| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045343 | A. Building<br>B. Wing | 10/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Nursing and Rehabilitation Center at Good Shepherd | 3001 Aldersgate Road<br>Little Rock, AR 72205 |

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|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>50505<br><br>Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to provide dignity regarding cleaning the resident after meals for one (Resident #72) of one resident reviewed for resident rights regarding dignity.<br><br>Findings include:<br><br>A review of a facility policy titled, Resident Rights, revised on 11/22/2016, indicated residents would receive adequate and appropriate nursing care and personal cleanliness in a safe and clean environment.<br><br>A review of the Admission Record, indicated the facility admitted Resident #72 with diagnoses that included Alzheimer's disease with late onset and chronic pain.<br><br>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/19/2024, revealed Resident #72 required set up or clean up assistance with eating and supervision and touching assistance with personal hygiene and upper body dressing.<br><br>A review of Resident #72's Care Plan, initiated on 01/19/2023, revealed the resident had an Activity of Daily Living (ADL) self-care performance deficit. Intervention included that the resident required extensive assistance of one staff member for personal hygiene and oral care.<br><br>During an observation on 09/30/2024 at 10:29 AM, Resident #72 was noted to have a large dropping of oatmeal on the top sheet of the bed and the resident's shirt was covered with food particles.<br><br>During an observation on 09/30/2024 at 1:49 PM, Resident #72 was noted to have a large dropping of oatmeal on the top sheet of the bed and shirt was covered with food particles.<br><br>During an observation on 10/01/2024 at 8:46 AM, Resident #72 was in bed, sitting up eating breakfast. Oatmeal was noted on the resident's shirt. At 1:01 PM, Resident #72 was in bed, wearing a shirt which had oatmeal droppings. The top sheet of the bed was stained with a yellowish/beige liquid. At 2:10 PM, Resident #72 was assisted by staff to change bed linens and the resident's clothing.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/01/2024 at 2:15 PM, Licensed Practical Nurse, (LPN) #9 confirmed that Resident #72 had oatmeal on the top sheet of the bed and food particles on the resident's shirt. LPN #9 confirmed that Resident #72 required assistance and needed to be cleaned after meals.<br><br>During an interview on 10/01/2024 at 2:20 PM, the Director of Nursing (DON) confirmed Resident #72 should have been cleaned after breakfast and that linens should have been changed at that time. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>49981<br><br>Based on observation, interview, and in-service review, it was determined that the facility failed to ensure resident's call lights were in reach for 5 (Residents #13, #24, #51, #80, and #96) of 25 sampled residents.<br><br>The findings are:<br><br>1. On 9/30/2024 at 9:52 am, observed Resident #80's call light was not in reach. Resident was sitting in a chair in front of the dresser and the call light was located under the right side of the bedframe.<br><br>a. At 11:18 am, Resident #96's call light was not in reach. The call light was located on the left side of the bed with the button dangling right above the floor.<br><br>b. At 12:30 pm, Resident #13's call light was not in reach. The call light was tied to the left side handrail that was pushed up against the wall and the button was hanging below the handrail where it was not visible.<br><br>2. On 10/01/2024 at 8:59 am, observed Resident #24's and Resident #51's call lights were not in reach. Resident #24's call light was tied to the left side of the handrail with the button dangling below the handrail, not visible to the resident. Resident #51's call light was hanging through the right side handrail dangling above the floor, out of reach of the resident. At 9:04 am, observed Resident #80's call light was not in reach. The call light was hanging below the left side of the bedframe. At 9:07 am, observed Resident #13's call light was not in reach. The cord was wrapped around the left side of the handrail with the button hanging below the handrail, not visible to the resident. At 9:11 am, observed Resident #96's call light not in reach. The call light was hanging over the handrail and dangling just above the floor where the resident could not reach it.<br><br>On 10/02/2024 at 8:24 am, Certified Nursing Assistant (CNA) #5 confirmed that residents are to have their call lights where they can reach them in case they have a need or an emergency.<br><br>On 10/02/2024 at 8:46 am, CNA #5 stated that the last thing that is done before leaving a resident's room is checking to ensure the call light is in the resident's reach in case they want or need something. CNA #5 stated that if the resident had an emergency and couldn't reach their call light, the resident may suffer harm.