January, 2025 Kansas Survey Findings
Normal Font-Health Survey
*Italics= Complaint Survey*
**Findings in Red=G+ Scope & Severity**
**Findings in Green from State Regulations**
SS=Scope & Severity; LN=Licensed Nurse
TX=treatment; Dx=Diagnosis; Fx=Fracture
CP=Care Plan; CP in pharmacy regulations=Consultant Pharmacist
PU=Pressure Ulcer; ID=identify; Hx=History

**October, 2024**

**F636 Comprehensive Assessments & Timing**

NE: SS=D: Failed to fully complete MDS for 1 resident when staff did not complete analysis for triggered CAA placing resident at risk for inaccurate CP & unidentified care needs

- MDS with all triggered CAA lacked completion with analysis of findings; failed to ensure staff fully completed Comprehensive MDS for resident when staff did not complete triggered CAA placing resident at risk for inaccurate CP & unidentified care needs

**F641 Accuracy of Assessments**

SW: SS=D: Failed to complete an accurate MDS for 1 resident r/t discharge to acute hospital

- Discharge MDS indicated resident discharged to acute hospital but EMR documented resident discharged to home; staff confirmed discharge MDS inaccurate; failed to complete accurate discharge MDS for resident who discharged to home

**F657 Care Plan Timing & Revision**

NE: SS=D: Failed to revise CP for 1 resident to provide direction to staff to ensure resident received care to eliminate or mitigate triggers that may cause re-traumatization of resident with PTSD for 1 resident placing resident at risk for impaired care due to uncommunicated care needs

- EMR documented PTSD, depression, dementia, COPD, DM; received antipsychotic & antidepressant routinely; PTSD-Trauma Assessment documented trauma from car accident & when flying in Air Force, fired a gun & resident considered it a traumatic experience & resident stated had flashbacks of car wreck; POS for Sertraline for depression & Aripiprazole for PTSD; LN unsure did not know what triggers might be for resident's PTSD; LN stated resident did not receive mental health services as HOH & with dementia; LN stated came from VA; CNA unaware of resident's PTSD; SSD stated aware of PTSD but did not know triggers; Adm nurse stated no triggers on CP; failed to revise resident's CP with individualized person-centered interventions to provide directions to staff to ensure resident received care to eliminate or mitigate triggers that may cause re-traumatization of resident placing resident at risk for impaired care due to uncommunicated care needs

**F684 Quality of Care**

SW: SS=D: Failed to ensure proper w/c positioning for 1 resident

- Resident dependent on staff for mobility in w/c & transfers; observed resident on multiple occasions with ankle crossed over other ankle & foot dangled above footrest of w/c; staff reported resident's feet did not usually come down far enough to reach footrests of w/c; failed to ensure proper w/c positioning for dependent resident

**F689 Free of Accident Hazards/Supervision/Devices**

SW: SS=D: Failed to ensure 1 resident's toilet safety rail was secure & 1 resident r/t failure to ensure resident was safe in use of lift chair

- CP documented resident dependent with toileting hygiene; observed toilet safety rail in resident's private BR extremely loose & lacked rubber boot where rail met floor; failed to ensure dependent resident's toilet safety rail was secure
- Resident dependent on staff for chair to bed & chair transfers; resident high risk for falls; EMR documented lift chair assessment dated 2-28-22 indicating resident safe to use lift chair recliner; EMR with lift chair assessments dated 8-25-24 & 8-26-24 indicating use of lift chair remote &/or chair a safety risk; no other lift chair assessments available; resident with fall on 8-25-24 & resident on floor in front of lift recliner which was in fully extended position & resident stated had tried to get up to walk on own & fell; family member stated facility unplugged lift chair & removed remote of recliner from resident's room; failed to complete lift chair assessment for dependent resident with significant change in condition

NE: SS=D: Failed to consistently implement interventions to prevent falls for 1 resident who had multiple falls placing resident at risk for further falls & related injuries

- EMR documented resident with non-injury falls on 7 occasions; record lacked evidence intervention implemented in response to 6 falls; failed to ID & implement interventions to prevent further falls for 1 resident placing resident at risk for further falls & related injuries

NE: SS=G (Past Non-compliance): Failed to ensure 1 resident remained free from preventable accident during sit-to-stand mechanical lift transfer resulting in fx'd finger & placed resident at risk for further complications

- EMR documented resident had to be assisted to floor during transfer with sit-to-stand mechanical lift; sling had become unhooked from lift during transfer; resident c/o pain in ring finger & resident able to complete active ROM to finger w/o difficulty; finger then

started to swell & bruise; NN documented resident from appointment with physician & was waiting results of X-ray; NN documented physician notified of fx of 4th digit & returned to office for fitting of correct splint; failed to ensure resident remained free from preventable accident during a sit-to-stand mechanical lift transfer by use of incorrect size of sling resulting in fx'd finger & placed resident at risk for further complications

**F690 Bowel/Bladder Incontinence, Catheter, UTI**

SW: SS=D: Failed to ensure consistent monitoring of 1 resident's penile erosion causing pressure of urinary catheter

- Resident with urinary retention with urinary catheter; NN documented during catheter care, LN noticed small split to penis & educated resident on importance of catheter anchor placement & effects of tugging on catheter; split continued & wound nurse & medical team notified; staff instructed by physician to ensure catheter anchor in place & secure; TAR documented resident refused night catheter care on consistent basis; consulting physician stated penile erosion "probably due to urinary catheter"; failed to ensure staff monitored resident's penile erosion to determine effectiveness of treatment to prevent further injury & infection

**F755 Pharmacy Services/Procedures/Pharmacist/Records**

SW: SS=D: Failed to ensure staff followed physician orders for medication for 1 resident receiving a lower dose of chemotherapy than ordered by physician

- POS for Temozolomide 240mg daily x 5 days for brain neoplasm & repeat every 4 weeks; October MAR documented resident received med on 3 days & resident stated concerned with administration of chemotherapy meds & thinks staff did not provide correct dose; at 8:15am resident revealed had not received 8am dose of chemotherapy med & breakfast had been delivered but did not want to eat until received med then waited 1 hour as directed by manufacturer; LN revealed awaiting delivery from pharmacy to administer med; Adm nurse revealed resident received 200mg on 10-5 instead of ordered 240mg; failed to ensure staff administered correct dose of Temozolomide as ordered by physician to ensure effective treatment for cancerous brain tumor for resident

**F812 Food Procurement, Store/Prepare/Serve-Sanitary**

SW: SS=F: Failed to prepare & serve food under sanitary conditions to residents of facility appropriately to prevent potential for foodborne bacteria by failing to ensure ice machine had appropriate drainage air gap from tubing to floor drain as required

- Failed to ensure ice machine had appropriate drainage air gap from tubing to floor drain as required

**F849 Hospice Services**

NE: SS=D: Failed to ensure collaboration between nursing home & hospice services to ID hospice-supplied services, supplies, medication, & equipment for 1 resident placing resident at risk for impaired end-of-life

- Failed to ensure collaboration between nursing home & hospice services to ID hospice-supplied services, supplies, medication & equipment for 1 resident placing resident at risk for impaired end-of-life care

**F880 Infection Prevention & Control**

SW: SS=D: Failed to provide appropriate catheter care for 2 resident with indwelling urinary catheters in clean & sanitary manner

- Observed LN provide catheter care & catheter bag rested directly on floor & lacked dignity bag; observed catheter bag ½ in & ½ out of dignity bag & rested directly on floor; failed to ensure dependent resident's indwelling catheter bag was kept off floor at all times
- Resident with urinary catheter & POS for change to leg bag during days; observed leg bag attached to lower leg & drain spout hung down from lower edge of bag & lacked protective cap to keep it from touching unclean surfaces; failed to ensure staff provided sanitary enclosed urine collection bag for resident to prevent contamination/infection

**F883 Influenza & Pneumococcal Immunizations**

NE: SS=D: Failed to offer or obtain informed declinations or physician-documented contraindication for PCV20 for 3 residents placing residents at increased risk for complications r/t pneumonia

- Failed to offer & administer PCV20 or obtain informed declinations for 3 resident who were eligible to receive vaccination placing residents at increased risk for acquiring, transmitting or experiencing complications from pneumococcal disease

**November, 2024**

**F558 Reasonable Accommodations Needs/Preferences**

*NE: SS=D: Failed to provide 1 resident with required adaptive equipment during mealtime placing resident at risk for decreased nutritional status, a decline in ADLs & physical complications*

- *CP documented resident needed plate guard opening to left side; resident with weight loss; observed resident at DR table & ate spaghetti off regular plate w/o plate guard around it & resident use fork to push spaghetti around plate; failed to provide resident with adequate adaptive equipment during mealtime placing resident at risk for decreased nutritional status, a decline in ADL independence & physical complications*

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

*NE: SS=D: Failed to notify 1 resident's representative of CP changes &/or results with risk of miscommunication between resident, representative & facility*

- *EMR documented resident with seizure activity along with documentation of communication with physician r/t seizure activity & new physician order to treat seizures; record lacked evidence facility notified representative of resident's seizure activity & new medication order; record lacked evidence facility notified representative of additional seizure activity or physician order for chest X-ray of CP in case of pneumonia or results of X-ray; record lacked evidence facility notified representative of open area to sacrum, weight loss & new w/c; record lacked evidence facility notified representative of further seizure activity; failed to notify representative of CP changes &/or results with risk of miscommunication between resident, representative & facility*

**F582 Medicaid/Medicare Coverage/Liability Notice**

SW: SS=D: Failed to issue accurate & complete Beneficiary Protection Notification forms to 1 resident

- SNF ABN & NOMNC had incorrect dates on form & lacked cognitively intact resident's signature, family member signed form for cognitively intact resident; Adm report no NOMNC issued for resident when discharged from therapy; failed to ensure correct & complete Beneficiary Protection Notification forms were issued to 1 resident as required

**F584 Safe/Clean/Comfortable/Homelike Environment**

SE: SS=D: Failed to ensure a safe, sanitary & homelike environment in 2 resident rooms & 1 hallway

- Observed strong urine odor in 1 hallway near resident room & inside room
- Observed black streaks on wall in resident room
- Observed stained ceilings

**F623 Notice Requirements Before Transfer/Discharge**

SE: SS=D: Failed to provide 1 resident a Bed Hold Policy upon admission to acute care hospital

- Failed to obtain signed bed hold for 1 resident who admitted to acute care hospital

**F637 Comprehensive Assessment After Significant Change**

SW: SS=D: Failed to ID significant change & complete assessment for 2 residents reviewed for significant change assessments; 1 resident with decline in ambulation, toileting hygiene, transfers, bed mobility & dressing & 1 resident with decline with ambulation, transfers, toileting hygiene, & bed mobility with potential to lead to uncommunicated needs which could lead to negative impacts on resident's physical, mental & psychosocial wellbeing

- Failed to ID significant change & complete assessment for 1 resident who had decline with ambulation, toileting hygiene, transfers, bed mobility & dressing with potential to lead to uncommunicated needs which could lead to negative impacts on resident's physical, mental & psychosocial wellbeing
- Failed to ID significant change & complete assessment for 1 resident who had decline with ambulation, toileting hygiene, transfers, bed mobility & personal hygiene with potential to lead to uncommunicated needs which could lead to negative impacts on resident's physical, mental & psychosocial wellbeing

**F655 Baseline Care Plan**

SW: SS=D: Failed to develop baseline CP within 48 hours of admission for 1 resident placing resident at risk for impaired care due to unidentified or uncommunicated care needs

- Record lacked baseline CP from admission date of 11-8-24; failed to develop baseline CP within 48 hours of admission placing resident at risk for impaired care due to unidentified & uncommunicated care needs

**F656 Develop/Implement Comprehensive Care Plan**

SE: SS=D: Failed to ensure development of personalized comprehensive CP for optimal toileting program for 1 resident

- Incontinence CP lacked instructions on frequency of check & change program, interventions for refusal of incontinence care & enhancement of incontinence products to prevent frequent urine saturation of bed to meet needs of incontinent resident; failed to provide dependent resident a personalized comprehensive CP to include strategies for refusal of incontinence care, a personalized check & change program & assessment of incontinence products to prevent leakage of urine to enhance resident's wellbeing

**F657 Care Plan Timing & Revision**

NE: SS=D: Failed to revise CP for 1 resident whose HCTZ was DC'd placing resident at risk for inappropriate care due to uncommunicated care needs

- Failed to revise 1 resident's CP when resident's HCTZ was DC'd placing resident at risk for inappropriate care due to uncommunicated care needs

**F677 ADL Care Provided for Dependent Residents**

SE: SS=D: Failed to shave 1 resident on regular basis

- Observed resident with long, unshaven facial hair on multiple occasions; failed to ensure dependent resident was shaven on regular basis

**F684 Quality of Care**

SW: SS=D: Failed to complete a weekly skin assessment for 1 resident; observed resident with dressing on elbow & no skin notes or progress notes in EMR r/t dressing with potential to lead to uncommunicated needs, which could lead to negative impacts on resident's physical, mental & psychosocial wellbeing

- POS lacked orders for wound care; EMR w/o further skin assessments r/t resident's elbow dressing from 10-18-24 thru 11-18-24; failed to complete a weekly skin assessment for 1 resident who was observed with dressing on elbow & no recent skin notes or progress notes in EMR r/t dressing with potential to lead to uncommunicated needs which could lead to negative impacts on resident's physical, mental & psychosocial wellbeing

**F697 Pain Management**

SW: SS=J (Removal Plan to G): Failed to assess pain & failed to take appropriate action to manage severe pain despite repeated complaints from 1 resident; additionally lacked communication between nurses, doctors & other healthcare providers r/t resident's pain management placing resident in immediate jeopardy

