March, 2024 Kansas Survey Findings
Normal Font-Health Survey
Italics= Complaint Survey
Findings in red=G+ Scope & Severity
Findings in Green from State Regulations
SS=Scope & Severity; LN=Licensed Nurse
TX=treatment; Dx=Diagnosis
CP=Care Plan; CP in pharmacy regulations=Consultant Pharmacist
PU=Pressure Ulcer; ID=identify

November, 2023

F550 Resident Rights/Exercise of Rights
SE: SS=D: Failed to provide cares to maintain 1 sampled resident's dignity

- Observed resident in w/c in DR wearing hospital gown which was loosely tied around resident's neck & exposed upper chest; observed resident in bed with HOB elevated slumped forward & to right with head pillow sliding to top of head & resident with hospital gown & bed blanket pushed to side exposing resident's incontinence brief & resident visible from hallway & another resident passing by remarked that resident had pillow over face; observed staff provided peri care for incontinence & noted dressing to resident's coccyx PU became saturated with urine & during care mid room privacy curtain was drawn but privacy curtain that shielded resident from view when staff opened room door pushed over to other side of room & CNA entered room but resident not shielded from view; then staff transported resident to DR still wearing hospital gown; observed resident on multiple occasions wearing hospital gown; failed to ensure privacy for resident & individuality to promote homelike experience

F657 Care Plan Timing & Revision
SE: SS=D: Failed to review & revise CP for 1 resident r/t staff instruction on utilizing gait belt during transfers

- CP lacked staff instruction on utilizing gait belt during transfers; observed staff 2 staff members transferred resident from w/c to bed & staff held onto back of resident's pant waist & other CNA held resident under arm during transfer & resident attempted to sit down in middle of transfer; failed to use gait belt during transfer; failed to review & revise CP for dependent resident to include staff instruction on use of gait belts during transfers

F686 Treatment/Services to Prevent/Heal Pressure Ulcer (PU)
SE: SS=D: Failed to ensure staff provided measures for PU treatment/prevention for 1/2 residents reviewed for PUs

- Resident with documented stage 3 PU; Observed resident in w/c that lacked pressure relieving cushion on multiple occasions; observed resident w/o ordered dressing to PU & CNA did not provide off-loading device for resident's heels; failed to provide pressure reducing cushion to resident's w/c, failed to provide heel offloading devices as CP'd for promotion of healing & prevention of further pressure injury

F689 Free of Accident Hazards/Supervision/Devices
SE: SS=D: Failed to properly reposition 1 dependent resident, failed to lower bed into low position for 1 dependent resident & failed to use gait belt while transferring 1 dependent resident from w/c to bed

- Fall report documented staff found resident hying on back on floor mat under bed & bed was in high positioned (CP directed staff to keep bed in low position); intervention was staff re-educated to ensure resident's bed in lowest possible position following cares; failed to lower bed to lowest position after providing cares to resident
- Failed to use gait belt while transferring dependent resident to ensure proper transfers
- Failed to provide safe repositioning techniques for resident who required partial to moderate assistance with repositioning in w/c to prevent potential injury when staff failed to assist resident to transfer either with grab bar or to hold onto while standing or staff to stand on either side while instructing resident for repositioning

NE: SS=G: Failed to ensure 1 resident remained free from accidents when CNA propelled resident down hallway in w/c w/o foot pedal for 1 leg/foot causing resident's foot to get stuck under w/c & resulted in fx to same leg; facility further frailed to prevent accidents for 1 resident when CNA failed to utilize 2 people with Hoyer lift transfer which resulted in resident slipping out of lift sling & landing on floor placing resident at risk for injuries & physical complications

- *Failed to ensure 1 resident remained free from accidents when CNA propelled resident down hallway in w/c w/o foot pedal for 1 foot causing resident's foot to get stuck under w/c & resulted in fx to leg*
- *Witness statement revealed CNA went into resident's room & resident stated wanted to go to bed; CNA transferred resident by self & CNA stated knew better & knew that sling was up too high on resident's body & not under resident's bottom far enough then tried to pull lift sling down the best possible then resident started sliding out of sling, resident then slid out of sling & resident found laying over legs of Hoyer lift with sling still attached above resident; CNA stated "had not idea" why had not asked for help; failed to prevent accidents for 1 resident when CNA failed to use 2 people with Hoyer lift transfer resulting in resident falling out of lift sling & landing on floor placing resident at risk for injuries & physical complications*

F758 Free from Unnecessary Psychotropic Meds/PRN Use
SE: SS=D: Failed to ensure monitoring for adverse effects of psychotropic medications for 2/5 residents to ensure no unnecessary medication usage

- Resident with dementia & paranoid personality with POS for Seroquel 50mg TID for dementia; Adm stated facility had tried GDR of resident's Seroquel resulting in escalation of behaviors & DISCUS assessments lacked completion quarterly; failed to ensure accurate monitoring of resident for adverse effects of antipsychotic medications to ensure no unnecessary psychotropic medication usage
- Resident with dementia; POS for Risperidone 1mg BID for dementia with anxiety; staff confirmed DISCUS not completed quarterly; failed to ensure staff monitored resident for adverse effects of antipsychotic medications to ensure no unnecessary psychotropic medication usage

F812 Food Procurement, Store/Prepare/Serve-Sanitary

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

- Observed: 2 reach-in freezers contained food debris on bottom shelf; multiple cutting boards with deep grooves; kitchen trash cans with dried food debris & liquids on lids & sides; flour & sugar bins with food debris on top of lids; resident fridge with multiple undated food items

F881 Antibiotic Stewardship Program

SE: SS=D: Failed to ensure appropriate antibiotic use for 1 resident

- Resident with UTI with POS for Cipro then Macrobid for recurrent UTIs; Infection Tracking Logs lacked inclusion of Cipro & Macrobid ABT; failed to assess administration of antibiotic for resident's chronic UTI to determine efficacy of implementation of nonpharmacological interventions to prevent inappropriate long-term use of antibiotics

December, 2023

F609 Reporting of Alleged Violations

NW: SS=D: Failed to ensure staff IDd & reported allegations of potential abuse to Adm of facility immediately placing residents at risk for ongoing abuse &/or mistreatment

- NN documented staff heard knocking & discovered resident on floor in BR & resident with blood on side of head near temple area & blood noted on floor; resident stated did not know what happened; record lacked documentation resident centered intervention put into place to prevent falls & lacked documentation an investigation completed for fall; NN documented resident rubbing hand & eval noted bruising to middle & right middle knuckle on hand with swelling & resident c/o tenderness & staff applied ice & would continue to monitor & EMR lacked any documented skin assessment that included bruised hand; Adm stated had not been informed of resident's fall or bruised hand & staff should have reported to Adm & investigation completed along with witness statements & reported to state if indicated; failed to ensure staff IDd & reported an allegation of potential abuse to facility abuse coordinator or Adm staff immediately to investigate placing residents at risk for ongoing abuse &/or mistreatment

F610 Investigate/Prevent/Correct Alleged Violation

NW: SS=D: Failed to investigate 1 resident's unwitnessed fall in BR resulting in swelling & bruising placing resident at risk for unidentified & continued abuse, neglect &/or mistreatment

- Cited findings noted in F609 r/t unwitnessed fall with injury; failed to investigate unwitnessed fall & bruising of unknown origin for 1 resident placing resident at risk for unidentified & ongoing abuse, neglect &/or mistreatment

F623 Notice Requirements Before Transfer/Discharge

NW: SS=D: Failed to notify ombudsman of facility-initiated discharge for 1 resident placing resident at risk for discharge w/o oversight of Ombudsman office

- Progress note to physician stated resident stated resident would have better acceptance of being in nursing home if could visit home, sit on porch & see dogs & asked physician if resident was ok to discharge to home with family for short visits during skilled stay; Progress noted to physician documented resident stated that resident intended on committing suicide "one way or another" & would continue attempts until successful; nurse spent time providing therapeutic conversation & resident stated had a plan in place to commit suicide & intended to follow through with it; 1:1 staff care provided to resident at all times & all items to harm self removed from room; family arrived at facility to sit with resident & agreed that resident needed to be sent to hospital for monitoring & physician gave verbal order to transfer resident o hospital for psychiatric eval; SS verified facility had not notified Ombudsman of discharge; failed to notify State Ombudsman office of facility-initiated discharge of 1 resident to hospital placing resident at risk for decreased oversight & assistance with transfers & discharge

F655 Baseline Care Plan

NW: SS=D: Failed to develop & implement baseline CP for 1 resident's use of supplemental O2 placing resident at risk for respiratory complications r/t uncommunicated care needs

- CP lacked documentation of 1 resident's O2 needs or use; failed to develop & implement baseline CP for 1 resident's use of supplemental O2 placing resident at risk for respiratory complications r/t uncommunicated care needs

F656 Develop/Implement Comprehensive Care Plan

SW: SS=D: Failed to develop a comprehensive CP for 1 resident r/t use of O2, 1 resident r/t nebulizer treatments & 1 resident r/t no diabetic interventions on CP

- CP lacked use & care of O2 therapy; failed to develop a comprehensive CP for 1 resident for use of continuous O2
- CP lacked guidance r/t resident's DM; failed to develop a comprehensive CP for care & tx of resident's DM

- CP lacked guidance r/t resident's nebulizer; failed to develop a comprehensive CP for resident's use of nebulizer tx

F657 Care Plan Timing & Revision

SW: SS=D: Failed to review & revise person-centered CP for 3 residents: 1 resident r/t ambulating independently w/o gait belt & 2 residents r/t interventions r/t O2 use & nebulized breathing tx use placing residents at risk to not receive appropriate cares & tx's

- CP documented resident at risk for falls r/t impaired balance & instructed staff to provide stand-by of 1 for all ADLs; use of gait belt & rolling walker for ambulation; POS lacked orders r/t fall prevention; observed resident ambulating in hallway with 4-wheeled walker w/o gait belt or staff assist; observed resident ambulating in hallway with staff member with gait belt in place; observed resident ambulating in hall with 4-wheeled walker w/o gait belt or assist from staff; failed to review & revise comprehensive person-centered CP for 1 resident placing resident at risk for uncommunicated care needs
- MDS indicated resident independent with all cares & received O2; CP lacked information r/t administration of inhaled (nebulized) medications; POS for O2 2-3 l/m per nasal cannula q shift r/t COPD; observed nebulizer device stored on top of bedside table, undated, with unknown clear liquid inside nebulizer chamber; failed to review & revise CP for 1 resident placing resident at risk for uncommunicated care needs
- POS for O2 & nebulizer tx for COPD; physician orders lacked guidance r/t changing of O2 or nebulizer tubing; failed to review & revise comprehensive person-centered CP for 1 resident placing resident at risk for uncommunicated care needs

NW: SS=D: Failed to review & revise 1 resident's CP with effective interventions for staff to follow when resident had behaviors placing resident at risk for unmet care needs

- CP documented resident with behaviors of yelling out & asking staff to "take a gun and shoot me" or "just kill me" or "take me outside and let me lay there and die"; CP lacked interventions for staff to follow when resident had these behaviors; failed to update 1 resident's CP with interventions for staff to use when resident had behaviors of yelling asking people to kill or shoot resident placing resident at risk for unmet care needs

F677 ADL Care Provided for Dependent Residents

NW: SS=D: Failed to provide necessary services for 1/4 residents reviewed for ADLs when 1 resident requested staff assist with repositioning & staff told resident would have to wait then did not return for 41 minutes later to assist resident placing resident at risk for impaired mobility & decreased comfort

