June, 2024 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

February, 2024

F657 Care Plan Timing & Revision

NE: SS=D: Failed to revise 1 resident's CP to include section with instructions to staff r/t resident's safety with smoking placing resident at risk for impaired care due to uncommunicated care needs

- CP lacked section with instructions to staff on resident's smoking safety; failed to update 1 resident's CP with smoking section with instructions to staff for keeping resident safe while smoking placing resident at risk for impaired care due to uncommunicated care needs

F684 Quality of Care

NE: SS=D: Failed to ensure nursing services met standard of care when staff failed to obtain physician-ordered lab work for 1 resident including lab work to monitor for serious side effects of 1 resident's atypical antipsychotic placing resident at risk for impaired quality of care & adverse effects

- *Resident with DM, hypothyroidism, schizoaffective d/o & dementia with behavior disturbance; CP lacked directions r/t lab work before 1-24-24; Record lacked evidence of lab draws/blood testing before 12-20-23; failed to ensure nursing services that met standard of care when staff failed to follow physician orders, obtain admission labs & monthly CB C for medication monitoring as ordered, & failed to notify physician r/t missed lab tests placing resident at risk for impaired quality of care & adverse effects*

F692 Nutrition/Hydration Status Maintenance

NE: SS=G: Failed to monitor oral intake, failed to ensure routine & consistent weight monitoring & failed to implement further interventions such as fortified foods until after a significant weight loss for 1 resident; further failed to ensure resident received necessary adaptive utensils required for eating resulting in loss of 15.57% in 3 months & placing resident at risk for further loss & malnutrition

- *Resident with regular thin-consistency liquids with Magic cup with meals & house supplement 4 oz BID & Mirtazapine 30mg qd for depression; RD assessment documented RD unable to fully assess resident due to lack of height & weight; Weight documentation of 10-19 was 122 & next weight was 11-9 with weight of 119.5 & next weight 12-11-23 with weight of 117.2; POS of 12-21 for regular mechanical soft diet with chopped meats & thin liquids; on 12-22 NN documented resident choked on piece of chicken & staff assisted in dislodging chicken & were successful with no injury & resident had hx of similar events but not in recent month; on 1-15 resident weighed 103 reflecting a loss of 12.12% in 35 days & EMR lacked evidence of physician or RD notification; on 1-22 weight was 101.4; on 1-25 POS for fortified foods with mechanical soft, chopped meat diet & order DCd on 1-31; on 1-29 weight of 100.8; on 2-9 weight of 92 reflecting loss of 21%; record lacked evidence staff routinely monitored % of food resident consumed at each meal; failed to monitor oral intake, failed to ensure routine & consistent weight monitoring & failed to implement further interventions such as fortified foods until after significant weight loss for 1 resident; facility further failed to ensure resident received necessary adaptive utensils required for eating resulting in loss of 15.57% in 3 months & placed resident at risk for further loss & malnutrition*

F726 Competent Nursing Staff

NE: SS=E: Failed to ensure staff possessed knowledge necessary to provide medications within acceptable standards of practice when staff pre-set 9 residents' medications before administration time placing residents at risk of receiving wrong meds

- Observed in top drawer of med cart med cups, each containing various unidentified & unlabeled pills & labeled with resident name & LN stated always "set them up" a little early; failed to ensure staff possessed knowledge necessary to provide meds within acceptable standards of practice when staff pre-set 9 residents' meds before administration time placing residents at risk of receiving wrong meds

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure consultant pharmacist (CP) IDd & reported lack of stop date for 1 resident's PRN psychotropic med placing resident at risk for unnecessary medication side effects

- POS for Lorazepam 1mg BID PRN & order lacked stop date; MRR lacked documentation CP IDd resident's PRN Lorazepam did not have stop date; failed to ensure CP IDd & reported lack of stop date for 1 resident's PRN psychotropic med placing resident at risk for unnecessary med side effects

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure a 14-day stop date for 1 resident's PRN antipsychotic & further failed to ensure 1 resident's PRN Lorazepam had 14-day stop date or specified duration with physician documented rationale for extended use placing residents at risk for unnecessary psychotropic meds

- POS for Haldol 10mg ½ tab PRN & order lacked stop date; failed to place stop date on 1 resident's PRN Haldol placing resident at risk for receiving unnecessary medication & complications
- Cited findings noted in F756 r/t lack of stop-date for PRN Lorazepam; POS for Lorazepam 1 mg BID PRN & order lacked stop date; failed to place stop date on 1 resident's PRN Lorazepam placing resident at risk for receiving unnecessary medication & complications

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to discard outdated insulin pen & failed to place open date on 2 insulin pens in med room; failed to store meds properly in original packaging which included medication name, dosage, & instructions for administration placing residents at risk for medication errors & receiving ineffective meds

- Observed 1 resident's Lantus insulin pen with open date of 12-25-23, Humalog pen w/o open date & unreadable open date on resident's Levemir insulin pen
- Observed top drawer of med cart with med cups with various unidentified & unlabeled pills & cups labeled with resident name; failed to appropriately store meds & failed to ensure insulin pens dated when opened & discarded when outdated placing affected residents at risk for medication errors & ineffective meds

F801 Qualified Dietary Staff

NE: SS=F: Failed to employ a full-time CDM for all residents residing in facility & receiving meals from facility kitchen placing residents at risk for inadequate nutrition

- Dietary Staff stated not certified & not enrolled in CMS class; failed to employ full-time CDM for all residents currently residing in facility & receiving meals from kitchen placing residents at risk of not receiving adequate nutrition

F851 Payroll Based Journal

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

- PBJ report documented facility did not have licensed nurse coverage 24 hrs/day, 7 days/wk on 10 dates; timeclock data for dates revealed LN was on duty for 24 hr/day, 7 days/wk; failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

March 2024

F550 Resident Rights/Exercise of Rights

NE: SS=D: Failed to treat 1 resident with dignity in 1/5 DRs during noon meal when staff stood over 1 resident while assisting resident to eat placing resident at risk for undignified experience

- Observed CNA served resident plate of food & stood over resident & gave resident bites of food & left table several times during noon meal to do other tasks then returned to resident's table, stood over resident & gave resident bites of food; failed to treat resident with dignity when staff stood over resident in DR during assisted dining placing resident at risk for undignified experience

F623 Notice Requirements Before Transfer/Discharge

NE: SS=D: Failed to provide written notice for facility-initiated transfer to 3 residents/representatives when residents were transferred to hospital placing residents at risk for uninformed care choices

- Record lacked evidence resident/representative was provided written notice when resident transferred to hospital; failed to provide multiple residents with written notice r/t resident's facility-initiated transfer to hospital placing resident/representative at risk for uninformed care choices

F625 Notice of Bed Hold Policy Before/Upon Transfer

NE: SS=D: Failed to provide 3 residents/representatives with written information r/t facility bed hold policy when residents were transferred to hospital placing residents at risk for not being permitted to return & resume residence in nursing facility

- Record lacked evidence resident/representative was provided bed hold policy when resident transferred to hospital; failed to provide 3 residents/representatives with bed hold policy when residents were transferred to hospital placing residents at risk for not being permitted to return & resume residence in facility

F645 PASARR Screening for MD & ID

NE: SS=D: Failed to ensure 3 residents received PASARR to ID potential care needs r/t mental disorder or ID placing residents at risk for unidentified needs & inadequate care

- Failed to ensure PASARR was completed for resident before admission placing resident at risk for unidentified needs & inadequate care for 3 residents; failed to adequately assess resident for placement in facility by obtaining a PASARR screening as required placing residents at risk for inadequate facility care & unidentified needs

F657 Care Plan Timing & Revision

NE: SS=D: Failed to revise CP with trauma triggers & coping strategies for 1 resident with PTSD placing resident at risk for impaired care due to uncommunicated care needs

- SS staff stated most of facility's residents were admitted from VA referrals & usually had PTSD & had not assessed or gathered information r/t resident's triggers of PTSD & SS had not spoken to resident's family about possible triggers to prevent re-traumatization; failed to ID & implement interventions for 1 resident's dx'd PTSD placing resident at risk of uncommunicated care needs

F684 Quality of Care

SE: SS=D: Failed to ensure 3 residents received treatment & care in accordance with professional standards of practice, comprehensive person-centered CP &/or residents' choices r/t skin treatments for ostomies

- *Resident with suprapubic catheter r/t urinary retention; POS for suprapubic catheter care & suprapubic site dressing daily; observed dressing dated 2 days previously; failed to ensure resident received treatment & care in accordance with professional standards of practice, comprehensive CP &/or resident choice r/t skin treatments for resident requiring supra pubic catheter dressing changes; Failed to ensure resident requiring supra pubic dressing changes received treatment & care in accordance with professional standards of practice, comprehensive person-centered CP, &/or residents' choices r/t skin treatments for ostomies*
- *Resident with G-tube; POS documented staff to wash resident's G-tube insertion site with soap & water, apply dressing q night & PRN, every night shift as ordered by physician; observed dressing dated 2 days previously; failed to ensure resident received treatment & care in accordance with professional standards of practice, comprehensive CP & residents' choices r/t skin treatments for resident that required G-tube insertion site dressing changes*

NE: SS=G: Failed to ensure 1 resident who had hx of DM & amputations of leg & toe r/t DM received appropriate wound care & services to prevent complications from medical conditions & as result toe wound became progressively worse & infected & ultimately required surgical removal placing resident at risk for increased pain & decreased mobility

- *CP lacked direction to staff r/t care of resident's foot; POS for wound care specialist; EMR lacked evidence staff monitored resident's foot after placing gauze on toe13 days later, lacked evidence of treatment orders obtained, physician notification & lacked formal assessment of area until 6 days later; representative reported resident fell in January & ripped toenail off & then hospitalized & then moved to facility & when moved to facility no signs of infection & almost healed; failed to ensure resident with hx of DM & amputations was closely monitored & assessed for complications after concern noted on 2-15-24 on toe & resident's foot & toe later became infected & required surgical removal placing resident at risk for increased pain & decreased mobility*

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

SW: SS=D: Failed to provide interventions to prevent a pressure injury for 1 resident who had recurring blisters to heel & was at risk for skin breakdown placing resident at risk for pressure injury & delayed healing

- Resident admitted with PU on heel; wound became recurrent with blistering; CP IDd skin risk but no interventions to prevent wounds; blisters noted in December then recurred in February; failed to provide interventions for PU prevention such as off-loading for 1 resident who was at risk for prolonged PU risks & infection

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to ensure 1 resident received appropriate treatment & services to maintain & prevent decline in mobility & ambulation placing resident at risk for decline in mobility & impaired independence

- CP directed staff to assist resident with dressing but lacked any direction for therapy or restorative assistance; Restorative CP documented RA would assist resident to walk 2-3x/wk using platform walker in therapy gym with gait belt for 100 feet twice with stand-by assist; documentation revealed resident refused on 1 day & lacked documentation resident was provided or asked to participate in ambulation from 3-9 thru 3-26; failed to ensure resident received appropriate restorative tx & services to increase or prevent further deterioration for resident placing resident at risk for decline in mobility & impaired independence

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=E: Failed to ensure environment free from accident hazards when accessible hot water at DR sink was 141 degrees F & further failed to provide effective interventions to prevent further falls for 1 resident placing residents at risk for injuries r/t hot water hazards & falls

- Observed DR sink with hot water temp of 130 degrees F; maintenance staff obtained water temp of 131.6 degrees F & stated had just turned up hot water thermostat that morning after finding dishwasher temp was not high enough at 115 degrees F & that both DR sink & kitchen were on same water line; & then turned off hot water valve under sink; water temp testing log documented: Feb 131, March 135, April 130 degrees F; failed to ensure environment free from accident hazards when accessible hot water at DR sink was 131 degrees F placing residents at risk for accidental skin injury
- Resident IDd as fall risk & with multiple falls with multiple repeat interventions; failed to implement different, effective interventions when to prevent further falls for 1 resident after repeated attempts at education were unsuccessful placing resident at risk for injuries r/t falls

NE: SS=E: Failed to secure hazardous materials when facility failed to ensure a Sharps container was maintained within acceptable standard of practice r/t capacity & access to used needles & lancets placing 4 cognitively impaired, independently mobile residents at risk for preventable injuries & accidents

- *Observed med cart with Sharps bin overfilled past fill line indicated on container & with lancets resting on top of bin that remained accessible; observed Sharps bin overflowed onto floor & were picked up by staff member who shoved contents back into box with bare*

hands & left area & med cart removed form area; failed to secure hazardous materials when facility failed to ensure Sharps container was safely maintained placing 4 residents at risk for preventable injuries & accidents

NW: SS=J (Past Non-Compliance): Failed to ensure all door alarms were in functional working order to alert staff to residents exiting facility unattended

- *At 11:13pm resident with cognitive impairment walked past CNA in common area & headed toward day room; at 11:15 exited out of DR & door did not alarm or set off alarm panel; resident went out into courtyard off DR with walker; chain link fence that enclosed courtyard was locked with spring-loaded chain; resident unhooked chain, exited courtyard then relocked chain; left walker on outside of fence & proceeded to walk away from facility 100-150 yards; resident crossed busy highway & approached neighboring house; resident knocked on door & told occupant of house that resident looking for resident's home; occupant called policy; at 11:44pm policy notified LN of resident's location & informed nurse EMS was on way; LN went across highway to assess resident; EMS then transported resident back to facility & LN assessed resident with "couple of scratches" on nose but no other injuries; failure to ensure door alarms were functional to alert staff to resident's elopement placed resident in immediate jeopardy*
- *Past Non-Compliance Plan:*
  - *Elopement assessment completed for resident*
  - *Staff placed WanderGuard bracelet on resident*
  - *Staff were posted to ensure constant visualization of door until alarm was fixed*
  - *DR door was fixed & alarming correctly & daily door alarm checks for all doors implemented*

NW: SS=J (Past Non-Compliance): Failed to ensure staff provided adequate supervision to cognitively impaired resident who had hx of wandering & elopement to prevent resident from exiting facility unsupervised through unlocked kitchen area & door

- *At 5:58am resident in DR; only CNA in DR assisted another resident out of DR; resident then got up from table & with walker, walked to dishwasher room, attempted to open door but it was locked; resident left walker at doorway & walked back towards front of DR; resident walked back to front of DR then walked to next doorway which was open & permitted resident to enter kitchen; resident walked through kitchen & went out back door of kitchen at 6:02pm; alarm sounded the LN checked alarm system & indicated interior kitchen door & another outside door; LN looked toward DR & dietary staff stated cook went out for break & must have set off alarm; LN shut off alarm; dietary staff walked out 4 minutes later & discovered resident outside by dumpsters & resident stated was "enjoying the weather"; resident was eating ice cream at that time; CNA came outside with trash & both aides redirected resident back into facility w/o incident; resident outside on property unattended 4 minutes; failed to ensure resident received adequate supervision to prevent resident from entering kitchen unattended & exiting facility unsupervised & unbeknownst to staff placing resident in immediate jeopardy*
- *Past Non-Compliance Plan:*
  - *Resident's WanderGuard checked & was working properly*
  - *Immediate education for all staff & kitchen staff to keep kitchen door closed when kitchen not occupied*
  - *Checked all resident who had WanderGuards to made sure WanderGuards were functioning properly*
  - *Checked all WanderGuards on doors to make sure they were functioning as well*
  - *All residents with WanderGuards were assessed & elopement assessment was updated if needed to make sure it was up to date*
  - *Facility will use walkie-talkies to communicate when exit-seeking behaviors were seen with any resident*
  - *Resident's CP was updated by adding a nursing order for nurse to sign off & write progress notes if resident was exit seeking & added it to CP for aides to document*

