February, 2022 Survey Findings

September, 2021

F623 Notice Requirements Before Transfer/Discharge

SW: SS=D: Failed to ensure staff completed notifications to the ombudsman for 1 resident's transfer to hospital & 1 resident's discharge to another long-term care facility

- Failed to ensure staff completed notifications to State LTC Ombudsman for 1 resident's facility-initiated hospitalization transfer
- Failed to ensure staff completed notifications to State LTC Ombudsman for 1 resident's facility transfer

F625 Notice of Bed Hold Policy Before/Upon Transfer

SW: SS=D: Failed to notify 1 resident's representative in writing & complete bed hold for resident's facility-initiated hospitalization transfer

- Failed to notify 1 resident's representative in writing & complete bed hold for resident's facility-initiated hospitalization transfer

F641 Accuracy of Assessments

SW: SS=D: Failed to ensure accuracy of completed MDS r/t falls experienced by 1 resident which were not noted on MDS

- MDS documented no falls in review period; failed to ensure accuracy of completed MDS for 1 resident r/t falls

F657 Care Plan Timing & Revision

SW: SS=D: Failed to ensure resident's comprehensive care plans reflected needs of residents to ensure person-centered care; 1 resident's CP lacked information r/t hospice care; 1 resident's CP lacked information/interventions r/t dialysis services received & 1 resident's CP lacked revisions r/t fall interventions

- Failed to ensure staff updated resident's CP to include hospice care frequency of visits or how hospice communicated care provided to facility staff
- Failed to ensure 1 resident's comprehensive CP included information/interventions r/t dialysis services received such as frequency & fistula evaluation
- Failed to ensure 1 resident's CP included revisions after each fall to prevent further falls for 1 resident

F661 Discharge Summary

SW: SS=D: Failed to complete a discharge summary to include the recapitulation of 1 resident's stay in discharge summary

- HER lacked evidence of a completed discharge summary or discharge papers which included a recapitulation of stay for resident; failed to document the discharge summary including recapitulation of stay for 1 resident

F684 Quality of Care

SW: SS=D: Failed to ensure hospice care/services were documented & communicated to staff for continuity of care for 1 resident

- Failed to ensure hospice care/services were documented & communicated to staff for continuity of care r/t 1 resident

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=D: Failed to adequately complete fall investigations to include IDing causal factors r/t falls & implement interventions to prevent further falls for 3 residents

- Failed to complete fall investigations with all documentation including root cause analysis & interventions to prevent future falls for 1 resident
- Failed to complete thorough fall investigations to include causal factors & interventions to prevent future falls for 1 resident
- Failed to complete thorough fall investigations after each fall when facility did not ID causal factors & develop fall interventions to prevent further falls for 1 residents

F698 Dialysis

SW: SS=D: Failed to complete pre-dialysis weights & vital signs, assess dialysis access site, record resident fluid intake & obtain physician ordered labs for 1 resident

- Failed to complete pre-dialysis weights & vital signs, assess dialysis access site, record resident fluid intake & obtain physician ordered labs for 1 resident

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

SW: SS=E: Failed to ensure 5 CNA staff reviewed completed 12 hours of required in-service training annually

- Facility Assessment lacked documentation r/t required in-service hours for each staff member annually; failed to ensure 5 CNA staff reviewed completed 12 hours of in-service training annually

F756 Drug Regimen Review, Report Irregular, Act On

SW: SS=D: Failed to maintain documentation of consultant pharmacist's (CP) IDd recommendations & failed to act on recommendations for multiple months for 3 residents

- Failed to document that pharmacist's IDd recommendations &/or failed to document action taken or not taken to address irregularities for multiple months for 1 resident r/t CP recommendation for lipid profile which was ordered as recommended but not completed per records
- CP recommended GDR for antidepressant & facility lacked evidence of decreased in Lexapro or follow up on recommendation; failed to act on CP's DRR recommendations for 1 resident
- CP recommended a GDR for antidepressant & facility lacked evidence of GDR or follow up on recommendation; failed to act on CP's DRR recommendations for 1 resident

F757 Drug Regimen is Free from Unnecessary Drugs

SW: SS=D: Failed to follow physician orders r/t 1 resident's diabetes when staff did not document & notify provider of blood glucose values outside designated parameter; further failed to ensure BP parameters for 2 residents

- Failed to establish BP parameters & when to notify provider for 1 resident & staff had been in-serviced on facility parameters for BPs
- Failed to follow physician's diabetic orders, notify provider of blood glucose & BP values that were high or low & document appropriately for 1 resident

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SW: SS=D: Failed to ensure an appropriate diagnosis for 1 resident's antipsychotic medications

- Resident with Seroquel & Depakote for dementia with sundowning & verbal/physical aggression; failed to ensure 1 resident's antipsychotic medications had an appropriate diagnosis

F801 Qualified Dietary Staff

SW: SS=F: Failed to ensure a qualified CDM worked in facility to carry out functions of food & nutritional services for all residents who resided in facility & received meals from facility kitchen

- Facility could not provide evidence Dietary Manager completed or enrolled in CDM training classes; failed to provide a CDM to carry out functions of food & nutritional services for all residents who resided in facility & received meals from facility kitchen

F804 Nutritive Value/Appear, Palatable/Prefer Temp

SW: SS=D: Failed to ensure staff prepared foods by methods which conserve nutritive value, flavor & appearance; observed kitchen staff not following a recipe for preparation of pureed lunch menu, resulted in unappetizing & runny food with a change in nutritive value when staff substituted milk in place of other thinning ingredients as listed in recipe & failed to follow recipe measurements & staff was "eyeballing" measurements of ingredients used in purees, meant to thin or thicken puree, & failed to serve all items on menu in puree form or offer substitutes for items not pureed

