

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Capistrano Beach Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 35410 Del Rey Capistrano Beach, CA 92624	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of six final sampled residents (Resident 7) reviewed for psychotropic use was informed of the indication for the use of psychotropic medications (medication affecting brain activities associated with mental processes and behavior).</p> <p>* The facility failed to ensure Resident 7's informed consent was obtained when the indication for the use of risperidone (an antipsychotic medication used for mental illness that causes disturbed or unusual thinking) was changed to racing thought. This failure had the potential for Resident 7 to not be informed of the medication and potential effects of risperidone.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Psychotropic Medication Use dated 7/2023 showed the residents, families, and/or representatives are involved in the medication management process. Residents (and/or representatives) have the right to decline treatment with psychotropic medications.</p> <p>Medical record review for Resident 7 was initiated on 9/19/24. Resident 7 was admitted to the facility on [DATE].</p> <p>Review of Resident 7's H&P examination dated 6/17/24, showed the resident had the capacity to understand and make decisions.</p> <p>Review of Resident 7's Facility Verification of Informed Consent form dated 6/17/24 , showed risperidone 0.5 mg at bedtime for schizoaffective disorder manifested by injury to self (suicidal ideation) signed by the physician on 6/19/24.</p> <p>Review of Resident 7's Order Summary Report dated 9/19/24, showed an order dated 7/26/24, for risperidone 0.5 mg tablet by mouth at bedtime for schizoaffective disorder manifested by racing thoughts.</p> <p>Review of Resident 7's MAR for September 2024 showed Resident 7 had received risperidone 0.5 mg tablet by mouth at bedtime since 7/11/24.</p> <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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/19/24 at 1444 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified the Facility Verification of Informed Consent form showed risperidone 0.5 mg at bedtime for schizoaffective disorder manifested by injury to self . LVN 2 stated the informed consent should have been obtained to indicate the use of risperidone for the manifestation of racing thoughts as per the physician's order.</p> <p>On 9/19/24 at 1514 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the above findings.</p>

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to assess one of 21 final sampled residents (Resident 74) for their self-administration of the medications. This failure had the potential to negatively impact the residents' physiological well-being and could administer the medications inaccurately.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Self-Administration of Medications revised February 2021 showed the residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. Further review of the policy showed resident who are identified as being able to self-administer the medication are asked whether they wish to do so. The policy also showed any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.</p> <p>On 9/17/24 at 0904 hours, a concurrent observation and interview was conducted with Resident 74. Resident 74 was observed sitting on the side of the bed, the tetrahydrozoline (medication that can relieve minor eye irritation and redness) eye drop medication was observed on the table located at the left side of the bed. Resident 74 stated she had been self-administering the eye drops.</p> <p>Medical record review for Resident 74 was initiated on 9/17/24. Resident 74 was admitted to the facility on [DATE].</p> <p>Review of Resident 74's H&P examination dated 4/19/24, showed Resident 74 had no capacity to understand and make medical decisions.</p> <p>Review of Resident 74's Admission/Readmission Data Tool v2 dated 4/18/24, under the self administration of medication evaluation section, showed Resident 74 did not want to self-administer the medications.</p> <p>Furthermore, there was no documented evidence of a physician's order for self-administration of the tetrahydrozoline eye drop and to be stored at the resident's bedside.</p> <p>On 9/17/24 at 0907 hours, an observation, interview, and concurrent medical record review for Resident 74 was conducted with LVN 6. LVN 6 verified Resident 74 had the tetrahydrozoline eye drop at the bedside and verified Resident 74 had no physician's order for the eye drop medication. LVN 6 stated Resident 74 should not have the eye drop medication at the bedside.</p> <p>On 9/19/24 at 1237 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the reasonable accommodations to meet the care needs for two of 21 final sampled residents (Residents 4 and 72).</p> <p>* The facility failed to ensure Residents 4 and 72's call lights were kept within the residents' reach. This failure had the potential to negatively impact the residents' psychosocial well-being or result in a delay to provide care and services to the residents.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Answering the Call Light revised 9/2022, showed the purpose of this procedure is to ensure timely responses to the resident's requests and needs. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.</p> <p>1. Medical Record review for Resident 4 was initiated on 9/19/24. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 4's MDS Quarterly assessment dated [DATE], Section B, showed the resident could make self-understood and can understand others. Section GG for functional abilities and goals showed Resident 4 had impairment in mobility of both upper extremities and in one of the lower extremities.</p> <p>Review of Resident 4's H&P examination dated 9/5/24, showed Resident 4 had the capacity to understand and make decisions.</p> <p>On 9/20/24 at 0814 hours, Resident 4 was observed in bed with the breakfast tray on the overbed table in front of the resident. Resident 4 requested for assistance from the surveyor as she could not reach the call light which was observed to be placed by her left knee on the bed. Resident 4 wanted to reach her juice in the meal tray that was placed on the right upper side of the meal tray. A facility staff was called to assist the resident.</p> <p>On 9/20/24 at 0828 hours, CNA 1 came by and assisted the resident to reposition the resident and placed the juice within the resident's reach.