 1 resident from room to shower room with resident seated in shower chair & resident covered in sheet from neck to knees but buttocks were exposed during transport visible to anyone in area; failed to protect dignity of resident when staff transferred resident from room to shower room with buttocks exposed with potential to lead to negative psychosocial effects r/t dignity
- Observed bin in DR used for used clothing protectors with lid with label reading "bibs only, no trash"; failed to protect dignity of residents by IDing clothing protectors as "bibs" with potential to negatively affect residents psychosocial wellbeing & dignity

**F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive**

SW: SS=E: Failed to have a process in place to ensure each resident's code status was accurate & easily ID'd for 4 residents

- Admission Packet documented request for copies of DPOA, living will & advance directives/DNR paperwork & lacked prompts or blank forms to be filled out by resident/representative; EMR lacked physical DNR form & physician order that reflected resident was DNR & did not wish to receive life sustaining treatment; POS lacked order for DNR; banner documented resident was DNR; CP documented resident full code
- EMR lacked physical DNR form & physical chart only contained advance directives that indicated no CPR but lacked physician or witness signatures for multiple residents
- CP documented resident did not was intubation as part of life-saving measures; EMR & physician orders documented resident a full code; failed to have process in place to ensure appropriate code status was ID'd for 4 residents

**F626 Permitting Residents to Return to Facility**

*SW: SS=J (Abated to G): Failed to readmit 1 resident back into facility; likelihood for a serious adverse outcome existed, due to threat of resident's continuity of care, feelings of insecurity to safety in not having a place to discharge to after facility had been providing care for past 2 years & 4 months; negative psychosocial impact is significant & traumatic with resident's hx of having to live in a men's shelter placing resident in immediate jeopardy*

- *Resident with schizoaffective d/o & autistic d/o with cognitive deficits with interventions in place; resident with multiple behaviors & with communication deficits but was usually able to make needs known; resident planned to remain in facility for long term; CP lacked any discharge focus of goals; EMR lacked discharge order or 30-day discharge in writing to resident/DPOA; resident transferred to hospital r/t symptoms of temp, tachycardia, HTN; no urine output; bed hold signed by 2 nurses & sent with resident; ER report documented resident with abdominal pain, decreased urine output & lethargy; CT revealed "massive rectosigmoid stool burden with associated rectal wall thickening r/t fecal impaction; hospital informed facility Adm not allowing resident to be re-admitted back to facility as care level outside facility's level of care due to falls; hospital staff documented contacted Adm r/t "abandoning" resident at hospital; Adm stated would not take resident back; DPOA stated had not received 30 day notice of discharge & was "surprised & upset" that facility would not accept resident back to facility; failed to allow 1 resident to return to facility after hospitalization; likelihood for serious adverse outcome existed due to threat to resident's continuity of care, feelings of insecurity to safety in hot having place to discharge to after facility had been providing care for past 2 years & 4 months; negative psychosocial impact is significant & traumatic with resident's hx of having to live in men's shelter placing all residents who are discharged to hospital are allowed to return to facility at risk in immediate jeopardy*
- *Plan of Removal:*
    - *ID residents who have suffered, or are likely to suffer a serious adverse outcome as a result of alleged noncompliance:*
    - *Resident currently not at facility*
    - *DON will conduct immediate review of all residents currently at hospital*
    - *Facility marketing staff went to assess resident at hospital*
    - *Facility marketing staff requested updated requests for resident*
    - *Adm will educate Adm/marketing, SS, DON & clinical manager on discharge & readmission policies*
    - *Adm review & update facility's policy & procedure r/t readmission of resident's post-hospitalization care needs*
    - *Adm & admission/marketing staff review & improve communication protocols with hospital staff ensuring that clear & timely decisions are made about resident readmissions*
    - *Adm educate admission/marketing staff on communication with hospital staff*
    - *Any refusal to readmit will be discussed thoroughly with hospital staff to ensure that all potential solutions or alternatives are explored & rationale for decision is documented*
    - *Resident will return to facility upon completion of hospital discharge planning*

**F656 Develop/Implement Comprehensive Care Plan**

*SW: SS=D: Failed to develop a comprehensive CP for 1 resident's risk for elopement placing resident at risk for inadequate care & services*

- *CP lacked any interventions r/t 1 resident's elopement potential or actual elopement; POS lacked orders for WanderGuard at time of elopement; Elopement eval documented resident low risk for elopement; failed to develop a comprehensive CP for 1 resident's risk for elopement placing resident at risk for inadequate care & services*

