May, 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

January, 2024

F550 Resident Rights/Exercise of Rights

SW: SS=D: Failed to ensure dignity/privacy of 1 resident with catheter/urine collection bag with lack of cover for urine collection bag to prevent full visualization of resident's urine

- Failed to ensure dignity/privacy of resident with lack of catheter/urine collection bag cover to prevent full visualization of resident's urine to anyone passing or entering room

NE: SS=E: Failed to ensure dignified dining experience for residents choosing to eat in rooms when facility provided plastic silverware with room trays placing residents at risk for undignified & enjoyable dining experience

- Staff reported loss of regular silverware then not having enough silverware available & the dietary budget; Observed room trays served with plastic silverware; failed to ensure dignified dining experience for residents who chose to eat in rooms by only providing plastic silverware placing residents at risk for undignified & unenjoyable dining experience

F584 Safe/Clean/Comfortable/Homelike Environment

SW: SS=J (Abated to E): Failed to maintain comfortable & safe temperature levels of 71 degrees or greater for 10 residents when facility furnace quit working mid-morning on 1-12-24; furnace supplied heat to ¼ wings covering 6 resident rooms with 10 residents affected

- *Following breakdown, repairment came to facility that afternoon & determined part needed to repair furnace required ordering & facility placed portable infrared space heaters in resident rooms until 1-16-24 at 2:04pm at which time Fire Marshal instructed facility to remove space heaters; 1/10 residents moved to another room on another wing while 9 other residents affected chose to remain in rooms; failed to monitor & document temps of resident rooms until 1-17-24 after surveyor was on site & failed to monitor affected resident body temps until 1-18-24; outdoor temps from 1-12 thru 1-17 ranged from -2 degrees to 40 degrees F with maximum wind speeds from 16 to 30 mph with windchill in effect due to -30 degrees F windchill factor; on 1-17 at 4:30pm 4/5 resident rooms affected had temps below 71 degrees F; failure to ensure resident areas maintained temp of at least 71 degrees F placed residents who remained in rooms in immediate jeopardy & at risk of hypothermia*
- *Plan to address heating outage included:*
  - *Charge nurse or delegate would check temps of each room hourly until furnace fixed*
  - *If resident gets uncomfortable, resident will be offered to move to different room on different wing*
  - *Resident offered extra blankets as they would allow*
  - *Resident & staff educated on keeping doors open to allow heat to move thru rooms except when cares being provided*
  - *Staff encouraged to dress residents appropriately for weather as residents would allow*
  - *Staff encouraged to use other exit doors to decrease drafts*
- *Abatement Plan:*
  - *Facility notified affected physicians & residents were offered to temporarily change rooms until furnace fixed & residents who elected to remain in affected rooms encouraged to keep doors open to room except during cares for heat from hallway could circulate into room; residents dressed warmly & offered extra blankets to provide warmth & encourage to keep extremities & head covered for warmth & encourage to drink fluids*
  - *Facility began monitoring temps of 6 affected rooms*
  - *Regional VP re-educated facility Adm, DON & maintenance director on requirement to maintain comfortable & safe temps of 71 degrees or greater & facility policy to monitor room temps when facility heating equipment is not working*
  - *Facility complete facility-wide audit of room temps to establish room temps maintained at 71 degrees F*
  - *Maintenance director/designee will monitor temps in affected rooms hourly to establish facility maintains room temps of 71 degrees during duration of furnace being inoperable; facility will continue to monitor temps every 4 hours for first 24 hours after heater is back in working order to establish room temps of 71 degrees F is being maintained*
  - *Facility implemented temporary heater to maintain room temps of 71 degrees F*

NE: SS=E: Failed to ensure residents were provided safe, clean, comfortable & homelike environment placing residents at risk for decreased psychosocial wellbeing & impaired safety & comfort for affected residents

- Observed dirty towel & washcloth draped over handrail outside 1 room; Room with large area of wall with missing paint & scratched/torn up; strong urine odor from hall outside 1 room & clothing with strong urine smell as well as bed linens; Main hall with wall next to elevator with large hole containing exposed wiring above elevator's control button; room with large discolored & sticky area on floor next to bed with smashed food particles in carpet that resident stated was food from previous night's dinner; hallway with water stains on ceiling; hall with several small holes in carpet; door & wall with brown spots of splash across door; common area with 3 upholstered armchairs smelled of urine; Adm staff stated facility awaiting permits & approval for massive renovations

F600 Free from Abuse & Neglect

SW: SS=J (Abated to D): Failed to provide safe environment when staff did not provide adequate supervision to prevent resident-to-resident sexual abuse

- *ON 12-10-23 staff found cognitively intact independent resident kissing another resident who had severe cognitive impairment who lacked ability to consent; staff reported resident had hand inside other resident's shirt & other resident had hand inside resident's pants; staff separated residents; practice placed other resident in immediate jeopardy; during interview resident denied incident; NN lacked information r/t sexual abuse between 2 residents & NN lacked notification of family r/t resident-to-resident sexual abuse; failed to provide a safe environment when staff did not provide adequate supervision to prevent resident-to-resident sexual abuse on 12-1023 when staff found cognitively intact, independent resident kissing other resident, a resident with severe cognitive impairment who lacked ability to consent; staff reported resident had hand inside of other resident's shift & other resident had hand inside resident's pants placing other resident in immediate jeopardy*
- *Abatement Plan:*
  - *All staff educated r/t resident-to-resident abuse; ANE & reporting of inappropriate sexual behaviors; all staff to receive education prior to reporting to designated work area*
  - *During staff education, staff will be asked if they are aware of any residents who they feel have potential to sexually abuse others'*
  - *Review of all residents' medical record conducted including behavior notes, IDT notes, CP entries & dx's*
  - *Further actions will be taken to increase monitoring or instituting appropriate CP interventions to mitigate potential for sexual abuse of at-risk-residents*
  - *Monitoring nursing will read all progress & behavior notes to ID sexually inappropriate behavior for all residents with potential for inappropriate sexual behaviors; during routine rounds ED/DON will interact with residents, staff providing opportunity to report incidents of sexual abuse*

F602 Free from Misappropriation/Exploitation

SW: SS=K (Abated to E): Failed to ensure a system in place for accurate accounting & reconciliation of resident fund accounts to prevent staff misappropriation & exploitation

- *Facility kept 14 manilla envelopes, each labeled with resident's name for personal funds; observed envelopes with no paper cash in any of the envelopes; 1 resident appointed facility as payee & responsible party for finances & facility kept resident's mone in bank account with debit card available; facility employee used resident's bank card to withdraw money from resident's bank account & made numerous unauthorized purchases w/o resident's consent; facility failed to record & track money in & out of resident fund accounts & lacked records of current or past balances placing 15 residents with personal fund accounts in immediate jeopardy & at risk for negative psychosocial impact in safety & security; Adm terminated SSD; next day staff entered locked cabinet & all resident funds, petty cash & money card were gone & discovered SSD did not account for resident funds since SSD began SSD position in 5-2022; MULTIPLE purchases & cash withdrawals noted on debit card; & MULTIPLE grocery store receipts purchased on bank card noted with use of "frequent shopper card" in SSD's name; failed to ensure 1 resident who facility was payee & responsible party for finances, remained free from misappropriation & exploitation when employee of facility used resident's bank card to withdraw money from resident's bank account & make unauthorized purchases w/o resident's consent; additionally facility failed to protect 15 residents, all of which had facility held resident fund accounts from misappropriation of resident funds; further failed to have system in place for accurate record keeping & reconciliation of resident fund accounts & lacked records of current or past balances placing 15 residents in immediate jeopardy & at risk for negative psychosocial impact to safety & security*
- *Abatement Plan:*
  - *AP terminated from employment; Adm concluded findings of misappropriation of funds by ex-employee & all residents fund accounts were suspended until further investigation by local law enforcement & KDADS was completed; resident's debit card was cancelled & new one issued, along with Adm staff becoming resident's new payee*
  - *Facility implemented new updated Management of Resident Funds policy; new resident envelopes created with 2-person signature for any cash in or cash out; policy & resident fund envelopes created after report made to local authorities, KDADS, Insurance & facility attorney; old resident fund envelopes reconciled by Adm nurse & local police chief*
  - *Adm staff in-services & re-educated all staff including education on facility ANE policy along with Kansas Ombudsman Tip Sheet over ANE & management of Resident Fund policy*
  - *Plan of Action for Managing Resident Personal Funds: implementation of new management of resident funds policy & BOM & Adm will oversee all resident funds & BOM will be main person to receive & disperse funds along with keeping receipts & balancing accounts & Adm will oversee accounts & do balance checks with BOM on 30th of every month or last Friday of every month along with signatures for approval; every quarter each resident/DPOA will receive statement of residents' personal account & will sign off on it for approval; Adm as payee for 1 resident will have BOM oversee balance & transactions for resident's account day after Adm receives bank statement for month & Adm, BOM & resident will sign off on balance of resident's account*

F657 Care Plan Timing & Revision

SW: SS=D: Failed to review & revise CP for 3 residents r/t revising CP to include intervention following 1 fall; 1 resident r/t revising CP to include staff instruction for verbalizations of suicidal tendencies; & 1 resident r/t revising CP to include interventions following multiple falls

- Failed to include preventative CP interventions r/t dependent resident's suicidal tendencies
- Failed to review & revise CP for dependent resident who experienced fall to prevent further falls
- Failed to initiate/implement new immediate, appropriate interventions on resident's CP to prevent further falls for cognitively impaired resident who had multiple falls

NE: SS=D: Failed to revise 1 resident's CP to reflect needs r/t type of w/c needed; failed to revise 1 resident's CP to ensure interventions listed matched resident's current needs & goals; failed to ensure 1 resident's CP revised to address antipsychotic medication use placing 3 residents at risk for impaired care due to uncommunicated care needs

- CP documented resident in high-back w/c & observed resident in low-back w/c; failed to revise CP to reflect needs r/t type of w/c needed placing resident at risk for impaired care due to uncommunicated care needs
- Failed to revise 1 resident's CP to ensure interventions listed matched resident's current needs & goals placing resident at risk for inappropriate care r/t uncommunicated care needs when CP documented resident with mat on floor next to bed & often preferred to lay directly on it rather than bed because of cooler temps; observed no floor mats next to resident's bed; LN stated resident did not need mat in current room
- POS for Risperdal, Effexor & Ativan; CP lacked evidence of interventions or monitoring to address antipsychotic drug use including direction to staff on associated side effects to monitor; failed to revise 1 resident's comprehensive CP to include directions to staff r/t antipsychotic medication & associated side effects & risks placing resident at risk for complications r/t antipsychotic medication due to uncommunicated care needs

F676 Activities of Daily Living (ADLs)/Maintain Abilities

NE: SS=D: Failed to provide necessary assistive care & services to 1 resident placing resident at risk for poor hygiene, decreased self-esteem & impaired dignity

- CP documented resident required extensive assist from 2 staff members for dressing; observed resident in bed on back with oat meal on hospital gown & face after staff removed breakfast tray from room; next day observed resident with oatmeal stain from previous day on gown after staff removed breakfast try from room; next day observed oatmeal from previous 2 days on gown; failed to ensure staff assisted resident with changing soiled hospital gown placing resident at risk of poor hygiene, decreased self-esteem & impaired dignity

F684 Quality of Care

SW: SS=D: Failed to ensure 1/5 resident reviewed received laxatives for lack of BM as ordered by physician

- EMR documented resident w/ bowel pattern of lack of BM for 4-5 days & record documented resident had lack of BM for 7 days; failed to monitor resident's BMs for constipation patterns & administer laxatives as ordered by physician to ensure optimal bowel hygiene

NE: SS=D: Failed to ensure compression glove was provided for 1 resident's hand placing resident at risk for increased hand edema, pain & skin related difficulties

- CP documented resident to wear compression glove on hand during day & removed at night; EMR lacked evidence compression glove was provided & placed as directed; observed resident with hand slightly swollen & lacked compression glove on multiple occasions; LN stated resident did not have compression glove; failed to ensure compression glove provided for 1 resident's hand placing resident at risk for increased hand edema, pain & skin related difficulties

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

NE: SS=D: Failed to ensure pressure-reducing measures were placed on 1 resident's bilateral lower extremities & failed to ensure staff implemented appropriate infection control practices during wound care placing residents at risk of development of PUs, wound worsening & complications r/t infections

- Resident with skin impairment risk & developed unstageable PU during observation period; CP documented resident was to wear bilateral heel float boots when in bed & staff to ensure boots on when in bed; POS for specific wound care treatment orders to heel; observed resident in bed with soft touch call light clipped to cord on wall out of resident's reach & heels rested directly on mattress; observed Adm nurse perform wound care: placed heel directly on pressure ankle foot orthotic boot & heel started to drain then lifted heel from PRAFO boot for physician to evaluate PU on heel & placed undressed heel directly back into PRAFO boot & strapped boot back onto resident's foot & ankle the Adm nurse & CNA transferred resident into bed with sit-to-stand lift & CNA removed PRAFO boot from foot & placed resident's heel directly onto bed then covered resident with blanket; CNA stated sometimes placed pillow under resident's lower extremities if facility had extra pillows; failed to ensure pressure-reducing measures placed on resident's bilateral lower extremities & ensure staff implemented appropriate infection control practices during wound care placing residents at risk of development of PUs, wound worsening & complications r/t infections

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to ensure 1 resident's carrot was applied as directed to prevent avoidable reduction of ROM &/or mobility of hand placing resident at risk for further decline & decreased ROM or mobility

- CP documented resident's hand contracted & directed staff to ensure resident's carrot in hand 2x/day; POS for carrot to be placed in hand 2x/day for contracture with orange carrot in left hand every morning & to change to a blue carrot at bedtime; TAR documented resident

wore carrot to hand each day & night shift & lacked evidence resident refused to use carrot for hand; observed resident w/o carrot on multiple occasions; failed to ensure resident's carrot applied as directed to prevent avoidable reduction of ROM /or mobility of hand placing resident at risk for further decline & decreased ROM or mobility

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=G: Failed to thoroughly investigate to ID causal factors of falls &/or initiate/implement immediate, appropriate interventions to prevent further falls for 3 residents including 1 resident r/ lack of w/c pedals for support while staff propelled resident; 1 resident who experienced fall with inappropriate intervention & multiple falls experienced by cognitively impaired resident with most recent fall resulting in major injury (2 fx'd vertebrae)

- Resident experienced incontinence r/t overactive bladder & CP lacked instruction on when to toilet resident; resident with fall & investigation failed to ID causal factors to determine immediate & appropriate intervention to prevent further falls; failed to thoroughly investigate to ID causal factors of fall &/or initiate/implement new immediate, appropriate interventions to prevent further falls for cognitively impaired resident who had multiple falls, 1 of which resulted in 2 fx'd vertebrae
- Failed to initiate appropriate fall intervention following injury fall for dependent resident to prevent further falls when staff failed to obtain UA which was post-fall intervention
- Failed to ensure proper w/c seating/positioning/foot pedals to prevent accidents for resident when staff aided with propelling to avoid injury as resident's feet skimmed along directly touching on floor under w/c

NE: SS=G: Failed to ensure adequate number of staff to provide assistance during mechanical lift transfer to prevent accidents for 1 resident; as result resident sustained mid to lower coccyx fx placing resident at risk for increased pain & further impaired mobility

- *CP lacked direction r/t number of staff to assist with resident's sit-to-stand or Hoyer transfers; investigation documented resident requested to transfer into bed & was assisted by CNA who used sit-to-stand lift for transfer & during transfer resident fell to ground; resident reported informed CNA that resident was falling but CNA failed to slow down; CNA documented being frustrated & overwhelmed; resident reported to LN that CNA went too fast with transfer & resident's legs failed to support resident & resident could not hold self up; failed to implement safe transferring with mechanical sit-to-stand lift for 1 resident which resulting in fall & resident sustained mid to lower coccyx fx also placing resident at risk for increased pain & further impaired mobility*

NE: SS=D: Failed to ensure 1 resident's non-slip floor strips remained in place next to bed per CP; further failed to ensure 1 resident had call light within reach placing residents at risk for preventable falls & injuries

- Observed bed lacked non-slip strips on right side & left side's strips were directly under bed; resident reported bed may have been moved over strips; failed to ensure 1 resident's non-slip floor strips remained in place next to bed placing resident at risk for preventable falls & injuries
- CP documented staff would place resident's call light within reach whenever resident in room; observed soft touch call light clipped to cord on wall out of resident's reach & bilateral heels rested directly on mattress; failed to ensure soft touch call light was within reach when resident was in room placing resident at risk of falls

NW: SS=J (Past Non-Compliance): Failed to ID likely avenues of exit including windows & failed to ensure windows were secured to prevent 1 resident who was severely cognitively impaired & high risk for elopement from exiting facility through window

- *On 12-20-23 at 8pm CNA assisted resident to bed then began constant surveillance of resident's room from nurses' station due to resident's high elopement risk & multiple attempts to elope; at 9:10pm CNA observed resident outside front door, knocking over patio furniture; temp outside was 39 degrees F; staff assisted resident back into facility & noted resident w/o injuries but was cool to touch; staff returned resident to room & noted resident's window was open & lacked screen; facility failed to ID & secure likely avenues for exit for 1 resident who was at high risk for elopement & falls; as a result of failure, resident eloped from facility via bedroom window placing resident in immediate jeopardy*
- *Abatement Plan:*
  - *All residents at risk for elopement had windows fixed with shims to only allow windows to open 3-4 inches*
  - *Completed facility-side door check to ensure all alarmed doors were in proper working order*
  - *All staff educated on elopement policy & resident's elopement incident before working next shift*
  - *All residents' "Elopement Assessments" & CPs reviewed for accuracy & appropriateness*
  - *Elopement book reviewed to ensure accuracy*
  - *Unscheduled QAPI meeting held to discuss incident*

NW: SS=J (Past Non-Compliance): Failed to adequately ID elopement risk & failed to ensure interventions in place to prevent elopement were fully functional placing 1 resident in immediate jeopardy

- *Cognitively impaired resident on secured memory unit with hx of wandering despite latest elopement assessment performed resident at low risk for elopement; at 12:05pm resident moved couch & table away from window, opened window & screen & exited facility via window; alarm on window did not sound & resident preceded to walk down steep hill to sidewalk which went around building towards front of building; CNA observed that resident was outside from kitchen window; CNA continued to watch resident from window while another staff went outside & talked resident into coming back into building; staff assessed resident w/o injuries*
- *Abatement Plan:*
  - *Education with all staff r/t Elopement Policy/Missing Elder Policy*
  - *Initiated window checks/alarm checks on all windows on memory care unit*
  - *Elopement Drill performed*
  - *Education presented r/t Elopement Risk Binder at nurses' desk*

- *Screws placed in outside windows to only allow windows to raise 4 inches*

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to provide catheter care that met standards of practice when staff failed to securely anchor 1 resident's suprapubic catheter tubing to abdomen placing resident at risk for catheter dislodgement & potential injury

- Resident with suprapubic catheter; CP documented resident unable to follow catheter protocol; observed resident coming out of room with catheter bag hanging out of back of pants & bag on floor then drug catheter bag down part of hallway before resident picked up bag & carried it with resident in w/c; observed LN performed wound & catheter care & no anchor to secure catheter tubing in place & tubing hung freely from abdomen w/o any way for it to be further secured to body; LN stated resident did not have order for anchor because it was a newly placed suprapubic catheter; failed to secure or anchor resident's suprapubic catheter to abdomen placing resident at risk for catheter dislodgement & potential injury

F692 Nutrition/Hydration Status Maintenance

NE: SS=D: Failed to ensure resident was provided physician-ordered supplemental shakes &/or failed to monitor intake for supplement placing resident at risk for additional weight loss & related complications

- EMR documented resident with 18.47% loss from previous month; no order for weights; POS for liquid house supplement BID; RD recommendation to add 4-oz house shake BID, monitor weights weekly & plan to have nursing evaluate weight accuracy; TAR lacked evidence supplemental shakes were provided &/or intake monitored; observed resident at table eating & no shake provided to re sident; failed to ensure resident was provided physician ordered supplemental shakes &/or failed to mon itor intake for nutritional supplements placing resident at risk of additional weight loss & related complications

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

NE: SS=F: Failed to provide RN for at least 8 consecutive hours, 7 days a week placing all resident i n facility at risk for decreased quality of care

- RN coverage for 2023 reviewed & 30 shifts in 2023 lacked RN coverage for 8 consecutive hours; facility unable to provide evid ence of 8 consecutive hours of RN coverage for noted dates; failed to provide RN for at least 8 consecutive hours, 7 days/wk placing all residents in facility at risk for decreased quality of care