</p> <p>On 9/20/24 at 0940 hours, an interview was conducted with CNA 1. CNA 1 verified Resident 4's call light was not within the resident's reach and was placed by the left knee of the resident.</p> <p>51539</p> <p>2. Medical record review for Resident 72 was initiated on 9/17/24. Resident 72 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51539</p> <p>Based on interview, facility P&P review, and facility document review, the facility failed to address and follow through with the concerns brought up in the resident council meetings (a group of residents gathered to discuss interests and issues noted in facility).</p> <p>* The facility failed to complete the request for the OCTA Access forms for the residents.</p> <p>* The facility failed to thoroughly address regarding the concerns about the CNAs' mannerisms when answering the residents.</p> <p>These failures had the potential for the residents' identified issues to go uncorrected.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Resident Council revised 2/2021 showed the facility supports the residents' rights to organize and participate in the resident council. A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern.</p> <p>1. Review of the facility's Resident Council Minutes showed the resident council meeting was held on 6/27/24 at 1430 hours.</p> <p>Review of the Resident Council Minutes New Business dated 6/18/24, attached to the Resident Council Minutes dated 6/27/24, showed: the request for the OCTA access forms appointment needed to be clear to the residents.</p> <p>Review of the Department Response Form dated 6/27/24, showed the concern to follow-up for the OCTA access form was delayed. The facility's response showed due to the director of social services no longer with the facility, they had the new Social Services Director who would follow up. The Department Response Form also showed the concern was resolved to Resident(s)'s satisfaction by a circled Yes response; however, there was no documentation to show regarding the follow-up efforts to obtain the OCTA access form for the residents.</p> <p>On 9/19/24 at 0902 hours, an interview and concurrent record review was conducted with the AD. The AD stated she facilitated the resident council meetings, notified the department heads of concerns and made sure there was a follow-through within 72 hours. The AD further stated if there was no follow-through within the 72 hours, she talked to the people responsible to address the concerns and then followed-up with the Administrator. Review of Department Response form dated 6/27/24, showed the concern to follow up for the OCTA access form was delayed. The AD stated the OCTA form was to get authorization for transportation access for the residents to go to the outings. The AD stated she gave the form to the previous Social Services Director, but she left. The AD stated she followed up with the new SSD; however, the SSD returned the blank OCTA access forms to her.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/19/24 at 0930 hours, an interview and concurrent record review was conducted with the SSD. When the SSD was asked about the concern documented in the Resident Council Minutes dated 6/27/24, regarding the OCTA access forms, the SSD stated she had not seen the form with the OCTA concerns and was not aware of the concern. The SSD further stated she would have followed up with OCTA and checked on the status of resident's applications had she known about the concern.</p> <p>2. Review of the facility's Resident Council Minutes showed the resident council meeting was held on 8/15/24 at 1400 hours.</p> <p>Review of the Resident Council Minutes New Business dated 8/15/24, showed the residents in room [ROOM NUMBER]C, 2B, 3C, and 4A were asking for the facility to give constant training to have the CNAs manner when they were answering the residents.</p> <p>Review of the Department Response Form dated 8/16/24, showed upon investigation with the resident in room [ROOM NUMBER]C, per the resident, no complaints. The Department Response Form also showed the facility had interviewed the resident in [NAME] 4A who was alert but with forgetfulness. Upon investigation, the resident did not recall any incident. The Department Response Form failed to show documentation on how the facility addressed the same concern from the residents in room [ROOM NUMBER]C and 2B. The section on the form asking if the concern was resolved to the resident(s) satisfaction was left blank.</p> <p>On 9/19/24 at 0902 hours, an interview and concurrent record review was conducted with the AD. The AD verified the concern documented in the meeting minute dated 8/16/24, by the residents in Rooms 1C, 2B, 3C, and 4A about the CNAs' manners when answering the residents. When the AD was asked who should follow though to make sure the concerns were addressed, she stated, me. When the AD was asked how she missed that all the concerns were not followed through, she stated she forgot about the two residents, (Residents 1C and 2B). The AD also verified the response to the section if the concern was resolved to the resident was left blank. The AD stated there should have been a response.</p> <p>On 09/19/24 at 0944 hours, an interview and concurrent record review was conducted with the DSD. The minutes for 8/16/24, was reviewed with the DSD. The DSD stated she followed-up on the concerns identified with her staff. When asked regarding the concerns brought up by the residents in Rooms 1C, 2B, 3C, and 4A about the request to give constant training to CNAs regarding their manner when they answered the residents. The DSD verified the resident council minutes mentioned four residents; however, the documentation on the Department Response Form only addressed Residents 3C and 4A. The DSD stated she spoke with the resident in room [ROOM NUMBER]B, who said he did not have concerns. The DSD verified she did not include the follow-up documentation for the resident in room [ROOM NUMBER]B . Furthermore, the DSD verified she did not speak with the resident in room [ROOM NUMBER]C regarding concerns about the CNAs. The DSD verified the follow-up section regarding the resident satisfaction was left blank and the investigation was not complete.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the advance directive information was documented and/or the information on formulating the advanced directives were offered for seven of 21 final sampled residents (Residents 2, 4, 19, 27, 35, 72 and 76) and one nonsampled resident (Resident 18).