

July, 2024 Kansas Survey Findings

Normal Font-Health Survey

Italics= Complaint Survey

Findings in Red=G+ Scope & Severity

Findings in Green from State Regulations

SS=Scope & Severity; LN=Licensed Nurse

TX=treatment; Dx=Diagnosis; Fx=Fracture

CP=Care Plan; CP in pharmacy regulations=Consultant Pharmacist

PU=Pressure Ulcer; ID=identify; Hx=History

March, 2024

F609 Reporting of Alleged Violations

NE: SS=D: Failed to ensure staff ID'd injuries of unknown origin as potential allegations of abuse & report to administrator to investigate placing residents at risk for unidentified & ongoing abuse &/or mistreatment

- NN documented skin tear to lower extremity that was bleeding with skin flap & flap covered entire tear; NN documented further skin tear on rt calf & staff approximated skin with Steri-strips; EMR lacked investigative notes r/t incidents; staff stated Adm nurse stated Adm unaware of how injuries occurred & verified facility did not investigate to try to determine cause of injuries; failed to ID resident's injuries of unknown origin as possible abuse, neglect or mistreatment & report to facility's Adm as required placing resident at risk for unidentified & ongoing abuse &/or neglect

F610 Investigate/Prevent/Correct Alleged Violation

SW: SS=D: Failed to suspend alleged perpetrator in response to allegation of ANE or mistreatment to prevent further potential abuse for residents of facility on 1/4 hallways of facility while investigation of abuse was in progress r/t resident

- On 3-4-24 Adm Nurse stated received report of allegation of abuse form CNA; allegation included CNA & LN restrained & dragged resident to room & forced resident to take meds; LN confirmed LN & CNA suspended next day & allowed CNA to work night shift after received allegation of abuse; failed to suspend alleged perpetrator in response to allegation of ANE or mistreatment to prevent further potential abuse for residents of facility on 1/4 hallways while investigation of abuse was in progress

NE: SS=D: Failed to investigate 1 resident's injuries of unknown origin to rule out possible abuse or neglect placing residents at risk for unidentified ongoing abuse or neglect

- Cited findings noted in F609 r/t multiple skin tears of unknown origin; failed to investigate 1 resident's 2 injuries of unknown origin to rule out possible abuse or neglect placing resident at risk for unidentified & ongoing abuse & neglect

F656 Develop/Implement Comprehensive Care Plan

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

- CP lacked any interventions or direction to staff on how to monitor for side effects from medications, signs & symptoms of hypoglycemia or hyperglycemia & how to manage diabetes; CP lacked interventions to prevent falls for resident assessed with fall risk; failed to develop a comprehensive CP for 1 resident with preventative measures for falls & for interventions or directions to staff on how to manage diabetes placing resident at risk for impaired care due to uncommunicated care needs
- CP lacked direction to staff r/t resident's mood & verbalizations of wanting to die; failed to develop CP for dementia care & services for resident who had behaviors & made multiple statements that he wanted to die placing resident at risk for impaired care due to uncommunicated care needs
- Admission assessment stated resident did not smoke; CP for smoking developed 4 months after admission then revised stating resident required supervision while smoking & directed staff to use cigarette holder & smoking apron; Adm assessment stated resident did not smoke then 1 month later, NN stated resident needed Band-Aid for finger because burned it 2 days ago while smoking; failed to initiate comprehensive CP for resident for smoking when resident began smoking at facility & immediately after a smoking-related incident placing resident at risk for unsafe smoking related to uncommunicated care needs

F657 Care Plan Timing & Revision

NE: SS=D: Failed to review & revise CP with interventions to address 1 resident's pain & skin tears placing 2 residents for impaired care due to uncommunicated care needs

- CP lacked staff direction for non-medication pain relief measures; failed to review & revise CP for 1 resident's pain management placing resident at risk for impaired care due to uncommunicated care needs
- CP lacked evidence interventions were added to prevent further skin injuries after a skin tear on 2 separate occasions; failed to review or revise CP with interventions that addressed causative factor to prevent further skin tears for 1 resident placing resident at risk for injuries r/t uncommunicated care needs

F677 ADL Care Provided for Dependent Residents

NE: SS=D: Failed to provide necessary services to maintain good personal hygiene including bathing for 3 residents placing residents at risk for impaired health & decreased psychosocial wellbeing

- January bathing record documented resident refused bath x 3 & lacked evidence resident received shower or bath that month; Feb documented resident received 2 showers in month & resident refused bath on 4 occasions with no documentation resident

reapproached; March revealed resident refused baths x 4 & no follow up that resident re-approached; observed resident with hair uncombed & appeared greasy; failed to provide necessary care & bathing services for 1 resident placing resident at risk for impaired health

- January bathing report documented resident refused showers x 3 with no follow up documentation & resident went 13 days w/o shower; Feb with 5 refusals with no follow up documentation & resident 20 days w/o shower; March with 4 refusals & resident 21 days w/o shower/bath; observed resident with long gray beard appearing uncombed; failed to provide necessary care & bathing services for 1 resident placing resident at risk for impaired health & wellbeing
- Feb & March shower paperwork documented all showers refused & staff asked several times & nurse signed papers; record lacked evidence staff reapproached resident at different times or offered alternative hygiene options when resident refused bathing; CNA stated did not offer showers as facility had shower aides; failed to provide necessary care & bathing services for 1 resident including offering alternatives or evening bathing opportunities placing resident at risk for impaired health

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=E: Failed to ensure environment free from preventable accident hazards for 1 resident who burned fingers while smoking; failed to assess 1 resident for ability to smoke safely & failed to provide interventions to prevent injuries & falls for 2 residents placing residents at risk for injuries r/t accidents

- Smoking Safety Assessment documented resident had burned skin & resident required supervision & fire-resistant apron while smoking; resident asked for Band-Aid r/t burning finger 2 days previously while smoking; Adm Nurse verified no further assessment of skin after resident burned fingers smoking & did not assess resident for safe smoking until after staff documented resident burned fingers smoking; failed to prevent smoking r/t accidents for 1 resident after resident burned fingers while smoking; staff failed to assess resident for safety while smoking or implement preventive actions to prevent future burns placing resident at risk for injuries & pain r/t burns
- CP documented resident smoked & facility would keep smoking materials in secured location; record lacked evidence of further assessment for safe smoking practices & policy since 11-13-21 assessment; failed to promote safe environment free from accident hazards for 1 resident when facility failed to assess resident's ability to smoke safely placing resident at risk for preventable accidents & related injury
- Cited findings noted in F609 r/t failure to report & investigate 2 significant skin tears of unknown origin; failed to thoroughly investigate causative factors & develop & implement interventions to reduce or prevent accidents resulting in skin tears for 1 resident placing resident at increased risk for further injuries
- Resident with dementia; CP lacked interventions to prevent falls; resident with fall with head injury with intervention to remind resident to wear nonskid socks; resident with further fall with nonskid socks on but did not use call light & staff reminded resident to call for assist; no fall investigation completed for 1 fall & verified resident did not have CP interventions; failed to ID & implement resident-centered interventions to prevent falls for cognitively impaired 1 resident placing resident at risk for further falls

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to provide care & services to prevent potential infection of urinary system for 2 residents during care for urinary catheters & failed to promote dignity with privacy bag placing 2 residents at risk for urinary infections & other catheter-related complications

- Progress note documented resident having bloody urine & no output in bag or tubing & resident with order to change indwelling catheter; staff attempted to change catheter & had no urine return & while removing catheter, blood began to flow so staff notified on-call provider & were advised to send resident to ER; resident transferred to ER & new catheter placed at ER; culture documented resident with infection; 29 days later resident saw resident & ordered resident sent to hospital due to low-grade fever in last few evenings to r/o UTI; observed resident in bed with catheter bag lacking privacy cover on floor; observed CNA emptied catheter & set measuring canister on bare, visibly soiled floor then wiped catheter bag port with moist wipe (no disinfectant) & began to drain urine & during draining, port end touched inside of used canister, then used moist wipe (no disinfectant) on port, rinsed measuring canister with water, then wiped inside & outside; CNA did not place drainage bag in privacy cover; resident stated bag on floor frequently; failed to ensure appropriate care & services for 1 resident's urinary catheter care bag when staff failed to use appropriate infection control practices when storing & handling drainage bag & did not place it in privacy bag placing resident at risk for catheter related complications
- POS for Foley catheter 16 French with 10mL balloon for neurogenic bladder r/t kidney failure; POS for IV ABT for E-coli IDd in culture; observed bag hung on side of bed with no privacy bag & urine visible from hallway on multiple occasions; observed CMA placed measuring container on bare floor, provided catheter care then emptied bag & did not disinfect port then emptied & rinsed measuring canister & did not change gloves or wash hands before handled & emptied nephrostomy bag of urine & CMA did not disinfect nephrostomy port; failed to provide appropriate catheter care & services practices when handling urinary catheter bag placing resident at increased risk for infection & other catheter-related complications

F697 Pain Management

NE: SS=D: Failed to provide non-medicinal pain relief measures & promote effective pain management for 1 resident who experienced almost constant severe pain placing resident at risk for ongoing severe pain & impaired quality of life

- CP lacked staff direction for non-medication pain relief measures; POS for Tylenol 1000mg TID for pain; POS for Oxycodone 10mg q 4 hrs PRN; resident reported pain never ended; NN documented resident's pain increasing or staying the same, w/o relief & resident watched clock & went out & sat by med cart looking at nurse waiting on pain med & staff reported resident would not be distracted; EMR lacked evidence staff consistently offered & attempted non-pharmacological interventions to treat pain; failed to provide non-medicinal pain

relief measures & promote effective pain management for 1 resident who experienced almost constant severe pain placing resident at risk for ongoing severe pain & impaired quality of life

F744 Treatment/Service for Dementia

NE: SS=D: Failed to provide necessary dementia care & services to attain or maintain highest level of practicable physical, mental & psychosocial wellbeing for 2 residents placing residents at risk for decreased quality of life

- CP documented resident with cognitive impairment with poor safety awareness & decision-making abilities & CP lacked further mention of cognitive impairment including interventions r/t behaviors; POS for Lexapro for depression then DC'd 7 months later; POS for Ativan PRN for agitation then DC'd 1-1/2 months later; POS for Celexa then DC'd 1 month later; POS for Seroquel PRN for anxiety then DC'd same day; NN documented resident with aggressiveness, hit, bit, kicked & pushed furniture around & hollered & screamed at staff & tried to pull roommate out of bed, & staff tried to put resident bed w/o success then received order for Ativan but resident refused; record lacked evidence facility investigated incident to ID potential triggers or causative factors r/t resident's incident with roommate & record lacked evidence facility ID'd & implemented interventions r/t resident's behavior; failed to provide person-centered interventions to address agitation & behaviors for resident who tried to pull roommate out of bed when resident was agitated placing residents at risk for abuse & decreased quality of life
- Resident with vascular dementia, depression; CP lacked direction to staff r/t resident's mood & verbalizations of wanting to die; POS for Sertraline for depression then DC'd 7 months later; NN documented resident kicked staff member in stomach & scratched another staff on side while repositioning resident; Adm nurse called Geri-Psych hospital but no beds available & staff directed to work in pairs; EMR lacked evidence of follow up with Geri-Psych hospital for placement after incident; NN documented resident refused all care during shift; NN documented resident stated wanted to die but did not have a plan to kill self & staff directed to place resident on 15-minute checks & continue to monitor; resident with multiple incidents of aggression & wanted to die; NN documented staff offered psychiatric eval but resident declined; NN documented resident urinated on floor then stated did it because could; NN documented resident on hunger strike because wanted to die & resident refused incontinence briefs & continued to urinate all over room to make staff mad; resident refused pain meds because "I want to die, don't you know that?"; failed to provide person-centered interventions to address mood & behaviors for 1 resident with dementia & made multiple statements that resident wanted to die placing resident at risk for abuse & decreased quality of life

F755 Pharmacy Services/Procedures/Pharmacist/Records

SE: SS=D: Failed to prevent a medication error when LN failed to document in resident's EMR; On 2-28 LN administered oxycodone 5mg tab PRN pain med; at 8am, 2 hours later, another LN administered resident's scheduled oxycodone which was to be administered 1 hour prior to leaving for dialysis for pain; failed to ensure no use of PRN administered within 6-hour time frame of scheduled doses as ordered by physician causing resident to receive 2 doses of oxycodone 5mg 2 hours apart

