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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>045365 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>09/12/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Dewitt Nursing Home |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1605 South Madison St<br>DE Witt, AR 72042 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48977</p> <p>Based on observations, interviews, record review, and facility policy review, the facility failed to ensure dignity was maintained for 2 sampled (Resident #21, #31) sampled residents.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. According to Physician's orders, Resident #31 had a diagnosis of transient cerebral ischemic attack. <ol style="list-style-type: none"> <li>a. A review of the admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 7/05/2024 revealed Resident #31 scored 13 on a Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact and had an indwelling catheter.</li> <li>b. A Care Plan for Resident #31 (problem date: 7/05/2024) revealed Resident #31 was experiencing incontinent episodes of bowel and/or bladder.</li> <li>c. On 09/09/24 at 12:53 PM, the Surveyor observed Resident #31 sitting in wheelchair in the room. The Surveyor noted the catheter bag was uncovered and easily visible.</li> <li>d. On 09/09/24 at 1:46 PM, the Surveyor observed Resident #31 sitting in wheelchair in the hallway. The Surveyor noted the catheter bag was uncovered and easily visible.</li> <li>e. On 09/09/24 at 1:46 PM, Certified Nursing Assistant (CNA) #5 confirmed Resident #31's catheter bag was uncovered and visible. CNA #5 stated the catheter bag should be covered. I don't know why the catheter bag does not have a cover.</li> <li>f. On 09/12/24 at 09:00 AM, the Director of Nursing (DON) stated Resident #31 had an indwelling catheter and the catheter had been observed uncovered. The DON stated is it important for an indwelling catheters to be covered to maintain the dignity of the resident</li> </ol> </li> <li>2. According to Physician's Orders, Resident #21 had a diagnosis of vascular dementia. <ol style="list-style-type: none"> <li>a. A review of the quarterly MDS with the ARD of 6/08/2024 revealed Resident #21 scored 2 on a BIMS, indicating severe cognitive impairment.</li> </ol> </li> </ol> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>b. A Care Plan for Resident #21 (problem date: 12/07/2023) revealed Resident #21 had impaired cognitive skills evidenced by short term memory loss related to inability to care for self without assistance and being a fall risk.</p> <p>c. On 09/11/24 at 09:43 AM, the Surveyor observed Certified Nursing Assistant (CNA) #4 pushing Resident #21 to the room in a shower chair. The Surveyor noted that Resident #21 was not fully covered, the right side of upper thigh was exposed.</p> <p>d. On 09/11/24 at 09:44 AM, CNA #4 confirmed Resident #21 was not covered all the way.</p> <p>e. On 09/12/24 at 9:00 AM, the Director of Nursing (DON) stated staff should ensure residents are cover down to the knees when transporting the resident from the shower room to the room in a shower chair to maintain the resident's dignity.</p> <p>f. A policy titled, Dignity, revealed, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem. 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a helping the resident to keep urinary catheter bag covered.</p> |   |  |

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| <p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to manage his or her financial affairs.</p> <p>48390</p> <p>Based on interviews, record review, and policy review, the facility failed to provide access to resident personal funds during the evening and weekends.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. On 09/11/2024 at 1:30 PM, the surveyor spoke with members of the Resident Council regarding residents being able to gain access to their trust funds during the evening and weekend. Resident #28 indicated that if you don't get your money on Friday, you don't have any money for the weekend. Resident #10 indicated that if you don't get your money during the week, you won't have any for the weekend.</li> <li>2. On 09/12/2024 at 9:00 AM, the Business Office Manager (BOM) indicated that as far as she knew the residents didn't get money on the weekend. The BOM indicated the residents get money before the weekend, or they don't get it.             <ol style="list-style-type: none"> <li>a. A policy titled, Management of Resident's Personal Funds, provided by the BOM on 09/12/2024 at 9:45 AM did not address how or when residents can access personal funds.</li> </ol> </li> </ol> |

