February, 2023 Survey Findings

November, 2022

F550 Resident Rights/Exercise of Rights

SS=D: Failed to treat 1 resident with respect & dignity & care for resident in manner that promoted quality of life placing resident at risk for impaired dignity

- Resident with indwelling urinary catheter; observed resident in bed with catheter bag hanging on side of bed uncovered with urine in it visible from doorway; failed to provide dignity for 1 resident placing resident at risk for impaired dignity

SS=D: Failed to promote care in a manner to maintain & enhance dignity & respect when staff had resident's physician ordered medication lists visible on unattended computer screen on 1 hall & failed to promote dignity for 1 resident when staff checked resident's blood sugar & administered insulin at dining room table in 1 hall with 2 other residents able to view during meal service

- Observed computer on med cart screen left open & screen visible with resident's name & medication orders pulled up on screen & cart left unattended for approximately 5 minutes with 2 residents & 1 staff walking by computer with resident's information visible; failed to promote care for 1 resident in manner to maintain & enhance dignity & respect
- Observed small DR where LN took resident's blood sugar test & administered insulin in abdomen at DR table with 2 residents able to view procedures; failed to treat resident with dignity when staff checked blood sugar & administered insulin in abdomen at DR table with 2 other residents able to view placing resident at risk for undignified experience

F567 Protection/Management of Personal Funds

SS=D: Failed to obtain permission for 1 resident's conservator/guardian before spending $1742.01 from resident's fund on an incontinent recliner, women's deluxe bath set, DVD player & special value clothing set with shifts, pants & pair of shoes placing resident at risk for mismanaged funds & unmet needs due to limit/decreased resources

- *Resident with dementia, psychotic disturbance & anxiety; CP documented resident had guardian to assist with making major decisions & directed staff to contact resident's guardian as needed; invoice documented total of $1742.01 to be paid from resident's trust fund; resident stated activity director had purchased resident "a whole bunch of stuff"; activity staff stated corporate informed activity staff that resident needed to "spend down" accounts & was unaware resident had guardian that needed to be contacted prior to an purchases; guardian stated was very upset with facility as had not found out about purchases that had been made 2 months previously until resident's CP meeting; failed to obtain permission from resident's conservator/guardian prior to spending resident's money from resident funds account placing resident at risk for mismanaged personal funds & unmet needs due to decreased resources*

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

SS=D: Failed to notify resident's physician of medications not administered in timely manner placing resident at risk for physical decline

- EMR lacked documentation of HTN CP for resident who received HTN medication; Pain CP directed staff to administer pain med as ordered, obtain pain assessment every shift & follow pain scale to medicate as ordered; POS for gabapentin for neuropathic pain; MAR documented gabapentin unavailable for 9 consecutive days in 1 month & atorvastatin unavailable for 4 consecutive days; Spironolactone unavailable for 5 consecutive days & 3 consecutive days; bisoprolol fumarate unavailable for 3 days, 6 days & 3 days; NN documented facility tried to contact pharmacy 2 times & was told resident's insurance would not cover medications & staff directed to contact family to get resident set up on another insurance; note further documented facility contacted resident's DPOA & was told she would contact VA to get meds sent out to resident & was not sure when facility would receive the medications; physician not contacted r/t medications not available in timely manner; failed to notify physician immediately of meds not administered in timely manner placing resident at risk for physical decline

F584 Safe/Clean/Comfortable/Homelike Environment

SS=E: Failed to provide housekeeping & maintenance services to maintain an orderly, sanitary, & comfortable environment for residents of facility, in 2/2 hallways & in facility DR

- *Observed: dirty floor throughout; dirt & grime build up in perimeters & corners of hallway floor; carpeting lining lower section of walls with multiple various dark colored stains; resident phone booth with dirty floor with grime build up around perimeter of floor & in corners & trash observed on floor; 10 rooms with multiple various sized marred areas to entrance doors & door jams; nurses' station with dirty countertops & stained carpet lining outside of station on wall; corner trim next to nurses' station pulling away from wall next to floor; women's shower room with cracked plastic shower chair, black mars on walls & marred entrance door & door jamb & walk-in tub with hair & grime on inside floor & toilet with dark colored stain around base on floor; rust-colored stain lined floor next to wall behind toilet*
- *Dirty floor throughout with dirt & grime build up in perimeters & corners of hallway floor; carpeting lining lower walls with various sized multiple dark colored stains; 10 rooms with various sized marred areas on entrance doors & door jambs; TV room with dirty floor & areas of debris; 2 large windows with multiple fingerprints on glass & torn curtains coming off track with various sized areas of missing paint on walls*
- *DR with dirty floor throughout & debris under tables, around perimeter of floor & in corners; flooring just outside of dining area with visible dirt & grime buildup*

SS=E: Failed to provide adequate housekeeping & maintenance services to ensure a safe, clean, comfortable, homelike environment for 5 residents on 4/6 halls of facility placing residents at risk for less than pleasant homelike environment

- Observed resident's room with scraped wall paint behind headboards & dirty linens on floor between resident's bed & roommate's bed; 1 room with gray stains on ceiling above bed & 2nd ceiling stain in middle of room; resident's room with 4 ceiling tiles with stains; resident room with both beds with missing wall mop board under head of bed with insulation & wall studs visible; resident room with paint scratched off BR door; failed to provide adequate housekeeping & maintenance services to ensure a safe, clean, comfortable, homelike environment for 5 residents on 4/6 halls of facility placing residents at risk for less than pleasant homelike environment

F600 Free from Abuse & Neglect

SS=D: Failed to protect 1 resident from verbal abuse/mistreatment from CNA when CNA chastised resident for moving around in bed, needing more assistance than other residents & needing pillows behind resident in w/c placing resident at risk for psychosocial wellbeing

- *Resident with major depressive d/o, schizophrenia & anxiety; resident interviewed while in hospital for constipation; resident stated did not want to go back to facility because resident was treated so badly there & stated she had not told anyone but family about verbal abuse & rough treatment; video showed 2 CNAs repositioned resident in bed & 1 CNA stated "you better stop wiggling around like that or you are going to undo everything I just did & it's so annoying. How do you want your legs?" CNA then placed resident's legs across each other & resident stated legs should not be touching; CNA then instructed resident that legs were not touching, "you know what? I am done. They are how they are & that's how they are going to stay." CNA then tossed blankets around bed then said "Stop moving! Can't you feel me trying to fasten your attends? You know the blankets aren't on you so you know I am not done!" Further review recorded 2 CNAs got resident up with full body lift & CNA stated "you know it takes us twice as long to get you up & ready as it does anyone else. You have been told you are not to be doing this to us & keep asking for things over & over again. How do you want your pillow? You know what? Your pillows are fine." Adm staff stated no idea any abuse happening in facility; Adm staff stated facility became aware of complaint of abuse when facility received letter from resident's insurance company which requested to know results of abuse investigation r/t CNA; Adm stated CNA had been suspended pending result of investigation; following investigation CNA terminated from facility because facility did not tolerate any verbal or physical abuse of residents in their care; failed to prevent 1 resident from experiencing verbal abuse &/or mistreatment which placed resident at risk for psychosocial impairment*

F609 Reporting of Alleged Violations

SS=L (Past Non-Compliance): Failed to ensure staff immediately reported witnessed abuse; in October, 2022, between 10pm & 11pm 3 CNAs repositioned cognitively impaired resident; resident swatted at 1 CNA, then another CNA slapped resident's hand & told resident "no"; CNA witnessed other CNA slap resident but did not report to charge nurse or facility administrative staff; later in shift CNA tested information to another CNA who recognized incident as reportable & encouraged CNA to report incident but CNA then delayed reporting abuse until 2:30pm on next day; 2 CNAs failed to immediately report abuse to Administrative staff until approximately 16 hours after event; due to failure to report, AP CNA worked remainder of shift until 6am placing resident & all other residents CNA had access to in immediate jeopardy

- *Adm stated AP CNA terminated from employment; failed to ensure staff immediately reported witnessed staff to resident abuse which allowed AP CNA to work remainder of shift placing resident & all other residents in facility in immediate jeopardy*
- *Abatement Plan*
  - *Staff education on immediate reporting of abuse*
  - *Root cause analysis & review*
  - *Staff education on facility's Abuse Prevention Program policy*

F610 Investigate/Prevent/Correct Alleged Violation

SS=D: Failed to implement protective measures for resident immediately after allegation of abuse placing resident at risk for impaired safety & psychosocial wellbeing

- Resident with vascular dementia, hallucinations & depressive d/o; Progress note documented staff alerted nurse that resident had a very large BM, crying & stated resident had been raped; nurse checked on resident & resident sleeping soundly; nurse offered tramadol but resident refused medication; NN documented nurse called resident's representative & reported resident's statement r/t being raped; nurse documented no male staff worked on the night shift when resident reported being raped; representative offered by staff to send resident to ER for rape kit but representative chose not to send resident to ER & did not believe resident had been raped; & resident had made allegations of a man taking & doing things to resident in past; during SS interview, resident denied telling anyone that resident had been raped & denied being touched inappropriately by anyone; Adm staff verified nurse did not document assessment of resident at time of allegation; Adm stated w/o potential perpetrator, staff established resident in a safe place & verified no immediate safety interventions were implemented from time of allegation to resident denying the allegation; failed to implement protective measures for 1 resident immediately after an allegation of rape, placing resident at risk for impaired safety & psychosocial wellbeing

SS=D: Failed to investigate burns on 1 resident who had burns on index & middle finger of hand placing resident at risk for further injury

- Resident with dementia w/o behavioral disturbance, seizures & heart failure; "hot liquids safety eval" documented resident ability to handle eating equipment with no risk; CP documented to assist resident o hold cup & provide 1 or more sips of liquid at any time or lift resident's hand to mouth, use coffee lids to cups with hot liquids; NN documented resident with open areas to index & middle fingers; NN lacked investigation as to how resident obtained open areas; investigation not signed or dated by adm staff; Observed LN ask CNA to take resident out for cigarette & LN stated resident had burned fingers & required assist; DON stated areas on fingers were not from a burn, but because of arthritis in hands & coffee cup handle rubbed areas on fingers; consultant stated wounds looked like burns; failed to investigate burns on cognitively impaired resident placing resident at risk for further injury

F637 Comprehensive Assessment After Significant Change

SS=D: Failed to complete a significant change assessment after development of an unstageable PU for 1/2 residents placing resident at risk to have inaccurate assessment of health status

- Failed to complete a significant change assessment after 1 resident developed an unstageable PU placing resident at risk to have an inaccurate assessment of health status

F656 Develop/Implement Comprehensive Care Plan

SS=D: Failed to develop a comprehensive CP for 1 resident for use of CPAP/BiPAP equipment