**F658 Services Provided Meet Professional Standards**

*SW: SS=D (Past Non-Compliance): Failed to ensure staff administration of resident's medication met professional standards*

- *CMA administered Trazodone to 1 resident at incorrect time & left 1 resident' medication in room w/o observing resident consume medication & staff later found 15 medication cups with 1 gabapentin & 1 tramadol in each cup & also found 19 tramadol pills in resident's drawer; NN documented resident with increased exhaustion last couple of days around noon; med cart review revealed nighttime Trazodone dose was placed with noon meds & given at noon; team notified physician r/t med given at wrong time & received orders to monitor resident for side effects; failed to ensure med administration met professional standards when CMA administered evening dose of 1 resident's Trazodone at noon & staff also administered 1 resident's evening dose of Trazodone; failed to ensure med administration met professional standards when CMA did not observe resident taking med 7 left med in room to which staff later found 15 med cups with Gabapentin & Tramadol med in each cup & also found 19 Tramadol in drawer*

**F675 Quality of Life**

*SW: SS=J (Removed to G): Failed to have an adequate system in place to ID known signs & symptoms of fecal impaction for 1 resident who required to have a large stool ball removed from upper rectum under anesthesia at local hospital placing all residents at risk in immediate jeopardy*

- *POS lacked orders for monitoring or meds for resident's bowel; EMR documented incontinence of BMs on multiple days with no other BMs documented on other days; NN documented resident attended therapy & became very lethargic & did not want to participate with VS's out of normal limits & no urine output with straight cath; resident sent to ER which resulted in treatment for "massive rectosigmoid stool burden with associated rectal wall thickening removed under anesthesia as meds & enemas ineffective; record indicated no bowel protocols initiated for resident; failed to have adequate system in place to ID known signs/symptoms of fecal impaction for 1 resident who was required to have large stool ball removed from upper rectum under anesthesia at local hospital placing all residents at risk in immediate jeopardy; IJ template notified staff of facility failure for staff pervasive disregard for 1 resident's dignity, in noting breath smelled of BM, lack of competent staff who were incorrectly charting smear BM as small BM & lack of staff ID of resident's lack of urine output, lack of behavioral management & staff neglecting to recognize known clinical si/sx of constipation & fecal impaction; lack of staff training r/t resident behavioral issues & staff not*

*providing adequate ADL assist r/t BM placing resident in immediate jeopardy to health & safety & placing all residents at risk; F675 constituted substandard quality of care*

- *Plan of Removal:*
  - *Cited resident currently at hospital*
  - *Clinical managers will interview interviewable residents for last BM, s/sx of constipation & fecal impaction*
  - *CNAs will document BMs before end of shifts*
  - *Nurses will assess non-interviewable residents for s/sx of constipation or fecal impaction*
  - *If any residents are ID'd with constipation & fecal impaction MD will be notified & orders will be followed as needed*
  - *DON/designee will educate clinical staff on proper BM documentation, urinary output, s/sx of constipation & fecal impaction*
  - *DON/designee will educate CNAs to document BMs on POC before leave shift*
  - *DON/designee will educate nurses to review POC documentation before end of shift that CNAs complete BM documentation*
  - *DON/designee will educate nurses to review alerts on PCC before end of shift*
  - *DON/designee will educate nurses to assess residents with no BMs for 3 days, s/sx of impaction or abdominal pain, notify MD & follow physician orders*
  - *DON/designee will educate clinical staff prior to next scheduled shift*
  - *Unit manager will review POC documentation on daily clinical meeting to ensure compliance with BM documentation, urinary output & necessary follow up*
  - *DON will perform random audit on POC documentation, progress notes, MD notification & med administration for residents ID"d with no BM x 3 days or s/sx of constipation or fecal impaction*
  - *If additional discrepancies are ID'd they will be corrected immediately according to physician orders*

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

SW: SS=J (Removed to G): Failed to ensure dependent resident remained free from accident hazards/harm r/t staff feeding resident pureed foods w/o ensuring pureed foods were at safe temp to eat