</p> <p>* Residents 4, 18, 35, and 72's medical records did not have documented evidence showing the residents were asked if they had an advanced directive in place and if they would like information about formulating one.</p> <p>* Residents 2 and 19's medical record showed the residents did not have an advance directive; however, there was no documented evidence the information on how to formulate advance directive was provided to the residents.</p> <p>* Resident 27's medical record did not show whether the residents had or did not have an advance directive.</p> <p>* Resident 76's copy of advance directive was not available in the medical record.</p> <p>These failures had the potential for the residents/residents' representatives decision regarding healthcare and treatment to not be honored.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Advance Directive revised September 2022 showed the resident or resident representative is provided with written information of their right to formulate an Advance Directive. Information about whether the resident has or does not have an advance directive will be prominently located in the resident's medical record, easily retrievable by staff.</p> <p>1. Medical record review for Resident 18 was initiated on 9/17/24. Resident 18 was readmitted to the facility on [DATE].</p> <p>Review of Resident 18's POLST dated 10/7/22, showed no documented evidence showing whether the resident had or did not have an advanced directive in place.</p> <p>Further review of Resident 18's medical record showed no documented evidence if the resident had an advanced directive or if the information about advance directive was provided to the resident.</p> <p>On 9/20/24 at 0910 hours, an interview and concurrent medical record review were conducted with the SSD. The SSD reviewed Resident 18's POLST and verified no documented evidence if the the resident had or did not have an advance directive in place, or if the resident wanted more information on formulating an advance directive.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Medical record review for Resident 35 was initiated on 9/17/24. Resident 35 was readmitted to the facility on [DATE].</p> <p>Review of Resident 35's Advanced Healthcare Directive Acknowledgement form, undated, showed it was blank.</p> <p>On 9/20/24 at 0910 hours, an interview and concurrent medical record review were conducted with the SSD. The SSD stated the Advanced Healthcare Directive Acknowledgement was used to communicate if the resident already had an advanced directive in place, or if the resident would like more information. The SSD reviewed Resident 35's POLST and verified the form was blank and the medical record did not show if the resident had an advanced directive or if the information about advance directive was provided to the resident.</p> <p>3. Medical record review for Resident 4 was initiated on 9/17/24. Resident 4 was readmitted to the facility on [DATE].</p> <p>Review of Resident 4's Advanced Healthcare Directive Acknowledgement, undated, showed it was blank.</p> <p>On 9/20/24 at 0910 hours, an interview and concurrent medical record review were conducted with the Social Services Director. The Social Services Director Reviewed Resident 4's Advanced Healthcare Directive Acknowledgement verified it was incomplete and the resident's medical record did not show if the information about advance directive was provided to the resident.</p> <p>4. Medical record review for Resident 19 was initiated on 9/17/24. Resident 19 was readmitted to the facility on [DATE].</p> <p>Review of Resident 19's Internal Medicine History & Physical/Progress Note dated 7/22/24, showed the resident had capacity.</p> <p>Review of Resident 19's POLST dated 7/22/24, showed no documented evidence if the resident had or did not have an advanced directive in place.</p> <p>Review of Resident 19's Advanced Healthcare Directive Acknowledgement, undated, showed the resident did not have an advanced directive; however it did not show if the resident wanted more information on formulating an advance directive.</p> <p>On 9/20/24 at 0910 hours, an interview and concurrent medical record review were conducted with the SSD. The SSD reviewed Resident 19's POLST and Advanced Healthcare Directive Acknowledgement and verified the resident's medical record did not show if the resident wanted more information about formulating an advance directive.</p> <p>5. Medical record review for Resident 27 was initiated on 9/17/24. Resident 27 was readmitted to the facility on [DATE].</p> <p>Review of Resident 27's POLST dated 9/2/24, showed no documented evidence if the resident had or did not have an advanced directive in place.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 27's Advanced Healthcare Directive Acknowledgement dated 8/31/24, showed it was signed by the resident and facility staff; however, there was no documented evidence to show if the resident had an advance directive in place.</p> <p>On 9/20/24 at 0910 hours, an interview and concurrent medical record review were conducted with the SSD. The SSD reviewed Resident 27's Advanced Healthcare Directive Acknowledgement and POLST and verified the resident's medical record did not show if the resident had an advance directive in place.</p> <p>29461</p> <p>6. Medical record review for Resident 2 was initiated on 9/17/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 2's Physician's Orders for Life-Sustaining Treatment (POLST) dated 7/28/24, showed Resident 2 did not have an advance directive.</p> <p>Review of Resident 2's Advanced Healthcare Directive Acknowledgement Form, undated, showed Resident 2 did not have an advance healthcare directive; however, there was no documentation to show the resident or the resident's representative was offered information regarding the formulation of an advance directive.</p> <p>On 9/20/24 at 1327 hours, an interview and concurrent medical record review for Resident 2 was conducted with the SSD. The SSD verified the Advance Healthcare Directive Acknowledgement form for Resident 2 was incomplete and stated it should have been completed. The SSD verified the form did not show Resident 2 or the resident representative was offered information regarding the formulation of an advance directive.</p> <p>7. Medical record review for Resident 72 was initiated on 9/17/24. Resident 72 was admitted to the facility on [DATE].