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

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

- Review of personnel records revealed 5/5 CNAs with no yearly performance evaluations available; Adm staff stated facility did not do yearly performance evaluation for employees & if an issue with a staff member it would be addressed at the time but did not otherwise do yearly performance evaluations; failed to provide 5/5 CNA staff reviewed had required yearly performance evaluations compl eted placing residents at risk for inadequate care

F756 Drug Regimen Review, Report Irregularities, Act On

SW: SS=E: Failed to follow up on pharmacy recommendations in timely manner for 2/5 residents & failed to ensure pharmacy revi ews for October 2023 & November 2023 for 5 sampled residents

- Failed to follow up on pharmacy recommendations to ensure resident did not experience adverse effects of medications for 3 residents; MRR not followed up by physician or facility until 31 days after recommendation made when physician DC'd medication; MRR ID'd facility lack of follow up to MRR dated 7-18-23; Resident lacked MRR for 9-23; Resident lacked MRR for 10-23; Failed to act on ID'd irregularities by consulting pharmacist (CP) in timely manner; failed to ensure resident received MRR by pharmacist as req uired to monitored for med irregularities
- Resident lacked MRR for 9-23 & 10-23; failed to ensure resident received MRR by pharmacist as required to monitor for any medication irregularities

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported resident's PRN Ativan lacked 14 day stop date or specified duration with rationale placing resident at risk for ineffective treatment & unnecessary side effects

- POS for Ativan q 8 hrs PRN anxiety & order lacked stop date; MRR for 2 months lacked ID/re commendation for resident's PRN Ativan order; CP stated medication started by hospice services r/t anxiety; failed to ensure CP ID'd & reported 1 resident's Ativan lacked stop date placing resident at risk for ineffective treatment & unnecessary side effects

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to provide a 14-day stop date or intended duration of therapy & rationale for extended use r/t 1 resident's PRN Ativan placing resident at risk for ineffective treatment & unnecessary side effects

- Cited findings noted in F756 r/t resident on Hospice services with POS for PRN Ativan w/o stop date; failed to provide 14-day stop date or intended duration of therapy & rationale for extended use of resident's PRN Ativan medication placing resident at risk for unnecessary side effects

F759 Free of Medication Error Rates of 5% or More

NE: SS=D: Failed to ensure medication error rate did not exceed 5% when staff failed to ensure 1 resident's Keppra was admini stered as ordered; failed to ensure insulin pen was appropriately primed before insulin administration to 2 residents resulting in medication error rate of 8.8 2%

- Observed CMA did not administer 1 resident's physician-ordered Keppra as it was "unavailable"; observed LN prepared to administer 1 resident's Novolog insulin & screwed new needle onto insulin pen & dialed in ordered 1`3 units on pen dial but failed to prime pen bef ore administration of insulin; observed LN Novolog pen & opened new insulin needle & screwed it onto top of pen & turn ed dial on pen to 20 units & administered insulin w/o priming insulin pen; LN stated had never primed needle before administration of insulin & wa s not certain what facility policy stated r/t priming pen; failed to ensure medication error rate was less than 5% placing residents at risk for avoidable medication complications

F760 Residents are Free of Significant Med Errors

SW: SS=J (Past Non-Compliance): Failed to prevent significant med error for 1 resident when facility staff prepared & wrongly administered 1 resident's meds which included high risk meds to another resident

- *CMA prepared resident's meds then asked other resident if ready for med & resident nodded yes so CMA administered 1 resident's meds to another resident; CMA though resident resembled picture in MAR for other resident; shortly after administration of meds; CAM heard Adm nurse speak to resident & realized had administered other resident's meds to resident; resident had change in condition, BP dropped & required emergency medical service intervention; staff transferred resident to hospital via EMS & resident admitted to observation for hypotension; CMA failed to implement standards of practice r/t medication administration when failed to verify right medicati on given to right residents placing resident in immediate jeopardy*
- *Abatement Plan:*
  - *Facility removed CMA from med cart & educated on 5 rights of medication pass*
  - *Facility educated all staff who pass meds on 5 medication rights before passing meds again*
  - *Facility interviewed 3 residents for any concerns with receiving another resident's meds w/o issues*
  - *Facility took new photograph for resident for profile picture in EMR*
  - *Adm Nurse conducted audit of all resident pics to ensure all resident pics were current photos*
  - *Adm Nurse would supervise CMA who made error while completing med pass to ensure CMA could give meds safely before allowed to pass meds alone*
  - *Adm Nurse would conduct med pass audits, 2x/wk for 2 months to ensure compliance with safe med pass following med rights*

F801 Qualified Dietary Staff

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

- Failed to employ 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

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

- Observed can opener with buildup of dried on food substance on cutting tip; cutting boards heavily grooved; inside of microwa ve with dried food on top, sides & bottom; plastic container with buildup of food substances & dust; fridge with spilled, dried chocolate milk in several places on inside; ice machine vents with heavy buildup of dust

NE: SS=F: Failed to ensure proper transportation of food items from kitchen to kitchenette; also failed to ensure that food items were properly stored in safe & sanitary manner after original sealed package had been opened & food items were not placed in sealed contain er/storage bag with proper labeling & date placing all residents who ate food from facility at risk for foodborne illness

- Observed unlabeled ham & cheese in fridge; observed dietary staff wore gloves as prepared grilled cheese sandwich & reached i nto pocket with gloved hands to remove phone then placed phone back into pocket & continued to prepare grilled cheese sandwich with soiled gloves; observed dietary staff gathered food items into arms & held items against shirt to relocate items to kitchenett e; failed to ensure safe food preparation & servicing area placing residents at risk for contamination & foodborne illness

F851 Payroll Based Journal

SW: SS=F: Failed to electronically submit PBJ complete & accurate direct care staffing information including information for agency & contract staff, based on payroll & other verifiable & auditable data in uniform format according to specifications established by PBJ r/t LN staff coverage 24 hrs/day

- PBJ revealed lack of LN for 24 hrs/7 days/wk on 14 occasions in 3rd quarter; review of time sheets revealed facility had required LN each day cited but facility reported inaccurate staffing data as required; 9 days in 4th quarter & time sheets revealed facility had LN staffing on cited days; failed to electronically submit to CMS complete & accurate direct care staffing information i ncluding information for based on payroll & other verifiable & auditable data in uniform format according to specifications established by PBJ r/t LN staff 24/ 7

F880 Infection Prevention & Control

SW: SS=D: Failed to maintain effective infection control program to prevent cross contamination & prevention infection r/t urinary catheter care & services provided to 1 resident with urinary catheter/urine collection bag

- Observed resident with indwelling catheter & catheter bag hanging on outside of trash can wi th urine collection bag in direct contact with floor; failed to ensure resident's urinary catheter bag remained w/o direct contact with floor to prevent cross contamination & infections

NE: SS=E: Failed to ensure infection prevention standards were followe d r/t disinfecting shared equipment, urinary catheter care, laundry services & wound treatment practices placing residents at risk for infectious diseases

- Observed bag of soiled linen on floor in resident room; observed 2 CNAs transferred resident from Bro da chair via Hoyer lift & while transferring resident to bed staff placed Foley catheter directly on resident's bed with urine tube backflowing into body as adjusted resident's positioning in bed them placed bag off side of bed & staff failed to complete h and hygiene or change gloves while handling catheter bag or repositioning then later revealed resident's catheter bag on floor
- Observed LN prepped glucometer & failed to put barrier under glucometer before it was placed on med cart then used glucometer to test resident's blood glucose w/o cleaning equipment; observed LN prepped glucometer then placed glucometer down on visibly soiled side table & LN failed to sanitize glucometer before testing resident's blood glucose
- Observed Adm nurse removed resident's dressing from heel, placed heel directly on PRAFO boot & noted heel had started to drain then lifted leg for physician to evaluate PU on heel then placed heel directly back into PRAFO boot
- Observed 2 CNAs transferred resident with sit-to-stand lift & wiped handles of lift off with disinfecting wipe but failed to wipe multiple-use sling with disinfection wipe
- Laundry room with no gloves or face shield PPE available & dryers with heavy lint build up in lint traps; failed to ensure in fection prevention standards were followed r/t shared equipment, urinary catheter care, laundry services & wound treatment practices placing residents at risk for infectious diseases

February, 2024

F550 Resident Rights/Exercise of Rights

NE: SS=D: Failed to promote care in manner to maintain & enhance dignity & respect when staff obtained 1 resident's blood sugar & administered insulin by DR with 5 other residents in full view; facility further failed to address residents with respect & dignity when s taff called residents who required meal assistance as "feeders" placing residents at risk for undignified experiences & impaired psychosocial wellbeing

- Failed to promote care in manner that maintained & enhanced dignity & respect when staff called residents that required assis tance with eating "feeders" placing residents at risk for undignified dining & living experience
- Failed to promote care in manner to maintain & enhance dignity & respect when staff obtained 1 resident's blood sugar & administered insulin in DR with 5 other residents in full view placing resident at risk for undignified care & services

NE: SS=D: Failed to treat residents with respect, dignity & privacy during blood glucose testing placing resident at risk for impaired psychosocial wellbeing

- Observed LN obtained 1 resident's blood sugar reading using glucometer from resident's finger at DR table with3 residents at table with resident & 10 other residents in DR eating meal; failed to promote care for 1 resident in manner that maintained & enhanced d ignity & respect placing resident at risk for impaired psychosocial wellbeing

NW: SS=D: Failed to treat 2 residents with dignity when staff administered 1 resident's Flonase nasal spray & 1 resident's eye drops at DR placin g residents at risk for undignified experience

- Failed to treat 2 residents with dignity when staff administered medications at DR table with other residents able to see pro cedures placing residents at risk for undignified experience

F561 Self-Determination

NE: SS=D: Failed to offer 1 resident a choice of showers instead of sponge baths placing resident at risk for decreased self-determination & impaired psychosocial wellbeing

- Resident full mechanical lift at time; LN reported "hard to get lift into shower room so staff decided to give resident sponge b aths"; LN further stated resident no longer used full lift but resident continued to received sponge baths; CAN stated never offered re sident shower; failed to offer choice of bathing to resident placing resident at risk for decreased self-determination & impaired psychosocial wellbeing

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

NE: SS=D: Failed to notify physician of 1 resident's behaviors & refusal to take psychotropic medications placing resident at risk for impaired care due to delayed physician involvement

- POS for Seroquel for dementia which was DC'd on 10-3-23; POS on same day for Seroquel for dementia DC'd 10-16-23; POS for Zoloft for depression; MAR documented resident refused or did not receive Zoloft on 8 days in December, 12 days in Januar y, 10 days in February; record lacked evidence staff notified resident's physician about missed doses of Zoloft; POS for Seroquel x 2 weeks for dementia with aggressive behaviors & DC'd 4 days later; MAR documented resident refused or did not receive Seroq uel for 3 days during November; 3 days in January, 8 days in February; record lacked evidence staff notified resident's physician about missed doses of Seroquel; NN documented multiple behaviors including exit seeking behaviors & resident-to-resident aggressive behaviors when staff called Sheriff's office; failed to notify physician of resident's behaviors & refusal to take psychotropic medications placing resident at risk for impaired care due to delayed physician involvement

F582 Medicaid/Medicare Coverage/Liability Notice

NE: SS=D: Failed to provide 2 resident/representative completed CMS ABN form 10055 placing residents at risk of uninformed de cisions & costs about skilled services

- Facility provided CMS-R-131 forms; Failed to provide 2 residents/representatives, correct 10055 form which included estimated cost of continued services when discharged from skilled care placing residents at risk of uninformed decisions & costs about services & continuation of skilled services

F584 Safe/Clean/Comfortable/Homelike Environment

NW: SS=E: Failed to clean dining tables & chairs to provide a comfortable homelike environment in DR placing residents who ate meals in DR at risk for unsanitary non-homelike environment

- Observed large amounts of dried brown, yellow & green particles on all edges of each DR table & dried particles on DR table legs & all DR chairs; Observed 2 residents placed napkins across table on top of dried particles before they received meal plates & 1 resident stated "I wish they would clean off these tables." Observed housekeeping staff with spray bottle of Lysol cleaner spraying tops of table & using paper towel to wipe them off; supv stated facility did not currently have any disinfectant to use until delivered to facility & went to local store to buy Lysol cleaner; failed to provide sanitary, homelike dining experience for residents who ate meals in DR by having unclean DR tables & chairs placing residents who ate meals in DR at risk for unsanitary non-homelike environment

F600 Free from Abuse & Neglect

NW: SS=G: Failed to ensure 1 resident remained free from abuse &/or neglect; on 2-9-24, CNA forcefully grabbed resident's wrist, took glass of orange juice out of resident's hand & slammed orange juice on table; then CNA aggressively grabbed resident's w/c to start moving her & resident put foot down on floor; CNA yelled at resident & aggressively placed resident's feet on foot pedals; SS attempted to intervene but CNA ignored SS & continued to try & wheel resident out of DR, CAN treatment resident in manner that did not uphold resident's sense of self-worth & individuality placing resident at risk for physical harm, pain & mental anguish

- *CAA documented resident had behaviors associated with dementia with sundowning episodes, was frequently frightened when staff approached resident & would hit, bite & scratch staff during care as a means of communicating fear; failed to ensure 1 resident was free from staff to resident abuse when resident was treated in manner that did not uphold resident's sense of self-worth & individuality & was handled with aggressive force; situation dehumanized resident & placed resident at risk for physical harm, pain & mental anguish; scope & severity determined to be actual harm based on "reasonable person" concept due to circumstances of resident's severe cognitive impairment & inability to self-identify & express feelings r/t event*

F609 Reporting of Alleged Violations

NE: SS=D: Failed to ID unwitnessed fall that resulted in serious injury as potential allegation of neglect or abuse & report immediately to State Agency (SA) when 1 resident, a cognitively impaired resident had unwitnessed fall with injuries placing resident at risk for further injury & unidentified abuse or neglect

- CP documented resident with fx femur & cervical spine; Incident Report documented staff heard resident yelling & observed resident lying on floor of BR; investigation did not include resident statement or root cause analysis; investigation lacked documentation r/t how facility ruled out abuse &/or neglect; staff failed to report resident's unwitnessed fall with injuries to SA as required placing resident at risk for further injury & unidentified abuse or neglect

F610 Investigate/Prevent/Correct Alleged Violation

NE: SS=D: Failed to ID unwitnessed fall that resulted in serious injury as potential allegation of neglect or abuse & conduct a thorough investigation when resident with cognitive impairment had unwitnessed fall with serious injuries placing resident at risk for further injury & unidentified abuse or neglect

- Cited findings noted in F609; investigation did not include resident statement or root cause analysis; investigation lacked documentation r/t how facility ruled out abuse &/or neglect; failed to thoroughly investigate potential abuse or neglect when 1 resident with cognitive impairment had unwitnessed fall with serious injuries placing resident at risk for further injury & unidentified abuse or neglect

NE: SS=D: Failed to complete full investigation to rule out abuse or neglect after unwitnessed fall resulting in injury for cognitively impaired resident placing resident at risk for further injury & unidentified abuse or neglect

- NN documented resident with unwitnessed fall with contusion & abrasions; EMR lacked documentation investigation completed; failed to investigate unwitnessed fall for cognitively impaired resident placing resident at risk for further injury & unidentified abuse or neglect

F656 Develop/Implement Comprehensive Care Plan

NE: SS=D: Failed to develop comprehensive CP for 1 resident's hospice care & services & physician-ordered fluid restriction placing resident at risk for impaired care due to uncommunicated care needs

- CP lacked fluid restriction amount of 2000 mL/24 hours & lacked information r/t hospice care; failed to develop comprehensive CP for 1 resident's hospice care & services & physician ordered fluid restriction placing resident at risk for impaired care due to uncommunicated care needs

F657 Care Plan Timing & Revision

NE: SS=D: Failed to revise CP for 1 resident's use of injectable medication for diagnoses skin condition placing resident at risk for impaired care r/t uncommunicated care needs

- *POS for Skyrizi for psoriasis; CP lacked documentation to address resident's use of, as well as directions &/or precautions, quarterly Skyrizi injections; resident's CP further lacked any measures of monitoring for effectiveness &/or unwanted side effects of medication; resident stated missed a dose in December but received shot recently; CP lacked reference to Skyrizi; failed to review & revise resident's CP to reflect*

resident's use of injectable medication to treat chronic skin condition placing resident at risk for impaired care r/t uncommunicated care needs

NE: SS=D: Failed to revise CP to include person-centered interventions to prevent falls for 2 residents; further failed to revise CP for 1 resident who was on dialysis placing resident at risk for impaired care due to uncommunicated care needs

- Resident with multiple falls; staff failed to follow resident's CP when placed footrest of recliner up & multiple duplicate fall interventions; failed to revise CP for 1 resident to include person-centered interventions to prevent falls placing resident at risk for further falls & injury related to uncommunicated care needs
- Resident with multiple fall with injury & EMR lacked documentation fall investigation completed; failed to revise CP for 1 re sident to include person-centered interventions to prevent falls placing resident at risk for further falls & injury related to uncommunicated care needs
- CP lacked information r/t to specific dialysis facility used for treatment & contact information; POS lacked information r/t resident's dialysis treatments; EMR lacked evidence of assessment before & after dialysis treatments & lacked evidence facility communicated assessment findings & other pertinent information to dialysis center; failed to revise & include 1 resident's dialysis-specific standard of practice, person-centered CP placing resident at risk for impaired care due to uncommunicated dialysis needs

NE: SS=D: Failed to revise comprehensive CP to include O2 therapy for 1 resident placing resident at risk for respiratory inf ection & complications due to uncommunicated care needs

- CP lacked direction to address care of O2 tubing & equipment for resident; failed to ensure 1 resident's CP reflected resident's O2 therapy with potential for alteration of continuous care among nursing staff placing resident at increased risk for respiratory infec tion & complications due to uncommunicated care needs

NW: SS=D: Failed to revise CP with trauma triggers & coping strategies for 1 resident & failed to address sexual behaviors fo r 1 resident placing 2 residents at risk for impaired care due to uncommunicated care needs

- Trauma assessment documented resident experienced sexual trauma perpetrated by family during resident's youth with documented triggers; CP lacked triggers & coping strategies; staff unaware of resident's triggers or coping strategies; failed to revise/include resident's CP to include trauma triggers & coping strategies placing resident at risk for impaired care due to uncommunicated care needs
- POS directed staff to document any sexual advances, behaviors & comments to staff &/or other residents q day & ev ening shift; MAR lacked behavior monitoring for 15 opportunities in November; 11 in December; 12 in January; NN documented multiple inappropri ate sexual behaviors; failed to revise 1 resident's CP to direct staff with interventions when resident had inappropriate behaviors placing resident at risk for impaired care due to uncommunicated care needs

NW: SS=D: Failed to update 1 resident's CP to include staff using gait belt to assist resident when standing from seated to a standing position after CNA did not use gait belt causing bruises & pain placing resident at risk for unsafe transfers due to uncommunicated care needs

- *CP lacked any intervention for staff to use gait belt when assisting resident from seated to standing position; resident with large dark purple/blue bruise on forearm & elbow; resident stated "it was (a staff member)…she grabbed me here to help me up. She didn't mean anything by it. She is not here anymore anyway so there is nothing to be done."; resident referred to CNA who worked as agency CNA; failed to update 1 resident's CP to include staff using gait belt to assist resident when standing from a seated to a standing position after staff did not use gait belt causing bruises & pain placing resident at risk for unsafe transfers due to uncom municated care needs*

F660 Discharge Planning Process

NW: SS=D: Failed to develop a discharge plan for 1 resident who discharged to home with family placing resident at risk for u nidentified discharge goals & impaired discharge planning

- EMR lacked evidence of discharge CP developed at admission to facility; failed to develop discharge plan for 1 resident who planned to go back to community after therapy placing resident at risk for unidentified discharge goals & impaired discharge planning

F662 Discharge Summary

NW: SS=D: Failed to develop discharge summary that included recapitulation of resident's stay & post-discharge plan for 1 resident placing resident at risk for impaired care & services

- EMR lacked evidence discharge CP had been developed at admission to facility; Record lacked evidence of recapitulation of resident's stay; failed to develop a discharge summary that included recapitulation of resident's stay & post-discharge plan for 1 resident placing resident at risk for impaired care & services

F676 Activities Daily Living (ADLs) Maintain Abilities

SE: SS=D: Failed to provide 2/2 non-dependent residents adequate bathing

- *CP lacked frequency when staff were to provide bathing; "Comprehensive Shower Review" from 12-23-23 thru 2020-24 resident lacked bathing for 7 days, 16 days, 5 days, 7 days & failed to provide bathing according to Bathing Sheet schedule for 12/21 opportu nities; observed resident with slight facial hair stubble; CNA stated hard to get bathing done due to lack of staff; resident's family member stated family took resident home & gave resident shower at house because resident "stunk" & resident was supposed to have 2-3 showers/wk but getting "maybe once a week & was told by staff there was 'not enough time' or day shift 'did not get it done' for resident to have a shower"; failed to provide bathing to 1 resident 12/21 opportunities between 12/23/23 thru 2-20-24*