- Observed resident placed pendant call light on & CMA entered room & resident requested to be repositioned in bed; CMA stated resident would have to wait until CMA had help & said would be back; 41 minutes later CMA & CNA entered resident's room & stated ready to assist resident with repositioning; CNA stated it took so long to get back to assist resident because staff were busy on unit taking care of other residents & stated had to work with restorative residents first & had to take break before accommodating resident's request; failed to provide necessary services in timely manner when resident requested staff assist with repositioning in bed & staff returned 41 minutes later placing resident at risk for decreased comfort

F688 Increase/Prevent Decrease in ROM/Mobility

NW: SS=D: Failed to provide neck stretching exercised for 1 resident to prevent further decline in resident's neck ROM as discussed during quarterly CP meeting placing resident at risk for decreased or impaired comfort

- EMR documented active ROM & did not specify neck stretching exercises; observed resident in room in w/c with head tilted far to right & neck pillow sat on bed; resident stated had Parkinson's & that was why neck was contracted & stated used to love to sing but could no longer do that; observed resident eating & head contracted to right & able to eat independently; therapy stated resident did not want neck brace; CNA stated no scheduled restorative aide; failed to provide restorative neck exercises for 1 resident to prevent further decline in neck ROM as discussed during quarterly CP meeting placing resident at increased risk for decreased ROM or contractures

F689 Free of Accident Hazards/Supervision/Devices

SW: SS=J (Abated to D): Failed to provide adequate supervision and ensure a safe environment

- *On 11-20-23 when facility sent cognitively impaired dependent resident to another resident's medical appointment; facility mixed up the 2 residents' identify and dropped off resident at front doors of medical clinic, alone, for other resident's appointment; resident did not have any identification on resident & did not know why resident was at appointment; facility did not know resident was out of facility until medical clinic called facility to point out facility dropped off wrong resident placing resident in immediate jeopardy; facility lacked investigation following return of resident to facility & did not make report to State Agency*
- *Abatement Plan:*
    - *Staff received re-education r/t resident ID, prior to any medical appointments & would verify picture of resident on face sheet & staff would ensure all residents with appointments had appropriate paperwork & be transported to front of building after verification of resident ID by photo & name on face sheet*
    - *Adm/designee would complete 10 random quizzes weekly r/t transportation process for 3 months with results taken to QAPI*
    - *Adm/designee would complete audits of transportation process 5x/wk x 4 week, then weekly x 4 weeks then monthly x 1 month*
    - *Facility policy dated 12-4-23 "Resident Identification System" revealed resident ID system is used to help facility personnel provide complete coordination of medication & nursing care; facility adopted photo ID record which is confidential & used by nursing service & other applicable personnel when administering medication, treatments & preparing residents for community appointments*

NW: SS=D: Failed to provide environment free from accident hazards when resident's bedrail exceeded acceptable safety dimension to prevent entrapment placing resident at risk for accidents & preventable injury

- CP stated resident required quarter side rail for transfers & mobility & staff to monitor use of side rail for entrapment & safety; observed rail on right side of resident's bed with other side of bed against wall & rail measured 16 inches wide x 32 inches tall; Adm nurse verified bed rail had too large opening; failed to provide safe environment free from accident hazards when resident's bedrail exceeded acceptable safety dimensions to prevent entrapment placing resident at risk for accidents & preventable injury

F695 Respiratory/Tracheostomy Care & Suctioning

NW: SS=D: Failed to provide 1 resident's supplemental O2 at physician ordered rate through nasal cannula & with use of non-invasive ventilator placing resident at risk for complications resulting from incorrect rate of O2 administered

- MDS documented resident used O2 & CPAP; CP lacked documentation of resident's O2 needs or use; Kardex lacked mention of O2 needs; resident stated had not been wearing CPAP machine at night & note did not mention O delivery while using CPAP; POS for O2 at 3 lpm; observed resident on multiple occasions with O2 running at 5 lpm; CPAP machine lacked O2 line; failed to provide 1 resident's supplemental O2 at physician ordered rate placing resident at risk for complications resulting from incorrect rate of O2 administered

F700 Bedrails

NW: SS=D: Failed to assess actual bedrail prior to use to assure safety for 1 resident placing resident at risk for injury

- Failed to assure 1 resident's bed rail/transfer bar was adequate for use, placing resident at risk for entrapment or injury

F745 Provision of Medically Related Social Service

NW: SS=D: Failed to provide adequate medically related social services to meet 1 resident's mental & behavioral health needs placing resident at risk for decreased quality of care & life

- CP documented resident with behaviors of yelling out & asking staff to "take a gun & shoot me" or "just kill me" or "take me outside & let me lay there & die"; CP lacked interventions for staff to follow when resident had these behaviors; Admission Patient Health Questionnaire documented resident with hx of trauma/PTSD; EMR lacked documentation SSD visited with resident r/t behaviors of wanting staff to shoot resident; failed to provide adequate medically related social services to meet resident's mental & behavioral health needs placing resident at risk for decreased quality of care & life

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SW: SS=D: Failed to administer 1 resident's antidepressant medication as ordered by physician

- Resident with depression dx; Psychotropic Drug Use CAA triggered but incomplete; PHQ-9 zero; POS for Sertraline 25 mg q day x 14 days then Sertraline 25 mg qod x 5 days then stop; MRR documented qod was outside recommended dose or frequency; MAR revealed staff administered Sertraline 25 mg daily in addition to Sertraline 25 my qod; failed to administered resident's medication as ordered by physician; resident received double prescribed amount on 4 occasions when order was to decrease medication then stop antidepressant

F761 Label/Store Drugs & Biologicals

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

- Observed 1 resident's Lantus flex pen had open date 31 days prior & lacked discard date; failed to dispose of outdated insulin flex pen for 1 resident placing resident at risk for ineffective medication

F801 Qualified Dietary Staff

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

- Failed to employ a full time CDM to evaluate residents' nutritional concerns & oversee ordering, preparing, & storage of food for all resident & 2 kitchens in facility placing residents at risk for inadequate nutrition

F812 Food Procurement, Store/Prepare/Serve-Sanitary

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

- Observed freezer with: unsealed & opened to air foods; foods lacked opened date; food items with visible freezer burn

NW: SS=F: Failed to store, prepare, distribute & serve food in accordance with professional standards for food service safety for all residents who received meals from facility's 2 kitchens placing all residents at risk for foodborne illness

- Observed: fridge with cracked eggshell; plastic wrap on floor; numerous different size pieces of paper under bottom shelf; freezer with ice around all inside & with numerous different sized, dried brown, liquid stains on bottom; counter ice machine with numerous different sized brown specks of food particles in & around tray; wall behind ovens with dried brown stains; under 3-sink area with detergent containers with food particles & dried substance; pipes under sink area with black substance; floor ice machine vents with gray fuzzy substance throughout them; ceiling vents with gray fuzzy substance; outside of 2 oven doors & bottom foot plates with brown dried liquid substance & handles with white powdery substance; cart with white powdery substance & white dried liquid; fluorescent lights with spices with burnt out bulbs; toaster with crumbs & gray greasy on top & sides; exchange air vent with gray fuzzy particles throughout; perimeter of kitchen floor with black substance; knife container with brown black substance; cabinet doors with different size dried pink & brown liquid; four 1-gallon containers full of water under steam table with gray black substance all around outside of each container of water; wall under dishwasher with black substance; shelf & legs rusted & bottom shelf with hole in middle
- 2nd kitchen observed: oscillating table fan with gray fuzzy fan mesh & fan blades; ceiling mounted heater & AC units grills rusted & covered with brown greasy/sticky substance & gray fuzzy substance

F849 Hospice Services

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

- CP documented resident admitted to hospice care with no evidence of coordination of care between hospice & facility & facility had not received hospice CP from hospice; hospice CP not available to review in EMR; failed to coordinate care between facility & hospice services for 1 resident who received hospice services placing resident at risk for inappropriate end of life care

F851 Payroll Based Journal

SW: SS=F: Failed to electronically submit to CMS complete & accurate staffing information through PBJ related to licensed nursing staff coverage 24 hours/day

- PBJ revealed lack of LN coverage 24 hours/7 days on 9 days in quarter 4, 2022; 18 days in quarter 1, 2023; 12 days in quarter 2, 2023; 7 days in quarter 3, 2023; review of nursing schedule & time sheets for LN revealed adequate hours to account for 24-hr nursing coverage but facility reported inaccurate staffing data for LN coverage 24 hr/7 days/wk; failed to electronically submit to CMS complete & accurate direct care staffing information based on payroll & other verifiable & auditable data in uniform format according to specifications established by CMS r/t LN coverage 24 hr/7 days/wk as required

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

- PBJ report indicated facility did not have LN coverage 24 hrs/day 7 days/wk on 5 dates for quarter 1 2023; review of LN payroll data for dates listed revealed LN on duty 24 hrs/day 7 days/wk; failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

F880 Infection Prevention & Control

SW: SS=F: Failed to maintain an effective infection control program with failure of staff to follow infection control standards when delivering laundry to residents' rooms, failure to place distilled water jugs on surface other than floor & failure of staff to appropriately clean nebulizers after use with potential to lead to cross contamination between residents & to place residents receiving O2 & nebulized medications at increased for respiratory infections

- Observed laundry staff carrying clean resident bed linens against body from cart in hallway to linen closet then into resident room; staff failed to follow infection control standards when delivering laundry to resident rooms with potential to lead to cross contamination between residents & negatively affect every resident in facility
- On 12-12-23 observed O2 concentrator humidifier dated 9-15-23; observed between resident's recliner & concentrator, stored on floor was opened & undated jug of distilled water; observed nebulizer device stored intact on bedside table with unknown clear liquid in nebulizer chamber; failed to appropriately clean nebulizers after each use as evidenced by unknown clear liquid in nebulizer chamber between uses with potential to lead to respiratory infections &/or complications for 1 resident
- Failed to clean nebulizers after each use as evidenced by unknown clear liquid in nebulizer chamber between uses with potential to lead to respiratory infections &/or complications for 1 resident
- Failed to appropriately clen nebulizers after each use as evidenced by unknown clear liquid in nebulizer chamber between uses with potential to lead to respiratory infections &/or complications for 1 resident

NW: SS=F: Failed to provide infection control measures for residents' O2 tubing when not in use & failed to implement surveillance plan for waterborne pathogens placing residents of facility at risk for infections

- Upon request, facility unable to provide evidence facility assessed risks & implemented surveillance plan to ID & prevent Legionella & other opportunistic waterborne pathogens
- Observed 1 resident's room with uncovered O2 tubing coiled up on O2 canister with nasal cannula touching back of tubing on multiple occasions; failed to provide infection control measures for residents' O2 nasal cannulas when not in use & failed to implement surveillance plan for waterborne pathogens placing residents of facility at risk for infections

F908 Essential Equipment, Safe Operating Condition

NW: SS=E: Failed to ensure 1/2 kitchens walk-in freezer was in safe operating condition, when freezer door continued to build up with ice & failed to completely shut placing residents of 1/2 buildings who received meals from kitchen at risk for foodborne illness

- Observed walk-in freezer door with ice buildup on frame of door & would not stay closed; dietary staff stated ice buildup for 6 months & had notified maintenance but nothing done; failed to ensure & maintain 1/2 kitchens walk-in freezer in safe operating condition when freezer door would build up with ice & would not completely shut placing residents who received meals from facility kitchen at risk for foodborne illness

F947 Required In-Service Training for Nurse Aides

SW: SS=F: Failed to maintain an in-service training program for CNAs that was appropriate & effective to ensure continuing competence of CNAs; facility IDd 3 CNAs had been employed over 1 year & 3/3 CNAs lacked required 12 hours of in-service training to include dementia & abuse trainings to ensure continuing competence of nurse aides & appropriate care & services to all residents of facility