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| <p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>48390</p> <p>Based on interviews, record review, and policy review, the facility failed to provide quarterly personal funds account statements to residents or legal representatives.</p> <p>1. On 09/11/2024 at 1:30 PM, during an interview the members of the Resident Council stated they do not receive a statement of their personal funds account.</p> <p>a. On 09/12/2024 at 9:00 AM, during an interview the Business Office Manager (BOM) she does not send out quarterly statements to the resident or their legal representatives, but she will print a statement when a resident asks for one.</p> <p>b. A policy titled, Management of Resident's Personal Funds, provided by the BOM on 09/12/2024 at 9:45 AM, did not address quarterly statements.</p> <p>2. On 09/12/2024 at 9:00 AM, the BOM indicated the they have a separate petty cash that they use to keep resident's money. The BOM indicated that she did not know how much money could be held in an account without drawing interest for Medicaid residents.</p> <p>a. Review of a list titled, Residents In House Account provided by the BOM on 09/12/2024 at 9:56 AM, revealed twenty-one residents who had an in-house account, seven of those residents were Medicaid residents and had balances over \$50.00. Resident #23 had a balance of \$120.14; Resident #10 had a balance of \$51.02; Resident #4 had a balance of \$147.14; Resident#15 had a balance of \$211.50; Resident #18 had a balance of \$99.25; and Resident #6 had a balance of \$61.00.</p> <p>3. A policy titled, Management of Resident's Personal Funds, provided by the BOM on 09/12/2024 at 9:45 AM did not address in-house accounts or petty cash accounts.</p> |

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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Keep residents' personal and medical records private and confidential.</p> <p>48977</p> <p>Based on observations, interviews, record reviews, and facility policy reviews the facility failed to ensure personal and medical information was protected for 1 sampled (Resident #14) resident.</p> <p>The findings include:</p> <p>According to Physician's orders Resident #14 had a diagnoses of sequelae of cerebral infarction and depression</p> <p>A review of the annual Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 8/21/2024 revealed Resident #14 scored 14 indicating cognitively intact.</p> <p>A Care Plan for Resident #14 (problem date: 8/21/2024) revealed Resident #14 had Activities of Daily Living (ADL) self-care deficit as evidenced by: left side weakness due to Cerebrovascular accident (CVA).</p> <p>On 09/11/24 at 7:30 AM, the Surveyor observed Registered Nurse (RN) #3 enter Resident #14's room and close the door. The Surveyor noted that the Medication Administration Record on the medication cart was open and displayed the resident's personal and medical information.</p> <p>On 09/11/24 at 7:32 AM, RN #3 stated the Medication Administration Record (MAR) was open and the resident's information was visible. RN #3 stated anyone passing could potentially see the resident's date of birth, medical diagnosis, orders, name, and room number.</p> <p>On 09/12/24 at 09:00 AM the Director of Nursing (DON) stated prior to the nurse walking away the MAR should be closed or the tab flipped over the MAR so no one can see the MAR. DON stated if the MAR is not closed or covered someone could walk up and read the MAR.</p> <p>A policy titled Resident Rights documented 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: privacy and confidentiality;.</p> |   |  |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>37925</p> <p>Based on record review, and interview, the facility failed to ensure a comprehensive plan of care was updated to include the use of oxygen for 1 (Resident #20) of 1 sampled resident who was reviewed for oxygen use.</p> <p>The findings are:</p> <p>On 09/09/2024 at 12:29 PM, Resident #20 was not in the resident's room and there was an oxygen (O2) concentrator on, and the flow rate was set at 2.5 liters per minute (l/min). At 12:36 PM, the resident was sitting up in a recliner with nasal cannula (NC) prongs in the resident's nose. The oxygen concentrator was on, and the flow rate was set at 2.5 l/min.</p> <p>Resident #20's annual Minimum Data Set (MDS) with an Assessment Reference Date of 07/09/2024 was reviewed and indicated the resident had a Brief Interview for Mental Status score of 9, which indicated moderately cognitively intact and received oxygen therapy.</p> <p>Resident #20's Physician's Orders for 09/01/2024 through 09/30/2024 were reviewed and indicated an order for oxygen at 2 liters/NC as needed for shortness of breath.</p> <p>Resident #20's Resident Plan of Care, with a review date 07/09/2024, was reviewed and oxygen use was not indicated.</p> <p>On 09/12/2024 at 1:15 PM, the Director of Nursing (DON) was interviewed and asked if she was completing the MDS assessments and she stated yes. She was asked when the care plans were updated, and she stated quarterly. She stated the information put in from the MDS triggers what all needs to be care planned.</p> <p>On 09/12/2024, the DON stated the facility did not have a policy for care plans.</p> |   |  |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>37925</p> <p>Based on record review, and interview, the facility failed to ensure care plans were revised at least quarterly and/or when the residents care needs changed for 1 (Resident #24) of 12 (Residents #2, #4, #6, #10, #14, #20, #21, #22, #24, #28, #30 and #31) sampled residents whose care plans were reviewed.