<br><br>On 10/03/2024 at 8:10 am, Licensed Practical Nurse (LPN) #8 confirmed that the residents should have their call lights before exiting their rooms because they may want or need something that they aren't able to get themselves. LPN #8 confirmed that emergencies can happen, and the residents need their call lights in reach.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 10/04/2024 at 8:08 am, observed Resident #51's call light on the nightstand. CNA #6 was asked where the resident's call light was located. CNA #6 confirmed that it was not where it was supposed to be. CNA #6 was asked if the resident could reach it on the nightstand. CNA #6 confirmed that the resident would not be able too. CNA #6 confirmed that if the resident choked or had an emergency that it would be very harmful if the resident didn't have their call light.<br><br>The Administrator provided in-services dated 11/17/2023, 4/11/2024, and 6/28/2024 that were issued to staff regarding call lights and confirmed that the facility did not have a policy specific to call lights. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50505<br><br>Based on observations, interviews, and facility document review, it was determined that the facility failed to clean and sanitize the shower room on 500 Hall which was reviewed for environmental concerns.<br><br>Findings include:<br><br>A review of a facility policy titled, Resident Rights, revised on 11/22/2016, indicated the resident would receive adequate and appropriate care to include personal cleanliness in a safe and clean environment.<br><br>During an observation on 10/01/2024 at 8:30 AM, the spa/shower room on the 500 hall was noted to have large scrape marks along the shower room stalls, an unidentified brownish/black residue was noted along the edges of each shower room stall where the floor meets the walls, there was unidentified brownish substance stain on the tiled walls and the sink area was cluttered with supplies.<br><br>During an interview on 10/01/2024 at 2:15 PM, the Director of Nursing (DON) confirmed that there was a black/brown substance noted along the edges of the shower stalls, brown substances splattered on the walls of the shower stalls and that the shower room needed to be cleaned.<br><br>During an interview on 10/01/2024 at 2:18 PM, the Housekeeping Supervisor confirmed there was a black-brown substance noted along the edges of the shower stalls, brown substances splattered on the walls of the shower stalls and that the shower room needed to be cleaned. The housekeeping supervisor stated that someone would be cleaning the shower room later in the afternoon.<br><br>During an interview on 10/02/24 at 3:00 PM, the Administrator showed the surveyor pictures of the shower room on the 500 hall and stated that the room had been cleaned.<br><br>During an observation on 10/3/2024 07:55 AM, the shower room on 500 hall was noted to have new white [NAME] over some of the shower stall edges. Some stalls were still noted to have the same brownish-black residue, and the shower room stalls were still with brown-black substances on the walls. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>50505<br><br>Based on observation, interviews, record review, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed for 2 (Resident #88, and Resident #30) of 25 residents reviewed for MDS accuracy. Specifically, the facility failed to ensure information regarding the resident's medication regimen was accurately completed for Resident #30 and failed to ensure information regarding a fall with major injury was accurately completed for Resident #88.<br><br>Findings include:<br><br>On 10/03/2024 at 11:05 AM, the nurse consultant stated the facility did not have a policy for the Minimum Data Set (MDS) and that the facility uses the Resident Assessment Instrument (RAI) manual.<br><br>1. A review of the Admission Record indicated the facility admitted Resident #88 with diagnoses that included polyneuropathy (damage to multiple nerves outside of the brain and central nervous system), muscle weakness, lack of coordination, muscle wasting and atrophy, chronic pain, and scoliosis.<br><br>The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/20/2024, revealed Resident #88 had one fall with no major injury.<br><br>A review of the care plan initiated 06/27/2024 indicated Resident #88 had an actual fall with serious injury with no interventions to prevent reoccurrence and a care plan initiated 06/16/2023 stating Resident #88 was at increased risk for falls due to gait instability and weakness and falls prior to hospitalization with no interventions listed to prevent fall from occurring or reoccurring. Care plan was updated on 06/26/2024 for shower bed for showers as tolerated related to leaning and was changed to a mechanical lift for transfers on 07/01/2024.<br><br>A review of the CMS-802 facility roster matrix was supplied on 09/30/2024 and failed to include a fall with major injury for Resident #88.