- Facility failure to ensure staff identified, updated providers and responded appropriately to complaints of 1 resident's pain that was consistently left without an effective pain medication being administered, leading to signs of distress, such as moaning, yelling and agitation which significantly impacts their quality of life and could potentially result in further complications if not addressed and resident's unrelieved pain could be a possible indicator of a returned strangulated hernia or other significant disease processes
- Plan of Removal:
    - Resident died
    - Pain assessed q shift by LN with staff interventions if applicable
    - Immediate QAPI meeting
    - LN education on pain assessment including assessment areas ID'd with pharmacological & non-pharmacological interventions & verbal notification
    - Adm Nurse/designee to audit pain goals & reported pain with interventions thru clinical excellence
    - Physician & responsible party notified & documented of need to change pain management intervention & CP revision
    - Results of audit reviewed during monthly QAPI meetings

**F689 Free of Accident Hazards/Supervision/Devices**

SE: SS=E: Failed to safely transfer 2 residents & failed to ensure chemicals were kept locked on 1 hallway which housed 8 confused residents

- Resident with maximum assist to total dependence on staff for transfers; CP directed 2 staff for transfers; EMR documented 2 staff transferred resident with total assist of 2 staff & use of gait belt & resident unable to bear weight during transfer with socked feet skimming floor & resident's socks not non-skid; observed staff transferred resident w/o non-skid socks on multiple occasions; failed to safely transfer dependent resident who was unable to fully bear own weight
- Resident dependent on staff assist for transfers; observed 2 CNAs transferred resident with use of sit to stand lift & resident unable to hold onto handles of lift for entire duration of transfer & resident slipped down & arms raised up causing belt to lift to move up & lodge in resident's arm pits placing resident in suspended position with arms splayed in manner that resembled a chicken wing; failed to safely transfer dependent resident who was unable to fully bear weight & unable to hold onto handles of sit to stand lift appropriately
- Failed to keep 8 confused residents safe by having unlocked chemicals in janitor's closet

NE: SS=E: Failed to ensure safe environment free from accident hazards for 1 resident when staff did not use right type of slide board for resident who had previous staff-assisted fall using slide board; further failed to address risk after staff-assisted fall; failed to ensure safe environment free from accident hazards for 1 resident who had large openings in side rails presenting risk of entrapment; additionally facility to ensure safe environment for 1 resident who had meds stored on bookshelf & for 1 resident who did not wear a smoke apron per CP while smoking placing all affected residents at risk for preventable accidents & related injuries

- Failed to ensure safe environment free from accident hazards for 1 resident when staff did not use right type of slide board; further failed to address risk after a staff-assisted fall placing resident at risk for falls & fall-related injuries
- Failed to ensure resident a safe environment free from entrapment risks r/t unsafe openings in resident's quarter-rails used on bed placing resident at risk for entrapment & related complications
- Observed resident's room with multiple biological substances including hydrogen peroxide, psoriasis shampoo, fungiCURE spray; Failed to ensure safe environment free from accident hazards for 1 resident placing resident at risk for injury & preventable accidents
- Failed to provide resident with smoking apron per CP placing resident at risk for accidents & injuries

**F690 Bowel/Bladder Incontinence, Catheter, UTI**

SE: SS=D: Failed to ensure adequate toileting opportunities for 1 resident

- Cited findings noted in F656 r/t resident's incontinence plan; Observed 2 CNAs provide incontinent care & resident saturated brief & urine soaked through onto mattress; failed to provide dependent resident thorough assessment of urinary incontinence to ensure staff provided optimal toileting plan to decrease risk of UTIs

**F698 Dialysis**

NE: SS=D: Failed to ensure ongoing communication with dialysis provider r/t dialysis treatments & monitoring for 1 resident placing resident at risk for complications & health decline

- Failed to ensure ongoing communication with dialysis provider r/t resident's dialysis treatments placing resident at risk for complications & health decline

**F700 Bedrails**

NE: SS=D: Failed to obtain written informed consent which included potential risks vs benefits from resident &/or representative for use of side rails for 1 resident placing resident at risk for accident or injury due to uninformed choices r/t side rail use

- Side Rail Assessment documented no alternative to bedrails attempted; no alternatives attempted & failed; assessments noted resident's family "demanded" side rails despite risks; failed to obtain written informed consent from resident/representative for using side rails placing resident at risk for accident or injury due to uninformed choices associated with side rail use

**F726 Competent Nursing Staff**

SW: SS=F: Failed to ensure 3/5 staff members reviewed possessed knowledge, skills, & competencies required for resident care needs placing residents at risk of impaired care

- Training records for 3/5 CNAs lacked evidence of facility's procedure checklist r/t direct care of residents; Adm Nurse stated facility had skills check-off previous summer & not all employees attended & facility had not rescheduled or completed any further competencies for staff who did not attend; failed to ensure 3/5 staff members reviewed possessed knowledge, skills, & competencies required for resident care needs placing residents at risk of impaired care

NE: SS=D: Failed to ensure CNA staff possessed adequate competency & skill for use of slide board for 1 resident who was lowered to ground during slide board transfer placing resident at risk for injury

- Failed to ensure CNA staff possessed adequate competency & skill for use of slide board for 1 resident who was lowered to ground during staff-assisted slide board transfer placing resident at risk for injury

**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 3/5 CNAs reviewed

- 3 CNA personnel files & 3 lacked annual performance reviews in files; failed to complete annual performance review for resident, employed by facility for greater than 1 year

**F756 Drug Regimen Review, Report Irregular, Act On**

SW: SS=D: Failed to ensure consultant pharmacist ID'd 1 resident lacked administration for heart medication

- MAR lacked documented for 70 days of review period indicating staff did not administer Vericiguat medication for health failure & did not notify physician; CP notes lacked documentation r/t resident not receiving Vericiguat as ordered; failed to ensure CP ID'd resident's lack of administration of heart medication

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported lack of appropriate indication or required physician documentation for 1 resident's use of antipsychotic & irregularities for 1 resident's BP & pulse monitoring placing residents at risk for unnecessary meds & related side effects

- EMR lacked documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management & risks vs benefits from Seroquel use; failed to ensure CP ID'd & reported unapproved indication for continued use of resident's antipsychotic med, Seroquel placing resident at risk for unnecessary psychotropic med & related side effects
- POS for Amiodarone with notification parameters; record revealed resident's DBP below ordered parameters & lacked documentation physician notified on 4 occasions from 9-12-24 thru 11-4-24; failed to ensure CP ID'd & reported facility irregularities in resident's BP & pulse monitoring placing resident at risk for unnecessary med side effects

**F757 Drug Regimen is Free from Unnecessary Drugs**

NE: SS=D: Failed to notify physician when 1 resident's BP & pulse were outside physician-ordered parameters placing resident at risk for ineffective med regimens & unnecessary med side effects

- Cited findings noted in F756 r/t lack of physician notification for BPs outside ordered parameters; failed to ensure 1 resident's drug regimen was free from unnecessary drugs when staff failed to notify physician when resident's BP & pulses were out of physician-ordered parameters placing resident at risk for ineffective medication regimens & unnecessary med side effects

**F758 Free from Unnecessary Psychotropic Meds/PRN Use**

SW: SS=D: Failed to obtain stop date from physician use of PRN Lorazepam for 1 resident placing resident at risk for complications r/t psychotropic meds & unnecessary medication

- POS for Lorazepam q 4 hs PRN for agitation or restlessness & order stated duration was "indefinite"; failed to obtain stop date from physician for use of PRN Lorazepam for 1 resident placing resident at risk for complications r/t psychotropic medications & unnecessary medication

NE: SS=D: Failed to ensure appropriate indication or documented physician rationale which included unsuccessful attempts for nonpharmacological symptoms management & risk vs benefits for continued use of resident's antipsychotic med placing resident at risk for unintended effects r/t psychotropic meds

- POS for Seroquel for unspecified dementia with behavioral disturbances, Clonazepam, Remeron, Sertraline; EMR lacked documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management & risk vs benefits for Seroquel use; failed to ensure resident did not receive antipsychotic medication w/o appropriate indication or required physician documentation for use placing resident at risk for unintended effects r/t psychotropic meds

**F760 Residents are Free of Significant Med Errors**

NE: SS=G: Failed to prevent significant med errors for 1 resident who received meds in error; subsequently resident required rehospitalization in ICU placing resident at risk for adverse med effects & other related complications

- Hospital Discharge Summary documented resident admitted to hospital for bradycardia, acute kidney injury & r/o CVA & directed staff to DC HCTZ & Lisinopril; MAR documented resident received HCTZ & Lisinopril; EMR lacked documentation resident's meds had been DC'd from MAR as ordered; resident became unresponsive & required rehospitalization; failed to prevent significant med error for 1 resident when staff failed to DC meds as ordered by physician then administered meds in error resulting in resident's rehospitalization & placed resident at risk for adverse med effects & other related complications

**F804 Nutritive Value/Appear, Palatable/Prefer Temp**

NE: SS=D: Failed to correctly prepare pureed diet for 2 residents that retained both nutritive value & palatability placing affected residents at risk for impaired nutrition or decreased quality of life

- Observed staff prepared purred diets; staff failed to prepared a bread roll per menu; observed staff did not use recipe when preparing meatloaf or vegetables; failed to provide food prepared by methods that conserve nutritive value, flavor & appearance while preparing pureed diet placing affected 2 residents at risk for impaired nutrition

**F812 Food Procurement, Store/Prepare/Serve-Sanitary**

SW: SS=D: Failed to store, prepare & serve food in sanitary manner to prevent possible foodborne illness to residents of facility

- Observed bowls upright & uncovered on cart; no foot operated trash cans by handwashing area; multiple unlabeled & undated food items; undated food items
- Observed dietary staff washed hands, dried hand then took damp disposable towel & wiped countertop of sink off with same towel then lifted lid on garbage can with hand & threw out paper towels; observed dietary staff laid knife on cookbook then picked knife back up & used knife to cut food items
- Observed drain for ice maker not off floor & lying directly on drain cover on floor was visibly dirty
- Observed ovens with black colored debris on bottom & air vent above stove with grease & dust stuck to them & curtains with grease & covered in thick amount of dust on window above prep area & cart in front of window with dishes facing upright
- Observed cutting boards with scratches, gouges & melted area & potholders worn & inner batting exposed

**F849 Hospice Services**

SW: SS=D: Failed to ensure communication process & collaboration between hospice provider & facility for 2 residents to coordinate hospice services provided including visit frequency & assessment, medications, & medical equipment placing residents at risk of impaired end-of-life care

- Hospice CP lacked any mention of hospice services; record lacked information r/t hospice staff assessments, care or visits; failed to ensure communication process & collaboration between hospice provider & facility for 2 residents placing resident at risk of impaired end-of-life care

**F851 Payroll Based Journal**

SE: SS=F: Failed to electronically submit to CMS accurate direct staffing information based on payroll & other verifiable & auditable data in uniform format according to specifications established by CMS r/t LN staffing when facility failed to accurately report weekend staffing for 3 quarters

- PBJ for 3 quarters revealed excessively low weekend staffing; review of staffing schedules revealed staffing was same as during weekdays; failed to electronically submit to CMS accurate direct staffing information based on payroll & other verifiable & auditable data in uniform format according to specifications established by CMS r/ LN staffing information when facility failed to accurately report weekend staffing from 1-1-24 thru 12-31-24

SW: 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 5 days; timesheets revealed LN was on duty 24 hrs/day 7 days/wk; failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

SW: SS=F: Failed to submit complete & accurate staffing information to CMS thru PBJ when facility failed to submit staffing hour data for all nursing personnel by required deadline

- PBJ report documented facility failed to have LN coverage 24 hrs/day on4 days in 1 quarter; facility provided proof of appropriate coverage; failed to accurately submit staffing information to PBJ for 1 quarter for 2024

**F880 Infection Prevention & Control**

SE: SS=F: Failed to provide sanitary dressing change for 1 resident; failed to track & trend infections & causative organisms & failed to store PPE in sanitary manner to prevent spread of infection

- Observed dressing change & LN failed to sanitize overbed table prior to laying supplies on it; failed to ensure staff provided sanitary dressing changes by sanitizing work surface prior to placing dressing supplies
- All UTI infections lacked culture reports, if done & all tx'd with ABT in multiple months; failed to complete Infection Surveillance Monthly Reports to include culture results for causative organisms & failed to determine compliance with McGeers criteria to determine ongoing infections in facility as required
- Observed open box of COVID tests resting directly on floor on multiple occasions; observed open box of plastic gowns used for PPE directly on floor on multiple occasions; failed to store PPE & COVID testing supplies in clean & sanitary manner

SW: SS=F: Failed to implement water management plan to mitigate risk for Legionella; failed to maintain antibiotic tracking system & did not review its infection control policies annually placing residents of facility at risk for infection

- IC log lacked documentation of onset, symptoms or cultures for residents on antibiotics
- Facility's Infection Control policy last reviewed on 7-1-21 & Vaccine policy last reviewed on 2-13-23
- Adm verified facility had not followed through with setting up water management program to address legionella risk; failed to implement water management plan to mitigate risk for Legionella & failed to maintain antibiotic tracking system & review infection control policies at least annually placing all residents of facility at increased risk for infection

**F881 Antibiotic Stewardship Program**

SE: SS=D: Failed to ensure staff followed principles of antibiotic stewardship to ensure residents received appropriate antibiotics for causative organisms