</p> <p>The findings are:</p> <p>Resident #24's, Physician's Orders, dated 09/01/2024 through 09/30/2024, were reviewed and indicated a diagnosis of loss of thinking abilities that interfere with daily life (dementia) and right artificial hip joint. There were two orders dated 03/06/2024 for a pain medication. One order indicated one tablet by mouth, and the second order indicated two tablets by mouth, and both were as needed for pain. An order dated 06/25/2024 indicated a patch for pain apply one patch every 72 hours and cover with a [brand name] clear adhesive.</p> <p>The quarterly Minimum Data Set with an Assessment Reference Date of 07/01/2024, was reviewed and indicated the resident had a Brief Interview for Mental Status score of 11, which indicated moderate cognitive impairment, and the resident was taking an opioid, which is a high-risk pain medication.</p> <p>b. Resident #24's Resident Plan of Care, with a review date of 07/09/2024, was reviewed and indicated a pain patch 12 micrograms per hour and cover with a clear adhesive every 3 days. The plan of care did not include any signs, symptoms or adverse reactions to monitor the resident for.</p> <p>On 09/12/2024 at 1:24 PM, the Director of Nursing was interviewed and asked if Resident #24 had an order for pain patches, a high-risk medication, and she stated yes. She was asked should the medication be care planned and she stated yes. She was asked why, and she stated for possible side effects of the medication to monitor the resident for. She stated the facility did not have a policy for care plans.</p> |   |  |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>48977</p> <p>Based on observations, interviews, and facility policy review, the facility failed to ensure potential hazardous chemicals were securely locked away.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. On 09/09/24 at 11:04 AM, the Surveyor observed an unlocked closet door titled, Janitor on East Hall. The Surveyor noted cleaning chemicals inside the unlocked closet door.</li> <li>2. On 09/09/24 at 11:04 AM, the Surveyor observed an unlocked Whirlpool room with cleaning chemicals and aerosol can of degreaser.             <ol style="list-style-type: none"> <li>a. On 09/09/24 at 11:05 AM, the Director of Nursing (DON) stated the Whirlpool room and the Janitor's closet doors should be locked when unattended when not in use.</li> </ol> </li> <li>3. On 09/09/24 at 11:17 AM, the Surveyor observed a closet door unlocked with a sign posted on the door that stated, If you open this door-please latch it back this door needs to be locked latched at all times!!on South Hall. The Surveyor noted several cleaning chemicals and aerosol cans in the unlocked closet.             <ol style="list-style-type: none"> <li>a. On 09/09/24 at 11:18 AM, during an interview Housekeeping #6 stated the door with the signage that states it should be latched at all times was not latched. Housekeeping #6 stated cleaning supplies that could be harmful were stored in the unlocked closet.</li> </ol> </li> <li>4. On 09/09/24 at 11:23 AM, the Surveyor observed a closet door unlocked titled, Soiled Linen on North Hall.             <ol style="list-style-type: none"> <li>a. On 09/09/24 at 11:25 AM, during an interview the Director of Nursing stated the unlocked door to the closet labeled Soiled Linen should be locked.</li> </ol> </li> <li>5. On 09/11/24 at 08:10 AM, the Surveyor observed an unattended housekeeping cart with a spray bottle hanging from the handle and the door slightly ajar.             <ol style="list-style-type: none"> <li>a. On 09/11/24 at 08:10 AM, during an interview Housekeeping staff #6 stated the spray bottle was air freshener. Housekeeping staff #6 stated the keys in her possession did not lock or unlock the housekeeping cart therefore she could not lock it.</li> <li>b. On 09/11/24 at 09:30 AM, during an interview the Environmental Supervisor stated the door to the closets titled, Janitor, Soiled Linen , Whirlpool, and door with the signage that states If you open this door-please latch it back This door needs to be locked latched at all times!! should be locked when not in use, because a resident could get hurt or get into the chemicals. The Environmental Supervisor stated some of locks on the housekeeping are broken and, We have never locked them in the year and half that I have been here.</li> </ol> </li> </ol> <p>(continued on next page)</p> |   |  |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>A policy titled, Policy and Procedure for Chemical Storage indicated The designated [Environmental Services] EVS area should be as follows: have locks fitted to all doors and restrict access only to cleaning staff.</p> |   |  |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>37925</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview, and record review, the facility failed to ensure oxygen was administered at the physician's ordered flow rate to decrease the potential for respiratory complications for 1 (Resident #20) of 1 sampled resident reviewed for oxygen therapy.</p> <p>The findings are:</p> <p>On 09/09/2024 at 12:36 PM, Resident #20 was sitting up in a recliner with nasal cannula (NC) prongs in the resident's nose. The oxygen concentrator was on, and the flow rate was set at 2.5 liters per minute (l/min).</p> <p>Resident #20's annual Minimum Data Set with an Assessment Reference Date of 07/09/2024 was reviewed and indicated the resident had a Brief Interview for Mental Status score of 9, which indicated moderately cognitively intact and received oxygen therapy.