<br><br>A review of the incident and accident report dated 06/26/2024 was supplied by the Director of Nursing on 10/02/2024 for Resident #88 for a witnessed fall on 06/26/2024 at 12:00 PM.<br><br>A review of hospital records for 06/26/2024, x-ray reports indicated that Resident #88 had a closed fracture of proximal end of left tibia.<br><br>2. A review of the Admission Record for Resident #30 indicated the facility admitted Resident #30 with diagnoses that included specified depressive episodes and schizoaffective disorder, depressive type.<br><br>The quarterly MDS with an ARD of 07/16/2024, indicated that Resident #30 was not currently taking an antidepressant medication.<br><br>A review of the Order Summary Report for Resident #30 indicated that the resident was currently receiving an antidepressant, which was ordered on 04/15/2024.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the care plan, initiated 04/11/2024, indicated Resident #30 used antidepressant medication.<br><br>During an interview on 10/03/2024 at 12:35 PM, Long Term Care (LTC) MDS Coordinator confirmed the long-term care MDSs were completed by the LTC MDS Coordinator. She confirmed that training had been completed but that it was difficult to understand and that as the coordinator, needed more training. Confirmation was given that the MDS had been coded incorrectly, because Resident #88 had a fall that resulted in significant injury. The LTC MDS Coordinator confirmed that Resident #30 was taking an antidepressant and that it was missed when the MDS was completed. When the LTC MDS Coordinator was asked what could occur if assessments were not completed accurately. She stated that it could cause a deficit in the residents' care.<br><br>During an interview on 10/04/2024 at 8:40 AM, the Director of Nursing (DON) confirmed Resident #88's MDS should have included the fall with major injury. The DON stated the Skilled Nursing Facility (SNF) MDS Coordinator assists when questions need to be answered or when something is not understood and the use of the RAI manual.<br><br>During an interview on 10/04/2024 at 9:06 AM, the Administrator stated the MDS should indicate if the resident had a fall with major injury. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>49688<br><br>Based on observations, interviews, record review, facility document review, it was determined the facility failed to update and/or revise the resident's care plan for 5 (Residents #7, #36, #91, #30, and #72) of 25 residents reviewed for comprehensive care planning. Specifically, the facility failed to include unnecessary medications for Resident #30, change in wound care status for Resident #72, and falls for Resident #7, #36, and #91.<br><br>Findings include:<br><br>On 10/03/2024 at 11:05 AM, the nurse consultant stated the facility did not have a policy for care plans and the facility followed the Resident Assessment Instrument (RAI) manual.<br><br>1. A review of the Admission Record, indicated the facility admitted Resident #7 with diagnoses that included dementia, cognitive communication deficit, age related osteoporosis, muscle wasting and atrophy, and glaucoma.<br><br>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/16/2024, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 4 which indicated the resident was had moderate cognitive impairment. Resident #7 required maximal assistance for mobility and has had two falls since the last assessment.<br><br>A review of Resident #7's care plan revised on 07/23/2024, indicated the resident was a high risk for falls due to weakness and the resident had a fall on 07/22/2024 without injury. The facility developed interventions to include staff to follow facility fall protocol. There were no interventions initiated after 2018. Further review indicated the resident had limited physical mobility; however, the resident was weight bearing. The facility also indicated Resident #7 had an Activity of Daily Living (ADL) self-care performance deficit related to cognitive deficit, weakness, and impaired mobility.<br><br>A review of Nsg [Nursing] [Named] Fall Scale and Care Plan with Tasks with an effective date of 02/14/2024 indicated Resident #7 was a high risk for falling and the resident overestimates or forgets limits. There were no new interventions listed.<br><br>A review of Un-witnessed Fall incident and accident (I&A) report indicated on 05/22/2024 at 4:15 AM, indicated Resident #7 had an unwitnessed fall in the resident's room and was found lying on the floor between the bed and the wall in the left lateral position. The resident's upper body was slightly under the bed. The resident could not state what happened. The immediate action taken was to continue to make sure the bed was in the lowest position and locked. There was no other information provided regarding the fall, including witness statements or investigation regarding the fall.<br><br>A review of Nsg [Nursing] [Named] Fall Scale and Care Plan with Tasks with an effective date of 05/24/2024 indicated Resident #7 was a high risk for falling and the resident overestimates or forgets limits. There were no new interventions listed.