- Failed to obtain culture results to ensure appropriate use of Macrodantin ordered on 4-3-24 was effective to ensure antibiotic stewardship to prevent multidrug resistant bacterial infections for incontinent residents with UTIs

**December, 2024**

**F550 Resident Rights/Exercise of Rights**

SW: SS=D: Failed to ensure 1 resident's right to be treated with respect & dignity when resident's clothing protector was not removed after meal was finished; also failed to ensure dignified dining experience for 1 resident when staff stood over resident instead of sitting beside resident placing residents at risk for negative psychosocial outcomes & decreased dignity

- Failed to ensure 1 resident's right to be treated with respect & dignity when resident's clothing protector was not removed after meal was finished placing resident at risk for negative psychosocial outcomes & decreased dignity
- Failed to ensure 1 resident's dignity when staff stood over resident to give resident a drink of juice & staff did not interact placing resident at risk for impaired dignity & decreased psychosocial wellbeing

SW: SS=D: Failed to promote dignity for 1 resident when staff referred to resident as "feeder" & stood to assist resident with meal placing resident at risk for impaired dignity

- Failed to promote care for 1 resident in manner to maintain & enhance dignity & respect placing resident at risk for impaired dignity

**F558 Reasonable Accommodations Needs/Preferences**

NE: SS=D: Failed to utilize & ensure appropriate use of foot pedals during w/c transports for 3 residents placing residents at risk for preventable accidents & injuries

- Failed to use & ensure appropriate use of foot pedals during w/c transports for 3 residents placing resident at risk for preventable accidents & injuries

NE: SS=E: Failed to ensure residents were provided foot pedals during w/c transports for 6 residents placing residents at risk for preventable accidents & injuries due to unmet care needs

- Failed to utilize & ensure foot pedals were provided & used during w/c transports for 6 residents placing residents at risk for preventable accidents & injuries due to unmet care needs

**F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive**

SW: SS=E: Failed to verify valid advance directives for 3 residents with potential to lead to uncommunicated needs specifically to end-of-life care

- Resident with BIMS of 6; Banner of EMR indicated resident with "valid DNR order"; POS lacked DNR order; documents lacked valid DNR
- Resident with BIMS of 99; Banner of EMR documented resident had valid DNR order; POS lacked DNR order; documented lacked valid DNR for multiple residents
- Failed to verify valid advance directives &/or DNR orders for 3 residents with potential to lead to uncommunicated needs r/t end-of-life care

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

SW: SS=D: Failed to notify 1 resident's guardian of changes r/t addition of psychotropic meds placing resident at risk for uninformed care choices or inability to consent or decline treatment

- POS for Lorazepam gel q 8 hrs PRN for anxiety & order lacked stop date; record lacked evidence guardian notification for new Ativan get order; failed to notify 1 resident's guardian of changes r/t addition of psychotropic meds placing resident at risk for uninformed care choices or inability to consent or decline treatment

**F582 Medicaid/Medicare Coverage/Liability Notice**

SW: SS=D: Failed to provide CMS Form 10055 (ABN) to resident/representative for 1 resident placing residents at risk for uninformed decisions r/t skilled services

- Failed to provide 1 resident with ABN form CMS 10055 as required placing residents at risk for uninformed decisions r/t skilled services

**F583 Personal Privacy/Confidentiality of Records**

NE: SS=D: Failed to keep 1 resident's protected health information (PHI) private on med cart parked in DR placing resident at risk for impaired privacy

- Observed med cart parked in DR with laptop computer sitting on top & LN walked away from cart & into DR & left computer screen unlocked & open & 1 resident's PHI on screen visible to all who passed by cart; information included resident's meds, date of birth, allergy information & code status; failed to keep & maintain 1 resident's privacy r/t PHI placing resident at risk for impaired privacy

**F600 Free from Abuse & Neglect**

SE: SS=D: Failed to ensure all residents remained free from abuse when 1 resident stomped on other resident's foot after other resident who was cognitively impaired went into resident's room placing residents at risk for injury & ongoing abuse

- NN documented resident reported had stomped on other resident's foot several times with other resident entered resident's room & staff educated resident not to do that; NN documented other resident had her foot stomped on by resident & resident w/o c/o pain or any other discomfort; incident not reported to SA or other agencies; failed to prevent resident-to-resident abuse when resident stomped on other resident's foot several times placing residents at risk for injury & ongoing abuse

**F609 Reporting of Alleged Violations**

SE: SS=D: Failed to ID a resident-to-resident incident as abuse & report immediately to Adm when 1 resident stomped on other cognitively impaired resident's foot after other resident who was cognitively impaired went into resident's room placing residents at risk for unidentified & ongoing abuse

- Cited findings in F600 r/t resident stomping on cognitively impaired resident's foot; failed to ID resident-to-resident incident as abuse & failed to report incident immediately to Adm when resident stomped on other resident's foot after other resident went into resident's room placing residents at risk for unidentified & ongoing abuse

**F610 Investigate/Prevent/Correct Alleged Violation**

SE: SS=D: Failed to provide protective measures & failed to investigate incident of resident-to-resident abuse by 1 resident who stomped on other resident's root after other resident who was cognitively impaired went into resident's room placing residents at risk for unidentified & ongoing abuse

- Cited findings noted in F600 & F609 r/t 1 incident; failed to provide protective measures & investigate incident of resident-to-resident abuse by 1 resident who stomped on other resident's foot after other resident went into resident's room placing residents at risk for injury & ongoing abuse

**F623 Notice Requirements Before Transfer/Discharge**

SE: SS=E: Failed to notify resident/representative in writing of reason for facility-initiated discharge; further failed to send copy of notice to State LTC Ombudsman for 6 residents placing residents at risk for uninformed care choices & impaired rights

- Failed to notify residents/representative in writing of reason for facility-initiated transfer/discharge & further failed to notify LTC Ombudsman for 6 residents placing residents/representatives at risk for uninformed care choices & impaired rights

SE: SS=D: Failed to provide written notification for facility-initiated transfers & further failed to notify Office of LTC Ombudsman (LTCO) when 3 residents discharged to hospital placing residents at risk for uninformed care decisions & impaired resident rights

- Records lacked evidence resident/representatives were provided written notice of transfer when 3 residents were transferred to hospital & facility unable to provide evidence of written notification of transfers or notification of LTCO

SW: SS=D: Failed to notify State LTC Ombudsman (LTCO) for 1 resident's facility-initiated discharge to hospital placing resident at risk for impaired rights

- Failed to notify the LTCO of 1 resident's facility-initiated discharge to hospital placing resident at risk for impaired rights

**F625 Notice of Bed Hold Policy Before/Upon Transfer**

SE: SS=E: Failed to provide 6 residents with written information r/t facility bed hold policy when residents were transferred to hospital placing 6 residents at risk for not being permitted to return & resume residence in nursing facility

- Failed to provide 6 residents with copy of facility bed hold policy when residents were transferred to hospital placing residents at risk for not being permitted to return & resume residence in nursing facility

**F641 Accuracy of Assessments**

SE: SS=D: Failed to ensure accuracy of MDS assessment for 2/14 residents; 1 resident with inaccurate assessment r/t impairment in extremities & 1 resident with inaccurate assessment r/t use of positioning bars as restraint

- BIMS 5 & MDS documented resident used 2 bed rails daily & was marked as restraint; Restraint Assessment documented resident used ¼ rails to promote independence/participation with bed mobility & documented side rails did not prevent resident from getting in & out of bed; observed resident used rail for bed mobility & transfers; failed to ensure 1 resident's use of positioning rail was accurately coded as not a restraint on MDS
- Failed to accurately assess 1 resident's impairment in upper extremity as required

SW: SS=D: Failed to ensure significant change MDS for 1 resident was accurately coded as required by RAI Manual placing resident at risk for inaccurate CP & unmet care needs

- Resident with dx of ESRD & gastrostomy; Sig Change MDS documented resident with BIMS of 8 & resident on physician-prescribed weight gain regimen; MDS section K0529 Nutritional Approaches lacked documentation of feeding tube & % of calories & amount of fluids provided per feeding tube; Tube Feeding CAA not triggered; failed to ensure 1 resident's significant change MDS accurately coded as required by RAI Manual placing resident at risk for inaccurate CP & unmet care needs

SW: SS=E: Failed to accurately complete MDS for 3 residents: 1 r/t behavioral & emotional needs; 1 r/t O2 not captured; 1 r/t section GG coded correctly

- Annual & Quarterly MDS revealed resident's behaviors not captured on MDS
- Annual MDS O2 not captured on MDS
- Quarterly MDS section GG not captured correctly; failed to accurately complete MDS for 3 residents placing residents at risk for uncommunicated care needs

**F656 Develop/Implement Comprehensive Care Plan**

SE: SS=D: Failed to ensure staff developed & implemented comprehensive CP for 1 resident that included care & interventions for dialysis; failed to develop & implement comprehensive CP for 1 resident to address DM & insulin use placing 2 residents at risk of impaired care due to uncommunicated care needs

- CP lacked care focus & staff direction for resident's dialysis care; failed to ensure staff developed & implemented a comprehensive CP for 1 resident that included care & interventions fore dialysis placing resident at risk for impaired care due to uncommunicated care needs
- CP lacked direction for diabetic conditions & insulin use; failed to develop a person-centered CP for 1 resident's DM & use of insulin placing resident at risk for diabetic complications due to uncommunicated care needs

**F657 Care Plan Timing & Revision**

SE: SS=D: Failed to review &/or revise CPs for 2 residents: 2 residents to include EBP r/t residents with catheters & nephrostomy tubes

- CP lacked instruction to staff r/t required use of EBP & associated PPE during provision of care for resident with indwelling catheter to prevent cross contamination & spread of infection; failed to review &/or revise CPs for 1 resident r/t EBP PPE provided for residents with catheters
- Failed to review & revise 1 resident's CP to include EBP as required for resident with nephrostomy catheter

**F660 Discharge Planning Process**

SW: SS=D: Failed to ensure active discharge planning occurred for 1 resident with risk for miscommunication of discharge goals & missed services for 1 resident

- CP w/o plans to discharge from facility; CP documented family did not feel resident would ever return home to live; EMR lacked evidence of active discharge planning prior to discharge; failed to ensure active discharge planning occurred for 1 resident with risk for miscommunication of discharge goals & missed services for 1 resident

**F676 Activities of Daily Living (ADLs)/Maintain Abilities**

SE: SS=D: Failed to ensure 1 resident received assistance eating meal placing resident at risk for choking, impaired nutrition & further decline in ADL ability

- Observed memory care unit with 2 CNAs while dietary staff & Adm staff passed meal trays at 9:05am; at 9:10am 2 residents sat at DR table waiting for breakfast; at 9:14am 1 resident provided meal & other cognitively impaired resident started feeding resident small bites of meal then held up other resident's cup to provide drink then continued to assist other resident until 9:30am when Adm staff told LN to tell resident not to assist other resident with meal; LN went to table & told resident not to assist other resident then went to table & told both residents that other resident able to feed self & resident not to assist other resident but LN did not offer to assist other resident; at 9:58am observed other resident trying to feed self oatmeal with hands & made a mess; other resident not wearing clothing protector; failed to ensure staff provided 1 resident with necessary ADL assist with meal placing resident at risk for choking, impaired nutrition & further decline in ADL ability

SW: SS=D: Failed to ensure staff provided appropriate & safe assistance with ADLs to 1 resident during transfer resulting in bruises to both arms placing resident at risk for decreased ADL ability, pain & psychosocial distress

- Resident on hospice, dependent for cares; CP'd for use of Hoyer lift for transfers; CP lacked use of gait belt or how many staff required for transfers; documentation that hospice nurse contacted Adm Nurse to report hospice aide reported that CNA

transferred resident in "rough manner" & that resident had purple mark in shape of thumb on each arm; resident reported CNA transferred resident & resident wanted pads in chair smoothed out but CNA did not smooth them out & CNA used resident's upper arms to transfer resident to chair & resident had bruise in shape of thumb on each upper arm; failed to ensure staff provided appropriate & safe ADL assistance to 1 resident during transfer which resulted in bruises to both resident's arms placing resident at risk of decreased ADL ability, pain & psychosocial distress

SW: SS=E: Failed to accurately revise 4 residents' CPs after psychotropic med changes for 3 resident; facility did not revise CP for 2 residents to reflect PU interventions placing residents at risk for uncommunicated care needs

- CP lacked revision for open area noted to mid-back area when re-admitted to facility
- CP lacked revision to include: psychotropic med orders/changes including Prozac ordered & DC'd; Lorazepam ordered & order to decares doses & eventually DC; Seroquel ordered then DC'd; Trazodone ordered for depression; EMR revealed CP lacked revisions to reflect changes in psychotropic meds when meds DCd but remained on CP; & Lexapro added but not added to CP
- Failed to revise 4 residents' CPs after PU injuries occurred for 2 resident; failed to revise CP for 3 residents r/t psychotropic med changes

NE: SS=D: Failed to revise 1 resident's CP to reflect increased behavioral episodes; additionally failed to revise 1 resident's CP to reflect sleeping preferences placing both residents at risk for impaired care due to uncommunicated care needs

- NN documented resident with aggressive behaviors towards staff on multiple occasions; failed to revise resident's CP to reflect increased behavioral concerns & interventions placing resident at risk for impaired care due to uncommunicated care needs
- CP lacked preferences or indications for sleeping & napping on couches in areas other than 1 resident's room & when resident yelled out for help; observed resident laying on couch in hallway with blanket & pillow & resident yelling out for help on multiple occasions; CNA stated did not have access to Kardex & stated LN keeps all CNAs updated on any changes with each resident; staff reported resident likes to sleep on couches & at times yells for help; failed to revise resident's CP with preferred preferences for napping on couches in common areas or for behavior of yelling out for help placing resident at risk for impaired care due to uncommunicated care needs