- Of 3 CNAs who were employed for at least 12 months, 1/3 completed training in ANE & 0/3 had training dealing with dementia residents
- 1 CNA has 14.25 training but not training for working with residents with dementia; 1 CNA had 425 hours & no training for ANE or dementia training; 1 CNA had 2.0 hours with no dementia or ANE training; failed to provide 3/3 CNAs with required 12 hours of in-service training to include dementia & abuse training

January, 2024

F550 Resident Rights/Exercise of Rights

SE: SS=D: Failed to show respect & dignity to 1 resident while staff provided cares in resident's room

- Observed LN entered resident's room to clean suprapubic area & supply new split gauze pad; while care being provided, CNA knocked on door & entered immediately w/o waiting for response from anyone in room & resident on back in bed with pants lowered down past groin while LN provided cares & when door opened resident exposed to anyone in hallway outside door; failed to show respect & dignity to exposed resident while staff provided cares

NE: SS=E: Failed to ensure dignified care environment for 5 residents; additionally failed to provide dignity while dining when facility used disposable silverware & dishware during meals placing residents at risk of unnecessary embarrassment & decreased psychosocial wellbeing

- Incident report documented resident assisted EMS by holding door so EMS could enter facility & Adm staff approached resident & told resident to move out of way & resident refused & Adm staff used profanity toward resident
- Observed residents ate breakfast with Styrofoam plates/cups & disposable plastic silverware & Dietary staff stated facility had enough silverware for all 3 meal services but staff did not return silverware to kitchen in time for next service
- Observed resident in Broda chair at DR table with head & arms resting on table & staff yelled out "I'll feed her" to another staff across room
- Observed LN administered 1 resident's morning meds through G-tube & completed dressing change & failed to close door or pull privacy curtain during provided care with multiple people walking past room within sight of provided care; during dressing change, DON walked by resident's room then stopped & closed door
- Observed staff stand next to resident in DR to assist with eating
- Observed CNA stood next to resident to assist with eating & failed to offer or alternate drinks with solid food
- Observed CNA assisted resident to reposition in Broda chair w/o telling resident cares to be provided; failed to ensure dignified care environment for 5 residents; additionally failed to provide dignity while dining r/t using disposable silverware & dishware during meals placing residents at risk for unnecessary embarrassment & decreased psychosocial wellbeing

NE: SS=D: Failed to ensure 2 residents were treated in dignified manner placing residents at risk for decreased psychosocial wellbeing

- Observed resident in bed on top of blankets & resident wore top that did not fully cover abdomen & resident wore adult brief & resident uncovered & brief & bare legs exposed & visible from hallway
- Observed resident in room with door open & strong urine odor detected in room & resident in bed, uncovered, with pants down around knees & resident wore brief & resident visible from hallway; failed to ensure 2 residents treated in dignified manner placing residents at risk for decreased psychosocial wellbeing

NW: SS=D: Failed to provide 1 resident with dignity & respect during care placing resident at risk for undignified experience

- Observed LN obtained blood sampled from resident's finger & then pulled up resident's shirt & exposed stomach then administered insulin injection while resident ate meal while 8 other residents present in DR; failed to provide 1 resident with dignity & respect placing resident at risk for undignified experience

F554 Resident Self-Administration of Meds-Clinically Appropriate

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

- CP documented resident requested to self-administer inhaler at bedside & safe administration of med assessment determined resident capable of completing task & CP documented resident could only self-administer inhalers; record lacked evidence facility assessed resident for ability to safely self-administer medications in pill or tablet form or medications other than inhalers; failed to ensure 1 resident had physician order & ability to safely self-administer meds before leaving meds at bedside placing resident at risk for improper use of medication & related side effects

F558 Reasonable Accommodations Needs/Preferences

NE: SS=D: Failed to ID & correct environmental challenges to 1 resident's mobility; additionally failed to provide 1 resident call light in room placing 2 residents at risk for decline in ADLs

- Resident with MS stated resident had difficult time exiting room due to roommate's bed blocking right side of bed; observed resident's side of room with roommate's bed slanted inward with foot of bed 2 feet from resident's bed; resident stood up on left side of bed but had difficulty maneuvering left side to exit bed area with support canes & resident had difficulty positioning support canes due to lack of room while exiting bed area; resident stated resident could not exit through right side due to curtain next to bed; failed to ID & correct environmental challenges to resident's mobility placing resident at risk for decline in ADLs & impaired mobility
- Resident stated call light button removed from room & Friday & never returned; observed no call light button installed on resident's side of room; failed to ensure 1 resident had functioning call light button installed in room placing resident at risk for preventable accidents & delayed care needs

F561 Self-Determination

NW: SS=D: Failed to honor 1 resident's preference to receive 3 showers per week placing resident at risk for decreased self-determination & impaired psychosocial wellbeing

- Failed to honor 1 resident's preference of receiving 3 showers/wk placing resident at risk for decreased self-determination & impaired psychosocial wellbeing

F576 Right to Forms of Communication w/Privacy

NW: SS=C: Failed to deliver mail to facility residents on Saturdays

- During Resident Council meetings residents verbalized there was no mail delivery on Saturdays; Adm Nurse verified CMAs would get mail during weekends at post office box downtown then deliver mail to residents & facility had recently hired new CMA & failed to tell CMA she should get mail on Saturdays at post office box downtown & worked every other weekend & facility did not pick up or deliver mail to residents every other Saturday; failed to deliver mail to resident in facility on Saturdays

F577 Right to Survey Results/Advocate Agency Info

NW: SS=C: Failed to ensure most recent survey & complaint survey results were available for public review

- Failed to ensure last 3 years of surveys & complaint survey results were available for public review placing residents at risk for lack of information r/t survey results

F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directive

SE: SS=D: Failed to ensure 1 resident's request for full resuscitative measures in case of cardiac or respiratory arrest was communicated in CP & to hospice provider

- CP instructed staff resident not at nor approaching end of life at t his time & resident was on hospice & had DNR; record contained DNR document signed by resident dated 7-24-19; Advance Directive dated 7-23-21 signed by resident indicated resident DID want CPR; failed to clarify Advance Directive Statement to ensure resident's choice for accurate resuscitation/DNR were honored

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

NE: SS=D: Failed to notify 1 resident's physician & representative r/t weight loss &/or change in health condition placing resident at risk for continued weight loss & malnutrition due to delayed physician & representative involvement

- EMR lacked evidence resident was weighed more than 3 times since admission on 11-16 or that weight was re-checked or addressed by facility; EMR lacked evidence resident refused to have weight obtained; EMR lacked evidence physician or representative was notified r/t change in resident's health status & weight loss; failed to notify physician & representative r/t weight loss &/or change in health condition placing resident at risk for continued weight loss & malnutrition due to delayed physician & representative involvement

F582 Medicaid/Medicare Coverage/Liability Notice

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

- Failed to ensure forms provided at end of skilled services contained required information for residents to make informed choices placing residents at risk for impaired decision-making

NW: SS=D: Failed to provide resident a fully completed ABN for skilled services for 3 residents which included estimated cost of services placing resident at risk for uninformed care decisions

- Failed to provide resident completed CMS 10055 form when discharged from skilled services for 3 residents including the estimated cost of continued services placing residents at risk of making uninformed decisions for skilled services

F583 Personal Privacy/Confidentiality of Records

NE: SS=D: Failed to ensure staff secured & protected privacy & confidentiality of 1 resident's medical record placing resident's personal & confidential information at risk of being accessed by unauthorized individuals

- Observed MAR left open, visible & unattended on med cart outside room; failed to ensure staff secured & protected privacy & confidentiality of 1 resident's medical record placing resident's personal & confidential information at risk of being accessed by unauthorized individuals

F584 Safe/Clean/Comfortable/Homelike Environment

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

- Observed heavy urine smell throughout facility; room BR w/o mirror & paper towel dispenser missing cover; wall behind bed torn & missing paint; room missing plaque on wall that showed room number; couch in TV area with unattended cup with clear liquid in it sitting on cushion; strong urine odor in resident room; very strong urine odor prevalent throughout hallways & common areas; failed to ensure residents were provided a safe, clean, comfortable & homelike environment placing residents at risk of potential for decreased psychosocial wellbeing & impaired safety & comfort for affected residents

NW: SS=E: Failed to provide safe, clean comfortable & homelike environment in DR placing residents at risk of unsafe & uncomfortable environment

- Observed DR with floor throughout DR with blackish gray build up & floor tile next to heater had missing piece of tile; failed to provide safe, clean, comfortable & homelike environment in DR placing residents at risk of unsafe & uncomfortable environment

F609 Reporting of Alleged Violations

NE: SS=D: Failed to ID preventable accident for 1 resident who was dependent on staff for transfers with Hoyer, as allegation of potential neglect & failed to report to state agency as required within required timeframe placing resident at risk for unidentified & ongoing neglect

- Incident Report documented LN called to resident's room & found resident on floor with pillow under head & staff present at time of incident reported transferred resident from chair to bed with Hoyer lift when 1 of loops on side "came loose" & caused resident to fall; resident with hard bump to back of head & resident sent to local ER for eval & treat; failed to ID preventable accident for 1 resident who was totally dependent on staff for transfers with Hoyer as allegation of potential neglect & failed to report to state agency as required within required timeframe placing resident at risk for unidentified & ongoing neglect

NW: SS=D: Failed to ensure staff ID'd concerning behaviors as potential allegations of abuse &/or mistreatment & failed to report to facility Adm as required placing resident at risk for unidentified & ongoing abuse &/or mistreatment

- Witness statement documented CMA observed LN yelled at 1 resident prior to 1-11-24 when resident had 2 drinks at DR table & CMA documented heard LN tell kitchen staff resident could only have small drinks & could not have more until resident drank what resident had; CNA witness statement documented resident approached CNA very upset & reported LN "not nice" to resident & LN in nurse-to-nurse report said resident was being (expletive) & LN stated did not like resident; (another) LN witness statement documented LN "did not make enough time for resident & did not respond to resident's requests & other LN had visualized LN shut nurses' station door "in resident's face" during shift-to-shift report while LN stated "here she comes" & had witnessed LN tell resident could not have breathing tx & cough syrup at same time even though resident had active physician order for both of them; LN stated saw LN speak to resident in condescending, authoritative manner when resident had behavior of yelling or screaming & LN told resident to "knock it off"; Adm stated staff had not immediately reported concerns r/t LN's behavior to Adm staff; failed to ensure staff ID'd concerning behaviors as potential allegations of abuse &/or mistreatment & failed to report to facility Adm as required placing resident at risk for unidentified & ongoing abuse &/or mistreatment

F623 Notice Requirements Before Transfer/Discharge

NE: SS=D: Failed to provide written notification as soon as practicable to 1 resident with risk of miscommunication between facility & resident

- Record lacked evidence written notification of transfer was provided to 1 resident/representative for 4 facility-initiated transfers of resident to acute care center; failed to provide written notification of facility-initiated transfers with required information to resident/representative in practicable amount of time with risk of miscommunication between facility & resident

NE: SS=D: Failed to provide written notification to long-term care ombudsman for 2 residents; failed to provide notice of transfer as soon as practicable to 1 resident/representative with risk of miscommunication between facility & resident with risk of miscommunication between facility & resident/family & possible missed opportunities for healthcare service for 2 residents

- Failed to provided written notification of transfer with required information to LTCO for 1 resident in practicable amount of time, or at least monthly with risk of miscommunication between facility & resident/family & possible missed opportunities for healthcare services for 1 resident
- Failed to provide written notification of reason & location for transfer to hospital to 1 resident/representative placing resident at risk of miscommunication & uninformed decisions