</p> <p>Resident #20's Physician's Orders for 09/01/2024 through 09/30/2024 were reviewed and indicated oxygen 2 liters/NC as needed for shortness of breath.</p> <p>Resident #20's Resident Plan of Care, with a review date 07/09/2024, was reviewed and oxygen use was not indicated.</p> <p>On 09/10/2024 at 3:44 PM, Resident #20 was sitting up in a recliner with nasal cannula prongs in the resident's nose. The O2 concentrator was on and set at 2.5 l/min.</p> <p>On 09/10/2024 at 4:04 PM, during an interview and concurrent observation, Licensed Practical Nurse (LPN) #2 was asked to look at the O2 concentrator to observe the flow rate. She looked at the oxygen concentrator and confirmed the resident's flow rate was set at two and a half liters (2.5l). She confirmed the resident's current physician's ordered oxygen flow rate was 2 liters. She was asked who checks the oxygen flow rate and she stated the nurse on shift checked the rate once a day. She was asked why the oxygen flow rate should be checked and she stated to make sure the flow rate was correct rate.</p> <p>On 09/12/2024 at 1:31 PM, the Director of Nursing was asked if the oxygen flow rate was on the medication administration record (MAR) for the nurses to check. She stated she did not think the MAR indicated the oxygen was to be checked for the correct liters.</p> |   |  |

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| <p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Post nurse staffing information every day.</p> <p>48977</p> <p>Based on observations, interviews, and record review, the facility failed to ensure nurse staffing was posted to include the census and names direct care staff with the total number of hours worked and actual hours worked per shift by licensed and unlicensed staff.</p> <p>The findings include:</p> <p>On 09/11/24 at 9:34 AM, the Surveyor noted a staff log on a table near the entrance. The Surveyor noted there was one name written on the staffing log.</p> <p>On 09/12/24 at 9:00 AM, the Director of Nursing (DON) stated there was a staff log visible, but it was incomplete. The DON stated the staff log did not have the census listed or all the staff members working at the time. The DON confirmed that the staff logs from previous days were also incomplete and did not have the total number of hours worked and actual hours per shift for licensed and unlicensed staff, and the facility did not have that information required but will from now on.</p> <p>On 09/12/24 at 10:25 AM, the DON provided the Surveyor with documentation that indicated the facility did not have a policy and procedure on staffing.</p> |   |  |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>37925</p> <p>48390</p> <p>48977</p> <p>Based on observations, interviews, and facility policy review, the facility failed to ensure that medications and/or biologicals were securely locked away.</p> <p>The findings include:</p> <p>On 09/11/24 at 7:30 AM, the Surveyor observed Registered Nurse (RN) #3 enter a resident's room and close the door. The Surveyor noted that the medication cart left unattended in the hallway was unlocked.</p> <p>On 09/11/24 at 7:32 AM, RN #3 stated the unattended medication cart was unlocked and stated someone could have gotten in the unlocked medication cart and taken the medications.</p> <p>On 09/12/24 09:00 AM, the Director of Nursing (DON) stated the nurses should lock the medication cart prior to leaving the cart unattended and staff and/or residents could get into the medication cart if left unlocked.</p> <p>A policy titled Storage of Medications indicated, 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.</p> |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37925</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure food items were properly stored and labeled in the refrigerator and freezer in 1 of 1 kitchen, and failed to ensure the ice machine was properly cleaned in 1 of 1 kitchen.</p> <p>The findings are:</p> <p>On 09/09/2024, initial kitchen rounds were performed, and the following observations were made:</p> <p>1. At 11:24 AM, the freezer had clear packages of pancakes with no dates on either side of the wrapper. There was a piece of toast in a clear plastic bag dated 9/3/24, with no indication what the date meant.</p> <p>2. At 11:34 AM, the Dietary Manager (DM) was interviewed, and concurrent observations were made. She was asked to check the ice machine located in the kitchen. With gloved hands, she took a clean, white paper towel, placed the paper towel on the area where the ice falls inside the ice machine, swiped from right to left, and she stopped mid-center. This surveyor and the DM looked at the paper towel, and there was a transfer of yellow residue to the paper towel. The DM took another clean paper towel and started in the middle of the ice machine where the ice falls, swiped mid-center, all the way left and there was a transfer of yellow residue to the paper towel. The DM was asked to describe the color of the residue, and she stated, Tan. She was asked who cleans the ice machine and she stated she checked it that morning but did not clean the area that she was asked to swipe. She stated maintenance cleans the ice machine yearly.