**F677 ADL Care Provided for Dependent Resident**

NE: SS=D: Failed to ensure staff assisted resident with grooming placing resident at risk for impaired dignity & further decline in ADLs

- EMR consistently documented resident refusal for showering; observed resident in DR & hair matted at back of head & top of hair sticking straight up; resident stated would take a shower & unable to comb own hair; failed to ensure staff assisted resident with grooming placing resident at risk for impaired dignity & further decline in ADLs

**F677 ADL Care Provided for Dependent Residents**

SW: SS=G: Failed to provide necessary services to maintain good personal hygiene for 1 resident placing resident at risk for poor personal hygiene & related complications; also failed to assist resident to DR for meals or provide assistance with meals in room to help prevent 10.75% weight loss over 4 months

- Resident with BIMS of 8, dependent with lower body dressing & maximum assist with all other cares except eating which required setup or clean up assist & resident frequently incontinent of B/B; POS lacked active orders specific to ADL cares; observed resident in DR in geri-chair & resident called out to staff & stated needed assist to BR for BM which was unacknowledged by any staff present in area; 5 minutes later resident called out to staff stating had soiled brief which was unacknowledged by any staff present in area; 10 minutes later unknown staff member assisted resident from left leaning to upright position & placed pillow; resident stated buttocks hurt & needed to use BR & staff did not acknowledge resident's statement; 15 minutes later resident cried out to alert staff needed to use BR; for 56 minutes resident sat in geri-chair & cried out to alert staff & staff responded by asking resident if he was hungry & provided additional food; resident continued to stated needed to use BR but was unacknowledged & unassisted by staff; after 1 hour 26 minutes after resident indicated needed to use BR & 1 hour 21 minutes after resident stated soiled brief before assist provided; LN stated resident's groin & intergluteal fold with redness with MASD; failed to ensure staff provided prompt ADL care to dependent resident when resident requested toileting & staff did not provide requested toileting care for 1 hour 26 minutes placing resident at risk for poor personal hygiene & risk for skin breakdown
- Resident with documented weight loss from 93 #'s 8-6-24 to 83.1 #'s 12-2-24; last 2 weight recordings 14 days apart; observed resident not assisted to DR for meals; failed to initiate weight loss interventions for cognitively impaired resident who had ID'd weight loss of 10.75% in 4 months with potential to negatively affect resident's physical wellbeing

**F679 Activities Meet Interest/Needs Each Resident**

NE: SS=E: Failed to provide consistent weekend activities on Saturdays to promote socialization placing affected residents at risk for decreased psychosocial wellbeing, boredom & isolation

- Activity Calendar recorded no activities for 2 Saturdays in October, 3 Saturdays in November; December with no Saturday activities; Resident Council reported not many activities on weekends & residents stayed in rooms & watched TV & weekends get "very long & boring"; failed to provide consistent weekend activities for residents to promote socialization placing affected residents at risk for decreased psychosocial wellbeing, boredom & isolation

**F684 Quality of Care**

SE: SS=D: Failed to follow up with physician for direction when 1 resident became ill with productive cough & coarse lung sounds placing resident at risk for physical decline & complications due to delayed physician involvement

- EMR lacked documentation staff followed up with physician when did not receive direction from physician for resident's cough; failed to follow up with physician after staff had not received response r/t 1 resident's productive cough placing resident at risk for further physical decline & complications due to delayed physician involvement

**F686 Treatment/Services to Prevent/Heal PU**

SW: SS=D: Failed to ensure 1 resident's heels were offloaded eight by boots or a pillow & further failed to ensure 1 resident was provided a pressure-reducing cushion for w/c placing 2 residents at increased risk for PU development & delayed healing

- Admission MDS documented resident with Stage 1 PU & unhealed PU on admission; POS for offloading heels; record lacked documentation resident refused offloading of heels; observed resident on multiple occasions with heels not offloaded; resident unaware of offloading order; failed to ensure 1 resident's heels were offloaded either by boots or pillow placing resident at increased risk for PU development & delayed healing
- CP documented resident to have pressure-reducing device in chair/w/c & pressure-reducing mattress; observed resident in DR in w/c w/o cushion in place; failed to ensure 1 resident had cushion in w/c placing resident at increased risk for PU development

SW: SS=G: Failed to prevent development of PUs & failed to provide treatment to promote healing for 2 resident who both developed PUs while resident at facility

- LN confirmed no treatment orders or dressing orders for any of 1 resident's wounds; failed to document & place interventions to prevent worsening & address pressure injuries for 1 resident who developed preventable stage 3 pressure injury
- Resident with air mattress; observed air mattress plugged in, green light on & dial setting set at 4; on 12-9 resident reported air mattress had been flat since 12-8 & resident stated had not said anything to staff about bed not inflated; failed to place appropriate weight-based intervention to prevent pressure injuries for 1 resident who developed multiple preventable, facility-acquired stage 2 pressure injuries; additionally facility failed to monitor, measure & assess resident's skin consistently placing resident at risk to worsen current PUs &/or develop more skin issues

NE: SS=D: Failed to ensure 1 resident's low air-loss mattress was set at appropriate weight for pressure reduction placing resident at increased risk for PU development & delayed healing

- Record lacked evidence of monitoring of resident's low air-loss mattress; observed resident in bed & low air-loss mattress pump set at 320 #'s & had setting to adjust in 30-pound increments; failed to ensure 1 resident's low air-loss mattress was set at correct weight wetting to prevent PUs placing resident at increased risk for PU development

NE: SS=D: Failed to ensure pressure-reducing heel protectors or boots were in place for 1 resident w ho had pressure-related injury on left heel placing resident at risk for complications r/t further skin breakdown & worsening of PUs

- CP instructed staff to apply bilateral heel protectors to 1 resident's feet when out of bed & Thera-boots when in bed in response to POS for boots; observed resident w/o heel protectors in place in both Broda chair & in bed; failed to ensure pressure-reducing heel protectors & boots were in place for 1 resident with pressure injury on left heel placing resident at risk for complications r/t skin breakdown & worsening PUs

**F689 Free of Accident Hazards/Supervision/Devices**

SE: SS=D: Failed to ensure 1 resident's low air loss mattress was functioning which resulted in avoidable fall; further failed to ensure 1 resident was assessed for safe use of recliner or need for updated toileting interventions after sustaining falls to prevent further falls placing 2 residents at risk for preventable falls & possible injuries

- Failed to ensure 1 resident's low air-loss mattress was functioning properly which resulted in resident rolling out of bed, an avoidable fall placing resident at risk for preventable falls & possible injuries
- Resident with multiple falls r/t recliner & self-toileting; failed to implement interventions to prevent falls from 1 resident's lift recliner & further failed to ID toileting needs as causative factor for repeated falls & failed to implement a plan to reduce toileting-related falls placing resident at risk for further falls & injury

SE: SS=G: Failed to ensure staff secured 1 resident in w/p bath chair which resulted in fall from chair onto floor & resident obtained forehead laceration that required 8 sutures in ER

- Failed to ensure staff used safety belt for 1 resident during transfer out of w/p bath resulting in fall with laceration & required 8 stitches

SW: SS=E: Failed to ensure safe environment free from accident hazards for 2 residents; additionally failed to implement CP'd fall interventions for 2 residents placing residents at risk for preventable falls & injuries

- Failed to ensure 1 resident's environment was free from accident hazards when staff intentionally placed bed in high position to try to prevent resident from getting into bed by self placing resident at risk for preventable accidents & injuries; failed to ensure 1 resident's bed was maintained at a safe height for fall prevention
- Failed to ensure 1 resident's Dycem was placed in w/c to prevent falls placing resident at risk for continued falls & related injuries
- Failed to ensure 1 resident's fall mat was placed beside bed per CP placing resident at risk for fall-related injuries

SW: SS=D: Failed to ensure environment free from accident hazards when staff left container of toilet bowl cleaner, a container of Comet, 2 aerosol spray deodorants & a container of Virex in unlocked wooden cabinet placing 2 cognitively impaired, independently mobile residents at risk for preventable accidents or injuries

- Failed to ensure environment free from accident hazard when staff stored harmful chemicals in unlocked cabinet placing 2 cognitively impaired, independently mobile residents at risk for preventable accidents or injuries

SW: SS=D: Failed to ID & remove accident hazards for 3 dependent residents: 1 resident r/t staff not using fall mats as directed, 1 resident with incorrect use of mechanical lift & 1 resident left unattended with disposable razor in reach & emergency call light out of reach with potential to lead to accidents that would negatively affect resident's physical & psychosocial wellbeing

- Failed to ID & remove accident hazards for 1 resident when staff failed to ensure resident had emergency call light within reach & failed to remove disposable razor from resident's bedside & outside of reach for resident
- Failed to provide environment free of accident hazards when on 12-11-24 staff failed to correctly use full mechanical lift with resident with potential to lead to accidents that would negatively affect resident's physical psychosocial wellbeing when staff failed to stabilize resident by operating lift at angle from chair if chair would not fit between legs of lift & unaware of policy for correct procedure

*NE: SS=G (Past Non-Compliance): Failed to prevent an avoidable accident on 12-16-24 when CNA propelled resident in w/c w/o using foot pedals; resident planted feet, leaned forward then fell out of w/c hitting floor resulting in ER visit where mildly displaced bilateral nasal bone fx's as a result of fall also placing resident at risk for pain*

- *Witness Statement included that resident's foot pedals on chair but not in use at time of incident; failed to prevent avoidable accident for 1 resident when staff failed to use foot pedals during w/c propulsion resulting in fall with nasal bone fx's for resident & also placing resident at risk for pain*
- *Past Non-Compliance Plan:*
  - *Updated resident's CP to include foot pedal usage*
  - *Educated nursing staff on using foot pedals during staff w/c propulsion*
  - *Cited CNA received corrective action*

NE: SS=E: Failed to secure electrical panels & cleaning chemicals in safe, locked area & out of reach of 10 cognitively impaired, independently mobile residents; additionally failed to provide adequate supervision for 2 resident's CP's fall interventions r/t w/c placement placing affected residents at risk for preventable accidents & injuries

- Failed to secure electrical panels & cleaning chemicals in safe, locked area & out of reach of 10 cognitively impaired, independently mobile residents placing affected residents at risk for preventable accidents & injuries
- Resident with high fall risk with multiple unwitnessed falls; resident with fall when resident fell while trying to toilet self in shower room directly across hall from resident & shower room had sign indicating door was to be secured at all times but door unsecured when inspected; failed to ensure consistent supervision for 1 resident resulting in fall in unsecured shower room placing resident at risk for preventable accidents & injuries
- Failed to ensure 1 resident's w/c was placed next to resident per resident's CP to prevent further falls placing resident at risk for falls & fall-related injuries

NE: SS=D: Failed to ensure safe care environment r/t use of 1 resident's fall prevention interventions for w/c placing resident at risk for preventable falls & injuries

- CP instructed staff to use Dycem in recliner & w/c to prevent slips & falls; observed resident with fall alarm in place & Dycem mat under resident in recliner; w/c revealed pressure relieving mat but lacked Dycem mat on multiple occasions; failed to ensure 1 resident's CP'd fall interventions were in place placing resident at risk for preventable falls & injuries

**F690 Bowel/Bladder Incontinence, Catheter, UTI**

SW: SS=D: Failed to provide services consistent with standards of care for 1 resident's urinary catheter placing resident at risk for catheter-related complications & UTI

- CP lacked guidance to use EBP; observed CNA washed hands & applied gloves to perform catheter care but did not don gown; observed resident in DR with catheter tubing resting on floor on multiple occasions; failed to provide services consistent with standards of care for 1 resident's urinary catheter placing resident at risk for catheter-related complications & UTI

**F692 Nutrition/Hydration Status Maintenance**

SE: SS=D: Failed to ensure 1 resident's physician-ordered fluid restriction was followed, monitored & documented placing resident at risk for fluid overload & related complications

- CP documented resident on carb controlled, regular texture diet, thin liquids & 12cc fluid restriction; CP lacked care focus & staff direction for dialysis care; TAR for Oct, Nov, & Dec lacked evidence of monitoring & documentation that reflected 1 resident's daily fluid intake value; EMR lacked staff documentation of resident's compliance with fluid restriction; failed to ensure 1 resident's fluid intake r/t fluid restriction was followed, monitored & documented placing resident at risk of fluid overload & related complications

SW: SS=G: Failed to initiate weight loss interventions for cognitively impaired resident who had ID'd weight loss of 10.75% in 4 months with potential to negatively affect resident's physical wellbeing

- Cited findings noted in F677 r/t to resident's unplanned weight loss; failed to initiate weight loss interventions for cognitively impaired resident who had ID'd weight loss of 10.75% in 4 months with potential to negatively affect resident's physical wellbeing

**F695 Respiratory/Tracheostomy Care & Suctioning**

SW: SS=D: Failed to ensure 1 resident's physician-ordered supplemental O2 supply was turned on; failed to ensure 1 resident's CPAP was stored appropriately when not in use placing 2 residents at risk of respiratory complications & possible infection

- Failed to ensure 1 resident's physician-ordered supplemental O2 supply was turned on placing resident at risk for respiratory complications & possible infection
- Observed resident's CPAP mask & tubing laid directly on CPAP machine on bedside table next to bed; failed to ensure 1 resident's CPAP mask was stored in sanitary manner placing resident at increased risk for respiratory infection & complications