</p> <p>Review of Resident 72's Advanced Healthcare Directive Acknowledgement Form dated 5/12/24, showed the form was blank. There was no documentation to show if Resident 72 had an advance directive, or if the resident or the resident's representative was offered information regarding the formulation of an advance directive.</p> <p>On 9/20/24 at 1327 hours, an interview and concurrent medical record review for Resident 72 was conducted with the SSD. The SSD verified the Advance Healthcare Directive Acknowledgement form for Resident 72 was blank and stated it should have been completed.</p> <p>44175</p> <p>8. Medical record review for Resident 76 was initiated on 9/17/24. Resident 76 was admitted to the facility on [DATE].</p> <p>Review of Resident 76's H&P examination dated 6/10/24, showed Resident 76 had the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 76's Physician's Orders for Life-Sustaining Treatment (POLST) dated 6/7/24, showed Resident 76 had no advance directive and had a legally recognized decision maker.</p> <p>Review of Resident 76's Advance Healthcare Directive Acknowledgement Form dated 6/7/24, showed Resident 76 had an advance healthcare directive; however, there was no indication whether or not Resident 76's advance directive was requested by the facility or available in the medical record.</p> <p>On 9/18/24 at 1457 hours, an interview and concurrent medical record review for Resident 76 was conducted with the SSD. The SSD stated the social services department was in charge of the residents' advance directives, and if the resident had an advance directive, they would ask the resident or responsible party for a copy and place it in their medical record. The SSD acknowledged there was no documented evidence if Resident 76 had an advance directive available in their medical record. The SSD further stated there was no documented evidence if the facility had followed up with the resident or resident representative to obtain a copy of Resident 76's advance directive.</p> <p>On 9/20/24 at 0927 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings.</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>29461</p> <p>Based on observation, interview, and facility P&P review, the facility failed to ensure the residents' medical records were safeguarded to protect their confidential health information for two nonsampled residents (Residents 56 and 59). This failure had the potential for the residents' personal and health information to be accessed from the unauthorized users.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Confidentiality of Information and Personal Privacy revised 10/2017 showed the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. Access to the resident personal and medical records will be limited to authorized staff and business associates.</p> <p>On 9/17/24 at 1642 hours, Nursing Station A was observed with three computer monitors turned on. One computer monitor showed the physician's orders for Resident 59. Another computer monitor showed the care tracker/dashboard for Resident 56. Both computer monitors showing residents' information were left unattended.</p> <p>On 9/17/24 at 1644 hours, an observation and concurrent interview was conducted with LVN 6. LVN 6 verified the two computer monitors were turned on and unattended showing the resident information for Residents 56 and 59. LVN 6 stated the computer monitors should not have been left unattended with the resident's information showing.</p> <p>On 9/17/24 at 1650 hours, an observation and concurrent interview was conducted with CNA 6. CNA 6 verified he was using one of the computer monitors and left the monitor unattended to help a resident. When asked, CNA 6 stated he needed to close the monitor.</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to notify the resident's representatives of the resident's transfer and reasons for the transfer to the acute care hospital in writing for one of three final sampled resident (Resident 2) reviewed for hospitalization . This failure posed the risk of the resident's representatives not being aware of their appeal rights.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Transfer or Discharge, Facility Initiated dated 10/2022 showed facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/ representative notification and orientation, and documentation as specified in this policy.</p> <p>Medical record review for Resident 2 was initiated on 9/20/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 2's H&P examination dated 1/5/24, showed Resident 2 had no capacity to understand and make decisions.</p> <p>Review of Resident 2's Orders Summary Report dated 9/20/24, showed an order dated 7/27/24, to send the resident to the acute care hospital via 911 for further evaluation.</p> <p>Review of Resident 2's Notice of Transfer/Discharge Form dated 7/27/24, showed the resident/resident's representative signature was blank.</p> <p>Review of Resident 2's Progress Notes failed to show a written notification of transfer or discharge was given to the resident's representative.</p> <p>On 9/20/24 at 1426 hours, an interview and concurrent record review was conducted with the SSD. The SSD stated the nurses would usually call or inform the resident or resident's representative of the transfer of the resident to the acute care hospital. The SSD further stated she would follow up as needed; however, the facility did not provide a written notice to the resident or the resident's representative.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683</p> <p>Based on interview and medical record review, the facility failed to complete a significant change MDS within 14 days after a significant change for one of two final sampled residents reviewed for hospice services (Resident 2). This failure resulted in a delay in a comprehensive reassessment of the resident's changing health status and plan of care, in the effort to attain the resident's highest level of well-being.</p> <p>Findings:</p> <p>Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2023, showed a Significant Change in Status Assessment (SCSA) must be completed within 14 days when a resident enrolls in a hospice program.</p> <p>Medical record review for Resident 2 was initiated on 9/17/24. Resident 2 admitted to the facility on [DATE], and was readmitted to the facility on [DATE].</p> <p>Review of Resident 2's Order Summary Report for active orders as of 7/29/24, showed a physician's order dated 7/29/24, for Resident 2 to be admitted to hospice services.</p> <p>Review of Resident 2's MDS assessments failed to show a SCSA, or a comprehensive assessment was completed for the resident within 14 days after hospice services started.</p> <p>On 9/20/24 at 1541 hours, a concurrent interview and medical record review were conducted with the MDS Coordinator. The MDS Coordinator verified Resident 2 was admitted to hospice services on 7/29/24, and a comprehensive or SCSA MDS assessment were not completed within 14 days, and should have been.</p>