- *Resident stated not getting showers as scheduled & if morning shift did not assist then shower usually did not get it done & sometimes getting shower 1/x wk & sometimes 1-1/2 wks w/o bathing & when asked staff responded "short of staff"; failed to provide bating for 1 resident on 8/22 opportunities from 12-24-23 thru 2-22-24 & on 2-20-24*

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to provide adequate bathing for 1 dependent resident

- *Observed resident's hair appeared greasy with numerous white flakes noted on scalp; failed to provide bathing to dependent resident for 12/17 bathing opportunities from 12-25-24 thru 2-21-24*

SE: SS=D: Failed to provide adequate bathing for 2/3 residents who were dependent on staff for bathing services

- *"Documentation Survey Report" for December 2023 revealed resident lacked bathing on 4/8 opportunities for bathing & went 10 days w/o being bathed & resident received 2 bed baths & 2 partial baths & lacked receiving a shower for the month; January, 2024 with 3/9 missing bathing opportunities & bed bath on 1-25 & lacked bathing from 1-26 thru 1-31; February revealed resident lacked bathing for 10 days & missed 2/4 bathing from 2-1 thru 2-12; observed resident with hair greasy & white flake visible in hair; failed to provide 1 resident with bathing 9/21 opportunities from 12-4-23 thru 2-12-24 resulting in 2 periods during that time when resident lacked bathing for 10 days*
- *Failed to provide 1 resident with bathing 9/21 opportunities from 12-2-23 thru 2-10-24 resulting in period of 17 days in that time resident lacked bathing*

NE: SS=D: Failed to provide necessary services to maintain good personal hygiene, including bathing for 1/5 residents reviewed for ADLs placing resident at risk for poor personal hygiene

- Bathing/shower task documentation revealed resident scheduled to have shower/bath twice weekly; January bathing report documented resident with 2 baths in January with 1 refusal w/o follow up or documentation resident reapproached later or on another shift; Feb with 3 showers (13 days w/o shower/bath) with 4 refusals with no follow up or documentation resident reapproached later or on another shift; observed resident in bed with hair uncombed; failed to provide 1 resident necessary care & bathing services for 1 resident placing resident at risk for poor hygiene

NW: SS=D: Failed to provide cueing or assist with eating for 1 resident with weight loss placing resident at risk for continued weight loss & unmet care needs

- Observed resident served meal & no staff offered assist to resident & resident did not eat meal; observed resident served meal & resident with tremor with difficulty managing food on utensils & no staff offered assist or cueing; failed to provide cueing or offer assist to 1 resident at mealtimes who had weight loss placing resident at risk for continued weight loss & unmet care needs

F678 Cardio-Pulmonary Resuscitation (CPR)

NE: SS=D: Failed to establish & maintain a system to ensure nursing staff maintained current CPR certification fore healthcare providers placing resident who desired CPR if needed at risk for inadequate resuscitative measures

- LN with expired date; failed to establish & maintain system to ensure nursing staff maintained current CPR certification for healthcare providers placing 1 resident who desired CPR at risk for inadequate resuscitative measures

F684 Quality of Care

NE: SS=D: Failed to notify physician when 1 resident's urine output was less than 360 mL in 12 hours as ordered placing resident at risk for physical decline

- Resident with neuromuscular dysfunction of bladder, MS, anxiety, depressive d/o; CP documented for staff to irrigate catheter with acetic acid & sterile water per orders; CP directed staff to monitor, record & report to physician any signs of infections & check catheter anchor; update documented to monitor resident's urine output & report concerns to physician; POS for document urine output q shift & notify physician if urine output less than 360 mL in 12 hours; TAR documented output 70 mL 2 days in February; EMR lacked evidence physician notified of less than 360 mL of urine that was outside ordered notification parameters; failed to notify physician as ordered when 1 resident's urine was out of parameters as set by physician placing resident at risk for physical decline

NE: SS=D: Failed to implement protective measures for prevention of skin tears & bruising for 1 resident who had large amount of bruising on forearms placing resident at risk for ongoing skin issues & impaired healing

- Resident with anemia & HIV & received anticoagulant; multiple assessments including admission assessment lacked documentation of bruising; observed resident with extensive deep purple bruising to resident's arms & hands & resident stated bruising from shower chair; failed to implement protective measures for prevention of skin tears & bruising for 1 resident placing resident at risk for further injury

NE: SS=D: Failed to ensure staff provided physician-ordered wound care services & off-loading intervention for 1 resident's vascular wounds placing resident at increased risk for complications r/t vascular wounds including delayed healing, infection & increased pain

- *Resident with hx of vascular wounds & PU's; CP documented resident refused skin assessments & wound assessments; CP documented resident with staph epidermitis infection with ABT; POS for wound care treatment orders with most recent tx's ordered daily; Wound Care consultant notes documented dressing dated 1-21-24 on 1-23-24 & resident c/o significant pain with palpation & unstable eschar on heel & occlusion of leg had likely worsened with recommendation for PRAFO boot; MAR documented dressing order completed on 1-22-24 despite consultant's observation dressing dated 1-21-24 & MAR/TAR blank for other heel dressing which was DC'd on 1-22-23; observed resident w/o PRAFO & feet pushed against pillow at foot of bed & heels not floated; failed to ensure staff provided physician-ordered wound care services & off-loading intervention for 1 resident's vascular wounds placing resident at increased risk for complications r/t vascular wounds including delayed healing, infection & increased pain*

NW: SS=J (Past Non-Compliance): Failed to accurately transcribe & administer antibiotic orders for 1 resident upon return from ER placing resident at risk for ineffective treatment for aspiration pneumonia & unwarranted physical complications

- *POS for Azithromycin 250mg 2 tabs BID for aspiration pneumonia x 5 days with order start date of 1-7-24 & DC date of 1-8-24 for amoxicillin 875 mg q 12 hours for aspiration pneumonia & order with start date of 1-8-24 & DC of 1-22 for Amoxicillin 875 mg q 12 hrs for aspiration pneumonia & order with start date of 1-10-24 & end date of 1-14 for Azithromycin daily for aspiration pneumonia; MAR documented Amoxicillin started 1-8 & DC'd on 1-22 & lacked documentation med was administered from 1-8 to 1-21 morning administration & 1-21 evening administration & 1 morning administration had documentation of "O"; documentation revealed multiple doses "out of stock" or "waiting on pharmacy"; or "on order"; failed to accurately transcribe & administer 1 resident's ABT orders for aspiration pneumonia upon return from ER placing resident at risk for ineffective treatment for aspiration pneumonia & unwarranted physical complications*

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

SE: SS=G: Failed to provide appropriate treatment services for 1 resident's PU at Stage 3 present on admission to coccyx when facility to obtain physician ordered treatment until 7 days after admission to facility, failed to assess wound until 3 days after admission to facility, failed to ensure resident had dressing replaced timely when soiled or absent & failed to provide pressure reducing device to seat of w/c until 3 days after admission; resident's pressure area deteriorated to unstageable wound, became infected & resident required hospitalization for wound management

- *Resident's friend stated had been at facility & resident had diarrhea & when back in room nurse told resident "needed a diaper change" & waited 1-1/2 before anyone came to change resident & another time resident waited 45 minutes after turning on call light before anyone came to change resident; friend stated went to physician's office with resident & resident had soiled brief before left for physician & staff stated "they could take care of it when resident got to doctor's office" & when got to physician office resident had feces "all the way up to her belly button and to her back & lacked bandage on sore" & when wound staff removed dressing, the "smell was so bad I almost puked" & nurse could not believe how bad wound smelled & resident put in hospital for infection; resident's friend stated wound went from size of ping pong ball to size of softball in short time & wound was "black"; failed to obtain physician ordered tx until 7 days after resident's admission to facility, failed to assess wound until 3 days after admission to facility, failed to ensure resident had dressing replaced timely when soiled or absent, & failed to provide pressure reducing device to seat of w/c until 3 days after admission; resident's pressure area deteriorated to unstageable wound, became infection & resident required hospitalization for wound management*

NE: SS=G: Failed to provide off-loading interventions to prevent re-opening of healed PUs for 1 resident & failed to implement interventions immediately upon discovering pressure injury; failed to ensure staff completed weekly wound assessment including wound measurements for 1 resident who had multiple skin issues placing 2 residents at risk for complications resulting from pressure injuries &/or delayed healing

- Weekly Skin Assessment documented "new skin concerns ID'd & EMR lacked further note or mention of new issues until 3 days later on wound care assessment ID'ing wound to heal on previous PU site; December TAR lacked evidence staff completed wound treatments on 7 occasions with 1 refusal; TAR lacked evidence resident refused to wear Prevalon boots or derma saver; January & February TAR lacked evidence resident refused to wear Prevalon boots or derma saver; resident stated PU developed after admitted to facility; staff confirmed no offloading boots or floating of heels after resident's PU resolved in October; wound consultant ordered to continue with padded heel protector (Derma saver) but did not order any Prevalon boots or floating or off-loading of resident's heels after PU healed in October; failed to provide off-loading &/or pressure relieving interventions to prevent re-opening of healed Stage 3 PU for 1 resident; further failed to implement interventions immediately upon ID of new wound & as result resident's PU returned as Stage 3 placing resident at risk for pain & other complications r/t PU
- Resident with hemiplegia & hemiparesis with pressure-induced deep tissue damage of heel, DM with skin complications & bullous pemphigoid (blister); Weekly Skin Assessment documented "previously ID'd areas see notes" & no wound bed or peri-wound assessments & no measurements noted & no further notes r/t assessment; multiple notes lacked wound bed or peri-wound assessments & no measurements noted & no further notes r/t assessment; staff verified staff had not documented assessment of wounds weekly during wound care & dressing changes since resident went to wound clinic; staff reported physician refused to allow facility staff to assess or change orders on resident; failed to ensure staff completed weekly skin assessment for 1 resident with existing skin issues placing resident at risk for complications resulting from pressure injuries &/or delayed healing

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=J (Abated to G): Failed to provide appropriate supervision, implement interventions & ID elopement behaviors to prevent elopement of 1 resident who remained on 30-minute checks from a prior elopement, eloped again from facility on 1-28-24 at 4:36pm with staff present; staff did not realize resident was missing until another staff member saw resident walk past a window outside building at 5:30pm, almost an hour after resident eloped; review of 30-minute check log revealed facility staff failed to check & log resident's whereabouts since 1-28 at 4:30pm placing resident in immediate jeopardy

- *Resident with high risk of elopement & with hx of elopement r/t past elopement incidents when resident broke out window to elope & required sutures; 7 days after January elopement event facility DC'd 1:1 staff supervision & implemented 15-minute checks; on 1-20 facility DC'd 15 minute checks & implemented 1:1 staff & requested resident be taken to county jail; 1-21 facility DC'd 1:1 supervision & initiated 15 minute checks; on 1-23 facility DCd 15 minute checks & initiated 30-minute checks; on 1-28 CNA & CMA observed resident outside building & assessed with no injuries & Law Enforcement notified by physician extender; investigation revealed resident went out back patio door with other residents & CAN to smoke then went over 6-foot wooden privacy fence surrounding courtyard; 30-minute check log lacked documentation of 30-minute check required; resident stated walked to store to ask someone to light previously lit cigarette then walked back to facility; 5pm check log blank; law enforcement revealed 911 dispatch received call r/t resident's elopement on 1-31-24 at*

6:49pm (2 hours, 13 minutes after resident left facility & 1 hr & 19 minutes after resident returned to facility & officer responded at 6:54pm & contacted physician extender filed report; failed to provide appropriate supervision, implement interventions & ID elopement behaviors to prevent elopement of resident who eloped on 1-28-24 at 4:35 with staff present but w/o staff knowledge; staff did not realize resident was missing until another staff member saw resident outside through window at 54:30pm; facility notified of IF for resident on prior 2567 dated 1-16-24; upon investigation into second elopement of resident on 1-28-24 at 4:36 revealed facility remained out of compliance & failure to prevent additional elopement of resident & placed resident back in immediate jeopardy

- *Abatement Plan:*
  - *Resident's CP updated with interventions to protect resident & other residents to monitor outside while smoking & ensure resident signs in & out during scheduled smoking periods*
  - *Adm staff placed resident on 1:1 observation at all times, even during scheduled smoking periods*
  - *All staff required to participate in tabletop scenario & write out process for what to do in event of elopement prior to returning to work*
  - *Facility created sign out & sign in sheets for residents who go outside to smoke*
  - *Daily staff sheet modified to include assignment for 1:1 observation of resident*
  - *Charge nurse would document q 2 hours to reflect 1:1 observation of resident*

SE: SS=J (Past Non-Compliance): Failed to provide adequate supervision to prevent elopement of cognitively impaired resident who had hx of fall; on 1-30-24 CNA heard facility doorbell ring & used access badge to let visitor out of facility but failed to ensure only visitor exited; resident followed visitor out & exited facility unsupervised on 1-30-24 at 10:26am; resident ambulated with walker on sidewalk on west side of parking lot for approximately 100 feet then across parking lot for approximately 147 feet then toward north side of building for 164 feet before CNA saw resident ambulating outside facility, unattended; 2 staff brought resident back to facility with w/c; failed to assess resident for elopement risk placing resident into immediate jeopardy

- *EMR lacked elopement risk assessment; resident reported enjoyed going outside on sunny, beautiful days & enjoyed going on walks outside; failed to provide adequate supervision to prevent elopement of cognitively impaired resident who had hx of falls & used walker for ambulation; CNA failed to ensure safety of resident when CAN used badge to let visitor out of facility but did not verify door closed w/o resident exiting facility unsupervised; facility had also not assessed elopement risk of 1 resident placing resident in immediate jeopardy*
- *Past Non-Compliance Plan:*
  - *Staff education r/t staff to stay at door when someone arrives &/or exits until door closes to ensure safety of all residents*
  - *Place exit notification sign placed on both sides of front door alerting staff/visitors to ensure door closes behind them prior to leaving*
  - *Updated resident's CP r/t resident being elopement risk*
  - *Decreased time main door remained open after badge or keypad number entry to ensure quicker locking time*

SE: SS=G: Failed to provide environment free from safety hazards when staff left 1 resident in mechanical recliner with footrest raised w/o assessing resident's ability to lower footrest; resident attempted to get out of recliner by climbing over footrest & fell; as result resident sustained fx'd sternum & rib placing resident at risk for pain, decreased mobility & impaired quality of life

- *Resident with fall risk & hx of falls; EMR lacked evidence staff assessed resident's ability to lower footrest on manual recliner; EMR & investigation lacked information r/t when resident last checked, assisted to BR or observed in recliner before fall; failed to provide 1 resident with adequate supervision or evaluation of ability of resident o safely lower footrest of manual recliner resulting in fall; resident sustained fx'd sternum & rib fx as result of deficient practice*

SW: SS=J (Past Non-Compliance): Failed to ensure seatbelt was snug prior to transport in facility van which resulted in fall with major injury & transportation of resident unsecured on floor of facility owned van approximately 20 miles back to facility constituting immediate jeopardy at F689 & also constituted Substandard Quality of Care

- *SSD failed to ensure lap belt was snug on resident prior to transport in facility van while traveling on highway; resident fell out of w/c onto floor of facility van, landing on knees; SSD failed to notify 911 or activate EMS for assistance; SSD assisted resident to lay on floor of van then drove back to facility, approximately 20 miles, unsecured & laying on floor of w/c van; upon arrival to facility resident required emergency medical transport to local hospital for evaluation & treatment of left femur placing resident in immediate jeopardy*
- *Abatement Plan*
  - *Education for all transportation staff on proper securing methods for securing residents into transportation vans & use of new seatbelt that was initiated*
  - *Education for all transportation staff on need to call 911 to activate EMS response during emergency event during transportation*
  - *On-the-spot education to SSD on necessity of calling 911 to activate EMS response during any emergent event*
  - *Resident's CP updated to include pummel cushion & use of transportation van's factory installed shoulder/lap belt for all resident transports*
  - *Facility ordered shoulder straps that attach to resident's w/c for added protection in addition to implementation of seatbelt device that allows for integration of transportation van's factory installed shoulder/lap belt*

NE: SS=D: Failed to evaluate effectiveness of fall interventions, change or modify interventions that were ineffective at preventing falls & failed to follow CP for fall prevention for 1 resident; further failed to ID causative factors & implement person-centered interventions for fall prevention for 1 resident placing residents at risk for further falls & injury

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

- Resident with multiple falls; failed to ID causative factors & implement person-centered interventions for fall prevention for 1 resident placing resident at risk for further falls & injury

NW: SS=E: Failed to ensure environment free from accident hazards when staff left 1/3 med carts & tx cart unsupervised & unlocked by dining area & failed to secure wall cabinet in shower room placing 7 cognitively impaired, independently mobile residents at risk for preventable accidents & injuries

- Observed shower room door open with unlocked unsupervised wall cabinet with multiple hazardous chemicals accessible to residents
- Observed unlocked & unsupervised tx cart in front of nurses' station; observed unlocked, unsupervised med cart outside DR & nurse in DR administering meds; failed to ensure environment was free from accident hazards when staff left tx cart & 1/3 med carts unsupervised, unlocked & accessible to 7 cognitively impaired, independently mobile residents who resided in facility placing residents at risk for preventable accidents & injuries

NW: SS=D: Failed to ensure resident's personal alarm system was monitored as ordered to prevent elopement placing resident at risk for preventable accidents

- MAR lacked documentation Wander Guard was assessed to be working on: 17 opportunities in November; 15 in December, 18 in January; failed to ensure personal alarm system used to prevent elopement for 1 resident monitored as ordered placing resident at risk for preventable accidents

NW: SS=D: Failed to provide 1 resident a safe environment with CNA did not use gait belt & pulled on 1 resident's arm causing bruises & pain placing resident at risk for pain, bruising, altered skin integrity & falls

- *Cited findings noted in F657 r/t agency CNA failure to use gait belt for transfers; Failed to provide 1 resident a safe environment placing resident at risk for pain, bruising, altered skin integrity & falls*

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to help with toileting as CP'd for 1 resident placing resident at risk for complications r/t incontinence including UTIs

- CP directed staff to check & change resident's brief on rising, after meals, at bedtime & 2x's during rounds at night & promote prompted voiding responses; resident developed UTI with MRSA; observed CNA failed to offer or assist resident to toilet on multiple occasions; observed CNA assisted resident with peri-care & failed to remove soiled gloves after peri-care & before touching resident's clothing & other care equipment; failed to provide 1 resident with assistance with toileting as CP'd placing resident at risk for complications r/t incontinence including UTI

F692 Nutrition/Hydration Status Maintenance

NE: SS=D: Failed to monitor 1 resident's physician-ordered fluid restriction placing resident at risk of complications r/t fluid overload

- CP lacked fluid restriction amount of 2000 mL/24 hours & lacked information r/t hospice care; failed to monitor resident's physician-ordered fluid restriction placing resident at risk for complications r/t fluid overload

F695 Respiratory/Tracheostomy Care & Suctioning

NE: SS=D: Failed to ensure physician orders were followed for 1 resident's O2 therapy when staff failed to change O2 bottle every 7 days as ordered placing resident at increased risk for respiratory infection & complications

- Cited findings noted in F657 r/t CP lacked direction to address care of O2 tubing & equipment for 1 resident; EMR documented POS to change O2 humidification bottles q 7 days; observed humidification bottle connected to O2 canister dated 12-3-23 on multiple occasions; failed to ensure resident's humidified O2 bottle was changed every 7 days per physician orders placing resident at increased risk for respiratory infection & complications

F698 Dialysis

NE: SS=D: Failed to ensure 1 resident received care & services for dialysis consistent with professional standards of practice which included ongoing assessments of resident's condition as well as ongoing communication & collaboration with dialysis facility placing resident at risk for complications & unmet care needs r/t dialysis treatments

- CP lacked information r/t specific dialysis facility used for treatment & contact information; POS lacked information r/t to 1 resident's dialysis treatments; EMR lacked evidence of assessment before & after dialysis treatments & lacked evidence facility communicated assessment findings & other pertinent information to dialysis center; failed to ensure 1 resident received care & services for dialysis consistent with professional standards of practice including ongoing assessments of resident condition & going communication & collaboration with dialysis facility placing resident at risk for complications & unmet care needs r/t dialysis treatments

F699 Trauma Informed Care

NW: SS=D: Failed to ensure 1 resident received trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization of resident placing resident at risk for impaired quality of life

- Cited findings noted in F657 r/t hx of trauma w/o CP for triggers to avoid re-traumatization; failed to communicate relevant information from 1 resident's trauma history to allow staff to provide trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization placing resident at risk for impaired quality of life