- Staff reported facility had recipes to follow for each food item that was to puree; staff stated previous supervisor had instructed it was acceptable to substitute milk as a substitute; stated "eyeballed" milk because did not have a Tbsp measuring spoon to use; staff failed to puree cake & cornbread; failed to ensure staff prepared foods by methods which conserved nutritive value, flavor & appearance of pureed foods; staff did not follow recipe for preparation of pureed lunch menu, resulted in unappetizing & runny food with a change in nutritive value when staff substituted milk in place of other thinning ingredients as listed in recipe & failed to follow recipe measurements & staff was "eyeballing" measurements of ingredients used in purees meant to thin or thicken puree & failed to serve all items on menu in puree form or offer substitutes for items not pureed

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SW: SS=F: Failed to ensure safe & sanitary meal preparation, service & storage when kitchen staff failed to adequately monitor daily temps of fridges & freezers, failed to monitor chemical sanitization of low temp dishwasher each shift & failed to test sanitizing solution used to clean surfaces in kitchen & DR; failures had ability to affect all residents served meals from kitchen

- No completed logs for low temp dishwasher or chemical sanitizer spray found in kitchen; no PPM test strips found in kitchen
- Temp logs for fridges or freezers lacked completion of daily temps/were not complete
- Staff unaware of how to use test strips
- Observed cleaning solution for surfaces below recommended values

F943 Abuse, Neglect & Exploitation Training

SW: SS=E: Failed to ensure all facility staff were trained on dementia care & social media annually

- Training records lacked evidence of dementia care training & social media training since hire dates for multiple staff members; DON revealed social media training only done on hire & not completed annually; failed to ensure staff received training on dementia care & social media annually

November, 2021

F656 Develop/Implement Comprehensive Care Plan

SW: SS=D: Failed to develop a comprehensive CP to include use of O2 for 1 resident

- CP lacked any interventions concerning use of O2; Failed to ensure CP included information about use of O2

F661 Discharge Summary

SW: SS=D: Failed to document a recapitulation of resident's stay upon discharge for 1 resident

- LN stated had never done a recapitulation of a resident's visit; failed to document a discharge summary including a recapitulation of resident's stay at facility upon discharge as required

NE: SS=D: Failed to document a recapitulation of facility stay on discharge from facility for 1 resident

- EMR lacked a recapitulation of 1 resident's stay; failed to document a recapitulation for 1 resident's stay at facility after discharge to another facility placing resident at risk for an interruption in continuity of care

F677 ADL Care Provided for Dependent Residents

NE: SS=E: Failed to provide consistent bathing for 7 residents creating risk for poor hygiene & decreased self-esteem & dignity for affected residents

- Resident stated did not get showers/baths regularly, maybe once a week & when did not get baths regularly it made resident feel like not important enough; failed to provide consistent bathing for 1 resident creating risk for poor hygiene & decreased self-esteem & dignity
- Failed to provide consistent bathing for 1 resident with risk for poor hygiene & decreased self-esteem & dignity for multiple residents

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to ensure restorative care was performed for 1 resident placing resident at increased risk for possible development of contractures & decreased ROM which could affect resident's ability to provide self-care & cause decreased self-esteem

- Failed to provide restorative care for 1 resident which had risk for a decline in functional mobility & ability to perform ADLs

F695 Respiratory/Tracheostomy Care & Suctioning

SW: SS=D: Failed to provide necessary respiratory care &/or services consistent with professional standards or practice when they failed to change disposable O2 equipment for 2 residents

- eTAR & eMAR did not include anything concerning O2 use or changing of O2 tubing for 1 resident; observed O2 tubing undated; failed to ensure staff changed out O2 tubing for 1 resident consistent with professional standards of practice & according to facility policy
- Failed to change nebulizer mask & tubing on monthly basis for 1 resident

F725 Sufficient Nursing Staff

NE: SS=E: Failed to have sufficient staffing available to meet the bathing needs of residents in a manner that promoted each resident's physical, mental, & psychosocial well-being with risk for poor hygiene & low self-esteem & dignity for affected residents

- Referenced F677; failed to provide sufficient staffing to meet the bathing needs of residents in a manner that promoted each resident's physical, mental, & psychosocial well-being with risk for poor hygiene & low self-esteem & dignity for affected residents

F756 Drug Regimen Review, Report Irregular, Act On

SW: SS=D: Failed to ensure pharmacist IDd & reported missing documentation concerning physician notifications for BPs that exceeded parameters for 2 residents

- eMAR lacked evidence facility staff notified physician for resident's BP exceeding ordered parameters on multiple occasions in multiple months; pharmacy reviews failed to ID lack of physician notifications for BPs that exceeded parameters; failed to ensure consulting pharmacist IDd & reported missing documentation r/t BPs that exceeded physician ordered parameters for 2 residents

F757 Drug Regimen is Free from Unnecessary Drugs

SW: SS=D: Failed to ensure adequate monitoring of BP medication for 2 residents; facility LN staff did not notify physician of elevated BPs which exceeded physician ordered parameters for 2 residents

- Cited findings noted in F756 r/t 2 residents' BPs exceeding physician ordered BP parameters; failed to ensure adequate monitoring of antihypertensive medications when facility staff did not notify physician as ordered for BPs greater than physician ordered parameters for 2 residents

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to discard expired suppository medications; failed to properly store & date insulin vials & pens; & failed to properly store medications with risk for unwarranted physical complications & ineffective treatment for affected residents

- Observed expired suppositories mixed in a bag with non-expired suppositories
- Med cart with multiple vials opened & not dated & insulin pens with expired dates & opened & undated
- Failed to discard expired medicated suppositories, failed to properly store & date multiple insulin vials/pens & failed to properly store medications with risk for unwarranted physical complications & ineffective treatment for affected residents