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Un-witnessed Fall incident and accident (I&A) report indicated on 07/22/2024 at 6:35 PM, indicated Resident #7 had a fall in their room and was found on the floor, lying in front of their wheelchair next to the resident's bed. Their legs were extended out in front of the resident and their arms were to the side of the resident. The resident requested assistance to bed. There was no other information provided regarding the fall, including witness statements or investigation regarding the fall.<br><br>A review of Nsg [Nursing] [Named] Fall Scale and Care Plan with Tasks with an effective date of 07/22/2024 indicated the resident was a high risk for falling and the resident overestimates or forgets limits. There were no new interventions listed.<br><br>During an interview on 10/03/2024 at 3:30 PM, Licensed Practical Nurse (LPN) #12 stated Resident #7 had dementia, and a mechanical lift was needed for all transfers. LPN #12 stated Resident #7 was in their room when the fall occurred and there were no injuries. LPN #12 could not recall the official interventions in place at that time but could recall Resident #7 had a fall mat in place. When a resident has a fall, staff were to fill out an I & A in the computer, notify the DON (Director of Nursing) and family, notify the doctor, chart how it happened, how they found the resident, complete neurological checks, monitor vital signs, assess for injuries and if injuries are present, staff notify the doctor. Staff make sure an intervention is put in place and documented in the I & A under risk management in the electronic health record<br><br>2. A review of the Admission Record, indicated the facility admitted Resident #36 on 10/10/2019 with diagnoses that included acute respiratory failure, severe speech and language deficits due to a stroke, partial paralysis, traumatic brain injury, dementia, post-traumatic stress disorder (PTSD), visuospatial deficit, and spatial neglect.<br><br>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/12/2024, revealed Resident #36 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated Resident #36 had moderate cognitive impairment. Resident #36 required partial to moderate assistance for mobility and had no falls since the prior assessment.<br><br>A review of Resident #36's care plan revised on 03/06/2024, indicated the resident was at an increased risk for falls due to gait instability, weakness, impaired mobility, and noncompliance with call light use. The resident had a fall on 01/26/2024 without injury. The facility developed interventions to include, attempt to maintain bed in low position and to remind to call for transfer assistance, to encourage non-skid socks, non-skid strips on bathroom floor, remind frequently to call for assistance, remind resident to call for assistance. Further review indicated the resident had another fall that was initiated on 05/17/2024 and to initiate neurological checks. No other interventions were indicated. The facility also indicated the resident had an Activity of Daily Living (ADL) self-care performance deficit related to cognitive deficit, weakness, and impaired mobility as well as the resident having a stroke that resulted in paralysis to the left non-dominant side.<br><br>During an interview on 10/03/2024 at 3:25 PM, with LPN #14, she stated the Long Term Care (LTC) Coordinator was responsible for updating the resident's care plan. Staff bring the I & A to attention of the LTC Coordinator when anything changes with a resident.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an Interview on 10/04/2024 at 10:25 AM, the Director of Nursing (DON) stated Resident #36's fall interventions included anti-roll backs for the wheelchair, fall mat, non-skid socks, and padding the bottom bed rail. Resident #36's last fall was on 09/26/2024, which resulted in an abrasion on the left ankle. The DON stated the resident's care plan did not include some of the fall interventions and there should be an intervention after each fall and interventions should be reviewed to see what is working and what is not.<br><br>During an interview on 10/04/2024 at12:44 PM, the LTC MDS Coordinator stated the resident's care plan should be updated when there is a change in condition, new orders, medication reduction, or if the resident falls. At this time, the LTC MDS Coordinator reviewed Resident #36's care plan and stated the care plan was not updated to reflect the most recent fall because they were on vacation until the end of September and still catching up from being off work.<br><br>3. A review of the Admission Record, indicated the facility admitted Resident #91 with diagnoses that included rheumatoid arthritis, one sided paralysis following stroke to the left non-dominant side, necrosis of unspecified bone, anxiety and depression.