- POS for Oxycodone, 5mg q M, W, F 1 hour prior to leaving for dialysis & PRN every 6 hours PRN for pain & ensure no use of PRN script within 6-hour time frame of scheduled doses; LN reported resident requested to take pain med early & reported administered PRN oxycodone & verified did not document administration in eMAR & did log it on controlled substance control log; failed to prevent medication error when LN failed to document in resident's EMR; on 2-28-24 at 6 AM LN administered oxycodone 5mg as PRN pain med & at 8am 2 hours later, another LN administered resident's scheduled oxycodone which was to be administered 1 hour prior to leaving for dialysis for pain; failed to ensure no use of PRN administered within 6-hour time frame of scheduled doses as ordered by physician causing resident to receive 2 doses of oxycodone 5mg 2 hours apart

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=E: Consultant Pharmacist (CP) failed to ID & reported meds administered outside physician-ordered parameters for 3 residents & failed to ID inappropriate indication for Seroquel for 1 resident placing residents at risk for adverse side effects, physical decline & unnecessary meds

- POS for Midodrine with holding parameters; MAR documented January with 29/93 opportunities resident received drug when out of ordered parameters; MRR lacked recommendations r/t staff not holding drug when BPs out of holding parameters; CMA stated did not understand < or > symbols definitions so did not know for certain when to hold medication; failed to ensure CP ID'd & reported to facility that staff were not holding BP med when BP was out of ordered parameters placing resident at risk for medication complications
- POS for Lisinopril with holding parameters; EMR lacked documentation staff obtained resident's BP before administering med for 78 administrations since start of medication; MRR documented no recommendations; failed to ensure CP ID'd & reported that staff were not monitoring resident's BP before administration of BP med as ordered placing resident at risk for medication complications
- MRR lacked notation that meds were administered when vital signs were less than physician-ordered parameters; CP had not noted staff administration of BP meds & insulin when physician ordered it to be held; CP failed to ID & report administration of BP meds & insulin when physician ordered it to be held placing resident at risk for adverse medication effects
- POS for Seroquel for Alzheimer's; EMR lacked documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued Seroquel use; MRRs for 11 months lacked recommendation for appropriate indication for continued use of Seroquel & 1 month CP recommended GDR & physician declined; failed to ensure CP ID'd & reported inappropriate indication for continued use of Seroquel placing resident at risk for unnecessary antipsychotic med with side effects

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to notify physician of blood sugars outside ordered parameters for 1 resident & further failed to monitor resident's BP before administration of medication for HTN; failed to hold BP med & insulin when med was out of physician-ordered parameters for 1 resident placing residents at risk for adverse effects r/t medication

- Cited findings noted in F756; Failed to notify physician of 1 resident's out-of-parameter blood sugars as ordered & failed to monitor BP before administration of meds placing resident at risk for adverse medication effects
- Failed to administer or hold meds as physician ordered placing resident at risk for unintended medication adverse effects

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 resident's Seroquel placing resident at risk for unintended effects r/t psychotropic drug meds

- POS for Seroquel for Alz; EMR lacked documented physician rationale including unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued Seroquel use; failed to ensure resident did not receive antipsychotic medication w/o appropriate indication or required physician documentation for use placing resident at risk for adverse med side effects

F760 Residents are Free of Significant Med Errors

NE: SS=D: Failed to prevent significant med errors for 1 resident placing resident at risk for adverse medication reactions & physical decline

- Resident with ESRD, HTN, DM, hypotension, heart failure with dialysis; POS for Midodrine with holding parameters; MAR documented multiple occasions when BP med administered outside ordered parameters in multiple months; failed to keep resident free from significant med errors when staff failed to hold medication when resident's BPs were out of physician-ordered parameters placing resident at risk for adverse effects r/t med errors

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to date 2 resident's insulin flex pens when opened & failed to discard 1 resident's insulin flex pen when outdated placing affected resident at risk for ineffective meds

- Observed 3 resident's insulin flex pens on med carts & 2 lacked open date & discard date & 1 with expired discard date; failed to date 2 resident's insulin with date opened & discard date & failed to discard 1 resident's outdated insulin vial placing residents at risk for ineffective meds

F880 Infection Prevention & Control

NE: SS=F: Failed to implement a water management program for Legionella; further failed to ensure adequate infection control practices r/t catheter care placing residents at increased risk for transmission of infectious diseases

- Failed to implement a water management program to manage waterborne pathogens placing residents who resided in facility at risk of contracting Legionella pneumonia
- Cited findings noted in F690; Failed to provide appropriate infection control practices when handling 1 resident's urinary catheter & nephrostomy bag & 1 resident's urinary catheter bag placing 2 residents at increased risk for infection

F947 Required In-Service Training for Nurse Aides

NE: SS=F: Failed to provide required 12 hours of in-service education for 3 CMAs & 1 CNA placing residents at risk of receiving impaired care

- Review of facility's 12 hour annual in-service documentation revealed 3 CMAs & 1 CNA lacked documentation of required 12 hours of in-service education; failed to provide required 12 hours of in-service for CNA staff placing residents at risk for receiving impaired care

April, 2024

F550 Resident Rights/Exercise of Rights

SW: SS=D: Failed to maintain 1 resident's dignity when staff talked to resident in demeaning manner; when staff failed to close window when providing incontinence cares; & failed to cover resident's urinary catheter collection bag when in public view

- Observed resident in room & resident reported there was a nurse that would speak to resident in demeaning manner telling resident "That's not my job" resident stated asked nurse what was wrong, to which nurse responded resident was "lying in waste" & asked nurse who was going to take care of resident & nurse stated nursing will; resident stated concerned there are residents in facility that are confirmed to room & cannot help it they cannot control bowels; resident stated no one had gotten back to resident about report r/t nurse speaking to resident in demeaning manner; failed to protect dignity of resident when staff talked to resident in demeaning manner
- Failed to provide privacy bag for 1 resident's indwelling foley catheter to promote dignity
- Failed to protect privacy & dignity of 1 resident when staff failed to close window during cares with potentially exposed to public

NE: SS=D: Failed to ensure 1 resident was treated with respect & dignity during incontinence care placing resident at risk for negative psychosocial outcomes & decreased autonomy & dignity

- Resident reported incident with CNA & resident stated CNA told resident that resident not allowed to wear incontinence brief throughout night & resident stated made resident very uncomfortable & embarrassed at night when did not get to wear brief to bed; LN stated CNA reported incident but LN forgot to report information to anyone; failed to ensure resident treated with respect & dignity & failed to ensure staff respected resident's choices placing resident at risk for negative psychosocial outcomes & decreased autonomy & dignity

F558 Reasonable Accommodations Needs/Preferences

SW: SS=D: Failed to ensure 1 resident's call light remained within reach

- Observed resident to be unable to easily reach call light & resident had to reposition self in bed with head pressed against grab bar with neck bent at unnatural angle & shoulder hung off bed so hand could grasp call light; resident attempted to grasp call light cord 3x's before being able to successfully hold device & press button for assist; resident stated that due to deformity of fingers due to RA had trouble grasping call light &/or pressing button; failed to provide resident with appropriate call light equipment which failed to accommodate resident's individual needs

F561 Self-Determination

NE: SS=D: Failed to ensure 1 resident was allowed to exercise right for self-determination w/o intimidation placing resident at risk for negative psychosocial outcomes r/t decreased autonomy & impaired rights

- 1 resident stated felt pressured by facility to switch pharmacy services during facility's ownership changeover; resident stated resident (spouse) & told by facility meds may be difficult to obtain by previous pharmacy once facility switched to new one & afraid of not receiving meds due to existing medical problems; resident stated after changed pharmacy resident had to wait 2 days for 1 med used to treat fungal infection to be delivered by new pharmacy; resident stated resident & spouse would not have changed pharmacies if facility had not told them meds would be difficult to obtain from local pharmacy where had been receiving meds from before change of ownership; failed to ensure support resident's right to self-determine healthcare providers & services including pharmacy services placing resident at risk for negative psychosocial outcomes r/t decreased autonomy & impaired rights

F585 Grievances

SW: SS=D: Failed to track grievances through conclusions & provide prompt efforts to resolve grievance filed by resident r/t behavior of staff, offer or provide written grievance decisions to resident r/t grievance & to offer or provide summary of pertinent findings or conclusions r/t resident's concerns, a statement as to whether grievance was confirmed or not confirmed, any corrective action taken or to be taken by facility as result of grievance

- Resident stated "a nurse told a lie"; cited findings noted in F550 r/t nurse stating "that's not my job" to another resident & this resident reported incident but no one had ever gotten back with this resident; Grievance Log lacked documented of this concern/grievance described by resident; failed to track grievances through to conclusions & provide prompt efforts to resolve grievance filed by resident r/t behavior of staff; offer or provide written grievance decisions to resident r/t grievance & to offer or provide summary of pertinent findings or conclusions r/t resident's concerns, a statement as to whether grievance was confirmed or not confirmed, any corrective action taken or to be taken by facility as result of grievance

F600 Free from Abuse & Neglect

SE: SS=D: Facility neglected resident when staff failed to provide incontinence care during 8-hour shift beginning at 2Pm when on-coming staff for 10pm shift was rounding & between 9:50pm & 10pm found resident with a urine & bowel soaked brief & yellow/brown colored ring surrounding sheet resident was on; additionally, failed to prevent verbal abuse to resident when staff member spoke to resident in irritated voice telling resident "We would not be doing this" and "go to your room" when resident was yelling up by nurses' station

- CP instructed staff resident to be checked & changed q 2-3 hours & PRN & resident often refused to be changed; investigation revealed CNA stated did not change resident because CNA thought residents had to be checked on 1x/shift; facility neglected resident when facility failed to provide incontinence care to resident during 2-10 shift resulting in resident having urine & bowel soaked brief & linens with yellow/brown ring surrounding resident
- Failed to prevent verbal abuse to 1 resident when CNA used irritated loud voice telling resident "not going to do this" r/t resident's dementia-related behaviors; & "go to your room" r/t dementia-related behaviors

NW: SS=D: Failed to ensure 1 resident remained free from verbal abuse &/or mistreatment from staff placing resident at risk for fear, intimidation & neglect

- Witness statement documented 2 CNAs went into resident's room to do rounds & performed normal routine; when turning resident to wall, resident's arm got caught under resident & resident yelled out, "My arm" several times; CNAs got resident's arm unstuck then rolled resident other direction; 1 CNA noted when staff finished cleaning resident up & laid resident on back, resident stated, "You almost broke my neck"; 1 CNA started yelling & pointing finger in resident's face; CNA AP stated, "We did not almost break your (expletive) neck. WE have been yelled at & cussed at all night & don't (expletive) deserve this (expletive). We don't get paid enough & we aren't robots". CNA then pulled resident's call light out of wall, plugged it back in & tossed the call light in chair & told resident not to call again & left room. Other CNA told resident sorry & that CNA would report situation to nurse; CNA stated left room & reported situation to LN; investigation was started & CNA AP was suspended pending results of investigation; resident unable to recall incident; law enforcement notified; follow up with resident completed throughout week & resident showed no indications of psychosocial effects; resident denied being fearful; failed to ensure resident remained free from staff abuse &/or mistreatment placing resident at risk for fear, intimidation & neglect

F610 Investigate/Prevent/Correct Alleged Violation

SE: SS=D: Failed to report neglect 1 resident when CNA found resident with brief full of urine & bowel & yellow/brown ring surrounding resident on sheet

- Cited findings noted in F600 r/t neglect findings; Failed to report neglect when 2 CNAs failed to inform facility within 2 hours of allegation of neglect to resident when lacked incontinence care & was found with full brief of urine & bowel with yellow/brown ring surrounding on sheet

F656 Develop/Implement Comprehensive Care Plan

SW: SS=D: Failed to develop a comprehensive, individualized person-centered CP for 1 resident r/t use of grab bar use for bed mobility & 1 resident to include use of O2 & O2-related equipment placing residents at risk for uncommunicated care needs

- CP lacked documentation r/t grab bar use for bed mobility; failed to develop comprehensive individualized person-centered CP for 1 resident r/t use of grab bar use for bed mobility & for 1 resident to include use of O2 & O2-related equipment placing residents at risk for uncommunicated care needs
- Failed to develop & implement CP for respiratory care r/t O2 use for resident

F676 ADLs/Maintain Abilities

NE: SS=D: Failed to assist 1 resident with maintaining amplified hearing device placing resident at risk for decline in communication & psychosocial wellbeing