- CP lacked use of CPAP/BiPAP machine; resident stated, "sometimes my fiancé cleans it"; staff unaware of who cleans machines; DON stated resident controlled CPAP self & mask should be in black bag when not in use; failed to develop a comprehensive CP for resident that included use of CPAP/BiPAP equipment & required care

SS=D: Failed to develop a comprehensive CP for HTN medication with signs & side effects of antihypertensive meds for 1 resident placing resident at risk for physical decline & complications r/t high blood pressure

- EMR lacked documentation of hypertension CP for 1 resident who received hypertension medication; failed to develop a comprehensive CP for 1 resident's antihypertensive medication placing resident at risk for physical decline & complications r/t high blood pressure

F677 ADL Care Provided for Dependent Residents

SS=D: Failed to provide scheduled bathing for 1 resident placing resident at risk for skin problems & poor hygiene

- Bathing record for 1 month revealed resident w/o documented bath for 8 day interval & 19 day interval; 1 month with 1 bath documented in entire month; currently resident with 29 days interval w/o bathing; observed resident with dried food on beard & mouth, clothing soiled with food stains, socks soiled & still & fingernails untrimmed & dirty on multiple occasions; failed to provide scheduled bathing for 1 resident placing resident at risk for skin problems & poor hygiene

SS=E: Failed to provide necessary services to maintain good personal hygiene including bathing for 6/8 residents reviewed for ADLs placing residents at risk for poor personal hygiene & infection

- Resident scheduled for 2 baths/wk & received 3 documented baths in September; 3 in October &2 in November; failed to provide necessary care & bathing services for 1 resident placing resident at risk for poor hygiene & skin breakdown
- Resident with documented baths 4x in September; 3x in October; failed to provide necessary care & bathing services for 1 resident placing resident at risk for poor hygiene & skin breakdown
- Resident with 3 baths documented in September, 2 baths in October, & 2 in November; failed to provide necessary care & bathing services for 1 resident placing resident at risk for poor hygiene & skin breakdown
- Resident with documented baths 2x in October; failed to provide resident bathing services placing resident at risk for poor hygiene
- Resident with no documented baths in October; observed resident with hair disheveled & not feeling well; failed to provide resident bathing services as CPd placing resident at risk for poor hygiene
- Resident with documented 2 baths in September; failed to provide resident bathing services as CPd placing resident at risk for poor hygiene

F684 Quality of Care

SS=D: Failed to ensure that 1/3 residents received appropriate nursing assessment with vital signs when resident having chest pains which sent resident to ER; also failed to provide skilled nursing assessments & update resident's medical record with those assessments including vital signs

- *EMR revealed staff assessed & documented resident's vital signs on 11-15 & no other documentation that facility staff assessed vital signs during time resident was in facility through discharge to ER on 11-16; resident admitted with skilled nursing care & no skilled progress notes with nursing assessments in documentation; NN documented resident's family came to nurses' station & reported resident having chest pain & family wanted resident to go to hospital; LN obtained orders from physician to send resident to ER & notified DON; EMR lacked assessment by LN before resident went to ER; failed to provide appropriate nursing assessments for resident who was sent to ER with chest pains*

SS=D: Failed to provide heel protectors as ordered by wound clinic for 1/2 residents placing resident at risk to worsen current diabetic ulcer or develop more skin issues

- Resident with CVA, DM & hemiplegia with BIMS 0 with total assist for ADLs & with unstageable PU or eschar; PU CP lacked documentation staff provided heel protectors at all times as recommended by wound clinic; record lacked documentation of resident's wound clinic ordered heel protectors 8 days after wound clinic order; failed to provide heel protectors as ordered by wound clinic for 1 resident placing resident at risk to worsen current diabetic ulcer or develop more skin issues

F686 Treatment/Services to Prevent/Heal Pressure Ulcer

SS=G: Failed to provide care consistent with professional standards to prevent PUs by failure to perform skin assessments under a medical immobilization device for resident allowing an unstageable PU to develop

- Resident with fx tibia & fibula, hemiplegia & PVD; MDS noted resident with pressure reducing device for chair & bed & with 1 stage 2 PU present on admission; resident required total assist with ADLs but had improved & required limited to extensive assist with most ADLs; PU CAA documented resident admitted with stage 2 PU to hip that healed since admission & staff should perform skin assessment weekly & observations of skin by care staff with cares & resident required immobilizer to lower extremity; CP documented resident with actual impairment to skin integrity r/t medical device & staff to perform daily skin & circulatory checks to LE r/t immobilizer; Progress note

documented resident with unstageable PU to lateral malleolus r/t medical device; multiple weekly skin assessments failed to document skin breakdown on malleolus; resident stated "mad" at facility because they "made her get" wound on leg; staff unaware of wound; physician reported PU should not have progressed from intact skin to unstageable PU as it did; failed to ID & provide care consistent with professional standard of practice to prevent development of unstageable PUs for 1 resident

F689 Free of Accident Hazards/Supervision/Devices

SS=J (Past Non-Compliance): Failed to provide adequate supervision to prevent cognitively impaired resident, who had a hx of exit seeking, from leaving the building w/o staff knowledge; resident exited building through an unlocked door, walked to fence in gated courtyard, climbed onto a grill located right next to fence, jumped over, & walked towards the highway; 30 minutes later, local law enforcement called facility & asked if they had any missing residents as they found an individual on side of highway; after head count, facility discovered resident missing from building placing resident in immediate jeopardy

- *Resident with schizoaffective d/o & anxiety disorder; wandered in facility; walked independently & required supervision of 1 staff for ADLs; wore personal alarm bracelet on ankle; IDd as elopement risk; hx of trying to climb over fence in courtyard with ladder that had been left propped on fence; resident last seen 11 minutes prior to resident's exit; resident found 0.9 miles away from facility; prior to incident, facility did not activate courtyard door with Wanderguard alarm & resident free to go in & out as desired; failed to provide adequate supervision to prevent 1 resident from exiting building through unlocked door w/o staff knowledge after displaying behaviors of attempting to leave facility by climbing fence in courtyard using ladder that staff propped against fence & did not remove; resident exited building through unlocked courtyard door, walked to fence in gated courtyard, climbed onto a grill located next to fence, jumped over & walked towards highway; 30 minutes later, local law enforcement called facility & asked if they had any missing residents as they found a person on side of highway; after head count in facility, facility discovered resident missing from building placing resident in immediate jeopardy*
- *Abatement plan:*
  - *Activated Wanderguard alarm on courtyard door & sounded when resident close to it & staff are required to let residents in & out of courtyard door*
  - *Maintenance completed checks on all doors & gates along with Wanderguards on 2 IDd at-risk residents*
  - *All staff educated on not placing items along courtyard fence & elopement policy*
  - *15 minute checks on resident x 48 hours*
  - *Maintenance increased sensitivity on exit door to courtyard so it would lock down & alarm when residents with Wanderguards approached*
  - *Perimeter check of courtyard fence everyday & will continue weekly x 6 weeks*
  - *Everyday alarm checks for all doors in facility*

SS=D: Failed to initiate planned intervention for 1/4 residents with use of motion alarm placed under resident in bed/chair/w/c to prevent further falls

- Fall CP instructed staff to place alarm pad under resident when resident in supine or sitting position; resident with 5 documented falls in recent month; EMR revealed staff observed resident on floor of room & staff observed motion alarm on resident's bed & not on recliner where resident had been sitting before fall; resident with facial bruising as result of fall; failed to place planned use of motion alarm pad under dependent, confused resident when they moved resident from bed to recliner resulting in fall with facial bruising

SS=D: Failed to provide adequate supervision for 1/3 residents assessed as high elopement risk, to ensure resident remained free from accident hazards, when resident exited facility through unlocked door w/o staff knowledge

- *Resident with schizoaffective d/o, bipolar type with BIMS 15; CP documented resident with hx of behaviors & elopement at prior facility; elopement assessment documented high risk for elopement; Adm staff reported camera footage shower resident walking down hallway with coat after 2am then there was a "glitch" in surveillance system so no camera footage of resident leaving building; exit doors always unlocked & residents could go outside all hours of night; no one in building saw resident leave; staff should have been checking on resident at least hourly; failed to provide adequate supervision to prevent resident from leaving building through unlocked or alarmed exit door of facility w/o staff knowledge placing resident at risk for accidents outside facility*

SS=D: Facility used side rails w/o safety assessment or accident hazard CPO for 1/3 residents placing resident at risk for entrapment & falls

- Resident with dementia, MS, paraplegia, muscle weakness & lack of coordination with fall risk & recent minor injury fall; side rail eval recorded resident high risk for falls & lacked assessment documentation for resident's safe use of side rails; DON stated staff should not raise side rails on bed due to hx of falls & side rails had gaps that could entrap resident; facility used side rails w/o safety assessment or accident hazard CP for 1 resident placing resident at risk for entrapment & falls

SS=D: Failed to provide a safe environment & failed to implement resident centered interventions for 1 resident placing resident at risk for further falls & injury

- Resident with multiple falls; resident with unwitnessed fall & note documented no injury but noted perimeter overlay mattress slipped off bed causing resident to fall; EMR lacked evidence of resident centered intervention put into place to prevent further falls; failed to ensure resident's perimeter overlay was securely strapped to bed frame which caused resident to fall out of bed & further failed to implement new fall interventions for cognitively impaired resident after a fall placing resident at risk for further falls & injuries

SS=G: Failed to provide adequate supervision to prevent accidents & failed to ID causative factors to prevent future injuries for 1 resident which resulted in burns to resident's fingers; further failed to ensure an environment as free of hazards as possible when facility stored chemical in unsecured areas accessible to residents placing residents at risk for further accidents

- Cited findings noted in F610 r/t lack of investigation of finger burns; failed to provide adequate supervision & ID potential causative factors to prevent future accidents for cognitively impaired resident & as result sustained burn injuries to fingers
- Observed unlocked shower room with thumb turned knob turned to unlock at all times; soiled utility room with hazardous chemicals; failed to store hazardous chemicals in safe environment placing 3 cognitively impaired independently mobile residents on 1 hallway at risk for injury

F690 Bowel/Bladder Incontinence, Catheter, UTI

SS=D: Failed to ensure sanitary catheter care for 2/3 residents to prevent UTIs

- Observed resident in w/c in room with approx. 8 inches of catheter tubing lay directly on floor with urine collection bag in privacy bag suspended from bottom of w/c on multiple occasions; failed to monitor for sanitary placement of resident's catheter tubing to ensure tubing remained off floor to prevent UTIs
- Observed catheter tubing resting directly on floor on multiple occasions; failed to take appropriate care of dependent resident's catheter tubing to keep it off floor & prevent UTIs