<br><br>The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/27/2024, revealed Resident #91 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact. Resident #91 used a wheelchair for mobility and had a fall with major injury since the prior assessment.<br><br>A review of Resident #91's care plan revised on 07/11/2024, indicated the resident was at increased risk for falls due to weakness and paralysis and had a fall without injury on 07/03/2024. The facility developed interventions to include a pommel cushion to the wheelchair, which was initiated on 07/03/2024. Further review of the care plan indicated the care plan was updated on 09/09/2024 to indicate the resident had a fall with no injury and to continue interventions on the at-risk plan. There was no indication what the at-risk plan was. The facility also indicated Resident #91 had an Activity of Daily Living (ADL) self-care performance deficit related to a stroke with residual left paralysis.<br><br>A review of Nsg [Nursing] [Named] Fall Scale and Care Plan with Tasks with an effective date of 07/03/2024, indicated the resident was a high risk for falling and the resident overestimates or forgets limit and the intervention was to add a pommel cushion to the wheelchair. This form was completed by LPN #14.<br><br>A review of Nsg [Nursing] [Named] Fall Scale and Care Plan with Tasks with an effective date of 09/04/2024, indicated the resident was a high risk for falling and the resident overestimates or forgets limits and the intervention was to lower the wheelchair seat. This form was completed by the Director of Nursing (DON). This form was completed prior to Resident #91's fall on 09/06/2024 and is linked to the resident's care plan, which was not updated until 09/09/2024<br><br>A review of Progress Notes indicated on 09/06/2024 at 2:43 PM, LPN #14 indicated there was a new order for an x-ray to Resident #91's left shoulder, left humerus, left elbow, left wrist, and left hand related to pain. There were no progress notes indicating Resident #91 had a fall that day or within the month.<br><br>(continued on next page) |

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| | 045343 | A. Building<br>B. Wing | 10/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Nursing and Rehabilitation Center at Good Shepherd | 3001 Aldersgate Road<br>Little Rock, AR 72205 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Un-witnessed Fall incident and accident (I&A) report indicated on 06/26/2024 at 5:15 PM, LPN #15 indicated Resident #91 had an unwitnessed fall from their wheelchair and was discovered against the wall, lying on their left side by a CNA. Resident #91 stated they were trying to lean over in their wheelchair to fix a shoe and stated they knew they should not have leaned over. The resident complained of pain and rated it an 8 out of 10, and denied any new pain related to the fall. Other information included that Resident #91 overestimated their abilities. There was no other information provided regarding the fall, including witness statements or investigation regarding the fall.<br><br>During an interview on 10/03/2024 at 3:25 PM, with LPN #14, she stated the Long Term Care Coordinator (LTC Coord) was responsible for updating the resident's care plan. Staff bring the I & A to the attention of the LTC Coordinator when anything changes with a resident.<br><br>During an interview on 10/04/2024 at 10:25 AM, the Director of Nursing (DON) stated the interventions of a drop seat and pommel cushion were in place when the resident fell . The DON stated it was appropriate to keep the resident from falling. The DON stated she was not aware the cushion did not fit the resident's wheelchair.<br><br>4. A review of the Admission Record, indicated the facility admitted Resident #72 with diagnoses that included Alzheimer's Disease with late onset, peripheral vascular disease (PVD) and polyneuropathy (damage to multiple nerves outside of the brain and central nervous system). No active diagnosis of leprosy.<br><br>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/19/2024, revealed Resident #72 was at risk of developing pressure ulcers and Resident #72 had one or more unhealed pressure ulcers/injuries.<br><br>A review of Resident #72's care plan, revised on 07/28/2024, revealed the resident had a pressure ulcer or potential for pressure ulcer development related to immobility. Resident #72 had a deep tissue injury (DTI) to the bottom of left foot, healed; DTI to right lateral heel, healed, DTI to left heel, resolved, a DTI to right heel that was unstageable and an unstageable to the medial aspect of the right second toe. Interventions included using a pressure relieving device for bilateral heels, a pressure relieving mattress and to utilize a foot cradle when in bed. The care plan updated 09/26/2024 also indicated Resident #72 had the potential to skin integrity related to leprosy, polyneuropathy and PVD with a history of ulcerations. Documentation on care plan included: 09/26/2024 - red, moist area under left abdominal fold; 09/17/2024 - Stage 3 Pressure Injury (PI) to right heel; 09/23/2024-Stage 3 PI to right ankle and 09/23/2024 - Skin tear (ST) to right shin.