- CAA documented resident had amplifier & chose to use device most of time & device assisted resident with hearing; Observed resident in room & resident stated needed to put hearing amplifier headphones on but headphones did not function upon putting them on head & resident stated could barely hear w/o them; inspection of headphones revealed batteries were dead; resident stated staff do not check headphones very often & did not get frequent visits due to most of residents moving to different hallway for remodeling & staff do not always come around & check on resident as often as they should & not sure when headphones last worked; 6 hours later resident's headphones still not working; at 10:10am resident stated had not seen staff since breakfast & headphone batteries were changed out previous evening; failed to assist resident with charging or changing batteries on amplified hearing device placing resident at risk for decline in communication & psychosocial wellbeing

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to provide adequate incontinence care to dependent resident during 8-hour shift when on-coming staff was rounding & found resident with urine & bowel soaked brief & yellow/brown colored ring surrounding sheet

- Cited findings noted in F600 & F610; Failed to provide incontinence care to 1 resident during 2p-10p shift resulting in resident having urine & bowel soaked brief & linens with yellow/brown ring surrounding resident

NE: SS=E: Failed to ensure shower/bath was consistently provided for 5 residents who were dependent on staff assist with ADLs; also failed to ensure 1 resident was assisted with dressing with potential to cause skin breakdown &/or skin complications due to poor personal hygiene & impaired psychosocial wellbeing

- Resident dependent on staff for all bathing needs; bathing documents for 46 days revealed resident received 1 shower, 1 full bath, 2 sponge baths, 2 refusals, 5 Not applicable; CMAs stated resident had not refused baths/showers; failed to provide consistent bathing for 1 resident who was dependent on staff assist for bathing placing resident at risk for complications r/t poor hygiene & impaired dignity
- CP documented resident required substantial to extensive assist with bathing; documentation for 46 days revealed resident with 2 refusals, 6 Not Applicable & EMR lacked evidence bath/shower provided for 46 days reviewed; LN stated staffing was "hectic" in March & some residents did not receive baths; CNA stated facility no longer staffing bathing aide positions; failed to provide consistent bathing for 1 resident who required extensive assist from staff for bathing placing resident at risk for complications r/t poor hygiene & impaired dignity
- CP documented resident required substantial assist from staff for bathing; bathing documentation for 46 days revealed: 3 showers, 2 Refusals; 5 Not Applicable; resident stated had been informed by staff there was not enough staff to provide resident with bath on occasions & resident stated felt dirty when missed bath/shower; failed to provide consistent bathing for 1 resident who required extensive assist from staff for bathing placing resident at risk for complications r/t poor hygiene & impaired dignity
- Time period from 3-12 to 3-31 lacked evidence shower/bath provided, offered or refused; resident stated in March resident did not receive bath or shower & stated usually refused a shower but never refused a bed bath; resident stated not enough staff to give baths; failed to provide consistent bathing for 1 resident who required assist with bathing placing resident at risk for complications r/t poor hygiene & impaired dignity
- Bathing documentation revealed 46 days period with 6 baths, Not Applicable x 4 & 3 Refusals; resident stated recent assist for grooming & bathing had gotten worse & had missed baths due to no one checking on resident; at 10:10am resident stated had not seen staff since breakfast & still waiting on assist to get dressed & resident still wearing nighttime PJs; at 11:34am resident stated staff finally assisted resident with personal hygiene & changing clothing & resident's blouse shirt on inside-out; failed to provide consistent assist for 1 resident r/t bathing & dressing placing resident at risk for infections & decreased psychosocial wellbeing

F686 Treatment/Services to Prevent/Heal PU

NE: SS=D: Failed to ensure 1 resident's pressure-reducing device was in recliner as CP'd placing resident at risk for complications r/t skin breakdown & PUs

- CP indicated resident used pressure-relieving cushion for w/c & recliner; Observed resident on multiple occasions w/o pressure relieving device on w/c; failed to use resident's pressure-relieving device in recliner as CP'd placing resident at risk for preventable pressure injuries

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=D: Failed to provide environment as free of accident hazards as possible for 1 resident when facility failed to prevent multiple electrical cords plugged into 2 power strips next to resident's recliner from being strewn about floor in walking path between resident's recliner & resident's bed & O2 tubing on floor in walking path from BR to resident's bed & recliner area with potential to create trip hazard for resident that could potentially lead to injury

- Resident with moderate risk for falls r/t use of O2 & long O2 tubing; observed on multiple occasions resident's room with 2-4 port power strips stored next to recliner with 7 items plugged in with cords that laid directly on floor in pathway between resident's recliner & resident's bed; resident's O2 tubing looped on floor between resident's BR & down pathway from BR to resident's recliner; failed to provide environment as free of accident hazards as possible for 1 resident when facility failed to prevent multiple electrical cords plugged into 2 power strips next to resident's recliner from being strewn about floor in walking path between resident's recliner & resident's bed & O2 tubing on floor in walking path from BR to resident's bed & recliner area with potential to create trip hazard for 1 resident that could potentially lead to injury which would negatively affect resident's physical & psychosocial wellbeing

SW: SS=E: Failed to ensure environment was free of accident hazards for 11 resident, including failure to keep hazardous chemicals out of reach; failed to maintain safe environment when staff utilized gait belt to secure resident's door to remain in open position

- Observed multiple residents' room with multiple unidentified, unlabeled chemicals with warning labels; observed door movement restricted with door stop; failed to keep hazardous chemicals out of reach of 11 confused, mobile residents of facility; failed to maintain a safe environment when staff utilized gait belt to secure 1 resident's door to remain in open position

NE: SS=E: Failed to secure hazardous materials out of reach of 5 cognitively impaired, independently mobile residents; also failed to ensure 1 resident's fall interventions were implemented per CP at mealtime placing affected residents at risk for preventable injuries & accidents

- Observed unsecured laundry rooms with accessible containers of sanitary bleach wipes with warning label; observed unsecured laundry room on another hallway with bleach wipes with warning label; failed to secure hazardous materials out of reach of 5 cognitively impaired, independently mobile residents placing affected residents at risk for preventable injuries & accidents
- Resident with hx of falls; CP documented resident with hx of leaning forward to pick up items on floor; observed resident in DR alone at table & pushed w/c away from table & attempted to stand multiple times before staff intervened; observed resident brought to DR & food not served & resident sat alone then pushed away from table & placed feet in between w/c's foot pedals & resident attempted to stand up from w/c multiple times w/o staff in immediate area to intervene; failed to ensure safe environment r/t resident's CP's fall interventions when staff brought resident to DR before meal served placing resident at risk for preventable falls & related injuries

F690 Bowel/Bladder Incontinence, Catheter, UTI

SW: SS=D: Failed to provide necessary services to decrease risk of UTI when staff failed to use proper hand hygiene & EBP when providing urinary catheter care for 2 residents

- Observed catheter bag stored on top of dignity bag stored directly on floor
- Observed LN catheter care & LN changed gloves w/o performing hand hygiene & carried urinal to BR with improper infection control techniques; failed to provide necessary services to decrease risk of UTI when staff failed to use proper hand hygiene & EBP when providing catheter care for resident
- Failed to provide necessary services to decrease risk of UTI when staff failed to use proper hand hygiene, catheter cleansing & EBP when providing catheter care for resident

F695 Respiratory/Tracheostomy Care & Suctioning

SW: SS=D: Failed to provide appropriate respiratory care in maintaining respiratory equipment for 3 residents; 1 for unlabeled nebulizer tubing & mask stored uncovered with unknown liquid remaining in chamber, hanging on side of nebulizer machine & undated O2 tubing with nasal cannula for 1 resident with 2 nebulizers left with unknown clear liquid in nebulizer chambers & 2nd nebulizer lacked date to indicate tubing placement & was stored in old coffee cup & 1 resident with unknown clear liquid in nebulizer chamber CPAP mask left hanging on bed rail with undated O2 tubing/nebulizer/CPAP tubing

- Failed to provide respiratory care consistent with professional standards of care for resident r/t use & cleaning of nebulizer equipment with potential to lead to respiratory illnesses that could negatively affect physical & psychosocial wellbeing for resident
- Failed to provide respiratory care consistent with professional standards of care for 1 resident r/t use & cleaning of nebulizer & CPAP equipment with potential to lead to respiratory illnesses that could negatively affect physical & psychosocial wellbeing
- Failed to provide respiratory care consistent with professional standards of care for 1 resident r/t use & cleaning of nebulizer equipment with potential to lead to respiratory illnesses that could negatively affect physical & psychosocial wellbeing

SW: SS=D: Failed to properly clean & store nebulizer for 2 resident in accordance with standards of care; additionally, facility failed to place date label on O2 tubing for 1 resident placing residents at risk for respiratory complications that could also have negative impact on resident's psychosocial wellbeing

- Failed to provide respiratory care consistent with professional standards of care for 1 resident r/t use & cleaning of nebulizer equipment for multiple residents
- Failed to provide appropriate respiratory care r/t maintaining respiratory equipment to prevent spread of infection for resident when O2 equipment unlabeled & undated

NE: SS=D: Failed to ensure nebulizer mask was stored in sanitary manner to decrease exposure & contamination for 1 resident placing resident at increased risk for respiratory infection & complications

- Observed resident with undated & unbagged nebulizer mask laying directly on nebulizer machine, observed mask laying on dresser; failed to ensure 1 resident's nebulizer mask was stored in sanitary manner to decrease exposure & contamination placing resident at increased risk for respiratory infection & complications

F700 Bedrails

SW: SS=D: Failed to assess 1 resident for safety & risk of entrapment from bed rail use & failed to ensure resident obtained informed documented consent from resident or representative prior to installation of siderails placing resident at risk for uninformed decisions r/t risks & benefits associated with use of side rails & placed resident at risk due to possible injury due to bedrail use

- CP lacked documentation r/t use of grab bars; EMR lacked documentation of grab bar assessment; failed to assess resident for safety & risk of entrapment from bedrail use & failed to obtain informed documented consent from resident/representative prior to installation of siderails placing resident at risk for uninformed decisions r/t risks & benefits associated with use of side rail & placed resident at risk for possible injury due to bedrail use

F726 Competent Nursing Staff

SW: SS=E: Failed to ensure certified nursing staff had appropriate competencies & skill set to provide nursing related services to assure resident safety & to attain or maintain highest practicable physical, mental & psychosocial wellbeing of each resident placing 3 residents at risk of injury during call light response & 2 residents for proper catheter care placing all residents at risk for decreased quality of care

- Failed to ensure certified staff had appropriate competencies & skill sets to provide nursing r/t services of incontinence care to assure resident safety & attain or maintain highest practicable physical, mental & psychosocial wellbeing of each resident placing resident at risk for decreased quality of care
- Review of call light log for 1 resident from 4-2 to 4-9 indicated call light remained unanswered for 18 occurrences ranging from 15 minutes to 30 minutes before staff answered call light for post hospitalization for cardiac care; failed to ensure certified staff had appropriate competencies & skill sets to provide nursing related services to assure resident safety & attain or maintain highest practicable physical, mental & psychosocial wellbeing of each resident placing all residents at risk for decreased quality of care
- Observed staff provide catheter care w/o EBP; failed to provide catheter anchor for tubing; failed to ensure certified staff had appropriate competencies & skill sets to provide nursing related services to assure resident safety & attain or maintain highest practicable physical, mental & psychosocial wellbeing of each resident r/t catheter & wound care placing resident at risk for decreased quality of care
- Review of call light log from 3-1 to 3-14 revealed 345 call light entries with 47 entries greater than 15 minutes including entries of 45.23 minutes, 32.5 minutes, 34.3 minutes, 33.3 minutes, 32.8 minutes, 37.8 minutes, 35.8 minutes, 36 minutes, 43 minutes & 39 minutes; failed to ensure certified staff had appropriate competencies & skill sets to provide nursing related services to assure resident safety & attain or maintain highest practicable physical, mental & psychosocial wellbeing of each resident placing all residents at risk for decreased quality of care
- Failed to ensure certified staff had appropriate competencies & skill sets to provide nursing related services to assure resident safety & attain or maintain highest practicable physical, mental & psychosocial wellbeing of each resident placing all residents at risk for decreased quality of care r/t prolonged call light response times
- NE: SS=D: Failed to ensure nursing staff demonstrated appropriate competencies & skill sets to provide nursing services to care for resident's needs when staff lacked knowledge r/t dosing & administering diclofenac gel placing resident at risk of adverse side effects
- Observed CMA prepared & dispensed meds for 1 resident; performed hand hygiene & applied clean gloves then opened tube of diclofenac gel & squeezed unmeasured amount onto glove & did not review order for dosage amount before applied medication; CMA stated unaware gel even had a dosage amount or that box for med had plastic measuring chart used to measure med amount to dispense from tube until informed by surveyor; failed to ensure staff demonstrated appropriate competencies & skill sets to provide nursing services to care for residents' needs when staff lacked knowledge on how to administer diclofenac gel for 1 resident placing residents at risk for adverse side effects