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</p> <p>Based on interview and medical record review, the facility failed to ensure the MDS assessment was accurate for two of 21 final sampled residents (Residents 2 and 71).</p> <p>* The facility failed to ensure Resident 71's gender was coded accurately.</p> <p>* The facility failed to ensure Resident 2's hospice services and weight loss was coded accurately.</p> <p>These failures placed the residents at risk for lack of continuity of care.</p> <p>Findings:</p> <p>1. Medical record review for Resident 71 was initiated on 9/20/24. Resident 71 was admitted to the facility on [DATE].</p> <p>Review of Resident 71's H&P examination dated 7/12/24, showed Resident 71 was male.</p> <p>Review of Resident 71's MDS dated ,d+[DATE], 2/1 and 2/13/24, showed Resident 71's gender was coded female.</p> <p>On 9/20/24 at 1039 hours, a concurrent interview and medical record review for Resident 71 was conducted with the MDS coordinator. The MDS coordinator verified above findings and stated Resident 71 was a male and the MDS for Resident 71's gender was not coded accurately on 1/25, 2/1 and 2/13/24.</p> <p>On 9/20/24 at 1549 hours, the DON and Administrator acknowledged the above findings.</p> <p>39683</p> <p>2. Medical record review for Resident 2 was initiated on 9/17/24. Resident 2 admitted to the facility on [DATE], and readmitted to the facility on [DATE].</p> <p>a. Review of Resident 2's Order Summary Report for active orders as of 7/29/24, showed a physician's order dated 7/29/24, for Resident 2 to be admitted to hospice services.</p> <p>Review of Resident 2's Annual MDS dated [DATE], failed to show the resident received hospice services.</p> <p>b. Review of Resident 2's Weight and Vitals Summary dated 9/20/24, showed the following:</p> <ul style="list-style-type: none"> - On 8/6/24, a weight of 110 pounds (9% weight loss since 7/4/24, and 20% weight loss since 2/4/24). - On 7/4/24, a weight of 121 pounds. - On 2/4/24, a weight of 139 pounds. <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 2's Annual MDS dated [DATE], showed the resident weighed 110 pounds. The MDS was coded no or unknown under the section asking if the resident had a weight loss of 5% or more in the last month, or 10% or more in the last 6 months.</p> <p>On 9/20/24 at 1541 hours, a concurrent interview and medical record review was conducted with the MDS Coordinator. The MDS Coordinator verified Resident 2 was admitted to the hospice services on 7/29/24, and stated Resident 2's MDS was not coded accurately to show they received hospice services. The MDS Coordinator reviewed Resident 2's past weights and verified Resident 2's MDS was not coded accurately to show the resident had a weight loss of 5% or more in the last month, or 10% or more in the last 6 months.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the plan of care was developed for three of 21 final sampled residents (Residents 13, 43, and 72).</p> <p>* The facility failed to develop a comprehensive person-centered care plan to address Resident 13's fall incident on 7/27/24, and Resident 13's significant weight loss.</p> <p>* The facility failed to develop a plan of care to address the actual fall for Resident 43.</p> <p>* The facility failed to develop a comprehensive person-centered care plan to address Resident 72's fall on 5/29/24.</p> <p>These failures had the potential risk of not providing appropriate, consistent, and individualized care to these residents.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised March 2022 showed the comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being including services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. The facility's P&P also showed comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs to be developed and implemented for each resident. The P&P further showed comprehensive person-centered care plan would reflect currently recognized standards of practice for problem areas and conditions.</p> <p>1. Medical record review for Resident 13 was initiated on 9/18/24. Resident 13 was admitted to the facility on [DATE].</p> <p>a. Review of Resident 13's H&P examination dated 4/29/24, showed Resident 13 had no capacity to understand.</p> <p>Review of Resident 13's Post Fall Review dated 7/29/24, showed Resident 13 had an unwitnessed fall on 7/27/24 at 0650 hours.</p> <p>Review of the Resident 13's Care Plan did not show care plan was developed to address Resident 13's fall incident on 7/27/24 at 0650 hours.</p> <p>On 9/20/24 at 0843 hours, a concurrent interview and medical record review for Resident 13 was conducted with the IP. The IP verified the above findings and stated the care plan for Resident 13 addressing the fall on 7/27/24, at 0650 hours, should have been initiated.</p> <p>(continued on next page)</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>On 9/20/24 at 0919 hours, a concurrent interview and medical record review for Resident 13 was conducted with the DON. The DON verified and acknowledged the above findings.</p> <p>b. Review of Resident 13's Weight Change Note dated 9/13/24 at 2041 hours, showed the following weights of Resident 13:</p> <ul style="list-style-type: none"> - on 3/4/24, 116 pounds; - on 6/4/24, 117 pounds; - on 8/6/24, 105 pounds; and, - on 9/6/24, 103 pounds. <p>Further review of the Weight Change Note showed Resident 13 had 12 % weight loss in 3 months and 11.2% weight loss in 6 months.</p> <p>Review of Resident 13's Care Plan did not show a care plan problem to address the above weight changes of Resident 13.</p> <p>On 9/20/24 at 0859 hours, a concurrent interview and medical record review for Resident 13 was conducted with RN 1. RN 1 verified the above findings and stated Resident 13 was on hospice services; however, the above weight changes were significant weight changes for Resident 13 and a care plan problem to address the above weight changes should have been initiated.