<br><br>A review of Order Summary Report, revealed Resident #72 had treatment orders as follows:<br><br>- Cleanse right shin with wound cleanser, apply moisture enhancing gel, cover with foam border dressing, change every Monday, Wednesday and Friday and as needed.<br><br>- Cleanse Stage 3 PI to right heel with wound cleanser, apply moisture enhancing gel, cover with border dressing every Monday, Wednesday and Friday and as needed.<br><br>- Paint DTI to tip of right big toe with iodine and leave open to air every day.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Right lateral malleolus, cleanse with wound cleanser, pat dry, apply moisture enhancing gel, apply anti-biotic, cover with protective dressing three times a week, and as needed.<br><br>A review of the Skin & [and] Wound Evaluation V7.0 reports for 09/26/2024 indicated that Resident #72 had:<br><br>- An in-house acquired DTI to the right shin measuring 3.3 centimeters (cm) x 1.7 cm x 0.1 cm.<br><br>- An in-house acquired (09/13/2024) Stage 3 pressure injury to the right lateral malleolus measuring 0.8 cm x 0.9 cm x 0.2 cm.<br><br>- An in-house acquired (06/20/24) Stage 3 pressure injury to the right heel measuring 2.0 cm x 2.0 cm x 0.2 cm.<br><br>- An in-house acquired DTI to the right dorsum-first digit (hallux-tip) measuring 0.7 cm x 0.7 cm x 0.1 cm.<br><br>During an interview on 09/30/2024 at 2:32 PM, the Treatment Nurse verified that Resident #72 had four wounds being treated which included the right outer ankle, right outer heel, the right great toe and the right shin. The Treatment Nurse stated all the wounds were caused by pressure and were acquired in the facility and that hospice would be bringing an air mattress for Resident #72. The Treatment Nurse stated that the Wound Advanced Practice Nurse had made rounds on 09/30/2024 and that changes in orders had been made.<br><br>50505<br><br>5. A review of the Admission Record indicated the facility admitted Resident #30 with diagnoses that included atherosclerotic heart disease of native coronary artery without angina pectoris and acute absence of right leg below the knee.<br><br>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/16/2024, revealed Resident #30 was not taking an anticoagulant but was marked for taking an antiplatelet with the indication noted.<br><br>A review of Resident #30's care plan, revised 04/11/2024, revealed the resident was on anticoagulant and/or antiplatelet therapy, aspirin (ASA) and (anticoagulant x 14 days). Intervention included: administer anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness every shift.<br><br>A review of the Order Summary Report, revealed Resident #30 had an order for aspirin one time a day. There were no other orders for antiplatelets, or anticoagulants noted.<br><br>A review of the medication administration record (MAR), revealed Resident #30 had been receiving aspirin once a day and no other anticoagulant or antiplatelet.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 10/03/2024 at 12:35 PM, Long Term Care (LTC) MDS Coordinator confirmed the care plans for long-term care residents were completed by the LTC MDS Coordinator. Confirmation was given that the care plan was not accurate with the wounds for Resident #72 and the anticoagulant needed to come off from the care plan on Resident #30, as the medication course had been completed.<br><br>During an interview on 10/04/2024 at 8:40 AM, the Director of Nursing (DON) confirmed Resident #72's care plan should have included the current wounds with the proper classification and Resident #30's should have had the anticoagulant resolved from the care plan.<br><br>49981 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>50505<br><br>Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to ensure an oxygen concentrator was clean, set at the correct rate for delivery, and the tubing was dated appropriately for 1 (Resident #25) of 1 sampled resident reviewed for oxygen therapy.<br><br>Findings include:<br><br>A review of a facility policy titled, Oxygen Safety, revised on 11/22/2016, indicated oxygen therapy is to be administered to the resident per physician orders and that it must be tagged, or properly labeled. There was no policy regarding oxygen concentrators provided.<br><br>A review of the Admission Record, indicated the facility admitted Resident #25 with diagnoses that included acute respiratory failure with hypoxia.<br><br>The 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/23/2024, revealed Resident #25 required oxygen therapy.<br><br>A review of Resident #25's care plan, initiated on 07/18/2024, revealed the resident had oxygen therapy. Interventions included to give the medications as ordered by the physician, monitor and document side effects and effectiveness and to monitor for signs and symptoms of respiratory distress.