February, 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
CP=Care Plan; CP in pharmacy regulations=Consultant Pharmacist
PU=Pressure Ulcer; ID=identify

October, 2023

F550 Resident Rights/Exercise of Rights
SE: SS=D: Failed to show respect & dignity to 1 resident by failing to ensure resident had appropriate clothing to wear rather than hospital-type gowns

- Staff reported resident came to facility w/o clothing; resident stated did not have any clothing to wear so facility kept resident in hospital gown & would like to have some clothing to wear through day; failed to show resident respect & dignity by not having clothing other than hospital-type gown for resident to dress in

F558 Reasonable Accommodations Needs/Preferences
SE: SS=E: Failed to ensure all residents were free from accident hazards r/t several residents no having access to call lights while in beds

- Observed multiple residents on multiple occasions in bed with call light out of reach; failed to ensure all residents were free from accident hazards by not having access to call lights while residents in bed

F584 Safe/Clean/Comfortable/Homelike Environment
SE: SS=E: Failed to maintain a clean, comfortable & homelike environment, r/t concerns in clean utility closet on 1/4 resident halls

- Observed COVID tests stored directly on floor; unopened briefs stored directly on floor; handwashing sink with random pieces of trash

F625 Notice of Bed Hold Policy Before/Upon Transfer
SE: SS=D: Failed to provide a bed hold notice to 2 residents/representatives when residents were sent & admitted to hospital placing 2 residents at risk to not be allowed to return to former rooms at facility

- CAA lacked documentation r/t hospitalizations; POS lacked orders to send resident to hospital or for post-hospitalization & readmission monitoring; failed to provide a bed hold notice to 1 resident/representative when resident sent & admitted to hospital placing resident at risk to not be allowed to return to former room at facility
- EMR lacked bed-hold for 1 resident's hospital admission; failed to provide a copy of facility bed hold policy for resident/representative with a written notice specifying duration & cost of bed hold policy at time resident transferred to hospital

F637 Comprehensive Assessment After Significant Change
NE: SS=D: Failed to ID a significant change in physical condition & complete a comprehensive "Significant Change MDS for 1 resident placing resident at risk of unidentified care needs

- Quarterly MDS lacked documentation that resident was receiving hospice services at that time; EMR lacked evidence significant change MDS completed for resident after resident went on hospice services; failed to ID significant change in physical condition & complete comprehensive Significant change MDS for resident when resident admitted to hospice care placing resident at risk for unidentified care needs

F656 Develop/Implement Comprehensive Care Plan
SE: SS=D: Failed to develop & implement a comprehensive person-centered CP for 3 residents r/t failure to develop CP until resident's death for 1 resident & 2 residents r/t failure to CP r/t O2 usage placing residents at risk to not receive appropriate cares & treatments

- EMR documented resident received O2 therapy; Failed to develop & implement a comprehensive person-centered CP for 1 resident placing resident at risk to not receive appropriate cares & treatments
- CP lacked guidance r/t resident's O2; failed to develop & implement person-centered comprehensive CP for use of O2 for resident r/t use of O2
- CP documented initiated 4 days after resident expired; failed to include O2 therapy & interventions for resident's breathing issues on comprehensive CP

F657 Care Plan Timing & Revision
SE: SS=D: Failed to review & revise person-centered CP for 3 residents: 1 resident r/t interventions to mitigate fall risk; & 2 residents r/t interventions to treat/prevent PU/injury development placing residents at risk to not receive appropriate cares & treatments

- Failed to review & revise comprehensive person-centered CP for 1 resident placing resident at risk for additional falls & potential for injury

- Failed to review & revise comprehensive person-centered CP for 1 resident placing resident at risk for complications & delayed healing of existing PU/injury resident resident's foot
- Failed to review & revise resident's CP following changes in resident's skin condition & development of PUs to promote healing & prevent development of further ulcers

NE: SS=D: Failed to review 1 resident's CP to include hand splint placing resident at risk or worsening contracture along with loss of independence

- CP lacked direction to staff for hand splint; failed to revise resident's comprehensive CP with direction for hand splint placing resident at risk of worsening contractures & further loss of independence with ADLs

F677 ADL Care Provided for Dependent Residents

SE: SS=F: Failed to ensure necessary services to maintain good personal hygiene for 9/10 residents sampled

- Review of "tasks" documented from 9-19-23 through 10-28-23 resident received 3 showers in 28 days; observed resident with long fingernails & soiled; skin flaky; hair untidy & sticking up; resident stated staff seldom offered bathing opportunities; failed to ensure necessary services to maintain good personal hygiene with bathing or fingernail care for 1 resident
- Failed to ensure necessary services to maintain good personal hygiene for resident r/t bathing; observed resident's hair with visible matting & oily & fingernails with black matter & resident stated staff do not give resident enough baths & wants a bath at least 1x/wk, not 1x/month
- Observed resident with stubbled beard approx. ¼ inch long; hair visibly dirty & oily; resident stated did not get offered a shower or shave as scheduled; failed to ensure necessary services to maintain good personal hygiene for resident
- Observed resident with unkempt hair stringy & appeared oily; resident voiced complaint about lack of bathing & received "very few showers" & was supposed to get at least 2 showers/wk; failed to bathe dependent resident per resident's preference
- Observed resident with facial hair growth & uncombed hair on multiple occasions; resident stated not happy & did not get shower again & received showering "very seldom"; failed to meet ADL needs of 1 resident by not bathing resident per preference & bathing schedule by only providing 4/8 baths scheduled
- Observed resident with greasy hair on multiple occasions; resident stated had not had shower since admission & would like to be given shower; failed to bathe dependent resident since admission to facility, a total of 25 days
- Observed resident with long, jagged, dirty fingernails & hair greasy on multiple occasions; failed to bathe & trim & clean fingernails of dependent resident
- Observed resident's fingernails long, jagged & dirty & with unkempt facial hair on multiple occasions; failed to trim & clean fingernails of dependent resident & failed to shave facial hair on regular basis
- Observed resident with fingers of hand contained dried substance between fingers & nails on both hands long, jagged & dirty & had long facial hair on chin on multiple occasions; failed to clean dependent resident's hand to prevent a build up of dried food substances between fingers; further failed to shave resident's facial hair & failed to keep resident's fingernails trimmed & cleaned

F679 Activities Meet Interest/Needs Each Resident

SE: SS=D: Failed to provide ongoing program of appropriate activities for 1 resident

- Documentation for resident for activities from Admission to current revealed resident participated in no activities other than watching TV 6 x's; no other activity documentation available; resident w/o activity schedule in room; resident stated would like to attend activities but had not been invited to attend & unsure of what activities were taking place in facility; failed to provide ongoing program of appropriate activities for dependent resident

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

SE: SS=D: Failed to reposition 1 resident with high risk for development of PUs over 2 hours & 15 minutes; additionally, facility failed to implement interventions to prevent further development of pressure areas for 1 resident

- Failed to perform ongoing turning & repositioning interventions to prevent development of pressure ulcer/injury areas for resident
- Failed to ensure provision of RD nutritional assessment for resident with PU/injury to promote healing & prevent further development of PUs

F688 Increase/Prevent Decrease in ROM/Mobility

SE: SS=D: Failed to provide restorative services for 1 resident to maintain or prevent decline in ROM ability

- EMR lacked evidence of restorative program for resident; observed resident with contracted hand; failed to provide restorative services for dependent resident with contracture to maintain or prevent decline in ROM ability

F695 Respiratory/Tracheostomy Care & Suctioning

SE: SS=D: Failed to ensure 1 resident's O2 tubing dated to ensure safe O2 treatment & failed to document in clinical records when resident required use of O2, IDd by staff that resident required O2 continuously

- CP lacked guidance r/t resident's O2; TAR lacked documentation that resident had O2; observed O2 lacked date when tubing had been replaced & no humidifier on concentrator; failed to ensure resident that required O2 had tubing dated to ensure safe O2 treatment & failed to document resident required use of O2 in TAR, IDd by staff that resident required O2 continuously

F699 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to provide care & services to prevent decrease in ROM/mobility &/or development of contractures for 1 resident placing resident at risk of loss of ability to perform ADLs & development or worsening of contractures

- Cited findings noted in F657 r/t hand splint not included in CP; observed resident w/o splint or pillow for hand elevation on multiple occasions; staff stated unaware of hand splint for resident; failed to ensure 1 resident received services & treatment for hand/arm contractures to prevent avoidable reduction of ROM &/or mobility placing resident at risk for further decline in independence & decreased ROM

F692 Nutrition/Hydration Status Maintenance

NE: SS=D: Failed to provide consistent weekly weight monitoring as IDd on resident's nutritional CP & physician orders placing resident at risk for complication r/t weight loss & malnutrition

- Resident with "overweight" & required set up assist with meals; CP instructed staff to weigh weekly x 4 weeks after admission then as ordered; POS for weekly weights; resident with dysphagia & reflux; GI consult r/t weight loss pattern; EMR for 35 weekly revealed 16 missed weekly weights; staff reported resident weighed q 2 weeks; failed to provide consistent weekly weight monitoring as IDd on resident's nutritional CP & physician orders placing resident at risk for complication r/t weight loss & malnutrition

F725 Sufficient Nursing Staff

SE: SS=F: Failed to ensure sufficient qualified nursing staff available at all times to provide nursing & related services to meet residents' needs safely & in manner that promotes each resident's rights, physical, mental & psychosocial wellbeing

- Facility Assessment did not specify required amount of staff required for resident care; PBJ revealed facility had excessively low weekend staffing; multiple residents stated not enough CNAs to provide care; resident stated had to wait hours for CNA to answer call light; CNA stated not enough CNAs to provide care; staff stated no restorative aide; staff stated when call-ins bath aides pulled to floor; failed to ensure sufficient qualified nursing staff to provide nursing & related services to meet residents' needs safely & in manner that promotes each resident's rights, physical, mental & psychosocial wellbeing

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

SE: SS=F: Failed to have RN for at least 8 continuous hours on 12 occasions during review period

- Failed to ensure 8 consecutive hours of RN nursing coverage to ensure adequate nursing cares provided to residents of facility

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

- Schedule revealed Adm Nurse provided RN coverage on 12 occasions & facility unable to provide verifiable clock-in times or timesheets for Adm Nurse on cited days; Adm stated no way to log hours for Adm Nurse who was previous DON due to DON being salaried; failed to provide RN service for at least 8 consecutive hours, 7 days a week placing all residents in facility at risk for decreased quality of care

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

SE: SS=F: Failed to complete annual performance review at least once every 12 months for 2/5 CNAs reviewed to ensure adequate appropriate cares & services provided to residents of facility

- Failed to completed annual performance review for 2 CNAs employed by facility for greater than 1 year to ensure adequate appropriate cares & services provided to residents of facility

NE: SS=F: Failed to ensure 3/5 CNAs reviewed had required yearly performance evaluations completed placing residents at risk for inadequate care

- 3 CNA records reviewed with no yearly performance evaluations; failed to ensure 3/5 CNA staff reviewed had required yearly performance evaluations completed placing residents at risk for inadequate care

F756 Drug Regimen Review, Report Irregular, Act On

SE: SS=D: Failed to ensure consultant pharmacist ID & reported lack of appropriate/timely AIMS for 1 resident who received antipsychotic medication

- Failed to ensure consultant pharmacist IDd & reported lack of appropriate/timely AIMS for resident administered Risperdal, an antipsychotic

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to ensure 1 resident's Diclofenac sodium gel had dosage for administration placing resident at risk for physical complications & unnecessary medication usage

- POS for Diclofenac sodium gel to apply to hip topically 4x/day r/t unilateral primary OA hip; order lacked measured dosage for staff to administer; failed to ensure medication order for 1 resident's Diclofenac Sodium gel had dosage for administration placing resident at risk for physical complications & unnecessary medication usage

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SE: SS=D: Failed to complete an AIMS assessment for 1 resident who takes antipsychotic medication

- Cited findings noted in F756 r/t lack of AIMS testing for resident taking Risperdal; Failed to complete appropriate AIMS assessments for resident receiving antipsychotic medication

NE: SS=D: Failed to document non-pharmacological intervention used & rationale for continued use of psychotropic medication with no GDR for 1 resident; facility also failed to ensure appropriate indication for use or documented physician rationale which included multiple unsuccessful

attempts for nonpharmacological symptom management & risk versus benefit for continued use of antipsychotic for 1 resident placing residents at risk for unnecessary psychotropic medication & related complications

- POS for Citalopram q hs for anxiety; record lacked evidence of GDR attempt or physician documentation of rationale for continued use of antidepressant med with no GDR; LN stated unaware of who needed GDR for psychotropic meds; failed to provide physician documented rationale stating why GDR was contraindicated for continued use of psychotropic med for 1 resident placing resident at risk for unnecessary psychotropic meds & related complications
- POS for Olanzapine r/t Alzheimer's disease, Haldol PRN for agitation r/t Alz x 14 days; facility unable to provide physician documentation for appropriate indication or documented rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of Olazapine; failed to ensure appropriate indication or required physician for continued use of antipsychotic meds for resident placing resident at risk for unnecessary psychotropic medication & related complications

F761 Label/Store Drugs & Biologicals

SE: SS=E: Failed to provide safe environment for 21 resident by failure to ensure medication cart used by facility remained locked when not in direct line of vision of nurse & CMA passing medications from carts

- Failed to provide safe environment for all residents by failure to ensure med cart used by facility remained locked when not in direct line of vision of licensed nurse passing medications from carts

F803 Menus Meet Resident Needs/Prep in Advance/Followed

SE: SS=D: Failed to ensure use of recipes reviewed by facility's RD or other clinically qualified nutrition professional for nutritional adequacy, also failure to prepare adequate nutritional food in accordance with menus/follow recipes for residents of facility