</p> <p>On 9/20/24 at 0912 hours, a concurrent interview and medical record review for Resident 13 was conducted with the DON. The DON verified and acknowledged the above findings.</p> <p>Cross references to F692, example #1 and F849, example #1.a.</p> <p>49780</p> <p>2. Medical record review for Resident 43 was initiated on 9/18/24. Resident 43 was admitted to the facility on [DATE].</p> <p>Review of Resident 43's Post-Fall Review dated 7/29/24, showed the resident had a fall on 7/29/24.</p> <p>Review of Resident 43's Progress Notes dated 7/29/24 at 0400 hours, showed at approximately 0330 hours this morning, the resident was found sitting on the floor to the right side of his bed. When asked, the resident stated he slowly slipped off his bed.</p> <p>Review of Resident 43's Minimum Data Set (MDS) - Section C dated 7/18/24, showed his BIMS score was 12 which meant the resident had moderate cognitive impairment.</p> <p>Review of Resident 43's Plan of Care did not show a care plan problem was developed to address the actual unwitnessed fall on 7/29/24.</p> <p>(continued on next page)</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>On 09/18/24 at 1225 hours, an interview was conducted with Resident 43 in his room. Resident 43 stated he probably slid off from the bed.</p> <p>On 09/18/24 at 1457 hours, an interview and concurrent medical record review for Resident 43 was conducted with LVN 7. LVN 7 verified there was no care plan developed for Resident 43's actual fall on 7/29/24. LVN 7 also stated the nurses should have initiated a care plan for the fall.</p> <p>On 09/19/24 at 1533 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated when the resident had a fall, the nurse should have initiated a care plan for the fall, and the IDT would update or revise the care plan within 72 hours. The DON verified there was no care plan initiated on 7/29/24, for Resident 43's actual fall.</p> <p>51539</p> <p>3. Medical record review for Resident 72 was initiated on 9/17/24. Resident 72 was admitted to the facility on [DATE].</p> <p>Review of Resident 72's H&P examination dated 8/13/24, showed the resident did not have the capacity to make medical decisions.</p> <p>Review of Resident 72's eINTERACT Change in Condition Evaluation - V 5.1 dated 5/29/24, showed Resident 72 went out of her room and wheeled herself around the facility awaiting for the activity room to open. While waiting, Resident 72 transferred herself from the wheelchair to the couch in front of the DON's office. Resident 72 slid off from the couch to the floor while transferring.</p> <p>Review of Resident 72's Plan of Care failed to show a care plan problem was developed to address the fall on 5/29/24.</p> <p>On 9/20/24 at 1032 hours, an interview and concurrent medical record review for Resident 72 was conducted with RN 1. RN 1 verified Resident 72 had a fall on 5/29/24. RN 1 verified there was no care plan problem to address Resident 72's fall in her comprehensive care plan. RN 1 stated there should have been a care plan initiated on the date of the fall to address the interventions for Resident 72.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50127</p> <p>Based on observation, interview, and medical record review, the facility failed to provide services to attain or maintain the highest practicable well-being for one of 21 final sampled residents (Resident 7).</p> <p>* The facility failed to follow the physician's order for Resident 7 for cervical collar at all times every shift. This failure posed the risk of adverse effects to Residents 7's well-being.</p> <p>Findings:</p> <p>Medical record review for Resident 7 was initiated on 09/18/24. Resident 7 was admitted to the facility on [DATE].</p> <p>Review of the MDS comprehensive assessment dated [DATE] showed the resident's BIMS score of 12.</p> <p>Review of Resident 7's H&P examination dated 9/16/24, showed the resident had the capacity. The H&P examination also showed diagnoses including cervical fracture.</p> <p>Review of the Order Summary Report dated 9/18/24, showed a physician's order dated 6/15/24, for cervical collar at all times every shift.</p> <p>Review of Resident 7's Plan of Care showed a care plan problem initiated on 6/16/24, for Immobilizer- At risk of skin alteration related to presence of neck immobilizer. The interventions initiated 7/14/24, included cervical collar at all times.</p> <p>.</p> <p>On 09/18/24 at 1010 hours, an observation and concurrent interview was conducted with Resident 7. Resident 7 was observed sitting in a chair in her room without a cervical collar. When asked if Resident 7 was supposed to have her cervical collar on, Resident 7 stated no, she stopped wearing the neck collar on Friday 9/6/24, after her appointment with her neurosurgeon. Resident 7 further stated she gave the neck collar to one of her friends on 9/6/24, for safe keeping in case she would need the cervical collar in the future.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/18/24 at 1017 hours, an observation and concurrent interview and medical record review were conducted with LVN 8. During an observation of Resident 7, LVN 8 verified Resident 7 did not have a cervical collar on as per the physician's orders. When asked if Resident 7 had an order for the cervical collar, observed LVN 8 printed Resident 7's physician orders from Resident 7's electronic health record and verified there was an order for the cervical collar to be worn at all times every shift, and there was no discontinuation date. LVN 8 also verified there was a care plan for the cervical collar to be worn at all times without a discontinuation date. LVN 8 further stated there should have been a follow up by the licensed nurse when Resident 7 returned from her appointment with her neurosurgeon on 9/6/24; and by not following the physician's order for the cervical collar to be worn at all times, this could potentially affect Resident 7's quality of care and that it was important to make sure Resident 7 was receiving the care as per the physician's orders for her overall health to get better.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</p> <p>Based on observation, interview, and medical record review, the facility failed to ensure the resident's low air loss mattress was set appropriately according to the resident's weight for one of two final sampled residents reviewed for pressure ulcer (Resident 13). This failure had the potential for Residents 13 not receiving the appropriate care and services to prevent the development of the pressure ulcers.