<br><br>A review of the Order Summary Report, revealed Resident #25 had an order for oxygen at 3 liters per minute (LPM) via nasal cannula as needed for shortness of breath, comfort or pulse oximetry reading of less than ninety percent, and an order to change oxygen tubing, clean filter, and oxygen cabinet, and to date all tubing every Sunday night on the eleven to seven shift for maintenance.<br><br>A review of Medication Administration Record (MAR), revealed Resident #25's oxygen tubing change, cleaning of oxygen cabinet, and tubing being dated, had been initialed as being completed on 09/01/2024, 09/08/2024, 09/15/2024, 09/22/2024 and 09/29/2024.<br><br>During an observation on 09/30/2024 at 10:53 AM, Resident #25 was receiving oxygen at a rate of 2.5 LPM via nasal cannula. The oxygen concentrator (cabinet) had undetermined particles and dust located on the machine. The oxygen tubing was dated 08/12/2024 and the humidified water bottle was dated 08/12/2024.<br><br>During an observation on 10/01/2024 at 09:29 AM, Resident #25 was receiving oxygen at a rate of 2.5 LPM via nasal cannula. The oxygen concentrator (cabinet) continued to have debris noted on the machine. The humidifier water bottle and oxygen tubing were dated 08/12/2024.<br><br>During an interview on 10/01/2024 at 9:35 AM, Licensed Practical Nurse (LPN) #9 confirmed that the oxygen tubing and water bottle were dated 08/12/2024 and that the oxygen concentrator (cabinet) was dirty with debris and that the oxygen rate was set at 2.5 LPM. LPN #9 stated that the resident had been placed on the oxygen on the previous Friday and that the bottle that was on the concentrator had not been opened and that is why it was used.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During observation on 10/03/2024 at 3:10 PM, upon arrival to Resident #25's room, the oxygen concentrator rate was set at 1.5 LPM. The oxygen concentrator had been cleaned with new tubing and humidified water bottle dated 10/01/2024.<br><br>During an interview on 10/03/2024 at 3:15 PM, LPN #9 confirmed that the rate of oxygen on the oxygen concentrator was set on 1.5 LPM. LPN #9 confirmed that rate should be at 3 LPM.<br><br>During an interview on 10/03/2024 at 3:21 PM, as the Director of Nursing (DON) and this surveyor were about to enter the room of Resident #25, LPN #9 was leaving the room and stated that the oxygen rate on the concentrator had just been adjusted.<br><br>During an interview on 10/03/2024 at 3:23 PM, the DON confirmed the oxygen had not been set at the rate of 3 LPM for Resident #25 and that resident's oxygen saturation would need to be checked. The DON checked Resident #25's pulse oximetry which was at 98 percent. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>03508<br><br>Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to ensure nutritionally balanced meals were provided for the residents for 2 of 2 meals observed.<br><br>The findings are.<br><br>1. On 9/30/2024, the noon meal menu indicated residents on pureed diets were to receive 8 ounces of pureed pizza, this was the resident's choice for the meal of the month.<br><br>2. On 9/30/2024 at 12:30 PM, Dietary [NAME] (DC) #3 used a #8 scoop, which is equivalent to 4 ounces, to serve<br><br>a single portion of pureed pizza to the residents who received pureed diets. Instead of 8 ounces of pureed pizza.<br><br>3. On 9/30/2024 at 1:19 PM, when asked during an interview the Dietary Manager stated this was residents' choice for the meal of the month. The residents on pureed diets were to receive 8 ounces of pureed pizza.<br><br>4. On 10/1/2024, the breakfast menu indicated residents on pureed diets were to receive pureed hot cereal.<br><br>On 10/01/24 at 7:45 AM, the residents on pureed diets were served regular oatmeal, instead of pureed oatmeal. The Dietary Manager confirmed the residents on pureed diets received regular oatmeal. Dietary [NAME] #3 stated it was her mistake for serving regular oatmeal, instead of pureed oatmeal. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508<br><br>Based on observation and interview, the facility failed to ensure foods stored in the refrigerator and freezer were dated to ensure first in and first out; expired dairy products were promptly removed/discarded on or before the expiration or use by date, to prevent the potential for foodborne illnesses; manufacturer's instructions were followed to prevent potential for food spoilage and or bacteria growth; dietary staff washed their hands before handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen, and hot food items were maintained at 135 degrees Fahrenheit or above on the steam table while awaiting service to prevent potential food borne illness for 1 of 1 meals observed.<br><br>The findings are:<br><br>1. On [DATE] at 10:03 AM, an opened bottle of Worcestershire sauce was on the rack. The manufacturer specification on the bottle indicated, Refrigerate after opening.