SS=D: Failed to provide timely incontinent cares for 2/5 residents reviewed for incontinence placing residents at risk for skin breakdown & impaired dignity & comfort

- Observed staff provided incontinent care & brief & pants & bed pad under resident wet with urine; failed to provide timely incontinent care for resident when incontinent brief was saturated & pants & bed pad were wet with urine placing resident at risk for skin breakdown & impaired dignity & comfort
- Observed resident sitting in soiled brief during breakfast as staff did not check resident prior to breakfast; Failed to provide continence care in timely manner for cognitively impaired resident placing resident at risk for skin breakdown & impaired dignity & comfort

F692 Nutrition/Hydration Status Maintenance

SS=D: Failed to accurately monitor fluid intake for a 2000 mL per day fluid restriction for 1 resident placing resident at risk for dehydration

- Resident with ESRD, CHF, CVA, hemiplegia, DM, refractory depression with dialysis; Dialysis CP recorded physician ordered 2000mL per day fluid restriction & directed nursing staff to provide 1280 fluids per day & dietary to provide 720 fluids per day; MAR revealed resident average 658 mL of fluids average per day in 1 month; 731 in 1 month; record lacked further documentation r/t daily fluid intake &/or intake provided by dietary; failed to accurately monitor resident's daily fluid intake for a 2000mL /day fluid restriction placing resident at risk for dehydration

F695 Respiratory/Tracheostomy Care & Suctioning

SS=D: Failed to change out O2 tubing per physician order & failed to obtain physician order for use, settings, & care of 1 resident's use of CPAP/BiPAP equipment increasing risk of resident developing respiratory infection

- Failed to change resident's O2 tubing weekly, clean O2 concentrator, obtain physician order for CPAP/BiPAP use & routine cleaning schedule in order to prevent occurrence of infection

F697 Pain Management

SS=D: Failed to provide pain medication for 1 resident placing resident at risk for further pain & discomfort

- Resident with closed fx of head of femur, CHF, HTN, PTSD DM; POS for hydrocodone 5/325 q 4 hours PRN for pain; resident reported almost constant pain that worsened with physical activity; MAR documented resident did not received pain medication until 20 hours after admission; resident stated did not receive pain medication until 2nd day in facility because nurse stated needed to get authorization code to get medication & resident state had a lot of pain; LN stated had tried several times to contact pharmacy & did not receive a response; failed to provide pain medication for 1 resident who had pain upon admission placing resident at risk for further pain & discomfort

F698 Dialysis

SS=D: Failed to provide appropriate dialysis care & services consistent with professional standards of practice for 1 resident placing resident at increased risk for adverse complications r/t dialysis

- *Resident with ESRD with dialysis 3x/wk outside facility; CP directed staff to provide regular mechanical soft diet, provide double protein & follow RD recommendation & CP lacked documentation to ID dialysis cares needed as indicated in CAA; POS lacked order for dialysis & lacked any other documentation to ID resident received dialysis as well as location, times, &/or information about dialysis center; record lacked direction or orders for dialysis assessments, observation &/or precautions & care of dialysis shunt site; NN documented resident returned from dialysis & had elevated BP & pulse & staff sent resident to hospital; failed to provide appropriate dialysis care for 1 resident placing resident at increased risk for adverse complications r/t dialysis*

F700 Bedrails

SS=D: Failed to complete an assessment for safe use of side rails for 3 residents placing resident at risk for entrapment & injuries

- Side Rail Evaluation recorded resident used partial side rails on both sides of bed but lacked assessment documentation for resident's functionality & safe use of side rails; observed resident in bed with HOB elevated & side rails raised on both sides & gaps that resident could easily pass extremities through; Failed to complete an assessment for safe use of side rails for 1 resident placing resident at risk for entrapment & injuries for multiple (3) residents

F726 Competent Nursing Staff

SS=D: Failed to ensure staff possessed skills & knowledge necessary to perform & record an immediate physical assessment of r esident after allegation of rape placing resident at risk for unidentified injury & delayed treatment decisions

- Cited findings noted in F610; record lacked physical or mental assessment of resident after allegation of rape; failed to ens ure licensed nurse staff possessed skills & knowledge necessary to perform a full assessment to assess for injuries & attempt to preserve scene in presence of rape allegation placing resident at risk for unidentified injuries

SS=D: Failed to ensure LN staff possessed necessary knowledge & skills when staff administ ered 1 resident's medication by mouth though order read & LN was aware medications were ordered via PEG feeding tube by physician placing resident at risk for aspiration

- Resident with dysphagia, aphasia, HTN & hemiplegia; CP directed staff to elevate HOB & maintain it at least 30-45 degrees at all times; CP directed staff to administer meds as ordered & monitor side effects & effectiveness; POS directed staff to administer FESO4, Folic acid via PEG; observed LN crushed & mixed residents meds with applesauce & administered meds by mouth; LN stated resident able to eat meals in room & if ate less than 50% of meal received nutrition through PEG; LN stated orders for meds were incorrect & said she co uld administer meds by mouth; DO stated orders were correct; failed to ensure LN possessed necessary knowledge & skills when staff administered 1 resident's medications by mouth though order read & LN was aware, meds were ordered via feeding tube placing resident at risk for aspiration

SS=F: Failed to ensure all direct care staff working with residents of facility had adequate competency assessments placing all residents of facility at risk to not have individual care needs met & failed to ensure licensed nursing staff possessed necessary skills, knowledge & awareness to care for resident who had returned to facility from hospital who had returned on previous shift placing resident at risk for unmet nee ds

- Facility provided information revealed 1 CNA hired by facility had worked at facility for more than 1 year & that CNA lacked competency assessment for past year; facility employed contract agency revealed 2 CNAs lacked competency check information & agency prov ided no competency checklists; 1 CNA lacked competency information & agency provided undated, unsigned quiz; 1 CNA lacked competency check information; observed 2 CNAs wore strip of masking tape on uniform with first names & "CNA" & observed 2 aides used tot al lift to transfer resident from bed to w/c then left resident to eat on own in room & CP directed staff t o supervise resident when eating due to risk for aspiration; facility lacked competency evals of all agency direct care staff employed at facility; facility lacked competency records for all direct care staff placing residents who were cared for by facility staff at risk to not have individual care needs met
- Resident with bipolar, DM, CHF & acute kidney failure; resident sent to ER r/t persistent nausea/vomiting then returned from ER with orders for Protonix; observed resident with emesis pan on lap & was v omiting; surveyor told LN that resident had vomited & needed assist & LN stated "no she isn't, she is at hospital" surveyor stated resident returned last evening & was in room & LN state d "Oh I did not know"; LN stated had gotten to work late & did not get report; failed to ensure LN aware of resident's return from hospital placing resident at risk for unmet needs

F732 Posted Nurse Staffing Information

SS=C: Failed to ensure daily staff postings included actual hours worked by nursing staff as required

- Review of Daily Staffing for 3 months & none of sheets contained actual hours worked when compared to nursing schedule; faile d to ensure daily staff posting included actual hours worked by staff as required

F755 Pharmacy Services/Procedures/Pharmacist/Records

SS=D: Failed to ensure a system to ensure that 2/3 residents received medications as ordered by physician for timely administ ration

- *Resident admitted to facility on 11-15 at 3:15pm with physician orders for medications; MAR revealed staff failed to ad minister any of physician ordered medications during stay at facility; resident discharged to ER on 11-16 at 6:30pm due to chest pain; pharmacy manifest dated 11-16 at 4:40pm documented pharmacy delivered medications & nursing staff signed for them & no me dications administered after that time pharmacy delivered meds & before resident transported to hospital; failed to ensure system to ensure ordering admin istration of resident's medications per physician orders*
- *Resident admitted on 10-13 with physician orders; MAR reviewed from 10-13 through 10-19 & resident did not receive multiple medications on multiple days & resident discharged to hospital due to respiratory issues & shortness of breath; failed to ens ure system for timely ordering & administration of resident's medications per physician orders*

SS=E: Failed to ensure a reconciliation of controlled medications at end of daily work shifts; further failed to ensure resid ent's medications were available for administration as ordered by physician placing resi dents at risk for misappropriation of medications by staff & ineffective medication regimen

- Med cart lacked evidence staff performed reconciliation of controlled substances & signed "Controlled Medication Count Sheet" at shift change 14 times between 10-1 to 10-26; failed to ensure reconciliation of controlled medications at end of daily work shi fts, placing residents at risk for misappropriation of medications by staff
- Cited findings r/t meds unavailable in F684; failed to ensure 1 resident's medications were available for administration plac ing resident at risk for decline due to not receiving physician ordered medications

SS=E: Failed to perform a reconciliation of controlled drugs at beginning & end of daily worked shifts for 5/6 med carts plac ing residents at risk for misappropriation of meds by staff

- Observed controlled drug count book lacked signatures for beginning & end of daily shifts for multiple consecutive & isolated dates from September through November for multiple med carts; failed to perform a reconciliation of controlled drugs at end of daily wor k shift for 5/6 med carts placing residents at risk of misappropriation of medications by staff

F756 Drug Regimen Review, Report Irregular, Act On

SS=D: Failed to ensure adequate follow up of consultant pharmacist recommendations r/t Depakote for 1 resident, r/t decreasing dose of this medication placing resident at risk for adverse effects r/t medication use

- Resident with dementia, anxiety & major depressive d/o; MRR for May through Nov documented recommendations reviewed & document recommendation on 5-17-22 to re-evaluate dose of Depakote & consider a reduction & provider signed recommendation 30 days after recommendation made & dosage change never implemented; Adm confirmed recommendation had been signed by provider & not implemented for resident; consultant pharmacist confirmed facility had issues with timely responses to recommendations & with getting documents scanned into EHR in timely manner; failed to act on consultant pharmacist ID'd recommendations for GDR in timely manner for 1 resident by failure to decreased Depakote when recommended

F757 Drug Regiment is Free from Unnecessary Drugs

SS=D: Failed to ensure reduction in Depakote for resident by not decreasing medication as ordered placing resident at risk for adverse effects r/t medication use

- Cited findings noted in F756; failed to act on provider signed recommendation for GDR in timely manner for 1 resident by failure to decrease Depakote when ordered that resulted in increased risk for adverse effects r/t medication

F760 Residents are Free of Significant Med Errors

SS=J (Past Non-Compliance): Failed to prevent a significant medication error for 1 resident when facility staff prepared & wrongly administered 1 residents including psychotropic & antipsychotic medications to another resident; CMS prepared resident's medications then realized resident was in shower; CMA labeled medication cup with resident's name, placed cup back in cart & began to prepare other resident's medications; CMA then observed first resident in DR & gave resident medication prepared for other resident; as result, resident had a significant change in condition which required transfer to local hospital where resident was intubated & transferred to larger hospital in intensive care; CMA failed to implement standards of practice r/t medication administration when CMA failed to verify right medication for right resident prior to administration placing resident in immediate jeopardy