</p> <p>3. At 11:39 AM, the refrigerator in the kitchen contained the following items:</p> <p>a. A clear plastic bag of cooked hamburger meat dated 9/8/24 with no indication of what the date meant.</p> <p>b. A container of black-eyes peas with a preparation (prep) date of 9/7/24, and the use by date was blank.</p> <p>c. A clear container with a green top labeled pork loin with a prep date of 9/7/24, and the use by date was blank. The green lid on the clear container was not completely sealed.</p> <p>On 09/09/24 at 11:42 AM, the DM was asked to look at the green lid that covered the clear container of pork loin inside the refrigerator in the kitchen. She was asked if the container was sealed, and she stated the container was not properly sealed. She was asked what the use by date was for the container with the green lid and she stated, The policy states we can keep it for three days and then throw it out. She was asked if that date was indicated on the container, and she stated it was not. She was asked if there were use by dates on the other items listed above, and she stated, No ma'am.</p> <p>4. At 11:51 AM, in the stand-up freezer, there was a bag of frozen chicken breasts, confirmed by the DM, with no date on either side of the bag.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>An Ice Machine Cleaning Schedule policy, not dated and provided by from DM on 09/12/2024, was reviewed and indicated weekly cleaning of the ice storage compartment, around the edges and areas where ice contact is made would be done and documented on the cleaning schedule log.</p> <p>A Storage policy, updated 11/12/2019 and provided by the DM on 09/12/2024, was reviewed and indicated all foods stored in the refrigerator would be tightly covered, labeled, and dated, and leftovers would be destroyed in 72 hours.</p> |   |  |

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| <p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>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.</p> <p>37925</p> <p>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. The total census was 32 residents.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. A review of the Comprehensive Facility Assessment, dated November 2017, was reviewed and did not contain the following required information:             <ol style="list-style-type: none"> <li>a. Documentation of staff involved with developing the assessment, which must include a member of the governing body, the medical director, the administrator, the director of nursing, and direct care staff.</li> <li>b. An initiated and/or revision date of completion to show a minimum of a yearly review</li> <li>c. The resident population including the facility's resident capacity</li> <li>d. The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population</li> <li>e. 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</li> <li>f. Staffing plan 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 and each shift to ensure coordination and continuity of care</li> <li>g. 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</li> <li>h. 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.</li> </ol> </li> </ol> <p>(continued on next page)</p> |   |  |

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| <p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>i. 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</p> <p>j. Health information technology resources for managing resident records and sharing information with other organizations</p> <p>k. 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.</p> <p>2. On 09/12/2024, the Administrator was asked to provide all data she had pertaining to the facility's assessment, including the emergency preparedness. She stated she knew she did not have the dietary information regarding the food and those vendors. The Administrator provided more modules for the public emergency service. She was asked for the information regarding the staff training, competencies, resident acuity levels and she stated she was not done completing the modules on the computer and knew she did not have all the required information. She stated she was scheduled to attend a meeting on how to complete the facility assessment later in the month.</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Provide and implement an infection prevention and control program.</p> <p>37925</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure isolation signage was posted in an area to alert staff, residents and visitors which precautions were required before entering a resident's room who was positive for Coronavirus Disease 2019 (COVID-19) for 1 (Resident #15) of 1 sampled resident who was reviewed for isolation precautions, and failed to ensure the water management program contained the necessary components and was consistently implemented to monitor for Legionella and other water-borne pathogens in 1 of 1 facility.</p> <p>The findings are:</p> <p>1. On 09/09/2024 at 11:10 AM, the entrance conference was conducted with the Administrator. She was asked if any residents were on transmission-based precautions, and she stated two residents in the facility were positive for COVID-19. The 3.0 Resident Roster, provided by the Administrator the same morning, was reviewed later in the day and did not indicate any residents had infections.