SW: SS=E: Failed to provide respiratory care & services including safe handling, storage & dispensing of O2 consistent with professional standards of practice for 5 residents to prevent spread of illnesses

- Observed O2 tubing unused & unbagged & stored in contaminated places including back of concentrator & on floor; failed to provide respiratory care & services including safe handling, storage & dispensing O2 consistent with professional standards of practice for 5 residents to prevent spread of illnesses

**F698 Dialysis**

SW: SS=D: Failed to monitor 1 residents' access site for complications at least daily & document AV fistula for thrill & bruit every day placing resident at risk of adverse outcomes & physical complications r/t dialysis

- Record lacked evidence of daily assessment of 1 resident's AVF & monitoring of thrill & bruit; failed to monitor 1 resident's dialysis access site for thrill, bruit & signs of infection, bleeding, & status of dressing in place placing resident at risk of potential adverse outcomes & physical complications r/t dialysis

**F699 Trauma Informed Care**

SE: SS=D: Failed to ID trauma-based triggers r/t 1 resident'
S PTSD & failed to implement individualized interventions to prevent re-traumatization placing resident at risk for decreased psychosocial wellbeing & ineffective treatment

- Failed to ID trauma-based triggers r/t 1 resident's history of trauma & failed to implement individualized interventions to prevent re-traumatization placing resident at risk for decreased psychosocial wellbeing & ineffective treatment

SW: SS=D: Failed to ID trauma-based triggers r/t 2 resident's PTSD & failed to implement individualized interventions to prevent re-traumatization placing 2 residents at risk for decreased psychosocial wellbeing & ineffective treatment

- EMR documented resident with history of trauma & intervention would be staff would recognize specific triggers & avoid re-traumatization; CP lacked individualized interventions that ID'd ways to decrease exposure to triggers that could re-traumatize resident; multiple staff unaware of resident's history of trauma; failed to ID trauma-based triggers r/t resident's history of trauma & failed to implement individualize interventions to prevent re-traumatization placing resident at risk for decreased psychosocial wellbeing & ineffective treatment
- EMR lacked evidence of Trauma Informed Care Assessment; resident with dx of PTSD; staff unaware of resident's PTSD dx; failed to ID trauma-based triggers r/t resident's dx of PTSD & failed to implement individualized interventions to prevent re-traumatization placing resident at risk for decreased psychosocial wellbeing & ineffective treatment

SW: SS=D: Failed to complete a trauma-informed care assessment & develop a trauma-informed CP for 2 residents who had dx of PTSD placing residents at risk for unmet behavioral & mental health needs

- Resident with PTSD, depression, anxiety, OCD; EMR lacked evidence trauma-informed care assessment completed; CP lacked interventions r/t PTSD to ID triggers & prevent re-traumatization; Adm Nurse unaware resident had PTSD & unaware of what assessments were required; failed to complete trauma-informed care assessment & develop trauma-informed CP for 1 resident with dx of PTSD placing resident at risk for unmet behavioral & mental health needs
- Resident with PTSD, depression, anxiety & schizophrenia; EMR lacked evidence a trauma-informed care assessment completed after admission; CP lacked interventions r/t resident's PTSD to ID triggers & prevent re-traumatization; staff unaware resident with PTSD; failed to complete trauma-informed care assessment & develop trauma-informed CP for 1 resident with dx of PTSD placing resident at risk for unmet behavioral & mental health needs

**F700 Bedrails**

NE: SS=D: Failed to ensure 1 resident had safety assessment for use of side rails that acknowledged risks when used with loss air-loss mattress placing resident at risk for uninformed decisions & impaired safety r/t risks associated with use of siderails

- CP documented resident with low air-loss mattress & positional rail mounted on side of bed; siderail screening failed to acknowledge use of low air-loss mattress; failed to ensure that 1 resident had safety assessment for use of side rails that acknowledged risks when used with low air-loss mattress placing resident at risk for uninformed decisions & impaired safety r/t risks associated with use of low air-loss mattress with siderails

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

NE: SS=E: Failed to ensure 1/5 CNA staff reviewed had yearly performance evaluations completed placing residents at risk for inadequate care

- 1 CNA, hired 9-5-23 had no yearly performance evaluation; failed to ensure 1/5 CNAs had required year performance evals completed placing residents at risk for inadequate care

**F742 Treatment/Services for Mental/Psychosocial Concerns**

SW: SS=D: Failed to provide necessary behavioral health care & services to attain or maintain highest practicable physical, mental & psychosocial wellbeing for 1 resident who had been sad & tearful since admission on 6-28-23

- POS for Sertraline routinely & Buspirone routine for anxiety; POS lacked order to monitor & document targeted behaviors; NN documented resident upset & requested phone that daughter removed from facility & resident offered cordless phone to call family member; NN documented resident requested to speak to therapist to discuss resident's depression; resident sated was sad with tears in eyes & reported had to live at facility did not know why then started to cry; resident stated never saw family members & reported no one cared; failed to provide necessary behavioral health care & services to attain or maintain highest practicable physical, mental & psychosocial wellbeing for 1 resident who remained tearful & sad since admission to facility on 6-28-23

**F744 Treatment/Service for Dementia**

SW: SS=D: Failed to provide dementia-related behavioral services for 1 resident to promote resident's highest practicable level of wellbeing placing resident at risk for decreased quality of life, isolation & impaired dignity

- Resident with Alzheimer's disease; CP lacked potential triggers or causes for behaviors toward others & individualized non-pharmacological interventions to prevent repeated behaviors around meal services; CP lacked techniques r/t redirecting resident during confusion & agitation; failed to provide dementia-related behavioral services for 1 resident to promote highest practicable level of wellbeing placing resident at risk for decreased quality of life, isolation & impaired dignity

**F756 Drug Regimen Review, Report Irregular, Act On**

SE: SS=E: Failed to ensure CP ID'd & reported 2 residents' BP meds were administered outside physician-ordered parameters & 2 resident's use of antipsychotic with unapproved dx placing residents at risk for inappropriate use of medication & related complications

- Failed to ensure CP ID'd & reported that resident's BP meds were administered outside physician-ordered parameters placing resident at risk for unnecessary medication use & related complications for 2 residents
- Failed to ensure CP ID'd & reported that 1 resident's administration of Quetiapine for dx of dementia placing resident at risk of unapproved medication use for 2 residents

SW: SS=D: Failed to ensure Consultant Pharmacist (CP) recommendations were acknowledged &/or acted on for 1 resident placing resident at risk for unnecessary medication use & possible adverse side effects

- POS for Ativan 0.5mg PRN for anxiety/restlessness; order lacked stop date; MRR addressed requirement for rationale for continued availability & specific further stop date for Ativan; lacked documentation physician reviewed & addressed CP's recommendations; failed to ensure CP recommendations had been addressed for 1 resident's PRN Ativan which lacked stop date placing resident at risk for adverse side effects of psychotropic med & unnecessary meds

SW: SS=E: Failed to ensure CP Idd & reported lack of required stop date for 4 resident's PRN antianxiety medication; failed to acknowledge & follow up on CP's request for dx for 1 resident's Effexor & Haldol placing residents at risk for inappropriate or unnecessary use of meds & related side effects

- POS for Ativan 0.5mg q 4 hrs, PRN for anxiety; order lacked stop date; MRR for 4 months had no recommendations r/t resident's PRN Ativan; failed to ensure CP ID'd & reported that 1 resident's PRN Ativan lacked stop date placing resident at risk for inappropriate or unnecessary use of meds & related side effects for multiple residents
- POS for Hydroxyzine 25mg q 12 hours PRN for anxiety; order lacked stop date; MRR w/o recommendations r/t PRN hydroxyzine use; failed to ensure CP ID'd & reported that resident lacked physician rationale for use of PRN hydroxyzine for 1 resident's anxiety with no stop date placing resident at risk for inappropriate or unnecessary use of meds & related side effects
- POS for Haldol 1mg q hs for antipsychotic & Effexor for depression; Record lacked physician's response to CP's recommendation to address lack of dx for use of Haldol & Effexor; failed to acknowledge & respond to CP's recommendation to add indication of use for 1 resident's Haldol & Effexor placing resident at risk of inappropriate us of psychotropic med & related side effects

NE: SS=E: Failed to ensure Consulting Pharmacist (CP) ID'd & made recommendations r/t 4 resident's indications for antipsychotic meds placing residents at risk for unnecessary psychotropic meds & related complications

- CP lacked documentation showing resident with behaviors & non-pharmacological interventions to address documented behaviors; CP lacked documentation r/t antipsychotic meds; POS for Seroquel TID for behavioral disturbances & paranoia r/t dementia; EMR revealed no documented rationale for indicated use of Seroquel for dementia-related behaviors; MRR with no recommendations noting inappropriate indication of use r/t resident's Seroquel medication; failed to ensure CP ID'd & made recommendations r/t 1 resident's inappropriate indication for Seroquel med placing resident at risk for unnecessary psychotropic meds & related complications
- EMR lacked documentation of non-pharmacological interventions tried & failed prior to antipsychotic med & EMR lacked evidence of documentation r/t informed consent for use of antipsychotic med; MRRs lacked evidence CP ID'd & reported resident's antipsychotic med did not have physician-documented rationale or risk vs benefit for continued use of antipsychotic w/o CMS-approved indication; failed to ensure CP ID"d & reported irregularities with 1 resident's Seroquel placing resident at risk for unnecessary med administration , ineffective benefit of med & possible adverse side effects
- Failed to ensure CP ID'd & made recommendations r/t 1 resident's inappropriate indication for Quetiapine Fumarate med placing resident at risk for unnecessary psychotropic meds & related complications when ordered for behavioral d/o's associated with dementia

- Failed to ensure CP ID'd & made recommendations r/t 1 resident's inappropriate indication for Risperidone placing resident at risk for unnecessary psychotropic meds & related complications

**F757 Drug Regimen is Free from Unnecessary Drugs**

SE: SS=D: Failed to hold BP meds per physician-ordered parameters for 2 residents placing residents at risk for physical decline & other related complications

- Cited findings noted in F756; failed to hold BP meds for 2 residents when BP out of physician-ordered parameters placing resident at risk for physical decline & other related complications

SW: SS=D: Failed to follow instructions r/t med monitoring when staff administered 1 resident's antihypertensive meds outside physician-ordered parameters placing resident at increased risk for unnecessary med & side effects

- POS for Amlodipine Besylate p.o. for HTN with holding parameters; POS for Terazosin for HTN with holding parameters; POS for Lisinopril for HTN with holding parameters; facility administered 1 resident's antihypertensive med outside physician-ordered parameters placing resident at increased risk for unnecessary medication & side effects

**F758 Free from Unnecessary Psychotropic Meds/PRN Use**

SE: SS=D: Failed to ensure 2 residents had approved dx or physician-documented rationale which included risk vs benefit for use of Quetiapine placing residents at risk of receiving unnecessary psychotropic medication

- POS for Quetiapine 50mg q hs for dementia with behavioral disturbance; EMR lacked evidence of physician-documented rationale which included risks vs benefits for resident's Quetiapine; failed to ensure 1 resident had approved indication for use or physician-documented rationale including risk vs benefits for use of Quetiapine placing resident at risk of receiving unnecessary psychotropic meds for multiple residents

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

- POS for Seroquel 25mg po q hs for restlessness & agitation ordered on 6-20-24 & DC'd on 8-24-24; Seroquel 50mg po qd for anxiety ordered on 6-20-24 & DC'd on 8-24-24; Seroquel 24 mg po q hs for restlessness & agitation ordered on 8-24-24; resident with AIMS completed on 10-9-24 w/o any further AIMS assessments; staff confirmed facility had not completed AIMS when physician first ordered antipsychotic in June as should have; failed to complete AIMS for monitoring of adverse reactions for 1 resident who received antipsychotic med

SW: SS=D: Failed to ensure PRN psychotropic med had 14-day stop date or specified duration with supporting physician documentation for 2 resident's PRN psychotropic meds placing residents at risk for unnecessary medication administration & possible adverse side effects

- Failed to ensure 1 resident's PRN Ativan had stop date or physician-ordered specified duration for administration placing resident at risk for unnecessary medication administration & possible adverse side effects
- Failed to ensure 1 resident had stop date for PRN Ativan placing resident at risk for unnecessary psychotropic medication administration

SW: SS=E: Failed to ensure 14-day stop date or specified duration for 5 resident's PRN antianxiety meds & failed to get appropriate dx for 1 resident's Effexor & Haldol placing residents at risk for unnecessary meds & related complications

- Cited findings noted in F756; failed to ensure 1 resident's Ativan had 14-day stop date or specified duration with physician rationale for extended use placing resident at risk for adverse medication side effects for multiple residents
- Failed to ensure stop date for PRN Hydroxyzine use for psychotropic qualities placing resident at risk for unnecessary meds & related complications
- Failed to ensure appropriate indication & required physician documentation for continued use of 1 resident's Haldol & Effexor placing resident at risk for unnecessary adverse side effects

SW: SS=D: Failed to complete AIMS assessment for 2/5 residents reviewed for unnecessary meds who received Seroquel; failed to provide rationale r/t why Pharmacy recommendation for GDR for resident's Seroquel was not completed

- Failed to prevent use of unnecessary meds for 1 resident when facility failed to respond appropriately to CP recommendation for GDR; failed to address appropriate dx for antipsychotic med for 1 resident; additionally failed to complete AIMS assessments for 2 resident with potential to lead to uncommunicated needs which could lead to negative impacts on residents' physical, mental & psychosocial wellbeing