NW: SS=D: Failed to notify State LTC Ombudsman of facility-initiated discharges for 1 resident who was hospitalized twice in November 2023 placing resident at risk for decreased oversight & assistance with transfers & discharge

- Failed to notify State of Kansas LTC Ombudsman of discharge from facility twice in November 2023 placing resident at risk for decreased oversight & assistance with transfers & discharge

NW: SS=D: Failed to notify state LTC Ombudsman as required of 1 resident's discharge from facility placing resident at risk for impaired rights &/or advocate involvement

- EMR lacked evidence a bed hold was issued & further unable to provide evidence Ombudsman was notified of facility-initiated discharge; failed to notify state LTC Ombudsman as required of resident's facility-initiated discharge from facility placing resident at risk for impaired rights &/or advocate involvement

F625 Notice of Bed Hold Policy Before/Upon Transfer

SE: SS=D: Failed to provide 2 residents &/or representative with written notice specifying duration & cost of bed hold policy at time of residents' transfer to hospital

- CP lacked staff instruction r/t need for bed hold should resident discharge to acute hospital setting; EMR laced signed bed hold for hospitalization; failed to provide resident &/or representative with written notice specifying duration & cost of bed hold policy at time of resident's transfer to hospital
- Resident transferred & admitted to acute care for bradycardia & returned 6 days later & EMR lacked bed hold on multiple occasions; failed to issue bed hold to resident/responsible party for resident's 2 transfers/admissions to acute care as required

NW: SS=D: Failed to provide bed hold notice as required to resident/representative upon discharge form facility placing resident at risk for impaired rights

- EMR lacked evidence a bed hold was issued; failed to provide bed hold notice as required to 1 resident/representative upon discharge from facility placing resident at risk for impaired rights

F640 Encoding/Transmitting Resident Assessments

NW: SS=F: Failed to submit to CMS a MDS assessment within 92 days of previous assessment for all residents of facility & 1 discharged residents placing residents at risk for lack of oversight to ensure needs were met

- Adm nurse stated had not been able to send in MDS for a few months since October 2023 due to system failure of facility's computer program; stated state agency was aware; Adm nurse stated facility did all assessments but had not completed an electronic MDS to submit/transmit to CMS; Adm nurse stated facility's system updated on 1-16 & would have all MDS submitted by 1-18; failed to submit to

CMS an MDS assessment within 92 days of previous assessment for all residents of facility & 1 discharged resident placing residents at risk for lack of oversight to ensure needs are met

F656 Develop/Implement Comprehensive Care Plan

SE: SS=D: Failed to develop a comprehensive CP for 2/12 residents reviewed: 1 resident for non-pharmaceutical interventions for pain & 1 resident for revision of resuscitation preferences

- Cited findings noted in F578 r/t inconsistent information in record r/t Advance Directives; failed to review & revise 1 resident's CP to reflect determination of preference for resuscitation/DNR
- MDS indicated no non-pharmacological interventions for pain were attempted; CP lacked instructions r/t non-pharmacological interventions for resident's pain; failed to complete a comprehensive CP to include non-pharmacological interventions for pain for resident who has pain

NW: SS=D: Failed to develop comprehensive CP for 2 residents: 1 for COPD supplemental O2 use & 1 resident's care r/t DM placing residents at risk for impaired care due to uncommunicated care needs

- CP lacked documentation of resident's dx of COPD & O2 use; failed to develop comprehensive CP for 1 resident with dx of COPD & used supplemental O2 placing resident at risk for unmet care needs
- CP lacked interventions r/t DM & blood sugar monitoring; failed to develop comprehensive CP r/t dx of DM placing resident at risk for impaired care due to uncommunicated care needs

NW: SS=D: Failed to develop comprehensive CP to include resident's dx of DM placing resident at risk for inappropriate care due to uncommunicated care needs

- CP lacked DM & use of insulin & blood glucose testing; failed to develop comprehensive CP for 1 resident placing resident at risk for inadequate care due to uncommunicated care needs

F657 Care Plan Timing & Revision

SE: SS=D: Failed to review & revise CP for 2 sampled residents r/t failure to revise CP to include constipation for 1 resident & 1 resident r/t failure to revise CP to include aphasia communication

- CP lacked staff instruction r/t interventions to relieve resident's constipation; failed to review & revise CP to include constipation
- CP lacked revision to include resident's unclear speech; failed to review & revise resident's CP to include goals & interventions for resident's aphasia to improve communication & decrease frustration

NE: SS=D: Failed to revise 1 resident's CP to reflect use of personal knee braces placing resident at risk for impaired care due to uncommunicated care needs

- CP lacked documentation r/t bilateral knee braces resident applies self daily; failed to revise 1 resident's CP to reflect use of personal knee braces placing resident at risk for impaired care due to uncommunicated care needs

NW: SS=D: Failed to revise CP with person-centered interventions for behavioral triggers for 1 resident with dx of PTSD placing resident at risk for decreased quality of life due to uncommunicated care needs

- "Negative Life Events or Traumatic Experiences Screening" documented resident did not have any negative life events; EMR lacked evidence trauma-informed assessment completed for resident after dx of PTSD; CP lacked ID'd triggers & interventions r/t resident's PTSD; POS for Prazosin for night terrors; POS for Propranolol for PTSD; POS for Trazadone for anxiety; POS for Duloxetine for depression; observed resident in DR & did not speak to tablemates; failed to revise 1 resident's CP with triggers r/t to PTSD placing resident at risk for decreased quality of life due to uncommunicated care needs

NW: SS=D: Failed to update 1 resident's CP with interventions for staff to follow r/t PTSD placing residents at risk for inadequate care due to uncommunicated care needs

- CP documented resident with fall with fx & CP lacked information or direction to staff r/t how to care for resident's wrist fx; CP lacked directions to staff on how to care for resident's wrist fx; failed to update resident's CP placing resident at risk for inadequate care due to uncommunicated care needs
- "Trauma collection Data Sheet" dated at admission incomplete; SS noted lacked mention of any social services to help resident with past traumatic events; SS noted documented resident "seemed depressed that day" & ate both meals in room which was not resident's normal & note lacked documentation of any social services support r/t behavior &/or mood; failed to update resident's CP with instructions to staff r/t PTSD placing resident at risk for inadequate care due to uncommunicated care needs

NW: SS=D: Failed to revise CP to include interventions r/t delusions when physician prescribed antipsychotic medication new to resident placing resident at risk for inadequate response to mental health needs due to uncommunicated care needs

- Failed to revise 1 resident's CP to include interventions r/t delusions when physician prescribed an antipsychotic medication new to resident placing resident at risk for inadequate response to mental health needs due to uncommunicated care needs

F676 Activities of Daily Living (ADLs)/Maintain Abilities

NE: SS=D: Failed to provide necessary level of assistance for 1 resident during mealtime & maintain abilities placing resident at risk for impaired nutrition & decline in ADLs

- Observed resident in room eating breakfast & staff no present in room during meal service & resident had no call light & resident stated sometimes kitchen served meals resident could not eat due to not having teeth & usually sent sausage links that were difficult for resident to chew; observed resident with lunch on bedside table & resident coughed several times then spit out apple slices from mouth & stated could not eat pie because slices were rubber & hard to chew & upon inspection apple slices difficult to cut with silverware; failed

to provide necessary level of assist for resident during mealtime to maintain abilities placing resident at risk for impaired nutrition & decline in ADLs

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to ensure 1/2 residents received assistance with grooming

- Observed resident with several days of hair growth on face & resident indicated did not want to grow a beard & needed staff assist to shave; failed to ensure staff provided shaving assist for resident who preferred a clean shaven appearance

NE: SS=D: Failed to provide necessary assistance to 1 resident for eating & drinking placing resident at risk of increased complications due to impaired ADL ability

- Observed CNA assisted 1 resident in DR by standing next to resident & began spoon-feeding food items & staff continued to provide assistive feeding w/o offering or alternating drinks with solid food; resident's solid-to-liquid meal intake was not alternated throughout meal per CP; failed to provide 1 resident with necessary assistance during staff-assisted meals placing resident at risk for complications

NE: SS=D: Failed to provide consistent bathing opportunities for 2 residents; additionally failed to provide aDL assist to 1 resident, a resident totally dependent on staff assist for all ADLs placing residents at risk for decreased psychosocial wellbeing & impaired ADLs

- Failed to provide consistent bathing opportunities for 1 resident placing resident at risk for infections, decreased psychosocial wellbeing & impaired ADLs
- Failed to provide consistent bathing for 1 resident who required assistance with bathing placing resident at risk for complications r/t poor hygiene & impaired dignity r/t strong urine odor & multiple missing bathing opportunities
- Failed to provide 1 resident with necessary ADL care & assistance resident required placing resident at risk for impaired quality of life & decreased dignity & comfort

NW: SS=D: Failed to provide consistent bathing services as CP'd for 1 resident placing resident at risk for poor hygiene

- October Bathing Report documented resident requested showers on Monday, Wednesday, & Friday & lacked documentation resident received requested 3 showers/wk; November bathing report documented resident requested showers on Monday & Thursday & lacked documentation resident received requested 2 showers; EMR lacked documentation resident refused showers; December Bathing Report documented resident requested showers on Monday & Thursday & lacked documentation resident received requested 2 showers/wk; resident stated when first came to facility, asked for showers 5x/wk & was told could have 3x/wk & told what days resident would received showers; resident stated now, resident never knows what days showers are because facility switches showers around & does not remember last time had a shower because not getting even 2 showers/wk; observed resident's hair uncombed & greasy; failed to provided 1 resident consistent bathing services placing resident at risk for poor hygiene

F679 Activities Meet Interest/Needs Each Resident

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

- Activity Calendars revealed "Resident Choice" was only facility-led activity on weekends for 3 months; Resident Council members reported weekend lacked consistent activities since facility's Activity Coordinator left in November 2023; resident reported resident not made aware of weekend activities when they occurred; failed to provide consistent activities for residents during weekends placing affected residents at risk for decreased psychosocial wellbeing & boredom

F680 Qualifications of Activity Professional

NE: SS=E: Failed to provide a certified activity professional placing affected residents at risk for decreased quality of life

- Failed to provide a certified activity professional placing affected residents at risk for decreased quality of life

F684 Quality of Care

SE: SS=D: Failed to ensure 1 resident received PRN medications to treat constipation when needed in timely manner

- Resident with dx constipation; CP lacked staff instruction r/t constipation; POS for multiple bowel management medications routine & PRN; EMR indicated resident w/o BM for 6 days & no PRN med given by staff; resident stated staff had not offered PRN medication for constipation & if offered would have taken it & does not refuse meds; failed to ensure resident received PRN medication for constipation when needed in timely manner

NE: SS=D: Failed to follow physician' order for daily weights to monitor for fluid overload for 1 resident placing resident at risk for delay in treatment r/t fluid overload & untreated illness

- TAR lacked evidence staff measured & recorded 1 resident's weight on 12 occasions in 2 month period; record lacked evidence of physician notification daily weight not obtained; failed to follow physician's order for daily weights to monitor weight gain for fluid overload for 1 resident who had CHF placing resident at risk of adverse side effects from unnecessary medication or complications r/t fluid overload

NW: SS=D: Failed to notify physician as ordered for 1 resident's weight increase placing resident at risk for complications r/t edema

- POS for daily weight & notify physician for 2# weight increase in 24 hours or 5# increase in 7 days for edema; MAR lacked evidence physician notified as ordered for 2# weight increase on 6 occasions from October-January; failed to notify resident's physician as ordered when resident had 2# weight increase on multiple dates placing resident at risk for complications r/t edema

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

NE: SS=D: Failed to ensure pressure-reducing measures were placed on 1 residents' bilateral lower extremities to prevent PUs & further failed to monitor refusals to evaluate ongoing necessity & effectiveness of interventions placing resident at increased risk for PU development