- Observed dietary staff prepared pureed diets w/o weighing or counting meat servings & adding water to contents of blender; staff stated did not know what recipe called for & did not understand measurements used in recipe; staff reported added water as facility did not have beef base to use to maintain flavor of food; CDM stated had not had onsite dietitian visit since started 10 months previously; failed to ensure use of recipes reviewed by facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; failed to follow menu with failure to follow recipes they did not understand & how to read/prepare to ensure nutritional foods for residents

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SE: SS=F: Failed to prepare, store & serve food under sanitary conditions to residents of facility

- Observed cup cake pans stacked together ready for use & pans inside with brown substance in contact in edges which would contact food when used; fridge with open-to-air meat & lacked opened date

F865 QAPI Program/Plan, Disclosure/Good Faith Attempt

SE: SS=F: Failed to maintain QAA committee that developed & implemented appropriate plans of action to correct IDd infractions of resident rights, nursing services, food & nutritional services, pharmacy services, comprehensive resident centered CPs, infection control, physical environment & quality of life & quality of care concerns for all residents

- Referenced: F677, F679, F686, F688, F695, F550, F584, F558, F625, F656, F657, F725, F727, F730, F756, F761, F803, F812, F880, F883, F921; failed to maintain QAA that developed & implemented appropriate plans of action t correct IDd infractions to meet needs of residents of facility

F880 Infection Prevention & Control

SE: SS=F: Failed to maintain an effective infection control program with failure of staff to perform proper transportation of soiled linen & hand hygiene when appropriate & failure of staff to clean resident transfer equipment between resident use with potential to negatively affect every resident in facility

- Observed CNA exited resident's room with full body lift & entered different room w/o sanitizing lift
- Observed staff carried clean linen & clean supplies into multiple rooms while carrying clean linen against persons, in & out of multiple resident rooms while manipulating hallway door handles & placing linens & supplies in residents rooms & lacked hand hygiene between delivering linen & supplies to resident rooms; failed to maintain effective infection control program with failure of staff to perform hand hygiene when appropriate & failure of staff to clean equipment between resident use with potential to cause cross-contamination between residents in facility
- Observed CNA provide incontinence care & placed soiled & wet clothing directly on floor; observed staff failed to sanitize lift between resident use; failed to ensure staff handle, store, process & transport linens to prevent spread of infection; failed to provide safe sanitary environment for residents r/t sanitizing full body lift between individual residents of facility

F883 Influenza & Pneumococcal Immunizations

SE: SS=D: Failed to ensure 2 residents acknowledged receipt of 2022-2023 vaccination information, r/t influenzas or pneumococcal vaccination; failed to ensure 1 resident acknowledged receipt r/t COVID vaccination information to make informed declination decisions as required

- Failed to ensure residents/representatives acknowledged receipt of vaccinations as required

F921 Safe/Functional/Sanitary/Comfortable Environment

SE: SS=F: Failed to provide a safe, functional & sanitary environment in kitchen

- Observed open slated iron grate surrounding ceramic tiles in food prep area & tiles not level with grate & posed a trip hazard in food prep area

November, 2023

F550 Resident Rights/Exercise of Rights

SW: SS=D: Failed to show respect & dignity to 1 resident by not having dignity bag for indwelling urinary catheter collection bag

- Observed indwelling catheter collection bag stored directly on floor & lacked dignity bag & was visible to residents & staff in hallway on multiple occasions; failed to ensure 1 resident was treated with dignity when bag not provided for indwelling catheter bag

NE: SS=D: Failed to ensure resident's rights & dignity were respected by staff with 2 residents both dependent residents, sat at dining table as staff stood in between resident to assist residents with eating placing residents at risk for decreased self-esteem & impaired dignity

- Observed resident in w/c at dining room table & other resident in Broda chair on other side of same table & CNA stood in between 2 residents while assisted 2 residents to eat; failed to ensure residents' rights & dignity were respected by staff when staff stood in between 2 residents to feed them meal placing residents at risk for decreased self-esteem & impaired dignity

NW: SS=D: Failed to promote dignity for 1 resident who was observed by resident of opposite sex while in shower & for 2 resident who did not have dignity bags over urine collection bags placing residents at risk for undignified care & services

- Resident stated was in shower & CNA opened door to shower room & started to bring male resident through door & male resident stated saw nude & CNA yelled at them to leave but it was too late & male resident had already seen resident & resident stated was "mortified"; Adm nurse unaware of incident & was very surprised that resident had not told Adm as they talked with resident almost daily; failed to promote dignity for 1 resident when staff failed to prevent resident of opposite sex from viewing resident in shower placing resident at risk for undignified experience
- Failed to ensure privacy bag provided to 1 resident to cover urinary catheter collection bag placing resident at risk for undignified experiences & embarrassment
- Failed to cover 1 resident's urinary catheter bag placing resident at risk for embarrassment & undignified living environment

F554 Resident Self-Administration of Meds-Clinically Appropriate

NE: SS=D: Failed to ensure 1 resident was assessed for ability to safely self-administer medications placing resident at risk for unsafe medication administration & adverse side effects

- CP lacked staff direction for resident's safe self-administration of meds/ointments; record lacked evidence of self-administration of meds; observed Vicks VapoRub on resident's nightstand & resident stated had Vicks since had been ill with COVID; resident stated did not believe nursing staff was aware resident had Vicks & put on Vicks before went to bed; failed to ensure resident was assessed for ability to safely self-administer meds placing resident at risk for adverse side effects & unsafe medication administration

F558 Reasonable Accommodations Needs/Preferences

NE: SS=E: Failed to provide w/c foot pedals for 4 residents placing residents at risk for impaired safety & comfort

- Observed staff transporting resident & w/c lacked foot pedals & resident's feet slid on floor as being pushed for multiple residents on multiple occasions; failed to use w/c foot pedals for 4 residents placing residents at risk for impaired safety & comfort

F565 Resident/Family Group & Response

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

- Review of Resident Council minutes indicated council had recurring concerns with staff not verifying meal tickets, offering choices, availability of snacks & fruits & vegetables, not taking orders before meal service & posting daily menus, call light response times; failed to adequately address & resolve recurring issues reported by Resident Council placing residents at risk for decreased psychosocial wellbeing & impaired quality of life

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

SE: SS=D: Failed to ensure resident/representative right to be informed, in advance of risks & benefits of proposed care & of treatment & treatment alternatives as well as right to choose options/treatments; on 11-14 resident's provider ordered Rexulti & failed to notify resident's representative of new order for Rexulti

- *Resident with major depressive d/o, vascular dementia with behavioral disturbance & major neurocognitive d/o; POS for Rexulti for agitation due to major neurocognitive d/o; LN documented spoke with representative's concerns about Rexulti & was not notified until pharmacy called them to see if they wanted medication filled due to cost of medication; nurse "sent order to pharmacy & did not notify facility of new order"; record lacked risk/benefit statement for Rexulti; representative reported facility failed to notify of change in medication pharmacy notified representative prior to filling r/t copay of $148 & would not have become aware of medication changes; failed to notify resident's representative of new medication initiated*

NE: SS=D: Failed to notify 1 resident's medical provider of weight loss or changes in meal intake placing resident at risk for complication r/t weight loss & malnutrition due to delayed physician involvement

- EMR between 10-25 through 11-1 lacked evidence physician notifications r/t weight loss or change in oral intake; EMR lacked meal intake monitoring from 10-21 to 10-29 for all meals; failed to notify 1 resident's medical provider of weight loss or changes in meal intake placing resident at risk for complication r/t weight loss & malnutrition due to delayed physician involvement

F583 Personal Privacy/Confidentiality of Records

NE: SS=D: Failed to secure PHI for 1 resident placing resident at risk for decreased psychosocial wellbeing due to lack of privacy

- Observed med storage room door propped fully open & unattended & laptop on top of med cart left unlocked with 1 resident's MAR displayed facing towards door & visible from doorway; failed to secure PHI out of view for 1 resident placing resident at risk for decreased psychosocial wellbeing due to impaired privacy

F585 Grievances

NE: SS=E: Failed to adequately resolve 1 resident's grievances r/t ongoing dietary concerns placing resident at risk for decreased psychosocial wellbeing

- CP documented resident requested "no pork"; POS for regular diet with "no pork"; Grievance Logs indicated grievance for resident but facility unable to provide grievance form r/t grievance; resident stated had complained to facility & staff multiple times & continue to receive pork; observed resident served biscuits & gravy & resident refused tray r/t gravy with pepper sausage; CNA stated all residents received same meals for breakfast; representative stated facility not checking dietary tickets before serving meals; failed to adequately resolve resident's grievances r/t ongoing dietary concerns placing resident at risk for decreased psychosocial wellbeing

NE: SS=D: Failed to log grievances received from or about 1 resident & failed to record actions taken & provide a resolution to resident/representatives r/t grievances placing resident at risk for unresolved grievances & decreased quality of care

- *CP documented resident would at times make threats to call staff, obsess r/t health concerns & fixate on past concerns that were resolved; Psychology note documented resident with depressed, angry mood & had negative interaction with staff member; Grievance Log lacked documentation of any concerns &/or complaints expressed by resident; resident c/o shower water temp & pressure being too low & explained there was a staff member that did not want to assist resident r/t previous incident & former Adm staff knew this; resident accused staff member of entering room in early morning to "empty commode" & stated staff member said, "cover yourself, I can see your lady parts" & did not want staff member to care for resident; resident stated had left voice messages on Adm phone but had not received any response; Adm staff denied having received any complaint, grievance or concern but then acknowledged had received letter a couple of weeks ago from resident's case manager r/t resident's concern with shower water temp & pressure & resident recently verbalized grievances r/t being able to display cat decorations at nursing station & wanting reimbursed for bed mattress which resident purchased & believed facility destroyed or discarded & wanted reimbursed for cell phone resident purchased & complaints that staff were unable to read; failed to log known grievances for resident & failed to take action to alleviate concerns & provide resolution to resident/representatives placing resident at risk for unresolved grievances & decreased quality of care*

F600 Free from Abuse & Neglect

SE: SS=G: Failed to ensure staff provided a safe environment, free from abuse for 2 residents

- *During cares on 10-26-23, CNA (agency) grabbed 1 resident by arm resulting in injury to resident's arm, near wrist which required steri-strips for wound closure; During cares for other resident, same CNA was verbally rude & physically forced a shirt on resident which resident voiced resident did not want to wear; facility notified CNA when left would not be allowed to return; failed to ensure safe environment free from abuse when 1 CNA grabbed residents arm & forced a shirt on another resident resulting in wound requiring steri-strips to close, made resident stay in bed when resident did not want to lie down & made 1 resident emotionally upset & cry; failed to prevent abuse when 1 agency CNA physically forced shirt on resident & was verbally rude to resident*

NE: SS=G: Failed to ensure 1 resident remained free from abuse when CNA struck resident on arm after resident had physical behaviors toward CNA resulting in impaired psychosocial wellbeing & placed resident at risk for continued abuse

- *Investigation revealed that as 2 CNAs transferred resident to Broda chair resident suddenly struck 1 CNA & CNA quickly released contact with resident dropping resident into chair & then slapped resident twice on each arm while yelling at resident to not hit people & resident did not react to CNA's aggression; CNA immediately escorted out of building & placed on suspension pending completion of investigation; failed to prevent physical abuse when CNA hit resident; scope & severity determined to be actual harm based on "reasonable person" concept due to circumstances of resident's impaired cognitive status & inability to self-identify & express feelings*

F602 Free from Misappropriation /Exploitation

NW: SS=D: Failed to ensure 1 resident was free from misappropriation when employee of facility used 1 resident's money to make purchases for resident but did not purchase items & could not produce receipts for money spent placing resident at risk for ongoing misappropriation & exploitation

- *NN documented staff visited with resident r/t shopping both in past & in future & obtained statement r/t issues with current shopping list to find out what was received vs what was outstanding; resident was informed that in future, activity personnel would be only ones doing resident shopping to help alleviate discrepancies with shopping trips & resident understood discussion; Incident Intake documented Adm Nurse suspected misappropriation of funds for 1 resident & SSD took money out of resident's trust account $200 on 10-20-23 & $320 on 10-26-23 to purchase items for resident & resident's partner & resident missing 2 cartons of cigarettes, battery pack, some shirts with built in bras, t-shirts with pockets, winter gloves & stocking cap; resident reported items brought to resident by SSD already opened & had not tags on them; resident did not receive any receipts & neither did BOM; facility notified police; SSD unable to produce significant evidence of what was purchased resulting in termination of SSD's employment; failed to ensure 1 resident was free from misappropriation when*

employee of facility used resident's money to make purchases for resident but did not purchase authorized items & could not produce receipts for any money spent placing resident at risk for ongoing misappropriation & exploitation

NW: SS=D: Failed to ensure 1 resident remained free from misappropriation when former staff, LN, diverted 10 oxycodone which were prescribed & dispensed for 1 resident placing resident at risk for ongoing misappropriation & untreated pain

- *Police report documented viewing video footage of LN opening drawer in rolling cart that contained prescription drugs & LN popped pills out of foil container & placed them in another drawer then took them out again & placed pills in pocket then walked into restroom then came out again then LN placed something into bag on rolling cart; later that day, law enforcement called back to facility for interrogation of LN & at first LN denied having stolen pills then admitted to stealing pills & ingesting them then law enforcement wrote LN a "Notice to Appear" in court; failed to ensure 1 resident remained free from misappropriation when former staff LN diverted 10 which were prescribed & dispensed for 1 resident placing resident at risk for misappropriation or untreated pain*

F609 Reporting of Alleged Violations

SE: SS=D: Failed to report allegations of abuse to State Survey Agency when allegation was made by 2 residents against 1 agency CMA; 1 resident reported CNA tried to get resident out of bed forcefully, grabbed resident by arm & hurt resident & 1 resident reported same resident forced a long sleeve shirt on resident when resident wanted a short sleeve shirt & treated resident with verbal abuse by being rude