F695 Respiratory/Tracheostomy Care & Suctioning

SE: SS=D: Failed to administer physician ordered amount of O2 for 1 resident & failed to ensure 1 resident's O2 tank did not run empty &/or was delivering O2 as prescribed by physician

- *POS for O2 at 3lpm continuously via nasal cannula r/t COPD; observed resident in bed with O2 setting between 3.5-4lpm on multiple occasions; failed to provide O2 as ordered for 1 resident*
- *POS for O2 2lpm via nasal cannula to maintain O2 sat above 90% for respiratory failure; cardiology physician letter documented resident arrived at appointment & O2 tank empty; family stated when visited nearly every day & O2 tank empty 9/10 days; failed to ensure 1 resident received O2 per physician order*

F740 Behavioral Health Services

NE: SS=D: Failed to adequately meet 1 resident's behavioral health needs r/t non-pharmacological care approaches resulting in repeated behavioral episodes placing resident at risk for behavioral outbursts & injuries

- *Resident with major depressive d/o, Alz disease & Bipolar d/o; BIMS of 14 & MDS indicated resident w/o behaviors during review period; CP documented hx of verbal aggression to other residents; CP lacked detail as to what interventions were implemented for 1 documented event; incident report documented resident to resident physical behavior; resident admitted to acute psychiatric care facility; resident with further documented behaviors that did not note non-pharmacological interventions; failed to adequately meet 1 resident's behavioral health needs r/t non-pharmacological approaches resulting in repeated behavioral episodes placing resident & other affected residents at risk for behavioral outbursts & injuries*

F742 Treatment/Services Mental/Psychosocial Concerns

SW: SS=D: Failed to provide necessary behavioral health care & services to attain or maintain highest practicable physical, mental, & psychosocial wellbeing for 1 resident placing resident at risk for impaired quality of life due to untreated & ongoing mental health concerns

- Resident with PTSD with BIMS of 15 & resident with disorganized thinking & inattention; SS notes documented SSD emailed APRN psych consultant r/t resident's need for psychotherapy appointment & would await update; record lacked evidence of psychotherapy appointment, notes or follow up on mental health services; failed to provide mental health services for 1 resident after APRN determined resident needed psychotherapy appointment placing resident at risk for impaired quality of life due to untreated & ongoing mental health concerns

F744 Treatment/Service for Dementia

NE: SS=D: Failed to provide dementia care & services for 1 resident when facility failed to assess, ID, record, respond to & reassess resident's specific behaviors & triggers to promote environment which supported resident's individualized care needs creating environment that affected resident's ability to maintain highest practicable level of physical, mental & psychosocial wellbeing

- *Resident with schizoaffective d/o & dementia with behavioral disturbances; MDS documented hallucinations & wandering behaviors; CP documented resident "had difficulty keeping his hands to himself at times"; CP lacked evidence of resident specific triggers r/t behaviors for 1 resident; failed to provide dementia care & services for 1 resident when facility failed to assess, ID, record, respond to, & reassess resident's specific behaviors & triggers to promote environment which supported resident's individualized care needs creating an environment that affect resident's ability to maintain highest practicable level of physical, mental & psychosocial wellbeing*

F755 Pharmacy Services/Procedures/Pharmacist/Records

SE: SS=D: Failed to start a physician ordered medication for 1 resident that resulted in 22 days w/o ordered medication

- *Resident with a-fib & dialysis; POS for Eliquis after fistula implant; MAR lacked instructions for staff to administer Eliquis; MAR lacked instructions for staff to administer Eliquis 23 days after initial order; failed to notify cardiologist of fistula appointment for instructions on restarting Eliquis & failed to initiate Eliquis ordered until 23 days later after initial order*

SE: SS=D: Failed to ensure 3 residents received treatment & care in accordance with physician orders r/t skin treatments for ostomies

- *Cited findings noted in F684 r/t ostomy dressing changes; failed to ensure resident received treatment & care in accordance with physician orders r/t care & treatment of suprapubic & G-tube dressing changes*

F760 Residents are Free of Significant Med Errors

NE: SS=J (Past Non-Compliance): Failed to ensure 1 resident remained free of significant med errors

- *Resident returned from cardiology appointment with new order for Metolazone 2.5mg that day & another dose 2 days later; LN incorrectly read order as 25mg & instructed LN to administer 5 of resident's 5mg Metolazone from PRN stock; when pharmacy delivered medication to facility a few hours later, LN saw dose was 2.5mg & called resident's cardiologist & received orders to monitor resident for depleted fluid volume & to obtain BMP which showed potassium level critical low & resident admitted to hospital & received IV fluids & potassium; resident's potassium level remained critically low through 2 days & low through 5 days later when returned to facility on oral potassium supplements; failed to ensure resident remained free from significant med errors resulted in 1 resident receiving 10 times ordered dose of Metolazone placing resident in immediate jeopardy*
- *Past Non-Compliance Plan:*
    - *Completed education including "The Rights of Medication Administration", Face to Face Order Entry using EMR template-if dose is not available get a double check; Pay attention to alerts & Transcribing Orders & Order Entry into PCC*

F761 Label/Store Drugs & Biologicals

SW: SS=E: Failed to discard 3 resident's insulin flex pens when outdated & failed to discard expired stock meds placing affected residents at risk for ineffective meds

- Observed 3 resident's insulin flex pens expired per open dates; failed to discard residents' outdated insulin flex pens placing residents at risk for ineffective meds
- Observed med cart with multiple stock meds with expired dates; failed to ensure outdated or expired meds were removed from medication cart, placing residents at risk of receiving ineffective meds

NE: SS=E: Failed to date 1 resident's insulin flex pen when opened & failed to discard 2 resident's insulin flex pen & 1 resident's insulin vial when outdated; further failed to discard expired stock meds placing affected residents at risk for ineffective medications

- Failed to date 1 resident's flex pen insulin with date opened & discard date & failed to discard 3 resident's outdated insulin vials; failed to discard expired stock meds placing residents at risk for ineffective medication

F801 Qualified Dietary Staff

SW: SS=F: Failed to provide services of fulltime CDM for all residents who resided in facility & received meals from kitchen placing residents at risk for inadequate nutrition

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

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=F: Failed to store foods safely & in sanitary conditions due to staff failure to date & properly seal food items & removal of undated bread items to prevent possible spread of foodborne illness

- *Observed fridge with health shakes lacking prep date; thawed health shakes lacked dates when pulled from freezer; multiple meat items in open bag but lacked date; multiple open bags of vegetables lacked open dates*

- *Observed bread items with no open date or use by date; dented cans*
- *Freezer with particles of gummy film on back of shelves*
- *Observed dietary staff in food prep area w/o covering/beard guard over beards on multiple occasions*

SW: SS=F: Failed to store food in safe & sanitary manner & failed to adequately sanitize dishes for all residents that resided in facility & received meals from kitchen placing residents at risk for foodborne illness

- Observed: multiple meat items in freezer with expired dates
- Observed dietary staff operated dishwasher & wash temp was 105 degrees F & rinse temp was 110 degrees F & staff ran 5 loads & temp remained at 105-110 degrees F; Dishwasher Temp logs for April documented temps of 100-110 degrees F & chemical sanitization checks recorded 200 ppm

NE: SS=E: Failed to follow sanitary dietary standards for food storage & maintain a sanitary food service environment placing residents at risk r/t foodborne illnesses & food safety concerns

- *Observed 1 floor kitchenette microwave with old food particles covering inside of microwave; chiller with food debris & stains covering outer & inner surfaces; coffee pot & pod machine with old coffee room-temp coffee inside coffee pot; coffee outside of coffee pot covered in old coffee grounds & brown stains; coffee flow reservoir with dried calcium-stained ring flowing into inlet of coffee pot; ice chest ½ full of warm stale-smelling water; fridge with dried food stains inside & outside & no evidence of fridge temps assessed; cabinets with towels with stains & uncovered food thermometer directly touching dirty cabinet surfaces; ice machine with calcium-encrusted stains on ice outlets of machine*
- *Kitchenette with temp log last checked 9-22; expired thickened juices; opened, undated milk; cabinets with stains & soiled utensils; ice machine with stains on ice outlets*

F849 Hospice Services

SW: SS=D: Failed to ensure a coordinated plan of care 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

- Baseline CP lacked any information r/t resident's hospice services & lacked evidence of coordination of care between hospice & facility; facility lacked communication book or external document; staff verified facility lacked any information from hospice such as admitting notes, assessments & hospice CP; failed to coordinate care between facility & hospice provider for 1 resident who received hospice services placing resident at risk for inappropriate end-of-life care

F880 Infection Prevention & Control

SE: SS=D: Failed to provide a safe sanitary environment for 2 residents r/t incontinent cares, to prevent spread of possible infections in facility

- *Observed 2 CNAs ambulate resident to room & took resident to BR; staff donned gloves w/o hand hygiene; staff failed to perform hand hygiene or glove change after removal of soiled clothing, after perineal care & before taking resident back to common area*
- *Observed CNA take resident to room via w/c & failed to remove soiled gloves & pulled resident's brief & pants up & touched mechanical lift with soiled gloves; no hand hygiene done after either gloves were removed; failed to ensure clean, sanitary environment for residents in facility by failure to change gloves & perform hand hygiene when going from dirty to clean while assisting 2 incontinent residents with toileting & changing disposable briefs*

F883 Influenza & Pneumococcal Immunizations

SW: SS=E: Failed to provide 5 resident with most recent CDC vaccination information statement VIS before administering vaccinations placing residents at risk for uninformed decisions r/t vaccinations

- Records revealed facility's vaccination consent forms lacked most recent CDC VIS; 5 r5esidents not provided most recent CDC VIS at time of vaccinations; failed to provide 5 residents with most recent CDC VIS before administering vaccinations placing residents at risk for uninformed decision making

April, 2024

F550 Resident Rights/Exercise of Rights

SW: SS=D: Failed to maintain 1 resident's dignity when in bed with only brief on, to expose self to residents, staff & visitors that would go by room

- Observed resident in room open & visualized from hallway resident in bed clothed in brief with sheet tangled & not covering brief or bare legs on multiple occasions; failed to maintain dependent resident's dignity when positioned in bed with only brief on, to expose self to residents, staff & visitors that would go by room

NW: SS=D: Failed to ensure 1 resident was treated with dignity placing resident at risk for impaired psychosocial wellbeing & decreased dignity & self-worth

- *Resident stated in w/c in front of building where resident vapes because LN took resident outside & LN was throwing cigarette away at care when Adm came outside & went to LN's car; resident state Adm staff asked LN why LN brought resident outside because it was not important at that time & Adm staff needed coverage on floor, not outside smoking; resident stated LN sat next to resident & stated wished Adm did not talk to LN that way & that resident had just as much of a right as anyone else resident stated interaction between Adm & LN made resident feel insecure & unimportant & nurse helping a resident is important & nurses were supposed to make residents a priority;*

failed to ensure 1 resident was treated with dignity placing resident at risk for impaired psychosocial wellbeing & decreased dignity & self-worth

F576 Right to Forms of Communication with Privacy

NW: SS=C: Failed to ensure residents received mail on Saturdays

- Resident Council verbalized no mail delivery on Saturdays; failed to ensure residents received mail on Saturdays

F558 Reasonable Accommodations Needs/Preferences

SW: SS=D: Failed to provide w/c foot pedals for 1 resident placing resident at risk for impaired care & decreased quality of life

- Failed to provide w/c foot pedals for 1 resident placing resident at risk for impaired care & safety

F563 Right to Receive/Deny Visitors

NW: SS=D: Failed to ensure 2 residents were able to exercise right to receive visitors of their choosing at time of residents' choice placing 2 residents at risk for impaired resident rights, impaired psychosocial wellbeing & social isolation

- *Resident with impaired cognition; representative stated worked at facility because facility needed help & had situation on that date with 1 resident & Adm; representative stated Adm & Adm nurse stated had been found guilty of abuse by State Agency (SA) & could not visit resident anymore unless made appointment with facility & visitation had to be away from other residents & had to be supervised by staff; representative stated called SA & LTCO for further information & that resident like when visited at meals so visited during meal & Adm staff entered DR, placed hand on representative's shoulder & directed residents representative to leave or facility would have representative escorted out & 3 law enforcement officers came in & 1 of them went into where representative was visiting with resident/mom; Adm nurse confirmed Adm called law enforcement when representative arrived before scheduled time; Adm nurse stated only abuse or neglect r/t representative was related to representative took another resident out to vape & smoked in her own vehicle while supervising other resident to vape; failed to ensure resident was able to exercise right to receive visitors of choosing at time of choice placing resident at risk for impaired resident rights, impaired psychosocial wellbeing & social isolation*
- *Resident stated facility told resident's husband he could not come up to DR & if went into DR, facility would call law enforcement; & stated husband no longer feels comfortable coming to facility & felt like her visitation was restricted; resident stated felt uncomfortable in facility & husband made resident feel comfortable & resident began crying; Adm stated dietary staff member felt uncomfortable with resident's family being in DR in evenings because of an outburst that had occurred & family was told could not go into DR with resident & had to wait until resident done eating; failed to ensure 1 resident was able to exercise right to receive visitors of choosing at time of choice placing resident at risk for impaired resident rights, impaired psychosocial wellbeing & social isolation*

F564 Inform Visitation Rights/Equal Visitation Privileges

NW: SS=D: Failed to inform 2 residents/representatives of visitation rights & any visitation restrictions placed on them placing 2 residents at risk for impaired resident rights, impaired psychosocial wellbeing & social isolation

- *Cited findings noted in F550, F563; facility unable to provide evidence notice was issued to 1 resident's DPOA stating visitation was restricted, what restrictions were & why; failed to notify 1 resident/DPOA of restricted visitation as required placing resident at risk for impaired resident rights, impaired psychosocial wellbeing & social isolation*
- *Cited findings noted in F563; failed to notify resident/representative of restricted visitation as required placing resident at risk for impaired resident rights, impaired psychosocial wellbeing & social isolation*

F575 Required Postings

SE: SS=E: Failed to post State Survey Agency contact information on how to report abuse in a manner accessible to residents & representatives placing residents at risk for ongoing abuse & other concerns