- CP documented staff to place Zero G boots on bilateral lower extremities when in bed as resident would allow; EMR lacked documentation of any refusal to wear boots; observed resident in bed & boots on floor at foot of bed on multiple occasions; failed to ensure pressure-reducing measures were placed on resident's bilateral lower extremities to prevent PUs & further failed to monitor refusals to evaluate ongoing necessity & effectiveness of interventions placing resident at increased risk for PU development

NE: SS=D: Failed to ensure 1 resident's low air-loss mattress pump was set up to resident's appropriate weight requirements & failed to provide wound care per resident's ordered tx; additional failed to assess 1 resident's pressure wounds upon admission placing 2 residents at risk for complications r/t skin breakdown & PUs

- CP instructed staff to weigh resident per physician orders due to risk of malnutrition; CP indicated resident with pressure-reducing mattress but did not provide guidance for low air-loss mattress settings; MAR indicated dressing not completed on 1 day in current month & no notes indicating status of tx for date of missing tx; failed to ensure 1 resident's low air-loss mattress pump was set up to resident's appropriate weight requirements & failed to provide wound care per resident's ordered treatment placing resident at risk for complications r/t skin breakdown & PUs
- Hospital paperwork from admission documented resident with pressure injury on bilateral buttocks stage 3 & unstageable PU to bilateral buttocks; no admission skin assessments completed; failed to ensure 1 resident w ho was admitted with PUs received proper care to avoid decline of deep tissue injury & new development of pressure injury/ulcer placing resident at risk for further skin breakdown & possible infection development

F689 Free of Accident Hazards/Supervision/Devices

NE: SS=E: Failed to secure 33 pressurized medical O2 tanks in safe, locked area & out of reach of 9 cognitively impaired independently mobile residents; facility additionally failed to appropriate transfer resident with 2 staff resulting in non-injury fall placing residents at risk for preventable accidents & injuries

- Observed unlocked O2 storage closet containing 15 fully pressurized supplemental O2 tanks stored in floor rack & 1 cylindrical container on portable stand; staff unaware if door was supposed to be locked but secured door; another hallway closet with unsecured O2 storage room with broken door & room contained 18 fully pressurized O2 tanks; failed to secure 33 pressurized medical O2 tanks in safe, locked area & out of reach of 9 cognitively impaired independently mobile residents placing residents at risk for preventable accidents & injuries
- CP documented transfer technique changed for resident to extensive assist of 1 or 2 staff then documented resident dependent on 2 staff or stand-up lift was to be used; NN documented CNA lowered resident to floor during transfer from bed to w/c; failed to ensure staff followed 1 resident's CP which included resident was dependent on 2 staff members' assistance with sit-to-stand lift for transfers placing resident at risk for further falls & related injuries

NE: SS=D: Failed to ensure environment free from preventable accidents when staff failed to correctly place loop of sling during Hoyer lift transfer resulting in resident's fall to floor from lift; further failed to ensure Dycem placed correctly in 1 resident's w/c placing 2 residents at risk for avoidable injuries

- Failed to ensure environment free from preventable accidents when staff failed to correctly place loop of sling during Hoyer lift transfer which resulted in resident falling to floor from lift placing resident at risk for avoidable injuries
- Failed to ensure proper placement of 1 resident's Dycem in w/c resulting in non-injury fall placing resident at risk for preventable accidents & injuries

NE: SS=E: Failed to secure hazardous materials when facility failed to ensure Sharps container mounted on side of cart & stored in hallway had lid to prevent residents from reaching into container placing 19 cognitively impaired independently mobile residents at risk for preventable injuries & accidents; additionally failed to ensure 1 resident's portable urinal was within reach resulting in non-injury fall placing resident at risk for preventable falls & injuries

- Observed tx cart next to nurses' station with cart revealed mounted Sharps container on side of cart & container lacked safety cover to prevent exposure to used lancets & hazardous materials within container; failed to secure hazardous material in defective Sharps container placing 19 cognitively impaired independently mobile residents at risk for preventable injuries & accidents
- Failed to provide investigation or evidence facility evaluated causative factors r/t 1 resident's fall; failed to ensure 1 resident's portable urinal was within reach resulting in non-injury fall placing resident at risk for preventable falls & injuries

NW: SS=E: Failed to provide safe environment free of chemical hazards for 5 cognitively impaired independently mobile residents & failed to ensure safe environment for 1 resident placing affected residents at risk for preventable accidents, falls & related injuries

- Observed Windex cleaner below fish aquarium & Lime Away bottle; failed to provide environment free of chemical hazards for 5 cognitively impaired, independently mobile residents who resided in facility placing resident at risk for preventable injuries
- Resident with hx of falls; fall investigation documented resident observed on floor beside w/c & documented staff had turned off lights in DR so resident thought needed to get out of DR & incident non-injury; observed staff assisted resident with toileting & in BR a walker & staff unable to ID who walker assigned to & staff gave walker to resident w/o sanitizing walker; failed to prevent cognitively impaired resident from fall after staff turned off lights in DR & resident thought had to get up & leave placing resident at risk for injury

NW: SS=D: Failed to ensure stovetop burners in activity room were disabled when not in use placing 1 cognitively impaired, independently mobile resident at risk for injury

- Observed facility's activity room with electric stove with 4 burners which were not disabled; when activated, burners became hot; observed 3 residents in activity room w/o staff present & stove top burner was able to be activated; failed to ensure stove was disabled when not in use placing 1 cognitively impaired, independently mobile resident at risk for burn injury

F690 Bowel/Bladder Incontinence, Catheter, UTI

NE: SS=D: Failed to ensure 1 resident's catheter bag was kept below bladder during Hoyer transfer placing resident at increased risk for infection & other catheter-associated complications

- Failed to ensure 1 resident's catheter bag was kept below bladder during Hoyer transfer placing resident at increased risk for infection & other catheter-associated complications

NE: SS=D: Failed to assess ongoing patterns of incontinence to establish bowel & bladder patterns in order to ID measures to maintain or improve 1 resident's incontinence placing resident at risk for complications r/t incontinence

- EMR indicated no bowel & bladder incontinence-related assessments completed since admission to establish toileting patterns for increased incontinence; observed resident smelled heavily of urine; failed to assess ongoing patterns of incontinence to establish bowel & bladder patterns to maintain or improve 1 resident's incontinence placing resident at risk for complications r/t incontinence

F692 Nutrition/Hydration Status Maintenance

NE: SS=D: Failed to complete weekly weigh monitoring as ordered by physician for 1 resident & failed to weigh 1 resident weekly upon admission per acceptable standards of practice placing both residents at risk for complications r/t weight loss

- Failed to complete weekly weight checks per physician's orders placing resident at risk for complications r/t weight loss
- Failed to monitor 1 resident's weights per acceptable standards of practice upon resident's admission placing resident at risk for continued weight loss & possible malnutrition

F695 Respiratory/Tracheostomy Care & Suctioning

NE: SS=D: Failed to maintain & store 1 resident's CPAP equipment in sanitary manner placing resident at risk for complications r/t respiratory infections

- CP lacked instructions to clean or maintain CPAP; observed CPAP & O2 tubing hung above resident's bed with no barrier bag; resident stated had recently had pneumonia; failed to maintain & store 1 resident's CPAP equipment in sanitary manner placing resident at risk for complications r/t respiratory infections

NW: SS=D: Failed to provide adequate respiratory care & services for 2 residents when staff failed to store O2 tubing & cannula in sanitary manner when not in use placing residents at increased risk for infection

- EMR lacked direction to staff when to change O2 tubing & concentrator filter; observed O2 tubing & cannula laid unbagged on seat of recliner & O2 concentrator running on multiple occasions; failed to provide adequate respiratory services for 1 resident when staff failed to store O2 tubing & cannula in sanitary manner when not in use placing resident at risk for infection
- CP lacked documentation of Dx of COPD & O2 use; observed resident's O2 tubing & cannula wound up inside handle of O2 concentrator on multiple occasions; failed to provide adequate respiratory services for 1 resident when staff failed to store O2 tubing & cannula in sanitary manner when not in use placing resident at risk for infection

NW: SS=D: Failed to provide adequate respiratory care & services for 2 residents when staff failed to store O2 tubing & cannula in sanitary manner when not in use placing residents at risk for infection

- Failed to provide adequate respiratory care & services for 2 residents when staff failed to store O2 tubing & cannula in sanitary manner when not in use placing residents at risk for infection for multiple residents

F697 Pain Management

SE: SS=D: Failed to offer non-pharmacological interventions for pain for 1 resident with chronic pain

- Cited findings noted in F656 r/t pain management; CP lacked non-pharmacological interventions for pain; resident stated had a lot of pain from diabetic neuropathy; failed to offer non-pharmacological interventions for resident's pain

F698 Dialysis

NE: SS=D: Failed to consistently monitor & document 1 resident's central venous catheter for signs of infection, bleeding, & other complications with potential for adverse outcomes & physical complications r/t dialysis

- Record lacked documentation staff monitored catheter site for bleeding, infection or complications on non-dialysis days; LN stated catheter site was only monitored before & after dialysis & when resident bathed; failed to consistently monitor & document 1 resident's dialysis access site for signs of infection, bleeding, & other complications on non-dialysis days placing resident at risk of potential adverse outcomes & physical complications r/t dialysis

NE: SS=D: Failed to monitor 1 resident's access site for signs of infection & bleeding & failed to obtain communication from dialysis center & assess post-dialysis placing resident at risk for potential adverse outcomes & physical complications r/t dialysis

- EMR for 1 month revealed 2 dialysis communication sheets which lacked evidence of communication from dialysis provider & post-dialysis completed upon return from dialysis; EMR lacked evidence dialysis provider contacted by facility for verbal report; failed to monitor resident's dialysis access site for signs of infection, bleeding & status of dressing in place & failed to obtain communication from dialysis center & assess post-dialysis placing resident at risk for potential adverse outcomes & physical complications r/t dialysis

F699 Trauma Informed Care

NW: SS=D: Failed to complete trauma informed care assessment for 1 resident who had dx of PTSD placing resident at risk for unmet behavioral & mental health needs

- "Negative Life Events or Traumatic Experiences Screening" dated 10-14-19 documented resident did not have any negative life events; EMR lacked evidence a trauma informed assessment completed for resident after dx of PTSD; CP documented resident with behavior problem r/t crying & attention seeking & easily overwhelmed if too many people in surroundings & behavioral health consults; CP lacked

ID triggers for staff r/t dx of PTSD; failed to complete trauma informed care assessment for 1 resident with past trauma placing resident at risk for unmet mental health needs

NW: SS=D: Failed to complete a trauma-informed care assessment for 1 resident to ID any hx of trauma placing resident at risk for unmet behavioral & mental health needs

- Trauma Collection Data Sheet incomplete & CP lacked instructions to staff on interventions to use when resident cried & had manic behaviors; failed to provide sufficient & appropriate trauma-informed care to meet resident's mental & behavioral health needs placing resident at risk for re-traumatization

NW: SS=D: Failed to complete trauma-informed care assessment for 1 resident who had behaviors & past traumatic events in life placing resident at risk for unmet behavioral health needs

- EMR lacked documentation trauma-informed care assessment completed for resident; POS for Trazadone for depression, Duloxetine for anxiety; Clonazepam for anxiety, Seroquel for schizophrenia; failed to complete a trauma-informed care assessment for 1 resident who had behaviors & loss of children placing resident at risk for unmet mental health needs