- *Incorrect medications administered included Carbidopa-levodopa, clozapine & venlafaxine; resident admitted to outlying hospital for acute encephalopathy with low Glasgow Coma Scale of around 7 & was intubated to protect resident's airway; resident's blood sugar 44 per EMS & O2 started; resident with noted change in condition; failed to prevent a significant medication error when facility staff wrongly administered another resident's medications including psychotropic & antipsychotic medications to resident; resident had significant change in condition which required transfer to local hospital where resident was intubated & transferred to larger hospital for care; CMA failed to implement standard of practice r/t medication administration when CMA failed to verify right medication given to right resident placing resident in immediate jeopardy*
- *Abatement plan:*
  - *Med error reviewed in QAPI & immediate corrective actions put into place*
  - *Medication drop lock box ordered for DCd narcotics*
  - *All CMAs & nurses were trained on facility medication policy, 5 medication rights & timely medication dispensing*
  - *Facility replaced resident's medications*
  - *Medication administration audits were completed by DON*
  - *Both medication carts & medication room were audited by DON*

F761 Label/Store Drugs & Biologicals

SS=D: Failed to ensure correct expiration dating/labeling of insulin for 2 residents

- Observed Novolog flex pen with label that staff documented open date of 10-27-22 & expiration date written as 10-31-24; Lantus Solostar insulin pen lacked label from pharmacy as required & staff wrote dates on them; failed to correctly document expiration date for 3 opened insulin pens for 2 residents & failed to ensure 1 insulin pen contained pharmacy label as required to ensure safe & effective administration of medication

SS=D: Failed to label & store drugs & biologicals for 2/5 medication carts placing affected residents at risk for ineffective medication regimens

- Observed med cart with insulin pen lacked date when opened for use; observed med cart unlocked & unattended by staff & cognitively impaired, independently mobile resident in w/c in vicinity of unlocked med cart; failed to label insulin pen when opened & failed to ensure unsupervised med cart was locked placing residents at risk to receive ineffective medication & provided unsafe access to medications

F812 Food Procurement, Store/Prepare/Serve-Sanitary

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

- Observed stove range hood with lg amount of brownish grey fuzzy substance covering top of hood & galvanized side wall panels; 3 black fire suppression spigots covered with brownish grey fuzzy substance; exterior of hood with lg sticker recording hood cleaned 10-24-22 (14 days previously); observed overhead return air grill covered with brownish grey fuzzy substance
- Observed dietary staff with hair bangs hanging out top of hairnet & wisps of hair hanging out back of hair net; Observed multiple dietary staff putting plated food in plastic cover for transport with hair not covered or not covered completely

F849 Hospice Services

SS=D: Failed to develop a comprehensive CP which included collaboration with hospice provider for 1 resident who received hos pice services placing resident at risk for inappropriate end of life care

- Record revealed CP lacked direction for staff r/t hospice services provided; record lacked evidence of coordination of care which IDd resident's dx, a common problem list, palliative interventions, palliative goals/objectives, responsible disciplines, respons ible providers & /or resident's end of life choices r/t care & goals; failed to develop a comprehensive hospice CP which included collaboration with hospice provider for 1 resident who received hospice services, placing resident at risk for inappropriate end of life care

F867 QAPI/QAA Improvement Activities

SS=F: Failed to maintain an effective QAA program to ID & develop corrective action plans & monitor them to correct IDd quali ty deficiencies prior to survey placing residents at risk for ineffective care

- Referenced: F584, F677, F689, F726, F755, F812
- Failed to ID & develop corrective action plans for potential quality deficiencies through QAPI plan to correct IDd quality is sues placing residents at risk for ineffective care

F868 QAA Committee

SS=F: Facility lacked documentation of facility's QAA program quarterly meeting for 3/4-month quarters within a year placing residents residing in facility to ID areas of concern which contribute to quality of care residents may receive

- Adm unable to locate information r/t QAA & QAPI meetings from past year r/t administrative changes; failed to retain documentation &/or ensure committee met at least quarterly for 3/4 quarters placing residents at risk of unidentified quality care services

F880 Infection Prevention & Control

SS=E: Failed to properly store trash & soiled linen & failed to use standard precautions during injection administration with risk to spread illness & infection to affected residents

- *Observed Adm nurse entered resident's doorway to administer injection into resident's upper arm; cleansed arm with alcohol pa d & administered injection & LN did not wear gloves during injection administration*
- *Observed large black trash bin & large black soiled linen bin in hallway & no lids covering bins & trash bin had soiled briefs & trash in it; multiple gnats observed around bins & strong odor coming from bins; residents reported multiple gnats around facility & trash bins get placed outside resident's room so gnats went into resident's room; failed to ensure proper storage of trash & soiled linen bins & failed to administer injection using standard precautions with risk to spread infection to affected residents*

SS=E: Failed to transport clean clothing in sanitary manner & failed to adequately disinfect glucometer placing residents at risk for infectious disease processes

- Observed laundry aide delivered clean residents' personal clothes w/o cover or barrier & staff stated not told laundry should be covered
- Observed LN cleaned glucometer after use using disinfecting wipes & container of wipes expired; failed to deliver transport r esidents' personal laundry in sanitary manner throughout hall & failed to cleanse multi-use medical equipment adequately placing re sidents at risk for infectious disease processes

SS=L (Abated to F): Failed to place enhanced barrier precaution signage by 1 resident's door who was positive with CRAB-infections of blood, urinary tract, lungs, wounds, & other body sites infection; staff failed to wear appropriate PPE to protect & prevent transmission of communicable disease when entering & providing care for 2 resident who were on enhanced barrier precautions for CRAB; facility failed to p rovide appropriate education to staff r/t CRAB infection & failed to provide surveillance for CRAB infection for 12 residents placing all residents in facility in Immediate Jeopardy due to likelihood for continued transmission of CRAB as result of deficient infection control practices

- Facility failed to place enhanced barrier precaution (approach of targeted gown and glove use during high contact resident care activities, to reduce transmission of infections) signage by 1 resident's door, who was positive with Carbapenem-Resistant Acinetobacter Baumannii (CRAB- causes infections of the blood, urinary tract, lungs, wounds, and other body sites which are very hard to treat due to antibi otic resistance) infection, staff failed to wear appropriate personal protective equipment (PPE-gowns, gloves, eyeshields, masks and other barrier equipment to protect and prevent transmission of communicable disease) when entering and providing care for 2 residen ts, who were on enhanced barrier precautions for CRAB. The facility failed to provide appropriate education to staff regarding CRAB infection and failed to provide surveillance for CRAB infection 12 residents, placing all residents in the facility in Immediate Jeopardy d ue to the likelihood for ongoing transmission of CRAB as a result of the deficient infection control p ractices. The facility further failed to to disinfect a shared glucometer (instrument used to calculate blood glucose) between 2 residents which placed the residents at risk for b loodborne pathogens and infectious disease.
- Observed LN checked 1 resident's blood sugar with shared glucometer then w/o disinfecting glucometer, checked another resident's blood sugar
- Abatement Plan:
  - Facility placed all untested residents on enhanced barrier precautions until testing & surveillance is completed
  - All CPs & Kardex updated with precaution information
  - Staff received education on CRAB, MDRO, hand hygiene, environmental cleaning & PPE
  - Facility communicated enhanced barrier precautions to all residents & family members & discussed with Resident Council

F882 Infection Preventionist Qualifications/Role

SS=F: Failed to provide an Infection Preventionist to manage & monitor facility's Infection Prevention & Control Program for all residents residing in facility placing residents at risk for infections & health problems

- Adm Nurse stated facility had no certified IP to provide oversight & monitor facility's IPCP; failed to provide an IP to manage & monitor facility's Infection Prevention & Control Program for all residents residing in facility placing residents at risk for infections & health problems

December 2022

F582 Medicaid/Medicare Coverage/Liability Notice

SS=D: Failed to provide 2 residents the completed Skilled Nursing Facility Advanced Beneficiary Notices (form 110055 placing residents at risk for uninformed decisions r/t skilled services

- Lacked documentation staff provided resident form 10055 which included estimated cost documentation for services to be able to make an informed choice whether or not resident wanted to receive the items or services, knowing resident may have to pay out of pocket; SS verified had not provided residents ABN forms when residents discharged from Med A; failed to fully inform 2 residents of liability or cost of continued stay with therapy in facility after Med A services ended placing residents at risk to make uninformed decision r/t cost of continued stay

F677 ADL Care Provided for Dependent Residents

SS=D: Failed to provide appropriate nail care & assistance for 1 resident

- Observed resident with hand in tightly closed fist & fingernails dug into palm of resident's hand; observed resident unable to open hand which had long nails that were leaving imprints on resident's palm; resident stated that nails on hand caused pain in palm; CNA stated resident alert & able to make needs known; failed to provide appropriate nail care for resident that depended on staff for ADLs

F688 Increase/Prevent Decrease in ROM/Mobility

SS=D: Failed to provide care, equipment & assistance to maintain or improve mobility with maximum practicable independence for 2 residents by failure to provide resident with provider ordered finger separator for 1 resident & "carrots" for 1 resident

- CP documented resident with finger separator & needed staff assist & encouragement to keep it in place as often as tolerated; POS documented order to apply finger separator to hand but lacked documentation of length of time per day to wear separated; records revealed resident did not have a restorative nursing program; observed resident w/o finger separator in place & resident held hand in tightly closed fist & fingernails dug into palm of hand; failed to provide care consistent with professional standard of practice to maintain or prevent further decrease in ROM for 1 resident
- CP documented resident had cones to be placed in both hands to help with contractures; POS documented order for cones to be placed in resident's hands but lacked documentation of length of time per day to wear; MAR & TAR lacked documentation of daily application of cones for resident; observed resident w/o cones in contracted hands; failed to provide care consistent with professional standard of practice to maintain or prevent further decrease in ROM for 1 resident

F689 Free of Accident Hazards/Supervision/Devices

SS=G (Past Non-Compliance): Failed to ensure 1 resident had foot pedals on w/c when CNA attempted to push resident in w/c to nurses' station; as result, resident put foot down on ground & w/c abruptly stopped, flipping resident out of w/c & forward onto face which resulted in laceration to 1 eyebrow; resident had to be transported to ER for sutures to be placed to laceration