</p> <p>Findings:</p> <p>On 9/18/24 at 0956 hours, and 9/19/24 at 1355 hours, Resident 13 was observed lying in bed on low air loss mattress. The low air loss mattress was observed being set to 250 pounds.</p> <p>Medical record review for Resident 13 was initiated on 9/18/24. Resident 13 was admitted to the facility on [DATE].</p> <p>Review of Resident 13's Order Summary Report showed a physician's order dated 12/7/23, for a low air loss mattress and to monitor the low air loss mattress for setting every shift.</p> <p>Review of Resident 13's Braden Scale For Predicting Pressure Sore Risk dated 8/21/24, showed Resident 13 was at a high risk for developing pressure ulcer.</p> <p>Review of Resident 13's MDS dated [DATE], showed Resident 13 was totally dependent on the staff assistance for bed mobility. Further review of the MDS showed Resident 13 had severely impaired cognitive skills for daily decision making.</p> <p>Review of Resident 13's H&P examination dated 4/29/24, showed Resident 13 had no capacity to understand and make medical decisions.</p> <p>Review of Resident 13's Weight and Vitals Summary showed on 9/6/24, Resident 13's weight was 103 pounds.</p> <p>On 9/19/24 at 1403 hours, a concurrent interview and medical record review for Resident 13 was conducted with the MDS Coordinator. The MDS Coordinator stated the low air loss mattress should be set according to the resident's weight. The MDS Coordinator verified Resident 13's weight was 103 pounds and the resident was at high risk for developing a pressure ulcer.</p> <p>On 9/19/24 at 1412 hours, a concurrent observation and interview was conducted with the MDS Coordinator. Resident 13 was observed lying in bed on air loss mattress, the setting on the air loss mattress showed 250 pounds, the MDS Coordinator verified the observation and stated the setting for the air loss mattress should be set based on the resident's weight which was 103 pounds. The MDS Coordinator was observed changing setting of the low air loss mattress for 103 pounds weight.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/19/24 at 1417 hours, an interview was conducted with LVN 9. LVN 9 stated she was responsible to monitor setting on the low air loss mattress. LVN 9 further stated the hospice services provided the mattress for Resident 13, and the setting should be set according to the resident comfort; however, Resident 13 was not able to verbalize the comfort level, so it should have been set according to Resident 13's weight.</p> <p>On 9/20/24 at 0919 hours, an interview was conducted with the DON. The DON acknowledged the above findings.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51539</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of 21 final sampled residents (Residents 2 and 86) received the necessary care and services to prevent accident hazards.</p> <p>* The facility failed to thoroughly investigate and document Resident 2's cause of skin tear on the right buttock.</p> <p>* The facility failed to ensure the physician's order for Resident 86 to wear WanderGuard at all times was followed.</p> <p>These failures had the potential to negatively impact the residents' well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Accidents and Incidents-Investigating and Reporting revised 7/2017 showed all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.</p> <p>Medical record review for Resident 2 was initiated on 9/17/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 2's Internal Medicine History & Physical/Progress notes dated 1/5/24, showed Resident 2 had no capacity.</p> <p>Review of Resident 2's Order Summary Report dated 9/18/24, showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 8/30/24, for the right buttock open wound (traumatic): to cleanse with wound cleanser, pat dry, apply hydrogel collagen (use to rehydrate dry wound), cover with a foam dressing every day and PRN every 12 hours x 21 days. - dated 8/30/24, for the right buttock open wound (traumatic): to cleanse with wound cleanser, pat dry, apply hydrogel collagen, cover with a foam dressing every day and PRN one time a day for 21 days. <p>Review of Resident 2's Plan of Care showed a care plan problem dated 6/12/24, for the right buttock open wound (traumatic).</p> <p>Review of the H&P Note from the wound physician dated 6/25/24, showed Resident 2 had a right buttock skin tear- traumatic due to fall-nonhealed.</p> <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 - Few</p>	<p>Review of the SOAP (Subjective, Objective, Assessment, Plan) Note dated 7/9, 7/24, 8/12, 8/20, 9/3, 9/10, and 9/17/24, showed Resident 2's assessment showing the right buttock skin tear- traumatic due to fall-non healed.</p> <p>On 9/20/24 at 1448 hours, an interview was conducted with LVN 9. LVN 9 stated a CNA notified her on 6/12/24, that Resident 2 fell. LVN 9 stated CNA 7 was the one who reported to her about Resident 2's fall incident LVN 9 stated she did not witness the fall; however, she told LVN 3 about what CNA 7 told her and LVN 9 stated she expected LVN 3 to report her findings. LVN 9 further stated she only focused on Resident 2's skin tear and not the fall.</p> <p>Review of Resident 2's eInteract Change in Condition Evaluation - V 5.1 dated 6/12/24, at 1558 hours, showed the resident had a skin tear to the right buttock and had a recommendation to cleanse with NS (normal saline) pat dry apply triad cream, cover with a foam dressing every day x 14 days. The eInteract Change in Condition Evaluation failed to show documentation about the cause of Resident 2's skin tear.</p> <p>On 9/20/24 at 1528 hours, an interview was conducted with CNA 7. When asked about the facility's process when a resident had an incident of fall, CNA 7 stated if he happened to see a fall or saw a resident on the floor, he needed to report it to the charge nurse immediately. When CNA 7 was asked if he had provided care to Resident 2, he stated, yes. When CNA 7 was asked if he had reported an incident of fall to the charge nurse for Resident 2, CNA 7 stated he did not remember the resident falling, but remembered reporting to LVN 9 about Resident 2's rash on her back. CNA 7 stated there were no falls reported.