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

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

- PBJ revealed facility triggered for no RN on 4 or more weekend days during quarter 1; quarter 2; facility failed to provide proof of 8 hrs of consecutive RN coverage/day/7 days/wk as required; facility lacked policy r/t staffing hours; failed to ensure RN coverage at least 8 consecutive hr/day/7 days/wk placing all residents at risk of delayed care & potential for physical or psychosocial harm

NW: SS=F: Failed to use services of RN for at least 8 consecutive hrs/day, 7 days/wk for all residents residing in facility placing facility & residents at risk for inadequate nurse guidance & leadership

- RN Staffing Schedule for October, November, & December 2022 & January through December 2023 recorded facility lacked RN: 1 day in October 2022; 2 days in November 2022; 1 day in December 2022; 1 day February 2023; 6 days in March 2023; 6 days in April 2023; 7 days in May, 2023; 7 days in June 2023; 6 days in July 2023; 3 days in August 2023; 4 days in Sept 2023, 6 days in October 2023; 9 days in Nov 2023; 11 days in December 2023; Adm verified facility did not have RN in building or working as charge nurse for required 8 consecutive hours on documented dates; failed to provide RN charge nurse for all residents who resided in facility for at least 8 consecutive hrs/day, 7 days/wk placing facility & residents at risk for inadequate nurse guidance & leadership

NW: SS=F: Failed to provide services of RN for at least 8 consecutive hrs/day 7 days/wk for all residents residing in facility placing facility & residents at risk for inadequate nurse guidance & leadership

- PBJ report indicated no RN hours on 4 days in August & Sept; Adm nurse verified 2/3 days w/o RN coverage & on those days, RN from hospital covered RN coverage; failed to provide services of RN for at least 8 hrs/day 7 days/wk for all residents who resided in facility placing facility & residents at risk for inadequate nurse guidance & leadership

F732 Posted Nurse Staffing Information

NE: SS=C: Failed to ensure nurse staffing data was posted daily; further failed to maintain posted daily nurse staffing data for minimum of 18 months

- On 1-2-242 current daily posted nursing staff data dated 12-29-23; failed to ensure hours of nurse staff data was posted daily as required; facility failed to maintain 18 months of posted daily nursing staff data

F744 Treatment/Service for Dementia

NE: SS=D: Failed to provide appropriate dementia care & services to address 1 resident's wandering behavior placing resident at risk for decreased quality of life due to inability to maintain highest practicable level of functioning

- Observed resident found in another resident's room asleep in other resident's bed; 8 minutes later resident awakened by staff & taken to DR & occurrence not documented in EMR & bedding not changed after occurrence; next day resident slept in roommate's bed & staff awakened resident & escorted resident to DR & incident not documented & bedding not changed after incident; failed to provide adequate supervision & activities to 1 resident to prevent resident from wandering into other residents' rooms & beds placing resident at risk for unmet care needs to maintain highest practicable level of functioning

F745 Provision of Medically Related Social Services

NW: SS=D: Failed to provide adequate medical social services to meet 1 resident's mental & behavioral health needs placing resident at risk for decreased quality of care & life

- Cited findings noted in F699 r/t trauma informed care; failed to provide sufficient & appropriate medical social services to meet 1 resident's mental & behavioral health needs placing resident at risk for decreased quality of care & life

F756 Drug Regimen Review, Report Irregular, Act On

NE: SS=D: Failed to ensure Consultant Pharmacist (CP) ID'd & reported lack of blood pressure & pulse monitoring for 1 resident prior to administration of Cozaar as ordered by physician; failed to ensure CP ID'd & reported resident's BP & pulse lacked monitoring as physician ordered; CP did not ID & report 1 resident was on antipsychotic which lacked appropriate indication for use or required physician documentation placing 3 residents at risk for unnecessary medications & possible adverse side effects

- Failed to ensure CP ID'd & reported 1 resident lacked physician-ordered BP & pulse readings before administration of Cozaar placing resident at risk for unnecessary meds & possible adverse side effects
- Failed to ensure CP ID'd & reported 1 resident lacked physician-ordered BP & pulse monitoring before administration of Cozaar placing resident at risk for unnecessary meds & possible adverse side effects

- Failed to ensure CP noted & recommended need for physician-documented rationale for continued use of antipsychotic medication for 1 resident who had dx of dementia placing resident at risk for unnecessary psychotropic medication & related complications

NW: SS=D: Consultant Pharmacist (CP) failed to notify facility of need to obtain appropriate indication for use of antipsychotic drugs for 2 residents placing residents at risk of receiving unnecessary antipsychotic drugs

- CP MRR for 6 months lacked need for approved indication for use of Risperidone; facility's CP failed to notify physician & DON of need to obtain appropriate indication for use of antipsychotic drugs for resident placing resident at risk of receiving unnecessary antipsychotic drugs
- Failed to ensure CP reported inappropriate indication for continued use of resident's antipsychotic medication, Geodon with side effects

NW: SS=D: Failed to ensure Consultant Pharmacist (CP) IDd & reported lack of appropriate indication or required physician documentation for 1 resident's use of antipsychotic medication placing resident at risk for inappropriate use of antipsychotic medication with side effects

- POS for Seroquel for dementia; CP for 10-23 recommended GDR & risk/benefit & physician declined dose reduction r/t aggressive behaviors r/t normal pressure hydrocephalus dx; CP MRR for 6 consecutive months lacked recommendation for appropriate indication for Seroquel; EMR lacked physician rationale which included unsuccessful attempts for nonpharmacological symptom management & risk benefits for continued Seroquel use; failed to ensure CP reported inappropriate indication for continued use of antipsychotic med Seroquel for 1 resident placing resident at risk for unnecessary antipsychotic med with side effects

F757 Drug Regimen is Free from Unnecessary Drugs

NE: SS=D: Failed to follow 1 resident's physician orders to notify medical provider of weight gain r/t diuretic medication placing resident at risk for unnecessary medications & side effects

- Resident with edema & CHF, DM & a-fib; POS for diuretic; CP instructed staff to weight resident daily & report weight gain of 2 pounds within 1 day or 5 pounds within 1 week to physician; POS for Lasix; EMR documented weight gains on 5 occasions & physician only notified of 1 day of weight gain; failed to follow 1 resident's physician's orders to notify medical provider of weight gain r/t diuretic medications placing resident at risk for unnecessary medications & side effects

NE: SS=D: Failed to ensure 1 resident's physician-ordered BP & pulse were monitored prior to administration of Cozaar; failed to ensure 1 resident's BP & pulse were monitored as physician ordered placing 2 residents at risk for unnecessary medications & possible adverse side effects

- Cited findings noted in F756 r/t medication monitoring of BP & pulses as ordered by physician; failed to ensure resident's physician ordered BP & pulse were monitored prior to administration of Cozaar placing resident at risk for unnecessary meds & possible adverse side effects
- Failed to ensure resident's BP & pulse were monitored twice daily as ordered by physician placing resident at risk for unnecessary meds & possible adverse side effects

NW: SS=D: Failed to notify resident's physician of elevated blood sugar per physician ordered parameters & failed to initiate 1 resident's prescribed bowel treatment placing both residents at risk for impaired care & adverse medication effects

- CP lacked interventions r/t DM & blood sugar monitoring; failed to notify 1 resident's physician of blood sugar levels outside physician ordered parameters placing resident at risk of diabetes complications
- Bowel Monitoring Record documented resident w/o BM for 4 & 5 consecutive days & lacked evidence staff provided interventions during lack of BMs on dates; failed to monitor & provide interventions for bowel management for 1 resident as ordered by physician placing resident at risk for fecal impaction & decline

F758 Free from Unnecessary Psychotropic Meds/PRN Use

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

- EMR lacked documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for POS for Risperidone for severe agitation for anxiety; failed to ensure appropriate indication or documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of resident's antipsychotic medication placing resident at risk of receiving unnecessary psychotropic medication

NW: SS=D: Failed to ensure appropriate indications or a documented physician rationale which included multiple attempts for nonpharmacological symptom management & risk versus benefits to continue use of antipsychotic for 1 resident who had dx of dementia, 1 resident who had dx of dementia & depression & 1 resident with dx depression placing residents at risk for unnecessary psychotropic meds & related complications

- POS for Lexapro for depression, Wellbutrin for depression, Buspirone for anxiety d/o, Risperdal for dementia; multiple MRR with recommendations to physician with "no change, symptoms were improved with current medications" & 1 MRR with no physician response; EMR lacked evidence of documented physician rationale which included multiple attempts for nonpharmacological symptom management & risk versus benefits to continue use of Risperidone; failed to ensure appropriate indication or required physician documentation for continued use of resident's use of Risperidone placing resident at risk for unnecessary adverse side effects
- POS for Seroquel for anxiety/agitation r/t major depressive d/o, Zyprexa for dementia with unspecified severity w/o behavioral disturbance, psychotic disturbance & Trintellix for depression; MRR requested risk/benefit statement & record lacked physician's response to request; failed to ensure appropriate indication or required physician documentation for continued use of 1 resident's use of Seroquel & Zyprexa placing resident at risk for unnecessary adverse side effects
- POS for Seroquel for major depression; Abilify for delusions; EMR lacked evidence of documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for ongoing Seroquel use; failed to

ensure appropriate indication or required physician documentation for continued use of resident's Seroquel placing resident at risk for unnecessary adverse side effects

NW: SS=D: Failed to ensure appropriate indication for use, or a documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of antipsychotic for 2 residents placing residents at risk for unnecessary psychotropic medications

- POS for Seroquel for Alzheimer's disease & dementia; EMR lacked evidence of documented physician rationale which included multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use of Seroquel; failed to ensure appropriate indication or required documentation for continued use of 1 resident's Seroquel placing resident at risk for unnecessary psychotropic medications
- POS for Seroquel for anxiety d/o; EMR lacked evidence of documented physician rationale including multiple unsuccessful attempts for nonpharmacological symptom management & risk vs benefits for continued use of Seroquel; failed to ensure appropriate indication or required documentation for continued use of Seroquel placing resident at risk for unnecessary psychotropic medications

NW: SS=D: Failed to obtain appropriate indication or required physician documentation for use of antipsychotic drugs for 3 residents placing residents at risk of receiving unnecessary antipsychotic drugs

- POS for Risperidone for agitation r/t psychosis; failed to ensure appropriate indication or required physician documentation was obtained for use of antipsychotic drugs for 1 resident placing resident at risk of receiving unnecessary antipsychotic drugs
- Failed to obtain appropriate indication or required physician documentation for use of antipsychotic drugs for 1 resident placing resident at risk of receiving unnecessary antipsychotic drug of Risperidone
- POS for Geodon for dementia with agitation; EMR lacked documented physician rationale including multiple unsuccessful attempts for nonpharmacological symptom management & risk versus benefits for continued use; failed to ensure 1 resident did not receive antipsychotic medication Geodon w/o appropriate dx or required documentation for its use, placing resident at risk for adverse side effects r/t use of Geodon

NW: SS=D: Failed to ensure appropriate indication or a documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management & risk/benefit for continued use of resident's antipsychotic placing resident at risk for unintended effects r/t psychotropic drug medications

- POS for Seroquel for dementia; cited findings noted in F756; EMR lacked documented physician rationale which included unsuccessful attempts for nonpharmacological symptoms management & risk/benefit for continued Seroquel use; failed to ensure resident did not receive antipsychotic medication w/o appropriate dx or required documentation for use placing resident at risk for adverse side effects r/t use of Seroquel

F759 Free of Medication Error Rates 5% or More

NW: SS=D: Failed to ensure 1 resident reviewed during med administration pass remained free of medication errors placing resident at risk for adverse reactions from medication & resulted in facility medication error rate of 5.13%