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

NE: SS=F: Failed to provide RN for at least 8 consecutive hours/day, 7 days/wk placing residents at risk of decreased quality of care

- PBJ reports for 3rd & 4th quarters of 2023 indicated 139 days facility did not have RN for 8 consecutive hours each 24 hour period; review of timeclock & payroll data revealed facility had RN hours for all but 4 days; Adm stated could not say what previous system was to track & ensure there were 8 consecutive RN hours 7 days/wk; failed to provide RN for at least 8 consecutive hours a day 7 days a wk placing residents at risk of decreased quality of care

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

NE: SS=F: Failed to complete required nurse aide performance review at least once every 12 months placing residents at risk for inadequate care for 4 CNAs & 1 CMA

- Failed to complete required nurse aide performance review at least once every 12 months placing residents at risk for inadequate care

F755 Pharmacy Services/Procedures/Pharmacist/Records

NE: SS=E: Failed to ensure an accurate & consistent reconciliation of all controlled substances on medication carts

- Review of "Licensed Nurse: Ass Needed (PRN) Narcotic Count Sheet" dated April 2024 revealed 17/88 opportunities the narcotic reconciliation was not performed on Med Cart A & 52/88 opportunities reconciliation not completed on Med Cart B1
- "Scheduled Narcotic Count Sheet" dated April revealed 34/132 opportunities narcotic reconciliation not completed on Med Cart C & 22/132 opportunities reconciliation not completed on Med Cart D
- "Shift to Shift Sheet Med Count East/West Station" from 4-8-24 thru 4-23-24 with 4 days with only 1 signature representing staff completing narcotic reconciliation for entire day; no reconciliation for 4 dates & only 1 staff signatures for entire day on 7 dates

- *“Shift to Shift Med Count West Sheets” from 4-1-24 to 4-23-24 with 1 staff signature for entire day on 11 days with no signatures or indications that oncoming or off-going shifts documented number of cards located in narcotic med lock box on 1 Med Cart & 3 days with no signatures or indications that oncoming or off-going shifts documented number of cards located in narcotic med lock box on 1 Med Cart; failed to ensure accurate & consistent reconciliation of all controlled substances on med carts placing residents at risk for misappropriation & ineffective medication regimens*

NE: SS=D: Failed to ensure 1 resident’s meds were available for administration w/o missed doses during facility’s change-over to new pharmacy provider placing resident at risk of unnecessary complications & ineffective med regimen

- Cited findings noted in F561 r/t lack of fungal cream med during change over of pharmacies; CMA stated facility was supposed to get delivery TID from new pharmacy but thus far, it had not happened; failed to ensure 1 resident’s meds were available for administration w/o missed doses during facility’s change-over to new pharmacy provider placing resident at risk for unnecessary complications & ineffective med regimen

F758 Free from Unnecessary Psychotropic Med/PRN Use

NE: SS=D: Failed to ensure multiple unsuccessful attempts for nonpharmacological symptom management were documented including risk versus benefits for continued use of antipsychotic for 1 resident with dx of dementia & received Risperdal placing resident at risk for unnecessary psychotropic med & related complications

- POS for Risperdal r/t restlessness, agitation & paranoid d/o; Pharmacy Consult asked for ID’d documented clinical rationale for administration of Risperdal; EMR lacked any documentation or evidence of nondrug behavioral interventions tried & failed before starting antipsychotic med; LN unaware what Risperdal used for; failed to ensure documented multiple unsuccessful attempts for nonpharmacological symptom management before use of Risperdal placing resident at risk for unnecessary psychotropic meds & related complications

F759 Free of Medication Error Rates 5% or More

SW: SS=E: Failed to ensure that medication administration error rate was no greater than 5% when errors occurred with 22/27 observed medication had errors when LN failed to confirm meds administered against physician’s order or eMAR; medication errors were due to failure to follow nursing standard of care resulting in error rate of 81.48%

- Observed LN administered 22 meds by removing meds from outer wrapper & removed meds from internal wrapping & failed to confirm meds against physician’s order on eMAR for multiple meds & multiple residents

F761 Label/Store Drugs & Biologicals

SW: SS=E: Failed to secure meds by failure to lock 2 med carts on 2 separate neighborhoods during administration of meds when nursing staff left med cart unlocked & unattended with potential to affect 20 residents on 1 neighborhood & 20 resident on another neighborhood

- Failed to secure meds by failure to lock 2 med carts on 2 separate neighborhoods during administration of meds when nursing staff left med cart unlocked & unattended

SW: SS=E: Failed to provide a safe environment for 11 residents by failure to ensure 2 resident rooms remained free of unsecured meds, when facility failed to secure meds in both resident rooms with potential to create accidental ingestion of meds to confused, mobile residents

- CP lacked information r/t self-administration of meds; EMR lacked self-administration assessment; observed 1 resident room with bottle generic antacid tablets on BR counter next to personal hygiene items; failed to provide safe environment for 13 residents by failure to ensure 1 resident’s room remained free of unsecured meds with potential to create accidental ingestion of meds to these confused, mobile residents
- CP lacked information r/t self-administration of meds; EMR lacked self-administration assessment; Observed 1 resident’s room with bottle of refresh eyedrops on over-bed table, Ciclopirox drops & Restasis drops on over-bed table; failed to provide safe environment for 13 residents by failure to ensure that resident’s room remained free of unsecured meds with potential to create accidental ingestion of meds to confused, mobile residents

F804 Nutritive Value/Appear, Palatable/Prefer Temp

SW: SS=E: Failed to provide food that was palatable, attractive & at safe & appetizing temperature

- Surveyors requested test tray; all foods appropriate temp & all foods palatable except for tater-tots which tasted stale & freezer burnt; staff provided test tray from 2nd kitchen & tater-tots at 130.9 & popcorn shrimp at 132 & staff reported foods should be at 135 degrees F; failed to provide food that was palatable, attractive & at safe & appetizing temp with potential to lead to residents not eating appropriate portion sizes & causing foodborne illnesses due to improper serving temps

F806 Resident Allergies, Preferences, Substitutes

SW: SS=D: Failed to follow menu for 1 resident to provide physician ordered gluten free diet

- EMR revealed allergy to gluten; Dietitian Recommendations revealed resident previously followed gluten free diet & resident avoided breads, pasta, etc. & physician agreed; Diet Type Report dated 4-11-24 revealed “Regular type, regular texture, regular fluid, gluten free diet”; “Gluten Free Menu” for week 1 lacked month & day; recipe for “Chicken Parmesan” revealed instructions to dredge chicken breast in flour, coat with egg & dredge in breadcrumb mixture & recipe included allergies to gluten; Dietary staff sat plate down next to resident’s meal ticket then realized resident was gluten free & took plate away then prepared a new plate & placed parmesan chicken, buttered peas & was going to serve when surveyor intervened about breaded chicken & staff stated chicken not gluten free & had been prepared with

flour; staff removed chicken & placed roast beef on plate then started to add gravy but stopped when questioned if gravy was gluten free; resident unaware of any allergies

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SW: SS=F: Failed to store, prepare & serve food under sanitary conditions for residents in facility

- Observed: dietary staff lacked beard cover had hat in place which did not cover all hair; dish machine log-high temp lacked documentation staff checked wash & rinse temps at all meals for 9 days in current month; fridge with undated, expired foods, expired foods, containers w/o lids, condiments lacked dates, hardboiled eggs lacked dates; multiple undated food items & w/o cover; multiple trays of muffins uncovered in kitchen area; fridge with thickened juice & water with expired dates; observed temps of mechanical soft chicken at 123 degrees F & staff failed to document measured temps of foods
- Failed to prepare & serve chicken parmesan according to recipe
- Observed dietary staff failed to change gloves & perform hand hygiene when left serving tray, re-entered kitchen then went back to serving line

SW: SS=F: Failed to provide sanitary food prep & storage of food to prevent spread of foodborne illness to residents of facility

- Observed: dietary staff with long hair exposed below level of buttocks with hair restraint covering only top of head
- Expired foods & liquids in fridge; unsealed & open to air foods in freezer; cutting boards with non-cleanable surfaces; unsealed & undated foods in freezer; undated food items

F814 Dispose Garbage & Refuse Properly

SW: SS=F: Failed to maintain &/or dispose of garbage & refuse properly in sanitary condition to prevent harborage & feeding of pests

- Observed outside dumpster littered with medial waste & lid in open position; failed to provide sanitary garbage & refuse containers that were maintained in sanitary condition free of debris with lids or otherwise contained & covered with potential to lead to harborage & feeding of pest animals

F849 Hospice Services

NE: SS=D: Failed to ensure communication process was implemented which included how communication would be documented between facility & hospice provider for 2 residents creating a risk for missed or delayed services & impaired physical, & psychosocial care for 2 residents

- Failed to ensure collaboration between facility & hospice provider for 2 residents placing resident at risk for delayed services which could affect residents' mental & psychosocial wellbeing

F851 Payroll Based Journal

NE: SS=F: Failed to submit complete & accurate staffing information to PBJ when facility failed to submit staffing data for all direct care personnel as required for 1 quarter & failed to submit accurate data on other quarters placing residents at risk for impaired care due to unidentified staffing issues

- PBJ report for 2nd quarter 2023 & 1st quarter 2024 indicated data suppressed though facility did not meet reasons for suppressed other than inaccurate data or failure to report; report documented 23 days w/o LN 24 hrs/day but time sheets indicated facility had LN coverage on days listed on PBJ; PBJ report indicated 139 days w/o RN 8 hrs/day but payroll data indicated facility RN coverage as required for all but 4 days; failed to submit accurate information to CMS PBJ placing residents at risk for impaired care due to unidentified staffing issues

F880 Infection Prevention & Control

SW: SS=E: Failed to follow infection control standards when delivering meal trays to residents in dining area, appropriately clean respiratory equipment for 3 residents or perform hand hygiene between phases of wound care for 1 resident with potential to lead to foodborne illness, respiratory illness & wound infections

- Failed to maintain effective infection control program with failure of staff to follow infection control standards when delivering meal trays to residents in dining area when CNAs carried plates with thumbs over edge of plate & deep into eating surface of plates with potential to negatively impact physical & psychosocial health of all residents on 1 neighborhood
- Cited findings noted in F695 r/t inappropriate respiratory equipment sanitation; failed to maintain effective infection control program with failure of staff to appropriately clean respiratory equipment for multiple resident with potential to lead to respiratory illnesses that could negatively affect physical & psychosocial wellbeing of resident for multiple residents
- Observed LN performed wound care to MASD on 1 resident's buttocks; during wound care, LN changed gloves but failed to perform hand hygiene on multiple occasions during wound care; failed to maintain effective infection control program with failure of staff to follow infection control standards when staff failed to perform hand hygiene between phases of wound care for 1 resident with potential to cause wound infections which would negatively affect resident's physical & psychosocial wellbeing

SW: SS=E: Failed to provide sanitary & safe environment to prevent cross contamination & infection r/t provision & appropriate use of PPE for 13 residents who required EBP to be in place & available for 9 resident with catheters, 5 residents with wounds, 2 residents with PEG tubes; 4 residents requiring EBP during care received in therapy; additionally failed to provide safe & sanitary handling of glucometer & doffing of gloves to prevent cross contamination & infections for 3 residents r/t glucometer use; furthermore, failed to provide appropriate catheter care & hand hygiene for 2 residents to prevent infection & prevent cross contamination

- Observed staff perform glucometer check & failed to perform hand hygiene prior to donning gloves then placed glucometer from dresser with gloved hand then reached into scrub uniform pocket with gloved hand & pulled out cell phone & explained needed to shut phone off then swiped hand, then swiped gloved hand & replaced phone into pocket then picked up meter with gloved hand used lancet with same

contaminated gloves then failed to sanitize glucometer prior to placing it in drawer; failed to provide sanitary & safe environment to prevent cross contamination & infection related to provision of appropriate use of PPE & safe & sanitary handling of glucometer between residents hand hygiene with donning & doffing gloves to prevent cross contamination & infection for residents

- All residents requiring EBP (13 resident) lacked EBP or readily available PPE nor signage during cares; Adm nurse stated had not implemented EBP for residents; therapist unaware had to use EBP; failed to provide sanitary & safe environment to prevent cross contamination & infection related to provision of EBP r/t availability & appropriate use of PPE for residents of facility
- Failed to provide resident requiring urinary catheter, infection control techniques to prevent possible urinary system infections r/t inappropriate hand hygiene before catheter care & with every glove change then at end of procedure
- Failed to provide necessary services to decreased risk of UTI when staff failed to use proper hand hygiene & EBP when providing catheter care for 1 resident
- Failed to provide necessary services to decrease risk of UI when staff failed to use hand hygiene, catheter cleansing & EBP when providing catheter care for 1 resident