- Failed to post SSA information in manner accessible to residents/representatives placing residents at risk for ongoing abuse & unresolved grievances & concerns

F576 Right to Forms of Communication with Privacy

SE: SS=C: Failed to ensure residents received mail services on Saturdays

- Failed to ensure residents received mail services on Saturdays

F577 Right to Survey Results/Advocate Agency Information

SE: SS=C: Failed to post previous state inspection information in location accessible to residents & visitors

- Failed to post state inspection survey results in place available to residents/representatives

F582 Medicaid/Medicare Coverage/Liability Notice

SE: SS=D: Failed to provide CMS Form 10055 which included estimated costs for 2 residents placing residents at risk for uninformed decisions r/t skilled services

- CMS ABN Form 10055 did not provide estimated cost to continue services for multiple residents; failed to provide 2 residents with estimated cost to continue services or option chosen on CMS 10055 placing residents at risk for uninformed decisions r/t skilled services

SE: SS=D: Failed to issue CMS 10123 NOMNC with required information for 2 residents placing residents at risk for decreased autonomy & impaired decision making

- Failed to ensure NOMNC was provided at end of skilled services for 2 residents placing residents at risk for decreased autonomy & impaired decision making

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

- Observed Form 10055 provided residents with wrong form; resident received CMS-R-131 instead of 10055 for 3 residents; failed to provide 3 residents/representatives correct form 10055 when discharged from skilled care placing residents at risk for uninformed decisions about services

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

- ABNs reviewed revealed 3 residents received CMS-R-131 instead of 10055; failed to provide 3 residents/representatives correct 10055 form which included estimated cost of continued services when discharged from skilled care placing residents at risk of uninformed decisions about services & continuation of skilled services

F584 Safe/Clean/Comfortable/Homelike Environment

SW: SS=D: Failed to ensure staff administered accurate dose of topical pain med for 1/6 residents reviewed

- Resident with OA with POS for Voltaren 4gm to bilateral knees TID for pain; observed CMA placed quarter size dollop in palms of gloved hands & rubbed med into resident's knees; CMA unaware med came with dosing card; failed to ensure 1 resident received accurate dose of pain med as ordered by physician to ensure full effectiveness for pain relief

NE: SS=D: Failed to provide clean, comfortable & homelike environment in 1 resident's room placing resident at risk for impaired comfort & dignity

- Observed overwhelming urine odor in 1 resident room; resident' urinary catheter not visible on multiple occasions; observed 12x12 inch wet spot on sheet & resident not in room; observed room door closed but overwhelming urine odor still evident by entrance to room on multiple occasions; records including CP lacked interventions or documentation r/t staff or facility efforts to decrease urine odor in resident's room; failed to provide a clean, comfortable & homelike environment for 1 resident placing residents at risk for impaired comfort & dignity

F585 Grievances

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

- Observed no designated grievance drop boxes or system available in areas accessible to residents & visitors of facility; resident council reported unaware if facility provided way to complete anonymous grievances; failed to implement system to allow residents/representatives to file grievances anonymously within facility placing residents at risk for decreased psychosocial wellbeing & unresolved grievances

F602 Free from Misappropriation/Exploitation

SW: SS=D: Failed to ensure residents remained free from abuse when multiple residents' medications were misappropriated placing all residents who had controlled meds stored in facility at risk for further misappropriation & impaired care r/t missing or stolen meds

- Facility investigation revealed 1 resident's entire card of oxycodone missing; facility unable to locate meds after search in all 4 households & upon ID of missing meds, Adm nurse contacted LN who came to facility to fill out witness statement & during investigation determined 3 narcotic cards along with count sheets; facility contacted police & gathered statements from staff; 3 residents affected by misappropriation; failed to ensure residents remained free from abuse when multiple residents' meds were misappropriated placing all residents who had controlled meds stored in facility at risk for further misappropriation, abuse & lack of pain care management r/t missing or stolen meds

F623 Notice Requirements Before Transfer/Discharge

SE: SS=D: Failed to provide written notice of transfer or discharge notice for 1 resident's facility-initiated transfer placing resident at risk of uninformed choices & miscommunication r/t care needs

- Failed to provide written notice of transfer or discharge notice for 1 resident's facility-initiated transfers placing resident at risk for uninformed choices & miscommunication r/t care needs

F625 Notice of Bed Hold Policy Before/Upon Transfer

SE: SS=D: Failed to provide bed hold notice when 1 resident was hospitalized placing resident at risk of uninformed choices

- Failed to provide bed hold notice for 1 resident's hospitalization placing resident at risk of uninformed choices

F641 Accuracy of Assessments

NE: SS=D: Failed to accurately & thoroughly completed MDS for 1 resident placing resident at risk for unidentified care needs

- *Dental CAA did not trigger; Quarterly MDS documented resident's oral & dental status not addressed on MDS; Oral assessment documented with probable extensive decay & moderate inflammation & resident stated all upper teeth hurt; & often had tooth pain & had asked for dental services; failed to develop accurate & thorough MDS assessment r/t 1 resident's oral status placing resident at risk for unidentified care needs*

F656 Develop/Implement Comprehensive Care Plan

SE: SS=E: Failed to accurately complete comprehensive CP for 4 residents with potential to lead to uncommunicated need for care & services to meet each individual resident's needs

- CP lacked documentation r/t respiratory care, O2 delivery or nebulized medication use; failed to complete an accurate comprehensive CP for 1 resident with potential to lead to uncommunicated needs that would have a negative impact on physical & psychosocial wellbeing of resident
- CP lacked any direction to staff r/t ADL assistance resident required until 6 days after X-Ray verified resident's shoulder dislocation, with suspected fx; failed to develop CP r/t ADLs for 1 resident which included instructions to staff for resident's transfers &/or bed mobility; failure resulted in actual harm when CNA pulled on resident's sore arm while assisting resident into bed; resident was transported to local ER & dx'd with shoulder dislocation & suspicion of Hill Sachs Fx
- Lacked CP r/t medication needs; failed to develop comprehensive CP for 1 resident
- CP lacked instructions for staff r/t ADLs, transfers or safety r/t resident's preference to sit on floor in random place/patterns; CP lacked interventions r/t maintaining or improving total incontinence of bowel & bladder; failed to develop & implement individualized comprehensive person-centered developed & implemented to meet 1 resident's preferences & goals, to address resident's physical, mental & psychosocial needs as required & within required time frame with potential to lead to negative psychosocial effects r/t safety & risk for unmet care needs

F657 Care Plan Timing & Revision

SE: SS=D: Failed to revise CP for 1 resident r/t falls

- CP lacked intervention for staff guidance when staff lowered resident to floor when combative on 12-28; CP lacked staff guidance when resident was on floor on 1-3 to prevent possible further fall; CP lacked staff guidance when resident on floor on 1-11 to prevent possible further falls; failed to revise CP when appropriate for 1 resident after falls occurred with potential to lead to negative psychosocial effects r/t safety could cause more falls

SE: SS=E: Failed to review & revise CP with resident-specific interventions for 4 residents placing residents at risk for impaired care due to uncommunicated care needs

- CP lacked documentation r/t low air-loss mattress on bed or correct settings; failed to review & revise CP with resident-specific interventions for 1 resident placing resident at risk for impaired care due to uncommunicated care needs
- CP lacked direction for hand splint; failed to review & revise CP with resident-specific interventions for 1 resident placing resident at risk for impaired care due to uncommunicated care needs
- CP lacked direction to staff r/t application of resident's hearing aids; failed to review & revise CP with resident-specific interventions for 1 resident placing resident at risk for impaired care due to uncommunicated care needs
- CP lacked direction r/t weight monitoring for CHF; failed to review & revise CP with resident-specific interventions for 1 resident placing resident at risk for impaired care due to uncommunicated care needs

SW: SS=D: Failed to revise CP with effective interventions for 1 resident r/t lack of w/c foot pedals & 1 resident r/t inability to self-administer meds

- CP lacked staff instruction r/t use of foot pedals while propelling resident in w/c; failed to review & revise dependent resident's CP to include use of foot pedals
- CP instructed staff resident occasionally refused to follow CP & instructed staff that resident's meds may be set up by nursing staff, placed in pill cup & left with resident at bedside or with resident in DR; staff to complete self-administration assessment quarterly & with changes; POS for self-administration; LN stated resident could no longer self-administer as resident requested meds crushed in applesauce; staff did not update CP & MAR with information; failed to review & revise resident's CP to reflect resident's change in condition for self-administration of meds to ensure compliance with prescribed meds

NW: SS=D: Failed to develop & implement individualized dementia treatment plan for 1 resident who had dementia & behaviors placing resident at risk for abuse & decreased quality of life

- CP lacked individualized dementia treatment plan or guidance for staff when resident had behaviors; POS for Risperdal 11-16-23 & DCd 2-14-24; resident with multiple documented inappropriate verbal & physical behaviors with staff & other residents; failed to revise Cp with person-centered interventions for 1 resident who had dementia & behaviors placing resident at risk for decreased quality of life due to uncommunicated care needs

F658 Services Provided Meet Professional Standards

SE: SS=D: Failed to provide services to meet professional standards of care when staff failed to assess 1 resident's feeding tube for proper placement before administering water & medications with potential to have a negative effect on 1 resident's physical wellbeing

- CP lacked instructions for nursing staff on how to assess feeding tube prior to feeding tube being used for administration of fluids & meds; failed to provide services that meet professional standards of quality when 1 resident did not have feeding tube evaluated for correct placement before administering water & meds with potential to have negative effect on 1 resident's physical wellbeing

F676 Activities Daily Living (ADLs)/Maintain Abilities

SE: SS=D: Failed to ensure 1 resident received necessary ADL assistance required for hearing aids placing resident at risk for inability to communicate with peers or staff, increased confusion, negative psychosocial outcomes & decreased dignity

- Failed to ensure assistance was provided for 1 resident's hearing aids to aid resident's ability to participate with ADLs placing resident at risk for inability to communicate with peers or staff, increased confusion, negative psychosocial outcomes & decreased dignity

SW: SS=D: Failed to provide adequate bathing services for 3 residents reviewed

- *Bathing Sheets documented resident w/o baths for: 8 days, 9 days, 15 days, 11 days & 3 days; resident stated lack of showers not because resident did not want 1 & & asked for bath after 10 days w/o & staff did not assist resident to get shower after hospitalization upon request; failed to offer/provide adequate bathing for 1 resident resulting in time periods of 8 days twice w/o bathing, 14 days & 10 days w/o bathing*
- *Failed to provide adequate bathing for 1 resident resulting in time periods of 28 days & 12 days w/o bathing*
- *Failed to provide adequate bathing for 1 resident for time period of 59 days w/o bathing*

F677 ADL Care Provided for Dependent Residents

SE: SS=G: Failed to provide appropriate ADL care to resident when staff hurt resident's shoulder failure resulted in actual harm when CNA pulled on resident's sore arm while assisting resident in bed, resident transported to local ER where resident dx'd with shoulder dislocation & suspicion of Hill Sachs Fx; additionally facility failed to provide assistance for dependent residents during meals for 1 resident; furthermore failed to provide grooming assistance for 1 resident

- Failed to develop CP r/t ADLs for 1 resident which included instructions to staff for resident's transfers &/or bed mobility; failure resulted in actual harm when CNA pulled on resident's sore arm while assisting resident into bed & resident transported to ER & dx'd with shoulder dislocation & suspicion of Hill Sachs Fx
- Observed resident had not eaten any food & was not offered any assistance; Failed to provide staff assistance for meals to 1 resident with potential to lead to negative psychological effects r/t nutrition could cause weight loss
- Observed staff failed to provide assistance for eating to 1 resident; failed to provide assistance for meals to 1 resident with potential to lead to negative psychological effects r/t nutrition causing weight loss

SW: SS=D: Failed to ensure 1 resident received facial hair grooming opportunities

- Observed resident with several days growth of facial hair on multiple occasions; failed to ensure dependent resident's received shaving opportunities to aide in clean facial hygiene when eating & maintenance of groomed appearance

F678 Cardio-Pulmonary Resuscitation (CPR)

SE: SS=E: Failed to have a clear system in place to document resident's choice r/t code status with ability to negatively affect mental, physical, & psychosocial wellbeing of 7 residents

- EMR documented resident DNR, POS for DNR; record lacked evidence of order r/t resident's code status again until 3-1/2 months later which indicated resident wished to have full code; EMR revealed signed DNR dated 11-7-14 with no revocation of resident's wishes signed or noted in record
- POS for full code 2-1/2 months after admitting to facility; CP documented 2-1/2 months after admission indicating resident wished full code status
- Resident admitted on 12-16-22; POS for full code 4 months after admission; CP with entry dated over 1 year after admission indicating resident with full code
- POS for full code dated 6 months after admission; CP with entry dated 6 months after admission indicating resident with full code
- Resident admitted 1-31-24; POS for full code on 2-5-24; CP with entry 2-1/2 months after admission indicated resident full code
- Resident admitted on 2-5-24 with POS for full code on date of admission; CP with entry 2 months later indicating full code
- Observed facility lacked evidence facility had a code system located on resident doors or within rooms; failed to have clear system in place to document residents' choice r/t code status; failure had ability to negatively affect mental, physical, & psychosocial wellbeing of 7 residents placing all residents at risk for potential negative outcomes r/t lack of system to ID & convey resident codes status during emergency

F679 Activities Meet Interest/Needs Each Resident

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

- Failed to provide consistent activities for residents during weekends placing affected residents at risk for decreased psychosocial wellbeing

F684 Quality of Care

SE: SS=D: Failed to provide needed care & services that were resident centered, in accordance with resident's preferences, goals for care & professional standards of practice that would meet resident's physical, mental & psychosocial needs r/t treatment for alcoholism for 1 resident

- Resident with alcohol use with unspecified alcohol induced d/o & major depression d/o; CP lacked any address of interventions to mitigate risk factors or provide treatment/support to resident r/t alcoholism; resident stated admitted to facility for rehab 8 months previously & did not get any help or support such as AA & now paying privately to stay while not getting any help with alcoholism; stated guardian not helpful & did not want to live life out at facility & no discussion of discharge planning or treatment plan for alcoholism & no communication; failed to provide needed c are & services that were resident centered, in accordance with resident's preferences, goals for care & professional standards of practice that would meet resident's physical, mental & psychosocial needs r/t treatment for alcoholism for 1 resident

SE: SS=D: Failed to follow physician's order for daily weights to monitor for fluid overload for 1 resident placing resident at risk for delay in treatment r/t fluid overload & untreated illness

- Record lacked documentation of daily weights on 24 occasions from 2-17 to 4-3; record lacked documentation physician notification daily weight not obtained & lacked evidence resident refused to be weighed; failed to follow physician's order for daily weights to monitor for fluid overload for 1 resident placing resident at risk for delay in treatment r/t fluid overload & untreated illness