- POS for KCl ER & Pristiq ER; observed CMA crushed resident's pills including KCl & Pristiq ER & administered spoonful of medication & resident ingested all meds; failed to ensure staff did not crush extended-release medication placing resident at risk for adverse reactions from medication & created a facility medication error rate greater than 5%

F760 Residents are Free of Significant Med Errors

NE: SS=D: Failed to prevent a significant medication error when 1 resident continued to receive anticoagulant & mood stabilizer after medications were DC'd placing resident at risk for increased complications & adverse side effects r/t medication interaction

- POS for Eliquis & Depakote; hospital discharge orders documented DC'd meds of Eliquis & Depakote; MAR revealed Depakote & Eliquis were administered from re-admission to current date; record lacked documentation including clinical rational from physician to reorder Eliquis or Depakote for resident; failed to ensure 1 resident was free from medication errors when staff administered Eliquis & Depakote despite orders to DC medications placing resident at risk for potential adverse side effects r/t medication interactions

NE: SS=D: Failed to prevent a significant medication error when 1 resident received twice physician-ordered dose of Eliquis from 11-30 to 1-2 placing resident at risk for adverse effects including bleeding r/t med error

- POS for Eliquis 2.5mg BID upon hospital discharge; MAR documented Eliquis 5mg BID; MAR documented resident received 5mg (twice ordered dosage) of Eliquis 67/67 opportunities; med cards for Eliquis contained 5mg tablets with instructions to give BID; failed to prevent significant med error when resident received 2x's ordered dose of Eliquis placing resident at risk for other complications r/t med errors

F761 Label/Store Drugs & Biologicals

SE: SS=D: Failed to ensure safe storage of anti-anxiety medication as required

- Adm nurse revealed had investigated incident with controlled Alprazolam that occurred on 8-13-23; medications for residents are dispensed by the pharmacy in a bubble card, with each dose separate and enclosed in a plastic bubble. Administrative Nurse D revealed on 08/12/23, Licensed Nurse (LN)H administered bedtime medications to R9. LN H placed a dose of Melatonin 5 mg, in a medication cup and used R6's bubble card of Alprazolam 0.25 mg, then realized she used R6's bubble card and she retrieved one of the pills in the medication cup, which was the melatonin, and placed it in the last dose issued from R6's Alprazolam 0.25 mg card and taped it. On coming shift LN, I discovered the taped dose of an unknown medication in the Alprazolam bubble card and notified Administrative Nurse D. Administrative Nurse D stated she would expect staff to never replace medications in a bubble card and to document an error to ensure safe storage of the medications; failed to ensure proper storage/destruction of controlled substance medication as required

NE: SS=E: Failed to ensure safe storage & handling of 1 resident's insulin medication placing resident at risk for diversion & ineffective medication regimen

- Observed tx cart with unsecured insulin med stored in plastic bins on top of cart; failed to ensure safe storage & handling of 1 resident's medications placing residents at risk for diversion & ineffective medication regimen

NW: SS=E: Failed to properly store medication & biologicals in 1/2 med rooms placing residents at risk for ineffective medication

- Observed med room fridge lacked evidence staff assessed & recorded temp from 1-11 through 1-15 (5 days); failed to properly store medication & biologicals placing residents at risk for ineffective medications

NW: SS=E: Failed to store drugs & biologicals for 2 med carts placing residents at risk for missing meds & unsafe access to meds

- Observed tx/med cart unattended & unlocked ; next day observed med cart in living room unattended & unlocked; observed resident in w/c in DR attempting to open drawers on med cart; failed to store drugs & biologicals in secure manner placing residents at risk for missing & unsafe access to meds

NW: SS=E: Failed to dispose of expired meds appropriately placing residents at risk of receiving ineffective medication

- Observed multiple medications with expired expiration date; failed to dispose of expired meds appropriately placing residents at risk of receiving ineffective medications

NW: SS=D: Failed to label 1 resident's insulin flex pen with name, date opened & discard date & failed to discard expired stock medication in 1 med cart placing affected residents at risk for ineffective medications

- Observed expired medications; observed Tresiba flex pen open but lacked name, date opened & discard date; failed to label & date 1 resident's insulin flex pen & failed to discard expired stock meds placing residents at risk for ineffective medication

F801 Qualified Dietary Staff

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

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

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

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

F803 Menus Meet Resident Needs/Prep in Advance/Followed

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

- Observed lunch meal & kitchen served ham & beans & cornbread; review of menu for meal included ham & beans, cornbread & 2 vegetables to be served; Dietary staff reported did not prepare any vegetables to serve with meal; failed to serve planned menu items placing residents at risk for unmet nutritional needs

F804 Nutritive Value/Appear, Palatable/Prefer Temp

NE: SS=E: Failed to follow nutritionally approved recipes during preparation of facility's pureed meals placing 6 residents at risk for complications r/t nutritional impairment

- Observed dietary staff placed meat items in food processor that had previously been used for food & had not been washed before puree use; staff added beef stock to processor w/o measuring amount of liquid stock to be added & mixer with wet pudding-like consistency for prepared meat & staff did not review pureed beef recipe throughout preparation of pureed meal; failed to follow nutritionally approved recipe during prep of facility's pureed meals placing 6 residents at risk for complications r/t nutritional impairment

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

- Observed staff dietary staff poured zucchini pieces from pan into blender then blended then took can of thickener, poured thickener into blender & blended w/o following a recipe; staff verified had not followed recipe & stated unsure if there was a pureed recipe; failed to follow recipe when preparing 2 residents' pureed diets placing residents at risk for impaired nutrition

NW: SS=D: Failed to provide food prepared by methods that conserve nutritive value, flavor & appearance when dietary staff failed to follow recipe while preparing 1 resident's puree diet placing resident at risk for impaired nutrition

- Observed dietary staff failed to follow recipe when preparing pureed food items; staff stated department did not have pureed diet recipes; failed to follow recipe when preparing 1 resident's pureed diet placing residents at risk for impaired nutrition

F812 Food Procurement, Store/Prepare/Serve-Sanitary

NE: SS=D: Failed to follow sanitary dietary standards r/t food preparation, service, & storage; additionally failed to ensure sanitary cleaning of kitchen service areas & equipment placing residents at risk r/t foodborne illnesses & food safety concerns

- Observed microwave with dried food residue; deep fryer with dark brown oil covering with old food debris inside & outside frying unit; 5-gallon bucket with used oil & old food debris under kitchen's convection oven; clean equipment storage area with saucers & water pitchers stored up & uncovered on rack; reach-in fridge with unlabeled, undated food & liquid items; freezer with unlabeled & updated opened bags of food items; open box of food with no covering barrier
- Kitchenette with unlocked fridge & only 2 days of temp checks completed for current month & top freezer with severe frost build up & lower fridge with unlabeled & undated biscuits & moldy cheese with meat; heater unit with food wrappers & trash on floor between heater & wall
- Observed staff pushed resident's w/c & assisted in positioning another resident's chair & returned to table & assisted resident with eating entire meal w/o completing hand hygiene

- Follow up observations revealed old dried-up food residue on inside & outside of glass barrier of steam table & bucket of used oil remained under convection oven

NE: SS=F: Failed to maintain sanitary dietary standards r/t storage of food placing residents at risk r/t foodborne illnesses & food safety concerns

- Observed plastic storage containers with cereal lacking labels & undated; freezer with unlabeled, undated food items; observed open to air & meat patties uncovered; multiple food items opened & undated;

NW: SS=F: Failed to check sanitization for dishwasher & 3-compartment sink in facility's only kitchen placing residents at risk for foodborne illness

- Observed 3-compartment sink & dishwasher; staff verified facility did not check sanitization for 3-compartment sink or dishwasher & no sanitization strips available to check sanitization for sink or dishwasher; failed to check sanitization for dishwasher & 3-copartment sink placing residents at risk for foodborne illness

NW: SS=F: Failed to store, prepare, distribute & serve food in accordance with professional standards for food service safety for all residents who received meals from facility's kitchens placing residents at risk for foodborne illness

- Observed unsealed, unlabeled food items in upright freezer; outside of fridge freezer with blackish substance; inside of fridge with specks of food particles on door shelves, below bottom drawers & top & middle compartments of door; walk in fridge with open box of produce with white substance on bottom of produce; walk-in freezer with personal-size pizzas & undated different flavored ice cream; cupboard above microwave with chips in corkboard; drawers would not open due to broken tracking; cabinet with missing piece of door; lazy Susan in cabinet stuck; cabinet with hinge bent; pipes under 3-sink area with back substances on them; missing floor tiles in dishwashing area; multiple fluorescent ceiling lights with numerous specks in them & 1 with burnt-out bulbs; ice machine pipe ½ inch down in drain hole; unlabeled, undated flour & sugar container
- Observed staff failed to perform temps of food prior to serving

F825 Provide/Obtain Specialized Rehab Services

SE: SS=D: Failed to ensure rehab services were obtained for 1/2 residents reviewed for rehab services

- POS with dx of hemiplegia; POS for consult to PT & OT for falls, low back pain & hx CVA; observed resident communicated with hand gestures & uses call light when needed assistance; consultant revealed resident screened for therapy & therapy did recommend services but did not receive POS for recommendations as of 1-3; failed to ensure resident received therapy services in timely manner as ordered by physician to ensure optimal physical functioning

F851 Payroll Based Journal

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

- Review of facility LN payroll data for dates listed in PBJ as not having LN on staff 24 hrs/day revealed LN was on duty for 24 hrs/day 7 days/wk; Failed to submit accurate PBJ data which placed residents at risk for unidentified & ongoing inadequate staffing

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

- PBJ report indicated facility did not have LN coverage 24 hours/day 7 days/wk on 5 days in 3rd quarter & 4 days in 4th quarter; review of facility LN payroll data listed on PBJ revealed LN was on duty for 24 hrs/day, 7 days/wk; failed to submit accurate PBJ data placing residents at risk for unidentified & ongoing inadequate staffing

F868 QAA Committee

NW: SS=F: Failed to ensure Medical Director attended QAA Committee meetings at least quarterly as required placing all residents who reside in facility at risk for impaired quality of care

- QAA attendance roster lacked evidence Medical Director attended any of meetings; failed to ensure required members of QAA committee including Medical Director met quarterly placing all residents who resided in facility at risk for impaired quality of care

F880 Infection Prevention & Control

NE: SS=D: Failed to ensure staff followed appropriate infection control practices & procedures when 1 resident's O2 tubing & nasal cannula were left on floor; failed to ensure nursing staff appropriately sanitized community-used Hoyer after each use placing residents at risk r/t infectious diseases

- Observed resident's portable O2 tank on back of w/c & O2 tubing & nasal cannula on floor & no bag noted
- Observed staff did not clean/sanitize Hoyer lift after use & prior to use on another resident; failed to ensure staff followed appropriate infection control practices & procedures when 1 resident's O2 tubing & nasal cannula were left on floor; further failed to ensure staff appropriately sanitized community-used Hoyer lift after each use placing residents at risks r/t infectious diseases

NE: SS=F: Failed to ensure proper infection control standards were followed r/t implementation of procedures to monitor & prevent Legionella disease or other opportunistic waterborne pathogens, failed to ensure sanitary storage of respiratory equipment; failed to ensure adequate laundry temps for laundry including laundry from residents with infectious disease & on transmission-based precautions & failed to ensure staff performed hand hygiene between resident care; further failed to ensure appropriate disposal of filled red biohazard boxes & failed to ensure Infection Preventionist tracked & trended infections within facility placing residents at risk for complications related to infectious diseases