- *Incident Report documented resident in DR when CNA attempted to move resident closer to nurses' station w/o foot pedals & resident's foot hit floor & resident fell forward out of w/c face first which caused laceration above resident's eye; resident sent to ER & resident received 4 sutures then returned to facility; Resident CPd to self-propel in w/c; investigation documented standard of practice was to have foot pedals on w/c when staff propelled resident; all nursing staff re-educated on use of foot pedals & daily monitoring by management of staff would be completed for correct use of foot pedals on w/c's; failed to ensure 1 resident had foot pedals on w/c when resident being propelled by CNA resulting in avoidable accident where resident sustained laceration that required emergent treatment & sutures*
- *Abatement Plan:*
  - *Reported incident to State Agency*
  - *All staff received education to ensure staff placed foot pedals on w/c's of all residents prior to any event when staff propelled residents in w/c's*
  - *Facility management staff reviewed & audited daily to ensure staff followed policy & training r/t use of foot pedals*

F690 Bowel/Bladder Incontinence, Catheter, UTI

SS=D: Failed to provide appropriate treatment & services to prevent possible UTIs for 2 residents

- Resident with neurogenic bladder with BIMS of 3 & with indwelling catheter; CP documented staff assisted resident with catheter care q shift & as needed; observed 2 CNAs entered room to empty catheter drainage bag; both performed hand hygiene, donned gowns & gloves, gathered equipment & went to bedside; CNA sat graduated cylinder directly on floor, sat wipes package directly on floor & removed drainage bag out of privacy cover; CNA emptied bag into graduated cylinder as edges of spout touched sides of cylinder, wiped spout with skin wipe & placed spout back in secured position; CNA took cylinder into BR to empty into toilet, rinsed it out using bed pan

washing system connected to back of toilet & placed it in designated bag; CNA removed dirty gloves & placed clean gloves on w/o performing hand hygiene then returned to bedside & assisted other CNA to reposition resident; CNA took catheter bag from othe r CNA & raised it well above resident's bladder to other side of bed; observed staff changed gloves w/o performing hand hygiene on multiple occasions; failed to provide treatment & services to prevent possible UTIs with use of indwelling catheter for 1 resident

- Other resident with catheter with same observation findings; failed to provide treatment & services to prevent possible UTIs for use of indwelling UTIs for resident

F756 Drug Regimen Review, Report Irregular, Act On

SS=D: Failed to ensure Consultant Pharmacist (CP) IDd & reported inadequate indication for use of 1 resident's antipsychotic medication, Seroquel with potential of unnecessary antipsychotic medication use & related side effects for 1 resident

- Resident with BIMS of 3 & received antipsychotic & antidepressant with order for Seroquel 100mg q hs for dementia with behavioral disturbance; MRR reviewed April 2022 through November 2022 documented no irregularities noted for resident; DON stated ongoin g problem with trying to get providers to change diagnosis for use of antipsychotic medication from dementia; rural area lacked geriatric psychiatry providers; failed to ensure CP IDd & reported inadequate indication for use of resident's Seroquel

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SS=D: Failed to ensure appropriate dx for antipsychotic for 1 resident's antipsychotic Seroquel with potential of unnecessary antipsychotic medication use & related side effects for 1 resident

- Cited findings noted in F756 r/t inappropriate dx for Seroquel; failed to ensure ina dequate indication for use of resident's antipsychotic medication Seroquel that was used to treat resident's dx of dementia with behavioral disturbance with potential of unnecessar y antipsychotic medication use & related side effects

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SS=F: Failed to ensure light fixtures above food prep areas in main facility kitchen were cleaned & storage shelving w/o rust placing residents at risk for foodborne illness

- Observed 10/19 overhead lights had lint on surface & some small objects inside cover; observed metal shelving holding steam table pans with small amount of rust at edges of 3/6 shelves & pan turned upside down directly on shelves; failed to ensure light fixtur es above food prep areas in main kitchen were cleaned & storage shelving w/o rust, placing residents at risk for foodborne illness

F867 QAPI/QAA Improvement Activities

SS=F: Failed to maintain an effective QAA program to ensure problems r/t resident care IDd & action plans developed through QAA program to address concerns with potential to affect all residents

- Referenced: F677, F688, F756, F758, F690
- Facility lacked documented for required meetings for 2022; failed to ID & address quality deficiencies through a lack of required QAPI quarterly meetings & address quality deficiencies cited on annual survey process

F868 QAA Committee

SS=F: Failed to conduct QAA committee meetings with required members present that included DON, Medical Director, Administrator, owner, board member or other individual in leadership role, Infection Preventionist & 2 other staff members when facility did not ha ve at least quarterly meetings with potential to affect all residents

- Cited findings noted in F867; Failed to conduct quarterly QAA committee meetings with required members present

January, 2023

F550 Resident Rights/Exercise of Rights

SS=D: Failed to provide dignity during dining for 1 resident who was brought to DR disheveled & then left unassisted while resident dropped food all down front of shirt placing resident at risk for impaired dignity & decreased psychosocial wellbeing

- Observed resident in DR in Broda chair sliding forward; arm pressed against table; resident used o ther arm & hand to reach across body to fork food & bring it to resident's mouth; resident dribbled food items onto shirt; no clothing protector provided for resi dent; observed resident dressed for day & hair had not been combed & resident being taken from DR; CP directed staff that resident required assist with eating; failed to provide dignity during dining for 1 resident who was brought to DR disheveled & then left unassisted while resident dropped food down front of shirt placing resident at risk for im paired dignity and decreased psychosocial wellbeing

F558 Reasonable Accommodations Needs/Preferences

SS=D: Failed to ensure adequate equipment available & used during w/c locomotion for 2 residents placing residents at risk fo r accidents & physical complications for affected residents

- Observed staff propelled resident in w/c w/o foot pedals & feet dragged on floor on multiple occasions for 2 residents; faile d to ensure adequate equipment was available & used during w/c locomotion for 2 residents placing residents at risk for accidents & physical complications for affected residents

F582 Medicaid/Medicare Coverage/Liability Notice

SS=D: Failed to provide 3 residents/representatives the completed ABN (form 10055) placing resident at risk to make uninformed decisions about skilled care

- Facility provided 1 resident completed form 10055 which estimated cost for services to be able to make an informed choice whether or not resident wanted to receive items or services, knowing resident may have to pay out of pocket; facility failed to have resident check box if they did or did not want the items or services & resident had signed form which resident had BIMS of 10 indicating moderately impaired cognition & resident signed form 2 days after services ended for multiple residents; DON verified staff provided residents 10055 & verified lack of documentation r/t resident/DPOA chose if they wanted to receive items or services of did not want to, boxes not checked either way; failed to provide 3 residents/representatives completed ABN 10055 form when discharged from skilled care placing residents at risk to make uninformed decisions about skilled care

SS=D: Failed to provide 1 resident with ABN form 10055 placing resident at risk for delay in care or missed services

- Review revealed ABN 10055 not completed & provided to resident upon discharge from Medicare services when resident had benefit days remaining; failed to provide 1 resident with ABN 10055 placing resident at risk for delay in care or missed services

F623 Notice Requirements Before Transfer/Discharge

SS=D: Failed to notify state Ombudsman of transfers & failed to provide a written notification of transfers with required information to 1 resident/representative in a practicable amount of time with risk of miscommunication between facility & resident/representative & possible missed opportunity for healthcare service for 1 resident

- Failed to notify State Ombudsman of transfers & failed to provide written notification of transfers for 1 resident/representative in practicable amount of time with risk of miscommunication between facility & resident/representative & possible missed opportunity for healthcare services for 1 resident

F625 Notice of Bed Hold Policy Before/Upon Transfer

SS=D: Failed to provide 1 resident with bed hold notice upon discharge to hospital placing resident at risk for impaired rights to return to facility & in same room as previously resided

- Resident with multiple discharges with return anticipated & resident readmitted each time; record lacked evidence a bed hold notice issued to resident/representative on 4 hospital discharges/readmissions; failed to provide 1 resident with bed hold notice upon discharge to hospital placing resident at risk for impaired rights to return to facility & in same room as resident previously resided

SS=D: Failed to provide a bed hold policy to 2 residents/representatives when resident transferred to hospital with risk of impaired ability to return to facility & to previous room for 2 residents

- Staff stated no written notification of transfer for 2 residents & SS staff stated bed hold policies were given upon admission but not with transfers; failed to provide a bed hold policy to 2 residents/representative when resident transferred to hospital with risk of impaired ability to return to facility & to previous room for 2 residents

F655 Baseline Care Plan

SS=D: Failed to develop a baseline CP in timely manner for 1 resident's urinary catheter & 1 resident's ADLs, hospice & end of life cares placing resident at risk for unmet & uncommunicated care needs

- Baseline CP lacked catheter care information; failed to develop a baseline CP in timely manner for 1 resident's urinary catheter placing resident at risk to not receive adequate care for catheter
- Baseline CP dated 3 days after required time frame; failed to develop a baseline CP for 1 resident placing resident at risk for unmet care needs

F656 Develop/Implement Comprehensive Care Plan

SS=D: Failed to develop a CP for 1 resident's indwelling catheter as well as need for assist with ADLs placing resident at risk for uncommunicated & unmet care needs

- CP lacked specific documentation for ADL assist & urinary catheter; CP was updated 1+ month later but lacked interventions; failed to complete a comprehensive person-centered CP as required & within required time frame for 1 resident placing resident at risk of unmet care needs

F657 Care Plan Timing & Revision

SS=D: Failed to revise CP to include 2 resident's antipsychotic medication & failed to revise 1 resident's CP with change in mobility status placing residents at risk for inadequate care or uncommunicated care needs

- CP stated resident received BBW medication & referenced "MAR in EMR"; CP lacked specific information r/t use of Seroquel use including targeted behaviors & side effects to monitor; failed to update 1 resident's CP with antipsychotic medication use placing resident at risk for increased behaviors
- CP documented resident with medications with BBW & lacked specific information including target behaviors for antipsychotic medication Seroquel for sundowning; record lacked monitoring for target behaviors for use of Seroquel; EMR lacked AIMS for over 1 year; failed to update 1 resident's CP with antipsychotic medication use placing resident at risk for increased behaviors
- CP had not been updated to inform staff resident no longer ambulated & now used w/c full time; facility failed to revise 1 resident's CP to reflect current mobility, placing resident at risk for inadequate care &/or uncommunicated care needs

F660 Discharge Planning Process

SS=D: Failed to establish a discharge plan with goals for 1 resident placing resident at risk for uncommunicated care needs & inappropriate discharge