SW: SS=D: Failed to monitor & provide sanitary dressing change for 1/3 resident's venous ulcer reviewed for skin issues

- Record lacked measurements/description of blisters documented in NN; observed LN changed dressing & resident with large amount of pitting edema & resident with 2 blisters; during wound care staff failed to document size & characteristics of blisters for monitoring & failed to place wound supplies on sanitary barrier, but placed supplies directly on floor; failed to ensure staff provided sanitary dressing change & appropriate technique for application of Unna boot for resident's lower extremity cellulitis with blisters/ulceration;

NW: SS=D: Failed to staff followed acceptable standard of practice r/t wound care for 1 resident with infected wound placing resident at risk for delayed healing & other complications

- EMR documented resident with DM, MRSA, neuropathy; CP instructed staff to float heels & provide safe transfers; POS for wound vac & tx orders & IV ABT; observed LN perform wound care & failed to sanitize table before placing wound items, failed to perform hand hygiene & change gloves between soiled & clean wound care; during treatment placed tx items directly on resident's bed; failed to sanitize scissors during wound tx; failed to follow acceptable standard of practice r/t wound care for 1 resident with infected wound placing resident at risk for delayed healing & other complications

F685 Treatment/Devices to Maintain Hearing/Vision

SW: SS=D: Failed to ensure 1 resident received vision care

- MDS documented resident with adequate vision with corrective lenses; resident stated glasses were stepped on by another resident & staff aware this happened but glasses now used not resident's prescription & could not see as well & needed eye appointment but did not think resident could see eye doctor due to insurance issues; failed to ensure 1 resident had access to vision care to provide enhance sense of wellbeing

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

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

- EMR documented resident weighed 338 #s; EMR lacked instructions r/t low air-loss mattress or pump settings; failed to ensure 1 resident's low air-loss mattress pump was appropriately set to current weight placing 2 residents at risk for complications r/t skin breakdown & PUs

SW: SS=D: Failed to ensure 1 resident's pressure-reducing interventions were implemented correctly when low air-loss mattress (LAL) pump was not set to appropriate weight setting placing resident at risk for complications r/t skin breakdown & PUs

- CP lacked instruction r/t monitoring & settings for LAL mattress pump; POS order lacked instructions r/t monitoring & setting for mattress pump; EMR lacked documented LAL mattress checks, preferences, or notes indicating resident's preferred bed firmer; failed to ensure 1 resident's pressure-reducing interventions were implemented correctly when low air-loss mattress was set for inaccurate weight placing resident at risk for complications r/t skin breakdown & PUs

NW: SS=J (Abated to G): Failed to ID, monitor & provide appropriate treatments & interventions to prevent PUs from worsening & prevent infection for 1 resident

- *Resident admitted with Stage 3 PU on coccyx; nursing staff did not perform consistent wound assessment to include measurements, presence of infection; 81 days after admission resident's wound had worsened & had foul-smelling yellow drainage & culture recorded resident with MRSA & E. Coli in wound; physician ordered new treatment & started resident on ABT; EMR alerted staff that ordered tx used in wound would interfere with absorption of ABT but staff did not notify provider so no action taken; diagnostic scan of resident's abdomen & pelvis revealed sacral osteomyelitis; resident with new order for IV & oral ABT & consultant gave new orders for daily wound dressing changes & staff did not follow orders as consultant issued multiple warning to staff to ensure AG rope was out of wound; multiple occasions when wound dressing not performed as ordered due to unavailable wound supplies & wound continued to worsen & resulted in stage 4 PU with exposed bone; resident's wound erupted with uncontrollable bleeding & resident sent to ER then transferred to higher level of care & admitted to hospital with sepsis & dehydration; resident died (November 2023); failed to provide appropriate pressure reducing interventions, failure to consistently monitor resident's wounds & assess & address signs of infection, failed to involve physician when needed & failed to provide appropriate wound care services & treatments including ensuring availability of treatment supplies placing resident in immediate jeopardy*
- *Abatement Plan:*
  - *Immediate education r/t F686 with current nursing staff & nursing staff not allowed to work until education on policy & clinical protocols on skin breakdown & PUs*
  - *Education included that residents must receive necessary services to promote healing & prevent worsening for PUs & to prevent wound infection*

F688 Increase/Prevent Decrease in ROM/Mobility

SE: SS=D: Failed to provide 1 resident with hand splint to assist in maintaining anatomical alignment of resident's hand

- Failed to ensure staff provided a positioning device for 1 resident's hand contracture as CP'd to maintain as much anatomical alignment as possible & prevent worsening of contracture

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

- Failed to ensure 1 resident received services & treatment 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=E: Failed to ensure safe environment free from hazardous materials for 8 cognitively impaired independently mobile residents; additionally failed to assess & ensure resident's siderails were mounted safely placing affected residents at risk for preventable accidents

- Observed unlocked O2 storage room with 25 O2 cylinders stored on racks; observed unsecured beauty shop with accessible hazardous wipes; failed to ensure safe environment free from hazardous materials & out of reach from 8 cognitively impaired independently mobile residents placing affected residents at risk of preventable accidents
- EMR lacked evidence of alternative attempted before use of bilateral ½ rails & risk vs benefits explained to resident/representative; observed ½ rail loose & with 10-12 inch gap between rail & bed frame; failed to ensure 1 resident's side rails were properly secured, to prevent accidents, injuries or entrapments placing resident at risk for injuries & possible entrapment

SE: SS=D: Failed to ensure 1 resident remained free from avoidable falls when staff failed to provide resident with necessary equipment to ensure safety including call light & mobility devices, on 2 separate occasions which resulted in falls on both occasions placing resident at risk for avoidable injury

- Resident with multiple falls with same intervention of ensuring call light within reach before exiting room & staff education on ensuring call light in reach when leaving room; failed to ensure 1 resident remained free from avoidable falls placing resident at risk for injury

SE: SS=G: Failed to provide an environment as free of accident hazards as possible for 4 residents reviewed; failed to place effective & timely fall interventions for 1 resident who had multiple falls causing actual harm when resident fell from w/c, required transport to ER & placement of 2 staples to resident's head; failed to ID causal factors for 2 falls experienced by 1 resident, a dependent resident with repeated falls to prevent further falls; failed to appropriately monitor for safety for 1 resident, a resident with wandering when staff pushed resident in w/c & allowed feet to drag floor; practices led to actual harm for 2 resident & at risk for further injury that could negatively affect overall health & wellbeing of residents in facility with potential to have negative psychosocial impact on affected residents

- Failed to place effective & timely fall interventions for 1 resident with multiple falls causing actual harm when resident fell from w/c, required transport to ER & placement of 2 staples in resident's head
- Failed to ID causal factors for 2 falls experienced by resident, a dependent resident with repeated falls to prevent further falls
- Failed to ensure that 1 resident's environment remained free from accident hazards when facility failed to appropriately monitor resident for wandering behavior & person-centered interventions with potential to lead to accidents, injuries & negative psychosocial impact for 1 resident

SW: SS=E: Failed to ensure hazardous chemicals were stored safely placing 5 residents ID'd by facility as cognitively impaired & independently mobile at risk for accidents & hazard-related injuries

- Observed 1 household with unlocked housekeeping closet with chemicals with warning labels; failed to ensure hazardous chemicals were stored safely, placing 5 residents ID'd by facility as cognitively impaired & independently mobile at risk for injury

SW: SS=E: Failed to secure pressurized O2 cylinders in safe, locked location & out of r each of 6 cognitively impaired independently mobile residents; additionally failed to maintain resident's bed at safe height while resident was unsupervised in room placing residents at risk for preventable accidents & injuries

- Observed O2 storage room closed but not locked & secured; failed to secure 37 pressurized O2 cylinders in safe, locked area & out of reach of 6 cognitively impaired independently mobile residents placing residents at risk for preventable accidents & injuries
- Observed resident in bed with bed at high position with back of bed inclined up & low air-loss mattress (LAL) set for 180 & 200 lbs; failed to ensure resident's bed was maintained at safe height while unsupervised in room placing resident at risk for preventable falls & injuries

SW: SS=D: Failed to safely transport 1 resident in w/c by failing to have foot pedals in place while propelling resident in w/c

- Observed CNA propelled resident in w/c & legs bent at knee with feet under w/c seat & toes of shoed feet skimmed floor during transport & w/c lacked foot pedals; failed to safely transport dependent resident in w/c by failing to utilize foot pedals

NW: SS=J (Past Non-Compliance): Failed to provide adequate supervision to prevent cognitively impaired resident, ID'd at high risk for elopement from eloping through facility window

- *Resident IDd at high risk for elopement; resident sat at end of 1 hallway & looked out window; resident's home visible from window; 5 minutes after resident visualized looking out window, neighbor in community noticed resident walking toward resident's home then noted resident sitting on porch at home & 40 minutes later neighbor called facility & alerted DON to resident's location; DON noted window at end of hall missing screen which was found outside on ground; investigation revealed resident removed screen & stepped through full-size window; resident wore Wander Guard but did not alert as resident exited via window & not door; resident refused to return to facility initially but after speaking to Law Enforcement resident returned to facility with no injuries; staff was unaware of resident outside for 40 minutes when staff alerted by community member; failed to provide adequate supervision to resident to prevent elopement placing resident in immediate jeopardy*
- *Abatement Plan:*
    - *Maintenance ensure window security system was installed to prevent windows from opening more than 10 inches & are routinely checking functioning of window security*
    - *Resident's responsible party brought more items from home to enhance homelike environment; facility set up resident to have some meals at nutrition center & staff will accompany resident*
    - *Staff encourage resident to perform activities resident enjoys like cooking & attending coffee groups*
    - *All educated on Wander Guard & Elopement Policy & procedures*

NW: SS=D: Failed to ensure environment was free of accident hazards for 2 residents when facility failed to assess residents to safely use electric w/c or to safely smoke placing residents at risk for preventable accidents & injuries

- EMR lacked documentation facility assessed resident's ability to safely operate electric w/c before resident's use of chair in facility; NN documented resident over other resident's feet with electric w/c & other resident got mad & there was fight between residents; multiple NN documented resident using electric w/c in unsafe manner; failed to ensure environment free of accident hazards for 1 resident who was unsafe on electric scooter placing resident at risk for injury
- EMR documented resident nicotine dependent, DM, mood d/o & COPD; CP documented resident required supervision while smoked; EMR lacked evidence facility assessed resident for safe smoking practices; failed to evaluate 1 resident for safe smoking practices placing resident at risk for preventable accidents & related injury

NW: SS=G: Failed to ensure 1 resident's safety during transfer when CNA used ceiling-mounted full body lift to transfer resident from bed to w/c & during transfer resident slid out of lift sling onto floor resulting in resident sustaining femoral fx & fibular fx & placing resident at risk for pain

- *CP documented staff would be educated on proper use of lift & directed staff to use 2 persons with stand-aid then revised to direct staff to use full body lift at all times but did not indicate how many staff; CNA stated when started to move resident in full body lift sling (extra large sling) & started move resident away from bed, resident slipped out of lift sling; witness statement noted sling w/o holes or tears; Adm nurse stated incident should have never happened as CNA used wrong size sling; failed to ensure resident remained free from preventable accidents involving use of full-body lift resulting in fx'd femur & fibula & placing resident at risk for pain*

F690 Bowel/Bladder Incontinence, Catheter, UTI

SE: SS=D: Failed to ensure 1 resident received sanitary catheter care when staff failed to provide resident education on performing sanitary catheter care & failed to assess 1 resident's ability to self-perform catheter care placing resident at risk for catheter-related complications

- Observed resident in w/c with urine collection bag hanging on back handle of w/c & resident stated resident hung bag on back of chairs so could easily reach it when returned from smoking & resident stated did own catheter care & resident stated had not had any training on appropriate catheter care; failed to ensure 1 resident received sanitary catheter care when staff failed to provide resident education on performing sanitary catheter care & failed to assess resident's ability to self-perform catheter care placing resident at risk for catheter-related complications

F692 Nutrition/Hydration Status Maintenance

SE: SS=D: Failed to establish physician-ordered fluid restriction for 1 resident placing resident at risk for dehydration or fluid overload

- CP documented instructions for fluid restriction; POS for fluid restriction of 1800mL q 24 hours; TAR lacked documentation resident on fluid restriction; staff unaware resident on fluid restriction; Adm nurse stated fluid restriction never implemented by staff & said staff should have been monitoring resident's fluid intake; failed to establish a fluid restriction as ordered for 1 resident placing resident at risk for dehydration or fluid overload

SE: SS=G: Failed to ensure pertinent & timely interventions were implemented as ordered to prevent 1 resident's significant weight loss of 12% in 63 days; facility did not weigh resident weekly, did not document nutritional intake for resident as ordered, did not provide appropriate assistive devices to help resident feed self & did not ensure staff knew of nutritional monitoring system r/t who provided nutritional shakes to resident resulting in resident losing 20.8#/12.06% body weight in 63 days & placed resident at risk for continued decline in nutritional status & at risk for development of life-threatening symptoms which could negatively affect mental, physical, & psychosocial wellbeing of resident

- Failed to ensure pertinent & timely interventions were implemented as ordered to prevent resident's significant weight loss of 12.06% in 63 days; facility did not weigh resident weekly, did not document nutritional intake for resident as ordered, did not provide appropriate assistive devices to help resident feed self & did not ensure staff knew of nutritional monitoring system r/t who provided nutritional shakes to resident resulting in resident losing 20.8pounds/12.06% body weight in 63 days & placed resident at risk for continued decline in nutritional status & at risk for development of life-threatening symptoms which could negatively affect mental, physical, & psychosocial wellbeing of resident

SE: SS=D: Failed to obtain accurate weights as ordered by medical provider to prevent avoidable weight loss for 1 resident placing resident at risk for complications r/t weight loss

- Resident with tube feeding; POS for weekly weight x 4 weeks & DCd on 4-1 & record lacked weights after 3-4; failed to obtain weekly weights as ordered by physician for 1 resident who received enteral nutrition placing resident at risk for complications r/t weight loss

F693 Tube Feeding Management/Restore Eating Skills

SW: SS=D: Failed to provide G-tube care per physician orders when staff failed to administer required amount of water prior to nutritional feeding through G-tube placing resident at risk for G-tube related complications

- POS for Jevity 1 carton thru tube 4x/day & provide 45 mL water flush before & after feedings with additional of 175 mL free water 6x/day; observed LN administered 1 carton of Jevity thru G-tube followed by 45 mL water after; LN did not administer 45 mL prior to administering meds & feeding per physician order; failed to flush 1 resident's G-tube with 45 mL water before nutritional feeding as ordered placing resident at risk for complications r/t G-tube

F695 Respiratory/Tracheostomy Care & Suctioning

SE: SS=D: Failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent spread of infection, consistent with standards of practice & person-centered care plan for 1 resident r/t unknown clear liquid left in nebulizer chamber