- Observed large bag of soiled linen rested on floor in hallway; observed unlocked soiled utility room with small fridge & thermometer with temp of 18 degrees; fridge had ice along back of fridge; 2 large red biohazard boxes on cart with 6 small red biohazard Sharps containers on top of 2 large red biohazard boxes & 4/6 Sharps containers filled past fill line on box; clean utility room with opened box of disposable gloves & gait belt on floor & hand splint directly on floor; observed resident's O2 tubing on floor next to resident's bed, unbagged; observed CPAP mask hung unbagged above bed; observed CMA failed to perform hand hygiene between administration of meds to 1 resident & administration of meds & inhaler to another resident; facility unable to provide plan, risk assessment or procedures r/t Legionella testing; temp logs for water temp logs documented before recommended 160 degrees for washing machines; IP stated

performed McGeer criteria completed after ABT started; failed to implement appropriate infection control practices placing residents at risk for transmission of infectious diseases

NW: SS=F: Failed to implement a water management program for waterborne pathogens including Legionella disease placing residents in facility at risk for infectious disease

- Maintenance staff stated did not know anything about water management process & plan not implemented; Adm stated Maintenance staff probably did not know building was at risk for Legionella; failed to implement water management program to ID risks & manage waterborne pathogens placing residents residing infacility at risk of contracting Legionella pneumonia

NW: SS=E: Failed to provide proper infection control practices r/t point of care testing for COVID-19 & also failed to sanitize resident's walker after used by another resident who had not been feeling well placing residents at risk for infectious disease

- Observed resident stated did not feel well & refused meds; observed CNA placed another resident's walker in front of resident & told resident to hold onto walker to stand up;
- Observed conference room & Activity staff took a COVID-19 test, waited for 15-minute wait time then threw used test into trash & left room; testing area revealed white note book with testing log on top of small fridge & 2 used COVID-19 tests with log on top of fridge; Failed to provide proper infection control practices when testing for COVID-19 & failed to sanitize resident's walker after walker was used by another resident who had not been feeling well placing residents at increased risk for infectious disease

NW: SS=F: Failed to implement water management program for prevention of Legionella disease & failed to store resident's O2 tubing in manner to prevent infection placing residents of facility at risk for infections

- Failed to thoroughly implement a water management program to test & manage waterborne pathogens placing residents who reside in facility at risk for contracting Legionella pneumonia
- Observed resident & staff draped O2 tank nasal cannula over back of w/c unbagged; failed to store 1 resident's O2 tubing in sanitary manner placing resident at risk for infection

F881 Antibiotic Stewardship Program

NE: SS=F: Failed to develop & implement core elements of antibiotic stewardship to ensure effective infection prevention & control program including antibiotic stewardship for residents of facility

- Infection Control Log for tracking & trending infections from January 2023 through December 2023 lacked evidence of organism identifications, duration of antibiotic prescribed & infections treated; facility unable to provide evidence of tracking upon request; failed to proactively apply principles of antibiotic stewardship for residents of facility from January 2023 through December 2023 to ensure antibiotics were administered in safe & effective manner to prevent unnecessary side effects of antibiotics & antibiotic resistance

F883 Influenza & Pneumococcal Immunizations

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

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

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

- Review of 5 resident records lacked evidence facility or representative received or signed consent or informed declination for current pneumococcal vaccine PCV20; records lacked evidence physician-documented contraindication; failed to offer pneumococcal PCV20 vaccination placing residents at risk of acquiring, spreading & experiencing complications from pneumococcal disease

F920 Requirements for Dining & Activity Rooms

NW: SS=E: Failed to provide adequate lighting in man DR placing residents at risk of not being able to see & enjoy meals

- Observed DR with ceiling fan light fixture with 3 burnt-out light bulbs; fluorescent ceiling light with burnt-out light bulbs; failed to provide adequate lighting in main DR for residents who ate meals in DR placing resident at risk of not being able to see & enjoy meals

February, 2024

F561 Self-Determination

SE: SS=D: Failed to ensure bathing opportunities per residents' preferences for 2/3 residents reviewed for choices

- Resident requested & CP'd for bathing 2x/wk; documentation revealed resident received 1x/wk during 4 weeks; resident stated did not receive bathing opportunities as frequently as would like; failed to provide bathing opportunities to resident 2-3 x/wk as per preference to promote wellbeing
- CP instructed staff to provide shower 2-3 x's/wk; bathing sheets documented resident received only 1 shower/wk on 1 occasion; failed to provide bathing opportunities to resident 2-3 x's/wk per preference to promote wellbeing

F655 Baseline Care Plan

SW: SS=E: Failed to complete a baseline CP on 4 of new admits into facility

- Record revealed baseline CP had not been completed within 48 hours of admission; failed to develop a baseline CP for 1 resident to guide nursing staff in care of resident for 4 new admits reviewed

F656 Develop/Implement Comprehensive Care Plan

SE: SS=D: Failed to develop a comprehensive CP to include 1 resident's use of Estrace for inappropriate sexual behaviors

- CP indicated male resident received Estrace with progress noted documenting resident received tx at behavioral health facility for inappropriate sexual behavior & practitioner added Estrace to medication regime for inappropriate sexual behavior; failed to develop a comprehensive CP to include resident's use of Estrace for inappropriate behaviors to provide interventions for resident's potential behaviors

SW: SS=D: Failed to develop a comprehensive CP for 1 resident r/t interventions on CP r/t fx of elbow & wrist

- CP lacked interventions r/t fx of wrist & elbow with increased assist required following fall with fx & continuous use of splint; failed to develop CP for fx's or treatment of fx's following fall

F677 ADL Care Provided for Dependent Residents

SE: SS=D: Failed to provide oral care for 1 dependent resident

- Observed resident with build up of white substance on lips & build up of food on teeth & LN unable to find any oral care supplies in resident's room; observed resident with dried substance on lips & teeth covered with whitish substance; staff reported resident to have oral care upon awakening & again after lunch & CNA confirmed had not performed oral care; failed to provide adequate oral care for dependent resident

F679 Activities Meet Interest/Needs Each Resident

SW: SS=E: Failed to provide scheduled activities to prevent boredom & impaired psychosocial wellbeing for residents that were confused & wandered in facility

- Lacked baseline CP; observed resident finished lunch & attempted to leave facility & staff able to distract resident; observed resident with anxiety & wanted to go home & staff redirected resident to dayroom to sit on couch & look at birdcage; observed resident wandered looking to exit & "go home", exit seeing, pacing; calendar indicated a morning activity & at least 1 afternoon activity scheduled every day & no activities witnessed on days of survey; staff reported facility lacked activities since staff "quit last month"; failed to provide scheduled activities to prevent boredom & impaired psychosocial wellbeing for confused, wandering residents of facility

F695 Respiratory/Tracheostomy Care & Suctioning

SW: SS=D: Failed to obtain written orders r/t rate of O2 flow for 1 resident, to receive per nasal cannula & lacked dates O2 tubing had been changed; failed to label/date 1 resident's O2 tubing to prevent adverse reactions from O2 tubing

- Failed to obtain written physician orders which indicated amount resident would receive through nasal cannula & staff failed to label/date O2 tubing weekly

F756 Drug Regimen Review, Report Irregular, Act On

SW: SS=D: Failed to obtain physician ordered parameters for insulin & lacked notification to physician for 1 resident when staff held physician ordered insulin

- POS lacked parameter to hold insulin or parameters when physician must be notified; multiple incidents of staff holding insulin w/o holding parameters & failed to notify physician of holding insulin; failed to obtain parameters r/t insulin & lacked notification of physician when staff held insulin w/o physician's orders

F757 Drug Regimen is Free from Unnecessary Drugs

SE: SS=D: Failed to clarify dx for medication for 1/5 residents reviewed for medications

- Progress note documented resident received Estrace for inappropriate sexual behaviors; Adm Nurse confirmed lack of appropriate dx for use of Estrace & lack of CP for inappropriate sexual behaviors; failed to ID dx for resident's use of Estrace & failed to develop comprehensive CP to provide interventions for resident's potential behaviors

F812 Food Procurement, Store/Prepare/Serve-Sanitary

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

- Observed: multiple undated, unlabeled food items; temp log for fridge dated December 2023
- Kitchenette observed: microwave with dried on food; inside of sink with build up of soap scum & dried food; coffee maker with dried-on coffee; opened, unlabeled condiments; shelf liners with build up of food debris & dust; spilled coffee grounds & food debris in drawers
- Main kitchen observed: ice machine with heavy build up of dust & debris in air vents & build up of dust on top of ice machine; coffee machine with thick layer of dried on coffee; microwave with dried on food debris; 2/5 cabinet doors with dried-on food substance; 8/10 drawers with dried, sticky substance on rim with food debris on inside of drawers; cabinet doors with food debris on inside; 4/4 cabinet doors with dried on food; fridge with undated & unlabeled foods; freezer with buildup of food debris on bottom & doors with dried on food & liquid substances; shelf with heavy buildup of food debris, dust & sticky substance; food prep table with rubber mat on bottom shelf with build up of food debris; can opener with dried on sticky substance; multiple cookie sheets put away wet & with water droplets in sheets; toasters with buildup of crumbs on inside & sticky substance covering toasters

SW: SS=F: Failed to store foods safely & sanitary manner to prevent foodborne illnesses for 22 residents of facility in 2/2 resident kitchens

- Observed 2 cartons of mighty shake expired; multiple food items w/o open date or use by date; observed expired ½ & ½

F851 Payroll Based Journal

SW: SS=F: Failed to submit complete & accurate staffing information to federal regulatory agency through PBJ when facility failed to submit staffing hourly data for all nursing personnel by required deadline

- Quarter 1 2023 failed to have LN coverage 24 hrs/day on 6 days in quarter; Quarter 2 failed to have LN coverage for 10 days in quarter; quarter 3 with 10 missing LN coverage; quarter 4 with 5 days w/o LN coverage; review of nursing schedule & clocking sheets revealed adequate hours to account for 24 hour nursing coverage; failed to submit complete & accurate staffing information to federal regulatory agency through PBJ when facility failed to submit staffing hourly data for all nursing personnel by required deadline

F867 QAPI/QAA Improvement Activities

SW: SS=F: Failed to provide good faith efforts to ID multiple issue of concern for 22 residents residing in facility

- Cited all other deficiencies: F655, F656, F679, F695, F757, F812, F851, F880, F947
- Failed to ID, develop & implement appropriate plans of action to have an effective quality assurance program that ID'd & addressed issues involving multiple concerns placing all resident residing in facility at risk for mental & /or physical decline

F880 Infection Prevention & Control

SW: SS=F: Failed to provide a safe & sanitary environment by failure to use appropriate disinfectant to sanitize washing machines after washing clothes/linens during outbreak of COVID-19

- Laundry staff stated staff use vinegar to run through washing machine after staff finish biohazard linens/laundry & no bleach or other disinfectant utilized for sanitization inside washer; failed to provide safe & sanitary environment by failure to use appropriate disinfectant to sanitize washing machines after washing clothes/linens during outbreak of COVID

F921 Safe/Functional/Sanitary/Comfortable Environment

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

- Observed floor with areas containing dried, liquid, sticky substance & perimeter of floor with heavy buildup of dirt & grime; failed to provide safe, functional, sanitary & comfortable environment for residents & staff

F947 Required In-Service Training for Nurse Aides

SW: SS=D: Failed to maintain in-service training program for nurse aides that was appropriate & effective to ensure continuing competence of nurse aides; 1/5 CNAs lacked required 12 hours of in-service training 1 other CNA lacked completed training in ANE to ensure continuing competence of nurse aides & appropriate care & services to all residents of facility

- 1 CNA training log indicated CNA had 8.25 total hours for year; 1 CNA had 15.5 hours with no ANE training; failed tot provide 1 CNA with required 12 hours of in-service training & 1 CNA to include ANE training