</p> <p>On 09/09/2024 at 1:01 PM, Resident #15 was in the room sitting up in a wheelchair and the door was open. There was a tan trash bin with a clear liner on the outside of the doorway. This surveyor stepped to the left of the doorway and observed two different signs posted on the door to the room. One sign indicated the personal protective equipment (PPE) was to be removed outside of the room and placed in the trash, unless a [type] mask was being used for the staff member's protection. The other sign indicated the resident was required to wear a surgical/cloth mask, if capable, when staff was in the room performing care. As this surveyor was standing in the doorway talking with the resident, an unidentified staff member walked up the hallway with a mask on and stated, Ma'am, [Resident #15] has COVID and is not supposed to have that door open. There was no other signage on the resident's door, doorway or walls on either side of the doorway, to indicate the resident was on contact or droplet precautions. There was a yellow isolation cart across the hall and to the side of another resident's doorway.</p> <p>On 09/09/2024, Resident #15's hard chart was reviewed. There was no order on the Physician's Orders, dated 09/01/2024 through 09/30/2024, to indicate the resident was on contact/droplet precautions.</p> <p>An annual Minimum Data Set with an Assessment Reference Date of 08/07/2024 was reviewed and indicated Resident #15 had a Brief Interview for Mental Status score of 9, which indicated moderate cognitive impairment.</p> <p>On 09/10/2024 at 3:49 PM, Resident #15 was sitting in the doorway of the resident's room in a wheelchair with no mask on. There was a beige trash can outside the resident's room with a clear plastic bag in it. There was no isolation signage on the resident's door to indicate the resident was on contact/droplet precautions.</p> <p>On 09/10/2024 at 3:53 PM, Licensed Practical Nurse (LPN) #2 was interviewed with concurring observations and asked if Resident #15 was on isolation precautions and she replied ,yes, droplet for COVID. She was asked how the staff and visitors knew what type of precautions and she stated signs on the door. The nurse was asked to state what the sign on the door indicated regarding PPE, and she stated, how to take off the PPE.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>On 09/12/2024 at 9:08 AM, the Infection Preventionist (IP) was asked what type of precautions Resident #15 was on and he stated, respiratory precautions. He was asked what PPE was required and he stated, gowns, face shield, face mask and full PPE. He was asked how staff / visitors knew what type of precautions to use for residents on isolation and he stated, by the signage posted outside the door. He was asked who was responsible for putting up the signage for staff / visitors. He stated, he, the DON, or Administrator could do it.</p> <p>2. On 09/11/2024 at 1:15 PM, the Maintenance Supervisor provided a Legionella Water Management Program policy and a diagram of the water flow. He was asked if this was all he had for the facility's Water Management Program and he stated, Yes. Another surveyor asked, What about your water temperatures? and he stated, I have that in another book. I think things got divided out to others.</p> <p>On 09/11/2024 at 10:00 AM, a Nursing Home Water Temp Check document, provided by the Maintenance Supervisor, was reviewed. 2024 was written under the title and four columns were labeled as follows: date, room, room, room. There were dates in each row under the date section, and each room column had a room number and temperature, but it did not indicate if the temperature was in Celsius or Fahrenheit. The log did not indicate where the temperatures were taken, such as the faucets. The log did not include any temperatures for any hot water heaters, boiler rooms, sinks, showers or the whirlpool, which were indicated on the diagram.</p> <p>On 09/12/2024 at 8:47 AM, the Administrator was asked to provide everything she had regarding the facility's water management program since the Maintenance Supervisor stated items may have been divided out over time to others. There was no information provided regarding the water management team members, no identified areas where Legionella could grow, no identification of situations that could lead to Legionella growth or control measures in the incident of an outbreak. There was no date to indicate when or if the program was reviewed / updated. The Administrator did not provide any other information prior to the surveyor's exit of the building.</p> <p>A Legionella Water Management Program policy, not dated, was reviewed and indicated the purpose of the water management program was to identify areas in the water system where Legionella bacteria could grow and spread and to reduce the risks of the disease. The policy indicated the elements to be included in the water management program to include the team members, a detailed description and diagram of the facility's water system, identified areas in the water system that could encourage Legionella growth, identified situations that could lead to Legionella growth, yearly review, or sooner of the water management program, and specific control measures for Legionella.</p> |   |  |