NE: SS=D: Failed to ensure 1 resident had CMS-approved indication or required physician-documented rationale including risk vs benefits & nonpharmacological attempts prior to use of antipsychotic med Zyprexa placing resident at risk for unnecessary med administration & possible adverse side effects

- POS for Zyprexa 5mg for delirium & anxiety; EMR lacked physician-documented rationale along with risks vs benefits & nonpharmacological interventions attempted & failed; failed to ensure resident had CMS-approved indication or required physician documented rationale including risks vs benefits for use of Zyprexa placing resident at risk for unnecessary medication administration & possible adverse side effects

NE: SS=E: Failed to ensure appropriate indication or documented physician rationale for 4 resident's antipsychotic meds placing residents at risk for unnecessary meds & related complications

- Cited findings noted in F756 r/t residents with antipsychotic medication orders; Failed to ensure appropriate indication or documented physician rationale for 1 resident's Seroquel medication ordered for behavioral disturbances & paranoia r/t dementia placing resident at risk for unnecessary psychotropic meds & related complications

- Failed to ensure appropriate indication or documented physician rationale for 1 resident's Seroquel medication for major depressive d/o placing resident at risk for unnecessary psychotropic meds & related complications
- Failed to ensure appropriate indication or documented physician rationale for Risperdal for delusions placing resident at risk for unnecessary psychotropic meds & related complications
- Failed to ensure appropriate indication or documented physician rationale for 1 resident's Quetiapine Fumarate for behavioral disturbance r/t dementia placing resident at risk for unnecessary psychotropic meds & related complications

**F759 Free of Medication Error Rated 5% or More**

SE: SS=E: Failed to ensure medication error rate less than 5% placing residents in facility who received meds at risk for physical decline & other related complications

- POS for Amlodipine 5mg qd for HTN with holding parameters; Hydralazine 25mg BID for HTN with holding parameters; HCTZ 12.5mg qd with holding parameters; Losartan 25mg qd with holding parameters; Observed CMA administered all resident's AM meds including antihypertensive meds; CMA stated unsure BP parameters for holding were & BP below ordered holding parameters & CMA verified mistakenly administered resident's BP meds when DBP outside parameters; failed to hold BP meds for 1 resident when BP out of physician-ordered parameters which created observed med error rate of 16% placing residents who received meds at risk for physical decline & other related complications

SW: SS=E: Failed to ensure 2/4 households observed & reviewed during med administration pass remained free of medication errors; 42 med opportunities observed with 15 med errors ID'd placing residents at risk for adverse reactions from meds & resulted in med error rate of 35.71%

- Observed LN administered meds via PEG tube when administered with less than water ordered & mixed meds w/o physician order; POS for Prednisone which was not available on 12-11 & LN stated unavailable since 11-29 because resident received meds from VA & had not obtained meds in timely manner; Metoprolol bottle lacked extended-release direction on label per POS; LN reported left meds in room while resident not in room per resident's request & CP lacked any documentation r/t self-administration of meds; failed to ensure 1 resident's meds were administered in secure environment, correct dosage & available med; additionally failed to administer correct water flush to 1 resident & failed to administer correctly; furthermore facility failed to ensure that overall med error rate was below 5% with potential to have negative effect on overall physical & psychosocial wellbeing of residents in facility

**F761 Label/Store Drugs & Biologicals**

SE: SS=E: Failed to ensure meds & biologicals were stored & monitored appropriately in 1/2 med rooms placing affected residents at risk of ineffective med

- 1 med room w/o evidence of fridge temps assessed & recorded for 9/17 days in December; 1 fridge with expired dates on Yogurt; failed to ensure meds & biologicals were stored & monitored appropriately placing residents at risk of ineffective meds

SW: SS=E: Failed to store & label biologicals as required when staff failed to ID & discard 6 expired vials of Prevnar in 1/3 med rooms; further failed to place open date on insulin pens in 1/3 treatment carts placing affected residents at risk of receiving expired & ineffective dose of Prevnar & insulin

- Failed to dispose of 6 expired Prevnar syringes placing residents at risk of receiving an ineffective dose of medication
- Failed to place open date on 4 residents' insulin pens placing residents at risk for receiving ineffective doses of insulin

SW: SS=E: Failed to ensure drugs & biologicals used in facility were labeled & stored in locked compartments & permitted only authorized personnel to have access to keys with potential to affect 3/4 households with expired meds for multi person use & unsecured meds in room of 4 residents

- Failed to ensure drugs & biologicals used in facility were labeled & stored in locked compartments & permitted only authorized personnel to have access to keys with potential to affect 3/4 households with expired meds for multi person use & unsecured meds in rooms of 4 residents

**F801 Qualified Dietary Staff**

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

- 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

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

- 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

**F812 Food Procurement, Store/Prepare/Serve-Sanitary**

SE: SS=F: Failed to prepare, store & serve food in sanitary manner for residents of facility

- Observed multiple expired foods including salad dressing, pickle relish & lunch meat; multiple food items lacked open dates
- Observed soiled trash can with food debris, grime & spillage on lid & other surfaces; rolling door window with dust & grime over entire surface; steam table with accumulation of rust-like discolorations in water bins; storage unit with grime on interior; outside of fridge with sticky substances on handles & smudges on doors; shelf oven with grime & food substances on interior; stove back

splash with brown substance; ovens used for storage with sticky handles; air vents above store with accumulation of sticky substance; shelf with grime; storage unit with food debris & exterior grime; drying rack with steam table food pans stacked on top of each other; ice machine placed directly in drainpipe leading to sewer & lacked 2-inch air gap; dry foods storage with spillage area

- Snack fridge with multiple opened, undated food items & 1 unlabeled food item
- Freezer with smashed ice cream sandwich & accumulation of ice on all interior surfaces
- Snack fridge with multiple opened, undated foods & expired foods & foods with frost accumulation & expired food items
- Snack fruit bowl with apple with rotten stop & oranges with wrinkled skins & undated food items

SE: SS=F: Failed to store food in safe, sanitary manner to prevent contamination or spoilage in main food prep kitchen & storage building with walk-in fridge units placing residents at risk for foodborne illness

- Observed walk-in fridge with food items stored on floor & opened box of desserts on floor; observed freezer with opened, undate4d food items

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

- Observed 1 DR with dirty plates stored on table next to kitchenette's serving window from previous evening's meal service & stack of domed plate covers stored in upward position; observed thickener w/o lid
- Observed staff failed to complete hand hygiene between assisting residents & providing meals

**F838 Facility Assessment**

SE: SS=F: Failed to conduct a thorough facility-wide assessment to determine resources necessary to care for residents competently during both day-to-day operations & non-routine situations that impact staffing & resident care placing all residents residing in facility at risk for impaired care

- Assessment did not identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, on each shift including weekends. The assessment lacked an informed contingency plan for events that do not require activation of the facility's emergency plan but have the potential to impact staffing and resident care. The assessment lacked a plan to maximize recruitment and retention of direct care staff.
- Failed to conduct thorough, updated facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations & events that had potential to impact staffing & resident care placing all residents residing in facility at risk for impaired care

NE: SS=F: Failed to conduct a thorough facility-wide assessment to determine resources necessary to care for residents competently during day-to-day operations & emergencies affecting all residents residing in facility

- Failed to identify the specific staffing levels needed and the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse's Aides (CNA) needed for each unit, shift, and per census. The assessment lacked staffing levels required for each shift, including evenings and weekends; failed to conduct a thorough, updated facility-wide assessment to determine what resources were necessary to care for residents competently during day-to-day operations & emergencies affecting all residents currently residing in facility

**F849 Hospice Services**

SE: SS=D: Failed to ensure collaboration between hospice provider & facility for 2 residents who were admitted to hospice placing residents at risk of inadequate end-of-life care

- Failed to ensure collaboration of care between hospice provider & facility placing resident at risk of inadequate end-of-life care for 2 residents

SE: SS=D: Failed to ensure collaboration between hospice provider & facility for 1 resident r/t CP & services provided including visit frequency, medications, & medical equipment placing resident at risk of impaired end-of-life care

- Hospice CP lacked contact number for hospice, what supplies, equipment & medications hospice would provide; when hospice staff would be in building & what care hospice would provide; failed to ensure collaboration between hospice provide & facility for 1 resident placing resident at risk for impaired end-of-life care

SW: SS=D: Failed to ensure collaboration of care between 1 resident's hospice provider & facility placing resident at risk of inadequate end-of-life care

- Hospice CP lacked staff direction r/t how to collaborate with hospice, what supplies hospice service provided or when hospice staff would make visits; failed to ensure collaboration of care between 1 resident's hospice provider & facility placing resident at risk for inadequate end-of-life care

SW: SS=D: Failed to ensure coordinated care & services provided by facility with care & services provided by hospice for 2 residents placing residents at risk for inadequate end-of-life care

- Record revealed CP stating "care provided by hospice" in communication book; Failed to coordinate care between facility & hospice provider for 1 resident who received hospice services placing resident at risk for inadequate end-of-life care
- CP lacked instruction on services provided by hospice including frequency & type of support visits, supplies & medical equipment provided by hospice, meds covered by hospice & hospice contact information; failed to coordinate care between facility & hospice provider for resident receiving hospice services placing resident at risk for inadequate end-of-life care

NE: SS=D: Failed to ensure coordinated care & services provided by facility with care & services provided by hospice for 2 residents placing residents at risk for inadequate end-of-life care

- CP lacked instruction on services provided by hospice including frequency & type of support visits, supplies & medical equipment provide by hospice, medications covered by hospice & hospice contact information; failed to coordinate care between facility & hospice provider for 2 residents receiving hospice services placing residents at risk for inadequate end-of-life care for 2 residents

**F851 Payroll Based Journal**

SE: SS=F: Failed to electronically submit complete & accurate direct care staffing information including hours of labor for Adm salaried nurse who provided direct care during weekend resulting in inaccurate PBJ r/t low weekend staffing for direct care based on payroll & other verifiable & auditable data in uniform format according to specification established by CMS for 2 quarters of 2024

- Failed to electronically submit to CMS a complete & accurate direct care staffing information including hours of labor for Adm salaried nurse who provided direct care during weekend resulting in inaccurate PBJ r/t low weekend staffing for direct care based on payroll & other verifiable & auditable data in uniform format according to specifications established by CMS for 2 quarters of 2024

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

- PBJ report indicated excessively low weekend staffing & no RN for 10 days in 1 month, 7 days in 1 month & 1 day in 1 month; review of staffing & RN hours of dates revealed appropriate weekend staff & RN coverage; failed to submit accurate PBJ data, placing residents at risk for unidentified & ongoing inadequate staffing

**F880 Infection Prevention & Control**

SE: SS=F: Failed to ensure sanitary & comfortable environment to help prevent development & transmission of communicable diseases & infections when staff failed to provide sanitary catheter care & failed to implement EBP for 1 resident; failed to implement adequate water management program to prevent &/or mitigate risks from waterborne pathogens placing residents at risk of contracting infection or communicable diseases

- TELS system instructed to conduct required monthly Legionella meetings & upload documentation; sheet lacked documentation of test for Legionella or that water was flushed throughout facility; 2nd sheet had picture of unlabeled device
- Hot water temp checks in logbook on 4 dates revealed documentation r/t hot water temps in random rooms but lacked documentation r/t if flush conducted
- Observed peri care for resident & CNA & LN donned gloves but not gowns; placed uncovered catheter bag on side of bed with bag touching floor; both staff revealed resident supposed to be on EBP

SE: SS=D: Failed to ensure staff donned appropriate PPE for 3/5 residents on EBP for 3/5 residents to prevent spread of infection

- Failed to ensure staff used EBP for provision of high contact resident care for 2 residents with PEG tubes & wounds
- Failed to provide safe & sanitary care with use of EBP for resident with urinary catheter to prevent cross contamination & spread of infection for 1 resident

SW: SS=E: Failed to ensure 1 resident's CPAP mask & nasal cannulas for 3 residents were stored in sanitary manner when not in use & further failed to implement adequate hand hygiene & ensure shared BP cuff was sanitized after resident use placing residents at risk for infectious diseases

- Failed to ensure 1 resident's CPAP mask was stored in sanitary manner
- Failed to ensure 3 residents' O2 nasal cannulas were stored in sanitary manner
- Failed to implement adequate hand hygiene ensuring shared BP cuffs were sanitized after each resident's use placing residents at risk for infectious diseases

SW: SS=F: Failed to use appropriate barriers while sorting soiled laundry, failed to maintain ongoing waterborne pathogen prevention program to address & mitigate risk for Legionella & failed to implement EBP for 3 residents placing residents at risk of infectious diseases

- Observed LN entered room to perform G-tube care & donned gloves but no gown on multiple occasions
- Observed CNA performed catheter care & washed hands & donned gloves but did not gown; CNA wiped drainage port to catheter with moist wipe r/t no alcohol wipes
- Observed laundry staff sorted laundry using only gloves for PPE & did not wear barrier gown or apron while sorting soiled laundry
- Failed to handle soiled laundry in manner to prevent spread of possible infectious material w/o using appropriate barriers; failed to implement water management program for waterborne pathogens placing residents residing in facility at risk for contracting Legionella pneumonia placing residents at increased risk for infections; failed to implement EBP for 3 residents placing residents at risk for increased infections

SW: SS=F: Failed to maintain an infection prevention & control program to provide safe & sanitary environment for all residents thru: facility failed to ensure effective infection control surveillance program r/t tracking of infections for 2 resident; failed to ensure staff performed hand hygiene prior to & during care for 3 residents; failed to ensure implementation of EBP when providing wound care for 4 residents with potential to affect all residents in facility