- Staff confirmed dietary staff do not obtain temp of pureed foods after food is placed on steam table; Staff attempted to give resident bites of pureed food which included: hot pureed soup with had been heated to 196 degrees F & placed in insulated container on steam table & pureed grilled sandwich which had been heated to 150 degrees F w/o obtaining temp prior to serving dependent resident placing resident in immediate jeopardy; failed to ensure that dependent resident remained free from accident hazards/harm r/t staff feeding resident hot pureed soup & pureed grilled sandwich which had heated over 150 degrees F w/o obtaining temp prior to serving
- Plan of Removal:
  - Education & policies immediately reviewed by CP team
  - Held immediate QAPI meeting to discuss issues ID'd & immediate plan of correction with Medical Director, CEO, COO, LTC Director, DON, ADON, Floor Charge Nurse, CSSD & Dietary Manager
  - Education provided ensure nursing staff & dietary staff know correct procedure for monitoring food temps prior to serving pureed food to resident
  - All staff notified of changes in procedure & given verbal education & instruction on serving pureed food to resident prior to returning to work & signatures collected to signify understanding
  - Dietary will track pureed food for temps prior to leaving kitchen & will not leave kitchen window unless between range of 145-165 degrees F; log created to allow staff to log temps prior to serving & includes section for "comments" if food did not leave kitchen for specific reason; DM checks documentation Monday, Wednesday & Friday for 180 days or until compliance is maintained
  - Audit performed during mealtimes & randomly
  - Results of audits reviewed at QAPI meetings

*SW: SS=D: Failed to provide adequate supervision to cognitively impaired, independently mobile resident ID'd as moderate risk for elopement*

- *On 2-22-25 at 11:28am resident exited facility when CNA opened exit door at front entrance for another resident to enter into facility; CNA reported resident quickly went out door & CNA came back into facility leaving resident outside by self to inform LN; practice could potentially result in injury; NN documented LN was alerted by another resident that resident left facility & LN ran to front door & observed resident walking outside on street & LN called out for resident & resident waved LN off; CNA instructed to "keep eye on resident" & LN returned into facility to retrieve keys to vehicle & instructed CMA to take CNA to return resident back to facility; investigation documented facility's plan of correcting including: al staff education, all residents reviewed for elopement, all CPs updated, policies reviewed, elopement drill & audits completed; failed to provide adequate supervision to cognitively impaired, independently mobile resident, ID'd as moderate risk for elopement; due to corrective actions facility completed prior to onsite survey, deficient practice deemed past noncompliance at a "D" scope & severity*

**F692 Nutrition/Hydration Status Maintenance**

SW: SS=G: Failed to offer sufficient fluid intake to maintain proper hydration & health for 1 resident resulting in hospitalization admission for 1 resident for dehydration

- Resident with dementia & amnesia with BIMS of 4; assessment documented no ID'd concerns with resident's swallowing; resident with hx of UTI; resident dependent on staff for cares; CP documented: family requested staff to place water pitcher close to resident when resident in recliner; family requested staff to encourage resident to drink more fluids; staff would encourage resident to drink more fluids; resident hospitalized & documented fluids consumed with meals & between meals with 7/9 dates with less than 1500 cc fluid intake from 1-27-25 thru 2-4-25; observed water sitting on over-bed table on opposite side of room, out of reach of resident on multiple occasions; failed to offer sufficient fluid intake to maintain proper hydration & health resulting in actual harm for resident when resident admitted to hospital for dehydration

**F732 Posted Nurse Staffing Hours**

SW: SS=C: Failed to ensure posted daily nurse staffing sheets included accurate & identifiable information to include facility name & daily licensed & unlicensed staff hours as required

- Observed staffing form lacked total number & actual hours worked per shift for licensed & unlicensed staff providing resident care; & most sheets from 11-28-24 to current lacked same information; failed to ensure posted daily nurse staffing sheets included accurate & identifiable information to include daily nursing hours as required

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

SW: SS=E: Failed to ensure facility had effective system in place for accurate accounting & reconciliation of controlled medication

- Observed med cart narcotic count & during count found count discrepancy; CMA statement indicated discrepancy "not caught" during count; CMA stated counted med cards but did not count pills in bottle; investigation revealed previous shift CMA had given resident evening Lyrica & did not record it on Lyrica count sheet & oncoming CMA did not perform actual count of Lyrica & recorded wrong number during morning counts; failed to have system in place for accurate accounting & reconciliation of controlled substances

**F756 Drug Regimen Review, Report Irregular, Act On**

SW: SS=E: Failed to ensure timely response to pharmacist's identify & reported irregularities to facility for 4/5 residents