- *Cited findings noted in F600; failed to report alleged violations between 1 agency CMA to 1 resident to State Survey Agency & other appropriate entities*
- *Failed to report alleged violations between same agency CNA to State Survey Agency & other appropriate entities*

F610 Investigate/Prevent/Correct Alleged Violation

NW: SS=D: Failed to investigate 1 resident's bruises of unknown origin on arm & breast area placing resident at risk for unidentified & ongoing abuse &/or mistreatment

- NN documented resident with bruises on left arm & lt breast & resident unable to recall or verbalize where bruises came from on arm & breast; record lacked further assessment or documentation of bruises & lacked evidence investigation completed to rule out abuse; failed to investigate resident's bruises on arm & breast placing resident at risk of unidentified & ongoing abuse &/or mistreatment

F636 Comprehensive Assessments & Timing

NW: SS=E: Failed to completed comprehensive MDS for 1 sampled resident & 8 unsampled residents placing residents at risk for unmet care needs & inaccurate assessments

- EMRs for 9 residents indicated MDS was in progress but not completed or submitted as required; Adm Nurse stated facility aware that MDS assessments were behind & staff trying to get them caught up; failed to complete comprehensive MDS for 9 residents placing residents at risk for unmet care needs & inaccurate assessments

F638 Quarterly Assessment at Least Every 3 Months

NW: SS=E: Failed to conduct quarterly MDS assessment in required timeframe for 5 sampled residents & 16 unsampled residents placing residents at risk for unmet care needs & inaccurate assessments

- EMR indicated quarterly MDS were in progress but not completed or submitted as required for 21 residents; Adm nurse stated facility aware MDS were behind & staff were trying to get them caught up; failed to conduct quarterly MDS within 92 days of previous assessment for 21 residents placing residents at risk for unmet care needs & inaccurate assessments

F640 Encoding/Transmitting Resident Assessments

SW: SS=D: Failed to electronically transmit 1 resident's Discharge Return not Anticipated MDS, tracking no later than 14 days after ARD &/or 7 days after completion date of MDS as required

- DON stated corporate nurse completed MDS & was unaware of reason it was not electronically transmitted; failed to electronically transmit resident's Discharge Return not Anticipated MDS in timely manner as required

F641 Accuracy of Assessments

SE: SS=D: Failed to accurately complete MDS for 1 resident r/t use of CPAP machine placing resident at risk for uncommunicated care needs

- MDS documented resident did not received O2 or non-invasive mechanical ventilator use; CAA lacked documentation r/t O2 therapy or CPAP use; CP lacked instructions r/t CPAP use; POS lacked orders r/t O2 therapy or CPAP use; MAR & TAR lacked documentation r/t administration of O2, changing O2 tubing, care of O2 concentrator or humidifier, administration of CPAP use & care of CPAP equipment; NN documented use of CPAP & O2 on multiple occasions; failed to accurately complete MDS for 1 resident r/t O2 & CPAP use placing resident at risk for uncommunicated care needs

NW: SS=D: Failed to assess 1/12 resident cognition on MDS placing resident at risk for inaccurate CP & unmet care needs

- MDS lacked documentation r/t resident's cognition; Adm nurse stated staff failed to get interview of resident's cognition before ARD so submitted w/o information; failed to assess 1 resident's cognition on comprehensive MDS placing resident at risk for inaccurate CP & unmet care needs

F655 Baseline Care Plan

NW: SS=D: Failed to develop a baseline CP for 1 resident which addressed immediate health needs including below knee amputation, surgical incision & daily dressing changes placing resident at risk for inappropriate care due to uncommunicated care needs

- *Baseline CP lacked mention of resident's amputation &/or presence of surgical incision & related treatments; failed to develop a baseline CP for 1 resident who had new BKA & required daily dressing changes placing resident at risk for inappropriate care & services due to uncommunicated care needs*

F656 Develop/Implement Comprehensive Care Plan

SE: SS=D: Failed to develop a person-centered comprehensive CP for 1 resident r/t resident's use of CPAP placing resident at risk for uncommunicated care needs

- CP lacked instruction r/t CPAP use; POS lacked orders for CPAP; failed to develop a person-centered comprehensive CP for 1 resident r/t O2 therapy & CPAP use placing resident at risk for uncommunicated care needs

NW: SS=D: Failed to develop a comprehensive CP for 1 resident who was prescribed an anticoagulant which placed resident at risk for uncommunicated care needs

- CP lacked information nr/t use & interventions r/t use of anticoagulant; failed to develop a comprehensive person-centered CP for 1 resident placing resident at risk of complications due to uncommunicated care needs associated with use of anticoagulant

F657 Care Plan Timing & Revision

NW: SS=D: Failed to revise, update & individualize CPs for 1 resident who received insulin & 1 resident with pain placing residents at risk for inadequate & inappropriate care r/t uncommunicated care needs

- CP lacked update or revision for assessment & monitoring for hyperglycemia or hypoglycemia or for use of insulin; failed to update 1 resident's CP placing resident at risk for inadequate care due to uncommunicated care needs
- Failed to update resident's CP r/t pain placing resident at risk for inadequate care due to uncommunicated care needs

NW: SS=D: Failed to revise CP with person-centered interventions for dementia related behaviors for 2 residents placing residents at risk for abuse & decreased quality of life

- Failed to develop & implement individualize interventions &/or dementia treatment plan for 1 resident who had dementia & related behaviors placing resident at risk for abuse & decreased quality of life
- Failed to develop & implement individualized interventions &/or dementia treatment plan for 1 resident with dementia periods of anxiety placing resident at risk for decreased quality of life

F677 ADL Care Provided for Dependent Residents

SW: SS=D: Failed to ensure necessary services to maintain good personal hygiene for 1 resident r/t bathing & hair care

- Resident's family member stated had concerns that resident did not get bathed as should at least 2x/wk as requested & unsure if resident's hair washed with each bath as had requested since no longer goes to beauty shop for shampoos; Bathing tab revealed from 10—17 thru 11-13 revealed resident received 5/8 minimally required bathing opportunities & lacked bathing from 10-20 until 10-30; observed resident with hair oily & laid flat against head; staff member stated thought resident went to beauty shop for shampoos; failed to ensure necessary services to maintain good personal hygiene with bathing & hair care for resident

NE: SS=D: Failed to provide necessary care & services for ADLs for 1 resident when staff pulled on 1 resident under arms instead of using available equipment to assist in repositioning resident placing resident at risk for injury

- Resident required Hoyer lift; observed resident in w/c with Hoyer lift sling under resident & representative requested assist in repositioning resident in w/c & Adm nurse came over & attempted to reposition by standing behind resident & placing arms under resident's arms & attempted to lift resident up & back into chair 2 times causing resident's shoulders & arms to raise upward before being assisted by another staff member then repositioned resident in w/c manually w/o aid of lift; failed to provide necessary care & services needed to reposition resident in w/c when staff pulled on resident under arms instead of using available equipment to assist in repositioning resident placing resident at risk for injury

NE: SS=D: Failed to provide consistent bathing opportunities for 3 residents placing residents at risk for infections, skin breakdown & impaired dignity

- Report for 76 days indicated resident received 8 baths in 76 days with 2 refusals; resident stated had issues with no consistently giving baths & representative indicated recently facility had consistently failed to provide resident with bathing; failed to provide consistent bathing opportunities for resident placing resident at risk for infections, skin breakdown & impaired dignity for multiple residents
- Review for 104 days with 1 shower documented & 1 refusal; observed resident with hair oily & stringy; failed to provide consistent bathing for 1 resident with risk for poor hygiene & decreased self-esteem & dignity
- Review of 30 days revealed resident provided 4 shower, then 42 days & resident with 5 occasions; failed to consistently provide bathing for resident with risk for poor hygiene & decreased self-esteem & dignity

NW: SS=D: Failed to provide 1 resident appropriate ADL care which included incontinence care for resident placing resident at risk for poor hygiene & impaired quality of life

- Observed resident in w/c at DR table at 7:40am; at 9:55am CNA pushed resident to activity room & did not provide check &/or change & again at 11:10am, then at 11:30am CNA pushed resident back to DR & did not perform check &/or change; at 12:50pm CNA pushed resident to room but did not perform check &/or change; at 4:55pm CNA pushed resident into DR; failed to provide 1 resident assistive ADL care & as directed in resident's CP placing resident at risk for poor hygiene & impaired quality of life

F679 Activities Meet Interest/Needs of Each Resident

NE: SS=E: Failed to provide consistent activities for residents during weekends placing affected residents at risk for decreased psychosocial wellbeing & boredom

- Activity calendar inconsistent activities on weekends; observed scheduled activity did not occur as listed on calendar; Resident Council reported most weekends do not have staff led activities or scheduled groups for residents to attend & weekends were boring & would like to see more staff led activities & involvement; failed to provide consistent activities for residents during weekends placing affected residents at risk for decreased psychosocial wellbeing & boredom

F684 Quality of Care

SE: SS=D: Failed to address edema for 1 resident's lower extremities placing resident at increased risk for development of additional medical problems

- CAA lacked documentation r/t lower extremity edema; CP lacked documentation r/t lower extremity edema; POS for Lasix for localized edema; NN lacked documentation of lower extremity edema; failed to address edema of 1 resident's lower extremities placing resident at increased risk for development of additional medical problems

NW: SS=D: Failed to provide 1 resident necessary care & services for positioning when in w/c or assessment & care of resident's skin placing resident at risk for discomfort & potential skin breakdown

- CP instructed staff to use elbow pillow under resident's elbow when in w/c; NN documented resident with small open area to left elbow; skin assessment lacked documentation of area on left elbow; observed resident in w/c & no left elbow pillow present or in use on multiple occasions; failed to provide positioning device as CP'd for 1 resident placing resident at risk for skin breakdown & discomfort

NW: SS=D: Failed to ensure 1 resident received wound care as ordered for 4 days after BKA placing resident at risk for infection & decline

- *Hospital discharge directed staff to keep wound clean & dry & continue with daily dressing changes, 4x4 gauze, Kerlix & ace wrap until seen at follow up appointment; TAR lacked evidence staff provided resident's dressing changes until 4 days after admission; Adm nurse stated dressing change order was missed upon admission; failed to ensure resident's dressing change to surgical wound was changed daily as physician ordered placing resident at risk for infection & decline*

F686 Treatment/Services to Prevent/Heal PU

NE: SS=D: Failed to ensure pressure reducing measures were placed on 1 resident's bilateral lower extremities to prevent PU placing resident at increased risk for PU development

- CAA documented resident at risk for PUs with intervention of foam heel lift boots; Braden indicated resident was moderate risk of skin breakdown; observed resident w/o any pressure reducing/heel lift boots & heels rested directly on mattress; failed to ensure pressure reducing measures were placed on 1 resident's bilateral lower extremities to prevent PUs placing resident at increased risk for PU development

F687 Foot Care

NW: SS=D: Failed to provide foot care to 2 residents who had dx's of DM & required foot care from LN placing residents at risk for complications including poor hygiene, discomfort & injuries

- *CP directed staff to have LN provide nailcare; resident stated had 2 sore toes & prone to ingrown nails; LN removed resident's socks & looked at feet & observed toe nails very thick, brown in color & grown over tips of toes; failed to provide foot care to 1 resident who had overgrown toenails on both feet placing resident at risk for complications & injury*
- *LN stated resident received nailcare from podiatrist that came to facility so staff did not do any nail care for resident; failed to provide foot care to resident who had overgrown toenails on both feet placing resident at risk for complications & injury*

F688 Increase/Prevent Decrease in ROM/Mobility

NE: SS=D: Failed to ensure 1 resident had physician-ordered ankle foot orthotics & services to prevent reduction of ROM &/or mobility leaving resident at risk for further decline & decreased ROM or mobility

- Observed resident with feet elevated on footrest & feet/toes pointed down, toward wall across from resident; representative stated resident did not have brace for feet/ankles & had never received one & facility never got braces for resident & representative had asked about getting something to help with resident's feet before facility changed ownership & was told staff would check into it & was recently told facility was checking into getting AFO braces but still had not received them; original orders dated 10-18-23; failed to ensure 1 resident had physician-ordered AFO & services to prevent reduction of ROM &/or mobility leaving resident at risk for further decline & decreased ROM or mobility

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

- CP instructed staff to place palm cushion in resident's hand at all times that splint not on; failed to ensure 1 resident's hand palm cushion was applied as directed to prevent avoidable reduction of ROM &/or mobility leaving resident at risk for further decline & decreased ROM

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=D: Failed to evaluate causative factors in order to ID & implement interventions to prevent falls for 1 resident who had multiple falls placing resident at risk for continued falls & fall related injury

- *Resident high risk for falls; CP lacked any interventions added between 5-12-23 & 11-10-23 r/t falls sustained prior to resident's discharge from facility to ER; resident with fall but lacked root cause analysis or intervention; documentation revealed resident with multiple falls during time period; failed to ID causative factors & implement relevant interventions to prevent falls for 1 resident placing resident at risk for ongoing falls & related injuries*

F690 Bowel/Bladder Incontinence, Catheter, UTI

NW: SS=D: Failed to provide 3 residents with appropriate catheter care placing residents at risk for infection