- Observed nebulizer on bedside table with unknown clear liquid remaining in med chamber & nebulizer cannula lacked date to indicate when staff changed tubing; failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent spread of infection, consistent with standards of practice & person-centered CP for 1 resident r/t unknown clear liquid in nebulizer chamber

SE: SS=D: Failed to ensure appropriate respiratory care & services for 2 residents placing residents at risk for respiratory complications

- Observed resident in w/c & w/o O2 cannula in nares & CNA brought O2 to resident with cannula wrapped around handle of O2 canister & cannula not inside bag or clean container; failed to ensure resident's O2 was stored in sanitary manner while not in use placing resident at risk for increased risk of respiratory complications
- Observed resident in w/c with O2 via nasal cannula & Adm nurse stated resident used to have order for O2 but order DCd in November; Failed to ensure resident had physician order for O2 use placing resident at increased risk for complications

SW: SS=D: Failed to ensure 1 resident's CPAP & O2 tubing was stored in sanitary manner to decrease exposure & contamination placing resident at increased risk of developing respiratory infection & complications

- Observed CPAP mask; CP lacked direction to staff on cleaning & storing CPAP mask; observed CPAP mask lay directly on bedside table & undated & unbagged O2 tubing lay directly on floor in front of O2 concentrator; failed to ensure 1 resident's CPAP mask & O2 tubing were stored in sanitary manner to decrease exposure & contamination placing resident at increased risk of developing respiratory infection & related complications

F697 Pain Management

NW: SS=G: Failed to provide 1 resident with pain relieving measures prior to or after PU dressing changes though resident had documented pain & demonstrated signs of discomfort during dressing change resulting in untreated pain for resident placing resident at risk for continued unnecessary pain & altered psychosocial wellbeing

- *Cited findings noted in F686 r/t inappropriate PU care & services resulting in pain, infection hospitalization & death; failed to provide 1 resident with pain relieving measures prior to or after PU dressing changes though resident had documented pain & demonstrated signs of discomfort during dressing change resulting in untreated pain for 1 resident & placed resident at risk for continued unnecessary pain & altered psychosocial wellbeing*

F699 Trauma Informed Care

SE: SS=D: Failed to complete a trauma-informed care assessment & failed to develop a comprehensive trauma-informed CP for 1 resident who had dx of PTSD placing resident at risk for unmet behavioral & mental health needs & re-traumatization

- EMR documented resident with PTSD, depression & anxiety; CP lacked direction to staff on resident's trauma triggers & coping strategies; EMR lacked trauma-informed assessment at admission; staff unaware of triggers for re-traumatization of PTSD; failed to complete a trauma-informed care assessment & failed to develop CP for 1 resident with PTSD placing resident at risk for unmet behavioral & mental health needs & re-traumatization

F700 Bedrails

SE: SS=D: Failed to ensure 1 resident had documented consent for use of siderails, failed to show alternative methods were attempted & failed to ensure resident/representative were advised of risks &/or benefits of use of siderails placing resident/representative at risk for uninformed decisions r/t risks & benefits associated with use of siderails

- CP lacked direction for siderails; failed to ensure resident had documented consent for use of siderails; failed to show alternative methods attempted & failed to ensure resident &/or representative were advised of risks &/or benefits of use of siderails placing resident/representative at risk for uninformed decisions r/t risks & benefits associated with use of siderails

F725 Sufficient Nursing Staff

SE: SS=F: Failed to ensure adequate staffing levels on weekends to meet needs of residents placing residents at risk for impaired mental & physical wellbeing

- 2 PBJ quarters revealed facility triggered for "excessively low" weekend staffing; Resident Council reported rare activities on weekend because low staffing resulted in no activities on weekends; Adm stated weekend staff was low at times; Act staff documented facility did not have activities on weekends; staff reported low staffing at times; failed to ensure adequate staffing levels on weekends to meet needs of residents placing residents at risk for impaired mental & physical wellbeing

F726 Competent Nursing Staff

SE: SS=I: Failed to ensure staff possessed appropriate competencies to provide nursing & related services to assure resident safety & attain or maintain highest practicable, physical, mental & psychosocial wellbeing with potential to have negative physical, mental & psychosocial affects to all residents in facility

- Adm staff unable to locate or provide training records that facility was in process of transitioning from paper-based training system on online training system & that process was incomplete & records could not be located; Failed to ensure staff possessed appropriate competencies to provide nursing & related services to assure resident safety & attain or maintain highest practicable physical, mental & psychosocial wellbeing with potential to have negative physical, mental & psychosocial affects to all residents in facility
- Cited ANE findings, falls findings, feeding tube findings, ADL findings, respiratory findings, medication error findings
- Failed to ensure nursing staff demonstrated appropriate competencies & skill sets to provide nursing services to care for resident's needs when staff lacked knowledge r/t lack of assessing 1 resident following 17 day hospital stay over 3 days reporting little to no urinary output & lack of monitoring by nursing staff & resident became unresponsive & required emergency medical transfer to hospital for kidney failure

SE: SS=D: Failed to ensure staff possessed appropriate skills & knowledge to administer resident's Midodrine placing resident at risk for impaired quality of care

- POS for Midodrine po TID for hypotension with holding parameters; MAR indicated med was given outside provided parameters 37 times in March & LN administered med 20/37 occasions; LN stated administered resident's med w/o realizing med was given for hypotension instead of high BP & did not understand medication order or indication before giving med outside parameters; failed to ensure staff possessed appropriate skills & knowledge to administer 1 resident's Midodrine placing resident at risk for impaired quality of care

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

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

- Failed to ensure 5/5 CNA staff reviewed had required yearly performance evals completed placing residents at risk for inadequate care

F732 Posted Nurse Staffing Information

SE: SS=C: Failed to retain daily posted nursing staffing data for 18 months as required

- Failed to retain daily posted nursing staffing data for 18 months as required

SW: SS=C: Failed to ensure posted nursing hours included required information & were posted in prominent, readily accessible location for residents or visitors

- Review of posted nurse staffing information for 18 months lacked evidence of daily census on posted staff sheet; Adm stated posted nursing staff information was posted on wall outside ADON's office under folder; failed to include required posted nursing staffing information that included daily census & failed to post that information in readily accessible location for all residents & visitors to review

F742 Treatment/Services Mental/Psychosocial Concerns

NW: SS=D: Failed to provide necessary behavioral health care & services to attain or maintain highest practicable physical, mental & psychosocial wellbeing for 1 resident placing resident at risk for impaired quality of life due to untreated & ongoing mental health concerns

- Resident with schizophrenia, bipolar d/o & depression; BIMS of 15; thoughts of being better off dead & hurting self; record lacked evidence or documentation from SS staff r/t resident's statements or behaviors; record lacked psychotherapy notes or evidence of mental health services; observed resident with hair scraggly & uncombed; failed to assess, monitor & provide mental health services for 1 resident after resident verbalized would be better off dead or had thoughts of self-harm placing resident at risk for impaired quality of life due to untreated & ongoing mental health concerns

F744 Treatment/Service for Dementia

NW: SS=D: Failed to develop & implement individualized dementia treatment plan for 1 resident who had dementia & behaviors placing resident at risk for abuse & decreased quality of life

- Resident with dementia w/o behavioral disturbance, mood d/o, depression, pain; CP lacked individualized dementia treatment plan or guidance for staff when resident had behaviors; POS for Risperdal 0.5mg daily for psychosis & then DCd; NN documented multiple episodes of verbal & physical aggressive behaviors; CP lacked person-centered interventions for resident's dementia behaviors & stated staff re-directed resident when inappropriate; failed to develop & implement individualized interventions &/or dementia treatment plan for 1 resident who had dementia & behaviors placing resident at risk for abuse & decreased quality of life

F745 Provision Of Medically Related Social Service

SE: SS=D: Failed to provide sufficient & appropriate medically related social services to meet 1 resident's psychosocial needs r/t alcohol use d/o

- Cited findings noted in F684; Failed to provide sufficient & appropriate medically related social services to meet resident's psychosocial needs r/t alcohol use d/o

F755 Pharmacy Services/Procedures/Pharmacist/Records

SE: SS=E: Failed to ensure reconciliation of controlled meds was completed consistently & per industry standards placing residents at risk for medication misappropriation

- Review of count sheets revealed missing signature either for on-coming or off-going signature 13/62 opportunities; failed to ensure accurate reconciliation of controlled meds was completed placing residents at risk for medication misappropriation & diversion

SE: SS=E: Failed to ensure effective pharmacy system in place to ensure accurate accounting, reconciliation & destruction of controlled/narcotic medications affecting 9 residents & placed any resident who received controlled medications at risk for staff diversion of medication & potential untreated symptoms management that could negatively affect physical, mental & psychosocial wellbeing

- Facility filed 2 FRIs r/t medication diversion; observed multiple discrepancies in narcotic sign out sheet; failed to ensure effective pharmacy system in place to ensure accurate accounting, reconciliation & destruction of controlled/narcotic meds affecting 9 residents & placing any resident who received controlled meds at risk of staff diversion of medication & potential untreated symptoms management that could negatively affect physical, mental & psychosocial wellbeing

NW: SS=D: Failed to ensure ABT for UTI for 1 resident was available for administration placing resident at risk for worsening UTI & health complications

- *POS for urine sample r/t increased confusion & agitation; resident refused to void in "hat"; UA documented resident with WBCs & bacteria & culture grew Gram + Enterococcus; POS for Macrobid BID x 5 days for UTI on 2-8-24; progress noted on 2-10 documented ABT not started because had not been received from pharmacy; resident not administered ABT for 5 days after POS; failed to ensure 1 resident's ABT for UTI was available for administration placing resident at risk for worsening UTI & health complications*

F756 Drug Regimen Review, Report Irregular, Act On

SE: SS=D: Failed to ensure 3/5 resident reviewed remained free of unnecessary meds by failure to ensure CP ID'd & reported medication irregularities by not having MMRs from 1-1 to 4-25 for 3 residents

- CP lacked addressing use of psychotropic meds & care directives associated with medication side effects; failed to provide MRR for any residents prior to 1-1-24 & was unable to locate any facility or provider responses to pharmacy MRR reports after 1-1-24; failed to prevent use of unnecessary meds for 1 resident when facility failed to track, monitor &/or respond to pharmacist's monthly recommendations & ID of irregularities for resident r/t facility's failure to provide monthly MRR & responses reviews prior to 1-1-24 & was unable to locate any facility or provider responses to pharmacy MRR reports after 1-1-24
- Failed to respond to pharmacist recommendations for appropriate indication for use & failure to respond to pharmacist recommendation for end date or appropriate rationale for continued use causing resident to receive unnecessary medication for 13 doses over 2 months after pharmacist initially IDd deficient practice
- CP lacked BBWs for 3 medications; failed to prevent use of unnecessary meds for 1 resident when facility failed to respond to pharmacist recommendations for appropriate indication for use & failure to respond to pharmacist recommendations

SE: SS=D: Failed to ensure CP IDd & reported need for physician documented rationale for continued use of antipsychotic med for 1 resident with dx of dementia; also failed to follow recommendations of CP r/t resident's Midodrine administration given outside physician-provided parameters repeatedly placing resident at risk for adverse med effects

- POS for Olanzapine for dementia; failed to ensure CP IDd & reported inappropriate indication for 1 resident's Olanzapine placing resident at risk for unnecessary psychotropic medication & related complications
- Failed to follow recommendations of CP r/t resident's Midodrine administration given outside physician-provided parameters repeatedly placing resident at risk for adverse med effects

SW: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported 1 resident's BP med administered outside physician-ordered BP parameters placing resident at risk for unnecessary meds & related complications

- POS for Midodrine TID with holding parameters; EMR documented Midodrine incorrectly administered on 17 occasions when BP outside ordered holding parameters; CP documented no significant irregularities & indicated to refer to nursing recommendation; EMR lacked evidence physician notified of Midodrine administration outside physician-ordered parameters; CP report lacked comment on administration of Midodrine when BP out of ordered parameters; failed to ensure CP ID'd & reported administration of Midodrine when staff should have held med placing resident at risk for unnecessary meds & related complications

SW: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported to facility that staff failed to follow physician's orders in response to blood glucose monitoring for 1 resident who received insulin placing resident at risk for physical decline & an ineffective medication regimen

- POS for Humalog 5 U PRN for blood sugar over 250 ml/dl; TAR documented February with no insulin administered as ordered on 3 occasions, March with 6 occasions; & 1 occasion in current month; record lacked evidence CP ID'd & reported resident's Humalog not administered per orders r/t blood glucose monitoring; facility's CP failed to ID & report to facility that staff failed to follow physician's orders in response to blood glucose monitoring for 1 resident placing resident at risk for physical decline & ineffective medication regimen

F757 Drug Regimen is Free from Unnecessary Drugs

SE: SS=D: Failed to prevent use of unnecessary meds when staff failed to enter 1 resident's re-admission medication orders into EMR for 5 days resulting in staff incorrectly administering meds from a prior order with some at incorrect dosages & omitted meds that were ordered in resident's treatment after return from hospital causing resident to be sent back to hospital with renal failure; failed to ensure 1 resident's med regimen was free of unnecessary meds when facility failed to respond to pharmacist recommendations on 6 months' occasions

- Med errors due to admitting nurse did not process resident's admission orders on return from hospital so resident received same meds from prior admission & previous med cards were still in med cart to be passed; failed to prevent use of unnecessary meds for 1 resident when staff did not enter 1 resident's re-admission orders into EMR for 5 days resulting in staff incorrectly administering meds from prior order with some at incorrect dosages & omitted meds that were ordered in resident's treatment after return from hospital causing resident to be sent back to hospital with renal failure
- Failed to prevent use of unnecessary meds for 1 resident when facility failed to respond to pharmacist recommendations for appropriation indication for use & failure to respond to pharmacist recommendation for end date or appropriate rationale for continued use causing resident to receive unnecessary medication for 13 doses over 2 months after pharmacist initially IDd deficient practice

SE: SS=D: Failed to provide adequate pulse monitoring for 1 resident's anti-hypertensive beta blocker; additionally failed to obtain physician ordered lab results for 1 resident's medication regimen placing residents at risk for unnecessary meds & adverse med effects

- Failed to provide adequate pulse monitoring for 1 resident's metoprolol placing resident at risk for unnecessary meds & adverse med effects
- EMR lacked evidence of results from lab tests ordered by physician; failed to ensure physician order was followed for 1 resident's lab tests to monitor for high-risk medications placing resident at risk for adverse side effects & unnecessary meds

SW: SS=D: Failed to hold 1 resident's BP medication per physician-ordered BP parameters placing resident at risk for unnecessary medications & related complications

- Cited findings noted in F756; failed to hold a BP med per physician-ordered parameters placing resident at risk for unnecessary drugs & related complications

SW: SS=D: Failed to administer PRN diuretic as ordered for 1 resident; also failed to follow POS for monitoring 1 resident's Metoprolol with potential for unnecessary medication side effects or ineffective therapeutic regimen