- MDS documented resident expected to remain in facility with no active discharge plan; approx. 2 months after admission, progress note documented resident discharged to facility in another town & all belongings were sent with resident & resident was agreeable & excited to go; EMR lacked capitulation of stay, a comprehensive CP that included a discharge plan & information r/t transfer out of facility; failed to establish a discharge plan with goals for 1 resident placing resident at risk for uncommunicated care needs & inappropriate discharge

F661 Discharge Summary

SS=D: Failed to complete a recapitulation of 1 resident's stay at facility placing resident at risk for uncommunicated care needs & missed health care opportunities

- Cited findings noted in F660; EMR lacked capitulation of stay, a comprehensive CP which included a discharge plan & information r/t transfer out of facility; failed to complete a recapitulation of 1 resident's stay at facility placing resident at risk for uncommunicated care needs & missed health care opportunities

F677 ADL Care Provided for Dependent Residents

SS=D: Failed to provide 1 resident who requires personal hygiene & dressing assistance required; further failed to provide consistent bathing per resident preferences for 3 residents placing affected residents at risk for impaired dignity, increased risk for skin issues & other complications

- CP documented resident required extensive assist of 1 for bathing; bathing records lacked documented showers for 16 days, 12 days, 7 days, 22 days in 3 month period w/o documentation of refusals; observed resident with disheveled appearance & hair uncombed on multiple occasions; failed to provide 1 resident with required personal hygiene assist & consistent bathing per resident preference placing resident at risk for impaired dignity, increased risk for skin issues & other complications
- Resident w/o documented bathing for 24 days with refusals x 4 occasions during that time period; 20 days with 3 refusals; 12 days; 20 days with 5 occasions in 3 month period; failed to provide 1 resident with required personal hygiene assist & consistent bathing per resident preference placing resident at risk for impaired dignity, increased risk for skin issues & other complications
- 1 month's bathing report revealed resident received 2 baths in 18 day period after admission; 1 month with 12 days; 12 days & 9 days with no documentation of bathing & no documented refusals; 1 month with 10 days w/o bath in current month & observed resident with hair uncombed; failed to provide necessary care & bathing services for 1 resident placing resident at risk for poor hygiene

SS=D: Failed to provide consistent bathing for 1 resident with risk for poor hygiene & decreased self-esteem & dignity for 1 resident

- Resident with extensive assist or 1 with bathing; record review indicated from 10-1 to 1-23 resident received 7 showers (none in 1 month); bed bath on 1 occasions & tub bath 2 occasions with 2 refusals & "not applicable" on 4 occasions; resident stated did not receive regular bathing; failed to provide consistent bathing for 1 resident with risk for poor hygiene & decreased self-esteem & dignity for 1 resident

F684 Quality of Care

SS=D: Failed to ensure appropriate w/c positioning for 1 resident whose feet dangled in an unsupported, dependent position while resident sat in w/c placing resident at increased risk for medical complications &/or injuries

- Observed resident in w/c in DR with both feet dangling & while seated at dining table, toes barely touched floor & both lower legs were a darker reddish color; observed resident self-propelling w/c with arms with toe only touching floor; observed resident in w/c with toes only touching floor & heels approx. 5 inches from floor; resident stated w/c seat was too high & had used w/c for "a few months"; failed to assess & provide 1 resident with an appropriately fitted w/c placing resident at increased risk for medical complications &/or injuries

SS=D: Failed to follow physician ordered daily weights for 1 resident who required use of diuretic placing resident at risk for excess fluid accumulation & physical complications

- CP documented staff to monitor weight per physician orders; POS for daily weight with notification parameters; July 2022 MAR revealed weight not obtained on 17/31 opportunities & resident refused weights on 11/31 opportunities; August weight not obtained 15/31 with refusals of 11/31; September not obtained 15/30 with 7/30 opportunities; October not obtained 12/31 opportunities with 7/31 opportunities; November not obtained 13/30 with 4/30 opportunities; Dec not obtained 9/31 with 11/31 opportunities; January not obtained 5/19 with 3/19 opportunities; failed to ensure a physician ordered daily weight was obtained for 1 resident who required use of diuretic for fluid retention with increased risk for excess weight/fluid retention & adverse side effects

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

SS=D: Failed to follow wound care as ordered by Consultant for 1 resident with risk for delayed wound healing & physical complications for 1 resident

- Resident admitted then discharged to hospital on 3 occasions since June 2022; EMR documented resident with stage 4 sacral PU & PU to coccyx; Consultant wound care note documented with posterior thigh PU & sacral PU with specific treatment orders; multiple order changes noted in record for multiple wounds; treatment orders & progress notes failed to match & Santyl not started on day of order; failed to follow wound care as ordered by consultant for 1 resident with risk for delayed wound healing & physical complications for 1 resident

F688 Increase/Prevent Decrease in ROM/Mobility

SS=D: Failed to ensure restorative care was performed for 1 resident with risk for decline in functional mobility for 1 resident

- Resident with hemiplegia affecting non-dominant side & generalized muscle weakness; with extensive assist & total assist of 2 for most ADLS; CP documented resident on restorative program & required splint or brace daily; documentation for 12-1 to 1-18 revealed missing documentation on 6 occasions; no splint observed on resident's arm; failed to ensure restorative care performed for 1 resident with risk for decline in functional mobility for 1 resident

F689 Free of Accident Hazards/Supervision/Devices

SS=D: Failed to ensure interventions IDd to prevent falls were implemented for 1 resident & failed to ID & implement interventions to prevent further falls for 1 resident placing residents at risk for further falls & fall-related injuries

- Resident with fall resulting in femur fx with intervention of foot cradle; observed no foot cradle on bed as indicated in CP; failed to ensure an intervention IDd to prevent falls was implemented for 1 resident placing resident at risk for further falls & fall-related injuries
- Resident with fall with femur fx; CP lacked interventions until 15 days later & intervention was non-specific on use of hospital bed; failed to ensure interventions were IDd & implemented to prevent falls for 1 resident placing resident at risk for further falls & fall-related injuries

SS=D: Failed to implement fall prevention interventions after falls for 2 residents & failed to investigate to determine root cause & implement interventions for 1 resident's non-injury fall placing affected residents at risk for injuries & accidents

- CP documented resident with fall in shower during transfer & intervention was 2 staff assist with transfer in shower room; CP documented bolster mattress applied to air mattress; Next day, NN documented skin concerns IDd during care including multiple bruising; next day LN notified physician & received order for X-ray; LN documented resident admitted to hospital with femur fx; failed to ensure fall interventions implemented to prevent future falls for 1 resident placing resident at risk for injuries from falls
- Resident with documented fall risk with intervention for anti roll back brakes & observed resident w/o anti roll back brakes on w/c; failed to ensure fall interventions implemented to prevent future falls for 1 resident with risk for injuries from falls
- CP lacked intervention r/t non-injury fall; facility unable to provide fall investigation for incident to determine root cause analysis to determine an individualized intervention to assist in preventing falls & possible injuries; failed to investigate to de3termine root cause & implement interventions for 1 resident's non-injury fall with risk of future falls & possible major injuries r/t falls

F690 Bowel/Bladder Incontinence, Catheter, UTI

SS=D: Failed to provide a resident-centered toileting program for 1 resident with risk for increased incontinence, skin breakdown, loss of dignity, & physical complications for 1 resident

- Resident with occasional incontinence of urine & frequent incontinence of bowel; CP did not address a toileting schedule; EMR lacked evidence of B/B diary or toileting schedule; resident c/o no getting assist with toileting & having accidents; failed to provide a resident-centered toileting program for 1 resident with risk for increased incontinence, skin breakdown, loss of dignity, & physical complications for 1 resident

F692 Nutrition/Hydration Status Maintenance

SS=D: Failed to offer & monitor intake of nutritional supplements for 1 resident who was at risk for weight loss placing resident at further risk for unintended weight loss & malnutrition

- CP documented supplements would be given as ordered; resident to receive health shake daily in AM; Carnation instant breakfast shake daily; with additional times for supplements; resident with weight of 130.6 on 10-17 & 113.5 on 1-17; observed resident at breakfast & staff did not provide verbal encouragement & no health shake offered during meal as ordered; failed to ensure physician ordered dietary supplements to promote increased calorie intake provided to resident placing resident at risk for continued weight loss & possible malnutrition

F698 Dialysis

SS=D: Failed to consistently complete dialysis communication sheets before &/or after dialysis which included vital signs & assessments for 1 resident with risk for adverse outcomes & unwarranted physical complications

- Dialysis Communication Book revealed multiple missing days of forms; failed to consistently complete dialysis communication sheets before &/or after dialysis which included vital signs & assessments for 1 resident with risk for adverse outcomes & unwarranted physical complications for 1 resident

F726 Competent Nursing Staff

SS=D: Failed to ensure nursing staff possessed knowledge & skills to assess neurological status for 1 resident after resident with unwitnessed fall with head injury placing resident at risk for fall related complications & further injuries

- Resident with unwitnessed fall with injuries; assessments lacked evidence of further neuro checks after initial check; facility unable to provide evidence of continued neuro assessments after fall; resident sent to ER 5 days after unwitnessed fall r/t family concerns; X-rays showed fx of arm & small subdural hematoma; failed to ensure competent nursing staff provided continued neuro assessments for 1 resident after resident with unwitnessed fall with head injury placing resident at risk for physical complications & further injuries for 1 resident

F744 Treatment/Service for Dementia

SS=D: Failed to provide consistent dementia related assist r/t meals, wandering & staff interactions with 1 resident placing resident at risk for impaired ability to achieve &/or maintain highest practicable level of physical & emotional wellbeing

- CP lacked interventions r/t wandering into peers rooms or personal space; NN documented resident p all night going in & out o f other residents' room waking them up & resident resistive of cares offered; note lacked documentation indicating if staff attempted to intervene or if interventions were attempted; NN documented resident agitated most of day & note lacked documentation indicat ing if staff attempted to intervene or if interventions were attempted; multiple NN documented behaviors but lacked documentation if interventions attempted; observed resident calling for specific needs & staff did not respond to request; failed to provide c onsistent dementia related assist r/t meals, wandering, & staff interactions with 1 resident placing resident at risk for impaired ability to achieve &/or maintain resident's highest practicable level of physical & emotional wellbeing

F756 Drug Regimen Review, Report Irregular, Act On

SS=D: Failed to act on recommendations of Consultant Pharmacist (CP) to monitor & report abnormal findings when 1 resident's blood glucose levels were outside acceptable parameters & failure to administer 1 resident's PRN insulin for elevated blood glucose levels placing affected residents at risk for medical complications r/t medication regimen