- Observed CNA removed 1 resident's catheter bag from dignity bag & proceeded to drain urine from catheter bag into container then reattached drainage port to bag & threw catheter bag onto floor; failed o provide 1 resident who had hx of UTI with appropriate catheter care while draining urine drainage bag placing resident at risk for infection
- Observed resident at DR table & resident had not taken drink & staff had not offered drink for 49 minutes then LN administered meds in applesauce & did not offer fluids then 62 minutes after first observation dietary staff offered resident drink; observed CNA removed catheter bag out of dignity bag, drained urine into container then reattached port to bag but did not disinfect tube; failed to provide 1 resident who had hx of UTI with appropriate catheter care while draining urine drainage bag placing resident at risk for infection
- Observed resident in DR in e/x with catheter drainage bag attached to under side of w/c & bag touched floor & not covered with privacy bag on multiple occasions; observed CNA provided perirectal cleaning due to incontinence of bowel, then with same gloved hands, emptied drainage bag into measuring container & CNA did not cleanse drainage spout & placed spout back into holder & hooked bag onto trash can which remained touching floor; failed to provide acceptable catheter care for 1 resident who was at risk for UTIs & hx of repeated UTIs placing resident at risk for complications r/t catheter use

F697 Pain Management

NW: SS=D: Failed to ensure adequate pain management was provided to 1 resident when resident reported pain in hip area placing resident at risk for unrelieved pain

- Observed resident with grimacing & holding hand against hip & resident stated "it hurts"; CMA reported resident's stated pain; observed SS attempt multiple non-pharmacological pain interventions; failed to ensure adequate pain management was provided to 1 resident when resident reported hip pain placing resident at risk for unrelieved pain

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=D: Failed to provide safe environment by failing to implement interventions prevent 1 resident with moderately impaired cognition from having repeated falls

- Resident with multiple falls &1 intervention included to re-educate resident to use call light for assist but resident's MDS indicated resident with moderately impaired cognition; resident with fall from recliner & staff moved remote & resident unhappy then had fall from recliner & intervention was to re-educate resident r/t not able to have remote to recliner but resident with moderate cognitive impairment; observed resident on multiple occasions with CP interventions not in place including bent over walking with brief pulled down to knees; lift chair in high standing position with remote in chair; leaning over recliner with reached on floor between legs; no shoes on; lift chair in high position; failed to provide safe environment by failing to implement interventions to prevent 1 resident with moderately impaired cognition from having repeated falls

SW: SS=G: Failed to ensure staff safely transferred 2 sampled residents including 1 resident with required mechanical sit-to-stand lift which resulted in 3 metatarsal fx's & failed to use a gait belt

- Resident with BIMS of 6; investigation documented resident reported pain in foot & voiced concern it occurred during transfer; POS for X-ray showing possible fx; resident stated CNA transferred resident w/o use of sit-to-stand lift which was confirmed; CNA stated resident's foot got caught in front wheel of w/c; POS for surgical shoe; failed to ensure staff provided safe transfer for resident who required extensive assist of 2 for transfers with sit-to-stand mechanical lift resulting in foot 2nd, 3rd & 4th digit fx's & pain
- CP instructed staff to transfer with 2 staff; EMR documented resident with moderate risk for falls; resident with fall from shower chair & CNA reported had not used gait belt; failed to properly transfer dependent resident with gait belt which resulted in non-injury fall

NE: SS=E: Failed to secure rooms containing hazardous materials out of reach of 17 cognitively impaired/independently mobile residents placing affected residents at risk for preventable injuries & accidents

- Observed 2 spa rooms with doors propped open & rooms contained boxes of COVID-19 testing kits in unsecured closet & both rooms with germicidal cylindrical containers of wipes stored on counter with warning labels; failed to secure chemicals in safe, locked area & out of reach of 17 cognitively impaired independently mobile residents placing affected residents at risk for accidents

NE: SS=E: Failed to secure rooms containing hazardous materials out of reach of 6 cognitively impaired/independently mobile residents placing 6 residents at risk for preventable injuries & accidents

- Observed Activity Room with multiple chemicals with warning labels; fridge next to rehab gym with full bottles of drinking alcohol unsecured in fridge; unlocked laundry room with chemical storage closet unlocked with numerous hazardous cleaning agents; unlocked laundry electrical panel room & panel doors left open; failed to secure rooms containing hazardous materials out of reach of 6 cognitively impaired independently mobile residents placing residents at risk for preventable injuries & accidents

NE: SS=D: Failed to provide adequate supervision & failed to ID & implement interventions to address elopement risk & attempts for 1 resident who had exit seeking behavior & actual attempts to elope from facility placing resident at risk for elopement & other preventable accident hazards

- *CP lacked resident's elopement risk or interventions to address resident's wandering & elopement behaviors; resident with multiple behavior notes; LN stated resident moved to secure unit because had behaviors of screaming & running up & down halls & exit seeking; failed to provide adequate supervision & failed to ID & implement interventions to address elopement risk & attempts for 1 resident who had exit seeking behavior & actual attempts to elope from facility placing resident at risk for elopement & other preventable accident hazards*

NE: SS=G: Failed to provide adequate assistance during transfer to prevent injury from avoidable accidents for 1 resident who required assistance of 1 staff member with use of gait belt during transfers; as result, resident sustained medial & lateral tibial plateau fx as well as associated fibular fx & increased pain

- *CP lacked directives r/t refusals to use gait belt or directions for alternative safe transfers for 1 resident if resident refused gait belt; resident with witnessed fall from bed to w/c while being assisted by CNA; resident stated stood too long before moving to w/c & knees started to buckle; CAN assisted resident to sit on floor & leg bent when sat down; resident refused to wear gait belt; failed to follow 1 resident's CP for transfers which resulted in fall & resident sustained fx'd tibia & fibula as result of deficient practice*

NW: SS=G (Past Non-Compliance): Failed to follow 1 resident's CP which directed 2 staff to assist resident for transfers with sit to stand lift resulting in large skin tear to resident's posterior calf measuring 4.5 cm x 3 cm

- *CNA transferred resident from toilet using sit to stand lift by self & resident sustained skin tear & blood blister to posterior leg; CNA did not notice resident was bleeding from skin tear until after transferred resident back to w/c using sit to stand lift by self placing resident at risk for skin tears, pain & delayed healing; failed to follow 1 resident's CP for requiring 2 staff assist for transfers with sit to stand lift; subsequently resident acquired significant skin tear to posterior calf placing resident at risk for skin tear, pain & delayed healing*
- *Past Non-Compliance Plan:*
    - *Re-educated all staff about always having 2 staff when operating any mechanical lift & skin tear protocol including charting & dressing changes*
    - *Educated staff to keep resident's legs elevated to prevent swelling*

NW: SS=G: Failed to ID fall risk & initiate fall interventions for 1 resident when resident admitted to facility with dx of frequent falls; on 11-9 staff found resident in room on floor; resident complained of severe pain in back & was transported to local hospital where resident dx'd with 4th & 5th rib fx's on right side placing resident at risk for falls, injury & pain

- *Facility failed to perform Fall Risk Assessment upon admission & post-fall assessment indicated resident at risk for falls; N documented LN called to resident's room & door was locked; LN unlocked door & found resident laying on left side next to w/c & bed with pants ½ down with clean brief on top of resident's pants then indicated in pain; Adm nurse stated fall risk assessment not completed on admission & no fall interventions put in place at time of admission & had not read resident's hospital paperwork; failed to ID resident's risk for falls & failed to initiate fall interventions upon admission to facility; resident fell which resulted in 2 rib fx's & severe pain placing resident at risk for falls, injury & pain*

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to implement individualized interventions to improve/maintain 1 resident's bowel & bladder incontinence placing 1 resident at risk for complications r/t incontinence

- MDS documented resident with incontinence with no toileting plan; assessment indicated resident alert & oriented & had initiative & willingness to participate in toileting program & a likely candidate for bowel & bladder re-training; failed to implement individualized toileting interventions r/t bowel & bladder incontinence for 1 resident who was candidate for bowel & bladder retraining placing resident at risk for complications r/t incontinence

NE: SS=D: Failed to ensure standard of care was provide during catheter care & failed to prevent catheter drainage bag from touching floor for 1 resident with hx of frequent UTIs placing resident at risk for catheter related complications & further UTIs

- Resident with multiple UTIs; observed catheter bag laid directly on floor; observed CNA provided catheter care & during care changed gloves w/o performing hand hygiene on multiple occasions; failed to ensure standard of care was provided during catheter care & failed to prevent catheter drainage bag from touching floor for 1 resident with hx of frequent UTIs placing resident at risk for catheter related complications & further UTIs;

F692 Nutrition/Hydration Status Maintenance

NE: SS=D: Failed to monitor 1 resident's weight loss or changes in dietary intake placing resident at risk for complication r/t weight loss & malnutrition

- Resident assessed as at risk for nutritional status r/t recent illnesses; resident with significant weight loss; EMR lacked evidence of physician notifications r/t weight loss or change in oral intake; failed to monitor 1 resident's weight loss or changes in dietary intake placing resident at risk for complication r/t weight loss & malnutrition

NE: SS=D: Failed to ensure ordered dietary supplements to promote increased calorie intake were monitored for effectiveness & failed to ensure weekly weights were obtained as ordered for 1 resident placing resident at risk for continued weight loss & possible malnutrition

- EMR lacked evidence that weekly weights obtained for 2 weeks at time resident experiencing significant weight loss; failed to ensure ordered dietary supplements to promote increased calorie intake was monitored for effectiveness & weekly weights were obtained as ordered for 1 resident placing resident at risk for continued weight loss & possible malnutrition

F727 RN 8 Hrs/7 days/Wk, full time DON

NE: SS=F: Failed to provide an RN for at least 8 consecutive hours, 7 days a week & failed to designate a full time RN as DON to oversee care provided to residents placing resident at risk for decreased quality of care

- *Daily nurse staffing in November lacked evidence of RN coverage for 8 consecutive hours on 7 occasions in November; LN revealed no DON for facility; failed to provide RN for at least 8 consecutive hours, 7 days a week & failed to designate a full time RN as DON to oversee care provided to residents placing resident at risk for decreased quality of care*

F744 Treatment/Service for Dementia

NE: SS=D: Failed to provide dementia care & services for 1 resident when facility failed to ensure 1 CNA followed CP'd interventions in response to resident's dementia related behaviors creating an environment that affected resident's ability to maintain highest practicable level for physical, mental & psychosocial wellbeing & placed resident at risk for ongoing abuse

- *Cited findings noted in F600 r/t resident abuse by CNA r/t dementia related behavior of resident; failed to provide dementia care & services for 1 resident when facility failed to ensure CNA followed CP'd interventions in response to behaviors creating environment that affected resident's ability to maintain highest practicable level for physical, mental & psychosocial wellbeing & placed resident at risk for ongoing abuse*

NW: SS=D: Failed to develop & implement individualized dementia treatment plan for 2 residents who had dementia & behaviors & failed to provide necessary dementia care & services to attain or maintain highest level of practicable physical, mental, & psychosocial wellbeing for 1 resident placing residents at risk for abuse & decreased quality of life

- Resident with depression, hallucinations, bipolar, anxiety; observed resident with behaviors; Failed to develop & implement individualized interventions &/or dementia treatment plan for 1 resident who had dementia & related behaviors placing resident at risk for abuse & decreased quality of life
- Resident with anxiety, insomnia, dementia with documented behaviors; EMR lacked evidence of professional mental health support services provided to resident; failed to develop & implement individualized interventions &/or dementia treatment plan for 1 resident who had dementia period of anxiety placing resident at risk for decreased quality of life

F755 Pharmacy Services/Procedures/Pharmacist/Records

SE: SS=D: Failed to ensure 1 resident received physician's ordered medication of Fentanyl patch when staff applied Fentanyl 200 mcg when physician ordered 112 mcg; failed to notify physician, perform any necessary clinical interventions, record medication as given in clinical record, observed, assess outcome of elder & document in clinical record, record any actions, clinical interventions necessary, report error on incident report & record notification of family in clinical record with any stated response, education & questions; staff also failed to notify facility Adm staff

- *Failed to ensure 1 resident received physician's ordered medication of Fentanyl patch when staff applied Fentanyl 200 mcg when physician ordered 112 mcg; failed to notify physician, perform any necessary clinical interventions, record medication as given in clinical record, observed, assess outcome of elder & document in clinical record, record any actions, clinical interventions necessary, report error on incident report & record notification of family in clinical record with any stated response, education & questions; staff also failed to notify facility Adm staff*

F756 Drug Regimen Review, Regular Irregular, Act On

SW: SS=D: Failed to follow recommendation of pharmacist for 1 resident r/t AIMS testing & 2 residents r/t PRN Lorazepam to obtain new prescription every 14 days

- MRR requested AIMS test on multiple occasions & facility did not act upon consulting pharmacist recommendations for AIMS assessment until months later; failed to follow up on pharmacist recommendation r/t AIMS assessment on 1 resident while resident received psychotropic medication
- POS included Lorazepam PRN ordered on 4-11-23; Seroquel BID ordered 8-2-23; Divalproex Sodium sprinkle BID r/t bipolar d/o & major depressive d/o dated 7-30-23; MRR recommended 14 day time period for Lorazepam & facility lacked evidence of any follow up on pharmacy recommendation; MRR with recommendation for GDR noting resident receiving 3 different psychoactive meds w/o GDR & physician follow up on recommendation not timely; failed to act on IDd irregularities & failed to act on CP's recommendation in timely manner
- Facility & physician failed to follow recommendation of pharmacist for 1 resident r/t stop date of Lorazepam or documented rationale r/t PRN Lorazepam

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) IDd & reported that resident's pulse was not being monitored as physician ordered prior to administration of Carvedilol placing resident at risk of unnecessary medication administration & possible adverse side effects

- POS with Carvedilol with holding & notification parameters; MAR documented pulse not being monitored prior to administration & CP did not report irregularity in monitoring pulses; pulse not documented prior to administration on 26 times in Jan, 56 x's in Feb, 62 x's in March, 60 x's in April, 62 x's in May, 60 x's in Sept, 62 x's in October & 28 x's in November; failed to ensure CP IDd & reported facility staff was not monitoring resident's pulse prior to administration of Carvedilol as physician ordered placing resident at risk for unnecessary medication administration & possible adverse side effects