- POS for Metolazone q 24 hrs for weight gain with parameters; MAR lacked evidence PRN Metolazone was administered as ordered by physician on 5 occasions from 2-12- thru 4-1; failed to administer resident's PRN diuretic as ordered with potential for unnecessary medication side effects or ineffective therapeutic regimen
- POS for Metoprolol for HTN with holding parameters; MAR & record lacked evidence resident's BP was monitored consistently prior to administration of Metoprolol; failed to consistently monitor resident's PB as ordered prior to administration of Metoprolol placing resident at increased risk for unnecessary medication & side effects

SW: SS=D: Failed to administer medication as ordered by physician in response to blood glucose monitoring for 1 resident who received insulin placing resident at risk for physical decline & ineffective medication regimen

- Cited findings noted in F756 r/t insulin orders for blood sugar parameters; failed to administer medication as ordered by physician in response to blood glucose monitoring for 1 resident who received insulin placing resident at risk for physical decline & ineffective medication regimen

NW: SS=D: Failed to notify physician of out-of-parameter blood sugars for 1 resident placing resident at risk for unnecessary medication side effects & other related complications

- POS for physician notification of blood sugars; TAR documented blood sugar out of parameters & physician not notified on 10 occasions in February & March 2024; 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

SE: SS=D: Failed to ensure residents remained free of unnecessary psychotropic meds by failure to have Consulting Pharmacist MRR reports from 1-1-24 to 4-25-24 including GDR & psychotropic monitoring for 3/5 residents reviewed

- Failed to prevent use of unnecessary meds for 1 resident when facility failed to track, monitor &/or respond to pharmacist's MRR & ID of med irregularities; failed to ensure physician documented contraindications for GDR which was not attempted or monitored by facility when facility failed to provide MMRs & responses/reviews prior to 1-1-24 & was unable to locate any facility or provider responses to pharmacy MRR reports after 1-1-24
- Failed to prevent use of unnecessary meds for 1 resident when facility failed to respond to pharmacist recommendations for appropriate indication for use & failure to respond to pharmacist recommendation for end date or appropriate rationale for continued use causing resident to receive unnecessary med for 13 doses over 2 months after pharmacist initially IDd deficient practice
- Failed to prevent use of unnecessary meds for 1 resident when facility failed to respond to pharmacist recommendations for appropriate indication for use & failure to respond to pharmacist recommendations

SE: SS=D: Failed to ensure appropriate indication or a documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of antipsychotic for 1 resident's Olanzapine placing resident at risk for unnecessary psychotropic meds & related complications

- Record lacked evidence of documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of Olanzapine; failed to ensure appropriate indication for use or required physician documentation for 1 resident's continued use of Olanzapine placing resident at risk for unnecessary psychotropic med effects

SW: SS=D: Failed to ensure PRN antianxiety med did not exceed 14-day reevaluation limit for 1/6 residents reviewed

- POS for Lorazepam 1mg q 24 hours PRN anxiety & may take 1-2 tab at night & may self-administer; Adm nurse revealed sent MRR 55 days after initial 14 days & evaluated that resident did not received meds that resident would tolerate a reduction/DC; physician returned document & changed Lorazepam to 2mg q night; failed to ensure physician reevaluated resident's use of PRN Lorazepam beyond 14-day reevaluation time frame to ensure resident did not receive unnecessary antianxiety med as required to prevent adverse effects

SW: SS=D: Failed to ensure 3/5 residents were monitored for adverse effects of antipsychotic meds in timely manner

- Resident with Seroquel; failed to ensure staff obtained 1 resident's baseline AIMS at start of antipsychotic drug therapy to determine adverse effects from medication for multiple residents
- Failed to ensure staff obtained 1 resident's baseline AIMS at start of antipsychotic & in 6 months afterwards to determine if resident sustained adverse effects from meds
- Failed to timely complete AIMS assessment for resident on antipsychotic med

NW: SS=D: Failed to monitor 1 resident's psychotropic med used off-label use of insomnia after a trial increase placing resident at risk for inadequate oversight, lack of physician involvement & ineffective dosing for Trazodone

- *POS for Trazodone at nighttime for insomnia; record lacked evidence staff monitored effectiveness of trial dose of Trazadone & lacked evidence staff notified physician r/t outcomes of trial or to inform order was expired & requires further orders; failed to monitor 1 resident's psychotropic med used off-label use for insomnia after trial increase placing resident at risk for inadequate oversight, lack of physician involvement & ineffective dosing for Trazodone*

F759 Free of Medication Error Rated 5% or More

SE: SS=F: Failed to ensure 2 residents reviewed during medication administration pass remained free of medication errors; 31 med opportunities were observed & 2 med errors occurred placing resident at risk for adverse reactions from meds & resulted in med error rate of 6.45%

- Observed LN administer meds per G-tube & did not check for placement of G-tube prior to administering 30cc water & meds
- Observed CMA began med prep for all oral meds for 1 resident, stopped preparing oral meds, donned gloves, administered eye drops, doffed gloves & resumed prep & administration of oral meds w/o performing hand hygiene; failed to ensure 1 resident's meds were not

given w/o checking for proper placement of G-tube; failed to ensure overall med error rate was below 5% with potential to have negative effect on overall physical & psychosocial wellbeing of all residents in facility

F760 Residents are Free of Significant Med Errors

SE: SS=G: Failed to prevent significant med errors for 1 resident when staff did not enter 1 resident's re-admission med orders into EMR for 5 days resulting in staff incorrectly administering meds from prior order with some at incorrect dosages & omitted meds that were ordered in resident's treatment after return from hospital

- Failed to prevent med errors for 1 resident when staff did not enter 1 resident's re-admission med orders into EMR for 5 days resulting in staff incorrectly administering meds from prior order with some at incorrect dosages & omitted meds that were ordered in resident's treatment after return from hospital

SE: SS=D: Failed to prevent a significant med error for 1 resident when staff administered Midodrine outside physician-provided parameters repeatedly placing resident at risk for adverse med effects

- MMR documented 28 occurrences of Midodrine given outside parameters; failed to prevent significant med error for 1 resident who received Midodrine outside physician-provided parameters on repeated occasions placing resident at risk for adverse med effects

F761 Label/Store Drugs & Biologicals

SE: SS=F: Failed to remove meds from circulation when no longer in use for 2 residents placing affected residents at risk for receiving meds that were not ordered by physician

- Narc sheet for 1 resident noted PRN Oxycodone removed & signed out but did not contain date staff signed out for administration; med cart with Ativan with 3 pills "wasted" but did not contain date entry for 2/3 wasted Ativan & 1 wasted dated 2-9-24 & all 3 signed off by 2 staff members & resident w/o order for Ativan since 11-7-23 end date; failed to remove DC'd meds from narcotic lock box on 2/2 med carts for 2 residents

SW: SS=E: Failed to properly label & store meds in ¼ med carts & 1 med room placing residents at risk for adverse outcomes or ineffective medication regimens

- Observed LN walked away from nurse's station & left med cart unlocked; observe treatment cart with multiple opened, undated insulin pens; observed cart with multiple opened, undated vials of TB vaccine serum; observed med fridge temp log with holes on 14 occasions from 3-1 thru 4-6; failed to properly label & store meds which could potentially cause adverse consequences or ineffective treatment to affected residents

SW: SS=E: Failed to date 4 residents' insulin flex pens when opened & outdated & failed to discard expired stock meds placing affected residents at risk for ineffective meds

- Observed multiple residents' insulin flex pens lacking open date & discard dates; observed expired stock meds; failed to date 4 residents' flex pen insulin with date opened & discard date & failed to discard expired stock meds placing residents at risk for ineffective medication

SW: SS=D: Failed to properly dispose of used Fentanyl after staff removed medicated patch from 1 resident

- Observed LN removed used Fentanyl patch from hip of 1 resident & after removing patch, LN folded patch with sticky side together & thew it into trash can in resident's room & stated always threw patch away in trash; failed to dispose of used Fentanyl patch in acceptable manner

NW: SS=D: Failed to date 1 resident's insulin flex pen placing resident at risk for ineffective medications

- Observed Levemir flex pen lacked open date; failed to dispose of outdated insulin flex pen for 1 resident placing resident at risk for ineffective medication

F791 Routine/Emergency Dental Services in NFs

NE: SS=D: Failed to ID & respond to 1 resident's dental needs which resulted in tooth pain & untreated dental issues placing resident at risk for pain & other complications r/t dental issues

- *Cited findings noted in F641 r/t dental issues not addressed on MDS; assessments lacked oral assessments from 1-1-23 to 4-15-24; record lacked evidence facility staff followed up on dental concerns & needs ID'd on 4-3-23; resident stated front teeth hurt & doctor aware that teeth hurt & teeth hurt all the time; failed to ID & respond to resident's oral needs which resulted in tooth pain & untreated dental issues placing resident at risk for pain & other complications r/t dental issues*

F810 Assistive Devices-Eating Equipment/Utensils

SE: SS=D: Failed to provide person-centered feeding assist to 1 resident as directed on CP with potential to negatively impact nutritional intake & psychosocial wellbeing of resident

- POS lacked documentation specific for feeding assistance; observed resident with standard plate of food & standard silverware & resident appeared with difficulty as attempted to consume food & did not eat any food; observed resident lacking bult-up silverware & fruit cup sealed; failed to provide person-centered feeding assistance to 1 resident as directed on CP when appropriate with potential to negatively impact nutritional intake & psychosocial wellbeing of resident

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=F: Failed to prepare & serve food under sanitary conditions to all residents in facility to prevent potential foodborne bacteria

- Observed fridge with opened, undated food items; staff unable to located testing strips; follow up revealed dishwasher machine tested at 100 ppm

- Observed staff removed container of onions from fridge with gloved hand, removed lid, removed handful of onions & placed in 2nd bowl then put lid back on bowl & placed onions back in fridge with same gloves then with same gloves removed other food items & place don prep table the retrieved cutting board & knife & placed them on prep table then used knife with same gloved hands to chop lettuce then cup up tomato & placed in same bowl then reached into cheese & placed on lettuce with same soiled gloves

SW: SS=E: Failed to store, prepare & serve food in sanitary manner for residents in 2/4 kitchens & DRs placing residents at risk for foodborne illness

- Observed opened, undated meat in freezer
- Observed CNA served plated food to residents & touched resident's body, chair, own face & did not wash or sanitize hands before service more residents; observed CNA touch multiple contaminated items & continued to serve food on multiple occasions in multiple households
- Observed toasters with numerous dried crumbs on top & edges & oven doors with dried food spills

SW: SS=F: Failed to follow sanitary dietary standards r/t food labeling, storage, & preparation placing all residents eating from facility at risk for foodborne illness

- Observed unlabeled, undated food items; canister of flour with no label or date; freezer with opened food items open to air & unsealed & unlabeled & undated; observed dietary staff carried multiple residents' fruit cups while touching tops of opened containers; observed dietary staff touched probe of food thermometer with bare hands w/o cleaning probe before completing temp checks on food

SW: SS=F: Failed to prepare & serve food under sanitary conditions to residents of facility appropriately to prevent potential for foodborne bacteria

- Observed kitchenette with microwave with layer of dust & heavy build up of dried-on food; cart with melted areas on top tier; cart with ground in food substances on top tier; trash can with dried-on food & liquid; cereal container w/o lid; cabinet with food debris; plate warmer with food debris; drawers with food debris

F835 Administration

SE: SS=I: Failed to have effective administration to ID & develop corrective action plans for potential quality deficiencies as found on current survey placing residents at risk for decreased quality of care, quality of treatment, & sense of wellbeing

- Referenced: F550, F561, F600, F602, F609, F610, F623, F625, F636, F641, F656, F657, F658, F677, F678, F684, F688, F689, F695, F726, F745, F755, F756, F758, F759, F760, F810, F812, F867, F880, F883, F947
- Failed to have effective administration to ID & develop corrective action plans for potential quality deficiencies as found on current survey placing residents at risk for decreased quality of care, quality of treatment & sense of wellbeing

F849 Hospice Services

SE: SS=D: Failed to ensure communication process was implemented, which included how communication would be documented between facility & hospice provider & failed to describe services & equipment provided to resident by hospice creating risk for missed or delayed services & impaired care

- Failed to ensure communication process was implemented which included how communication would be documented between facility & hospice provider & failed to describe services & equipment provided to resident by hospice creating a risk for missed or delayed services & impaired care for 1 resident

SW: SS=D: Failed to maintain ongoing communication with hospice services r/t resident's bi-weekly hospice visits; additionally failed to ensure collaboration between nursing home & hospice services to ID hospice-supplied services, supplies, medication & equipment for 1 resident placing both residents at risk for delayed services & uncommunicated care needs

- CP lacked information r/t services provided by hospice including medications, equipment & supplies & failed to ID frequency of visits from hospice nursing staff; EMR lacked scanned hospice communications showing bi-weekly visits were being completed & what services were provided at time of visits; failed to maintain ongoing communication with hospice services r/t resident's bi-weekly hospice visits
- Failed to ensure collaboration between nursing home & hospice services to ID hospice-supplied services, supplies, medication & equipment for 1 resident placing both residents at risk for delayed services & uncommunicated care needs

NW: 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

- CP lacked evidence of coordination of care between hospice & facility; facility had not received hospice Cp from hospice so hospice CP was not available to review in EMR & no communication book or external document for hospice care; failed to coordinate care between facility & hospice provider for 1 resident who received hospice services placing resident at risk for inappropriate end-of-life care

F851 Payroll Based Journal

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

- PBJ report indicated facility did not have LN coverage 24 hrs/day, 7 days/wk on 18 days in quarter 2 & 9 days in quarter 3 & 12 days in quarter 4; LN payroll data revealed LN on duty for 24 hrs/day 7 days/wk; Adm stated facility submitted accurate nursing hour data for PBJ but corporate staff failed to document correct hours & corporation has new employee that is currently submitting data & verified hours & LN coverage on all days; failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

F867 QAPI/QAA Improvement Activities

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

- Referenced: F550, F561, F600, F602, F609, F610, F623, F625, F636, F641, F656, F657, F658, F677, F678, F684, F688, F689, F695, F726, F745, F755, F756, F758, F759, F760, F810, F812, F867, F880, F883, F947
- Failed to ID & develop corrective action plans for potential quality deficiencies through QAPI plan to correct IDd quality issues placing residents at risk for ineffective care

F868 QAA Committee

SE: SS=F: Failed to ensure required members, including Infection Preventionist attended QAA meetings at least quarterly placing residents who resided in facility at risk for decreased quality of care

- 4 quarterly attendance sheets lacked evidence designated infection preventionist attended QAPA meetings; failed to ensure required participants including Infection Preventionist attend QAPI/QAA meetings at least quarterly placing residents at risk for decreased quality of care