- Failed to ensure effective infection control surveillance program r/t tracking of infections of 2 residents; failed to ensure staff performed hand hygiene prior to & during care for 3 residents; failed to ensure implementation of EBP when providing wound care for 4 residents with potential to affect all residents in facility

NE: SS=E: Failed to develop & implement system to alert staff & visitors of EBP needs & additionally failed to complete hand hygiene during wound care & to ensure sanitary storage of O2 therapy equipment placing residents at risk for infectious diseases

- Observed no signage r/t EBP or required EBP; rooms w/o visible indicator or signage for EBP
- Observed nebulizer mask laying directly on coffee table alongside recliner; observed 1 resident's nasal cannula &O2 tubing hanging over end of bed on multiple occasions & nebulizer mask laying directly on bedside table on multiple occasions
- Failed to ensure staff were aware of EBP indicators in place for residents; failed to complete hand hygiene during wound care & failed to ensure sanitary storage of O2 therapy equipment placing residents at risk for infectious diseases

NE: SS=D: Failed to ensure BP cuff, pulse monitor, & O2 saturation equipment were sanitized after each resident's use placing residents at risk for infectious diseases

- Failed to ensure BP cuff, pulse monitor, O2 saturation equipment was sanitized after each resident's use placing residents at risk for infectious diseases

**F881 Antibiotic Stewardship Program**

SW: SS=F: Failed to implement effective antibiotic stewardship program that included antibiotic use protocols, an effective system to monitor antibiotic use &/or effective system to track & trend infections in building for facility's IPCP with potential to affect all residents

- Adm stated facility did not have effective IPCP including Antibiotic Stewardship Program & staff untrained & IP not completing surveillance logs; failed to implement effective antibiotic stewardship program that included antibiotic use protocols, an effective system to monitor antibiotic use &/or effective system to track & trend infections in building for facility's IPCP with potential to affect all residents

**F882 Infection Preventionist Qualifications/Role**

SW: SS=F: Failed to ensure IP assessed, implemented & monitored facility IPCP with potential to affect all residents

- Failed to ensure IP assessed, implemented, & monitored facility IPCP with potential to affect all residents

**F883 Influenza & Pneumococcal Immunizations**

SW: SS=E: Failed to provide pneumococcal vaccine or consent/declination form to 2 residents; further failed to provide influenza vaccine or consent/declination form to 3 residents & failed to complete & document assessment prior to giving influenza vaccine

- Failed to provide pneumococcal vaccine or consent/declination form to 2 resident; further failed to provide influenza vaccine of consent/declination form to 3 residents & failed to complete & document assessment prior to giving influenza vaccine to 1 resident

NE: SS=D: Failed to ensure 1 resident received pneumococcal vaccine after consenting to vaccination placing resident at risk for acquiring, transmitting or experiencing complications from pneumococcal disease

- EMR lacked documentation that other pneumococcal vaccination s (PCV20 or PCV21 were offered or given; failed to ensure 1 resident received pneumococcal vaccine after consenting to vaccination placing resident at risk for acquiring, transmitting or experiencing complications from pneumococcal disease

NE: SS=D: Failed to offer & administer or obtain informed declinations for PCV20 for 2 residents placing residents at increased risk for complications r/t pneumonia

- Failed to offer PCV20 or obtain informed declinations for 2 residents placing residents at increased risk for complications r/t pneumonia

**F942 Resident Rights Training**

SW: SS=E: Failed to ensure direct care staff had received required resident rights training placing residents at risk for impaired care & decreased quality of life

- Review of provided training for agency 3 CNAs revealed lack of evidence of training completed for resident rights; failed to ensure direct care staff had received resident rights training placing residents at risk for impaired care & decreased quality of life

NE: SS=E: Failed to ensure agency staff received required resident rights training placing residents at risk for impaired care & decreased quality of life

- Failed to ensure required resident rights training was completed by staff who provide care in facility placing residents at risk for impaired care & decreased quality of life

**F945 Infection Control Training**

NE: SS=E: Failed to ensure agency staff received required infection control training placing residents at risk for impaired care & decreased quality of life

- Failed to ensure completion of required infection control training for staff who provided care in facility placing residents at risk for impaired care & decreased quality of life

**F947 Required In-Service Training for Nurse Aides**

SW: SS=F: Failed to develop, implement, & permanently maintain in-service training program for CNAs with required topics & no less than 12 hours per year; 2 CNAs lacked required training topics & 1 CNA lacked required 12 hours per year of in-service training

- Failed to develop, implement & permanently maintain in-service training program for CNAs with required topics & no less than 12 in-service training hours per year

**January, 2025**

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

SW: SS=D: Failed to notify physician for blood sugars outside physician-ordered parameters for 1 resident placing resident at risk for hyperglycemic & hypoglycemic episodes r/t delayed physician involvement

- Failed to notify physician as ordered when 1 resident's blood sugar was out of physician-ordered parameters placing resident at risk for hyperglycemic & hypoglycemic episodes r/t delayed physician involvement

**F584 Safe/Clean/Comfortable/Homelike Environment**

SW: SS=E: Failed to ensure a clean, safe, homelike environment for residents who ate in DR & residents who resided on 2/4 resident hallways

- Observed DR with broken tile with missing piece; DR exit with missing door trim & foam insulation visible; DR wall with hole
- Observed hallways with numerous damaged or ill-fitting ceiling tiles; shower room with framed hole in fall with pipes & inner wall visible; staff stated no developed plans to repair maintenance issues observed

**F600 Free from Abuse & Neglect**

*SW: SS=J (Past Non-Compliance & Abated to G): Failed to ensure 1 resident remained free from neglect & mistreatment*

- *On 12-27-24 at 7:39am LN went to resident's room to pass meds; resident's vital signs were wnl; at 9:30am, laundry person went to resident's room & resident asked person to get LN; laundry person went directly to LN & told LN resident needed nurse; LN continued to pass meds & answer phone calls; resident placed call light on at 9:42am & call light alarmed for 1 hour & 45 minutes with no one answering call light; at 11am Environmental Services heard CNA state that had seen resident's call light going off but CNA not gowning up to go into room just to be told resident needed LN; LN went to resident's room & found resident pale, cold to touch & pulseless; LN failed to initiate CPR & pronounced resident dead at 11:27am; practice placed resident at risk for grave psychosocial outcomes including fear, anxiety & neglect due to staff not responding to resident's needs & placed resident in immediate jeopardy; record documented resident designated as "full code"; failed to ensure resident remained free from neglect & mistreatment placing resident at risk for grave psychosocial outcomes including fear, anxiety & neglect due to staff not responding to resident's needs & placed resident in immediate jeopardy*
- *Abatement Plan:*
  - *Submitted education r/t CPR, Advance Directives, Abuse & Neglect & answering call lights*
  - *Call light audits implemented*

**F640 Encoding/Transmitting Resident Assessments**

SW: SS=D: Failed to verify CMS received transmissions of MDS containing RAI for 2/65 residents

- Facility failed to verify CMS received transmissions for MDS containing RAI for 2 residents

**F645 PASARR Screening for MD & ID**

SE: SS=D: Failed to ensure 1 resident had current & valid PASARR

- Failed to ensure 1 resident had current & valid PASARR

**F656 Develop/Implement Comprehensive Care Plan**

SW: SS=D: Failed to develop & implement a person-centered comprehensive CP for 3 residents: 1 resident r/t psychotropic meds use & dementia care; 1 lacked interventions r/t PRN O2 use & scheduled nebulized med use & 1 CP lacked timely intervention r/t care of PU; 1 resident's CP lacked interventions r/t care of PU with potential to lead to uncommunicated needs which would negatively impact physical & psychosocial wellbeing of residents

- Failed to develop & implement person-centered comprehensive CP for 1 resident r/t PRN O2 use & scheduled nebulized med use; additionally resident's CP lacked timely intervention r/t care of PU/injury with potential to lead to uncommunicated needs which had potential to negatively affect physical & psychosocial wellbeing of resident
- Failed to develop & implement person-centered comprehensive CP for 1 resident r/t wound care with potential to lead to uncommunicated needs which had potential to negatively affect physical & psychosocial wellbeing of 1 resident

**F657 Care Plan Timing & Revision**

SW: SS=E: Failed to revise fall CP with appropriate intervention for 2 residents; additionally facility failed to update CP with facility-acquired PU for 1 resident & 1 resident's CP not updated with psychotropic med changes with potential to have negative effect of overall physical & psychosocial wellbeing of residents in facility

- Failed to revise 4 residents' CPs after PU injuries occurred for 1 resident; 1 resident r/t addition of Buspar & after falls for 2 residents

**F678 Cardio-Pulmonary Resuscitation (CPR)**

*NW: SS=J (Past Non-Compliance): Failed to ensure staff provided CPR to 1 resident who desired resuscitative measures as indicated by full code status*

- *Cited findings noted in F600 r/t failure to initiate CPR to resident desiring full code; LN went to resident's room 1 hour 45 minutes after resident initiated call light & found resident pale, cold to touch & pulseless; LN failed to initiate CPR & pronounced resident*

*dead; failed to activate EMS & withheld CPR despite resident's documented full code status; resident died in facility placing resident & all resident with full code status in immediate jeopardy; Adm staff stated 1 LN & 1 CNA were enough staff to care for 17-18 residents & on day of incident 1 housekeeper & AD/SSD were also CNAs; failed to ensure staff provided CPR to resident who desired resuscitative measures as indicated by full code status placing resident & all residents with full code status in immediate jeopardy*

- *Removal Plan*
  - *Submitted education r/t CPR, Advance Directives, Abuse & Neglect & answering call lights*
  - *Call light audits implemented*
  - *(Addition Information: LN terminated & reported to KSBN)*

**F686 Treatment/Services to Prevent/Heal PU**

SW: SS=D: Failed to perform ongoing assessment of stage 3 facility-acquired PU for 1 resident

- Review of the EHR, Wound Clinic notes, and wound book notes from 05/31/24 to 06/25/24, 09/03/24 to 09/17/24 and beyond 11/22/24 lacked documentation of ongoing weekly assessments per physician orders for 1 resident's stage three pressure ulcer; failed to perform ongoing assessment of stage 3, facility-acquired PU for 1 resident

**F689 Free of Accident Hazards/Supervision/Devices**

SE: SS=D: Failed to ensure safe environment free from accident hazards for 1 resident who had medication located in room that was not secured placing affected resident at risk for preventable accidents & related injuries

- Observed resident with spray wound cleaning medication on over bed table with warning label on multiple occasions; ; failed to ensure safe environment free from accident hazards for 1 resident placing resident at risk for injury & preventable accidents

SW: SS=E: Failed to ensure environment free from accident hazards when staff left activated steam table in unlocked closet with unsecured gate & coffee station left accessible to residents with unclosed gate placing 8 cognitively impaired independently mobile residents at risk for preventable accidents or injuries

- Failed to ensure resident environment remained free from accident hazards when staff left activated steam table unsupervised & unlocked placing 8 cognitively impaired independently mobile residents at risk for preventable accidents or injuries
- Failed to ensure environment free from accident hazards when staff left beverage station (which contained hot coffee & hot water) gate open placing 8 cognitively impaired independently mobile residents at risk for preventable accidents or injuries

*SW: SS=J (Past Non-Compliance): Failed to ensure 1 resident remained free from accidents when CMA did not utilize safety belt for 1 resident before transporting in facility van*

- *On 12-11-24 at 3pm CMA failed to secure dependent resident in w/c with w/c safety belt in facility van prior to transporting; CMA entered busy highway with speed limit of 60mph & had to slam on brakes to avoid an accident causing resident to slide forward out of w/c onto floor due to lack of seatbelt use; resident sustained multiple injuries including skin tears & laceration; CMA used gait belt to loop around each of arm rests of w/c for resident*
- *Removal Plan:*
  - *Suspended CMA then terminated*
  - *Suspended CNA then self-terminated*
  - *Van immediately taken out of service until van could be inspected*
  - *Van inspected & discovered passenger safety belt not in disrepair but rather working as intended*
  - *All staff trained in "lock out/tag out" for equipment that was out of order*
  - *All staff trained on when to report equipment that was not functional & how to use work order system to alert administration*
  - *Staff members who transported residents for passenger pick up were educated on van safety & asked to demonstrate how to use safety equipment in van*
  - *All staff educated that passenger safety was the responsibility of both driver & transportation companion*

SW: SS=E: Failed to ensure safe environment free from accident hazards for 4 residents: 1 resident who had meds located in resident's room that was not secured; 3 residents had repeated falls with inappropriate or lacked CP revision after falls placing affected residents at risk for preventable accidents & related injuries

- Observed resident's room with unsecured meds including 3 over-the-counter meds on bedside table all with warning labels; resident stated had always kept meds on over bed table & had never been educated to secure meds in room
- During review of the "Care Plan" the falls that occurred on 03/14/24 and 05/21/24 had no immediate intervention to prevent further falls. The intervention used after fall was reviewed was an order for Physical and Occupational therapy. The fall that occurred on 12/12/24 had no intervention implemented to prevent further falls
- Failed to ensure safe environment free from accident hazard free from accident hazards for 4 residents placing residents at risk for injury & preventable accidents

SW: SS=D: Failed to implement grip strips in front of 1 resident's toilet & failed to implement anti-rollbacks on w/c placing resident at risk for future preventable falls

- Observed CP to provide anti-rollbacks on w/c & observed w/c w/o anti-rollbacks on w/c; failed to implement grip strips in front of 1 resident's toilet & failed to implement anti-rollbacks on w/c placing resident at risk for future preventable falls