NW: SS=D: Failed to ensure Consultant Pharmacist (CP) IDd & reported lack of 14 day stop date for 1 resident's PRN Lorazepam & failed to ID & report lack of appropriate indication or documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for use of antipsychotic for 2 residents placing residents at risk for unintended effects r/t psychotropic drug medications

- POS for Ativan q 2 hrs PRN for anxiety & agitation & order lacked stop date & MRR documented no irregularities; failed to ensure CP IDd & reported lack of 14 day stop date for 1 resident's PRN Lorazepam placing resident at risk for inappropriate use of PRN psychotropic medication with side effects
- EMR lacked evidence of documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of Risperidone; CP failed to ID & report 1 resident's inappropriate indication for use of antipsychotic medication placing resident at risk for unnecessary medications
- EMR lacked evidence of documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of Risperidone; CP failed to ID & report 1 resident's inappropriate indication for use of antipsychotic medication placing resident at risk for unnecessary medications

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to provide adequate pulse monitoring for 1 resident's anti-hypertensive beta-blocker placing resident at risk for unnecessary medications & adverse medication effects

- POS for Metoprolol Tartrate for HTN; MAR indicated resident scheduled to be administered at 7am & orders lacked instruction to monitor 1 resident's pulse before administration; EMR revealed no consistent pulse monitoring to correspond with administration of Metoprolol; LN stated facility currently had no standing orders to monitor meds due to recent ownership change & nurses were to use nursing judgement when administering meds; failed to provide adequate pulse monitoring for 1 resident's antihypertensive med placing resident at risk for complications r/t unnecessary meds & adverse med effects

NE: SS=D: Failed to ensure dosing instruction for Voltaren get for 1 resident; failed to follow physician ordered parameters for 1 resident's antihypertensive beta-blocker placing residents at risk for unnecessary medication use & physical complications for affected residents

- POS for Voltaren gel & order lacked dose; failed to ensure dosing instructions for Voltaren gel for 1 resident placing resident at risk for unnecessary medication
- Cited findings noted in F756 r/t lack of pulse monitoring for Carvedilol; failed to ensure staff monitored 1 resident's pulse prior to administration of Carvedilol as physician ordered placing resident at risk for unnecessary medication administration & possible adverse side effects

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SW: SS=D: Failed to have appropriate end date for PRN anti-anxiety med administered past 14-day regulatory requirements for 2 residents

- Cited findings noted in F756; Failed to have appropriate end date for PRN Lorazepam administered past 14 day regulatory requirements for 1 resident
- POS included Lorazepam PRN ordered on 4-11-23; Seroquel BID ordered 8-2-23; Divalproex Sodium sprinkle BID r/t bipolar d/o & major depressive d/o dated 7-30-23; Failed to monitor for adverse reactions of psychotropic meds for resident to ensure no unnecessary medication use

NW: SS=D: Failed to ensure a 14 day stop date for 1 residents' PRN Lorazepam; further failed to ensure 2 residents had appropriate indication or documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for use of antipsychotic placing affected residents at risk for unintended effects r/t psychotropic drug medications

- Cited findings noted in F756; Failed to ensure 1 resident was free of use of unnecessary psychotropic drugs when staff failed to obtain stop date for use of PRN Ativan placing resident at risk for adverse effects from continued use of medications
- Failed to ensure appropriate indication or required documentation for use of antipsychotic placing resident at risk for adverse side effects r/t psychotropic medication
- Failed to ensure appropriate indication or required documentation for use of antipsychotic placing resident at risk for adverse side effects r/t psychotropic medication

F760 Residents are Free of Significant Med Errors

NW: SS=D: Failed to prevent a significant medication error for 1 resident whose Zyprexa was not given for 2 days; further failed to prevent medication errors when staff crushed 3 medications for 1 resident that were supposed to be given whole placing residents at risk for decreased wellbeing & ineffective medication regimen

- MAR documented Zyprexa "not available"; CMA did not find medication & did not notify charge nurse or pharmacy; after missing 2 days medication resident sent to ER for behaviors that were unable to be redirected; failed to prevent significant medication errors for 1 resident whose Zyprexa was not given for 2 days placing resident at risk for decreased wellbeing
- Failed to prevent significant medication error when staff crushed & administered ASA due to "modified release" & Colace due to leaving bad taste & Namenda SR due to modified release placing resident at risk for adverse reaction from medication

F761 Label/Store Drugs & Biologicals

SW: SS=D: Failed to ensure appropriate storage of 1 resident's inhaler for 1/6 residents

- POS for Advair diskus; observed LN prepared to administer meds to resident & unable to locate resident's inhaler & looked in resident's room & unable to find inhaler; resident sitting at DR table & LN noted inhaler in flower arrangement on table; resident stated used inhaler at supper the night before & staff must have picked it up & placed it in flower arrangement; failed to ensure staff stored resident's inhaler in safe, sanitary manner to prevent spread of infection or inadvertent use by another resident

NE: SS=E: Failed to ensure safe storage of meds for 1/3 med rooms placing residents at risk for unnecessary medication & administration errors &/or diversion

- Cited findings noted in F583 r/t med room open & unsecured; failed to ensure safe storage of meds for 1/3 med rooms placing residents at risk for unnecessary medication & administration errors or diversion

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

- Failed to dispose outdated insulin flex pen for 1 resident placing resident at risk for ineffective medication

F801 Qualified Dietary Staff

NW: SS=F: Failed to employ a CDM placing residents at risk for unmet nutritional needs

- Failed to employ a CDM placing residents at risk for unmet nutritional needs

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

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

NW: SS=F: Failed to provide services of full time CDM for all residents who resided in facility & received meals from kitchen

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

F803 Menus Meet Resident Needs/Prep in Advance/Followed

NE: SS=D: Failed to follow 1 resident's cultural dietary preferences placing resident at risk for decreased psychosocial wellbeing & weight loss

- Cited findings noted in F585 r/t resident's grievance r/t being served pork; failed to follow 1 resident's cultural dietary preferences r/t pork products at meal services placing resident at risk for decreased psychosocial wellbeing & weight loss

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NW: SS=D: Failed to provide food prepared by methods that conserve nutritive value, flavor & appearance when dietary staff failed to follow recipe while preparing for 2 residents' pureed diets placing residents at risk for impaired nutrition

- Observed staff prepared pureed diet & failed to follow recipe while preparing; dietary staff stated not trained on how to prepare pureed diets & just used way grandmother's food used to look for reference; failed to follow recipe when preparing pureed diet for 2 residents placing residents at risk for impaired nutrition

NW: SS=F: Failed to serve palatable food during meals that maintained appetizing temperatures & conserved nutritive values for residents who resided in facility & received food from facility kitchen placing residents at risk for decreased enjoyment of meals & increased risk for weight loss

- Observed noon meal revealed staff brought insulated food cart to 1 hall dining area & staff uncovered food on steam table & obtained following temps: tortellini 161.7 degrees F, broccoli 171.7 degrees F; broccoli brown with no green visible & not readily identifiable as broccoli; dietary staff stated food item was "dead broccoli" & should not have left kitchen looking as it did; observed dietary staff plated food & included brown broccoli & served to resident who started toe at brown broccoli; resident stated food often cold, had no flavor frequently gave resident diarrhea; failed to serve palatable food during meals that maintained appetizing nutritive values for residents who resided in facility & received food from facility kitchen placing residents at risk for nutritional status problems & weight loss
- Observed hamburger temp at 127 degrees & staff gave burger to resident w/o reheating & stated "spaced it off" & did not go back & get it from resident; observed resident did not eat burger; failed to serve hamburger to 1 resident at proper temperature placing resident at risk for foodborne illness & decreased palatability

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SW: SS=F: Failed to follow proper food handling practices to prevent outbreak of foodborne illness

- Observed: fridge with opened, undated food items; dry storage with expired bread items & dented can of vegetables & food items

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

- Observed: freezer with food debris on bottom shelf; ice machine drainage pipe lacked air gap & rested directly touching on grate of floor drain; can opener with dried, sticky food debris on tip & surrounding holding device; fan with build up of dust & debris on cage surrounding blades

NE: SS=F: Failed to ensure that dietary staff appropriately dated, labeled, & stored opened foods with potential for foodborne illnesses for residents

- Observed unsealed food items in storage; fridge with opened & unsealed food items; multiple open, undated food items

NW: SS=F: Failed to prepare food in accordance with professional standards for food service safety when staff failed to check temperatures of food items prior to serving & failed to ensure clean & sanitary refrigerators & food prep areas placing residents at risk for foodborne illness

- Observed fridge with bottom 2 shelves with numerous different-sized yellow dried liquid stains & freezer with numerous undated 4-ozz health shakes; fridge in activity room with numerous undated 4 oz health shakes & bottom 2 shelves with numerous different sized red, dried, food & liquid stains; observed unlabeled, undated flour & sugar containers; failed to prepare food in accordance with professional standards for food service safety when failed to ensure clean & sanitary fridges & food prep areas placing residents at risk for foodborne illness
- Observed staff prepared pureed diets & temped pureed mac & cheese w/o temping food & temp was 112 degrees F; then attempted to serve tomato soup w/o temping food; failed to check food temps prior to serving 32 residents who received food from facility kitchen placing all residents at risk for foodborne illness

F851 Payroll Based Journal

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

- PBJ report indicated facility did not have LN coverage 24 hr/day, 7 days/wk on multiple (10) dates; failed to submit complete & accurate staffing information through PBJ as required placing residents at risk for unidentified & ongoing inadequate nurse staffing

F880 Infection Prevention & Control

SE: SS=F: Failed to ensure good infection control techniques for residents in facility by failure to change gloves & perform hand hygiene when going from soiled to clean while providing wound care for 1 resident & while providing incontinent care on resident & failure to disinfect fully body mechanical lift after use on 1 resident who required use of lift for transfers

- Observed staff provide incontinent care & failed to change gloves & perform hand hygiene prior to wiping resident's nose; observed staff failed to sanitize mechanical lift between resident use; observed incontinent care & staff failed to change gloves or provide hand hygiene after incontinence care & placed soiled pad directly on floor; failed to ensure infection control techniques for residents in facility by

failure to change gloves & perform hand hygiene when going from dirty to clean while providing incontinent care on residents & failure to disinfect mechanical lift after use on 1 resident who required use of lift for transfers

- Failed to ensure appropriate hand hygiene & glove use during wound care placing resident at risk for delayed wound healing & spread of communicable & contagious diseases in facility

SE: SS=F: Failed to maintain an effective infection control program with failure of staff to change gloves & perform proper hand hygiene between phases of wound care for 2 residents with potential to lead to cross contamination between residents & negatively affect residents that resided in facility

- *Observed LN & CNA assisted with wound care; LN placed new wound dressing supplies directly on resident's bed w/o setting up clean field with non-permeable barrier then removed old dressing & discarded soiled dressing into trash then cleansed wound with wound cleanser & gauze & failed to perform hand hygiene & change gloves, then applied Selan cream on wound bed; failed to maintain effective infection control program with failure of staff to change gloves & perform proper hand hygiene between phases of wound care & failure to place barrier for wound care supplies when staff laid clean wound dressing directly on bed with potential to lead to cross contamination between residents & negatively affect residents that resided in facility*
- *Failed to maintain effective infection control program with failure of staff to change gloves & perform proper hand hygiene between phases of wound care & failure to place barrier for wound care supplies when staff laid clean wound dressing directly on bed with potential to lead to cross contamination between residents & negatively affect residents that resided in facility*

SW: SS=D: Failed to maintain an effective infection control program r/t 1 resident r/t urinary catheter care & placement to help prevent contamination & spread of infection

- Observed resident with urinary catheter laying directly on floor w/o barrier from bag to floor on multiple occasions; observed catheter care & CNA placed collection bag onto recliner that caused bag to rest directly on floor & did not use alcohol swab to clean port after emptying catheter bag; failed to maintain effective infection control program r/t 1 resident r/t urinary catheter care & placement to prevent contamination & spread of infection

SW: SS=F: Failed to ensure sanitary storage of clean linen in beauty shop, lack of housekeeping staff knowledge of cleaning products for C-diff, use of expired sanitizing wipes & unsanitary catheter care for 1 resident

- Observed beauty shop with plastic wrapped clean towels directly on floor; during interview with housekeeping staff, staff revealed did not know what cleaning solutions were required to clean isolation room for C-diff & thought nursing staff would provide cleaning supplies; observed container of sanitizing wipes from storeroom with expired date; failed to maintain effective infection control program to ensure staff stored towels in sanitary manner, had knowledge of cleaning products required for C-diff infections & ensured stock cleaning items were not past expiration date to prevent spread of infections
- Resident with indwelling urinary catheter with orders for catheter care q shift; observed staff emptied catheter bag & disconnected nozzle from port of bag & placed it inside used urinal & nozzle came into direct contact with inside of urinal multiple times then wiped tip of nozzle with peri-wipe & reconnected nozzle into port of catheter bag; failed to properly drain urine from catheter bag into urinal for dependent resident with indwelling urinary catheter

SW: SS=F: Failed to maintain an effective infection control program with failure of staff to perform proper hand hygiene between resident contacts while delivering meal trays & failure to don appropriate PPE when delivering meals to resident under isolation precautions with potential to lead to cross contamination between residents & negatively affect every resident in facility

- *Resident with MRSA with sign indicating visitors don gown/gloves required for entry; observed dietary staff entered room & carried tray with 2 meal tray setups & failed to apply PPE then left room w/o performing hand hygiene & walked into another resident room & delivered tray then left room & failed to perform hand hygiene; failed to maintain effective infection control program & failure of staff to perform proper hand hygiene between resident contacts while delivering meal trays & failure to don appropriate PPE when delivering meals to resident under isolation precautions with potential to lead to cross contamination between residents & negatively affect every resident in facility*