F725 Sufficient Nursing Staff

SE: SS=F: Failed to have sufficient nursing staff at all times to meet resident's bathing needs & adequate call light response time

- *Cited multiple incidents that staffing provided did not meet staffing required as ID'd in Facility Assessment; multiple residents reported prolonged call light response times; multiple staff reported being short staffed; failed to provide adequate staff to meet bathing needs & timely call light response for residents in facility*
- *Referenced F676, F677*

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

NE: SS=F: Failed to ensure 6/6 CNAs reviewed for regular in-service education had completed in-service as required placing residents at risk for inadequate care

- Review of 5 CNAs & 1 CMA in-service records revealed no completion dates on documentation of in-services; Adm verified facility unable to verify dates of in-services completed; failed to ensure CNAs completed 12 hours of required in-services annually placing residents at risk for inadequate care

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

- 5 CNAs personnel file with no yearly performance evaluations provided upon request; staff reported facility did not complete yearly performance evals & relied on other nursing staff to provide education to peers on spot when issues arose; failed to ensure 5/5 CNA staff reviewed had required yearly performance evals completed placing residents at risk for inadequate care
-

F740 Behavioral Health Services

NW: SS=D: Failed to monitor 1 resident for sexual behaviors & failed to provide supervision for 1 resident who had resident-to-resident altercations placing residents at risk for decreased quality of life

- Cited findings noted in F657 r/t lack of documentation of symptoms of inappropriate sexual behaviors; failed to monitor 1 resident's behaviors placing resident at risk for decreased quality of life
- NN documented resident with multiple resident-to-resident altercations; failed to provide adequate supervision & redirection to 1 resident who had behaviors placing resident at risk for decreased quality of life

F741 Sufficient/Competent Staff-Behavioral Health Needs

SE: SS=G: Failed to provide sufficient staff with appropriate competencies & skill sets to meet behavioral health needs of 1 resident who had known elopement behaviors & hx of elopement to prevent an additional elopement from facility

- *Cited findings noted in F689 r/t repeat elopements from facility; failed to provide training records r/t behavior monitoring for 4 staff members as requested; failed to provide sufficient staff with appropriate competencies & skill sets to meet behavioral health needs of 1 resident who had known elopement behaviors & hx of elopement to prevent additional elopement from facility*

F742 Treatment/Services Mental/Psychosocial Concerns

NE: SS=D: Failed to immediately involve physician & provide supportive emotional & mental health services to attain 1 resident's highest practicable mental & psychosocial wellbeing after resident made statements of self-harm &/or verbalized feelings of sadness & desire to die placing resident at risk for unmet mental health care needs

- Resident with vascular dementia w/o behavioral disturbance, depression, repeated falls, HTN, PTSD & ADHD; MDS documented resident had no behaviors & declined to respond to questions r/t mood; CP lacked mention of resident's self-harm statements & lacked direction on 30-minute checks for resident's safety; POS for Sertraline which was increased 5 weeks after original order; POS for Mirtazapine for depression; NN documented resident stated "I'm just lying here thinking about the start and finish and how there just isn't any point anymore"; then followed with "Earlier was just a suicidal idea I didn't do well enough" then told LN "I'm going to jump out that window" & EMR lacked evidence physician notified at that time; physician noted documented facility would check with family r/t referral to behavioral health facility or possibly starting hospice; SS notes documented family will visit more with resident & set up electronic face chat with resident; staff unaware resident had made self-harm statements; Adm nurse stated resident placed on 30-minute visuals but unable to produce documentation of times staff monitored resident; SS stated did not get involved with situation for 15 days & Adm nurse sent email but SS did not see emails & had not routinely visited with resident & family declined behavioral health or hospice in hopes medication changes would make resident feel better & that 30-minute checks were sufficient; failed to immediately involve physician & provide supportive services to attain highest practicable mental & psychosocial wellbeing for 1 resident who made statements of self-harm placing resident at risk for unmet mental health care needs

F744 Treatment/Service for Dementia

NE: SS=D: Failed to develop & implement individualized dementia treatment plan for 1 resident with dement & behaviors & failed to provide necessary dementia care & services to attain or maintain highest level of practicable physical, mental & psychosocial wellbeing for 1 resident placing resident at risk for decreased quality of life

- Cited findings noted in F580 r/t refusals of medications for dementia; POS for Seroquel for dementia then DC'd 3 weeks later then POS for Zoloft for depression; resident with multiple refusals of medication; record lacked evidence staff notified physician about missed doses; resident with exit seeking behaviors, agitation & refusals of meds & treatments, entering other resident rooms, yelling obscenities, aggressive with staff & other residents with some behaviors requiring 1:1 staff interventions; physician not notified that resident not taking medications; failed to develop & implement individualized dementia treatment plan for 1 resident with dementia & behaviors &

failed to provide necessary dementia care & services to attain or maintain highest level of practicable physical, mental & psychosocial wellbeing for 1 resident placing resident at risk for decreased quality of life

F745 Provision of Medically Related Social Service

NE: SS=D: Failed to provide medically related social services to attain or maintain highest practicable physical, mental & psychosocial wellbeing of 1 resident who made statements of self-harm placing resident at risk for further decline in emotional & mental wellbeing

- Cited findings noted in F742 r/t resident with verbalization of self-harm; failed to ID & provide medically related social services to attain or maintain highest practicable physical, mental & psychosocial wellbeing for 1 resident who made statements of self-harm placing resident at risk for further decline in emotional & mental wellbeing

F755 Pharmacy Services/Procedures/Pharmacist/Records

NE: SS=E: Failed to provide consistent reconciliation of controlled drugs at end of each work shift placing 14 residents with controlled substances on cart at risk for misappropriation of medications

- Med cart revealed staff counted & signed "Controlled Drug Record" 8/38 work shifts; failed to provide consistent reconciliation of controlled drugs at end of daily work shifts placing 14 residents with controlled substances on cart at risk for misappropriation of medications by staff

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported lack of appropriate indication or required physician documentation for 1 resident's use of antipsychotic & failed to ID & report lacked of 14-day stop date or specific duration for 2 resident's PRN antianxiety meds placing residents at risk for unnecessary psychotropic medication side effects

- MRRs for 9 months lacked recommendation for appropriate indication for continued use of Seroquel ordered for dementia; CP review recommended Lorazepam needed 14-day stop date & physician responded on 1-22 to continue drug w/o stop date; failed to ensure CP reported inappropriate indication for continued use of antipsychotic medication Seroquel & failed to ensure 14-day stop date for use of PRN Lorazepam for resident placing resident at risk for unnecessary psychotropic medication with side effects
- MRR lacked evidence CP ID'd & notified facility & physician that Clonazepam required stop date; CP failed to ID & report lack of stop date for 1 resident's PRN Clonazepam placing resident at risk for inappropriate use of PRN antianxiety medication

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported lack of required stop date for 1 resident's PRN Lorazepam placing resident at risk for receiving unnecessary psychotropic meds

- POS for Lorazepam q 6 hours PRN for tremors & order lacked stop date; EMR lacked 14-day stop order or specified duration with physician-documented rationale for extended use of resident's PRN Lorazepam; failed to ensure CP ID'd & reported lack of required stop date for resident's PRN Lorazepam placing resident at risk for receiving unnecessary psychotropic meds

NW: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported that resident lacked a 14-day stop date or specified duration with physician rationale for PRN psychotropic medication & 1 resident lacked evidence of blood sugar checks & insulin administration as orde red placing residents at risk for inappropriate use of medications

- POS for Lorazepam PRN with no stop date; CP's MRR lacked mention of required 14-day stop date or need for specific duration for PRN Lorazepam; failed to ensure CP ID'd & reported that 1 resident lacked 14-day stop date or specified duration with physician rationale for PRN lorazepam use placing resident at use placing resident at risk for inappropriate use of medication
- MAR lacked blood sugar check on 5 opportunities in November; 3 in December; 6 in January; POS for insulin administration on 3 opportunities in November; 2 in December; 3 in January; MAR failed to ID lack of documentation for resident's insulin & blood sugar checks; CP failed to ID & report lack of insulin administration documentation for 1 resident placing resident at risk for physical decline

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to monitor & provide interventions for bowel management for 2 residents placing residents at risk for fecal impaction & physical decline

- Bowel Monitoring Record documented resident w/o BM for 5 days & 5 days & TAR lacked documentation staff provided physician-ordered intervention during noted dates; failed to monitor & provide interventions for bowel management for 1 resident who had hx of constipation placing resident at risk for fecal impaction & physical decline
- Failed to monitor & provide interventions for bowel management for 1 resident placing resident at risk for fecal impaction physical decline

NE: SS=D: Failed to ensure physician notified when 1 resident's systolic BP was outside physician ordered parameters placing resident at risk for unnecessary medication use & delay in treatment or services r/t HTN

- POS for Amlodipine daily for HTN with notification parameters; eMAR documented resident's BP outside of notification parameters on 16 occasions w/o evidence of physician notification; failed to ensure physician notified when 1 resident's BP was outside physician-ordered parameters placing resident at risk for unnecessary medication use & delay in treatment or services r/t HTN

NW: SS=D: Failed to follow physician orders for 1 resident who received insulin & failed to monitor resident's blood sugar as ordered placing resident at risk for physical decline

- Cited findings noted in F756; failed to follow physician orders for 1 resident who received insulin & failed to monitor resident's blood sugar as ordered placing resident at risk for physical decline

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NE: SS=D: Failed to ensure appropriate indication, or documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of 1 resident's antipsychotic & failed to ensu re 14-day stop date or specified duration with rationale for 3 resident's PRN antianxiety medication placing residents at risk for unintended effects r/t psychotropic drug medications

- Failed to ensure 1 resident did not receive antipsychotic medication w/o appropriate indication o r required documentation for its use & failed to ensure resident's PRN Lorazepam had 14-day stop date or specified duration placing resident at risk for adverse side effects
- Failed to ensure 1 resident's PRN Lorazepam had 14-day stop date or specified duration with physician rationale for extended use placing resident at risk for adverse side effects
- Failed to obtain stop date for use of PRN Clonazepam for 1 resident placing resident at risk for receiving unnecessary psycho tropic medication

NE: SS=D: Failed to ensure 1 resident had stop date for use of PRN Lorazepam placing resident at risk of receiving unnecessary psychotropic medications

- Cited findings noted in F756 r/t no stop date for PRN Lorazepam; failed to ensure 1 resident had stop date for use of PR N Lorazepam placing resident at risk of receiving unnecessary psychotropic meds

NW: SS=D: Failed to ensure 1 resident had stop date for use of PRN Lorazepam; 1 resident had approved indication or required documentation for use of Seroquel & 1 resident had complete behavior documentation r/t use of 3 psychotropic meds placing residents at risk for receiving unnecessary psychotropic meds

- Failed to ensure 1 resident had stop date for use of PRN Lorazepam placing resident at risk of receiving unnecessary psycho tropic medication
- POS for Seroquel for dementia; failed to ensure approved indication or required physician documentation for 1 resident's use of Seroquel placing resident at risk of receiving unnecessary psychotropic meds
- Failed to complete behavior documentation r/t use of 3 psychotropic meds placing resident at risk of receiving unnecessary psychotropic meds

F760 Residents are Free of Significant Med Errors

NE: SS=D: Failed to prevent a significant medication error when 1 resident did not receive scheduled injectable medication fo r treatment of psoriasis; on 1-21-24, after inquiry from resident's representative, ID'd resident's quarterly injection overdue by 40 days placing resident at risk for decreased therapeutic effect of medication & complications r/t resident's skin disease

- *MAR for Sept 2023 documented resident last received Skyrizi injection on 9-22-23 & MAR for December 2023 lacked documentation resident received medication on 12-15-23 per POS; no medication error report & no documentation in EMR r/t missed dose; failed to prevent a significant medication error when resident's scheduled dose of psoriasis medication not administered per physician's order placing resident at risk for decreased therapeutic effect of medication & complications r/t resident's skin disease*

F761 Label/Store Drugs & Biologicals

NE: SS=D: Failed to date 1 resident's insulin flex pen when opened & failed to discard 2 residents' i nsulin flex pen when outdated placing affected residents at risk for ineffective medications

- Observed Humulin flex pen lacked open date & discard date; 2 residents' insulin outdated; failed to label & date resident's flex pen with date opened & expiration date placing residents at risk for ineffective medication

NE: SS=E: Failed to date 1 resident's insulin flex pen when opened & failed to discard 1 resident's insulin flex pen when out dated; further failed to monitor medication fridge temp for 18 days placing affected residents at risk for ineffective medications

- Failed to label & date 1 resident's flex pen with date opened & expiration date & failed to discard expired insulin pen placing residents at risk for ineffective medication
- Observed med room with fridge temp daily log had temp recorded on 2-19 & rest of days lacked documentation; failed to monitor & record 1 med room fridge temps daily placing residents who received medications from fridges at risk of receiving less potent or unintended effects from medications

F801 Qualified Dietary Staff

NW: SS=F: Failed to employ a full time CDM for all residents who resided in facility & received meals from facility kitchen p lacing residents at risk for impaired nutrition

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

F803 Menus Meet Resident Needs/Prep in Advance/Followed

NW: SS=J (Past Non-Compliance): Failed to provide physician-ordered thickened liquids to 1 resident with hx of dysphagia & aspiration; on 1-7-24 CNA served resident thin liquids instead of nectar thick liquids

- *LN observed resident coughing & choking & suctioned resident multiple times but resident continued to sound congested; staff sent resident to ER & resident in respiratory distress with abnormal lung sounds & required BiPAP treatment; resident returned to facility that day on ABT; facility's failure to follow resident's therapeutic diet order for thickened liquids placed resident in immediate jeopardy; failed to provide 1 resident with physician-ordered thickened liquids on 1-7-24 when resident received thin liquids & aspirated; facility sent resident to ER for eval & tx for aspiration & resident returned with ABT for aspiration pneumonia placing resident in immediate jeopardy*

- *Past Non-Compliance Plan:*
  - *Dietary & Nursing staff educated on diets & fluid consistencies*
  - *Resident evaluated by ST with diet recommendations for puree with honey-thickened liquids*
  - *CNA received written warning for failing to follow policy*
  - *Resident diet order changed to puree with honey-thickened liquids*
  - *Resident' CP updated*

F812 Food Procurement, Store/Prepare/Serve-Sanitary

NE: SS=E: Failed to measure & record food temps for pureed food items at mealtimes placing 2 residents who received pureed diets at risk for foodborne illness

- Observed preparation of pureed diets & placed servings into bowls then placed uncovered bowls on lid of compartment on steam table then served pureed diets to residents w/o checking food items' temps before serving meals; Weekly Steam Table Temp Logs lacked documentation staff obtained pureed diet food temps at mealtimes for multiple days in multiple months on multiple units; failed to obtain meal temps for pureed food items before meal service placing residents who received pureed diets at risk for foodborne illness

NE: SS=F: Failed to store, prepare & serve food in sanitary manner for residents who resided in facility & received meals from facility's main kitchen placing residents at risk for foodborne illness

- Observed blades of box fan in dishwashing area with debris; food transport carts visibly soiled; shelving throughout kitchen with pans bowls with greasy, sticky film; cabinets & drawer fonts with peeling paint & sticky & with debris adhered; wall with paint loss & spatters along with dusty, gritty top; stove top & oven front with dark staining on doors alone; backsplash not clean; stainless steel containers with sugar & flour with liquid staining & debris on outer walls & tops; ceiling tiles with brown staining & coming loose at support edges; 7 air intake screens with thick dark substance adhered

NW: SS=F: Failed to ensure refrigerator seals were intact & failed to use sanitation strips for 3-compartment sink placing residents at risk for foodborne illness

- Observed multiple 2-door fridges with door seals peeling off both doors; observed 3-compartment sink with water in sink & cork board above sink with large pieces of cork falling into sink; observed sanitation strips with expired strips

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

- Observed walk-in fridge with open, unsealed, undated roll of meat on eye level shelf with bowls of produce directly under thawing meat; observed open, undated, unsealed bags of produce; walk-in freezer with opened unsealed box of meat strip that lacked open date; observed staff prepared over-easy cooked eggs for resident consumption

F835 Administration

SE: SS=F: Failed to provide administrative services in manner to effectively & efficiently use resources to attain/maintain each resident's highest physical, mental, & psychosocial wellbeing when administrator failed to follow up on plans for correction from a resident's elopement from facility to prevent another elopement with potential to affect all residents residing in facility

- *Cited findings noted in F689 & F741; Cited F867 (QAPI); failed to provide administrative services in manner to effectively & efficiently use resources to attain/maintain each resident's highest physical, mental & psychosocial wellbeing when administrator failed to follow up on plans for correction from resident's elopement from facility to prevent another elopement with potential to affect all residents residing in facility*

F851 Payroll Based Journal

NE: SS=F: Failed to submit complete & accurate staffing information to PBJ when facility failed to submit staffing hour data for all direct care personnel as required placing residents at risk for impaired care due to unidentified staffing issues

- PBJ reported indicated no RN hours for 4 or more days during 1 quarter & was triggered for 1 staff rating; Adm stated inaccurate PBJ reporting due to change of staff responsible for reporting & facility had ID'd error & started a PIP; failed to submit accurate information to CMS PBJ placing residents at risk for impaired care due to unidentified staffing issues

F867 QAPI/QAA Improvement Activities

SE: SS=F: Failed to ensure QAPI program ID'd resident care issues to enhance residents' quality of life, failed to implement appropriate & effective action plans for mitigation of ID'd elopement risk of 1 resident who had known elopement behaviors & hx of elopement to prevent additional elopement from facility

- *Cited findings noted in F689, F741 & F835 r/t repeated elopement from facility; failed to provide sufficient staff with appropriate competencies & skill sets to meet behavioral health needs of 1 resident who had known elopement behaviors & recent hx of elopement (previously on 1-5-24) to prevent additional elopement on 1-28-24 from facility*

NE: SS=F: Failed to provide good faith efforts to ID multiple issues of concern for all residents currently residing in facility placing all residents at risk for unidentified & ongoing care issues

- Referenced: F550, F580, F610, F656, F657, F677, F684, F686, F689, F690, F692, F698, F730, F742, F744, F745, F756, F757, F758, F761, F812, F880, F883; failed to ID multiple issues of concern for all residents residing in facility placing residents at risk for quality of care

F868 QAA Committee

NW: SS=F: Facility lacked evidence required Infection Preventionist attended QAA quarterly meetings placing residents who resided in facility at risk for decreased quality of care

- Failed to retain evidence of required QAA & QAPI member, Infection Preventionist, attended meetings at least quarterly placing residents at risk of unidentified quality of care services

F880 Infection Prevention & Control

NE: SS=E: Failed to ensure COVID isolation protocols were followed placing residents at increased risk for COVID infection

- Observed resident in COVID isolation with symptoms of COVID infection; observed therapy staff assisted resident but did not wear face mask & resident did not wear mask & coughed a few time; observed CNA came out of isolation room wearing isolation gown & face mask then removed mask & glow, wadded them up together & carried them across dining & common area to soiled utility then walked back across common area to wash hands; observed CNA donned PPE & entered resident's isolation room then came out with contaminated PPE on, stood in hall to remove PPE, wadded it up & carried it across common area to soiled utility; observed CNA donned PPE including goggles then came back out & removed PPE in hall before wadding up PPE against uniform & carrying it across common area to soiled utility room then returned to room with trash bags for cart outside resident's room; failed to ensure COVID isolation protocols were followed, placing residents of facility at risk for COVID infection

NE: SS=F: Failed to ensure proper infection control standards were followed r/t implementation of procedures to monitor & prevent Legionella disease or other opportunistic waterborne pathogens placing residents at risk for complications r/t infectious diseases

- Water Management Program lacked text & diagrams specific to building's water flow system & program did not ID building-specific areas at risk for Legionella or ID specific points within system checked by water management program team; maintenance staff stated did not have diagramed flow chart of facility water system; failed to ensure proper infection control standards were followed r/t implementation of procedures to monitor & prevent Legionella disease or other opportunistic waterborne pathogens placing residents at risk for complications r/t infectious diseases

NW: SS=D: Failed to handle soiled linen in sanitary manner to prevent development & transmission of communicable diseases & infection placing affected resident at risk for infection

- Observed multiple CNAs walked out of residents' rooms carrying unbagged soiled linen, walked to end of hallway & then placed soiled linen in soiled linen barrel on multiple occasions; failed to handle soiled linen in manner to provide safe, sanitary environment to prevent development & transmission of communicable diseases & infection placing affected residents at risk for infection

F882 Infection Preventionist Qualifications/Role

NE: SS=F: Failed to designate a staff member with required qualification & certification as Infection Preventionist who was responsible for facility's IPCP placing all residents at risk for lack of identification, tracking/trending, & treatment of infections