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SW: SS=F: Failed to store & prepare food under sanitary conditions when facility failed to properly store food items, clean kitchen equipment, ensure fridge & freezer temps were documented & dietary staff did not properly restrain hair affecting all resident of facility

- Observed fridge lacked 19 entries for 1 month & lacked temp documentation for 1 month & 1 day in 1 month; observed fridge with undated food items; floor storage in walk in fridge & freezer; ice stacked on top of each other stored on floor of walk in freezer; can opener with grim inside base holder & near puncture mechanism; 1 fridge lacked temp log completed

- Observed dietary staff wore baseball cap with hair not fully restrained & failed to wear beard guard on multiple occasions; opened food items with no open date or use by date; expired foods; observed dietary staff touched food items with contaminated gloves

NE: SS=F: Failed to ensure sanitary food storage placing residents at risk for foodborne illness & contamination

- Observed walk-in freezer with significant water leak on unit compressor/blower hanging on ceiling of freezer unit; ice build up located around compressor unit was leaking down onto rack under compressor; metal sheet pans placed under leak to catch leaking water; boxes under sheet with open packages of food items; tray of uncovered Jello bowls stored directly below hose with hanging debris; failed to ensure sanitary food storage by allowing food to be stored directly under contaminant sources within storage unit & not properly covering food items placing residents at risk for food borne illnesses & food safety concerns

F825 Provide/Obtain Specialized Rehab Services

NE: SS=D: Failed to provide physical & occupational therapy services for 1 resident placing resident at increased risk for physical impairment & decreased mobility

- Resident with hemiplegia & hemiparesis following CVA; Baseline CP lacked directions r/t physical mobility & ADLs; POS noted orders for PT & OT eval; records lacked documentation showing a PT eval had been completed; OT eval not completed for 10 days after admission; failed to provide physician ordered therapy services to 1 resident in a timely manner; resident did not receive therapy services until 10 days after admission & date of therapy order placing resident at increased risk for physical impairment & decreased mobility

F880 Infection Prevention & Control

SW: SS=E: Failed to follow CMS & CDC recommended practices to prevent transmission of COVID-19; failed to ensure that all staff had a mask in place while in resident care areas on 2/3 nursing units of facility, increasing risk of transmission o pandemic COVID-19 virus to vulnerable residents who resided in 2 nursing unis of facility

- *Observed consultant sitting at table with 4 residents with mask pulled down off nose & mouth & sitting under chin & were not 6 feet apart for social distancing; observed CMA entered DR with mask pulled down off nose & mouth & sitting under chin then pulled mask up & went outside to administer medication to resident on patio; observed LN in DR with face mask sitting below nose but covering mouth then walked back to med cart & removed mask & talked to nursing student who was wearing mask appropriately*
- *Observed dietary staff standing in kitchenette with mask pulled down & away from nose & mouth & sitting under chin while talking to another staff member on multiple occasions; failed to ensure that all staff had a mask appropriately in place while in resident care areas to prevent spread of infections among residents of 2 nursing units*

NE: SS=E: Failed to ensure proper hand hygiene during meal service & failed to ensure appropriate hand hygiene & glove usage during wound care & peri-care for 1 resident placing resident at risk for cross contamination & increased risk for infection for all residents

- Observed dietary staff wore gloves to serve food then touched multiple contaminated surfaces & continued to wear same gloves; observed dietary staff brought extra cups out of kitchen & touched outside of straws after removing paper, touched table & silverware for resident w/o hand hygiene
- Observed nurse perform wound care & failed to perform hand hygiene between soiled & clean procedures; failed to clean hands after removing soiled gloves & donning clean gloves; observed staff transporting soiled linen touching clothing
- Failed to ensure proper hand hygiene during meal service & failed to ensure appropriate hand hygiene & glove usage during wound care & peri-care for 1 resident placing residents at risk for cross-contamination & increased risk for infection for all residents

December, 2021

F550 Resident Rights/Exercise of Rights

NE: SS=E: Failed to promote care in a manner to maintain & enhance dignity & respect when staff served 1 resident from each table & tablemates had to wait for long periods of time for their meals, affecting 9 residents

- Observed 2 residents sat at same DR table & 1 resident received supper meal & other resident had to wait & did not receive meal until 45 minutes after tablemate when surveyor asked when resident would be receiving supper meal; same pattern occurred on multiple other occasions of observation; DON stated “a lot of concerns with dining process that they are trying to work on”; failed to promote care in a manner to maintain & enhance dignity & respect when staff served 1 resident from each table & tablemates had to wait for long periods of time for their meals

F584 Safe/Clean/Comfortable/Homelike Environment

NE: SS=E: Failed to provide a safe environment in kitchen & front entry which placed affected residents at risk for an impaired home-like environment

- Observed kitchen with multiple 4-5 inch holes in concrete flooring & numerous areas of floor with paint scraped off; kitchen dry storage area with black stains on floor 3x5 feet
- Observed front entrance/living room area carpeting with numerous large dark stains & numerous areas where carpet backing was visible; hallway doors with gouges; hallway carpet areas on walls with numerous stains & ripples; failed to provide a safe, functional, sanitary & comfortable environment for 8 residents residing on 1 hallway; failed to provide a safe environment in kitchen & front entry placing affected residents at risk for an impaired home-like environment
- Observed ceiling with plaster missing; floor tile dingy & lacked a shine with brownish debris along baseboard where wall & floor met; resident BR & room baseboard tile with debris along baseboard; room entrance door with gouges, missing varnish; failed to provide a safe, functional, sanitary environment placing residents who resided on 1 hall at risk for an unhome-like environment