- Physician responded to pharmacist recommendation r/t GDR recommendations 20 days later for Duloxetine the 21 days after follow up recommendation; recommendation for GDR of Risperidone then physician order not transcribed until 10 days following physician response & 15 days after pharmacist recommendation; failed to ensure timely response to pharmacist's ID & reported irregularities & recommendations for resident
- Failed to ensure timely response to pharmacist's identify & reported irregularities & recommendations for resident for multiple residents
- Failed to ensure resident's medication remained free of unnecessary meds when facility failed to ensure that resident's physician responded in timely manner to GDR request from CP
- Failed to ensure resident's medication remained free of unnecessary meds when facility failed to respond to consultant pharmacist's recommendation on 7-31-24; failed to ensure CP performed monthly MRR for 12-24 for 1 resident

**F758 Free from Unnecessary Psychotropic Meds/PRN Use**

SW: SS=E: Failed to ensure residents using psychotropic drugs r/t timely response to pharmacist's ID & reported irregularities to facility for 4/5 residents

- Cited findings noted in F756 r/t appropriate responses to CP MRR; Failed to ensure residents using psychotropic drugs r/t timely response to pharmacist ID & reported irregularities to facility for resident for multiple residents
- Failed to ensure 1 resident free of unnecessary psychotropic meds leading to resident receiving 109 unnecessary doses of antianxiety medication & 44 unnecessary doses of antidepressant med & had potential to lead to unintended side effects with negative physical & /or psychosocial effects
- Failed to ensure 1 resident was free of unnecessary psychotropic meds with failure to provide evidence of facility's response for 7-31-24 MRR from consultant pharmacist; additionally facility failed to ensure CP performed monthly MRR for 12-24 with potential to lead to unnecessary doses of psychotropic meds with negative physical &/or psychosocial effects

**F761 Label/Store Drugs & Biologicals**

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

- Observed unlocked & unattended med cart between DR & common area; failed to ensure safe & secure storage of resident meds when observed unlocked & unattended med cart, not in line of vision of staff

**F805 Food In Form to Meet Individual Needs**

*SW: SS=J (Past Non-Compliance): Failed to ensure staff provided cognitively impaired resident with prescribed mechanical soft diet with ground meat texture & instead served cut-up chicken to resident on plate*

- *Resident began to cough & choked on food; staff had to suction resident when resident could not clear airway with coughing; facility transferred resident to hospital later that evening; hospital resident admitted resident for fever, pneumonia, & dehydration placing all residents at risk in immediate jeopardy; RD reported mechanical soft diet order was more for meat consistency & RD had concern that resident received cut up chicken instead of ground chicken on day resident choked on food served by facility staff*
- *Plan of Removal:*
    - *Suspended employee who prepared food*
    - *Ad Hoc QAPI meeting held by IDT*
    - *Re-educated staff mitigation for choking to include re-education on following CPs & food prep per diet classification*
    - *Audit of all residents' diet classifications orders & CPs*
    - *Audit of tray cards for correct diet classifications*
    - *Correction of CPs & tray cards if discrepancies found*
    - *Audit diets prepared correctly with 2 cooks, 2x/wk x 30 days*
    - *Audit of altered diets 2x's/wk x 30 days*
    - *Adm oversight of audits & dietary choking compliance*

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

SW: SS=F: Failed to store, prepare & serve food in sanitary manner placing all residents at risk for foodborne illness

- Observed trash can at hand washing sink w/o foot operated lid & lid had flip top & closed by swinging next to food prep & staff pushed down trash into trash can with gloved hand then resumed prep with same gloved hand

**F880 Infection Prevention & Control**

SW: SS=F: Failed to maintain a comprehensive infection control program r/t laundry delivery with potential to lead to contamination of clean linens during delivery which had potential to negatively affect all residents in facility

- Observed laundry personnel transported clean resident laundry in laundry cart thru facility halls with 1 of side covers draped over top of cart exposing clean laundry; failed to ensure that clean linens were covered during delivery & while linen cart was unattended in hallway with potential to lead to contamination of clean linens during delivery

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

SW: SS=F: Failed to provide safe, functional & sanitary environment in laundry service area

- Observed 2 uncovered soiled linen bins with soiled linen & clothing which had a sock hanging off side of bin; walkway tiled floor from soiled linen area to clean area was not sanitizable due to 2 broken & missing floor tiles; floor in clean linen processing area not sanitizable due to 2 missing floor tiles beside washing machine; egress from clean room to hallway entrance/exit doorway with multiple abrasions across width of door exposing bare wood which was not sanitizable