NE: SS=E: Failed to ensure proper infection control standards were followed r/t catheter care, disinfecting shared equipment & storage of O2 tubing when not in use placing residents at risk for complications r/t infectious diseases

- Observed resident with nasal cannula on & O2 concentrator & nasal cannula on floor & CPAP mask draped over bedrail & not stored in bag
- Observed catheter bag laid directly on floor
- Observed CNA completed Hoyer transfer & then pushed lift from room & into hallway w/o disinfecting lift then left lift in hallway & entered another room
- Observed CNA performed catheter care & during care changed gloves w/o performing hand hygiene; failed to ensure proper infection control standards were followed r/t hand hygiene during catheter care, catheter bags resting on floor, disinfecting of shared equipment, & storage of O2 tubing when not in use placing residents at risk for complications r/t infectious diseases

NW: SS=D: Failed to change gloves & perform adequate hand hygiene when providing 1 resident with incontinent cares placing resident at increased risk for infection

- Observed CNA performed incontinent care & CNA removed wet brief then with same soiled gloves applied new incontinent brief then dressed resident with same soiled gloves then removed gloves but did not sanitize hands; failed to change gloves & wash hands when providing 1 resident incontinent cares & continued to provide care with same soiled gloves &/or hands placing resident at risk for infection

NW: SS=D: Failed to use acceptable infection control practices r/t caring for indwelling catheters for 3 residents placing residents at increased risk for infectious disease

- Cited findings noted in F690 r/t catheter care; failed to use acceptable infection control practices r/t caring for indwelling catheters for 3 residents placing residents at increased risk for infectious disease

F921 Safe/Functional/Sanitary/Comfortable Environment

SW: SS=E: Failed to provide a safe, functional, sanitary & comfortable environment for residents & staff r/t parameter of kitchen floor containing trash & debris

- Observed perimeter of kitchen floor with food & trash debris throughout; failed to provide safe, functional, sanitary & comfortable environment for residents & staff

F923 Ventilation

SW: SS=E: Failed to ensure beauty shop exhaust ventilation remained in good working order for residents of facility

- Observed beauty shop operator unaware if beauty shop had exhaust fan; observed ventilation exhaust fan non-working; failed to ensure beauty shop exhaust fan was maintained in good working order as required for residents of facility who utilize beauty shop

December 2023

F553 Right to Participate in Planning Care

NW: SS=D: Failed to include 2 sampled residents in development & planning of residents' CP placing residents at risk of impaired care & decreased autonomy

- Care Plan Conference Summary documented family & resident not present; resident stated knew what CP meeting was but had never been invited or participated in CP process & would attend if invited; failed to include 1 resident in development & planning of resident's CP placing resident at risk for impaired care & autonomy
- CP Conference Summary documented family & resident were not present; resident reported had lived at facility for 4 years & had never participated in CP meeting & did not know what meeting was for; failed to include 1 resident in development & planning of resident's CP placing resident at risk for impaired care & autonomy

F554 Resident Self-Administration Meds-Clinically Appropriate

NW: SS=D: Failed to ensure 1 resident had physician's order & was assessed for ability to safely self-administer medications left at bedside placing resident at risk for improper use of medication & related side effects

- EMR lacked physician order which allowed resident to keep meds at bedside & self-administer; EMR lacked evidence facility assessed resident for ability to safely self-administer medication; Observed LN asked resident several times to sit up in bed so resident could take meds & resident stated did not want to take pills right then so LN placed pills on bedside table & left resident's room & stated would return later to make sure resident took meds & LN stated often left meds on resident's bedside table to take later; failed to ensure resident had physician order & ability to safely self-administer meds prior to leaving meds at bedside placing resident at risk for improper use of medication & related side effects

F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to ensure 2 residents each had a call light within reach placing residents at risk for impaired care

- Failed to ensure staff provided 2 residents call light within easy reach placing resident at increased risk for falls & unmet needs

F609 Reporting of Alleged Violations

NW: SS=D: Failed to report 1 resident's allegation of physical & verbal abuse to State Agency placing resident at risk for unidentified &/or ongoing abuse

- Grievance Log documented resident reported CNA had abused resident; resident stated verbal & physical abuse & incident occurred 11-20-23 when CNA called resident a liar & CNA told resident that resident would have to wait until everyone was assisted to DR before being assisted with transferred resident to recliner then grabbed resident's leg & caused resident pain & had reported incident to another CNA who brought a grievance form & assisted resident in filling it out; Adm nurse verified had not documented conversation with resident but felt, after talking to resident, there was not abuse or neglect r/t resident stated CNA was not in good mood & resident not fearful; facility did not report incident to state agency; failed to report resident's allegation of physical & verbal abuse to state agency as required placing resident at risk for unidentified &/or ongoing abuse

F623 Notice Requirements Before Transfer/Discharge

NW: SS=D: Failed to provide written notice for facility-initiated transfer to 1 resident/representative within practicable time for resident was transferred to hospital placing resident at risk for uninformed care choices

- SS staff stated mailed transfer information to resident's representative but had not received it back & lacked documentation r/t when mailed form; failed to provide 1 resident/representative written notice r/t resident's transfer to hospital placing resident/representative at risk of uninformed care choices

F625 Notice of Bed Hold Policy Before/Upon Transfer

NW: SS=D: Failed to provide 1 resident/representative with written information r/t facility bed hold policy when resident transferred to hospital placing resident at risk for not being permitted to return & resume residence in nursing facility

- SS staff stated mailed transfer information to resident's representative but had not received it back & lacked documentation r/t when mailed form; failed to provide resident/representative with bed hold policy when resident transferred to hospital placing resident at risk for not being permitted to return & resume residence in nursing facility

F641 Accuracy of Assessments

SW: SS=D: Failed to complete an accurate MDS for 2 residents including 1 resident by failure to include resident's PU & 1 resident's indwelling urinary catheter use on MDS

- Sig change MDS failed to include coccyx wound/pressure ulcer IDd by staff upon acute care readmission; failed to complete accurate MDS for 1 resident by failure to include resident's PU on MDS
- Failed to accurately assess MDS for 1 resident r/t indwelling catheter placing resident at risk for uncommunicated care needs including catheter care

F655 Baseline Care Plan

NE: SS=D: Failed to develop a person-centered baseline CP for 1 resident r/t bathing preferences placing resident at risk for impaired care r/t uncommunicated care needs

- CP lacked person-centered direct for resident for resident's ADLs; failed to develop a person-centered baseline CP for resident r/t bathing preferences placing resident at risk of impaired care r/t uncommunicated care needs

F656 Develop/Implement Comprehensive Care Plan

SW: SS=D: Failed to develop a comprehensive CP for 1 resident by failure to include resident's PU

- Failed to develop a comprehensive CP for 1 resident by failure to include resident's PU on CP when resident returned from acute care with it

F657 Care Plan Timing & Revision

NE: SS=D: Failed to ensure 1 resident's CP was revised to include use of insulin placing resident at risk for complications r/t insulin use due to uncommunicated care needs

- CP lacked direction or interventions r/t insulin use; failed to ensure resident's CP was revised to include use of insulin placing resident at risk for complications r/t insulin use due to uncommunicated care needs

NW: SS=D: Failed to revise CP for 1 resident to include BBW for Risperidone for staff direction to monitor for side effects from antipsychotic medication placing residents at risk due to uncommunicated care needs & adverse side effects

- CP failed to Risperidone med on CP & what BBW signs & symptoms to monitor for; failed to revise CP for adverse side effects for 1 resident's Risperidone medication placing resident at risk for possible side effects & decline due to uncommunicated care needs

F677 ADL Care Provided for Dependent Residents

NE: SS=D: Failed to provide consistent bathing for 2 residents with risk for poor hygiene, skin infections, decreased self-esteem & impaired dignity

- Observed resident with several days of facial hair growth noted; lacked documentation resident received bath for 13 days; Failed to provide consistent bathing for 1 resident placing resident at risk for complications r/t poor hygiene & impaired dignity for 2 residents

F679 Activities Meet Interest/Needs of Each Resident

NE: SS=E: Failed to provide consistent activities for 1 resident & other cognitively impaired residents who resided outside locked unit placing affected residents at risk for decreased psychosocial wellbeing & boredom

- Observed group of cognitively impaired resident sat in fireplace social area & not alerted or invited to attend scheduled activity event at that time; observed cognitively impaired residents not invited to other activities; failed to provide consistent activities for cognitively impaired residents who did not reside on locked unit placing affected residents at risk for decreased psychosocial wellbeing & boredom

F684 Quality of Care

NE: SS=D: Failed to follow a physician order for daily weight to monitor for fluid overload for 1 resident placing resident at risk for delay in treatment r/t fluid overload & untreated illness

- POS for daily weights; Record lacked documentation of physician notification of daily weight not obtained on 87 days; failed to follow physician order for daily weights to monitor weight gain for fluid overload for 1 resident placing resident at risk of adverse side effects for unnecessary medication or complications r/t fluid overload

NW: SS=D: Failed to apply compression hose to 1 resident as ordered by physician placing resident at risk for ongoing complications r/t edema

- Observed resident lacking compression hose or ACE wrap to legs as ordered by physician & as CPd; failed to apply compression hose to resident as directed by physician placing resident at risk for ongoing complications r/t edema

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=D: Failed to provide consistent Roam Alert (bracelet alarm) functionality checks on 1 resident's Roam Alert band placing resident at risk for elopement; additionally failed to prevent avoidable accidents during 1 resident's Hoyer lift transfers resulting in minor injuries & failed to utilize 1 resident's CP'd Hoyer lift while transferring resident to bed resulting in non-injury fall placing residents at risk for preventable accidents & injuries

- TAR indicated placement of Roam Alert bracelet was being completed lacked documentation showing functionality was tested; 1 resident's Alert had not been tested since 10-27 as of 12-12; failed to provide consistent functionality checks on 1 resident's Roam Alert bands placing resident at risk for elopement
- Failed to prevent avoidable accidents during 1 resident's Hoyer lift transfers resulting in minor injuries placing resident at risk for preventable injuries & falls
- Failed to utilize 1 resident's CP'd Hoyer lift while transferring resident to bed resulting in non-injury fall placing resident at risk for preventable accidents & injuries

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

- Resident high fall risk with multiple documented falls; Adm nurse stated "had run out of interventions to prevent falls" for resident & verified repetitive interventions on resident's CP; failed to evaluate effectiveness of fall interventions & change or modify interventions which were ineffective at preventing falls for 1 resident placing resident at risk for further falls & injury

NW: SS=D: Failed to provide a safe environment for 3 cognitively impaired independently mobile residents who resided on 2 hallways; further failed to ensure environment free from accident hazards for 1 resident placing affected residents at risk for injury

- Observed door with keypad & unlocked & room contained multiple chemicals with hazard warnings; failed to store hazardous chemicals in safe environment placing 3 cognitively impaired, independently mobile resident on 2 hallways at risk
- MDS lacked documentation resident had siderails; observed ½ rails on 1 side of bed; side rail on top right side & bottom left foot of bed with openings 16.5 inches x 32 inches; failed to ensure 1 resident's environment was free from accident hazards relayed to side rail in use which exceeded safe opening & created risk for entrapment placing resident at risk for accident or injury

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to provide individualized incontinence interventions based on 1 resident's significant status change; additionally failed to provide consistent monitoring of urinary catheter care for 1 resident placing residents at risk for complications r/t incontinence &/or UTIs

- Facility unable to provide toileting trial as requested; failed to provide individualized incontinence interventions based on 1 resident's significant status change placing both residents at risk for complications r/t incontinence
- Failed to ensure staff provided appropriate treatment & services including monitoring urine output for 1 resident who had indwelling catheter placing resident at risk for infection & further urinary problems

F692 Nutrition/Hydration Status Maintenance

NE: SS=G: Failed to provide consistent weight monitoring per professional standards of practice after admission, failed to obtain weekly weights as ordered by physician, & failed to provide cueing for meals as needed for 1 resident; further failed to implement nonpharmacological interventions to prevent weight loss for 1 resident until after significant unplanned loss occurred resulting in loss of 12.15% in 3 months

- EMR lacked evidence staff obtained weekly weight as ordered on 2 consecutive dates; observed staff not in resident's room during meal to provide resident assistance & resident ate only 25% of meal & then refused lunch but drank supplement; failed to provide consistent weight monitoring per professional standards of practice after admission, failed to obtain weekly weights as ordered by physician & failed to provide cueing for meals as needed for 1 resident; further failed to implement nonpharmacological interventions to prevent weight loss until after significant unplanned loss occurred for 1 resident resulting in loss of 12.15% in 3 months

NW: SS=D: Failed to consistently monitor 1 resident's fluid intake r/t physician-ordered fluid restriction placing resident at risk for fluid overload

- CP documented resident on 2000cc fluid restriction with specific breakouts for fluid intake; progress note documented resident admitted to hospital r/t weight gain & hospital staff removed fluid; MAR/TAR lacked documentation of resident fluid intake on 8 days in December occurring in all shifts; failed to consistently monitor & record resident's fluid restriction placing resident at risk for fluid overload

NW: SS=D: Failed to implement RD recommendations for 1 resident's weight loss placing resident at risk for further weight loss; further failed to monitor 2 resident's physician ordered fluid restriction placing 2 residents at risk of complication r/t hydration status

- Record lacked evidence RD recommendation acted on; failed to implement RD intervention r/t resident's weight loss placing resident at risk for complications of continued weight loss
- Failed to monitor 1 resident's physician ordered fluid restriction placing resident at risk of complication r/t hydration status for 2 residents