F600 Free from Abuse & Neglect

NE: SS=J (Past Non-compliance): Failed to prevent 1 resident from inappropriately touching resident's roommate in an unwanted sexual nature; on specific date, Activity staff observed resident seated next to roommate's bed & resident had hand under roommate's shirt on chest; activity staff did not report this occurrence to resident's nurse or Administrative staff; subsequently, roommate was awakened by resident who was performing a sexual act on roommate & roommate did not consent to this activity placing roommate in immediate jeopardy

- *Roommate stated resident had sat on roommate's bed & started to rub roommate's leg & private parts & stated it happened again on multiple occasions; roommate stated felt roommate should have said something before but didn't want to say anything because roommate felt like resident manipulated roommate & roommate did not want to be resident's roommate anymore; roommate stated resident had taken advantage of roommate 4 different times & roommate was one that told nurse what happened; failed to ensure residents remained free from abuse when facility failed to prevent 1 resident from inappropriately touching roommate in an unwanted sexual nature placing roommate in immediate jeopardy*
- *Abatement plan:*
    - *Roommate moved to different room*
    - *Resident placed on constant observations by staff to ensure no inappropriate behaviors*
    - *Staff re-educated on ID & prevention of abuse*

NW: SS=E: Failed to prevent incidents of abuse/neglect; On specific date, CMA failed to provide cares to 1 resident allowing resident to sit in fecal matter for a prolonged period; on specific date, CMA failed to provide cares to another resident, allowing resident to sit in fecal matter through lunch; on other day, CMA provided cares to another resident in a hostile, rough manner; recently during CMAs tenure at facility CMA promoted a hostile environment when answering another resident's call light by yelling at resident; this deficient practice placed 4 cited residents & all other residents at risk for injury &/or impaired psychosocial well-being

- Failed to prevent an incident of neglect when CMA failed to provide resident necessary assistance with toileting & hygiene which placed resident at risk for injury, skin complications & impaired psychosocial wellbeing for multiple residents
- *Failed to prevent an incident of staff to resident verbal abuse which placed resident at risk for impaired psychosocial wellbeing when another CNA witnessed CMA in resident's room when CMA was providing care with another CNA & CMA was being very hostile & yelling & providing rough care; resident, who was not alert & oriented was yelling at CMA to get out of room; CNA stepped in & told CMA to leave & CNA would take over caring for resident*
- *Resident stated CMA entered room & started yelling at resident causing resident to feel disrespected; resident stated resident did not deserve to be yelled at & resident did not want CMA to enter room again; failed to prevent an incident of staff to resident verbal abuse placing resident at risk for impaired psychosocial wellbeing*

F602 Free from Misappropriation/Exploitation

NE: SS=D: Failed to ensure 1 resident remained free from misappropriation of funds when LN received checks & monetary withdrawals in nurse's name from resident placing resident at increased risk for financial instability, loss of dignity & risk for further misappropriation

- *Resident with BIMS of 9 (moderate cognitive impairment), then 99 on quarterly MDS; investigation revealed resident's family had meeting with business office manager where family presented evidence that resident wrote a check to a facility employee, LN in amount of $5,000; family unaware of reasons why it occurred or what bills money would have been used for as resident was long-term care resident at facility; bank statements for last 3 months were collected by facility business office to prepare Medicaid documentation; LN put on suspension; LN failed to provide witness statement after multiple attempts; resident sated wrote checks to LN so nurse could pay bills for resident & none of money was for personal gain for LN; Medicaid application showed 6 different transactions occurring with LN's name on records totally $7,800; LN terminated due to violations; failed to ensure resident was safe from misappropriation of funds placing resident at risk for financial instability, loss of dignity, & risk for further misappropriation for resident*

F609 Reporting of Alleged Violations

NE: SS=D: Failed to submit a completed investigation of a staff to resident abuse allegation involving resident & licensed nurse (LN) to state survey agency within 5 working days of incident as directed by federal regulations

- *Allegation initially reported to state agency via email on 8-7-21 & documented LN reported to Administrative staff an incident which occurred previous day with resident; initial report included allegation, information r/t ongoing investigation including suspension of LN & notification to all responsible parties, medical doctors & required agencies; facility unable to find completed investigation r/t incident; failed to report results of completed investigation for resident's allegation of staff to resident abuse to state agency within appropriate timeline as directed by federal regulations*

NE: SS=J (Past Non-compliance): Failed to ensure staff IDd a situation of inappropriate touching as a possible incident of abuse; further failed to ensure staff immediately reported incident to facility Administrator; on specific date, activity staff observed resident seated next to roommate's bed & resident had hand under roommate's shirt; activity staff did not report this occurrence to residents' nurse or Administrative staff; activity staff did alert another activity staff next morning of observation & other activity staff did not follow up with resident, resident's nurse or Administrative staff; allegation not reported until resident reported it to trusted nurse on evening shift day after incident placing resident in immediate jeopardy

- *Failed to ensure staff IDd a situation of inappropriate touching as a possible violation involving abuse; further failed to ensure staff immediately reported potential (alleged) violation to facility Administrator placing resident in immediate jeopardy;*
- *Abatement plan:*

- *Roommate moved to different room*
- *Resident placed on constant observations by staff to ensure no inappropriate behaviors*
- *Staff re-educated on ID & prevention of abuse*

NW: SS=D: Failed to report to state agency incidents of abuse/neglect; On specific date, CMA failed to provide cares to 1 resident allowing resident to sit in fecal matter for a prolonged period; on specific date, CMA failed to provide cares to another resident, allowing resident to sit in fecal matter through lunch; on other day, CMA provided cares to another resident in a hostile, rough manner; recently during CMAs tenure at facility CMA promoted a hostile environment when answering another resident's call light by yelling at resident; this deficient practice placed 4 cited residents & all other residents at risk for injury &/or impaired psychosocial well-being

- *Cited findings noted in F600 r/t CMA with neglect & abusive behaviors; failed to report to state agency incidents of abuse/neglect placing resident at risk for ongoing abuse/neglect for multiple residents*