- Adm nurse stated facility did not have certified infection preventionist; failed to designate staff member with required qualification & certification as Infection Preventionist, responsible for facility's ICPC placing all resident residents at risk for lack of ID, tracking/trending, & treatment of infections

F883 Influenza & Pneumococcal Immunizations

NE: SS=E: Failed to follow latest guidance from CDC when facility failed to offer, obtain informed declination or a physician-documented contraindication for pneumococcal PCV20 vaccination placing residents at risk for acquiring, spreading & experiencing complications from pneumococcal disease

- 5 resident records lacked evidence of consent, informed declination or physician-documented contraindication for current pneumococcal vaccine PCV20; failed to offer pneumococcal PCV20 vaccinations per CDC recommendations placing residents at risk of acquiring, spreading & experiencing complications from pneumococcal disease

NE: SS=E: Failed to follow latest guidance from CDC when failed to offer, obtain informed declination or physician-documented contraindication for pneumococcal PCV 20 vaccination placing residents at risk of acquiring, spreading & experiencing complications from pneumococcal disease

- Review of 5 resident clinical records lacked evidence facility or resident representative received or signed consent or informed declination for PCV20; failed to offer &/or obtain informed declinations for PCV 20 pneumococcal vaccinations placing residents at risk of acquiring, spreading & experiencing complications from pneumococcal disease

F908 Essential Equipment, Safe Operating Condition

NW: SS=E: Failed to ensure kitchen's plate warmer & prep sink were in safe & operable condition placing residents who received meals from kitchen at risk of receiving cold food & inoperable prep sink created risk for foodborne illness

- Failed to maintain all mechanical equipment in safe operating condition placing residents who received meals from kitchen at risk of receiving cold food & inoperable prep sink at risk for foodborne illness

F947 Required In-Service Training for Nurse Aides

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

- 5 CNA w/o evidence of in-service/education hours in past 12 months; Adm nurse stated facility provided education for staff but facility did not have a way to track hours of education provided for year; failed to ensure 5/5 CNA staff reviewed had required 12 hours of in-service including required topics per year placing residents at risk for inadequate care

March, 2024

F550 Resident Rights/Exercise of Rights

SE: SS=E: Failed to show respect & dignity for 4 residents for: 1 resident for standing over resident while feeing resident & 1 resident r/t failure to use dignity bag on catheter collection bag; 1 resident r/t not knocking on door before entering resident's room while cares b eing given & 1 resident r/t facility not allowing resident to wear compression stockings

- Failed to ensure staff dressed resident in support hose per resident's preference to promote resident's sense of wellbeing
- Failed to maintain resident's dignity by staff entering room unannounced during personal care & remained in room when resident was exposed
- Failed to show respect & dignity to dependent resident while feeding resident meal
- Failed to utilize dignity bag to hold catheter bag of dependent resident with indwelling urinary catheter

NE: SS=D: Failed to promote care for 1 resident who was dependent on staff assist for all ADLs in manner that preserved resident's dignity placin g resident at risk for impaired psychosocial wellbeing & undignified living environ ment

- Observed resident's room across from open communal dining room & resident's door open & observed resident in bed with incontinence brief & uncovered from waist down & resident visible from hallway & part of DR while resident in bed with brief & legs e xposed on multiple occasions; failed to promote care for 1 resident who was dependent on staff assist for all ADLs in manner that prese rved resident's dignity placing resident at risk for impaired psychosocial wellbeing & undignified living environment

NE: SS=D: Failed to ensure 1 resident was treated with respect & dignity r/t personal hygiene & facility also failed to ensure di gnified dining experience when staff stood over 2 residents instead of sitting beside resident while assisting residents with meal s placing residents at risk for negative psychosocial outcomes & decreased dignity

- Observed resident on multiple occasions with hair uncombed & sticking up; failed to ensure 1 resident was assisted with combi ng hair placing resident at risk for negative psychosocial outcomes & decreased dignity
- Failed to ensure 2 residents were treated with dignity during dining placing residents at risk for weight loss & impaired dig nity

NE: SS=D: Failed to provide care in respectful, dignified manner for 1 resident when s taff failed to place resident's catheter bag inside dignity bag & failed to provide a dignified dining experience for 1 resident when staff stood beside resident while assisting with meal pla cing residents at risk for impaired dignity & quality of life

- Failed to ensure resident treated with dignity during dining when staff stood beside resident while assisting resident with meal with risk for weight loss & impaired dignity
- Failed to provide care in respectful, dignified manner for 1 resident when staff fail ed to place resident's catheter bag inside dignity bag placing resident at risk for impaired dignity & quality of life

NW: SS=E: Failed to promote care in manner to maintain & enhance dignity & respect when staff administered injection to resid ent beside front entry to facility & in view of other residents & when residents were served meals in Styrofoam bowls instead of regular dinne rware placing residents of facility at risk for impaired dignity

- Observed lunch meal served with Styrofoam bowls for baked beans & desserts; observed LN obtained finger stick blood sugar then administered insulin in resident's abdomen by front entry with 1 resident nearby & resident watching from DR; staff reported facility only had large bowls & used Styrofoam bowls for desserts for at least past year; failed to promote care in manner to maintain & enhance dignity & respect when staff administered insulin to 1 resident in view of other residents & when residents were served meals on disposable dinnerware placing residents at risk for impaired dignity

F553 Right to Participate in Planning Care

NE: SS=D: Failed to include 1 resident in development & planning of resident's CP placing resident at risk for I paired care & autonomy

- CP documented last care conference was on 11-29-22; EMR lacked further documentation of care conferences; failed to include resident in development & planning of resident's CP placing resident at risk for impaired care & autonomy

F558 Reasonable Accommodations Needs/Preferences

SW: SS=D: Failed to provide 1 resident reasonable accommodations to physical environment when resident could not access mirror

- Observed resident in w/c in room & with areas of unshaven facial hair & stated had difficulty seeing mirror to shave due to l ocation in BR as he did not stand to shave; observed resident with several days of facial hair growth & resident stated preferred to be clean shaven but could not see mirror to complete task; failed to provide reasonable accommodations to physical environment when resident coul d not access mirror

NE: SS=D: Failed to ensure 1 resident's call light remained within reach; additionally failed to honor 1 resident's preferenc es r/t bathing leaving both residents vulnerable to impaired care & decreased autonomy

- Failed to ensure resident's call light remained within reach placing resident at risk for preventable accidents & injuries
- Resident stated did not get shower 2 days earlier & had asked CNA on evening shift but did not get a shower; Failed to honor resident's preferences for bathing leaving resident vulnerable to impaired care & decreased autonomy

F565 Resident/Family Group & Response

NE: SS=E: Failed to adequately address & resolve recurring issues reported by Resident Council placing residents at risk for decreased psychosocial wellbeing & impaired quality of life

- Meeting noted documented recurring concerns r/t missing property & clothing, slow call light response & staff response time, staff cell phone use, lack of healthy snacks, specialized diets & grievances not being resolved; failed to adequately address & resolve recurring issues reported by Resident Council placing residents at risk for decreased psychosocial wellbeing & impaired quality of life

F576 Right to Forms of Communication with Privacy

NE: SS=D: Failed to ensure 1 resident's right to private communications when resident's package was opened placing resident at risk for impaired privacy & decreased autonomy

- Failed to ensure 1 resident's right to private communications when resident's package was opened, & contents were removed prior to resident receiving package placing resident at risk for impaired privacy & decreased autonomy

F582 Medicaid/Medicare Coverage/Liability Notice

SE: SS=E: Failed to ensure 3 residents received CMS form 10123 as required when skilled services ended; in addition facility failed to issue CMS 10055 to 1 resident as required

- Failed to issue CMS 10123 & CMS 1005 to ensure residents/representatives were informed of expedited review for discontinuation of therapies & estimated cost of continuing therapies & desire for continuation of skilled services as required

SW: SS=D: Failed to notify 1 resident a NOMNC at least 2 days before end of Medicare covered Part A stay

- Failed to give 1 resident a NOMNC at least 2 days before end of Medicare covered Part A stay

NE: SS=D: Failed to issue CMS SNF ABN form 10055 with required information for 2 residents placing residents at risk for decreased autonomy & impaired decision-making

- Staff reported SSD responsible to complete ABNs but had quit about 6 weeks prior; Failed to ensure forms provided at end of skilled services contained required information for residents to make informed choices & appeal non-coverage decisions placing residents at risk for decreased autonomy & impaired decision-making

NE: SS=D: Failed to issue SNF ABN form 10055 for 2 residents placing residents at risk for decreased autonomy & impaired decision-making

- Facility unable to provide evidence staff issued SNF ABN 10055; Adm stated unaware needed to use form 10055 with estimated cost for continued services; failed to ensure forms provided at end of skilled services contained required information for residents to make informed choices & appeal non-coverage decisions placing residents at risk for decreased autonomy & impaired decision-making

F584 Safe/Clean/Comfortable/Homelike Environment

SE: SS=E: Failed to ensure to maintain environment in safe, sanitary & homelike manner to promote wellbeing of residents

- Observed beauty shop with torn floor mat across entire surface & stained tiles around base of HVAC unit & vent on ceiling with accumulation of dust; shower room with missing/loose tile around drain; multiple resident rooms with unoccupied, unmade sanitized beds; resident room with unused commode bucket under bed; multiple resident room hall doors with broken/buckled plastic door guards; multiple resident rooms with torn door molding; resident room with wooden cupboards with scratches horizontally across surface & drawers to wooden unit with mismatched wood stain; large bird cage with streaks of white substances down front windows; wooden doors with multiple scratches in wood horizontally; heating units with scratches in paint along entire horizontal surface

SE: SS=E: Failed to provide unstained towels & washcloths to residents in 1 Green House

- Resident reported certified staff does laundry, supplies towels & washcloths to residents but towels are often stained, rough &/or worn; observed hand towel with large gray stain over 3% of towel; observed 8 hand towels & 2 washcloths with stains of varying sizes with rough coarse texture & several areas or worn texture

F585 Grievances

NE: SS=E: Failed to implement a system to allow residents/representatives to file grievances anonymously; additionally failed to maintain results of all grievances for required 3 years placing residents at risk for decreased psychosocial wellbeing & unresolved grievance & concerns

- Grievance Logs revealed facility missing logs from November 2023 thru February 2024 & facility unable to provide missing documentation; inspection revealed no designated grievance drop boxes or system available in areas accessible to residents & visitors of facility; failed to implement system to allow residents &/or representatives to file grievances anonymously within facility; additionally failed to maintain grievance records placing residents at risk for decreased psychosocial wellbeing & unresolved grievances

F606 Not Employ/Engage Staff w/Adverse Actions

SW: SS=D: Failed to conduct criminal background checks for 1/3 staff members to ensure no abuse to residents of facility

- Review of employee files revealed lack of criminal background check for 1/3 employee records reviewed; failed to conduct a CBC with potential to negatively affect care delivered to residents

F609 Reporting of Alleged Violations

NE: SS=D: Failed to report allegation of resident-to-resident abuse between 2 residents to State Agency (SA) within mandated timeframe placing resident at risk for unresolved & ongoing abuse

- *Resident with schizophrenia with hallucinations; CP documented resident "had difficulty keeping his hands to himself at times"; "Report of Concern" documented CNA reported resident was touching other residents sexually & inappropriately alleging resident was rubbing other resident's private areas; other resident told resident to "stop" & pushed resident away; failed to report allegation of abuse between 2 residents to SA within mandated timeframe placing resident at risk for unresolved & ongoing abuse*

F623 Notice Requirements Before Transfer/Discharge

SW: SS=E: Failed to ensure staff notified State Ombudsman of 4/4 discharged/transferred residents reviewed; 1 resident who left facility AMA & 3 other residents who transferred to acute care

- Failed to notify state Ombudsman when resident discharged/transferred from facility as required for 4 residents placing residents at risk for impaired rights &/or advocate involvement

NE: SS=D: Failed to provide written notice of transfer as soon as practicable to 2 residents/representatives for facility-initiated transfers &/or discharge with risk of miscommunication between facility & resident/family & possible missed opportunities for healthcare service for 2 residents

- Failed to provide written notice of transfer as soon as practicable to 1 resident/representative for facility-initiated transfer with risk for miscommunication between facility & resident/family & possible missed opportunity for healthcare service for 1 resident
- Failed to provide written notice of transfer as soon as practicable to 1 resident/representative & failed to provide notification to LTCO as well placing resident at risk for miscommunication between facility & resident/family & possible missed opportunities for healthcare service for resident

NE: SS=D: Failed to provide notification to Stated LTC Ombudsman for 2 residents' facility-initiated transfers; failed to provide written notice of transfer as soon as practicable to 2 residents/representatives for facility-initiated transfers with risk of miscommunication between facility & resident/family & possible missed opportunities for healthcare services for 2 residents

- Failed to provide notification of facility-initiated transfer to LTCO for 1 resident; also failed to provide a written notice of transfer as soon as practicable for resident/representative with risk of miscommunication between facility & resident/family & possible missed opportunities for healthcare service for 2 residents

F625 Notice of Bed Hold Policy Before/Upon Transfer

SW: SS=D: Failed to provide 2 residents/representatives with written notice specifying duration & cost of bed hold policy at the time of resident's transfers to hospital

- EMR lacked signed bed hold for hospital admission; failed to provide resident/representative with written notice specifying duration & cost of bed hold policy at time of resident's transfer to hospital for 2 residents

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

- Failed to provide bed hold with required information to 1 resident/family representative when resident transferred to hospital placing resident at risk for impaired ability to return to facility or same room

NE: SS=D: Failed to provide a bed hold with required information for 2 residents/representatives when residents were transferred to hospital placing residents at risk for impaired ability to return to facility or same room

- Failed to provide bed hold with required information to 2 residents/representatives when residents transferred to hospital placing residents at risk for impaired ability to return to facility or residents' same rooms

F636 Comprehensive Assessments & Timing

SE: SS=D: Failed to complete accurate MDS for 2 resident including 1 resident r/t failure to complete CAA for nutrition & PUs & 1 resident r/t failure to complete CAAs for psychotropic drugs, pain, & mood state

- Adm stated aware of MDSs not being completed properly & had new MDS coordinator who was currently learning process to complete MDSs & CAAs appropriately; failed to complete accurate MDS for dependent resident r/t failure to complete Nutrition & PU CAAs
- Failed to ensure staff completed CAAs for resident for psychotropic meds, pain & mood state

SW: SS=E: Failed to develop comprehensive assessments by failure to completed CAAs for further investigation & development of comprehensive CP for 7 residents included in sample: 1 resident for respiratory status, 1 resident for med, ADLs & pain; 1 resident for skin issues; 1 resident for ADLs, PUs & meds; 1 resident for pain; 1 resident for pain, urinary catheter & skin conditions & 1 resident for medications

- CAA dated 2-20-24 revealed no CAAs triggered for further investigation to develop comprehensive CP; failed to develop comprehensive assessments by failure to complete CAAs for further investigation & development of CP for multiple residents as listed in findings statement
- Failed to completed pain CAA for resident with pain & received pain med
- Failed to completed "Psychotropic Drug Use", Psychosocial Well-Being" & "Cognitive Loss/Dementia" CAAs for resident who had dementia with psychotic disturbances

NE: SS=E: Failed to fully complete comprehensive MDS Section V, CAAs for 12 residents to include analysis & rationale for CPing decisions placing residents at risk for not accurately reflecting each resident's needs to develop individualized comprehensive CP

- Adm nurse stated did not realize there was separate page to go in to document analysis data for information that needed to be added to CP & after signed that page it would take staff back to original page with all sections on it & that allowed to validate everything & finalize section w/o completing worksheets; failed to completed comprehensive MDS Section V CAAs for 12 residents placing residents at risk for not accurately reflecting each resident's status & needs to develop individualized comprehensive CP

F637 Comprehensive Assessment After Significant Change

NE: SS=D: Failed to ID significant change in physical condition & complete significant change MDS for 1 resident with addition of hospice services placing resident at risk for unidentified care needs

- EMR lacked evidence facility completed Significant Change MDS to address resident's recent physical decline & addition of hospice services within required timeframe; failed to ID a significant change & addition of hospice services for 1 resident's physical condition & complete a comprehensive significant change MDs placing resident at risk for not receiving needed care

NE: SS=D: Failed to completed Significant Change MDS for 1 resident after addition of hospice services to ID needs, in order to develop an individualized comprehensive CP

- Record lacked evidence facility completed Sig Change MDS to address resident's recent physical decline & addition of hospice services within required timeframe; failed to ID addition of hospice services for 1 resident as significant change & complete comprehe nsive Sig Change MDS placing resident at risk for unidentified care needs

F641 Accuracy of Assessments

NE: SS=D: Failed to ensure accurate assessment & documentation on MDS r/t resident's discharge location with risk of miscommu nication r/t resident's continued care needs

- Discharge MDS documented resident discharged to hospital but left facility as planned discharge; Failed to ensure accurate assessment & documentation on MDS r/t resident's discharge location with risk of miscommunication r/t resident's continued care needs

NE: SS=D: Failed to completed accurate MDS for 1 resident's status r/t use of restraint placing resident at risk for inappropriate CPing & care needs

- CP lacked direction for trunk restraint; POS lacked order for trunk restraint; failed to accurately document resident's status on MDS for use of trunk restraint that was not ordered placing resident at risk for inappropriate CPing & care needs

F644 Coordination of PASARR & Assessments

SE: SS=D: Failed to obtain a reassessment for 1 resident to determine mental health needs as required

- Resident with schizophrenia with psychotic d/o, delusions, hallucinations & osteomyelitis; Record revealed PASARR determinati on letter which indicated level of services provided in facility for mental health for temporary period for stabilization of resident's mental health condition & letter instructed facility to request another assessment if at end of 12 months resident required more time in fa cility; record lacked reassessment documentation; failed to request reassessment for 1 resident to det ermine continued care needs for services in nursing facility/nursing facility for mental health as required

F655 Baseline Care Plan

SW: SS=D: Failed to develop a baseline CP for 3 residents including: 1 resident r/t not having baseline CP; 1 resident r/t failure to include dialysis & 1 resident r/t failure to include psychotropic medication

- Record lacked Baseline CP; failed to complete Baseline CP as required
- Failed to include antipsychotic, Aripiprazole for dementia with psychosis on Baseline CP for depen dent resident who took antipsychotic med
- Failed to include dialysis cares on Baseline CP for resident who received dialysis 2x/wk

NE: SS=D: Failed to ID resident's required level of care assistance & high-risk medication (Seroquel) on CP; additionally failed to completed baseline CP for 1 resident placing both residents at risk for preventable falls & injuries due to uncommunicated care needs

- Failed to ID required level of care assistance & Seroquel med on baseline CP placing both residents at risk for prev entable falls & injuries due to uncommunicated care needs

F656 Develop/Implement Comprehensive Care Plan

SE: SS=E: Failed to develop comprehensive CPs for 4/22 residents reviewed: 1 resident for use of support hose; 1 resident for fluid restriction; **1 resident for type of music, TV shows & religious preferences** & 1 resident for shaving preferences

- Failed to include 1 resident's preference for wearing support hose in CP to promote sense of wellbeing
- CP lacked genre of music resident enjoyed, TV shows resident liked to watch & lacked resident's religion; failed to complete a person-centered comprehensive CP to meet dependent resident's activity preferences
- CP lacked staff instruction on facial shaving; failed to complete person-centered comprehensive CP to meet dependent resident's preferences for facial shaving
- CP lacked guidance r/t resident's fluid restriction; failed to include resident's fluid restriction for staff guidance on comprehensive CP

NE: SS=D: Failed to develop comprehensive CPs for 3 residents placing residents at risk for impaired care due to uncommunicated care needs

- Failed to develop comprehensive CPs for 1 resident r/t air mattress settings placing resident at risk for impaired care due t o uncommunicated care needs
- Failed to ensure 1 resident's comprehensive CP included personal preference r/t trimming facial hair was included on person-centered CP placing resident at risk of impaired care due to uncommunicated care needs
- CP lacked interventions r/t resident's insulin & use of daily leg wraps; failed to develop & implement comprehensive, person-centered CP for 1 resident placing resident at risk for impaired care due to uncommunicated care needs

NW: SS=D: Failed to develop & implement a comprehensive person-centered CP for 1 resident's respiratory needs & equipment placing resident at risk for respiratory wellbeing due to uncommunicated care needs