*NE: SS=J (Plan of Removal Past-Non-Compliance): Failed to provide adequate supervision for cognitively impaired resident, resident with risk for elopement & falls, to prevent elopement*

- *On 01/26/25, resident self-propelled in his wheelchair down a hallway to a locked door with a keypad. The door was not latched and resident left the unit and proceeded out a set of double doors that exited the building. When resident opened the double doors, an alarm sounded at the nurse ' s station, but the staff turned the alarm off without checking the door. Per interview and investigation, resident exited the facility building at 05:58 AM and entered the Assisted Living (AL) building at 07:02AM. The weather ranged from 22 degrees Fahrenheit (F) to 23 degrees F. AL staff contacted the nursing staff in resident's building and nurses from resident's unit came to get him. The lack of supervision and response to the door alarms placed resident in immediate jeopardy.*
- *Plan of Removal:*
    - *A new elopement risk assessment was completed for the resident on 01/26/25*
    - *The nurse involved received corrective actions for not following elopement procedures and received education on 01/26/25.*
    - *Maintenance assessed and adjusted the door and checked door alarms on 01/26/25.*
    - *Staff education on policy, elopements, and door alarm response was completed on 01/26/25.*
    - *A QAPI meeting related to elopements was completed on 01/27/25.*
    - *Signs posted on door alarm mechanism at each nursing station to ensure all alarms are on and reminder that under no circumstances will an alarm be turned off until the source of the activation has been determined completed by 01/27/25.*
    - *An all-staff in-service completed 01/27/25.*
    - *Reviewed elopement risk posters to ensure all were up to date and completed by 01/27/25.*
    - *The resident' s care plan was updated to include interventions and monitoring of wandering completed on 01/28/25.*

**F693 Tube Feeding Management/Restore Eating Skills**

SW: SS=D: Nurse failed to listen for placement of G-tube before administering medications & nutritional feeding for 1 resident placing resident at risk for complications r/t feeding tube

- Observed LN failed to listen for placement or check stomach residual prior to administration of medications & nutritional supplements; failed to check 1 resident's G-tube placement, prior to medication administration & nutritional feeding as ordered, placing resident at risk for complications r/t G-tube

**F695 Respiratory/Tracheostomy Care & Suctioning**

SE: SS=D: Failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent spread of infection for 1 resident; failed to ensure safe storage of O2 nasal cannula & O2 tubing when not in use to prevent cross contamination & spread of infection

- Observed resident in bed in room & nasal cannula & O2 tubing laid directly on floor w/o storage bag present; failed to provide appropriate respiratory care for 1 resident r/t storage of O2 nasal cannula when not in use to prevent cross contamination & spread of infection

**F699 Trauma Informed Care**

SW: SS=D: Failed to ID trauma-based triggers r/t 2 residents' PTSD & failed to implement individualized interventions to prevent re-traumatization placing resident at risk for decreased psychosocial wellbeing & ineffective treatment

- CP lacked documentation of trauma-based triggers & individualized interventions for resident with PTSD; failed to ID trauma-based triggers r/t 1 resident's hx of trauma & implement individualized interventions to prevent re-traumatization placing resident at risk for decreased psychosocial wellbeing & ineffective treatment
- Failed to ensure care & services for 1 resident were delivered using approaches that address needs of trauma survivors by minimizing triggers &/or re-traumatization placing resident at risk for re-traumatization

**F700 Bedrails**

SW: SS=D: Failed to assess actual rail being used to assure safety for 2 residents placing residents at risk for preventable injury

- MDS lacked documentation resident had siderails; side rail assessment did not check "side rails had been measured, gaps between rails themselves or gaps between rails & mattress were conducive to resident safety"; observed rails with openings 3.75 inches x 32 inches; failed to adequately assess 1 resident's actual rail in use to ensure safe openings & failed to assess for safe use of side rail prior to placing it on resident's bed placing resident at risk for preventable entrapment, accident or injury for 2 residents

**F725 Sufficient Nursing Staff**

*NW: SS=G (Past Non-Compliance): Failed to provide sufficient nurse staffing with appropriate competencies & skill sets to assure residents' safety & attain or maintain highest practicable physical, mental & psychosocial wellbeing for 1 resident which resulted in resident's needs not being met & ultimately resident's death*

- *Cited findings noted in F600, F678 r/t resident's call light initiated for 1 hour 45 minutes & failure to initiate CPR for full code resident; failed to provide sufficient nurse staffing with appropriate competencies & skill sets to assure residents' safety & attain or maintain highest practicable physical, mental, & psychosocial wellbeing for 1 resident resulting in residents not being met & ultimately resident's death*
- *Removal Plan:*

- *Submitted education r/t CPR, Advance Directives, Abuse & Neglect & answering call lights*
- *Call light audits implemented*
- *(Addition Information: LN terminated & reported to KSBN)*

**F726 Competent Nursing Staff**

*NW: SS=G (Past Non-Compliance: Failed to provide competent nurse staffing who were unable to recognize resident required CPR which resulted in resident's needs not being met & ultimately resident's death*

- *Cited findings noted in F600, F678, F725 r/t prolonged call light response time & failure to initiate CPR for full code resident; failed to provide sufficient nurse staffing with appropriate competencies & skill sets to assure residents' safety & attain or maintain highest practicable physical, mental & psychosocial wellbeing for 1 resident resulting in resident's needs not being met & ultimately resident's death*
- *Abatement Plan:*
  - *Submitted education r/t CPR, Advance Directives, Abuse & Neglect & answering call lights*
  - *Call light audits implemented*
  - *(Addition Information: LN terminated & reported to KSBN)*

**F730 Nurse Aide Performance Review-12 hrs/yr In-Service**

SE: SS=F: Failed to conduct annual performance reviews for 5/5 direct care staff reviewed to ensure residents received adequate cares

- Failed to complete annual performance reviews for 5/5 CMA/CNAs sampled; failed to conduct annual performance reviews for 5 direct care staff to ensure residents received adequate cares

**F755 Pharmacy Services/Procedures/Pharmacist/Records**

SE: SS=D: Failed to provide adequate pharmaceutical services to ensure 1 resident had prescribed meds available in timely manner for administration placing 2 residents at risk of delayed treatment which could have adverse consequences

- POS for Atorvastatin q hs; & January MAR documented med not administered from 1-8-25 thru1-17-25; failed to provide adequate pharmaceutical services to ensure 1 resident received prescribed meds placing resident at risk of delayed treatment which could have adverse consequences
- POS for Farxiga, Gabapentin; MAR documented resident's Gabapentin ordered for 11-20 not administered & Farxiga for 12-21-24 thur 12-31-24 & January from 1-1-25 thru 1-27 as not administered; failed to provide adequate pharmaceutical services to ensure 1 resident received prescribed meds placing resident at risk of delayed treatment which could have adverse consequences

**F756 Drug Regimen Review, Report Irregular, Act On**

SW: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported lack of appropriate indication or required physician documentation for 2 resident's use of antipsychotic medication & for lack of specific 14-day stop date for 1 resident's PRN Ativan placing residents at risk for inappropriate use of medication & related complications

- Failed to ensure CP ID'd & reported lack of appropriate indication for use of Seroquel & for lack of specific 14-day stop date for resident's PRN Ativan placing resident at risk for inappropriate use of medication& related complications
- Failed to follow CP's recommendations to obtain physician's rationale for continued use of Risperdal for 1 resident who had dx of Alzheimer's dementia placing resident at risk for adverse effects of antipsychotic medication

SW: SS=D: Failed to ensure CP ID'd & reported inappropriate indication for use of antipsychotic med for 1/5 residents placing resident at risk for unnecessary meds & related side effects

- POS for Rexaulti 0.5mg po daily for dementia with agitation; EMR lacked evidence of physician-documented rationale including risks vs benefits for drug; MRR lacked recommendation for appropriate indication for use; record lacked documentation physician rationale including multiple unsuccessful attempts for nonpharmacological symptom management & risk vs benefit for continued use of Rexaulti; failed to ensure CP ID'd & reported to facility, DON, medical director & physician inappropriate indication for 1 resident's use of Rexaulti placing resident at risk for inappropriate use of antipsychotic med

**F757 Drug Regimen is Free from Unnecessary Drugs**

SW: SS=D: Failed to notify physician of blood sugars outside physician ordered parameters for 1 resident placing resident at risk for hyperglycemic & hypoglycemic episodes & adverse effects r/t medications

- Cited findings noted in F580; failed to notify physician as ordered when resident's blood sugar was out of physician-ordered parameters placing resident at risk for complications & adverse effects related to medications

**F758 Free from Unnecessary Psychotropic Meds/PRN Use**

SW: SS=D: Failed to ensure 2 residents had approved dx or physician-documented rationale which included risks vs benefits for 1 resident's use of Seroquel & 1 resident's use of Risperdal; further failed to ensure 14-day stop date to be reassessed on regular basis for 1 resident placing residents at risk for unnecessary medications & related complications

- Cited findings noted in F756 r/t orders for psychotropic medications; EMR lacked evidence of physician-documented rationale including risks vs benefits for resident's use of Seroquel; failed to obtain appropriate physician rationale or indication for use of Seroquel & failed to ensure stop date for PRN Ativan placing resident at risk for unnecessary medications & related complications

- Failed to obtain physician's rationale for continued use of antipsychotic Risperdal for resident with dx of Alzheimer's dementia placing resident at risk for adverse effects of antipsychotic medication

SW: SS=D: Failed to ensure 1 resident's PRN psychotropic med had required 14-day stop date or clinical rationale for continued use beyond initial 14 days with potential to lead to resident receiving unnecessary psychotropic meds

- POS for Xanax 0.25mg q 6 hrs PRN for anxiety; order lacked stop date or rationale for continued use of meds; failed to ensure 14-day stop date or physician evaluation for continued use beyond 14 days for 1 resident's PRN Xanax with potential for resident to receive unnecessary psychotropic medication

SW: SS=D: Failed to ensure 1 resident had approved dx or physician-documented rationale which included risks vs benefits for 1 resident's use of Rexaulti & 1 resident's use of Seroquel; further failed to ensure 1 resident had 14-day stop date for use of Ativan placing residents at risk for unnecessary meds & related complications

- Cited findings noted in F756 r/t use of Rexaulti; failed to ensure appropriate indication or required documentation for use of 1 resident's Rexaulti placing resident at risk for adverse side effects
- Failed to ensure 1 resident's PRN Ativan had 13-day stop date placing resident at risk for unnecessary medication effects
- Failed to ensure CMS appropriate indication for use of Seroquel placing resident at risk for unnecessary psychotropic meds, related complications & adverse side effects

**F760 Residents are Free of Significant Med Errors**

SW: SS=D: Failed to follow physician orders when administering medication to 2 resident resulting in med error continuing for 4 days placing resident at risk for adverse effects from medication

- 1-10-25 POS to decrease Risperdal to 0.5mg ½ tab at bedtime; order documented as noted on 1-10-25; January 2025 MAR no change in dose of Risperdal staring 1-10-25 to 1-14-25; MAR documented staff administered 0.5mg ½ BID on 1-11, 1-12, 1-13 & 1-14-25 which was 4 doses more than physician ordered; failed to follow physician orders when administering medication to resident resulting in med error that continued for 4 days placing resident at risk for adverse effects from medication

**F761 Label/Store Drugs & Biologicals**

SW: SS=D: Failed to dispose of expired meds in timely manner placing residents at risk to receive ineffective medication

- Observed ASA with expired date & GeriMox expired; failed to dispose of expired meds in timely manner placing residents at risk to receive ineffective medications

**F849 Hospice Services**

SW: SS=D: Failed to ensure coordinated care & services provided by facility with care & services provided by hospice for 1 resident placing residents at risk for inadequate end-of-life care

- CP lacked instruction on services provided by hospice including frequency & type of support visits, supplies & medical equipment provided by hospice, medications covered by hospice & hospice contact information; failed to coordinate care between facility & hospice provider for 1 resident receiving hospice services placing resident at risk for inadequate end-of-life care

**F880 Infection Prevention & Control**

SE: SS=E: Failed to ensure staff followed protocols when nurse provided tube feeding for resident placing resident at risk for infectious diseases

- Resident with PEG tube; observed LN administered tube feeding w/o wearing proper PPE as only had gloves in place; failed to ensure staff followed EBP protocol with tube feedings placing residents at risk for infection

SW: SS=D: Failed to complete proper hand hygiene during wound care for 2 residents to ensure best practice r/t infection control & prevention

- Observed LN removed dressing from skin tear w/o hand hygiene then did not change gloves or perform hand hygiene before placing new dressing then transitioned to morning ADLs with glove change only, no hand hygiene
- Observed 2 CNAs assisted resident with dressing then removed gloves & donned clean gloves w/o hand hygiene then applied Foley tubing to resident's leg
- Observed LN & CNA applied PPE w/o concerns then cleansed wound to buttock then removed 4x4 from package with soiled gloves then removed gloves & failed to wash hands, donned clean gloves & applied clean dressing; when finished put remaining dressing in packet & back into pocket & back into box & cleaned up area; failed to ensure staff followed appropriate hand hygiene during wound care for 2 residents with potential to spread possible infections to residents in facility

**F881 Antibiotic Stewardship Program**

SW: SS=D: Failed to ensure effective & ongoing antibiotic stewardship for appropriate antibiotic use for residents of facility to prevent antibiotic resistance & spread of multi-drug-resistant organisms

- Failed to ensure effective & ongoing antibiotic stewardship for appropriate antibiotic use for residents of facility to prevent antibiotic resistance & spread of multi-drug-resistant organisms