F610 Investigate/Prevent/Correct Alleged Violation

NE: SS=J (Past Non-compliance): Failed to ensure resident safety & provide protection when facility failed to implement interventions & take immediate measures to protect 1 roommate from resident to resident sexual abuse on specific date, activity staff observed resident seated next to roommate's bed & resident had hand under roommate's shirt; activity staff did not report this occurrence to residents' nurse or Administrative staff; activity staff did alert another activity staff next morning of observation & other activity staff did not follow up with resident, resident's nurse or Administrative staff placing resident in immediate jeopardy

- *Cited findings noted in F600 & F609 r/t inappropriate sexual aggression to roommate; record lacked documentation that resident had 1:1 staff supervision until 4 days after incident; failed to ensure resident safety & provide protection when facility failed to implement interventions & take immediate measures to protect roommate from resident to resident sexual abuse placing resident in immediate jeopardy*
- *Abatement plan*
  - *Roommate moved to different room*
  - *Resident placed on constant observations by staff to ensure no inappropriate behaviors*
  - *Staff re-educated on ID & prevention of abuse*

F657 Care Plan Timing & Revision

SE: SS=D: Failed to review & revise CP for 1 resident with unplanned weight loss

- CP failed to address physician's order for fortified foods & failed to provide guidance when resident consistently refused breakfast; failed to revise dietitian's recommendation for staff assistance at all times; failed to revise 1 resident's CP r/t interventions to prevent unintentional weight loss

F659 Qualified Persons

SE: SS=F: Failed to ensure qualified licensed staff provided adequate care & services to residents in facility when Administrative Nursing Staff's RN license expired & then lapsed for over 3 weeks

- *KBON's license verification website revealed staff D's RN license did reinstate & was current at the present time; record lacked actual re-instatement date of license; DON verified that RN license expired 1+ month & forgot about renewing it; when realized RN had forgotten, immediately contacted KBON who assisted RN to get license reinstated; failed to ensure qualified staff maintained an active nursing license to provide residents with adequate care & services; failed to ensure Administrative Staff's RN license remained current to ensure adequate care & services provided to residents of facility*

F660 Discharge Planning Process

NE: SS=D: Failed to follow up on 1 resident's request to be transferred to another facility closer to guardian

- *Resident stated had asked to be transferred to a facility closer to guardian about 6 months ago but had not heard anything back from SS; SS stated had tried to contact guardian months previously but had received no return phone call; failed to follow up on resident's request to be transferred to another facility placing resident at risk for impaired psychosocial well being*

F661 Discharge Summary

NE: SS=D: Failed to document a recapitulation of facility stay upon discharge from facility for 1 resident placing resident at risk for impaired continuum of care

- No MDS completed during resident's stay r/t length of stay; failed to document a recapitulation for resident's stay at facility after resident's discharge to community placing resident at risk for impaired continuum of care

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to ensure 2 dependent residents had appropriate bathing opportunities & 1 resident r/t shaving of facial hair

- Documentation lacked evidence of bathing opportunities as scheduled; observed resident with hair dirty & greasy; failed to ensure dependent resident received showers in order to maintain proper hygiene
- Failed to ensure dependent resident received showers in order to maintain proper hygiene
- Failed to ensure personal hygiene needs were taken care of for dependent resident with long facial hair

NE: SS=D: Failed to provide consistent bathing for 1 resident placing resident at increased risk for skin breakdown & decreased self-esteem & dignity

- *Resident admitted for rehab & extensive assist; anonymous reporter reported that when resident moved to another side of facility, not added to shower list & resident lacked bath for well over a month; documentation verified 13 episodes of schedule bathing lacked documentation; failed to provide consistent bathing for 1 resident placing resident at increased risk for skin breakdown & decreased self-esteem & dignity*

NE: SS=D: Failed to provide necessary services to maintain grooming & personal hygiene for 2 residents

- Observed resident with multiple facial hairs on chin on multiple occasions; observed resident with greasy hair, multiple facial hairs on chin & around mouth; resident stated had a shower day before & had asked staff to shave her but staff told resident staff did not have time; failed to ensure 1 resident received proper grooming placing resident at risk for poor hygiene
- Observed resident with hair uncombed & multiple white hairs on chin & clothing with numerous stains on front; next 2 days observed resident with uncombed hair, long white hairs on chin & wore same stained clothing; failed to provide adequate cares to ensure 1 resident was well-groomed & neatly dressed, placing resident at risk for poor hygiene & skin problems

NE: SS=E: Failed to provide bathing services & daily personal hygiene as CPd for 4/8 residents

- Failed to provide necessary care & bathing services for 1 resident placing resident at risk for poor hygiene for multiple residents

NE: SS=E: Failed to provide necessary services to maintain good personal hygiene, including bathing for 3/4 residents & good personal hygiene for 1 resident

- Based on bathing log documentation resident missed multiple scheduled baths; failed to provide resident necessary care & services for bathing & dressing, placing resident at risk for poor hygiene
- Observed resident with dark flaky substance on both hands & front of shirt; observed resident with hair uncombed & dark brown substance under nails on both hands; failed to provide 1 resident necessary care & services for personal hygiene, placing resident at risk for poor hygiene
- Failed to provide bathing services placing resident at risk for poor hygiene for multiple residents

NE: SS=E: Failed to ensure that bathing was provided for 8 residents who required partial or complete assistance from staff for bathing; deficient practice placed 8 residents at risk for potential skin breakdown &/or skin complications from not maintaining good personal hygiene & bathing practices & impaired psychosocial well-being

- Based on bathing log documentation resident missed multiple bathing opportunities on multiple occasions in multiple months; failed to ensure a shower/bath was provided for 1 resident who required extensive assistance with bathing which had potential to cause skin breakdown &/or skin complications due to poor personal hygiene & impaired psychosocial wellbeing for multiple residents