NE: SS=E: Failed to ensure guidelines for EBP were followed when facility failed to have PPE readily available for staff use, stored outside room; failed to ensure staff sanitized resident equipment when it fell on floor placing residents at risk of infection development

- Observed facility did not have PPE readily available for staff usage if needed stored outside room; facility had PPE stored in resident's room & not in covered cart or storage area; observed LN outside resident's room with med cart & grabbed continuous glucose monitor & dropped on floor & picked machine up off floor but failed to properly sanitize machine or hands before use on resident; failed to ensure required EBP guidelines were followed when facility failed to have PPE readily available for staff use outside residents' room; failed to ensure staff sanitized resident equipment when it fell on floor placing residents at risk for infection development

F887 COVID-19 Immunization

SW: SS=E: Failed to ensure 5 residents/representatives acknowledged receipt r/t COVID-19 vaccination information/education for 5/5 residents

- Multiple residents' documentation revealed COVID vaccination as "resident refused" but facility unable to provide declination information
- 1 resident's documentation revealed resident received COVID vaccination but lacked education for risk versus benefits & failed to provide written consent to administer vaccination for multiple residents; failed to ensure 5 residents/representatives acknowledged receipt r/t COVID-19 vaccination information/education &/or signed consent verification

May, 2024

F550 Resident Rights/Exercise of Rights

NE: SS=D: Failed to honor 1 resident's request during dining; further failed to ensure 1 resident's dignity maintained during care provided in common area placing residents at risk for decreased self-esteem & decreased self-worth

- Observed resident in w/c in DR & was given shake then resident asked staff if could go into RV room to eat then asked staff repeatedly to take resident to TV room & LN, CNA & CMA continued to stay seated assisting other residents; staff did not respond to resident's requests & staff did not assist resident in moving w/c; observed resident continued to ask to be moved to TV room & staff ignored resident's requests & did not reply; observed resident served breakfast & as ate bacon began to cough & resident spit out bacon & another resident asked resident if resident ok & resident stated staff didn't care; resident asked CNA name & CNA gave name & resident continued to cough & LN & CNA continued to sit & assist other residents to eat & CNA instructed resident to take drink of water; LN then cleaned off resident's lap full of crumbs then walked away & LN made no vocal interaction with resident; failed to ensure resident's rights & dignity were respected when staff failed to acknowledge resident's request to go to another room placing resident at risk for decreased self-esteem & decreased self-worth
- Observed resident in w/c in common area & LN placed gait belt around resident's abdomen then stood in front of resident & asked resident to stand; resident's knees bent & heels off floor with only tips of toes touching floor then LN lifted resident from w/c & gait belt slid upward which raised resident's shirt upward & exposed resident's skin from waist to breast area during transfer; no pivot disc or walked used during transfer; failed to ensure 1 resident was treated with respect & dignity placing resident at risk for negative psychosocial outcomes & decreased autonomy & dignity

F600 Free from Abuse & Neglect

NE: SS=D: Failed to ensure 1 resident remained free from verbal abuse when staff made inappropriate statements to 1 resident; CNA became irritated with resident & made disparaging remarks about size of resident's genitals placing resident at risk for impaired psychosocial wellbeing including humiliation & degradation

- Investigation documented CNA told resident that resident "had a small penis" while providing peri care & 2nd CNA reported incident next day; resident did not want to discuss incident with investigating staff; resident stated was embarrassed & refused to share who made inappropriate comment but confirmed 3 CNAs were in room providing cares; investigation lacked witness statements from 2nd & 3rd CNAs in room; resident stated there were times that staff would be rude to residents but nothing more than that, hot heavy abuse in resident's opinion but staff did get upset with resident because resident pushed call light too often; resident stated was afraid to say too much because concerned that direct care staff would punish resident; failed to ensure resident remained free from verbal abuse placing resident at risk for impaired psychosocial wellbeing including humiliation & degradation

F609 Reporting of Alleged Violations

NE: SS=D: Failed to ensure staff ID'd incident as verbal abuse & reported incident to Adm immediately creating risk of unidentified & ongoing abuse

- Cited findings in F600 r/t verbal abuse r/t staff discussing size of resident's genitals; failed to ensure staff ID'd incident as verbal abuse & reported incident to Adm immediately creating risk of unidentified & ongoing abuse

F676 Activities Daily Living (ADLs)/Maintain Abilities

NE: SS=D: Failed to ensure 1 resident received necessary assistive care & services with ADL to maintain highest practicable ability & promote independence placing resident at risk for injury, pain, & decreased ability to perform ADL

- MDS documented BIMS could not be completed; CP lacked directions for ADLs r/t assist required or any weight-bearing restrictions; POS for weight bear as tolerated for transfer with no further orders active or DC'd r/t resident's weight bearing status; representative stated staff walked resident to BR in commons area & representative questioned staff about incident because resident had restrictions with walking & weight-bearing & staff continued to walk to BR even after representative pointed it out; staff opened chart & stated resident had no weight-bearing restrictions listed in record; representative stated when staff assisted resident back to recliner & appeared to be in pain & 20 minutes later came back & confirmed there were orders limited resident's weight-bearing status to transfers only; failed to ensure 1 resident received necessary assistive care & services with ADL to maintain highest practicable ability & promote independence placing resident at risk for injury, pain, & decreased ability to perform ADLs

NE: SS=D: Failed to ensure 1 resident received necessary assistive services for transfers placing resident at risk for loss of independence, decreased self-esteem & impaired dignity

- CP documented resident used pivot disc & walker for transfers; cited findings noted in F550 r/t inappropriate transfer in common area; failed to ensure resident provided with necessary assistive devices for transfers placing resident at risk for loss of independence, decreased self-esteem & impaired dignity

F677 ADL Care Provided for Dependent Residents

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

- NN lacked documentation r/t refusal of staff assist with toileting hygiene &/or eating; observed resident in bed covered with blanket from legs to lower abdomen & with folded washcloth on chest with 11 crumbs from breakfast on washcloth; resident wore hospital gown with brown clump on which appeared to be food on upper chest area; resident's room with distinct foul odor present; observed resident almost 4 hours later in same condition; failed to ensure resident received ADL assist as required placing resident at risk for skin breakdown, a decreased quality of life & impaired psychosocial wellbeing

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

NE: SS=D: Failed to ensure 1 resident's pressure-reducing interventions were implemented correctly when low air-loss mattress pump was set at inaccurate weight for resident; additionally failed to complete weekly wound assessments of 1 resident placing all affected residents at risk for complications r/t skin breakdown & PUs

- Resident with Stage 3 PU with CP for pressure-reducing devices for bed & w/c & with hospice; hospice provided low air loss mattress overlay; manufacturer guide with recommendations for settings based on resident's weight; observed mattress set to 280 lbs & resident weight 107 pounds on multiple occasions; failed to ensure that resident's low air-loss mattress pump was appropriately set to current weight placing resident at risk for complications r/t skin breakdown & PUs
- Resident with risk & actual skin breakdown; resident at moderate risk for PU; Skin Evaluation Form documented full-thickness pressure wound to buttock & eval lacked measurements; EMR lacked evidence of further wound assessment from 3-5 until 3-19 (14 days later); EMR lacked evidence of wound assessment from 3-19 to 4-23 (34 days); EMR lacked evidence of weekly wound assessment from 4-24 thru 5-13; failed to ensure staff appropriately assessed & monitored resident's pressure injury at least weekly placing resident at risk for complications r/t skin breakdown & PUs

NW: SS=J (Abated to G): Failed to ensure adequate treatment to prevent worsening of facility acquired PU & failed to promote healing

- On 12-15-23 resident who required assist from 2 staff for bed mobility, developed a facility-acquired unstageable PU to heel; facility applied heel protectors but did not involve provider until 7 days later; provider ordered dressing to wound, changed every 7 days; wound became stagnant & lacked any signs of healing from 12-22-23 thru 3-23-24 when new treatment was started; facility also did not measure wound for 2 weeks from 3-9-24 thru 3-22-24; on 3-29-24 facility spoke with dietitian & telehealth wound nurse & received new orders for resident's deteriorating wound but did not involve physician despite increased wound dimensions & presence of signs of possible infection including increased drainage & pain until 4-2-24 when facility received new order from wound nurse & facility's medical director; on 4-3-24 facility ID'd drainage from wound & new open area on inside of foot but did not notify physician; on 4-6-24 facility documented resident would go for podiatry referral in 3 days; on 4-7-24 resident assessed by provider & sent to hospital for respiratory issues & wound care; upon admission to hospital, resident's heel wound was necrotic with purulent foul-smelling drainage & had advanced to stage 4 PU with exposed bone; further testing revealed resident with osteomyelitis of heel bone; resident sent to higher level of acute care for wound care & vascular evaluation; surgeon recommended amputation of lower extremity above knee; resident family did not want procedure; resident placed on palliative care & passed away on 4-27-24 at local hospital; failure to notify & involve physician & ensure physician assessment of evolving & progressively worsening facility-acquired PU placed resident in immediate jeopardy
- Abatement Plan:
 - ID of residents with PUs

- Facility Medical Director received wound status report on affected resident & was in facility on 5-9-24 to address & make recommendations
- All residents at risk for PUs were reviewed & CPs reviewed to ensure interventions were in place to prevent wounds
- Nursing staff received education on P/P r/t skin assessment, pressure ulcer prevention & documentation requirements
- Education provided to staff that facility Medical Director along with residents' primary care physicians & wound consultants would be notified of ID of wounds
- Wounds would be discussed weekly at risk meeting
- Medical team would be updated weekly after risk meeting to make recommendations to promote healing

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=G: Failed to ensure 1 resident received post-fall care including neurological evals & nursing assessments following an unwitnessed fall that resulted in obvious head trauma & resident later sent out to hospital where resident found to have nasal bone fx's & multiple rib fx's placing resident at risk for increased pain & other complications

- Resident with vascular dementia with BIMS 0; fall on 4-24 documented "resident had the right to fall, and he continued to fall with interventions in place"; POS for Apixaban (anticoagulant); RCA recorded resident in new environment & not using call light or asking for assist with ADLS & intervention was staff received education to help orientate resident to new surroundings & use call light for assist; resident with multiple falls (8 falls in month); Resident with fall at 3:28am & record with no neuros after 4:15am; hospital notes documented resident with nasal fx's & bilateral rib fx's; failed to ID & implement appropriate, resident-centered interventions to prevent falls for 1 resident & failed to ensure 1 resident received post-fall care including neuro evals & nursing assessments following unwitnessed fall; resident sustained nasal bone fx's & multiple rib fx's & placed resident at risk for increased pain & other complications

NE: SS=G: Failed to ensure environment free from accidents for 1 resident & as result, resident sustained avoidable injury to leg which required sutures; also placed resident at risk for increased pain & impaired wellbeing

- CP documented resident needed 2 staff members to help transfer using Hoyer lift with full-body, large sling' NN documented resident with skin tears to bilateral lower legs & orders to be sent to ER for eval & treat; facility investigation documented resident assisted up in Hoyer lift from w/c into recliner & while CNA lowered resident into recliner 2nd CNA placed hands on residents bilateral legs & pushed back to assist resident to get further back into recliner; then 2nd CNA noted resident's lower legs were bleeding & LN assessed; 2nd CNA noticed that resident's legs were bleeding where CNA had placed hand to push resident closer to recliner; failed to ensure resident remained free from avoidable accidents & as result resident sustained laceration to leg which required sutures placing resident at risk for increased pain & impaired wellbeing

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to provide appropriate treatment for 1 resident with indwelling catheter when facility failed to prevent drainage bag from resting on floor placing resident at risk for catheter complications including infection

- Resident with indwelling catheter with Macrobid x 60 days for UTI prophylaxis; resident with multiple orders for ABT for UTIs; observed resident in bed with catheter bag laying directly on floor; failed to prevent catheter drainage bag from touching floor for 1 resident who had frequent UTIs placing resident at risk of catheter-related complications & further UTIs

F695 Respiratory/Tracheostomy Care & Suctioning

NE: SS=D: Failed to ensure 1 resident's CPAP mask stored in sanitary manner placing resident at increased risk for respiratory infection & complications