- Resident with DM with POS to administer Novolog insulin 10 units q 2 hours PRN for blood glucose greater than 500 mg/dL & to notify physician if resident's blood glucose greater than 500; current month's MAR documented 20 times greater than 500 mg/dL; PRN Novolog administered 5 times in current month; DRR recommended facility ensure staff notify physician of blood glucose greater than 5 00 mg/dL on multiple months' reports; records lacked notification of physician; failed to act on recommendations of CP to monitor & report abnormal findings when 1 resident's blood glucose levels were outside acceptable parameters & failure to administer resident' s PRN insulin for elevated blood glucose levels placing resident at risk for continued high blood glucose levels

F757 Drug Regimen is Free from Unnecessary Drugs

SS=D: Failed to monitor & report abnormal findings when 1 resident's blood glucose levels were outside ordered parameters & f urther failed to administer resident's PRN insulin for elevated blood glucose levels; facility further failed to monitor BMs for 2 residents placing affected residents at risk for medical complications r/t medication regimen

- Cited findings noted in F756 r/t POS for parameters for PRN insulin & physician notification; failed to monitor & report abno rmal findings when 1 resident's blood glucose levels were outside acceptable parameters & further failed to administer resident's PRN insulin placing resident at risk for complications resulting from high blood glucose levels
- Resident with POS for bowel protocol; records documented lack of recorded BMs for 10 days & 6 days in 1 month; record lacked documentation of BMs 7 days & 5 days in 1 month & record lacked evidence of nursing interventions including medication administration per orders to treat constipation; failed to ID & respond to lack of BM for 1 resident placing resident at risk for constipation & bowel obstruction
- BM record lacked documentation of BM for 6 days & record lacked interventions to treat constipation in 1 month; failed to fol low physician standing orders for constipation placing resident at risk for constipation & bowel obstruction

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SS=D: Failed to ensure an appropriate indication for 2 residents' antipsychotic medication, failed to ensure a 14-day stop date for 1 resident's PRN psychotropic that lacked a 14 day stop date or rationale for use placing affected residents at risk for unintended effects r/ t psychotropic drug medications

- Resident with POS for Seroquel q hs for Alzheimer's; failed to ensure 1 resident did not receive an antipsychotic medication w/o appropriate diagnosis or clinical justification for use placing resident at risk for adverse side effects r/t use of Seroquel
- Resident with POS for Ativan 0.5mg q 4 hours PRN anxiety; order lacked stop date; failed to ensure 1 resident was free of use of unnecessary psychotropic drugs when they failed to obtain a stop date for use of PRN Ativan placing 1 resident at risk for ad verse effects from continued use of medications
- Resident with POS for Seroquel 12.5mg in afternoon for sundowning; record lacked monitoring for target behaviors for use of Seroquel; EMR lacked AIMS for over 1 year; failed to monitor target behaviors including abnormal movements for use of Seroquel & failed to CP BBW medications placing resident at risk for continued use of antipsychotic medication w/o monitoring for effectiveness

SS=D: Failed to ensure 1 resident was free from unnecessary psychotropic medications when facility failed to ensure resident' s PRN Lorazepam had required stop date of 14 days placing resident at risk for unnecessary medications & side effects associated with Lorazepam use

- POS with Lorazepam 0.25 q 4 hours PRN for anxiety & order lacked stop date; EMR lacked evidence physician evaluation & rationale for continued use of PRN Lorazepam; DON unaware of regulation requiring 14 day stop date; failed to ensure 1 resident was free from unnecessary psychotropic medication use when facility failed to ensure physician evaluated & documented a rationale for conti nued use of PRN Lorazepam & failed to ensure a specified duration for PRN psychotropic Lorazepam placing resident at increased risk for unnecessary medications & increased risk for adverse effects r/t psychotropic medication use

F761 Label/Store Drugs & Biologicals

SS=E: Failed to ensure drugs were in locked storage when unattended by licensed staff placing residents at risk for missing or tamp ered with medications

- Observed med cart unlocked & no nursing staff in sight & drawers of meds were accessible; observed med cart on hallway with cart unlocked & medication accessible with no licensed staff in sight of the cart; Adm staff locked cart as passed by; failed to ensure drugs were in locked storage when unattended by licensed staff placing residents at risk for missing or tampered with medications

SS=E: Failed to maintain fridge temp logs in 2/4 med rooms used for medication & biological storage placing residents at risk for ineffective medication & related side effects

- Observed fridge in med room with temp log dated August 2022; observed med room on 2nd floor revealed incomplete temp log from current month; failed to assess & maintain fridge temp logs in 2/4 med rooms r/t medication & biological storage placing residents at risk for ineffective medication & related side effects

F801 Qualified Dietary Staff

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

- Observed facility kitchen with damage to ceiling covered with plastic & no staff working in kitchen; dietary staff stated damage was from water pipe damage 23 days previously & kitchen was shut down for repairs starting the day of the survey & facility was buying takeout from multiple restaurants; observed fridge with opened, undated food items; freezer with opened, undated food items & no temp logs for 22 days; fridge temp in DR was 40 degrees; staff not measuring food provided to residents; staff member verified manager but not certified & had just started classes; staff verified RD had not been to facility for at least 2 months; failed to employ a full time CMD for all resident residing in facility & receiving meals from facility kitchen placing residents at risk for receiving inadequate nutrition

F804 Nutritive Value/Appear, Palatable/Prefer Temp

SS=F: Failed to ensure foods remained at a safe, hot, holding temp during meal service placing all residents who received meals from facility at risk for food-borne illness

- Observed breakfast with all items below required temps as indicated in temp log book; upon further observation, staff discovered steam table outlet not working & changed to another electrical outlet & hot food temps remained lower than required; facility failed to maintain food temps at minimum of 135 degrees during meal service placing residents at risk for unpalatable food or food-borne illness

F808 Therapeutic Diet Prescribed by Physician

SS=D: Failed to ensure 1/3 residents received appropriate therapeutic diet as ordered by physician

- *Resident with cerebral infarction, dysphagia, hx of malignant neoplasm of colon & recent COVID infection; required supervision for eating & no swallowing or dental issues; POS ordered level 4 pureed diet with nectar thick liquids; observed resident in bed with difficulty with liquids & resident stated staff did not assist with liquids; observed CNA positioned resident upright in bed & placed plate of regular textured scrambled eggs, thin consistency water & apple juice on resident's table & placed silverware on resident's weak side which resident was unable to reach; resident observed with oral thrush; dietary staff revealed did not receive change in diet from regular to pureed & would need to obtain order from hospice agency; hospice orders revealed lack of dietary instructions; failed to clarify conflicting physician orders for therapeutic diet for dependent resident at risk for aspiration*

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SS=F: Failed to store, prepare & serve food to residents of facility in safe, sanitary manner placing all residents of facility who received meals from kitchen at risk for food-borne illnesses

- Cited findings noted in F804; fridge with opened, undated food items, undated items; multiple missing temps on temp logs; fridge with temp of 40 degrees; observed dishwasher with no temp or sanitation log found; observed dietary staff obtained food temps using same thermometer w/o cleaning between different foods & when staff plated food for residents handled bacon, sausages & biscuits with same gloved hands, not tongs; handled toast with gloved hands then placed on plates

SS=F: Failed to maintain sanitary dietary standards r/t food storage, preparation & handling placing residents at risk r/t food borne illnesses & food safety concerns

- Observed: 2 kitchen handwashing sinks with paper towel dispensers empty with no clean hand drying option available; microwave with old food stains & residue splattered on inside of microwave; clean storage rack for pan with saucepan with visible grease & food residue stuck on inside; ice machine with old food & trash directly under machine & behind machine; oven & grill covered in grease & food residue; overhead oven hood with grease dripping onto stove burners & floor; floor surrounding oven with layer of grease drippings; juice dispenser with sticky residue covering bottom of vent tray, control wand & output nozzle; dry food storage with food & trash on floor; opened, undated food items; walk in fridge with fruit bowls with no cover or barrier; dishwashing area with trash & food particles on floor & inside floor drains; cart of clean plates with no barrier or covering to keep plates sanitary
- Observed CNA assisting with meal service & touched several residents, then sat down & assisted resident with meal then adjusted Broda chair & sat back down to assist resident with meal the picked up silverware & began feeding resident; observed uncovered drinks during transport

F814 Dispose Garbage & Refuse Properly

SS=F: Failed to ensure staff discarded bags of trash in dumpsters in manner to allow closure of lids to prevent spread of infections

- *Observed 2 facility dumpsters contained bags of trash stacked on top of 1 end of dumpster at height which did not allow closure of lids; failed to contain trash in dumpsters in manner to allow lid closure to prevent spread of infection*

F849 Hospice Services

SS=D: Failed to ensure collaboration with hospice provider to establish a plan for 1 residents' care & included shared information r/t resident's care needs, medication & equipment provided by hospice as well as frequency of nursing visits & nursing care provided by hospice placing resident at risk for uncommunicated or unmet care needs r/t end of life cares

- Failed to collaborate with hospice for care & services provided to 1 resident which placed resident at risk for unmet care needs

F880 Infection Prevention & Control

SS=F: Failed to ensure staff provided effective infection prevention to prevent spread of infections r/t to: staff transported soiled resident laundry by dragging it on floor from a resident room to a soiled utility room, staff failed to assist 1 resident to keep opened bags of food items off floor & 1 resident t keep O2 tubing & cannula off floor; staff failed to sanitize a multi resident use blood glucose monitor after obtaining a blood glucose to prevent spread of infection; staff failed to provide COVID testing for 1 newly admitted unvaccinated resident

- *Failed to ensure staff provided sanitary storage for resident's opened food items, opened drinks & cups to prevent spread of infection; failed to ensure sanitary storage of resident's O2 tubing & cannula to prevent spread of infection*
  - *Observed resident room with 2 opened bags of chips, opened bottle of soda & drinking cups directly on floor & resident also had bottles of personal care items directly on floor; resident stated did not have room for items*
  - *Observed CNA dragged bag of soiled linen from resident room to soiled utility room*
  - *Observed resident's room with O2 tubing & cannula stored directly on floor*
- *Record revealed resident admitted to facility from home & record lacked indication of COVID status or vaccination status; resident's room door contained sign for isolation precautions; sign advised staff/visitors to see charge nurse & don face shield, mask, gloves & gown prior to entry; area outside room lacked a cart containing these items & lacked effective trash disposal for items; review of county transmission rate was in red indicating high transmission rate; staff stated resident admitted from home & was unvaccinated & admitted for respite care & was HIV positive; records revealed & confirmed staff did not administer a COVID test; failed to determine a resident's COVID status upon admission to prevent spread of infection for newly admitted unvaccinated resident*
- *Observed LN obtained blood glucose from resident & LN placed glucometer on top of another glucometer in treatment cart w/o sanitized device; failed to ensure staff sanitized multi resident use equipment to prevent spread of infection amongst 10 residents who required blood glucose testing to prevent spread of infection*