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

NE: SS=D: Failed to ensure weekly skin assessments were completed on 1 resident who was at risk for & had a hx of developing PUs, increasing risk for delayed ID of complications or worsening of existing pressure injuries for 1 resident

- *Failed to ensure weekly skin audits were completed on 1 resident who was at risk for & had a hx of developing PUs increasing risk for delayed ID of complications or worsening of existing pressure injuries for 1 resident*

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=E: Failed to ensure 1 resident transferred in a safe manner & 1 resident's shoelaces secured in a way to prevent entanglement in w/c wheels; failed to ensure hydrocollator used by therapy staff remained locked in therapy room when staff were not in area; failed to secure chemicals in beauty shop to prevent accidental contact with 7 cognitively impaired mobile residents in facility & failed to ensure kick plate on exterior side of patio door was securely attached to prevent accidental injury for residents who used patio

- Failed to transfer dependent resident in safe manner to prevent possible injury when staff used pivot transfer for totally dependent resident
- Failed to ensure resident's foot wear with long dragging shoelace were maintained in safe manner to prevent entanglement in wheels of w/c to prevent possible accident hazard after observed resident's shoelaces got caught in front wheel of w/c & foot dragged by wheel
- Observed therapy room unlocked & door opened & hydrocollator was in BR & door to BR with broken doorknob & door had no other means of locking & hydrocollator turned on; failed to ensure hydrocollator in a secured area to prevent accidental exposure by 7 cognitively impaired mobile residents of facility
- Observed beauty shop with hazardous items & door to beauty shop did not have a locking mechanism & revealed housekeeping staff should keep chemical in locked cupboard; failed to ensure chemical were stored in a manner to prevent accidental contact by 7 confused mobile residents
- Failed to maintain outside patio door in safe secure manner to prevent possible accidents to residents that resided in facility when observed door to patio with metal kick plate with area with protruding edges on outside surface

NE: SS=D: Failed to ensure proper positioning of 1 resident's Broda Chair as directed by resident's CP when facility staff failed to ensure chair was reclined after resident finished eating meal which resulted in resident falling forward & hitting the built-in dresser beside recliner placing resident at increased risk for injury due to accident/falls

- *Failed to prevent resident from falling when staff removed food tray & failed to recline resident's Broda chair resulting in resident pulling self forward & hitting head on stationary dresser which resulted in hematoma*

NE: SS=E: Failed to provide an environment free of accident hazards when staff left chemicals in unlocked cabinet in activity room

- Observed unlocked cabinet in activity room with multiple hazardous chemicals; failed to provide an environment free of accident hazards when staff left chemicals in unlocked cabinet placing 6 cognitively impaired independently mobile residents at risk for harm

NE: SS=D: Failed to assess & remove hazards in residents' environment resulting in a fall placing resident at increased risk for future injuries r/t accidents &/or hazards

- Facility failed to inspect resident's living environment for hazards as outlined in resident's CP resulting in resident slipping on urine & falling on hip & buttock placing resident at increased risk for future injuries r/t accidents & hazards

F692 Nutrition/Hydration Status Maintenance

SE: SS=D: Failed to ensure 1 resident received appropriate nutritional opportunities & interventions to prevent unintentional weight loss

- Staff reported resident did not eat breakfast; RD stated staff did not inform RD that resident was inconsistent with getting up for breakfast; failed to ID resident's inconsistent consumption of breakfast to implement measures to provide missed nutritional intake to prevent unintentional weight loss

NW: SS=D: Failed to obtain an admission weight on 1/3 residents & failed to follow RD's recommendations for obtaining weights weekly on 1 resident, placing resident at risk for unidentified weight loss &/or delayed interventions

- *Resident admitted to facility with DVA, protein calorie malnutrition & dysphagia with PEG tube in place & received all nutrition from the PEG tube; resident at high risk for weight loss; RD note documented no admission weight for RD to review & RD recommended facility obtain weekly weights; 1 week later RD documented still no admission weight; failed to provide necessary weight monitoring for 1 resident who had tube feedings & failed to follow RD's recommendations r/t obtaining weights for 1 resident placing resident at risk for unintentional weight loss &/or delayed interventions*

F698 Dialysis

NE: SS=D: Failed to retain communication sheets which included information from dialysis provider for 1 resident which had potential for unwarranted & unidentified physical complications r/t dialysis

- Failed to retain dialysis communication sheets for 1 resident which had potential for adverse outcomes & unwarranted physical complications r/t dialysis

F732 Posted Nurse Staffing Information

SE: SS=C: Failed to display accurate, publicly accessible & identifiable staffing information on a daily basis for all residents who reside in facility

- Failed to properly complete daily staffing sheets for residents of facility

F755 Pharmacy Services/Procedures/Pharmacist/Records

NE: SS=D: Failed to provide physician ordered medications for 1/5 residents

- Resident with major depressive d/o; eMAR revealed facility did not administer Trazodone on multiple occasions; eMAR revealed multiple occasions in multiple months when facility failed to administer ordered Melatonin; DON revealed facility did not administer medications as physician ordered due to unavailability from pharmacy & verified a "problem" with medication reordering system & pharmacy ability to deliver medications timely; failed to provide resident with physician ordered Trazadone & Melatonin placing resident at risk for ineffective medication management

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Facility's Consultant Pharmacist (CP) failed to report to DON, physician & medical director medication concerns for 1/5 residents; resident's medication not held when pulses were out of physician ordered parameters

- POS indicated order for amiodarone with holding parameters; MAR revealed on multiple occasions pulse was below ordered holding parameter but medication administered; CP failed to report to DON, physician & medical director that resident's medication was not held per physician orders for out of parameter pulses, placing resident at risk for physical decline