- *CP lacked any documentation or direction r/t resident's Trilogy non-invasive ventilator; observed resident in w/c with O2 via nasal cannula & resident had 2-3-word dyspnea & Trilogy non-invasive ventilator sat on table behind resident's recliner; resident stated had missed medication multiple times in February & pain had been uncontrollable & could hardly move or sleep; resident stated had difficulty at night getting staff to hook up Trilogy & make sure O2 settings were moved up to 7 because nurse not always on unit; resident then s tated felt like staff would then yell at resident about why resident did not call somebody to put it on or have CNAs put it on & resident stated had been told CNAs could not touch Trilogy or titrate O2 & just could not understand why nurses were not taking responsibility fo r Trilogy & O2 titration; LN verified no orders for resident's Trilogy non-invasive ventilator & nothing in resident's CP r/t Trilogy non-invasive ventilator;*

failed to develop & implement comprehensive person-centered CP for 1 resident's respiratory needs & equipment placing resident at risk for respiratory wellbeing due to uncommunicated care needs

F657 Care Plan Timing & Revision

SE: SS=E: Failed to review & revise CPs for 4 residents including 2 residents r/t fall interventions; 2 residents r/t specifi c, individualized parameters for hypertensive meds

- Resident at high fall risk; resident with multiple falls; failed to review & revise CP for dependent resident following 2 non-injury falls
- Resident with fall; lacked intervention for multiple falls; failed to review & revise CP for dependent resident following 3 n on-injury falls
- CP lacked resident's specific BP parameters for hypertensive meds as ordered by physician; failed to review & revise CP for resident with specific BP parameters for BP medications
- Failed to review & revise CP for resident with specific BP parameters for BP medications

SE: SS=D: Failed to revise CPs for 2 residents: 1 r/t failure to CP fall with fx'd foot that required special walking boot & 1 r/t sk in care for PU

- CP failed to revise CP to include fall which resulted in fx'd toe & use of walking boot; failed to revise CP r/t resident's fall/interventions to guide staff with cares
- CP failed to include heel PU which developed & failed to include updated interventions for off-loading devices; failed to review & revise 1 resident's CP to include development of heel deep tissue injury & assess effectiveness of off-loading interventions for prevention/healing of deep tissue injury

SE: SS=D: Failed to review & revise CP for 1 resident r/t use of eyeglasses

- CP lacked staff instruction on resident's use of eyeglasses; resident stated glasses broken a long time ago & had not been repaired & had told staff but no one had taken them to be fixed & having wear old glasses & was unable to see well; Failed to review & revis e dependent resident's CP to include eyeglasses

SW: SS=E: Failed to revise CPs for 4 resident including 2 residents r/t falls & 2 resident r/t use of nebulizer equipment

- Failed to update or revise 2 residents' CPx to reflect use of nebulizer
- Failed to update or revise resident's CP to reflect new intervention for falls
- Failed to update CP for 1 resident r/t falls & accident hazards leading to additional falls & with potential for 1 resident suffering p hysical & psychosocial injuries

NE: SS=D: Failed to revise 1 resident's CP to include Spironolactone medication & 1 resident's CP t o include Eliquis; additionally failed to revise 1 resident's CP to include ordered hand splint placing residents at risk for impaired care due to uncommunicated care needs

- Failed to revise 1 resident's CP to include Spironolactone med placing resident at risk for impaired care due to uncommunicated care needs
- Failed to revise 1 resident's CP to reflect resident's use of anticoagulant placing resident at risk for impaired care due to uncommunicated care needs
- Failed to revise 1 resident's CP with application of hand splint on person-centered CP placing resident at risk of worsening contractures & further loss of independence with ADLs

F676 ADLs/Maintain Abilities

SW: SS=D: Failed to provide 1 resident assistance with facial shaving

- Cited findings noted in F558 r/t resident w/o access to mirror for shaving; failed to ensure resident received assistance with shaving as needed when resident could not effectively see mirror to ensure clean shaven appearance to enhance personal wellbeing

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to provide appropriate care to 1 dependent resident r/t facial shaving

- Resident dependent on staff for all ADLs; observed resident unshaven with scraggly overgrowth of facial hair; failed to provi de appropriate care to dependent resident r/t facial shaving

NE: SS=D: Failed to provide ADL assist to 2 resident who was dependent on staff assist for all ADLs placing residents at risk of decreased psychosocial wellbeing & impaired ADLs

- Cited findings noted in F550 r/t exposure of resident with door open; Adm staff stated if resident was in room with only a brief & was uncovered it was resident's choice as some people are comfortable that way & resident did not always want door shut; Adm nurse further stated believed staff knew resident's preferences as they worked with resident regularly; failed to provide ADL assist to 1 resident who was dependent on staff assist for all ADLs placing residents at risk of decreased psychosocial wellbeing & impaired ADLs

NE: SS=D: Failed to provide consistent bathing opportunities for 2 residents placing residents at risk for infections & decreased psychosocial wellbeing

- Observed documentation charting "NA" under bathing; Failed to provide consistent bathing opportunities for 1 resident placi ng resident at risk for infections & decreased psychosocial wellbeing; failed to provide consistent bathing opportunities for 1 resident placing resident at risk for infections & decreased psychosocial wellbeing
- Failed to ensure staff provided consistent bathing for resident who was unable to carry out ADLs placing resident at risk for impaired care & decreased quality of life

NE: SS=D: Failed to provide necessary assistance with personal hygiene for 1 resident placing resident at risk for poor hygie ne, decreased self-esteem & impaired dignity

- Failed to ensure resident received assistance with trimming facial hair placing resident at risk for poor hygiene, decreased self-esteem & impaired dignity; CP lacked direction to nursing staff of resident's preference for facial hair; failed to ensure resident received assistance with trimming facial hair placing resident at risk for poor hygiene, decreased self-esteem & impaired dignity

F679 Activities Meet Interest/Needs of Each Resident

SE: SS=E: Failed to ensure appropriate activities for 5/6 residents reviewed for activities

- Failed to provide activities to residents of facility to increase sense of wellbeing when observed activities listed on calen dar not provided; evening staff stated did not provide activities & lacked tools/supplies to provide residents with activities for 5 residents sampled for activities; records revealed minimal documentation of activity participation for multiple residents
- Failed to implement ongoing resident centered activity program for dependent resident

F684 Quality of Care

SW: SS=D: Failed to ensure 1/3 residents received appropriate treatment for unidentified skin injury & sanitary dressing chan ge

- Resident with lymphedema & muscle weakness; MDS revealed resident at risk for PUs & had skin tear & MASD; PU CAA not developed; Skin Evaluation documented thigh wound with drainage & open area to buttock, bilateral upper extremity bruising & bilateral l ower extremity edema & bruising/discoloration; POS for treatment order for all wounds; obse rved staff assisted resident to turn on side & sheet under bed saver pad with large area of yellow tan drainage & resident w/o dressing on coccyx & was incontinent of stool ; staff provided incontinent care then removed gloves 7 donned another pair of glove s w/o hand hygiene; Consulting provider noted area of fluid seepage; dressing on back of thigh undated & contained serosanguinous drainage across entire surface of dressing & area a previous blister had opened; Adm Nurse confirmed area on posterior thigh had not been assessed until current day & dressing should have date on it & wound treatment not documented; failed to ensure sanitary dressing change for 1 resident & failed to ID & treat posterio r thigh wound & failed to provide sanitary bed line to prevent spread of infection

NE: SS=D: Failed to ensure staff implemented nursing services consistent with standards of care when staff failed to follow a physician's order t o notify EMS when 1 resident had chest pain & required a 2nd dose of nitroglycerine (NTG) & failed to assess vital signs to monitor resident status placing resident at risk for delayed emergency care & complications r/t use of nitroglycerin

- *POS for Nitroglycerin q 5 minutes & repeat up to 2 times at 5-minute intervals & to call 911 if pain persisted longer than 5 minutes after first dose & resident continued to take 2nd & 3rd dose if pain persisted; March MAR documented resident received 3 doses; vitals documentation lacked evidence staff assessed BP directly before 1st or 2nd dose of NTG; record lacked evidence physician notified after 2nd dose as ineffective; failed to ensure staff implemented nursing services consistent with standards of care when staff failed to follow physician's order to notify EMS when resident received 3 consecutive doses of NTG; further failed to ensure that resident's BP was checked in between doses & that physician was contacted after first dose administered*

NE: SS=D: Failed to provide services to maintain 1 resident's highest practicable level of physical function & promote comfort; further failed to implement protective sleeve to resident's arm per POS & CP placing resident at risk for increased impairment, pain & contract ures & placed 1 resident at risk for skin injury

- Resident receiving hospice care & should not have been precluded from restorative services due to being on hospice services; Failed to provide services to maintain resident's highest practicable level of physical function & failed to promote comfort placing resident at risk for further impairment, pain & contractures
- Failed to apply protective sleeve to 1 resident per physician order & CP placing resident at risk for skin injury

F685 Treatment/Devices to Maintain Hearing/Vision

SE: SS=D: Failed to ensure 1 resident received adequate assistive devices to maintain proper vision by failing to have glasses repaired in timely manner

- Cited findings noted in F657 r/t broken eyeglasses; failed to ensure dependent resident received assistive devices resident required to maintain proper vision

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

SE: SS=D: Failed to ensure alternative methods of pressure relief provided for 1/3 residents reviewed for PUs

- Resident with facility-acquired deep tissue injury to heel with note to use off-loading boots; observed resident in bed with pillow under resident's calves but heels directly on bed; failed to provide effective heel off-loading interventions in timely manner for prevention/healing of 1 resident's deep tissue injury

SW: SS=D: Failed to appropriate clean PU of 1 resident by failing to cleanse wound before applying a new dressing to area

- EMR with POS for PU treatment order; Observed Adm nurse & CNA to change dressing to PU & removed old dressing & re-dressed wound & failed to clean wound before placing calcium alginate & dry dressing onto wound as ordered; failed to appropriately clean PU of dependent resident

NE: SS=D: Failed to ensure 2 residents received pressure-reducing interventions for PUs placing 2 residents at increased risk for PU development

- CP documented to float heels; CAA documented resident readmitted to facility with stage 2 wounds to buttocks; TAR lacked evid ence resident refused to allow staff to float heels while in bed from 3-1 to 3-5; observed resident's heels rested directly on mattress & soles of

feet pressed against footboard of bed & no evidence of pillow, wedge or other device in place to float resident's heels as resident in bed; failed to ensure resident's heels were floated while resident in bed to prevent PUs placing resident at risk for PU development

- MDS documented resident had 1 unhealed PU during observation period; CAA documented pressure relieving measures in place for resident was low air loss mattress, cushion in w/c & staff would float heels; CP with Prevalon boots on bilateral extremities at all times; POS for Prevalon boots at all times as tolerated & float heels; observed resident in bed & heels not floated & not wearing Prevalon boots; failed to ensure pressure-reducing measures were placed on resident's bilateral lower extremities as ordered placing residents at risk of development of PUs, & of wound worsening

NE: SS=D: Failed to ensure pressure-reducing measures were placed on 2 resident's bilateral lower extremities placing residents at risk for developing PUs & worsening of current wounds

- Failed to ensure pressure-reducing measures were placed on resident's bilateral lower extremities currently with pressure-related ulcer placing resident at risk of developing further PUs & worsening of current pressure injuries
- Failed to ensure pressure-reducing boots were placed on 1 resident's bilateral lower extremities as ordered placing resident at risk for delayed healing &/or wound worsening

NE: SS=D: Failed to ensure 1 resident's low air-loss mattress pump was set to tolerable comfort level & correct for current weight; additionally failed to utilize pressure-relieving boots for 1 resident placing both residents at risk for complications r/t skin breakdown & PUs

- Failed to ensure 1 resident's low air-loss mattress pump was set to tolerable comfort level & correct weight placing resident at risk for complications r/t skin breakdown & PUs
- Failed to implement pressure-reducing boots for 1 resident who was at risk for developing PUs placing resident at risk for development of PUs

F688 Increase/Prevent Decrease in ROM/Mobility

SE: SS=D: Failed to ensure restorative services for 1/3 residents reviewed for positioning/mobility

- EMR lacked documentation of restorative program; failed to provide restorative services for resident with impairments in function in extremities to maintain functional ROM

SE: SS=D: Failed to ensure staff provided ROM services for 1/3 residents reviewed for restorative

- Resident dependent for all ADLs & with impairment on both sides & received active ROM 4days of assessment period; CP for restorative instructed staff to provide PROM to upper & lower extremities & neck; Restorative plan for 15 minutes 3-6x/wk; EMR revealed staff failed to complete restorative cares for 8 days between 2-28 & 3-27; failed to provide appropriate tx & services to prevent further decrease in ROM for dependent resident with hand contractures

NE: SS=D: Failed to ensure 1 resident was provided services & treatment to prevent contractures from worsening in bilateral hands leaving resident at risk for further decline & decreased ROM or mobility

- CP lacked direction for staff to provide tx for resident's hand contractures; failed to ensure resident received services & treatment for multiple contractures to prevent avoidable reduction of ROM &/or mobility leaving resident at risk for further decline & decreased ROM

NE: SS=D: Failed to ensure 1 resident's splint was applied as directed to prevent avoidable reduction of ROM &/or mobility of hand leaving resident at risk for further decline & decreased ROM or mobility

- Failed to ensure 1 resident's hand splint was applied & removed as directed to prevent avoidable reduction of ROM &/or mobility leaving resident at risk for further decline & decreased ROM

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=D: Failed to initiate appropriate interventions following non-injury falls for 2 residents

- Resident at high fall risk; resident with multiple falls with multiple post-fall interventions that were duplicate interventions from previous falls; failed to initiate appropriate interventions following 2 non-injury falls for resident with high risk for falls
- Resident at high fall risk; multiple post-fall investigations lacked interventions to prevent further falls; failed to initiate appropriate intervention following 2 falls for resident with high risk for falls

SW: SS=D: Failed to ensure staff provided safe environment as free of accident hazards as possible for 1 resident

- Failed to ensure staff provided a safe environment as free of accident hazards as possible for 1 resident leading to additional falls & with potential for 1 resident suffering physical & psychosocial injuries r/t no IDT meeting or fall huddle after falls & staff confirmed staff did not follow CP interventions to prevent further falls

NE: SS=D: Failed to provide environment free of accident hazards resulting in 1 resident's non-injury fall in facility's spa room; additionally failed to implement wandering interventions for 1 resident & failed to provide safe transferring practices for 1 resident placing both residents at risk for preventable falls & injuries

- Failed to provide environment free of accident hazards resulting in 1 resident's non-injury fall in facility's spa room; additionally facility failed to implement wandering interventions for resident after non-injury fall to prevent further accidents placing resident at risk for preventable falls & injuries
- CP instructed staff to ensure resident with footwear on & staff to assist resident with use of gait belt; observed CNA did not place resident's tennis shoes on feet or use gait belt during walk from bed to BR; failed to ensure staff applied appropriate footwear & used gait belt during ambulation for 1 resident who had hx of falls & was high fall risk placing resident at risk for further falls & possible injuries

NE: SS=J (Abated to G): Failed to ensure a safe environment free from preventable accidents for 1 resident when resident slipped from sling during staff=assisted transfer using Hoyer lift; 2 CNAs attempted to transfer resident from bed to chair using Hoyer lift with toileting sling; resident slipped out of opening in toileting sling & fell to floor; resident hit head on metal leg of Hoyer lift & as result of fall, resident admitted to ICU with head

laceration, thoracic fx & intracranial hemorrhage; facility failed to ensure resident remained free from preventable accidents when staff used wrong sling during mechanical lift transfer & failure placed resident in immediate jeopardy

- *CP lacked documentation of specific size & type of sling used to transfer resident; Failed to ensure 1 resident remained free from preventable accidents when staff used wrong sling during mechanical lift transfer & resident fell through sling & as result of fall, resident admitted to ICU due to head laceration, spinal fx & brain bleed & bruising placing resident in immediate jeopardy*
- *Abatement Plan:*
  - *Facility retrained staff on using proper lift & sling for Hoyer transfers*
  - *Compiled a list of residents that used Hoyer lift for transfers & Kardex for each of those residents was updated to include proper size/type of sling*
  - *"Patient Lift Safety Guide" was reviewed with nursing staff & facility completed education on current policy*

NE: SS=E: Failed to ensure environment free from accident hazards when staff failed to secure chemicals in safe, locked area & out of reach of 13 cognitively impaired, independently mobile residents; additionally failed to utilize safe assistive techniques r/t resident's w/c foot pedals & safe mechanical lift transfer techniques for 2 residents placing residents at risk for preventable accidents & injuries

- Observed unlocked janitor closet with hazardous chemicals accessible; observed spa rooms with unlocked cabinets with hazardous chemicals accessible; failed to secure chemicals in safe, locked area & out of reach of 13 cognitively impaired, independently mobile residents placing residents at risk for preventable accidents & injuries
- Failed to ensure environment free from accident hazards when staff failed to use foot pedals when staff propelled resident in w/c placing resident at risk for preventable accidents & injuries
- Failed to ensure environment free from preventable accidents when staff hit 1 resident in head with Hoyer lift bar during transfer placing resident at risk for preventable injuries for 2 residents

F690 Bowel/Bladder Incontinence, Catheter, UTI

SE: SS=D: Failed to use anchoring device for 1 resident & failed to ensure catheter tubing was kept off floor for 1 resident

- Staff stated resident's catheter tubing anchor kept coming off so staff di not always put anchor back on resident; failed to use anchoring device for dependent resident with urinary catheter in order to prevent injury to resident
- Failed to prevent dependent resident's catheter tubing from coming into contact with floor

NE: SS=D: Failed to ensure appropriate Foley catheter care for 1 resident when staff failed to maintain urine collection bag below resident's bladder to encourage dependent drainage placing resident at risk for complications r/t UTIs

- Observed staff failed to ensure catheter bag was placed below resident's bladder causing urine to be allowed to pool in catheter tubing; failed to ensure appropriate Foley catheter care & services for 1 resident placing resident at risk for complications r/t UTIs

NE: SS=D: Failed to follow standards of practice r/t sanitary catheter care for 1 resident placing resident at risk for complication-related UTIs

- Resident with indwelling catheter for neurogenic bladder; resident with hx of UTI; observed resident in room & tubing & collection bag with urine & LN performed catheter care & raised bag above level of bladder & laid it on top of other side of resident's bed & urine noted to flow backward in tubing; during pericare, bag fell to floor & LN pulled it back onto bed by tubing; failed to ensure 1 resident's catheter collection bag was kept below bladder during catheter care & brief change placing resident at risk for infection & cathete r-related complications

F692 Nutrition/Hydration Status Maintenance

SE: SS=D: Failed to monitor 1 resident for physician ordered fluid restriction

- POS for 2000 mL fluid restriction; CNA stated did not know how staff monitored resident's fluid restriction; failed to monitor physician prescribed fluid intake for resident that required fluid restriction

NE: SS=G: Failed to obtain accurate weights & verify weight changes r/t resident's physician-ordered weekly weights to effectively monitor weight trends & ID concerns before significant weight loss occurred; further failed to ensure staff served resident diet resident could safety consume; as result resident had significant unplanned weight loss of 28.38% within 1 month

- Resident with CHF, dysphagia, cognitive-communication d/o & dementia; POS for diet with regular, minced & moist; POS for daily weights x 3 days, then weekly weights for 4 weeks then monthly weights; Admission weight of 148 on 2-14-24 & 107 on 3-7-24; observed resident served Brussel sprouts that were not minced & resident unable to eat; failed to obtain accurate weights & verify weight changes r/t 1 resident's physician ordered weekly weights to effectively monitor weight trends & ID concerns before a significant weight loss occurred; further failed to ensure staff served resident diet resident could safely consume; as result, resident had significant unplanned weight loss of 28.38% within 1 month

NW: SS=D: Failed to ID & implement interventions to prevent weight loss for 1 resident placing resident at risk for further weight loss or health issues

- CP directed staff to weigh resident weekly, invite to food-related activities & offer food or beverages of choice to encourage intake; EMR lacked documentation staff added fortified foods as recommended by RD; POS for Ensure BID; Adm nurse verified staff had not obtained resident's weights weekly & stated staff should have notified physician & RD earlier than 2 weeks after significant loss & should have started supplement when resident refused to eat; failed to provide fortified foods to prevent weight loss for 1 resident placing resident at risk for further weight loss or health issues

F694 Parenteral/IV Fluids

NE: SS=D: Failed to assess & document location, appearance & patency each shift for 1 resident's IV access site placing resident at risk for infection & complications r/t IV therapy

- Resident with inflammation reaction r/t internal joint prosthesis with methicillin-susceptible staph aureus infection; CP documented staff to change IV dressing as ordered & to check dressing site daily; TAR documented to observed PICC line site & document q shift & before & after administration of meds during dressing changes & PRN for infiltration & extravasation q shift for PICC site observation; LN stated only documented on PICC line if noted any abnormal findings or complications during administration of ABT; Adm nurse stated facility charted by exception for PICC line observations; failed to ensure that nursing staff appropriately assessed & documented location, appearance, & patency of resident's PICC line IV access site placing resident at risk for infection & complications r/t IV