SS=E: Failed to ensure proper infection control standards followed r/t transporting clean linens & hygiene supplies in sanitary manner placing residents at risk for complications r/t infectious diseases

- Observed drawer with incontinent briefs & bed pads open with opened pack of incontinent briefs out on top of drawer in hallway outside 1 resident's room; trash bag filled with trash on floor in resident's room for extended period of time; laundry cart w/o cover or barrier
- Observed CNA picked up resident's silverware & began feeding resident w/o completing hand hygiene; clean bed linen stored on top of drawer in hallway with no cover or barrier; supply cart with opened packs of incontinent briefs & clean towels with no cover or barrier; soiled incontinent brief at footboard of resident's room next to entry door to room

F882 Infection Preventionist Qualifications/Role

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

- DON stated responsible for IPC program & lacked certification as Infection Preventionist & had completed most of or all training modules but had not taken test or received certification; failed to ensure person designated as Infection Preventionist completed required certification placing residents at risk for lack of ID & treatment of infections

F883 Influenza & Pneumococcal Immunizations

SS=E: Failed to ensure 2 residents received vaccine information for influenza to determine benefit verses risk for administration & opportunity to accept or decline vaccination when offered annually as required; failed to offer 3 residents who decline pneumonia vaccine in 2021 an opportunity to receive pneumonia education & vaccination in 2022

- *Record lacked declination for 2022 influenza vaccine or an opportunity for resident to receive annual vaccination in 2022*
- *Record revealed resident declined influenza vaccine in 2021 but record lacked declination for 2022 influenza vaccine or an opportunity for resident to receive annual vaccination in 2022*
- *3 resident records lacked evidence an opportunity for resident to change mind or vaccination education from declinations for pneumonia before 2022; staff stated facility did not offer pneumonia vaccine to residents that declined it in past; failed to offer residents who decline influenza/pneumonia vaccine prior to 2022 an opportunity to accept vaccines for 2022 to ensure optimal health & prevention of infections for high-risk population*

SS=E: Failed to offer & provide &/or obtain informed refusals for influenza & pneumococcal vaccinations & failed to offer & provide residents/representatives current year's "Vaccine Information Statement" that explained both benefits & risk of vaccine to vaccine recipients for 5 residents placing residents at increased risk for illness & infection

- 5 residents' record lacked evidence current year "Vaccine Information Statement" form was provided to resident/representative or an informed refusal obtained; failed to offer & provide &/or obtain informed refusals for influenza & pneumococcal vaccinations for 5 residents & failed to provide current year VIS placing affected residents increased risk for illness & infection

F887 COVID-19 Immunization

SS=E: Failed to ensure 5 residents that declined COVID-19 vaccine prior to 2022 were offered opportunity to receive vaccination in 2022

- Record documented resident declined COVID-19 vaccination prior to 2022 but lacked documentation staff offered opportunity to receive vaccination in 2022 for multiple residents; facility lacked documentation of staff providing an opportunity for residents that declined COVID vaccine in 2021 an opportunity to receive/decline vaccine in 2022; failed to offer residents that declined COVID-19 vaccine in 2021, opportunity to receive vaccination in 2022 to ensure these high-risk residents understood benefits/risks of vaccine to ensure optimal heath & wellbeing

February, 2023

F582 Medicaid/Medicare Coverage/Liability Notice

SS=D: Failed to provide appropriate NOMNC form CMS 10123 to all Medicare beneficiaries at least 2 days before the end of Medicare covered Part A stay or when all Part B therapies were ending for 3 residents reviewed

- Failed to produce signed NOMNC for multiple residents; failed to provide appropriate Beneficiary Protection Notification forms for 3 residents reviewed to ensure residents' right to appeal upon discontinuation of services

F641 Accuracy of Assessments

SS=D: Failed to complete an accurate comprehensive assessment for 1 resident including 1 resident r/t wounds present on admission to facility

- Admission MDS documented resident had 0 venous & arterial ulcers present at admission; CP documented interventions for staff to perform wound care for chronic venous stasis wounds; POS included instructions for wound care for resident's venous stasis ulcers; HER progress notes documented wounds to resident's lower legs; family stated resident admitted with venous stasis ulcers on both lower legs; failed to accurately code MDS for resident r/t wounds

F657 Care Plan Timing & Revision

SS=D: Failed to review & revise CPs for 2 residents r/t fall prevention interventions & 1 resident r/t DNR

- CP documented resident at risk for injuries r/t multiple falls & lacked updated intervention r/t fall ; failed to revise CP with interventions after resident fell to prevent further possible falls
- CP documented resident to be "full code"; POS with order for DNR; documents revealed physician & resident signed DNR; DON stated failed to update CP to reflect resident's current order of DNR; failed to review & revise resident's wishes on resident's CP r/t code status placing resident at risk for receiving medical procedures that resident did not want

F677 ADL Care Provided for Dependent Residents

SS=D: Failed to change gloves to provide a sanitary environment while performing peri-care to 1 resident following BM

- Observed resident; CNA donned gloves & removed resident's bed covers to check resident's incontinent brief; resident's brief soiled with feces & urine; CNA removed soiled brief & cleansed resident's perineal area with disposable wet wipes then applied clean brief with same gloves used to clean BM; staff failed to remove dirty gloves; CNA placed incontinent pad under residents then placed foot cradle under resident's lower legs, covered resident up, all with same soiled gloves; failed to change gloves to provide sanitary environment while performing peri-care to 1 resident following BM

F689 Free of Accident Hazards/Supervision/Devices

SS=D: Failed to ensure fall prevention interventions implemented to prevent further falls for 1 resident

- CP documented resident at risk for injuries r/t multiple falls & lacked updated intervention r/t 1 fall of resident; resident with fall with no injuries; immediate intervention was resident' PCP would review medications & facility would move resident to family room for supervision; failed to implement interventions after resident fall to prevent further possible falls

F695 Respiratory/Tracheostomy Care & Suctioning

SS=D: Failed to provide necessary respiratory care & services for 1 resident who required physician ordered O2 & nebulizer inhalation treatments

- Resident with acute respiratory failure & COPD; resident with hospice services; POS for O2 via nasal cannula @ 2 l/m to keep O2 sats above 90%; POS ordered tubing & nasal cannula to be changed q 2 weeks & date must be on humidifier tubing & cannula; nebulizer in dated plastic bag at resident's bedside with order for Ipratropium-Albuterol; observed O2 tubing or cannula along with nebulizer tubing lacked date when staff changed them; failed to provide necessary respiratory care & services on 1 resident who required physician ordered O2 & nebulizer treatments

F755 Pharmacy Services/Procedures/Pharmacist/Records

SS=D: Failed to follow physician orders in timely manner for 1 resident placing resident at risk for adverse effects r/t medication use

- Progress notes documented visit from resident's provider with new orders to change supplement to mid-morning & mid-afternoon & not offer at mealtime & start Mirtazapine for depression & weight loss & to DC Lexapro; HER documented Lexapro remained on MAR & lacked order for Mirtazapine; failed to ensure physician orders were followed for 1 resident for a total of 12 days placing resident at risk for adverse effects r/t medication use

F756 Drug Regimen Review, Report Irregular, Act On

SS=D: Consultant Pharmacist failed to ensure 1/6 residents r/t PRN psychotropic medication stop date

- Resident with order for anxiety & encephalopathy; MDS documented resident with BIMS of 5 & hallucinations present; CAA documented symptoms of delirium; POS with Ativan 0.5mg q 4 hours PRN for anxiety/restlessness; order lacked 14 day stop date or an evaluation/justification statement for long term use; MAR revealed resident received PRN Ativan on 59 occasions in 2-month period; progress notes lacked documentation for resident's physician r/t stop date 14 days from initiation or a justification to continue medication beyond initial 14-day period; DON unaware of requirement for evaluation/justification & believed if PRN psychotropic medications that came from hospice could be open-ended; pharmacy consultant revealed oversight that did not request a stop date or justification; consultant pharmacist failed to ID possible irregularities for resident who received anti-anxiety medication beyond 14 days after physician ordered medication w/o evaluation/rationale by resident's physician placing resident at risk for receiving unnecessary medications

F758 Free from Unnecessary Psychotropic Meds/PRN Use

SS=D: Failed to ensure 1/6 residents r/t monitoring for EPS symptoms & for 1 resident r/t PRN psychotropic medication stop date & monitoring behaviors

- Resident with hypertensive heart disease with heart failure, cerebral infarction, anxiety & encephalopathy; BIMS of 5 with hallucination & delirium; POS with Ativan 0.5mg PRN anxiety/restlessness; order lacked 14 day stop date or an evaluation/justification statement for long-term care use; MAR revealed resident received Ativan 59 occasions in 2-month period; progress notes lacked documentation from resident's physician r/t stop date 14 days from initiation or justification to continue medication beyond initial 14-day period; failed to ID possible irregularities for resident who received anti-anxiety medication beyond 14 days after physician ordered medication w/o evaluation/rationale by resident's physician ordered medication w/o evaluation/rationale by resident's physician; failed to monitor resident's behavior placing resident at risk for receiving unnecessary medications
- Resident with anxiety d/o, dementia with psychotic disturbance; BIMS 5 & resident received scheduled pain medication with pain controlled; resident with no psychotropic drugs used; CP documented staff should monitor resident's behavior r/t Zoloft & resident with behaviors of hallucination & wandering; believed bugs in ears & legs; resident hoarded Kleenex in pants, would make maps out of objects & would urinate in cups & in sink; POS with Sertraline qd r/t dementia with behavioral disturbances, Risperdal 0.5mg BID for dementia with behavioral disturbances then increased to 1.0mg in previous month; staff lacked behavior monitoring on 18/49 occasions; CNA reported resident w/o behaviors; failed to ensure resident was free of unnecessary medications by failure to monitor behaviors every shift as ordered by physician

F812 Food Procurement, Store/Prepare/Serve-Sanitary

SS=F: Failed to provide sanitary food preparation, storage & serving to prevent spread of food borne illness to residents of facility

- Observed cutting boards with deep cuts in surface & 1 cutting board with flakes of surface that came off during use; dish cart full of dishes all right-side-up; top dishes contained debris of unknown composition; free-standing fridge with unsealed food items; food items lacking date of preparation or expiration date; expired items; opened undated condiments & food items; free-standing freezer with undated food items; opened & undated food items
- Observed dietary staff placed utensils for food service on counter of steam table & lacked barrier; dietary staff IDd several dishes in slotted dish cart with dried food & unidentified debris on eating surfaces; staff placed 3 bins of pureed food into warmer w/o lids or coverings; 2 full trays of food in warmer that lacked covering