NE: SS=D: Failed to Consultant Pharmacist failed to ID & report to DON, facility medical director & physician, an inappropriate diagnosis for use of an antipsychotic medication for 1/5 residents

- Resident with Seroquel for agitation; behavior monitoring revealed no documented behaviors; Pharmacist revealed no recommendation from pharmacist r/t inappropriate diagnosis for use of Seroquel; Pharmacist failed to ID & report to DON, medical director, & physician, an inappropriate diagnosis for use of Seroquel placing resident at risk for inappropriate use of antipsychotic medication

NE: SS=D: Facility's Consultant Pharmacist failed to report to DON, physician & medical director medication concerns for 2/5 residents: 1 resident's pulses out of physician ordered parameters & medication not held when pulses were out of physician ordered parameters for 1 resident

- Facility's Consultant Pharmacist failed to report to DON, physician & medical director; resident's physician ordered out of parameter pulses placing resident at risk for physical decline for multiple residents

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to hold amiodarone when pulses were out of parameter for 1/5 residents

- Cited findings noted in F756 r/t failure to hold amiodarone for pulses below ordered parameters; failed to hold amiodarone medication for 1 resident's out of parameter pulses placing resident at risk for physical decline

NE: SS=D: Failed to hold & report physician ordered out of parameter pulses for 2/5 residents

- Cited findings noted in F756 r/t failure to hold cardiac drugs when pulse below physician ordered parameters; failed to report resident's out of parameter pulses to physician placing resident at risk for physical decline for multiple residents

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SE: SS=D: Failed to monitor 2 residents r/t psychotropic medications to ensure no unnecessary antipsychotic medication usage

- Resident with Risperdal for dementia; MAR revealed staff failed to monitor/document resident's behaviors r/t psychotropic medications; failed to document behaviors for resident who receives a psychotropic medication every day to ensure no unnecessary antipsychotic medication usage
- Resident with Seroquel for behaviors; MAR revealed staff failed to document resident's behaviors r/t resident's psychotropic medications; failed to document behaviors for resident who receives a psychotropic medication every day to ensure no unnecessary antipsychotic medication usage

NE: SS=D: Failed to ensure 1/5 residents received PRN Xanax with a 14 day stop date & 1/5 resident with an appropriate diagnosis for use of antipsychotic

- Record lacked documentation Xanax had 14 day stop date; failed to ensure resident's antianxiety medication had a 14 day stop date placing resident at risk for receiving unnecessary psychotropic medications
- Failed to have an appropriate diagnosis for use of antipsychotic, Seroquel for anxiety placing resident at risk for adverse side effects

F760 Residents Free of Significant Medication Errors

NE: SS=D: Failed to prevent a significant medication error when staff failed to accurately monitor blood sugar values & administer insulin as ordered for 1 resident; LN administered resident's morning dose of insulin at 1:18pm placing resident at increased risk for adverse outcomes r/t medication errors

- *Review of time stamp of medications in EMR recorded resident received morning insulin at 1:16pm, 3 hours 16 minutes after physician ordered timeframe; MAR documented at 4:30pm resident's blood sugar was 37 mg/dL; resident transported to ER; failed to prevent a significant medication error for 1 resident, a cognitively impaired resident when LN administered resident's scheduled morning insulin after noon placing resident at risk for adverse outcomes r/t medication errors*

F761 Label/Store Drugs & Biologicals

NE: SS=D: Failed to label 2 residents insulin pens with date opened, expiration date & resident name in 2/4 medication carts

- Observed med cart with Humalog flex pen lacked a date opened, date of expiration & resident name for multiple residents; failed to label & date when opened the expiration date & resident name for Humalog flex insulin pen & 1 resident's Levimir flex pen placing residents at risk for receiving ineffective medications

NE: SS=E: Failed to discard Gerri Tussin from medication cart & failed to replace expired emergency med kit in 1 med room

- Observed expired Gerri Tussin & med was still being used; observed e-kit in med room with multiple expired medications; failed to discard expired stock medication in med cart & failed to discard expired medications in e-kit in med room placing residents at risk for receiving ineffective medications

F801 Qualified Dietary Staff

NE: SS=E: Failed to employ a full time CDM for all residents who resided in facility & received meals from facility kitchen

- Failed to employ a full time CDM for all residents who resided in facility & received meals from facility kitchen, placing residents at risk for receiving inadequate nutrition

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NE: SS=D: Failed to correctly prepare a pureed diet for 2 residents

- Observed dietary staff prepared pureed diet; staff stated unaware needed to follow a pureed recipe; failed to prepare a pureed diet using professional standards to maintain nutritive value for 2 residents placing residents at risk for not receiving adequate nutrition

F812 Food Procurement, Store/Prepare/Serve-Sanitary

NE: SS=E: Failed to prepare & serve food in facility kitchen under sanitary conditions

- Observed air unit above a food prep area with blackish & gray substance on air vents & filter full of blackish substance with a small amount falling down; peeling ceiling paint around air unit & over bakery prep area with strip hanging down; failed to prepare & serve food in sanitary kitchen for all residents who resided in facility & received meals from facility kitchen placing residents at risk for food borne illness

NE: SS=E: Failed to store, prepare & serve food under sanitary conditions for all residents who received food from facility kitchen

- Observed stove range hood with black fuzzy substance covering hood; range hood not cleaned & serviced every 6 months per policy

NE: SS=F: Failed to store, prepare & serve food under sanitary conditions for all residents who received food from facility kitchen

- Observed: fridge & freezers lacked temp documentation for multiple days in multiple months; freezers lacked documentation of temps on multiple days in multiple months; wall-mounted fan in dishwashing room covered with thick layer of gray lint material; clean cups & glasses on shelf under microwave next to trash can; ceiling vent above serving steam table with lint material; oven doors with brown & black dry material inside & outside oven; mixer with dried debris on stand; failed to store, prepare & serve food under sanitary conditions for all residents who received meals prepared in facility kitchen