F695 Respiratory/Tracheostomy Care & Suctioning

SW: SS=D: Failed to provide necessary respiratory care consistent with professional standards of practice r/t use of nebulizer for 2 residents

- Resident with COPD; POS for O2; CP failed to include interventions r/t use of nebulizer &/or interventions r/t care of nebulizer; observed nebulizer tubing & med chamber/mouthpiece hung off bed side cabinet, hooked on drawer handle on multiple occasions; failed to provide respiratory care consistent with professional standards of care for 1 resident r/t use & cleaning of nebulizer
- Observed resident in bed with O2 hooked to nebulizer; Adm nurse revealed nebulizers have not been washed or rinsed after each use; failed to provide respiratory care consistent with professional standards of care for resident r/t use & cleaning of nebulizer

NE: SS=D: Failed to provide adequate respiratory care & services for 1 resident when staff failed to ensure orders to clarify settings & failed to ensure sanitary storage for 1 resident's respiratory equipment placing resident at increased risk for respiratory infection & complications

- EMR lacked evidence staff disinfecting BiPAP routinely & BiPAP mask laid on top of machine & not stored in container or bag on multiple occasions; failed to provide adequate respiratory care & services for 1 resident when staff failed to ensure orders to clarify settings & failed to ensure sanitary storage for resident's respiratory equipment placing resident at increased risk for respiratory infection & complications

NW: SS=D: Failed to provide appropriate care & services to provide respiratory care with Trilogy non-invasive ventilator to 1 resident; facility did not have orders from PCP r/t how to run Trilogy non-invasive ventilator needed to be set at or how & when to clean Trilogy placing resident at risk for respiratory failure

- *Cited findings noted in F656 r/t lack of CPing for Trilogy; failed to provide appropriate care & services to provide respiratory care with Trilogy non-invasive ventilator for 1 resident placing resident at risk for respiratory failure*

F697 Pain Management

NE: SS=D: Failed to recognize, evaluate, manage & treat underlying cause of pain for 1 resident resulting in unmanaged pain placing resident at risk for impaired mobility & diminished quality of life

- **CP lacked direction to staff r/t pain & lacked indication r/t resident's tolerable or acceptable level of pain;** MAR lacked evidence Tramadol was administered, offered, or refused during review period; failed to recognize, evaluate, manage, & treat underlying cause of pain for 1 resident resulting in unmanaged pain & placing resident at risk for impaired mobility & diminished quality of life

NW; SS=D: Failed to ensure 1 resident received pain medication as ordered to help alleviate pain placing resident at risk for pain & emotional distress from being in pain

- *Cited findings in F656 & F695 r/t lack of treatment instructions for Trilogy ventilator care & unrelieved pain; Resident with polyneuropathy & chronic pain; POS for hydrocodone/acetaminophen QID for pain & Duloxetine BID for fibromyalgia; MRR requested GDR for Duloxetine & physician responded, "Duloxetine is for fibromyalgia. Continue the same dose." February MAR documented resident had not received hydrocodone/acetaminophen at all on 1 day due to med being "unavailable" & had not received Duloxetine for 3 days in February due to med being "not available"; record lacked evidence staff notified physician that pain meds were not given to resident as ordered; resident stated had missed medication multiple times in February & pain had been uncontrollable in middle of February & could hardly move or sleep & resident felt it was the facility's responsibility to make sure that resident had all meds available for resident o take & felt it showed irresponsibility on the facility's part in not making sure resident had ordered medications; failed to ensure 1 resident had pain medication administered as ordered to help alleviate resident's pain placing resident at risk for pain & emotional distress from being in pain*

F698 Dialysis

SE: SS=D: Failed to ensure staff assessed 1 resident post hemodialysis

- "Nursing Center Post Dialysis Vital Signs" revealed lack of assessment for 15 opportunities for from 11-22-23 to 2-28-24; record lacked notation of status of resident & access site upon return to facility from dialysis; failed to ensure LN provided completion of "Nursing Center Post Dialysis Vital Signs" & assessment of resident's access site to ensure stability & assess for adverse reactions to dialysis procedure

SW: SS=D: Failed to ensure appropriate system for ongoing communication with dialysis facility r/t dialysis care & services for 1 resident

- Baseline CP lacked staff instruction r/t dialysis; "Dialysis Communication Form" lacked information including name of resident's physician, contact person for resident at facility, facility phone number, face sheet, medication list, vital signs, medications received before dialysis & meds sent with resident to dialysis center; 1 Communication Form made available; failed to ensure appropriate system for ongoing communication with dialysis facility r/t dialysis care & services for resident

NE: SS=D: Failed to ensure ongoing communication & collaboration with dialysis facility r/t dialysis care & services for 1 resident placing resident at risk for delayed services, potential adverse outcomes & physical complications r/t dialysis

- Dialysis forms for 90 days missing 9 opportunities; failed to ensure ongoing communication & collaboration with dialysis facility r/t dialysis care & services for 1 resident placing resident at risk of delayed services, potential adverse outcomes & physical complications r/t dialysis

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

SW: SS=D: Failed to completed annual performance review at least once every 12 months for 3 CNAs to ensure adequate appropriate cares & services provided to residents of facility

- Review of employee files revealed lack of performance evaluations for 3/3 records reviewed for CNAs; failed to complete annual performance review at least once every 12 months for 3 CNAs reviewed to ensure adequate appropriate cares & services provided to residents of facility

SE: SS=F: Failed to complete annual performance review at least once every 12 months for 3/3 CNAs & failed to complete annual performance review at least once every 12 months for 2 CMAs reviewed

- Review of personnel files revealed 5 CNAs lacked annual performance review; 3 CMA records lacked annual performance review; failed to complete annual performance review for 5 staff members employed by facility for greater than 1 year

F732 Posted Nurse Staffing Information

SE: SS=C: Failed to display accurate, publicly accessible & identifiable staffing information daily for all residents currently residing in facility

- Review of Daily Staffing Sheets from 2-11-24 thru 3-11-24 revealed actual hours worked had not been completed on daily staffing sheets; failed to properly complete daily staffing sheets for residents of facility

F755 Pharmacy Services/Procedures/Pharmacist/Records

SE: SS=D: Failed to follow physician orders for 1 resident r/t notification to physician of blood sugars outside ordered parameters

- Failed to notify physician of residents' blood sugar being out of ordered parameters on multiple occasions

NE: SS=E: Failed to provide a consistent reconciliation of controlled drugs at end of each work shift placing 14 residents with controlled substances on cart at risk for misappropriation of meds; facility also failed to ensure 1 resident's physician-prescribed meds were available from pharmacy for administration placing resident at risk for ineffective medication regimen & related complications

- Observation of 1 unit's med cart controlled drug record lacked evidence staff completed narcotic reconciliation for 25 shifts on day shifts & 23 shifts on night shifts (48/109 work shifts); failed to provide consistent reconciliation of controlled drugs at end of daily work shifts placing 14 residents with controlled substances on cart at risk for misappropriation of meds by staff
- Failed to ensure 1 resident's physician-ordered levothyroxine was available for administration placing resident at risk for ineffective medication regimen & related health consequences

NE: SS=E: Failed to provide a consistent reconciliation of controlled drugs at end of each work shift on 1 cart placing 16 residents with controlled substances on cart at risk for misappropriation of meds

- Controlled drug record lacked evidence staff completed narcotic reconciliation for night shifts on 10 occasions & 5 occasions on evening shifts; & 2 occasions on day shift (16/126 work shifts); failed to provide a consistent reconciliation of controlled drugs at end of daily work shifts placing 16 residents with controlled substances on cart at risk for misappropriation of medications by staff

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported irregularities r/t lack of dosing instructions for Voltaren gel for 1 resident with risk of unnecessary medication use & physical complications for 1 resident

- POS for Voltaren external gel 1% apply to neck topically TID for neck pain; MMR lacked evidence of notification for lack of dosing instructions for Voltaren; failed to ensure CP ID'd & reported irregularities in lack of dosing instructions for Voltaren gel for 1 resident placing resident at risk for unnecessary med use, side effects & physical complications

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) IDd & reported 2 residents' meds lacked indication for use placing residents at risk for unnecessary med administration & adverse side effects

- POS for Medroxyprogesterone & lacked dx or indication for use; CP's monthly MRR w/o recommendation or report of resident's meds not having dx or indication for use; failed to ensure CP ID'd & reported lack of indication for use or dx for 1 resident's physician-prescribed meds placing resident at risk for unnecessary med administration & possible adverse reactions
- POS for Amitriptyline, ASA, Famotidine, Lexapro, Lasix, Losartan, Metoprolol, Raloxifene, lacking indication for administration; failed to ensure CP IDd & reported irregularities r/t physician notification of blood sugars outside physician-ordered parameters & lack of indication for use of resident's physician-prescribed meds placing resident at risk for unnecessary medication administration & possible adverse reactions

F757 Drug Regimen is Free from Unnecessary Drugs

SE: SS=D: Failed to ensure 2 residents remained free from unnecessary medications r/t failure to hold hypertensive medications

- Resident with HTN & BIMS of 10; CP lacked resident's specific BP parameters for HTN meds as ordered by physician; failed to hold resident's hypertensive meds when resident's BP's were outside ordered parameters
- Failed to hold resident's hypertensive meds when resident's BP's were outside ordered parameters

SE: SS=D: Failed to monitor 1/5 residents for hypotension & BMs & 1 resident r/t failure to follow physician ordered BP parameters

- POS for vital sign monitoring weekly; Adm nurse confirmed lack of vital signs/BP monitoring since 3-3 due to "computer issues"; failed to monitor 1 resident's vital signs which included BP at least weekly to determine presence of & adverse effects of hypotension; failed to monitor resident's bowel status as at risk for constipation due to opioid use which resulted in lack of BM for 10 days
- Failed to hold dependent resident's HTN meds when BPs were outside physician's ordered holding parameters on multiple days

SW: SS=D: Failed to ensure staff followed physician ordered parameters for administration of medications for 2 residents

- POS for Midodrine Hydrochloride with holding parameters; MAR revealed staff administered 6 times outside of holding parameters; failed to ensure staff followed physician prescribed parameters for administration of Midodrine to ensure resident
- POS for Admelog Solostar Subcutaneous Solution Pen-injector per sliding scale with notification parameters; MAR revealed 10 occasions when staff failed to administer insulin as ordered; failed to administer sliding scale insulin to resident that required sliding scale insulin as ordered by physician

NE: SS=D: Failed to ensure dosage indicated for use of Voltaren for 2 residents placing residents at risk for unnecessary medication administration & possible adverse side effects

- TAR lacked indicated dose amount to apply; failed to ensure dosage indicated on 1 resident's order for Voltaren placing resident at risk for unnecessary medication administration & possible adverse side effects for resident
- Failed to ensure dosing instruction for Voltaren gel for 1 resident placing resident at risk for unnecessary medication use, side effects & physical complications

NE: SS=D: Failed to ID 2 residents' meds lacked indication for use placing residents at risk for unnecessary medication administration & adverse side effects

- Cited findings in F757; Failed to ensure 1 resident's physician-prescribed meds had indication for use placing resident at risk of unnecessary medication & possible adverse side effects
- Failed to ensure physician notified of blood sugars outside physician-ordered parameters & failed to ensure indication for use for resident's physician-ordered meds placing resident at risk for unnecessary medication administration & possible adverse reactions

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SE: SS=D: Failed to ensure 1 resident received reevaluation for continued use of PRN psychotropic med & 1 resident r/t lack of AIMS to monitor for adverse effects of antipsychotic medications

- Resident with hospice services POS for Clonazepam BID PRN anxiety; MAR revealed resident received 7 doses for January; 10 doses in February & 4 doses in March; physician did not reevaluate Clonazepam to indicate duration for use after consulting pharmacist made recommendation to reevaluate use; failed to ensure prescriber reassessed resident for continued administration of PRN Clonazepam beyond 14-day initial period as required
- CP documented resident received Haldol for delusional d/o; POS for Haldol TID for agitation & aggression; EMR lacked AIMS; failed to monitor dependent resident for side effects of antipsychotic med

SW: SS=D: Failed to monitor 1 resident for use of antipsychotic meds

- Resident with dementia with psychotic disturbance; CAA triggered but lacked analysis of findings; POS for Seroquel & EMR lacked AIMS; failed to monitor dependent resident for use of antipsychotic med

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

- Record lacked documentation showing appropriate indication or documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits before 1 resident's medication was started; facility was unable to provide documentation upon request placing resident at risk for unnecessary psychotropic meds & related complications

NE: SS=D: Failed to ensure 1 resident's psychotropic meds had indication for use placing residents at risk for unnecessary medication administration & adverse side effects

- Failed to ensure lack of indication for resident's physician prescribed meds r/t Amitriptyline & Lexapro placing resident at risk for unnecessary medication administration & possible adverse reactions

F759 Free of Medication Error Rates 5% or More

NE: SS=D: Failed to ensure medication error rate did not exceed 5% when staff failed to administer resident's medications as ordered resulting in medication error rate of 26.67%

- POS for Gabapentin via enteral tube each morning for neuromuscular pain, Amiodarone via enteral tube; Sennoside Docusate via enteral tube, Eliquis via enteral tube; POS lacked evidence any order allowing enterally administrated meds to be given orally; observed LN administered resident amiodarone, Gabapentin, Senna & Eliquis by mouth; failed to ensure medication error rate did not exceed 5% resulting in med error rate of 26.67%

F760 Residents are Free of Significant Med Errors

NE: SS=D: Failed to ensure 1 resident was free from significant med errors when staff failed to administer insulin & antihypertensive meds as ordered placing resident at risk for adverse side effects & medication complications

- MAR lacked staff sign-off that Levemir injected 2 occasions as ordered & basaglar not administered as ordered due to resident still having Levemir pens left but MAR documented basaglar administered on 2 occasions; MAR lacked documentation on 1 occasions documented as NA & documented for BP & pulse readings; MAR lacked documentation midday BP & pulse monitored & physician ordered hydralazine

administered as ordered; failed to ensure resident was free from significant med errors when staff failed to administer insulin & antihypertensive meds placing resident at risk for adverse side effects & medical complications

NW: SS=D: Failed to ensure 1 resident was free from medication errors placing resident at risk of medical complications from not receiving medications as ordered by physician

- *Cited findings noted in F697 r/t resident not receiving ordered routine pain meds for fibromyalgia & chronic pain; failed to ensure 1 resident was free from medication errors placing resident at risk of medical complications from not receiving medication as ordered by physician*

F775 Lab Reports in Record-Lab Name/Address

NE: SS=D: Failed to ensure physician-ordered lab test results for 1 resident were included in resident's clinical record with potential to result in unnecessary tests & delayed treatment

- Record lacked evidence of results of physician-ordered lab tests; facility able to provide unsigned copies of results after request from lab's portal; Adm nurse stated expected physicians to log into lab portal & review lab work ordered daily & facility nurses do not print or review lab results or notify physician unless critical lab value called to facility; failed to ensure physician-ordered lab test results for 1 resident were included in resident's clinical record with potential to result in unnecessary tests & delayed treatment

F801 Qualified Dietary Staff

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

- Failed to ensure director of food & nutrition services was a CDM placing affected residents at risk for unmet dietary & nutritional needs

NW: SS=F: Failed to employ a fulltime CDM to supervise preparation of meals & sanitation in facility's kitchen placing all residents of facility at risk for inadequate nutrition or foodborne illness

- Adm verified dietary manager not certified; failed to employ CDM or equivalent to supervise preparation of meals & sanitation in facility's kitchen placing all residents of facility at risk for inadequate nutrition or foodborne illness

F803 Menus Meet Resident Needs/Prep in Advance/Followed

NE: SS=D: Failed to follow 1 resident's specialized dietary requirements during meal services placing residents at risk for impaired nutrition & aspiration

- Cited findings noted in F692 r/t resident served Brussel sprouts; failed to follow resident's specialized dietary requirements during meal services placing resident at risk for impaired nutrition & aspiration

F806 Resident Allergies, Preferences, Substitutes

NE: SS=D: Failed to provide & serve food substitutions that accommodated 1 resident's preferences placing resident at risk for impaired autonomy & decreased quality of life

- POS for regular diet; Progress Notes documented resident verbalized frustrations that facility offered no diabetic diet & that meals were high in carbs & physician recommended & encourage resident to follow no-concentrated sweets diet; Resident Council minutes documented requests for diabetic cookies, low-carb foods & c/o some residents & staff "hoarded snacks after dinner; failed to provide & serve food substitutions that accommodated resident's preference placing resident at risk for impaired autonomy & decreased quality of life

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=F: Failed to maintain 2-inch air gap between ice machine drainpipe & drain in kitchen to prevent back up of contaminated water into ice machine

- Observed water drain in kitchen full of water with drainpipe from ice machine positioned directly in water; failed to ensure 2-inch air gap between ice machine drain & kitchen drain to prevent contamination & foodborne illness amongst residents

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

- Observed inside of toaster with heavy build up of crumbs; top of stove with dried-on food debris; corn chips lacked lid & corn chips on floor; freezer with food debris on bottom; silverware drawer with wet silverware & food debris; greasy fingerprints on hood of range
- Kitchenette with fridge with opened, unlabeled & undated drink; sink with brownish substance on back rim against wall; trash can with dried-on food debris & lacked lid
- Fridge with heavy build up of black substance between front lip of multiple racks; top of ice machine & oven with layer of dust
- Cart with ground in dirt & debris into plastic tiers & handles of cart causing them to be discolored; knives handles deeply grooved & with ground in dirt & debris causing handles to be discolored; containers with tools with food debris; inside of microwave with dried-on food debris; shelves with layer of dust; shelf on steam table with deep cuts causing surface to be discolored & uncleanable; doors of cold cart with large amount of ground-in food debris in rubber seal of doors;
- Green House with opened, undated supplement; undated food items; cucumbers with slimy appearance; undated juice; undated juice concentrate

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

- Observed fridge with food debris on bottom shelf; shelf under coffee/tea machine with raised shelf with dark brown stain; shelves under tray line with clean plates & clean pate covers with build up of food debris; shelf under worktable with build up of food debris; shelf under toaster with build up of crumbs; cutting boards deeply grooved

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 of foodborne illness & cross-contamination

- Observed freezer with open bags of food item w/o label or date & were not in sealed bag; freezer unit leaked & had ice around pipes; freezer with area of what appeared to be water that had dripped on floor & froze; observed plates, bowls & saucers stored right-side up on counter & staff wore gloves while serving food on residents' plates & left serving area to obtain bowl from cupboard & returned to serving area w/o changing gloves or performing hand hygiene; observed staff prepared pureed foods & staff failed to sanitize metal food container & lid after each food item but rinsed food container & lid under hot water at sink after each food item

NE: SS=E: Failed to ensure food was appropriately labeled & dated during storage; failed to ensure tableware was stored appropriately before meal service; failed to ensure dining staff handles plates in sanitary manner placing residents at risk for foodborne illness

- Observed freezer with open, unlabeled, undated food items; fridge with items with no open date; temp log for dishwasher with 1 hole in March; food temp logs with holes on 2 occasions
- Observed dietary staff & clean meal plates & bowls were face up on serving table; observed staff donned clean gloves w/o performing hand hygiene

NW; SS=E: Failed to ensure residents' dinnerware was not broken or chipped placing all residents at risk for unsafe food service

- Observed stack of plates with 4 chipped plates which dietary staff used during meal service; failed to ensure residents' dinnerware was not broken or chipped placing all residents at risk for unsafe food service

F849 Hospice Services

NE: SS=D: Failed to ensure communication process was implemented which included how communication would be documented between facility & hospice provider & failed to provide description of services, medication & equipment provided to resident by hospice creating risk for missed or delayed services & impaired physical & psychosocial care for 1 resident

- Failed to ensure communication process was implemented which included how communication would be documented between facility & hospice provider & failed to provide description of services, medication & equipment provided to resident by hospice placing resident at risk for delayed services which could affect resident's mental & psychosocial wellbeing

NE: 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 physical, & psychosocial care for 1 resident

- Failed to ensure collaboration between facility & hospice provider & failed to develop CP both by hospice & facility that included description of services, medication & equipment provided to 1 resident by hospice placing resident at risk for delayed services which could affect mental & psychosocial wellbeing

F851 Payroll Based Journal

SE: SS=F: Failed to electronically submit to CMS with complete & accurate direct staffing information, based on payroll & other verifiable & auditable data in uniform format according to specifications established by CMS of PBJ r/t weekend staffing when facility failed to accurately report weekend staffing during 3rd & 4th quarter of 2023

- PBJ reports for quarter 3 & quarter 4 revealed "extremely low weekend staffing"; Staffing sheets revealed equal staffing on weekends as during week; failed to accurately complete PBJ to reflect actual staffing on weekends as required