<br><br>2. On [DATE] at 10:15 AM, Dietary Aide (DA) #1 picked up the water hose with his gloved hand and used it to spray off leftover food from inside of the dishes, contaminating his gloves in the process. He placed the dirty dishes in the dirty racks and pushed the racks into the dish washing machine to wash. After the dishes stopped washing, he placed new gloves on his hands, contaminating the gloves, he moved to the clean side of the dishwasher area and picked up clean dishes and placed them on the clean counter to be used in serving noon meal to the residents. DA #1 stated he should have washed his hands.<br><br>3. On [DATE] at 10:42 AM, the following observations were made on a shelf in the refrigerator in the medication room for the 100, 200, 300, 400 Halls to the front 700 Halls:<br><br>- One undated and unlabeled box of country chicken dinner.<br><br>- One undated and unlabeled jar of peanut butter.<br><br>- One undated and unlabeled sugar free dipping sauce.<br><br>On [DATE] 10:50 AM, the following observations were made in the freezer in the medication room for the 100, 200, 300, 400 Halls to the front 700 Hall:<br><br>- One carton of nutritional drink with expiration date of [DATE].<br><br>- An opened and undated box of homemade ice cream. The ice cream was discolored and had ice cycles on it. Licensed Practical Nurse (LPN) #2 stated it looked like it started melting and was stuck back in the freezer.<br><br>4. On [DATE] at 10:59 AM, the following observations were made on a shelf in the refrigerator in the medication room for the 400, 500, and 600 Halls, to the front of 700 Hall:<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - One container of nectar thickened apple juice with an expiration date of [DATE].<br><br>- One bottle of yellow mustard with an expiration date of [DATE].<br><br>5. On [DATE] at 12:16 PM, the temperatures of the food on the steam table in the kitchen were checked and read by Dietary [NAME] (DC) #3 with the following results:<br><br>- Mashed potatoes - 120 degrees Fahrenheit.<br><br>- Pureed vegetable blend - 120 degrees Fahrenheit.<br><br>- Gravy - 115 degrees Fahrenheit.<br><br>- Cheese sticks - 119 degrees Fahrenheit, the first pan on the steam table. |

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.<br><br>49866<br><br>Based on record review and interview, the facility failed to ensure the facility assessment included pertinent information to assure the necessary care and resources were allocated to meet the needs of the residents in 1 of 1 facility. This deficient practice had the potential to affect all residents of the facility.<br><br>The total census was 100 residents.<br><br>The findings are:<br><br>A review of the Comprehensive Facility Assessment, dated November 2017, did not contain the following required information:<br><br>- The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population.<br><br>- The care required by the resident population, using evidence-based, data-driven methods that consider an evaluation of diseases, conditions, physical and behavioral health needs, cognitive status, acuity of the resident population consistent with resident assessments to help the facility understand the potential implications regarding the intensity of care and services needed.<br><br>- Staffing's plan is to evaluate of the overall number of facility staff needed to ensure available and sufficient number of qualified staff are available to meet each resident's needs based on the facility census and address staffing needs for each resident unit, each shift, and to include weekend and emergencies to ensure coordination and continuity of care<br><br>- Competency-based skill set approach to make informed staffing decisions to ensure there are a sufficient number of staff to ensure residents are able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice as identified through the resident assessments and plans of care<br><br>- Plan to recruit and retain enough medical personnel who are adequately trained and knowledgeable in the care of residents and/or how management expectations of medical personnel.<br><br>- The facility's resources including all buildings and/or other physical structures and vehicles, medical and non-medical equipment necessary to provide for the needs of residents, services provided (physical therapy, pharmacy, behavioral health, etc.), and all personnel, (management, direct care staff, and volunteers) which include employees and contracted employees along with their education and competencies<br><br>- Heath information technology resources for managing resident records and sharing information with other organizations.<br><br>(continued on next page) |

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | - A contingency plan for events that do not require the activation of the facility emergency plan but have the potential to impact resident care, such as the availability of direct care nurse staffing or other resources needed for care of residents.<br><br>On 10/04/2024 at 12:45 PM, an interview with the Administrator was completed. The interview revealed that overall, the facility assessment was not completed, and the facility would work on the facility assessment to make it more accurate. |