- CP lacked staff direction for care of resident's CPAP mask; observed resident's room with CPAP mask laid directly on bedside table w/o containment on multiple occasions; failed to ensure 1 resident's CPAP was stored in sanitary manner placing resident at increased risk for respiratory infection & complications

F700 Bedrails

NE: SS=D: Failed to ID resident's low air-loss mattress & bolstered overlay as possible risks on residents' side rail assessment placing resident at risk for inadequate care due to unidentified care needs

- Cited findings noted in F686 r/t low air-loss mattress application for hospice resident; CP indicated resident required use of bilateral transfer bars on bed for repositioning, transfer & bed mobility; risk assessment for side rails did not DI low air-loss mattress or bolstered mattress overlay on bed as risk & no device screenings were completed as CPd; failed to ID resident's low air-loss mattress & bolstered overlay as possible risks on resident's side rail assessment placing resident at risk for inadequate care due to unidentified care needs

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to store meds & biologicals appropriately when facility failed to lock medication room & additionally failed to appropriately label 1 resident's insulin once opened placing residents at risk for unnecessary medication & administration errors

- During walkthrough observed med room entry door unlocked
- Observed med cart with insulin pen & opened Novolog pen not dated when opened; failed to store meds & biologicals appropriately when facility failed to lock med room & failed to appropriately label resident's insulin med once opened placing residents at risk for unnecessary med & administration errors

F744 Treatment/Service for Dementia

NE: SS=D: Failed to provide dementia care & services for 1 resident when facility failed to ensure staff utilized resident-specific interventions for behaviors creating environment that affected resident's ability to maintain highest practicable level of physical, mental & psychosocial wellbeing

- Resident with Parkinson's disease, unsteadiness on feet, generalized muscle weakness, repeated falls & dementia with agitation; BIMS 3 with behaviors directed to others, rejected care & wandered; investigation documented resident wheeled to table to join a coloring activity & when resident reached for supplies, Activity Aide began smacking resident's hands several times & stated to resident "(expletive, expletive), leave it alone, your husband just left, do not be bad, you are so bad"; resident then tried to stand from w/c & AA grabbed by arm; consultant stepped in & told AA could not grab resident's arm; AA removed from unit & suspended pending investigation; CNA stated did not have access to CPs; failed to provide dementia care & services for 1 resident when facility failed to ensure staff utilized resident-specific interventions for behaviors creating an environment that affected resident's ability to maintain highest practicable level of physical, mental, & psychosocial wellbeing

F812 Food Procurement, Store/Prepare/Serve-Sanitary

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

- Observed bowls stored upright; 3 fridge & 4 freezer temp logs lacked evidence staff checked temp on 1 day; freezer with meat items uncovered & undated; meat slicer uncovered by not in use; dishwasher temp logbook lacked evidence staff checked water temp on 2 days; cottage cheese & mild open & undated

F880 Infection Prevention & Control

NE: SS=E: Failed to ensure adequate infection control standards r/t following EBP, wearing PPE & indwelling catheter maintenance placing residents at risk for infectious diseases

- Resident with indwelling catheter & no EBP signage or PPE posted in or around room for urinary catheter for multiple residents
- Resident with wound care & no EBP signage or PPE posted in or around room
- Observed CNA entered room & completed peri-cares for resident in contact isolation w/o donning & required PPE to prevent exposure to resident's bacterial UTI; failed to follow sanitary infection control standards r/t EBP, wearing PPE & indwelling catheter maintenance placing residents at risk for infectious diseases

June, 2024

F550 Resident Rights/Exercise of Rights

SW: SS=E: Failed to ensure dignity in resident dining when facility served 7 residents meals in Styrofoam containers due to lack of plates, cups & flatware for residents who chose to eat in room

- Observed dietary staff delivered cart with Styrofoam containers of food to each hall & CNAs delivered trays to resident who chose to eat in rooms; failed to ensure dignity in resident dining when facility served 7 residents meals in Styrofoam containers, due to lack of plates, cups & flatware for residents who chose to eat in room

NE: SS=D: Failed to ensure 1 resident's right to be treated with respect & dignity when staff provided personal care with window blinds open to side street of facility placing resident at risk for negative psychosocial outcomes & decreased dignity

- Observed 2 staff members transferred resident with Hoyer lift with window blinds open to street on side of facility; failed to ensure resident's right to be treated with respect & dignity, related to staff providing personal care with window blinds open to side street of facility placing resident at risk for negative psychosocial outcomes & decreased autonomy & dignity

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

SW: SS=D: Failed to ensure the right of 1 resident's representative to be informed of changes when resident had increase in behaviors & staff placed resident on 1:1 observation due to resident's behaviors

- Failed to notify resident's representative of cognitively impaired 1 resident's behaviors which resulted in staff placing resident on 1:1 supervision

F584 Safe/Clean/Comfortable/Homelike Environment

SW: SS=F: Failed to maintain a clean, comfortable & homelike environment throughout facility for all residents of facility r/t 4 residents who had no means to control temperature of rooms

- Observed 4 residents with blankets laying over vents; door to 1 resident's room was being held open with gait belt that was tied to doorknob & to handle on dresser drawer in multiple rooms; resident stated had to cover vent to room because unable to control temp of room r/t resident in neighboring room had thermostat in room & it was too warm for resident; maintenance staff confirmed 1 thermostat in every 3rd room & staff confirmed not conducive to homelike environment for residents; failed to maintain clean, comfortable & homelike environment throughout facility for all residents r/t room temps & inability for 1 resident to close door to room with potential to negatively affect psychosocial wellbeing of residents in facility

F600 Free from Abuse & Neglect

SW: SS=L (Abated to E): Failed to ensure staff IDd & responded appropriately to all allegations of abuse to include resident-to-resident abuse

- 1 resident with hx of hitting other residents, continued to hit residents in facility on multiple occasions including grabbing another resident's sweatshirt by collar & pushed w/c backwards then grabbed resident's nose between index & middle finger & continued to pull on resident's nose causing pain; resident hit another resident with closed fist in back of head; resident hit spouse then hit another

resident knocking resident out of chair; resident swung baby doll & hit another resident twice on face across glasses; resident punched another resident on side of jaw; resident raised closed fist to another resident & made contact with other resident's face; continued incidents of resident-to-resident abuse & lack of supervision & interventions to prevent abuse placed residents in immediate jeopardy for continued abuse; additionally 2nd resident who had hx of sexual behaviors & physical aggression, hit unknown resident after unknown resident bumped resident's w/c & grabbed other resident's breast through other resident's shirt & on another occasions masturbated in public area; failed to ensure staff IDD & responded appropriately to all allegations of abuse to include resident-to-resident abuse; continued incidents placed residents in immediate jeopardy for continued abuse

○ Abatement Plan:

- Staff in-serviced on facility's ANE policy/procedure & staff not allowed to work until signatures received
 - IDT in-serviced for ANE reporting
 - Staff placed resident on 1:1 & would remain on 1:1 until deemed no longer a threat or discharged from facility
 - Referrals sent to Behavioral Units for temporary placement
 - Hospice & Medical Director to complete medication review
 - QAPI meeting held
- Resident's EMR revealed resident with dx of Intermittent Explosive Disorder, bipolar, dementia & sexual dysfunction; NN documented resident seated in doorway of DR when another resident bumped into resident in electric w/c & other resident yelled at resident to get out of way then other resident moved close to resident's side & resident punched other resident in arm & yelled at resident then grabbed other resident's breast through shirt; NN documented resident in DR with penis out & masturbated in front of residents & resident provided 1:1; NN documented resident overheard saying sexually inappropriate statements to staff & made sexual comments to another resident; failed to ensure staff IDD & responded appropriately to all allegations of abuse to include resident-to-resident abuse

F602 Free from Misappropriation/Exploitation

SW: SS=J (Abated to G): Failed to ensure 1 resident remained free from misappropriation of funds when housekeeping staff coerced resident to write staff member a check for \$300 placing resident & other residents of facility in immediate jeopardy with risk for negative psychosocial impact in safety & security

- On 6-27-24 Resident documented that on 5-22 housekeeping staff came into room & asked for \$500 with promise to repay next day & resident stated could not loan out that much money; next day housekeeping staff returned to resident's room & requested smaller loan of \$300 & resident stated resident in pain from recent fall & just wanted housekeeping staff to leave room so write staff member a check for \$300; Adm documented on 5-27- that DON notified Adm that housekeeping staff request \$300 & resident wrote staff a check; Adm documented gave directly to terminate housekeeping staff immediately then notified resident's family of events & lost funds refunded to resident; resident stated felt exploited due to housekeeper repeatedly asking for money & would not take no for an answer so resident finally write staff a check so she would just "leave resident alone"; failed to ensure resident remained free from misappropriation of funds when housekeeping staff exploited resident of \$300; resident stated felt coerced into providing housekeeper as staff would not leave resident alone until check was written placing resident & other residents in facility in immediate jeopardy with risk for negative psychosocial impact in safety & security
- Abatement Plan:
 - All staff received either group or individual ANE training with member of management; All staff notified by facility's communication app that prior to returning to work staff must receive ANE training with member of management
 - Facility's Medical Director & resident's PCP notified about alleged exploitation
 - LTC State Ombudsman notified about alleged exploitation
 - Ad-hoc QAPI meeting held

F609 Reporting of Alleged Violations

SW: SS=L (Abated to F): Failed to ensure timely reporting of alleged abuse to State Agency (SA) or local law enforcement as required; failed to report 2 allegations of resident-to-resident abuse as described in F600 r/t abusive incidents

- Cited findings noted in F600 r/t resident-to-resident abuse & inappropriate sexual behaviors of 2 residents; failed to ensure staff reported alleged abuse to SA or local law enforcement as required for resident-to-resident abuse; continued incidents placed residents in immediate jeopardy
 - Abatement Plan
 - Staff in-serviced on facility's ANE policy/procedure & staff not allowed to work until signatures received
 - IDT in-serviced for ANE reporting
 - Staff placed resident on 1:1 & would remain on 1:1 until deemed no longer a threat or discharged from facility
 - Referrals sent to Behavioral Units for temporary placement
 - Hospice & Medical Director to complete medication review
 - QAPI meeting held
- Failed to report all allegation of abuse to include resident-to-resident abuse

SW: SS=L (Abated to F): Failed to ensure timely reporting of alleged exploitation to State Agency (SA) or local law enforcement as required when facility failed to report allegation of exploitation of resident when housekeeping staff coerced resident to write a check for \$300 placing resident & other residents of facility in immediate jeopardy with risk for negative psychosocial impact in safety & security

- *Cited findings in F602 r/t exploitation of resident when staff coerced resident into writing staff a check for \$300; staff confirmed law enforcement or SA not notified of exploitation of resident; On 6-27-24 Adm confirmed had been informed that on 5-27, informed that unknown staff member had asked resident for money & questioned resident & resident confirmed; failed to ensure timely reporting of alleged exploitation to SA or local law enforcement as required when facility failed to report allegation of exploitation of resident when housekeeping staff coerced resident to write check for \$300*
 - *Abatement Plan:*
 - Staff in-serviced on facility's ANE policy/procedure & staff not allowed to work until signatures received
 - IDT in-serviced for ANE reporting
 - Staff placed resident on 1:1 & would remain on 1:1 until deemed no longer a threat or discharged from facility
 - Referrals sent to Behavioral Units for temporary placement
 - Hospice & Medical Director to complete medication review
 - QAPI meeting held

F610 Investigate/Prevent/Correct Alleged Violation

SW: SS=L: Failed to investigate all allegations of resident-to-resident abuse to protect residents from further incidents of abuse; failed to thoroughly investigate 2 abuse allegations r/t 1 resident who had hx of hitting other residents & continued to hit residents in facility on multiple occasions

- Cited findings noted in F600 & F609 r/t resident-to-resident abuse & inappropriate sexual behaviors; facility did not thoroughly investigate abuse allegations which allowed continued resident-to-resident abuse incidents; facility lacked investigation into resident-to-resident altercation on 1 occasion & CP lacked updated interventions to deter resident's resident-to-resident aggression; failed to ensure staff IDD & responded appropriately to all allegations of abuse to include resident-to-resident abuse
 - Abatement Plan
 - Staff in-serviced on facility's ANE policy/procedure & staff not allowed to work until signatures received
 - IDT in-serviced for ANE reporting
 - Staff placed resident on 1:1 & would remain on 1:1 until deemed no longer a threat or discharged from facility
 - Referrals sent to Behavioral Units for temporary placement
 - Hospice & Medical Director to complete medication review
 - QAPI meeting held
- SW: SS=L (Abated to F): Failed to thoroughly investigate incidents of misappropriation of funds & failed to protect residents from further misappropriation when housekeeping staff coerced resident to write resident at check for \$300 placing resident & other residents of facility in immediate jeopardy & placed residents at risk for misappropriation of funds
 - *Cited findings in F602 & F609 r/t exploitation of resident who felt "coerced" to give staff a check for \$300; failed to thoroughly investigate incidents of misappropriation of funds & failed to protect residents from further misappropriation when housekeeping staff coerced resident to write check for \$300 placing resident & other residents of facility in immediate jeopardy & placed residents at risk for further misappropriation of funds*
 - Abatement Plan:
 - Staff in-serviced on facility's ANE policy/procedure & staff not allowed to work until signatures received
 - IDT in-serviced for ANE reporting
 - Staff placed resident on 1:1 & would remain on 1:1 until deemed no longer a threat or discharged from facility
 - Referrals sent to Behavioral Units for temporary placement
 - Hospice & Medical Director to complete medication review
 - QAPI meeting held