F880 Infection Prevention & Control

SE: SS=E: Failed to maintain effective infection control program r/t improper cleaning of respiratory equipment, lacked proper hand hygiene during med administration & cleaning of glucometers to prevent spread of possible infections to residents in facility

- Failed to maintain effective infection control program r/t improper cleaning of respiratory equipment, lacked proper hand hygiene during med administration & cleaning of glucometers to prevent cross contamination in facility

SE: SS=E: Failed to ensure adequate infection control standards r/t following EBP, laundry services & sanitary care practices placing residents at risk for infectious diseases

- 3 Residents with Foley catheter & EMR lacked indication residents on EBP; resident with G-tube & EMR lacked indication resident on EBP; resident with recovering surgical wound & no EBP; & all affected rooms lacked signage & required PPE readily available outside room; staff reported no training on EBP
- Observed clean linen room left open with multiple linen sheets touching floor multiple times
- Ice machine left open with melted ice & ice scoop left inside
- Observed O2 tubing on floor
- Observed trash bag of soiled incontinence briefs on floor in hallway
- Observed housekeeping staff transported uncovered cart with clean linen down hallway
- Observed O2 tubing wrapped around handle of O2 canister
- Observed 2 CNAs perform peri care & completed multiple glove changes w/o performing hand hygiene between glove changes
- Failed to ensure adequate infection control standards r/t following EBP, laundry services & sanitary care practices placing residents at risk for infectious diseases

SW: SS=D: Failed to ensure housekeeping staff maintained proper isolation standards for TBP

- Observed 4 residents on TBP for COVID infections; observed housekeeping cart inside 1 resident's room & 2 staff in room w/o gowns; failed to ensure housekeeping staff adhered to TBP when providing terminal cleaning to isolation room to prevent spread of infection

SW: SS=D: Failed to monitor & provide sanitary dressing change for 1 resident's venous ulcer

- Cited findings noted in F684 r/t dressing change for venous ulcer; failed to ensure staff provided sanitary dressing change to 1 resident's lower extremity cellulitis with blisters/ulceration

NW: SS=D: Failed to ensure adequate infection control measures for 1 resident before, during & after wound care placing residents at risk for continued wound infection, cross contamination & other infectious disease

- Cited findings noted in F684 r/t inappropriate wound care based on infection control procedures; failed to ensure adequate infection control measures during wound care for 1 resident who had infection in wound placing resident at risk for continued wound infection, cross contamination & other infectious disease

F883 Influenza & Pneumococcal Immunizations

SE: SS=F: Failed to provide proof of vaccination or declination of vaccines for 2023-2024 influenza or pneumococcal for 5/5 residents reviewed

- EMR for 1 resident lacked documentation of 2022 to 2023 influenza vaccine or declination of any pneumococcal vaccine or declination of vaccines for 5/5 residents

SE: SS=D: Failed to provide consent, declination, or documentation of ineligibility for 3 resident's pneumococcal vaccinations placing residents at risk for complications r/t pneumococcal diseases

- Failed to provide consent, declination, or documentation of ineligibility for 3 resident's pneumococcal vaccinations placing residents at risk for complications r/t pneumonia

F887 COVID-19 Immunizations

SE: SS=D: Failed to provide consent, declination or documentation of ineligibility for 1 resident's COVID-19 immunizations placing residents at risk for complications r/t COVID-19

- Failed to provide consent, declination, or documentation of ineligibility for 1 resident's COVID-19 vaccinations placing resident at risk for complications r/t infectious diseases

SW: SS=D: Failed to verify resident/representative were provided vaccine information/risk versus benefit information to document informed choices for COVID vaccinations for 2/5 residents reviewed for COVID vaccinations

- Record revealed lack of COVID vaccination since 9-23-22 & lacked declination for 2023 vaccination; Adm staff stated facility provided COVID vaccine clinics & lacked declination for resident; failed to ensure documentation that residents/representatives received vaccine information sheets/risk versus benefits for COVID vaccinations to make informed decisions r/t declinations/acceptance of vaccines

F919 Resident Call System

SW: SS=D: Failed to provide a functional & fully operational call light system for each resident placing residents at risk for delayed care & decreased psychosocial wellbeing

- Resident stated call light had not worked since resident was admitted; stated nursing instructed resident o yell out for help if needed anything & did not receive a bell & was unsure if staff completed frequent checks on resident & afraid of falling with no way to alert anyone to come help resident; call light inspection & test revealed resident's call light did not work upon pushing button & CNA confirmed call button was not functioning in resident's room
- Resident stated felt call light did not work & inspection & test of call light revealed call button was not functioning & Adm Nurse reported non-functioning call light to maintenance; Maintenance staff stated facility had new call light system & system is checked every week & unaware of what protocol would be if maintenance staff could not get call light to work right away; failed to ensure 2/4 hallways had operational call lights for each resident to call for assistance placing resident at risk for delayed care & decreased psychosocial wellbeing

F925 Maintains Effective Pest Control Program

SE: SS=E: Failed to provide effective pest control so that facility was free from pets placing residents at increased risk for impaired comfort & disease

- Failed to provide effective pest control so that facility was free from pests placing residents at increased risk for impaired comfort & disease

F947 Required In-Service Training for Nurses Aides

SE: SS=F: Failed to maintain in-service training program for nurses' aides that was appropriate & effective to ensure continuing competence of nurse aides; 5/11 CNAs lacked required 12 hours of in-service training to include dementia & abuse training to ensure continuing competence of nurse aides & appropriate care & services to all residents of facility

- Failed to maintain in-service training program for nurse aides that included required 12 hours of in-service training t include dementia & abuse training to ensure continuing competence of nurse aides & appropriate care & services to all residents of facility

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

- Failed to ensure 5/5 CNA staff reviewed had required 12 hours of in-service education placing residents at risk for inadequate care

May, 2024

F550 Resident Rights/Exercise of Rights

SE: SS=D: Failed to protect privacy & dignity of 2 residents leading to resident being disturbed in room on multiple occasions by another resident with wandering behaviors & 1 resident being seated in dining area wearing a shirt & incontinence brief with lap partially covered with blanket with potential to lead to negative psychosocial effects r/t dignity

- Failed to protect privacy & dignity of 1 resident r/t resident being frequently "bothered" by another resident wandering into resident's room leading to resident being disturbed in room on multiple occasions by other resident with wandering behaviors
- CP lacked interventions r/t maintaining or protecting resident's privacy or dignity r/t to what clothing to be worn & shaving; failed to protect privacy & dignity of 1 resident leading to resident not having clothing on from waist down covered only by blanket; additionally facility failed to shave resident per resident's preference with potential to lead to negative psychosocial effects r/t dignity

NE: SS=D: Failed to provide dignified care environment for 1 resident placing resident at risk for impaired dignity & quality of life

- Observed resident with door open, resident in bed with covers pulled up over upper body & lower body exposed with only incontinent brief on for at least 1-1/2 hours & staff walked by room numerous times; failed to provide dignified care environment for 1 resident placing resident at risk for impaired dignity & quality of life

F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to provide resident with w/c lap meal tray as CP'd for meals; additionally failed to ensure 1 resident's call light remained within reach while unsupervised in room placing both residents at risk for impaired quality of life & care

- Failed to provide 1 resident with w/c lap meal tray as CPd for meals placing resident at risk for impaired quality of life & care
- Failed to ensure 1 resident's call light was within reach placing resident at risk for impaired physical, mental & psychosocial wellbeing

F561 Self-Determination

SE: SS=D: Failed to promote & facilitate resident self-determination through support of resident's choice when resident not given a choice about meals resident ate with potential to have a negative effect on resident's psychosocial wellbeing

- POS for regular diet, regular texture, regular consistency; observed resident raised arm around as staff walked by resident & behind resident & waved 3 times for 15 minute period when LN acknowledged resident & resident stated still hungry & requested more food & resident unable to verbalize what wanted & dietary staff brought resident ½ peanut butter & jelly sandwich in bag & resident declined

food stating did not like what was offered & dietary staff stated no more food left from dinner & walked away from resident, then observed 2 dietary staff offered several other residents in DR more food; resident no acknowledged from 5:0pm until 6:13pm by dietary staff; failed to promote & facilitate resident self-determination through support of resident's choice when resident not given choice about meals eaten with potential to have negative effect on resident's psychosocial wellbeing

F600 Free from Abuse & Neglect

SE: SS=L (Remained at L): Failed to ensure environment free from neglect & alleged abuse with potential to negatively affect all residents of facility; (1) failed to prevent neglect of 1 resident through lack of appropriate nursing care & follow-up/monitoring after resident returned to facility following 17-day hospitalization for sepsis; facility LN staff failed to prevent medication errors for 1 resident when staff did not enter resident's re-admission medication orders into EMR for 5 days resulting in staff incorrectly administering meds from prior order with some at incorrect dosages & omitted meds that were ordered in resident's treatment after return from hospital; failed to ensure competent nursing staff to respond to change-in condition for 1 resident when resident reported had not voided in 2 days; failed to ensure LN staff assessed, followed up & notified physician of resident's critically low to complete lack of urine output; failed to ensure staff monitored resident's oral input & urinary output for 12 hours as ordered & after over 3 days of resident reporting little to no urinary output resulting in resident became unresponsive & required emergency medical transfer to local hospital for kidney failure & resident then re-admitted to hospital & returned 7 days later; cumulative deficient practices of neglect placed resident in immediate jeopardy; (2): failed to ensure 1 resident was free from resident abuse & neglect with resident was on 1:1 observation due to "screaming & yelling"; CNA was in 'quiet room' with only resident & doors closed & at 10am CNA reported to LN that resident fell to floor when CNA looked away to get something out of purse; resident repeatedly stated CNA struck resident & resident had bruising & scuffs to eye & knot on forehead; CNA continued to sit in chair net to resident in 1:1 observation; LN reported incident to DON but incident not investigated or reported to State Agency for approx. 5 weeks when facility suspended CNA & Adm nurse placing resident in immediate jeopardy and placed all residents at risk for potential abuse; (3): Failed to ensure environment free from neglect when staff did not know how to provide transfer assist safely & appropriately to 1 resident; CNA proceeded to lift & drag resident backwards across DR floor during meal service approximately 5 feet with heels dragging on floor; cumulative deficient practices resulted in immediate jeopardy & placed all residents at risk for abuse & neglect

- Failed to prevent neglect & alleged abuse of 1 resident with chronic kidney disease & electrolyte imbalances through lack of appropriate nursing care after resident returned to facility following 17-day hospitalization for sepsis placing resident in immediate jeopardy
    - Abatement Plan:
        - All LN re-educated on admission/readmission checklist process
        - All LN re-educated on change of condition, notification to physician & POA of change of condition & re-educated in ANE r/t lack of follow up in residents' change in condition
        - Facility will educate direct care staff to report to charge nurse immediately of any noticeable change in residents' baseline ADLs including no urinary output or behavior prior to next shift; no staff will work until received education; all LNs re-educated on change of condition & physician notification immediately or as soon as feasible
- CP lacked interventions specific to resident's falls on 2 occasions & further lacked interventions r/t behavioral outbursts; failed to ensure resident was free from abuse & neglect when resident allegedly fell out of w/c hurting face while on 1:1 observation in closed room with 1 CNA & resident repeatedly stated CNA struck resident; facility did not investigate allegation of abuse or protect resident from potential further abuse & CNA continued to work in facility until suspension 36 days after allegation; facility further failed to report allegation of abuse to State Agency
    - Abatement Plan:
        - DON & CNA suspended by Adm & Adm Nurse
        - Adm, Adm nurse, Adm staff, Maintenance director, dietary manager, housekeeping manager, SSD, therapy staff re-educated r/t ANE policy & processes by nurse consultant
        - Local police notified & arrived to initiate investigation
        - Staff completed head-to-toe assessment of resident with no changes in skin conditions found
        - Facility notified resident's responsible party/POA of incident that occurred 36 days earlier
        - Facility notified resident's physician of incident & received no new orders
        - Facility held Ad Hoc QAPI meeting
        - Facility completed & submitted FRI report to KDADS r/t event
        - Consultant nurse conducted review of documentation of current residents with no findings of abuse IDd by facility
        - Resident impacted by event had post-trauma assessment completed; SSD showed no avert changes from resident's prior assessment
        - Facility safe surveys conducted of 9 alert & oriented resident & no concerns or additional findings IDd by facility
        - Staff interviews with 6 current team members completed with no new concerns IDd by facility
        - All current team members re-educated at mandatory training r/t ANE
        - Resident would be documented on every shift x 72 hours & reviewed by Adm staff during morning clinical review on each day that followed documentation
        - Facility provided documentation that resident was followed by Physician Extender who specialized in psychiatric care
        - Facility provided documentation that when new team members would begin employment, would receive ANE training as part of initial onboarding & all other employees would receive ANE training annually & with any allegation of investigation r/t abuse

- Failed to ensure environment free from neglect when staff did not know how to provide transfer assistance safely & appropriately to 1 resident & CNA proceeded to lift & drag resident backwards across DR floor, approx.. 5 feet

NE: SS=J (Past Non-Compliance): Failed to ensure 1 resident remained free from abuse & mistreatment

- *Resident with hx of trauma & Huntington's disease asked 2 CNAs for some chocolate mild saying "chocky milk"; resident attempted to retrieve milk from fridge in residents' DR but 2 CNAs instructed resident not able to get milk from fridge self & told resident staff would get milk if resident asked for it "correctly" in "big boy words"; resident continued to pull on fridge door & 2 CNAs stepped in between fridge & resident & physically obstructed resident from opening door resulting in struggle between staff & resident & during struggle resident kicked at staff, attempted to stand up from w/c & subsequently fell; CNA then grabbed resident by legs & turned resident around while staff locked fridge; as result of mistreatment resident attempted to choke self & verbalized intent to eventually kill self; facility's failure to ensure resident remained free from abuse & mistreatment placed resident in immediate jeopardy*
- *Abatement Plan:*
    - *All staff in-service on preventing ANE & reporting abuse*
    - *Updated resident's CP to include past trauma & relevant interventions for staff to follow*
    - *2 CNAs not permitted back in facility after incident & subsequently terminated*

F602 Free from Misappropriation/Exploitation

SE: SS=F: Failed to ensure effective system in place to prevent misappropriation of resident property when staff diverted controlled medications & could not account for numerous controlled/missing narcotic medications affecting 5 residents of facility affecting 5 residents & placing any resident who received controlled meds at risk for staff diversion of medication & potential untreated symptoms management that could negatively affect physical, mental & psychosocial wellbeing

- Review of FRI's hx for facility revealed 2 FRI investigations r/t drug diversions; 5 FRIs r/t potential drug diversion with interventions implemented; observed narcotic sheet for 1 resident noted PRN Oxycodone removed & signed out but did not contain date staff signed it out; Card of Ativan 0.5mg noted 3 "wasted" & narc sheet w/o date entry for 2 of wasted pills; surveyor noted resident did not have order for Ativan since 11-7-23 end date; failed to ensure effective system in place to prevent misappropriation of resident property when staff diverted controlled meds & could not account for numerous controlled/missing narcotic meds affecting 5 residents of facility & placing any resident who received controlled meds at risk for staff diversion of medication & potential untreated symptoms management that could negatively affect physical, mental & psychosocial wellbeing