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

- Review of PBJ revealed facility failed to have LN coverage 24 hrs/day on multiple days in multiple quarters; review of nursing schedule & clocking sheets for dated reveled adequate hours to account for 24-hour nursing coverage; failed to submit complete & accurate staffing information to Federal regulatory agency through PBJ when facility failed to accurately submit hourly staffing dats for all nursing personnel

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

- Although PBJ report indicated facility lacked appropriate LN coverage on multiple days in multiple quarters; review of facility's LN payroll data for dates listed on PBJ revealed LN was on duty for 24 hours a day 7 days/wk; failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

F880 Infection Prevention & Control

SE: SS=F: Failed to ensure infection control techniques for 1 resident r/t O2 tubing/cannula storage, 1 resident r/t urinary catheters & perineal care; 1 resident r/t storage of soiled catheter collection device stored next to personal care items of toothbrush & toothpaste & 1 resident r/t incontinence cares to prevent spread of infections in facility

- Failed to ensure good infection control techniques by failure to store O2 tubing & nasal cannula in sanitary manner when not in use
- Failed to ensure good infection control techniques by failure to change gloves between dirty & clean while performing perineal care for 1 resident & failure to properly clan catheter spigot when emptying resident's indwelling urinary catheter
- Failed to use appropriate hand hygiene after performing perineal care for dependent resident

- Failed to use appropriate standard precautions when performing catheter care for dependent resident with urinary catheter

NE: SS=E: Failed to ensure adequate infection control standards were followed during 1 resident's enteral meal administration & storage of O2 therapy equipment; additionally failed to ensure clean linen storage placing residents at risk for infectious diseases

- Observed linen storage closet with dusty, visibly soiled vacuum cleaner stored in closet next to uncovered clean linen
- Observed CPAP mask placed face down on nightstand next to bed & no clean storage container present in room for tubing or mask
- Observed LN removed gloves after placing clean barrier over resident's stomach area & removed gloves & donned new gloves but did not complete hand hygiene between glove changes; failed to ensure appropriate infection control standards were followed during resident's enteral meal administration & storage of 1 resident's O2 therapy equipment; failed to ensure clean line storage placing residents at risk for infectious diseases

NE: SS=D: Failed to ensure proper infection control standards were followed r/t hand hygiene, disinfecting of shared equipment & replacement of respiratory equipment; also failed to ensure laundry temps for laundry including laundry for transmission-based precaution rooms with infectious diseases were assessed for appropriate temps placing residents at risk for complications r/t infectious diseases

- Observed resident's O2 tubing dated 1-3-24 on 3-25-24 & staff informed facility did not have long enough tubing to replace tubing; observed LN entered isolation room & pushed vital sign machine into room & after temp placed thermometer back into basket w/o disinfecting thermometer or BP cuff & placed cuff back onto machine then pushed machine back into hallway & removed gloves but failed to perform hand hygiene then donned new gloves to prepare resident's meds & administered meds & when exited room doffed gloves but did not perform hand hygiene; observed laundry room with water temps monitored weekly

NE: SS=E: Failed to ensure proper infection control standards were followed r/t disinfecting shared equipment & sanitary storage of respiratory equipment; failed to ensure appropriate chemicals were used to clean C-diff isolation room & failed to post correct type of isolation precautions for 1 resident with C-diff placing residents at risk for complications r/t infectious diseases

- Resident with PPE in hallway & staff verified resident on isolation for C-diff; BiPAP on top of nightstand table not stored in bag; O2 tubing coiled & resting on seat of w/c & tubing lacked plastic bag or container for storage when not in use; Observed CNA pushed Hoyer lift into multiple areas & failed to sanitize lift between use
- Housekeeping staff using product not approved to kill C-diff virus

F882 Infection Preventionist Qualifications/Role

NE: SS=F: Failed to designate a staff member with required qualification & certification as Infection Preventionist who was responsible for facility's Infection Prevention & Control Program placing all residents at risk for lack of identification, tracking/trending & treatment of infections

- Adm reported facility did not have certified IP & Adm nurse in process of becoming certified

F883 Influenza & Pneumococcal Immunizations

NE: SS=E: Failed to ensure resident &/or resident's representatives were informed & educated on pneumococcal vaccination options & provide current VIS for 5 residents placing residents at risk for complications r/t infectious diseases

- Failed to ensure 5 resident's representatives were informed & educated on pneumococcal vaccination options & provided a VIS for 5 residents placing residents at risk for complications r/t infectious diseases

NE: SS=D: Failed to provide 3 residents with PCV20 as consented placing residents at increased risk for complications r/t pneumonia

- 3 resident records revealed signed consent to receive PCV20 & facility unable to provide evidence vaccine was administered as resident had consented to; failed to provide 3 residents with PCV20 vaccination as consented placing residents at increased risk for complications r/t pneumonia

NE: SS=D: Failed to ensure 2 residents were offered & educated r/t Prevnar 20 pneumococcal vaccination or assessed by physician to determine if contraindicated as recommended by CDC placing residents at risk for acquiring, transmitting or experiencing complications form pneumococcal disease

- Failed to offer 2 residents PCV20 vaccination as recommended by CDC placing facility residents at risk of acquiring, transmitting or experiencing complications from pneumococcal disease

F887 COVID-19 Immunization

SE: SS=E: Failed to ensure residents of facility received up-to-date COVID vaccinations, if desired, & failed to ensure residents were given opportunity to rescind previous year declination

- Resident record revealed resident received COVID vaccination on 11-17-22 & no COVID vaccine offered in 2023; record revealed resident refused COVID booster on 11-13-21 with no opportunity to change declination in 2022 & 2023
- Resident's record revealed resident not offered COVID vaccine in 2023 for multiple residents; failed to ensure residents received COVID-19 vaccinations in timely manner & were given opportunity to make informed decisions to change acceptance/declination as required

F921 Safe/Functional/Sanitary/Comfortable Environment

SW: SS=F: Failed to provide a safe, functional, sanitary & comfortable environment for residents & staff

- Perimeter of kitchen floor with large amount of food debris & several areas around perimeter of floor with ground-in dirt & kitchen floor under steam table, cooks' line & tray lines all with large amount of food debris; kitchen floor with 3 drains with food debris & trash

F941 Communication Training

NE: SS=E: Failed to ensure agency nurse, LN had required effective communication education placing residents at risk for impaired communication with LN

- *Grievance documented resident's family stated felt resident not being cared for appropriately & when family arrived resident in bed with brief on, no incontinence pad & brown stain on sheet; facility asked staff to change resident & staff stated they were giving a bed bath; family requested again & staff stated resident had to wait until help came; LN came to resident's room, pulled the privacy curtain & stated loudly & rudely that staff were "done" with resident's family; upon request facility unable to provide documentation that LN completed education on effective communication before started working at facility; Adm nurse stated facility made sure agency nurses had license before started working at facility but did not look at education documentation; failed to ensure LN had required effective communication education placing residents at risk for impaired communication with LN*

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

- Review of facility's training for 3 CNAs & 3 LNs revealed lacked of training for communication; failed to ensure completion of required communication training for staff who provided care in facility placing residents at risk for impaired care & decreased quality of life

F942 Resident Rights Training

NE: SS=E: Failed to ensure agency nurse, LN had required Resident Rights education placing residents at risk for impaired resident rights

- *Cited findings noted in F941; failed to ensure LN had required resident rights education placing residents at risk for impaired resident rights*

NE: SS=F: Failed to ensure all staff were educated on Resident Rights & facility's responsibilities to provide proper care placing residents at risk for impaired care & decreased quality of life

- Review of facility's training for 3 CNAs & 3 LNs revealed lacked of training for Resident Rights; failed to ensure completion of required Resident Right training for staff who provided care in facility placing residents at risk for impaired care & decreased quality of life

F943 Abuse, Neglect, & Exploitation Training

NE: SS=F: Failed to provide evidence of required prevention of abuse, neglect & exploitation training for 2/5 CNAs that were sampled

- Employee records revealed facility failed to provide evidence that 2 CNAs received required ANE training; Training records lacked duration or tracked time period for education provided; documentation lacked any clear way that demonstrated education hours & topics were tracked; failed to provide evidence of required prevention of ANE training for 2/5 CNAs that were sampled

F947 Required In-Service Training for Nurse Aides

NE: SS=F: Failed to ensure 1/5 CNA staff reviewed had required 12 hours of in-service education placing residents at risk for inadequate care

- Review of in-service records revealed PRN CNA hired 6-7-23 had 3.5 hours of in-service education in past 12 months; failed to ensure 1/5 CNA staff reviewed had required 12 hours of in-service education placing residents at risk for inadequate care

NE: SS=F: Failed to ensure 5/5 CNA staff reviewed had required 12 hours of in-service education & 2/5 CNA staff had required in-service for dementia care placing residents at risk for inadequate care

- CNA with 8 hours of in-service in past 12 months
- CNA with 6 hours of in-service in past 12 months
- 2 CNAs with 0 hours of in-service & record lacked evidence of required education on topic of dementia in past 12 months
- CNA with 6 hours of in-service in past 12 months
- Binders with in-service documentation provided to surveyors; binders contained various education topics with sign-in sheets & majority of topics lacked duration or tracked time period for education provided; binders lacked any clear way that demonstrated education hours & topics tracked; failed to ensure 5/5 CNA staff reviewed had required 12 hours of in-service education & 2/5 CNA staff had required in-service education for care placing residents at risk for inadequate care

NW: SS=F: Failed to ensure 1/5 CNAs employed at facility for at least 1 year completed minimum 12 hours of in-service training per year & lacked system for accurately tracking CNA education

- CNA training records for 1 CNA who had been employed at facility for over 1 year revealed lack of 12 hour in-service training for CNA & had completed 4.5 hours; Adm nurse stated facility had not monitored completion of CAN in-service hours & verified that 1/5 CNA's lacked 12 hours of yearly in-service training; failed to ensure 1/5 CNA staff reviewed completed minimum 12 hours of in-service training per year & lacked system for accurately tracking CNA education

April 2024

F609 Reporting of Alleged Violations

SW: SS=D: Failed to ensure staff reported allegation of staff-to-resident abuse for 1 resident to facility Administrator immediately; additionally failed to report resident's allegation of abuse to State Agency as required placing resident at risk for unidentified & ongoing abuse &/or neglect

- MDS documented resident with venous wounds to heel; CP documented resident at risk for pain r/t neuropathic pain & LE wound; CP lacked evidence showing hx of accusations & behaviors; NN documented resident reported that CNA taking care of resident hurt resident's leg & was rough with resident & resident sobbing & crying & noted lacked evidence situation reported to Adm, physician & family; "Concern" documented resident reported to Adm nurse that during shower previous evening resident requested plastic wound covering had rolled down & was causing pain & staff pulled wound cover off leg causing severe pain & burning sensations to wounded leg

& grievance signed by Adm nurse & Adm; Adm nurse stated aware of issue but did not report issue as alleged abuse; Adm nurse stated called to resident's room by staff to talk to resident & resident crying &resident reported hurt by overnight staff during shower as staff pulled cover off wound rather than cutting it off; failed to ensure staff immediately notified Adm of allegation of abuse & additionally failed to report allegation of abuse to State Agency placing resident at risk for unidentified & ongoing abuse &/or neglect

F610 Investigate/Prevent/Correct Alleged Violation

SW: SS=E: Failed to protect 1 resident & other vulnerable residents during facility investigation after abuse allegation placing resident & other residents under care of 1 CNA at risk for unidentified & ongoing abuse &/or neglect

- Cited findings noted in F609 r/t 1 resident's pain when dressing removed; Concern form indicated LN placed on "Do Not Return" list for facility after incident occurred; investigation indicated no protective measures, corrective actions or additional training occurred after abuse allegation made known to facility; CNA's timecard revealed CNA worked scheduled hours the day of the incident & again for month; failed to protect 1 resident after alleged abuse allegation placing resident & other residents under care of CNA at risk for unidentified & ongoing abuse &/or neglect

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=K (Abated to E): Failed to ensure adequate staff to safely transfer residents in accordance with professional standards, OSHA guidelines, FDA guidelines & manufacturer recommendations with use of mechanical lift

- *Facility ID'd 8 residents who required full body mechanical lift & 4 residents who required a sit-to-stand mechanical lift for transfers; nursing staff reported used mechanical lifts for resident transfers w/o second staff member present, due to lack of staff availability to perform transfers correctly; interviews with 6 residents confirmed staff regularly did not utilize 2 staff members with mechanical lift transfers placing 12 residents in immediate jeopardy*
- *During onsite survey 4-17-24 & 4-18-24, concern ID'd that facility staff did not use 2 staff for mechanical lift transfers per best practice & safety guidelines; interviews with alert & oriented residents who required use of mechanical lift transfers revealed multiple concerns from residents r/t transferring residents with 1 staff with mechanical lift "most of the time"; multiple CNAs reported knew full body mechanical lift & sit-to-stand lift required at least 2 staff members for use but "quicker" to transfer with 1 instead of waiting for "float" CNA; 1 CNA reported transferred by self for approximately 3 months; Adm nurse & consultant nurse reported unaware that staff used mechanical lifts alone; failed to ensure safe transfers of 12 residents facility ID'd as requiring mechanical lift for transfers when staff used 1 staff during mechanical lift transfers placing 12 residents in immediate jeopardy*
- *Abatement Plan:*
  - *QAPI meeting held with Medical Director*
  - *All nursing staff educated from DON/designee on requirement to have 2 staff present for mechanical lift transfers & resident transfer requirements to have 2 staff present for mechanical lift transfers & resident transfer requirements located in CP/Kardex*
  - *All staff complete skills demonstration on mechanical lift transfers by end of day or before start of next shift*

SW: SS=D: Failed to provide 1 resident's fall interventions as directed by CP placing resident at risk for falls & related injuries

- CAA documented resident at risk for falls & hx of falls; CP documented staff would place fall mat next to bed & bed against wall for resident's safety; observed resident in bed & floor mat rolled up next to dresser & bed pulled away from wall; failed to ensure 1 resident's bed was next to wall & fall mats in place while resident in bed placing resident at risk for falls

F690 Bowel/Bladder Incontinence, Catheter, UTI

SW: SS=D: Failed to follow standards of practice r/t indwelling catheter care for 1 resident placing resident at risk for catheter-related complications including UTIs

- Resident with neurogenic bladder & required indwelling urinary catheter; Observed resident in bed with bed in lowest position with fall mat positioned on floor & resident's catheter bag laid on floor at foot of bed for 2+ hours
- Observed LN perform catheter care & when placing supplies on bedside table knocked off 2 bottles onto floor & reached down with gloved hands & retrieved items & replaced them on table then wearing same gloves proceeded to flush catheter & during procedure resident became agitated & requested task be stopped; LN then removed gloves but failed to complete hand hygiene before donning clean gloves; LN confirmed staff supposed to check placement of drainage bag to ensure not touching floor; failed to follow standards of practices r/t indwelling catheter care for 1 resident placing resident at risk for complications r/t UTIs

F698 Dialysis

SW: SS=D: Failed to monitor 1 resident's access site for complications at least daily & failed to obtain communication from dialysis center r/t 1 resident's treatment placing resident at risk of potential adverse outcomes & physical complications r/t dialysis

- Record revealed staff assessed AV site safter resident returned from dialysis but lacked evidence staff assessed site on non-dialysis days & as needed; Record lacked evidence of communication between facility & dialysis provider on 13 occasions since 1-1-24; failed to monitor 1 resident's dialysis access site at least daily for signs of infection, bleeding, & status of dressing in place & failed to obtain communication from dialysis center placing resident at risk for potential adverse outcomes & physical complications r/t dialysis

F726 Competent Nursing Staff

SE: SS=E: Failed to ensure nursing personnel had knowledge, competencies & skill sets to provide care to safely transfer residents in accordance with professional standards, OSHA guidelines, FDA guidelines, & manufacturer's recommendations with use of mechanical lift

- *Cited findings noted in F689 r/t using mechanical lifts with 1 staff members; failed to ensure staff competency & skill sets to ensure safe transfers of 12 residents facility ID'd as requiring mechanical lift transfers*

F755 Pharmacy Services/Procedures/Pharmacist/Records

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

- Observed of narcotic reconciliation sign-off sheets lacked signatures on 11/152 opportunities from 3-7-24 to 3-31-24 & 16/136 opportunities from 4-1-24 to 4-21-24; failed to ensure accurate reconciliation of controlled substances consistently completed placing residents at risk of medication misappropriation & diversion

F757 Drug Regimen is Free from Unnecessary Drugs

SW: SS=D: Failed to follow physician ordered parameters r/t 1 resident's PRN bumetanide placing resident at increased risk fo r unnecessary medication & side effects

- POS for Bumetanide 2mg BID for edema & staff to monitor resident's weight & administer additional 2mg PRN for weight gains over 3 pounds; MAR indicated PRN med had not been administered since ordered; Weight documentation indicated resident with gains ove r 3 pounds on 5 occasions; failed to follow physician-ordered parameters r/t 1 resident's PRN diuretic medication placing resident at increased risk for unnecessary medication & side effects

F759 Free of Medication Error Rates 5% or More

SW: SS=E: Failed to ensure medication error rate did not exceed 5% when staff failed to ensure 1 resident was administered scheduled morning medications within ordered timeframe; failed to ensure insulin pen & needle were appropriately primed before insulin administ ration for 1 resident resulting in medication error rate of 46.15%

- At 12:20pm observed CMA pulled 1 resident's med cards from cart & dispensed each med into med cup then walked med cup over to resident in DR & resident placed several meds in hand at a time & placed them in mouth & swallowed w/o difficulty & continued to place meds into mouth until all pills taken & CMA returned to cart & signed off meds administered; POS revealed scheduled administration time of 8am for 6 meds; resident administered physician-ordered meds outside allowable timeframe for med administration which included up to 1 hour before & 1 hour after scheduled administration time of 8am & 6am-10am;
- LN observed administering 1 resident's scheduled Lispro insulin & failed to prime pen & needle with 2 units of insulin before administration of 15 units as scheduled; LN stated unaware of need for insulin needle to be primed; failed to ensure medication error rate did not exceed 5% when staff failed to ensure 1 resident was administered scheduled morning meds within allowable timeframe & failed to ensure insulin pen & needle were appropriat ely primed before insulin administration to 1 resident resulting in med error rate of 46.15%

F761 Label/Store Drugs & Biologicals

SW: SS=E: Failed to ensure safe & secure storage of meds & biologicals placing resident at risk for side effects & ineffectiv e medication administration

- Observed med fridge in multiple houses left unlocked & insulin left unsecured; observed inside of fridge with large amount of ice formation at top; med cart on 1 house left unlocked & no nursing staff around cart to monitor; fai led to ensure safe & secure storage of meds & biologicals creating risk for adverse medication effects & ineffective medication administration

F880 Infection Prevention & Control

SW: SS=E: Failed to ensure consistent infection control standards were follo wed r/t enhanced barrier precautions, storage of O2 tubing, indwelling catheter care, laundry & shared equipment placing residents at risk for complications r/t infectious diseases

- Inspections of EBP rooms lacked required signage identifying precautions ne eded to provide care & all reviewed enhanced barrier precaution rooms stored PPE inside rooms
- 1 house laundry with soiled pillows, clothing & foot brace lying directly on floor
- Observed supplemental O2 tubing & nasal cannula draped over back of stationary O2 machine & portable O2 cylinder with tubing draped over O2 cylinder; no storage bags or containers available in room to store O2 tubing & tubing remained outside sanitary stora ge device until staff provided bags
- Observed 1 resident's urinary catheter bag lay on floor at foot of bed & remained for 2+ hours
- Observed CNA pushed Hoyer out of 1 resident's room back into hallway after use & returned to resident's room w/o disinfecting lift after use
- Observed LN prepared 1 resident's enteral feeding supplies & resident on EPB due to PEG & LN failed to wear required gown while administering enteral feeding
- Cited findings noted in F690 r/t lack of appropriate hand hygiene
- Failed to ensure consistent infection control standards were followed r/t EBP, O2 equipment, i ndwelling catheter care, laundry & shared equipment placing residents at risk for complications r/t infectious diseases

F947 Required In-Service Training for Nurse Aides

SW: SS=Failed to ensure 3/3 CNA staff reviewed had required 12 hours of in-service education which included required dementia management training placing residents at risk for inadequate care

- 3 CNA personnel files lacked evidence of dementia in-service training; “Elopement & Missing Resident’s in-service training included 1 slide on dementia & progressive dementia but lacked direction for staff on interventions & methods of approach for residents with deme ntia; “Communication” in-service training included “Ten Tips for Improving Communication with a Resident with Dementia” but lacked direction on providing care to residents with dementia & how to ID & implement interventions to promote quality of life for r esidents with dementia; failed to ensure 3 CNA staff reviewed had dementia management training part of required 12 hours of in-service education placing residents at risk for inadequate care