F637 Comprehensive Assessment After Significant Change

SW: SS=D: Failed to recognize a significant change in resident's physical condition & perform a comprehensive MDS within required 14-day period with potential to lead to uncommunicated needs & placed resident at risk of further deterioration of physical, mental & psychosocial wellbeing

- Failed to recognize a significant change in resident's physical condition & perform a comprehensive MDS within required 14-day period with potential to lead to uncommunicated needs & place resident at risk of further deterioration of physical, mental & psychosocial wellbeing

F641 Accuracy of Assessments

SW: SS=E: Failed to accurately completed MDS for 5 residents related to: 1 r/t hospice & medications on CAA; 1 r/t accidents not addressed on CAA; 1 r/t dialysis & nutrition not addressed on CAA & 1 r/t meds not addressed on Section N on MDS with potential to lead to uncommunicated need for care & services to meet each individual residents' needs

- CAA lacked documentation r/t hospice services; failed to accurately reflect resident's status r/t hospice & medications on CAA analysis placing resident at risk for uncommunicated care needs
- Failed to accurately reflect resident's status r/t dialysis & insulin administration r/t DM on CAA analysis leading to uncommunicated care needs which had potential to negatively impact physical, mental & psychosocial wellbeing of 1 resident
- Failed to accurately reflect resident's status r/t fall & accident hazards on CAA analysis leading to uncommunicated care needs which negatively impacted physical, mental & psychosocial wellbeing of resident

- Failed to accurately complete MDS for 1 resident r/ antidepressant meds with potential to lead to negative psychosocial effects r/t safety & uncommunicated needs

F656 Develop/Implement Comprehensive Care Plan

SW: SS=E: Failed to develop a comprehensive person-centered CP for 7 residents: 1 resident's CP lacked interventions r/t hemodialysis & insulin use r/t DM; 1 CP lacked interventions r/t hospice or end-of-life care; 1 CP lacked interventions r/t PTSD; 1 resident's CP lacked interventions r/t aggressive behaviors which involved resident-to-resident abuse; 3 residents' CPs lacked interventions r/t care & treatment of PU/injury with potential to lead to uncommunicated needs which could lead to negative impacts on residents' physical, mental & psychosocial wellbeing

- Failed to develop comprehensive person-centered CP for 1 resident r/t hemodialysis or insulin use r/t DM with potential to lead to uncommunicated needs that would negatively affect physical, mental & psychosocial wellbeing of 1 resident
- Failed to develop comprehensive person-centered CP for 1 resident r/t PU/injury prevention & wound care with potential to lead to uncommunicated needs that would negatively affect physical, mental & psychosocial wellbeing of 1 resident
- Failed to develop a comprehensive person-centered CP for 1 resident when CP lacked interventions r/t hospice or end-of-life care with potential to lead to uncommunicated needs which would negatively affect physical, mental & psychosocial wellbeing of 1 resident
- Failed to develop a comprehensive individualized CP for 1 resident's PU placing resident at risk to receive inadequate care & services r/t PU
- Failed to develop a comprehensive, individualized CP for 1 resident's PTSD placing resident at risk to receive inadequate care & services r/t PTSD
- Failed to CP interventions for 1 resident r/t aggressive behaviors involving resident-to-resident abuse with potential to lead to negative impacts on resident's physical, mental & psychosocial wellbeing
- Failed to place interventions to prevent pressure injuries for 1 resident who developed a preventable, facility-acquired stage 3 pressure injury; further failed to place interventions on resident's CP to prevent worsening of wound

F657 Care Plan Timing & Revision

SW: SS=D: Failed to revise fall CP with interventions for 3 residents placing all 3 residents at risk for impaired ability to achieve &/or maintain highest practicable level of physical & emotional wellbeing due to uncommunicated care needs

- CP lacked interventions for 3 falls; failed to implement CP interventions for resident who had repeated falls placing resident at risk for preventable falls & injuries
- CP lacked revisions & updated interventions for 7 falls; Failed to revise 1 resident's comprehensive person-centered CP to include fall & accident hazards with potential to lead to uncommunicated needs that would negatively affect physical, mental & psychosocial wellbeing of 1 resident
- CP lacked any interventions that corresponded to 1 fall; Failed to revise 1 resident's CP with interventions to prevent further falls when resident had multiple falls in 2 months

NE: SS=D: Failed to revise 1 resident's CP to reflect toileting needs after meals placing resident at risk for preventable accidents & falls r/t uncommunicated care needs

- CP lacked instructions to toilet resident after meals as discussed in IDT note; failed to revise 1 resident's CP to reflect toileting after meals placing resident at risk for preventable accidents & falls r/t uncommunicated care needs

F677 ADL Care Provided for Dependent Residents

SW: SS=D: Failed to provide appropriate & timely ADLs for 1 resident r/t untrimmed facial hair for 1 resident

- Observed 1 resident unshaven & with growth of facial hair stubbles & resident reported staff had not shaved resident for quite awhile & staff would sometimes shave resident but was not able to remember the last time staff shaved resident; failed to provide dependent resident with removal of facial hair

F684 Quality of Care

SW: SS=D: Failed to provide treatment & care in accordance with professional standards with failure to coordinate resident care with hospice services

- CAA lacked documentation r/t resident's hospice services; resident admitted to hospice for cachexia; CP lacked guidance for staff r/t hospice; failed to provide treatment & care in accordance with professional standards with failure to ensure coordinated resident care with hospice services

F686 Treatment/Services to Prevent/Heal PU

SW: SS=G: Failed to place interventions to prevent pressure injuries for 2 residents who developed preventable facility-acquired stage 3 pressure injuries at facility for 1 resident & stage 3 PU for 1 resident; further failed to place interventions on resident's CPs to prevent worsening of wounds

- CP lacked any intervention intended to prevent development of pressure injuries even though resident was IDd as at risk on 2 occasions & after surgical repair of 2 femur fx's; CP lacked interventions r/t pressure injuries when resident developed actual pressure injuries to bilateral buttocks; failed to place interventions to prevent pressure injuries for 1 resident who developed preventable, facility-acquired stage 3 pressure injury; further failed to place interventions on resident's CP to prevent worsening of wound

- CP lacked documentation & interventions r/t PU prevention &/or ID of facility-acquired PU on 1 resident's heel stage 3 PU; failed to place interventions to prevent pressure injuries for 1 resident who developed preventable, facility-acquired stage 3 pressure injury; further failed to place interventions on resident's CP to prevent worsening of wound
- Failed to place interventions r/t pressure injuries for 1 resident r/t stage 3 pressure injuries; further failed to place interventions on resident's CP to prevent possible worsening of wounds

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=E: Failed to secure electrical panels & cleaning chemicals in safe, locked area & out of reach of 9 cognitively impaired, independently mobile residents placing residents at risk for preventable accidents; additionally failed to implement fall interventions for 2 residents

- Observed unlocked laundry room containing 2 unlocked high-voltage circuit panels & also contained laundry detergent pods with warning label & unknown chemical inside spray bottle; findings observed on 2 units; failed to secure electrical panels & chemicals in safe, locked area & out of reach of 9 cognitively impaired, independently mobile residents placing affected residents at risk for preventable accidents
- Resident with documented falls; Observed resident in bed on multiple occasion with w/c not by bed within resident's reach per CP intervention; failed to ensure 1 resident's w/c was placed next to bed within resident's reach placing resident at risk for falls & possible injuries
- CP documented staff would toilet resident after meals & staff would place resident's w/c by bedside; observed multiple times with w/c not by resident; failed to ensure resident's fall interventions followed placing resident at risk for falls & fall-related injuries

NE: SS=J (Past Non-Compliance): Failed to provide safe environment, free from preventable accidents for 1 resident

- *On 5-29 at 12:15pm transportation staff strapped resident's w/c into facility's transportation van but did not place seatbelt around resident; when staff braked before making turn & resident slid out of w/c onto van floor; resident taken to hospital for eval where it was found to have tibia & fibula fx's as result of accident placing resident in immediate jeopardy*
- **Abatement Plan:**
 - *OT eval for resident ordered*
 - *All facility transportation suspended until training & competencies completed by transportation staff*
 - *Resident's CP updated*
 - *Transportation staff completed competencies*

SW: SS=K (Abated to E): Failed to ensure environment as free from accident hazards as possible when hot water in 4 resident rooms & beauty shop measured at hazardous levels ranging from 138 & 157 degrees F; failure affected 6 residents, 2 or which were cognitively impaired & independently mobile & any resident who received services in beauty shop rinse sink placing resident in immediate jeopardy to health & safety & at risk for burns & injury r/t hot water exposure; furthermore, facility failed to thoroughly document & place effective interventions for 12 documented falls in 2 months for 1 resident; facility also failed to conduct thorough fall investigations & provide adequate supervision & effective all interventions to prevent falls for 1 cognitively impaired resident who fell multiple times with no fall prevention interventions implements & 2 falls resulted in major injury which required emergency medical treatment & surgical repair

- Water temps in 1 room at 157 degrees F; 1 room at 144 degrees; 1 room at 152 degrees; 1 room at 140 degrees; beauty shop at 138 degrees F in rinse sink; maintenance staff reported unaware of small water heater & had not been monitoring that tank;
 - **Abatement Plan**
 - Staff in-serviced on facility physical environment-water temps P&P & staff not be allowed to work until signatures received
 - Drained hot water tank at end of hall
 - Checked temps of all rooms after tank drained & all were below 120 degrees F
 - Ordered new temp gauge for hot water tank
 - Facility will check water temps daily x 30 days for affected rooms then resume weekly temp checks per policy
 - QAPI meeting held
- Failed to provide necessary care & services to attain or maintain highest practicable physical, mental & psychosocial wellbeing for cognitively impaired resident who was IDd with high risk for falls; failed to implement interventions after multiple falls; 1 fall resulted in fx'd hip, resident with 6 mores falls, 1 resulting in another fx hip resulting in deficient practice for quality of life & had negative psychosocial outcome r/t risk for further falls, further injury, pain, decreased ROM & delayed healing of surgical repairs; failed to ensure appropriate & effective fall prevention interventions & thorough fall investigations for cognitively impaired resident who was IDd with high risk for falls & had fall hx, to prevent repeated falls with major injury; failed to implement fall prevention interventions after multiple falls experienced by resident which resulted in fx'd hip & required hospitalization & surgical repair; resident fell 4 additional times in current month resulting in skin tears & placing resident at risk for further injury & delayed healing to hip fx; less than 1 months after resident's fall with hip fx, resident fell again resulting in another fx'd hip which also required hospitalization & surgical repair; resident fell again for 7th time in 2 months
- Failed to thoroughly document & place effective interventions for each of 1 resident's 12 documented falls in approximately 2 months

NW: SS=G (Past Non-Compliance): Failed to safely operate a mechanical lift resulting in fall with injury

- *On 5-22 CNA prepared resident for mechanical lift transfer from bed to w/c; CNA failed to ensure lift sling harness loops were attached to mechanical lift correctly; during transfer resident fell out of lift sling to floor & required emergency transfer & evaluation; resident then transferred to higher level of care to treat comminuted distal femoral fx as result of incorrect placement of harness loops & subsequent fall placing resident at risk for unnecessary injury & pain*
- **Past Non-Compliance Plan:**

- Education on ceiling lift policy & use
- Lift Triple Check System initiated & checks placed on all lifts in facility
- Resident's CP re-evaluated on return from hospital & will be monitored weekly during At Risk meeting & monthly QAPI meetings

F695 Respiratory/Tracheostomy Care & Suctioning

NW: SS=J (Past Non-Compliance); Failed to ensure 1 resident received physician-ordered O2 as required resulting in respiratory distress & arrest placing resident in immediate jeopardy