F700 Bedrails

NW: SS=D: Failed to assess actual rail being used to assure safety for 1 resident placing affected resident at risk for injury

- Cited findings r/t side rails in F689; failed to assess actual rail being used to assure safety for 1 resident placing affected resident at risk for injury

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

SW: SS=F: Failed to staff facility with RN for 8 consecutive hours each day as required

- Time sheets for last 4 quarters revealed 63 days w/o required 8 consecutive hours of RN coverage; Adm confirmed facility lacked required RN staffing as noted & reported facility had difficulty recruiting RNs in facility's rural setting; failed to provide RN coverage for 8 consecutive hours each day for residents of facility as required on 63 occasions over previous 4 quarters

F755 Pharmacy Services/Procedures/Pharmacist/Records

NW: SS=D: Facility's pharmacy services failed to provide medication in specific dosage prescribed when pharmacy packaged pills for resident placing resident at risk for incorrect dose of medication

- Observed CMA administered 25mg Metoprolol; pills in bubble card not cut in 1/2 & card stated 25mg, give ½ tab; LN stated pills should have been cut in ½; facility's pharmacy services failed to provide medication in specific dosage prescribed when packaged pills for facility placing 1 resident at risk for incorrect dose of medication

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) IDd & reported irregularities with 1 resident's insulin placing resident at risk for complications r/t insulin use

- Resident with sliding scale insulin; note lacked evidence physician notified when maximum dose administered & when blood sugar was low; failed to ensure CP IDd & reported irregularities with 1 resident's insulin placing resident at risk for complications r/t insulin use

NW: SS=D: Failed to ensure Consultant Pharmacist (CP) IDd & reported that resident's PRN Xanax lacked 14-day stop date or specified duration which included physician rationale placing resident at risk for inappropriate use of medications

- POS for Xanax 25mg po q 8 hrs PRN for anxiety & order lacked stop date; MRR revealed no recommendations; failed to ensure CP IDd & reported resident's PRN Xanax lacked 14-day stop date placing resident at risk for inappropriate use of medications

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to ensure 1 resident received insulin as ordered by physician & failed to ensure blood glucose levels outside of physician ordered parameters were reported to physician as ordered placing resident at risk for complications r/t insulin use

- Cited findings noted in F756 r/t insulin sliding scale; Failed to ensure 1 resident received insulin as ordered by physician & failed to ensure blood glucose levels outside of physician ordered parameters were reported to physician as ordered placing resident at risk for complications r/t insulin use

F758 Free from Unnecessary Psychotropic Meds/PRN Use

NW: SS=D: Failed to ID 1 resident's allergy medication, Benadryl with psychotropic properties being use to treat anxiety & failed to apply required 14-day stope date or obtain specified duration for use with physician rationale as required for PRN psychotropic meds; further failed to ensure appropriate indication for 1 resident's Risperidone or required physician documentation & failed to ensure 1 resident's PRN Lorazepam had physician's rationale for extended use; also failed to ensure 1 resident's PRN Xanax had 14-day stop date as required placing residents at risk for unnecessary psychotropic meds & related complications

- Record lacked evidence of documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of antipsychotic; further lacked specified duration with physician rationale for extended PRN Lorazepam & Benadryl being used for anxiety w/o stop dates; failed to ensure appropriate indication or required physician documentation or continued use of Risperidone, Lorazepam & Benadryl placing resident at risk for unnecessary adverse psychotropic medication side effects
- Failed to obtain stop date for 1 resident's PRN Xanax placing resident at risk for receiving unnecessary psychotropic medications & related adverse effects

F759 Free of Medication Error Rates 5% or More

NW: SS=D: Failed to ensure medication error rate of less than 5% when staff incorrectly administered medications to 1 resident placing resident at risk for improper use of medication & related side effects & resulted in medication error rate of 27%

- Cited findings noted in F554 r/t LN leaving meds at bedside resulting in medication error rate of 27%; failed to ensure medication error rate of less than 5% when staff incorrectly administered 1 resident's medications placing resident at risk for improper use of medication & related side effects & resulted in medication error rate of 27%

F760 Residents are Free of Significant Med Errors

NW: SS=D: Failed to prevent significant medication error for 1 resident placing resident at risk for adverse medication effects

- Cited findings noted in F755 r/t pharmacy failure to cut pills in ½ as ordered; observed CMA administered whole pill; failed to prevent significant med error when resident received twice ordered dose of Metoprolol placing resident at risk for adverse medication effects

F761 Label/Store Drugs & Biologicals

NE: SS=E: Failed to ensure accurate labeling of medications to facilitate consideration of precautions & safe administration of medications in accordance with professional standards; failed to ensure safe & secure storage of medications creating a risk for adverse side effects & ineffective medication administration

- Observed unlocked exam room with unlocked med fridge with multiple boxes of COVID vaccine & multiple doses of pneumococcal vaccine & 1 vial opened, undated TB serum & temp log for previous month posted with no current month's log available
- Observed nurses' cart with multiple opened insulin pens opened & no open & discard date & Systane gel open with no dates or resident name & albuterol with resident name blacked out & opened 9-7; & shift med count log with 10 opportunities where narcotic count not done in current month
- Med room with fridge temp logs for current month with multiple missing entries & bottle liquid Lorazepam opened & not dated; failed to ensure accurate labeling of medications to facilitate consideration of precautions & safe administration of medications in accordance

with professional standards; failed to ensure safe & secure storage of medications creating risk for adverse side effects & ineffective medication administration

NW: SS=E: Failed to label & store drugs & biological medications appropriately placing affected residents at risk to receive ineffective or inappropriate medication

- Observed med room with fridge temp logs not assessed & recorded daily; observed insulin vial w/o open or expiration date; failed to label & store drugs & biological medications appropriately placing residents who received refrigerated meds at risk to receive ineffective medication
- Observed med cart with plastic med cup with numerous pills labeled with "B" in top drawer; LN retrieved cup & Placed it on top of med cart, then unlocked lock box & pulled med card, popped a pill & added it to cup on top of cart then took cup to resident's room; LN verified meds should not be preset; failed to store medication in accordance with professional standards of practice placing residents at risk for incorrect or ineffective medication administration

F801 Qualified Dietary Staff

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

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

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

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

F803 Menus Meet Resident Needs/Prep in Advance/Followed

NW: SS=F: Failed to meet nutritional needs of residents in accordance with established national guidelines placing residents at risk for unmet nutritional needs

- Observed lunch meal kitchen served lasagna & strawberry short cake for dessert & menu called for lasagna, garlic bread & vegetable to be served; dietary staff verified did not prepare vegetable or garlic bread to serve with meal; failed to serve menu items placing residents at risk for unmet nutritional needs

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NW: SS=E: Failed to provide food prepared by methods that conserve nutritive value, flavor & appearance when dietary staff failed to follow recipe while preparing 4 residents' pureed diets placing residents at risk for impaired nutrition

- Observed dietary staff prepared pureed diets & failed to use recipe; failed to follow recipe when preparing 4 residents' pureed diet placing residents at risk for impaired nutrition

F812 Food Procurement, Store/Prepare/Serve-Sanitary

NE: SS=F: Failed to follow sanitary dietary standards r/t cleanliness of kitchen/dining room equipment, clean ventilation, equipment storage, hygienic serving practices, & food storage placing residents at risk for foodborne illness

- Failed to follow standards of practice r/t cleanliness of kitchen/dining room equipment, clean ventilation, equipment storage, hygienic serving practices & food storage placing resident at risk for foodborne illness

NW: SS=F: Failed to store, prepare, distribute & serve food in accordance with professional standards for food service safety for all residents who received meals from facility's kitchens when staff stored uncovered hamburger in 2 freezers; kitchen staff failed to defrost chest freezer & clean outside of chest & upright freezer; staff failed to ensure dishwasher sanitizing test strips were still effective placing residents at risk for foodborne illness

- Observed chest freezer with ¼ inch ice buildup; 13 uncovered hamburger patties & sliders in unsealed zip-lock bag; outside of chest freezer & upright freezer with numerous different size areas of black substance; observed staff attempted to check dishwasher sanitization level by placing sanitizing test strip in sanitizing cycle & test strip failed to read on strip & when checked, expiration date was 6-22; observed peeling paint on cupboards, ice build up inside freezer

NW: SS=F: Failed to prepare food in accordance with professional standards for food service safety when staff failed to check temps of food items prior to serving, failed to ensure clean & sanitary refrigerators & food prep areas, failed to check sanitation for dishwasher & failed to keep food items off floor in food storage rooms placing residents at risk for foodborne illness

- Observed freezer with food particles smeared on freezer surface, open & uncovered tub of ice cream with ice particles on top; fridge with container with white substance & brown particles in container, unlabeled & undated & container of shredded cheese unlabeled & undated; multiple uncovered food items; numerous boxes on floor
- Observed food temp logs with no documentation of temps since October 2023; observed cart with uncovered desserts pushed down hallway

F849 Hospice Services

NE: SS=D: Failed to establish a communication process including how communication will be documented between facility & hospice provider to ensure that needs of resident were addressed & met 24 hours/day for 2 residents; failed to ensure 2 resident's written CP included both most recent hospice CP & description of services furnished by both facility & hospice placing residents at risk of decline &/or from maintaining highest practicable physical, mental & psychosocial wellbeing

- CP lacked care area for hospice services that directed staff on who hospice provider was, how to contact hospice provider, hospice provided supplies &/or medications or how communication was to be collaborated between facility & hospice provider; failed to establish a communication process including how communication will be documented between facility & hospice provider to ensure needs of resident are addressed & met 24 hours/day for resident; failed to ensure that resident's written CP included both most recent hospice CP, description of services furnished by facility & contact & address information for hospice provider placing resident at risk for decline &/or maintaining highest practicable physical, mental & psychosocial wellbeing for 2 residents

NW: SS=D: Failed to ensure coordinated plan of care which coordinated care & services provided by facility with care & services provided by hospice was developed & available for 1 resident placing resident at risk for inappropriate &/or unmet end of life cares

- Failed to coordinate care between facility & hospice services for 1 resident who received hospice services placing resident at risk for inappropriate &/or unmet end of life care

F851 Payroll Based Journal

SW: SS=F: Failed to electronically submit to CMS complete & accurate direct care staffing information including information for agency & contract staff based on payroll & other verifiable & auditable data in uniform format of PBJ r/t licensed nursing staff coverage 24 hours a day & RN coverage for 8 consecutive hours each day

- Failed to electronically submit to CMS complete & accurate direct care staffing information including information for agency & contract staff, based on payroll & other verifiable & auditable data in form of PBJ r/t LN staff & RN coverage

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

- PBJ reported for 2 quarters indicated facility did not have licensed nurse coverage 24 hrs/day/7 days a week on multiple days (5 days in quarter 2 & 6 dates in quarter 3); Review of staffing schedules revealed LN on duty 24 hrs/day, 7 days a week; failed to submit accurate PBJ data which placed residents at risk for unidentified & ongoing inadequate staffing

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

- PBJ report indicated facility w/o LN coverage 24 hrs/day, 7 days/wk for 36 days in quarter 1, 27 dates quarter 2, 20 dates quarter 3, & 17 dates quarter 4; Adm staff verified facility did not send correct data to CMS for PBJ; failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

F880 Infection Prevention & Control

SW: SS=F: Failed to maintain effective infection control program with failure of staff, failed to clean full body mechanical lift between resident uses, to change gloves & perform hand hygiene between phases of incontinence care & to perform hand hygiene between resident room contacts when delivering laundry to resident rooms with potential to lead to cross contamination between residents & negatively affect every resident in facility

- Failed to clean mechanical lift between resident uses with potential to lead to cross contamination between residents & negatively affect every resident that required mechanical lift in facility
- Failed to change gloves & perform proper hand hygiene between phases of incontinent care with potential to lead to cross contamination between residents & negatively affect every resident in facility
- Failed to perform handy hygiene between resident room contacts when delivering laundry to resident rooms with potential to lead to cross contamination between residents & negatively affect every resident in facility

NE: SS=E: Failed to implement appropriate infection control practices placing residents at risk for transmission of infectious disease

- Observed exam room unlocked with bin of hair products including clippers & hairbrush with hairs in it & unlabeled & chair in exam room with hairs all over seat surface & handwashing sink not equipped with paper towels for drying
- Observed staff walked down hall w/o mask & held piece of paper up to face to cover mouth & nose
- Observed 2 lifts with debris & visibly soiled & observed staff used lift on multiple resident w/o sanitizing lift; observed ice cooler next to fish tank & inside of cooler with black particles mixed with melted ice
- Observed laundry cart uncovered & unattended in hallway
- Observed unlocked clean linen room with clean linen stored uncovered in room
- Observed resident in w/c with catheter bag dragging on floor under w/c on multiple occasions
- Observed large bag of trash on floor in hallway outside bathing room; failed to implement appropriate infection control practices placing residents at risk for transmission of infectious disease

NW: SS=D: Failed to exercise appropriate hand hygiene when providing 1 resident incontinent & catheter cares placing resident at risk for infection

- Observed CNA toilet resident & provide incontinent & catheter care; donned gloves then removed & discarded brief into trash can then with same gloves retrieved new brief & placed brief on resident's them wearing same soiled gloves placed 3 paper towels on floor & took urinal out of plastic bag & touched front f bag to open it & placed urinal on towels then with same soiled gloves opened port of leg bag & drained it then closed port; while wearing same soiled gloves took alcohol pad & wiped spout then reconnected bag then with same gloves, took washcloth & wiped from tip of resident's penis down catheter tubing then placed cloth into plastic bag then attempted to place new brief, touched bottom of resident's shoes with brief & gloved hands; failed to change gloves & wash hands when providing 1 resident incontinent & catheter cares & continued to provide care with same soiled gloves placing resident at risk for infection