NE: SS=E: Failed to ensure sanitary equipment cleaning & food storage placing residents at risk for food borne illnesses & food safety concerns

- Observed ice machine cleaning & maintenance log indicated last cleaning was 3 months previously & machine with brown stains on opening area; freezer with opened food items w/o cover or barrier to protect contents

F839 Staff Qualifications

SE: SS=E: Failed to ensure only qualified CMA staff administered medication for all residents of whom resided on 1 unit of facility

- *Review of KSBON for credentialing revealed LN had an active RN license in Kansas; Nurse Aide Registry Notice documented CNA certified & active through 2023 as a CNA but was not certified as a CMA; CAN was not to administer medications to residents of facility w/o that certification; Review of WeCare Online CMA Completion Course dated in 2021; staff member confirmed not certified as a CMA & stated completed CMA course online & passed with score of 89% but had not tested for state certification yet but was waiting for an email to schedule test; further explained an incident that occurred during which staff member had passed medications prior to state certification; failed to ensure qualified certified medication staff administered various types of medications to residents residing on 1 unit of facility on 1 date*

F880 Infection Prevention & Control

NE: SS=D: Failed to prevent development & transmission of infection when staff failed to properly store 2 residents' O2 tubing & nasal cannula

- Observed 2 resident's O2 tubing & nasal cannula coiled up, unbagged & placed under handle of O2 concentrator in DR on multiple occasions; failed to store 2 residents' O2 tubing & nasal cannula in sanitary environment placing resident at risk for infection

NE: SS=E: Failed to provide a safe, sanitary & comfortable environment to help prevent development & transmission of communicable diseases & infection when staff failed to change gloves during incontinent care, carried unbagged soiled linens against clothing down hall to dirty utility room & failed to disinfect a shared glucometer

- Observed staff failed to change gloves during peri-care after removing soiled brief & before applying clean brief & following peri-care; staff unaware need for changing gloves between soiled & clean components of procedure; failed to change gloves after providing peri-care & touching urine filled incontinent brief & pad placing resident at risk for development of communicable disease & infection
- Observed CNA carried resident's unbagged soiled linens down hall to soiled utility room touching staff member's clothing
- Observed LN placed basket with lancets & glucometer directly on resident's bed side table w/o a barrier, then obtained resident's blood sugar, put glucometer back into basket & went back to cart & did not disinfect glucometer after use; failed to disinfect multi resident use blood sugar glucometer placing residents at risk for infection

F881 Antibiotic Stewardship Program

NE: SS=F: Failed to ensure principles of antibiotic stewardship would be followed by nursing staff to ensure antibiotics used in a safe & effective manner to prevent unnecessary side effects of antibiotics & antibiotic resistance in an ongoing proactive manner

- Infection Control Log revealed lack of diagnosis for ABTs prescribed in 1 month for 3 residents; Infection Control Logs lacked ID of residents who were prescribed ABTs on maps & ABT usage by providers was not tracked; failed to determine antibiotic trends in facility by lack of assessment of all ABTs utilized by providers & lacked completion of the Infection Control Worksheet to proactively monitor ABT usage to prevent unnecessary ABT use & development of resistance

F925 Maintains Effective Pest Control Program

NE: SS=F: Failed to maintain an effective pest control program so facility remained free of pests

- Observed kitchen cabinet with numerous tiny black flying insects in sink & on wall & observed broken open pipe & numerous tiny black flying insects; failed to maintain an effective pest control program placing all residents residing in facility at risk for pests & food contamination

January, 2022

F726 Competent Nursing Staff

NE: SS=D: Failed to ensure all nursing staff possessed competencies & skill sets necessary to provide nursing & related services to meet residents' needs safely & in a manner that promoted each resident's physical well-being; CNA failed to report resident's fall to a licensed nurse & failed to ensure resident was assessed by a licensed nurse prior to assisting resident off floor

- *Resident with osteoporosis, cognitive communication deficit & anxiety; resident required limited assist with ADLs & hx of falls; NN documented LN notified by CNA that resident reported a fall; LN recorded that upon entering resident's room, resident in bed, face up & stated had fallen "a while ago"; resident stated staff member in room when fell & IDd CNA as that staff member & CNA helped resident stand up & put resident in bed; resident c/o arm pain & assessment revealed arm swollen & tender to touch; LN notified practitioner; CNA stated observed resident walking & observed resident stumble but by time able to get to resident, resident on ground; observed resident's arm hit chest by resident's bed; CNA stated asked resident if "ok" and resident stated "yes"; then CNA helped resident back into bed; CNA stated did not talk to any facility staff after incident & did not report fall prior to clocking out & leaving facility; CNA unavailable for interview; failed to ensure competent nursing staff provided nursing care to meet resident's needs safely when CNA failed to report resident's fall to LN on duty allowing resident to be assessed by LN prior to transferring after fall*

F803 Menus Meet Resident Needs/Prep in Advance/Followed

NE: SS=D: Failed to ensure 1 resident received correct diet as ordered by resident's physician when resident received food that was not appropriate for mechanical soft diets resulting in resident choking & required Heimlich maneuver placing resident at risk for complications r/t aspiration & choking

- *Resident with Alzheimer's disease, set up help with meals; witness statement document LN overheard staff ask resident if ok, then LN entered DR & IDd resident choking; resident weakly coughing; LN performed Heimlich maneuver 4 times until resident coughed out sliver of carrot; resident unable to recall choking incident; staff had given resident coleslaw with shredded carrots & residents with mechanical soft diet were not to receive coleslaw; failed to ensure resident received only mechanical soft or minced meal items in accordance to ordered diet placing resident at risk for complications r/t aspiration & choking*