- POS for O2 at 4L continuously; NN documented LN called to w/p & resident's eyes rolled into back of head & resident with grey skin color & no respirations & no response to verbal or painful stimulation; LN noted resident did not have supplemental O2 on; resident responded briefly prior to becoming unresponsive again; staff failed to apply continuous O2 during bathing as ordered; failed to provide resident with continuous supplemental O2 as ordered by physician placing resident in immediate jeopardy
- Abatement Plan
 - Re-education for all nursing staff on importance of providing necessary care including administering O2 appropriately per orders
 - Appropriate staff completed O2 competency check-off completed
 - Incident reviewed by QAPI

F698 Dialysis

SW: SS=D: Failed to develop a comprehensive person-centered CP for 1 resident's hemodialysis; resident received dialysis 3x/wk with potential to lead to uncommunicated needs r/t dialysis care which could lead to negative impacts on resident's physical, mental & psychosocial wellbeing

- CP lacked documentation r/t insulin use of dialysis; Review of 3-29-24 thru 5-30-24 Dialysis Communication sheets used to communicate care between Dialysis center & facility r/t each dialysis tx for 1 resident revealed facility staff did not fill out bottom section of form post dialysis for 1 resident on numerous occasions; failed to ensure & develop a comprehensive person-centered CP to ensure coordination of care for resident r/t 3x/wk hemodialysis received outside facility at local Dialysis Center with potential to lead to uncommunicated needs that would negatively affect physical, mental & psychosocial wellbeing of 1 resident

NE: SS=D: Failed to consistently communicate 1 resident's medical condition with pre-dialysis assessment prior to hemodialysis placing resident at risk of potential adverse outcomes & physical complications r/t dialysis

- Review of clinical record including facility communication forms lacked evidence of pre-hemodialysis assessment for dialysis on 9 occasions from 4-24-24 thru 6-14-24; failed to consistently communicate 1 resident's medical condition with pre-dialysis assessment prior to hemodialysis placing resident at risk of potential adverse outcomes & physical complications r/t dialysis

F700 Bedrails

NE: SS=D: Failed to ensure that 1 resident had documented risk assessment for use of side rails, consent for use of side rails & failed to ensure resident/representative were advised of risks &/or benefits of use of side rails placing resident at risk for uninformed decisions & impaired safety r/t risks associated with use of side rails

- CP lacked evidence of documentation of safety assessment & use of bedrails; EMR lacked evidence of safety assessment for side rails prior to installation of bed canes & facility unable to provide risk assessment & consent for use of bed canes for 1 resident; failed to ensure that resident had documented side rail risk assessment, a consent for use of side rails & failed to ensure resident/representative were advised of risks &/or benefits of use of side rails placing resident at risk for uninformed decisions & impaired safety related to risks associated with use of side rails

F725 Sufficient Nursing Staff

SW: SS=F: Failed to ensure adequate staffing to meet needs of residents of facility; in 2023 facility lacked 8-hour RN coverage for 29 days as reported by facility; in 2023, facility lacked 24-hour LN coverage for 127 days, about 35% of year; practice affected all residents in facility

- Multiple residents reported issues involving lack of staff, staff do not respond to call lights promptly & regularly not answered for over 45 minutes/20-30 minutes on any shift & weekend staffing slower & staff slow to respond & said waited 45 minutes for staff assist with toileting
- PBJ for 2023 reported documented facility lacked 8 hour RN coverage: 3 days in January, 5 days in February, 3 days in March, 6 days in April, 5 days in May, 1 day in July, 2 days in August, 4 days in November
- PBJ for 2023 reported facility lacked LN coverage: 17 days in January, 18 days in February, 17 days in March, 15 days in April, 7 days in May, 6 days in June, 1 day in July, 11 days in August, 10 days in September, 6 days in October, 2 days in November, 17 days in December
- Multiple direct care staff reported low staffing concerns; failed to provide sufficient staffing to meet needs of residents to include 8-hour RN coverage & 24-hour LN coverage; failure with potential to negatively affect all residents in facility & placed residents at risk for decreased quality of life, treatment & care

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

SW: SS=F: Failed to ensure 8-hour RN coverage each day as required in order to meet needs of residents; failure had potential to negatively affect all residents in facility & placed residents at risk for decreased quality of life, treatment & care

- Cited findings noted in F725 r/t sufficient staffing; observed numerous (5 or more) instances of residents hollering out from room for assist from staff; almost constant sounds of call lights in hallways but no visual indication of room activated when looking down each hallway; observed multiple instances of residents asking surveyors for assistance & stating waiting on staff for help but had not come; surveyors went to find staff & had to catch staff between rooms; multiple direct care staff reported low staffing concerns; failed to ensure

8 hour RN coverage each day, as required, in order to meet needs of residents; failure had potential to negatively affect all residents in facility & placed residents at risk for decreased quality of life, treatment & care

F742 Treatment/Services Mental/Psychosocial Concerns

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

- CP lacked guidance to address resident's PTSD or resident's adjustment difficulties &/or hx of trauma; Cp lacked any description of resident's indications of distress &/or interventions intended to assist resident to reach maintain highest level of mental & psychosocial wellbeing; failed to provide necessary behavioral health care & services to attain or maintain highest practicable physical, mental & psychosocial wellbeing for 1 resident who had hx of personal trauma & dx of PTSD

F756 Drug Regimen Review, Report Irregular, Act On

SW: SS=D: Failed to follow up on pharmacy recommendations in timely manner for 1 resident r/t needed Lorazepam to obtain new prescription every 14 days to minimize or prevent adverse consequences r/t medication therapy

- Failed to follow up on pharmacy recommendations in timely manner for resident r/t needed Lorazepam to obtain new prescription every 14 days to minimize or prevent adverse consequences r/t medication therapy

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SW: SS=D: Failed to ensure 2 residents r/t PRN Lorazepam & 1 resident r/t failure to monitor use of antipsychotic medication

- Consulting Pharmacist noted resident with PRN Lorazepam with no end date & EMR lacked physician response; failed to obtain new orders ever 14 days or provide appropriate rationale for extended PRN use of Lorazepam for resident as required
- Record lacked evidence facility completed AIMS assessments quarterly while resident continued use of antipsychotic meds; failed to ensure staff performed AIMS for 1 resident quarterly & PRN when resident received antipsychotic meds for extended period of time

F804 Nutritive Value/Appear, Palatable/Prefer Temp

SW: SS=F: Failed to serve residents of facility food which was palatable, attractive & served at appropriate temps

- Resident stated when staff delivered meals to room, food always cold; survey team requested sample tray & vegetables measures at 122 degrees F which was below required serving temp of 135 degrees F; team tasted tray for palatability & determined vegetables not palatable due to temp; failed to serve residents of facility food was palatable, attractive & served at appropriate temps

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SW: SS=F: Failed to prepare & serve food under sanitary conditions to residents of facility appropriately to prevent potential for foodborne illness with potential to negatively affect all residents of facility

- Observed: kitchen with opened, undated foods; spoiled produce; unlabeled, undated foods

NE: SS=E: Failed to ensure that food items were properly stored in safe & sanitary manner after original sealed package had been opened; failed to ensure all foods were labeled & dated after opening placing affected residents who ate food from facility at risk for foodborne illness

- Observed ice machine with lid up & bowl sitting on top of ice; steam table in freezer with meat in plastic bag w/o label or date; bag of vegetables & frozen cookie dough open to air & undated in freezer
- Observed open undated foods; undated foods; foods open to air unlabeled & undated

F814 Dispose Garbage & Refuse Properly

SW: SS=F: Failed to properly dispose of garbage & refuse by not ensuring dumpster lid was always closed

- Failed to properly dispose of garbage & refuse by not ensuring dumpster lid was closed at all times

F835 Administration

SW: SS=F: Failed to put in place an effective administration who ensured facility was administered in manner that enabled it to use its resources effectively & efficiently to attain or maintain highest practicable physical, mental & psychosocial wellbeing of each resident who resided at facility placing residents at risk for decreased quality of care, quality of treatment, & sense of wellbeing

- Referenced: F550, F580, F584, F600, F609, F610, F637, F641, F656, F657, F677, F684, F686, F689, F698, F725, F727, F742, F756, F758, F804, F812, F814, F851, F867, F880 and FF835
- Failed to have effective administration to ID & develop corrective action plans for potential quality deficiencies as found on current survey placing residents at risk for decreased quality of care quality of treatment, & sense of wellbeing

F851 Payroll Based Journal (PBJ)

SW: 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 PBJ r/t LN staffing information when facility failed to accurately report RN coverage on 29 dates between January 1, 2023 & 9-30-23

- Adm nurse stated facility had RN on duty on all days except 1 cited date & PBJ report was inaccurate; failed to electronically submit to CMS with complete & accurate direct staffing information, based on payroll & other verifiable & auditable date in uniform format

according to specifications established by CMS PBJ r/t LN staffing information when facility failed to accurately report 24 hour per day RN coverage on 29 days between 1-1-23 & -30-23

F867 QAPI/QAA Improvement Activities

SW: SS=F: Based on survey & numerous findings of deficient practice including 5 IJ citations which constituted Substandard Quality of Care & with several of deficient practice areas noted as repeat citations from prior survey, facility failed to demonstrate an effective QAPI program with potential to affect all residents of facility & placing all residents at risk for decreased quality of life, decreased quality of care & continued resident to resident abuse

- Cited findings from previous annual re-survey results & multiple complaint surveys and F550, F580, F584, F600, F609, F610, F637, F641, F656, F657, F677, F684, F686, F689, F698, F725, F727, F742, F756, F758, F804, F812, F814, F851, F867, F880 and FF835
- Failed to have an effective QAPI program to ID quality issues in facility & implement & maintain corrective actions to ensure highest mental, physical, & psychosocial wellbeing of each resident with potential to affect all residents of facility & placed residents at risk for substandard quality of care

F880 Infection Prevention & Control

SW: SS=F: Failed to maintain an effective infection control program when laundry services failed to maintain a closed clean linen cart while delivering laundry & further failed to maintain EBP when providing cares to resident with chronic wound

- Observed laundry aide push laundry cart down hall with cover down, raised cover & delivered laundry items to resident's room, exited room, performed hand hygiene then delivered linens to 2nd resident's room & left laundry cart in hall with raised cover
- Observed LN provided wound care & LN stated staff should have been on EBP during wound care & should have implemented EBP intervention but did not; failed to maintain effective infection control program with failure of laundry services to maintain closed clean linen cart while delivering laundry & failure to maintain EBP when providing cares to resident with chronic wound

NE: SS=E: Failed to follow sanitary infection control standards r/t EBP, hand hygiene & disinfection of shared mechanical lifts placing residents at risk for infectious diseases

- Observed CNA pushed Hoyer lift out of resident's room & walked back into room w/o sanitizing lift; observed soiled linens on floor of 1 resident room
- Observed CNA M exited R1's room with the Hoyer lift while wearing an enhanced barrier precaution gown. CNA M removed the gown and discarded it in the "Utility" room. The mechanical lift was not sanitized after use. CNA M retrieved a glass of orange juice and took it to a resident at the dining room table. CNA M did not complete hand hygiene after handling the Hoyer lift and removing her gown, and before or after she served drinks to residents; failed to follow sanitary infection control standards r/t EBP, hand hygiene & disinfection of mechanical lifts placing residents at risk for infectious diseases

F883 Influenza & Pneumococcal Immunizations

NE: SS=D: Failed to offer &/or obtain PCV20 pneumococcal vaccination & influenza vaccination consents or informed destinations for 1 resident increasing risk for influenza, pneumonia & related complications

- 1 resident's record lacked documentation that PCV20 vaccine of influenza vaccine for last flu season was offered & given or declined; failed to obtain PCV20 or influenza vaccine consents or declinations for 1 resident who was eligible to receive vaccinations placing resident at increased risk for acquiring, transmitting, or experiencing complications from pneumococcal disease or influenza

July, 2024

F609 Reporting of Alleged Violations

NE: SS=D: Failed to report an allegation of abuse between staff & 1 resident & an injury of unknown source for resident to State Agency (SA) as required placing resident at risk for unidentified & ongoing abuse

- CP documented resident with bruising on both upper extremities due to thin skin & meds; CNA told hospice nurse that at times another CNA could be rough when transferring & rolling residents; hospice nurse reported bruising on resident's left upper arm; Adm staff stated investigation on bruising did not find any abuse so it was not reported to SA; failed to report allegation of abuse & injury of unknown origin for 1 resident to SA placing resident at risk for unresolved & ongoing abuse