F609 Reporting of Alleged Violations

SE: SS=L (Abated to I): Failed to ensure timely reporting of alleged abuse to State Agency or local law enforcement as required

- *Cited findings noted in F600; failed to ensure allegation of abuse was reported to Adm, State Agency & local law enforcement as required; on 3-19 resident allegedly fell out of w/c hurting face while on 1:1 observation in closed-door room with only 1 CNA present & resident repeatedly stated CNA struck resident; facility did not report allegation of abuse or protect resident from potential further abuse & CNA continued to work in facility until suspension 36 days after allegation*
    - *Abatement Plan*
        - DON & CNA suspended by Adm & Adm Nurse
        - Adm, Adm nurse, Adm staff, Maintenance director, dietary manager, housekeeping manager, SSD, therapy staff re-educated r/t ANE policy & processes by nurse consultant
        - Local police notified & arrived to initiate investigation
        - Staff completed head-to-toe assessment of resident with no changes in skin conditions found
        - Facility notified resident's responsible party/POA of incident that occurred 36 days earlier
        - Facility notified resident's physician of incident & received no new orders
        - Facility held Ad Hoc QAPI meeting
        - Facility completed & submitted FRI report to KDADS r/t event
        - Consultant nurse conducted review of documentation of current residents with no findings of abuse IDd by facility
        - Resident impacted by event had post-trauma assessment completed; SSD showed no avert changes from resident's prior assessment
        - Facility safe surveys conducted of 9 alert & oriented resident & no concerns or additional findings IDd by facility
        - Staff interviews with 6 current team members completed with no new concerns IDd by facility
        - All current team members re-educated at mandatory training r/t ANE
        - Resident would be documented on every shift x 72 hours & reviewed by Adm staff during morning clinical review on each day that followed documentation
        - Facility provided documentation that resident was followed by Physician Extender who specialized in psychiatric care
        - Facility provided documentation that when new team members would begin employment, would receive ANE training as part of initial onboarding & all other employees would receive ANE training annually & with any allegation of investigation r/t abuse

F610 Investigate/Prevent/Correct Alleged Violation

SE: SS=L (Remained at F): Failed to ensure 1 resident was free from abuse & neglect on 3-19 when 1 resident allegedly fell out of w/c hurting face while on 1;1 observation in closed room with 1 CNA & resident repeatedly stated CNA struck resident; facility did not investigate allegation of abuse or protect resident from potential further abuse, & CNA continued to work in facility until suspension 36 days after allegation; facility further failed to report allegation of abuse to SA or local law enforcement

- Cited findings in F600 & F609
- Abatement Plan:
    - DON & CNA suspended by Adm & Adm Nurse
    - Adm, Adm nurse, Adm staff, Maintenance director, dietary manager, housekeeping manager, SSD, therapy staff re-educated r/t ANE policy & processes by nurse consultant
    - Local police notified & arrived to initiate investigation
    - Staff completed head-to-toe assessment of resident with no changes in skin conditions found
    - Facility notified resident's responsible party/POA of incident that occurred 36 days earlier
    - Facility notified resident's physician of incident & received no new orders
    - Facility held Ad Hoc QAPI meeting
    - Facility completed & submitted FRI report to KDADS r/t event
    - Consultant nurse conducted review of documentation of current residents with no findings of abuse IDd by facility
    - Resident impacted by event had post-trauma assessment completed; SSD showed no avert changes from resident's prior assessment
    - Facility safe surveys conducted of 9 alert & oriented resident & no concerns or additional findings IDd by facility
    - Staff interviews with 6 current team members completed with no new concerns IDd by facility
    - All current team members re-educated at mandatory training r/t ANE
    - Resident would be documented on every shift x 72 hours & reviewed by Adm staff during morning clinical review on each day that followed documentation
    - Facility provided documentation that resident was followed by Physician Extender who specialized in psychiatric care
    - Facility provided documentation that when new team members would begin employment, would receive ANE training as part of initial onboarding & all other employees would receive ANE training annually & with any allegation of investigation r/t abuse

F623 Notice Requirements Before Transfer/Discharge

SE: SS=D: Failed to notify 2 residents/representatives of transfer or discharge to hospital & reasons for transfer in writing & in language & manner they understood affecting 2/3 residents reviewed for hospitalization

- Failed to notify resident &/or representative with written notice specifying when resident hospitalized & reason for hospitalization for 2 residents

F625 Notice of Bed Hold Policy Before/Upon Transfer

SE: SS=D: Failed to provide a copy of facility bed hold policy to 2 resident &/or representative with written notice specifying duration & cost of bed hold policy at time of residents' transfer to hospital

- Failed to notify 2 residents &/or representatives with written notice specifying duration & cost of bed hold policy at time of residents' transfer to hospital for 2 residents

F636 Comprehensive Assessments & Timing

SE: SS=E: Failed to complete or complete an analysis of CAA triggered on residents' MDS for 4 residents

- CAA lacked analysis for further investigation; CAA lacked analysis of findings r/t CAA's noted were merely a restatement of codes themselves rather than analysis to underlying issues as required to develop a CP for individual resident's root causse of triggered areas; failed to develop comprehensive assessments by failure to complete CAAs for further investigation & development of comprehensive CP for 4 residents; failed to complete accurate comprehensive MDS & analysis of findings on residents with potential to lead to negative psychosocial effects r/t safety & uncommunicated needs

F641 Accuracy of Assessments

SE: SS=E: Failed to accurately completed MDS for 3 residents r/t inaccurate documentation of restraints, 1 resident r/t use of w/c & O2 usage, 1 resident r/t inaccurate documentation of falls, urinary catheter & contracture to resident's hand, 1 resident r/t inaccurate documentation of falls & 1 resident r/t no CAA development with potential to lead to uncommunicated need for care & services to meet each individual residents' needs

- Failed to accurately complete MDS for resident with potential to lead to uncommunicated need for care & services to meet each resident's needs for multiple residents

F676 Activities of Daily Living (ADLs)/Maintain Abilities

NE: SS=D: Failed to ensure 1 resident received required assistance with ADLs placing resident at risk for complications including skin breakdown, discomfort & impaired psychosocial wellbeing

- Resident with dementia, dysplasia oropharyngeal phase, combined systolic & diastolic heart failure, HTN, anxiety; MDS documented resident dependent on 2 staff for all toileting needs, positioning, transfers & all ADLs; Observed resident with 2 staff in room at 8:17am, at 10:23 resident in same position; at 11am 2 staff entered & picked up stuffed animal that had fallen to floor & at 11:20 1 staff left room &

left resident in same position & at 11:36am staff propelled resident to DR where remained until 1:35pm; failed to ensure 1 resident was assisted with ADLs as directed in CP placing resident at risk for complications including skin breakdown, discomfort & impaired psychosocial wellbeing

F679 Activities Meet Interest/Needs Each Resident

NE: SS=D: Failed to provide 1 resident opportunity to go to activities resident enjoys placing resident at risk for decreased psychosocial wellbeing

- CP instructed staff to take resident to all spiritual activities & music-related activities with goal for resident to engage in activities 5x/wk; observed staff did not offer or invite resident to attend planned Bible Study; staff did not offer or encourage resident to attend music activity held; failed to ensure resident was invited, encouraged & assisted to go to activities resident enjoyed placing resident at risk for decreased psychosocial wellbeing

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=E: Failed to ensure safe environment free from hazardous materials for 9 cognitively impaired independently mobile resident; failed to ensure environment free from avoidable accidents for 1 resident who was injured during lift-assisted transfer placing residents at risk for preventable accidents & injuries

- Observed multiple rooms with hazardous chemicals accessible to residents including laundry room, unlocked spa room; unsupervised supplemental O2 storage rack with 10 O2 cylinders & accessible; failed to ensure safe environment free from hazardous materials & out of reach from 9 cognitively impaired independently mobile residents placing residents at risk for preventable accidents & injuries
- Incident Report documented resident received injury while being transferred with Hoyer lift when resident placed hand in between 2 moving levers of lift & suffered quarter-size skin tear on top of hand; failed to ensure safe Hoyer lift practices were followed during 1 resident's Hoyer transfer resulting in avoidable accident placing resident at risk for preventable accidents & injuries & resulted in minor injury

NE: SS=G: Failed to utilize safe heat therapy practices for 1 resident resulting in 2nd degree burn on resident's knee; additionally failed to ensure safe environment r/t maintaining resident's w/c & bed fall-prevention alarm placing resident at risk for preventable accidents & injuries

- Incident Report documented therapist staff applied moist heating pack to resident's knee & heating pack lacked protective cover & therapist improvised using multiple layers of towels; therapist completed treatment, removed towels & noted resident acquired blister with clear fluid on outside of knee from heating pack; therapist reported burn to nursing staff, practitioner & representative; video documented therapist applied gait belt around towels on knee; heat therapy immediately suspended by facility until protective covers for heating packs could be found or ordered; observed blister no longer present; failed to utilize safe heat therapy practices during therapy for 1 resident resulting in 2nd degree burn on resident's knee
- Observed resident confused & attempting to transfer self multiple times & pressure pad tested & did not work appropriately; failed to ensure safe environment r/t maintaining resident's w/c & bed fall prevention alarm placing resident at risk for preventable falls & injuries

F755 Pharmacy Services/Procedures/Pharmacist/Records

NE: SS=E: Failed to ensure accurate reconciliation of controlled medications was completed consistently placing residents at risk of medication misappropriation, diversion, & ineffective medication regimens

- Controlled med record log from 4-20 to 5-6 lacked evidence of 2 nurse signatures indicating reconciliation was completed on 10/72 opportunities; failed to ensure accurate reconciliation of controlled meds was completed consistently placing residents at risk of medication misappropriation, diversion & ineffective medication regimens

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure physician-documented rationale for extended use of PRN psychotropic med for 2 residents placing residents at risk for unnecessary medication administration thus leading to possible harmful side effects

- POS for Lorazepam 2mg po TIC for agitation, anxiety & restlessness r/t Alz disease x 6 months & Lorazepam oral concentrate 0.25mL q 22 hours PRN for mild to moderate anxiety & 0.5mL q 2 hours PRN for moderate to severe anxiety or restless for 6 months; EMR lacked evidence of physician rationale for extended duration for PRN Lorazepam; failed to ensure physician documented rationale for extended duration of use of PRN Lorazepam for 1 resident placing resident at risk for potential of unnecessary med administration leading to possible harmful side effects
- POS for Lorazepam 0.5mL PRN q hr for restlessness &/or anxiety for 6 months; EMR lacked evidence of physician-documented rationale for extended duration of 1 resident's PRN Lorazepam; failed to ensure physician documented rationale for extended duration for PRN Lorazepam for 1 resident placing resident at risk for potential of unnecessary med administration leading to possible harmful side effects

F759 Free of Medication Error Rates 5% or More

SW: SS=E: Failed to prime insulin KwikPens prior to administration to 1 resident resulting in medication error rate of 5.06% & placed residents who received insulin at risk for medication errors

- Observed medication administration revealed LN turned dial on resident's Humalog KwikPen & Lantus KwikPen but did not prime either pen; failed to ensure residents received medications with an error rate of 5% or less when staff failed to prime a Humalog & Lantus KwikPen before administration resulting in error rate of 6.06% & placed residents who received insulin at risk for medication errors

F801 Qualified Dietary Staff

SW: SS=F: Failed to employ a full-time CDM for all residents residing in facility & received meals from kitchen placing residents at risk for inadequate nutrition

- Failed to employ a full-time CDM for all residents residing in facility placing resident at risk for inadequate nutrition

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NE: SS=D: Failed to ensure dietary staff prepared food that conserved nutritive value, flavor & appearance when preparing pureed foods placing resident who received pureed foods at risk for decreased palatability & impaired nutritional status

- Observed staff prepare pureed foods & staff used water to prepare pureed foods & foods appeared runny & lacked attractive appearance; staff reported software doesn't provide recipes for pureed foods; meats with no color & did not appear or smell like barbecued pulled pork; lima beans with appearance of green soup-like consistency; failed to ensure dietary staff prepared food that conserved nutritive value, flavor & appearance when preparing pureed foods placing residents who received pureed foods at risk of decreased palatability & impaired nutritional status

F807 Drinks Available to Meet Needs/Preferences/Hydration

NE: SS=D: Failed to provide 1 resident's therapeutic diet as ordered by physician placing resident at risk for complications including choking

- POS for nectar thick liquids; observed staff placed cup of thin water in resident's room & no thickened liquids visible in room on multiple occasions; failed to provide 1 resident's therapeutic diet as ordered by physician placing resident at risk for complications including choking

F812 Food Procurement, Store/Prepare/Serve-Sanitary

NE: SS=E: Failed to ensure staff stored, prepared & served food items & maintained freezer unit in accordance with professional standards for food service safety placing residents at risk for foodborne illness & cross-contamination

- Observed freezer with opened box & bag of meat strips not in sealed bag & lacked open date & had frozen water icicles that had dropped onto opened box of food below it
- Observed pureed foods preparation & staff failed to properly wash & sanitize Robo coupe container & lid between each food item pureed

NE: SS=F: Failed to follow sanitary dietary standards r/t cleaning, food storage, equipment storage & food preparation practices placing residents at risk for foodborne illnesses & food safety concerns

- Observed kitchen with utensil storage rack stored upward; fryer station with old crumbs & food particles covering outside of fryer & side of baking oven next to fryer; dry food storage with old pieces of food on floor throughout storage room
- Observed dietary staff & donned gloves w/o completing hand hygiene; during puree prep placed scoop face down directly on dirty food prep area w/o clean barrier then used scoop to transfer pureed food into food bin
- DR with opened, unlabeled ice cream & other food items
- Observed freezer with opened, undated food items

F849 Hospice Services

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

- CP lacked documentation r/t hospice equipment, medications, services, & scheduled visits from hospice staff; failed to ensure collaboration between nursing home & hospice services to ID hospice-supplied services, supplies, medication, & equipment for 1 resident placing resident at risk for delayed services & uncommunicated care needs

F880 Infection Prevention & Control

NE: SS=E: Failed to ensure infection control standards were followed during shared equipment use, transport of clean linens & storage of 1 resident's O2 therapy equipment placing residents at risk for infectious diseases

- Observed resident BR with supplemental O2 face mask & 2 O2 connector ports stored on paper towel on shared sink
- Observed LN failed to sanitize shared BP equipment between taking residents' vitals
- Observed staff pushed Hoyer lift into 1 resident's room then transferred resident from bed to w/c & lift then pushed back out to hallway w/o sanitizing machine before or after use
- Observed large, uncovered cart carrying towels transported through hallway