NW: SS=E: Failed to provide ice water in sanitary manner; failed to ensure appropriate infection control principles r/t use of indwelling catheter for 1 resident placing residents at risk for infection

- Observed dietary staff with cart by facility ice machine & staff used bare hands to grab ice out of ice machine & place in water glasses; staff reported should use ice scoop but holder broken & did not know where scoop was; failed to provide ice in sanitary manner placing residents at risk for infection
- Observed resident with urinary catheter & tubing sliding along floor as resident self-propelled w/c; observed CNA took resident to room & set container on floor then laid catheter collection bag on floor to drain tubing then wiped port with alcohol before & after emptying bag then placed bag back into privacy bag & hung bag under w/c with tubing touching floor; failed to implement adequate infection control practices r/t resident's urinary catheter placing resident at risk for increased transmission of infectious disease

F882 Infection Prevention Qualifications/Role

NW: SS=F: Failed to ensure staff person designated as Infection Preventionist, who was responsible for facility's IPCP completed specialized training & possessed required certification in infection prevention & control placing residents at risk for lack of ID & treatment of infections

- Adm Nurse stated responsible for IPCP & verified lacked certification as IP & had not completed training modules & had not taken test for certification; failed to ensure person designated as IP possessed required certification placing residents at risk for lack of ID & treatment of infections

F921 Safe/Functional/Sanitary/Comfortable Environment

SW: SS=F: Failed to provide sanitary environment by failure to have lids on trash cans in soiled utility rooms with potential to be unsanitary environment which would affect all residents in facility

- Observed 3 soiled utility rooms with trash cans lacking lid or cover; failed to provide sanitary environment by failure to have lids or covers on trash cans in soiled utility rooms with potential to be an unsanitary environment which would affect all residents in facility

F943 Abuse, Neglect & Exploitation Training

NE: SS=F: Failed to provide evidence of required prevention of abuse, neglect & exploitation training for 1/5 CNAs that were sampled placing residents at risk for abuse

- Employee record of 1 CNA revealed facility failed to provide evidence that CNA received required ANE training; failed to provide evidence of required prevention of ANE training for 1/5 CNAs that were sampled placing residents at risk for abuse

F947 Required In-Service Training for Nurse Aides

NE: SS=F: Failed to ensure 2/5 CNA staff reviewed had required 12 hours of in-service education which included dementia care training placing resident at risk for decreased quality of life &/or inadequate care

- 1 CNA had 1.75 hours of in-service in 12 months
- 1 CNA had 6.59 hours of in-service in 12 months
- Failed to ensure 2/5 CNA staff reviewed had required 12 hours of in-service education & dementia care training placing residents at risk for decreased quality of life &/or inadequate care

January, 2024

F584 Safe/Clean/Comfortable/Homelike Environment

NW: SS=D: Failed to provide 1 resident with safe, clean, comfortable & homelike environment when staff stripped residents' urine-soaked bedding & left resident on end of bed creating an unpleasant smell in resident's room placing resident at risk for unclean & uncomfortable environment

- *Observed resident's room reeked of old urine smell; resident's bedding was at foot of bed visibly soaked with urine throughout bedding; failed to provide resident with safe, clean, comfortable & homelike environment placing resident at risk for unclean & uncomfortable environment*

F600 Free from Abuse & Neglect

SE: SS=K (Abated to E): Failed to provide adequate supervision & care planned interventions to prevent 1 resident with hx of sexual behaviors since admission from sexually assaulting & harassing female residents in facility

- *On 12-25 resident grabbed 1 resident's breast & masturbated in public area & facility failed to place any interventions to protect female resident & other residents from resident's unwanted sexual advances/touching; resident again on same day masturbated in public area; on 1-2-24 resident attempted to grab female resident's breast with no interventions in place placing resident & all other residents in immediate jeopardy; CP lacked interventions specific to resident's sexual behaviors to prevent further inappropriate sexual advances toward other residents, statements &/or behaviors; female resident stated did not feel safe in current environment & was uncomfortable with resident's sexual actions; law enforcement revealed no reports on file r/t resident-to-resident sexual abuse & officer stated should be notified anytime of unwanted sexual contact; failed to provide a safe & secure living environment for residents of facility by failure to provide adequate supervision & CP'd interventions to prevent resident, with hx of sexual behaviors since admission from sexually assaulting & harassing female residents in facility; on 12-25-12 resident grabbed resident's breast & masturbated in public area & facility failed to place an interventions to protect resident & other residents from resident's unwanted sexual advances/touching; resident again on 12-25 masturbated in a public; on 1-2 resident attempted to grab same female resident's breast with no interventions in place placing resident & all other residents in immediate jeopardy*
- *Abatement Plan:*
  - *Facility updated CPs for residents with sexually inappropriate behaviors completed for 4 IDd residents*
  - *Facility educated staff on ANE policy*

- *Facility educated staff on policy of "Sexual Consent"*
- *Facility initiated online training module for staff to complete on Relias with topic of "Preventing, Recognizing, & Reporting Abuse*
- *Facility initiated online training module for staff to complete on Relias on ANE*
- *Facility initiated online training module for staff to complete on Relias with topic of "Ethical Issues of Sexuality and the Older Adult"*
- *Facility initiated process through which SSD would conduct "resident interview questions r/t ANE*
- *Facility placed resident with concerns of unwanted sexual advances under 1:1 supervision until LEO investigated & resident would be assessed by Physician Extender &/o0r Adm nurse*
- *Facility instructed staff to redirect/intervene/distract/encourage self-soothing activities in privacy of resident's room & is ongoing intervention*
- *Facility instructed all staff to maintain visual contact with resident when out of room & updated CP with intervention*
- *Facility placed door alarm on resident's door to alert staff when resident left room & will be maintained for minimum of 30 days & reviewed at next QAPI meeting*
- *Resident seen by psychological provider for medication follow up & will be seen on PRN basis until 30 day review period including medication changes with Lithium r/t schizophrenia & started on Trazodone r/t insomnia*

F609 Reporting of Alleged Violations

SE: SS=L (Abated to F): Failed to ensure reporting of incidents of sexual assault & harassment to local law enforcement as required; failed to provide adequate supervision & CP'd intervention to prevent 1 resident with hx of sexual behaviors since admission from sexually assaulting & harassing female residents in facility; on 12-25 resident grabbed female resident's breast & masturbated in public area & facility failed to place any interventions to protect resident & other residents from resident's unwanted sexual advances/touching; resident again on 12-25 masturbated in public; on 1-2 resident attempted to grab same female resident's breast with no interventions in place placing resident & all other residents in immediate jeopardy

- *Cited findings noted in F600 r/t inappropriate sexual behaviors; law enforcement stated no reports on file r/t resident-to-resident sexual abuse & should have been notified; failed to report allegation of sexual abuse to local law enforcement as required*
- *Abatement Plan:*
  - *Facility updated CPs for residents with sexually inappropriate behaviors completed for 4 IDd residents*
  - *Facility educated staff on ANE policy*
  - *Facility educated staff on policy of "Sexual Consent"*
  - *Facility initiated online training module for staff to complete on Relias with topic of "Preventing, Recognizing, & Reporting Abuse*
  - *Facility initiated online training module for staff to complete on Relias on ANE*
  - *Facility initiated online training module for staff to complete on Relias with topic of "Ethical Issues of Sexuality and the Older Adult"*
  - *Facility initiated process through which SSD would conduct "resident interview questions r/t ANE*
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  - *Facility placed door alarm on resident's door to alert staff when resident left room & will be maintained for minimum of 30 days & reviewed at next QAPI meeting*
  - *Resident seen by psychological provider for medication follow up & will be seen on PRN basis until 30 day review period including medication changes with Lithium r/t schizophrenia & started on Trazodone r/t insomnia*

F610 Investigate/Prevent/Correct Alleged Violation

SE: SS=L (Abated to F): Failed to protect residents from incidents of sexual assault & harassment; failure to provide adequate supervision & CP'd interventions t prevent resident with hx of sexual behaviors since admission from sexually assaulting & harassing female residents in facility; on 12-25 resident grabbed female resident's breast & masturbated in public area & facility failed to place any interventions to protect female resident & other residents from resident's unwanted sexual advances/touching; resident again on 12-25 masturbated in public area; On 1-2 resident attempted to grab same female residents' breast with no interventions in place placing resident & all other residents in immediate jeopardy & at risk for negative psychosocial impact of female residents' safety & wellbeing

- *Failed to ensure protection of residents from sexual assault placing them in immediate jeopardy*
- *Abatement Plan:*
  - *Facility updated CPs for residents with sexually inappropriate behaviors completed for 4 IDd residents*
  - *Facility educated staff on ANE policy*
  - *Facility educated staff on policy of "Sexual Consent"*
  - *Facility initiated online training module for staff to complete on Relias with topic of "Preventing, Recognizing, & Reporting Abuse*
  - *Facility initiated online training module for staff to complete on Relias on ANE*
  - *Facility initiated online training module for staff to complete on Relias with topic of "Ethical Issues of Sexuality and the Older Adult"*
  - *Facility initiated process through which SSD would conduct "resident interview questions r/t ANE*

- *Facility placed resident with concerns of unwanted sexual advances under 1:1 supervision until LEO investigated & resident would be assessed by Physician Extender &/o0r Adm nurse*
- *Facility instructed staff to redirect/intervene/distract/encourage self-soothing activities in privacy of resident's room & is ongoing intervention*
- *Facility instructed all staff to maintain visual contact with resident when out of room & updated CP with intervention*
- *Facility placed door alarm on resident's door to alert staff when resident left room & will be maintained for minimum of 30 days & reviewed at next QAPI meeting*
- *Resident seen by psychological provider for medication follow up & will be seen on PRN basis until 30 day review period including medication changes with Lithium r/t schizophrenia & started on Trazodone r/t insomnia*
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F686 Treatment/Services to Prevent/Heal Pressure Ulcer (PU)

NW: SS=G: Failed to prevent 1 resident from acquiring two Stage 3 PUs on bilateral posterior upper thighs; resident sustained shearing & friction injuries to back of bilateral thighs; failed to implement PU prevention interventions after shearing & friction injuries which subsequently progressed to Stage 3 pressure injuries placing resident at risk for further PUs, pain & related complications

- *Resident with Parkinson's, morbid obesity, DM & weakness; BIMS of 12 & dependent on staff for ADLs; MDS documented resident not at risk for PUs & entered facility w/o skin alterations; only intervention on interim CP included to inspect resident's skin per facility protocol; CP lacked mention of pressure reduction device in resident's recliner; CP implemented 22 days after resident's admission; CP included resident had shearing to bilateral posterior thighs & directed staff to assist resident with turning/repositioning during rounds, check resident for incontinence & provide care as needed; CP directed staff to administer treatments as ordered & report changes; CP documented resident had Roho cushion in w/c; Braden indicated low risk for skin impairment; 8 days after admission wound nurse notified resident had skin issues on bilateral legs IDd as shearing & friction bilateral posterior thighs; 9 days after admission physician notified facility that resident had low sodium level & was admitted to ICU at local hospital; hospital discharge instructions documented residents' wounds which had improved since admission to hospital; POS for TAP system (strap lifting & turning/repositioning system to minimize risk for PUs) & Prevalon boots & ordered pressure-relieving mattress, friction-reducing surfaces & turning regimen & orders to notify physician if wounds started to worsen; first post-hospitalization lacked measurements or wound description; progress note documented resident with low potassium level when admitted to hospital; progress note documented to start MVI & liquid protein to aid in wound healing; resident admitted to hospice 21 days after readmission from hospital; 3 days later resident found w/o vital sounds; CNA stated did not remember resident being on turn/repositioning schedule until after returned from hospital & did not remember resident having cushion in w/c or recliner; Adm nurse did not agree facility had not done anything to prevent PU formation & did not agree shearing & friction were r/t PU formation; failed to implement PU prevention interventions for 1 resident when resident developed shearing & friction-related wounds which subsequently progressed to stage 3 PUs placing resident at risk of development of more PUs, pain & other related complications*

F689 Free of Accident Hazards/Supervision/Devices

SE: SS=J (Abated to G): Failed to provide adequate supervision, identify likely avenues of exit, including windows, & failed to ensure windows were secured after 1 resident broke window out in room, to prevent elopement, constituting IJ

- *Resident eloped from facility & suffered lacerations to leg which required 13 sutures; Failed to provide adequate supervision, identify likely avenues of exit, including windows & failed to ensure windows were secured after 1 resident broke window out in room, to prevent elopement when CNA did not provide supervision of resident, as directed by LN & at 8pm, unsupervised resident went to room; at 8:01 PM resident climbed through known broken window & eloped from facility & injured leg placing resident in immediate jeopardy*
- *Abatement Plan:*
  - *Resident placed on 1:1 upon return to facility from ED after receiving sutures & will remain on 1:1 until deemed stable by Physician Extender*
  - *Plywood sheeting placed over broken window*
  - *Contractor contacted by facility about permanent window replacement & documents revealed no set date for repair but facility is placed on waiting list for repairs to be completed as soon as practical*
  - *Staff education r/t elopement policy initiated*
  - *Computer learning module titled "Understanding Wandering and Elopement" initiated*

F880 Infection Prevention & Control

NW: SS=D: Failed to utilize accepted infection control practices when CNA performed peri care on 1 resident w/o using gloves placing resident at risk for infections & unclean environment

- *Observed CNA provided peri care after incontinent episode; with ungloved hands CNA removed resident's urine-saturated incontinence brief, grabbed cleansing wipes & wiped resident's perineum with bare hands then replaced with clean brief with bare hands; w/o performing hand hygiene CNA touched resident's face, clothing with unclean hands then picked up gait belt with unclean hands & with assist transferred resident into w/c & then washed hands; failed to use accepted infection control practices for 1 resident placing resident at risk for infections & unclean environment*