</p> <p>On 9/20/24 at 1545 hours, an interview and concurrent medical record review for Resident 2 was conducted with LVN 3. LVN 3 verified she was the one who created and closed the eInteract Change in Condition Evaluation dated 6/12/24, for Resident 2's skin tear to the right buttock. When asked what was the process when someone reported a resident sustained a skin tear, LVN 3 stated she would find out how and what happened. LVN 3 verified there was no documentation of the cause of Resident 2's skin tear.</p> <p>On 9/20/24 at 1711 hours, a telephone interview was conducted with the DON, with the presence of RN 1. When asked what she recalled regarding the cause of Resident 2's traumatic wound on the right buttock, the DON stated it was reported to her by LVN 9 regarding Resident 2 had a skin tear on the right buttock. When asked for the reason or cause of Resident 2's skin tear on the right buttock, the DON stated she could not remember. The DON stated it could have been in the progress notes or the COC form. RN 1 verified the COC dated 6/12/24, for Resident 2's skin tear on the right buttock. When asked about the facility's protocol when an injury was identified, the DON stated they looked at the injury, treated the skin tear, notified the family, and notified the physician. The DON further stated if it was an injury of unknown origin, they were to investigate and document in the post event. When asked if the facility investigated and documented in the post event, the DON stated she did not remember, but it would have been documented under post-fall. RN 1 accessed the PCC records to find the documentation to address Resident 2's skin tear on 6/12/24. RN 1 verified there was no documentation of the investigation and the cause of Resident 2's skin tear on the right buttock.</p> <p>50127</p> <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 - Few</p>	<p>2. Review of the facility's P&P titled Wandering and Elopements revised 3/2019 showed the facility will identify residents who are at risk for unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.</p> <p>Medical record review for Resident 86 was initiated on 9/18/24. Resident 86 was admitted to the facility on [DATE].</p> <p>Review of Resident 86's H&P examination dated 8/22/24, showed the resident was unable to make decisions.</p> <p>Review of Resident 86's Orders Summary Report dated 9/18/24, showed a physician's order dated 8/21/24, for WanderGuard on the left wrist, to monitor placement every shift.</p> <p>Review of Resident 86's Plan of Care showed a care plan problem initiated on 8/21/24, for at risk for elopement/wandering related to cognitive loss, impaired decision making, wanders outside of facility property, and wanders into the other resident's rooms. The Care plan interventions showed applied WanderGuard to the left wrist.</p> <p>On 9/18/24 at 1211 hours, Resident 86 was observed in bed without a WanderGuard to his left wrist.</p> <p>On 9/18/24 at 1218 hours, an observation and concurrent interview and medical record review for Resident 86 was conducted with LVN 7. LVN 7 verified Resident 86 had a physician's order to wear WanderGuard on the left wrist and was not wearing a WanderGuard. LVN 7 stated Resident 86 should be wearing the WanderGuard for his safety and because he was at risk for wandering and elopement.</p> <p>On 9/18/24 at 1305 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified Resident 86 was not wearing a WanderGuard. RN 1 stated she knew of Resident 86's physician's order for a WanderGuard to be applied to his left wrist; however, Resident 86 was never provided with a WanderGuard and it was never applied. RN 1 further stated the Wanderguard should have been applied to Resident 86 as per the physician's orders and care plan.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure three of six final sampled residents reviewed for weight loss (Residents 4, 13, and 35) received the appropriate services needed to maintain acceptable parameters of nutritional status.</p> <p>* The facility failed to implement interventions to maintain Resident 13's nutritional status when the resident experienced severe weight loss. The facility failed to notify Resident 13's physician and responsible party in timely manner and failed to ensure the IDT analyzed and implemented the necessary interventions to address Resident 13's severe weight loss.</p> <p>* Residents 4 and 35's weekly weights were not completed as ordered by the physicians.</p> <p>These failures had the potential to result in the lack of implementation, monitoring, and evaluation of the effectiveness of nutritional interventions and related outcomes and increase the potential for further weight loss and/or nutritional decline.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Weight Assessment and Intervention dated May 2023 showed the resident weights are monitored for undesirable or unintended weight loss or gain. The P&P showed the suggested parameters:</p> <p>a). 1 months- 5% weight loss is significant, greater than 5% is severe;</p> <p>b). 3 month- 7.5% weight loss is significant; greater than 7.5% is severe; and,</p> <p>c). 6 months- 10% weight loss is significant; greater than 10% is severe.</p> <p>Further review of the facility's P&P showed the physician and multidisciplinary team identify condition and medication that may be causing anorexia, weight loss or increasing the risk of weight loss.</p> <p>Medical record review for Resident 13 was initiated on 9/18/24. Resident 13 was admitted to the facility on [DATE].</p> <p>Review of Resident 13's Weight Change Note dated 9/13/24 at 2041 hours, showed Resident 13's weights on the following dates:</p> <p>- on 3/4/24, 116 pounds;</p> <p>- on 6/4/24, 117 pounds;</p> <p>- on 8/6/24, 105 pounds; and,</p> <p>- on 9/6/24, 103 pounds.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the Weight Change Note showed Resident 13 had 12 % weight loss in 3 months and 11.2% weight loss in six months.</p> <p>Review of the Resident 13's Change in Condition evaluation dated 9/19/24, showed the resident's physician and responsible party were notified of the weight loss (six days after severe weight loss was identified).</p> <p>Further review Resident 13's medical records failed to show documented evidence an IDT evaluation of the severe weight loss was conducted.</p> <p>On 9/20/24 at 0859 hours, a concurrent interview and medical record review for Resident 13 was conducted with RN 1. RN 1 verified the above findings and stated Resident 13 was on hospice services; however, when the facility identified Resident 13's significant weight changes on 9/13/24, the resident's physician and responsible party should have been notified immediately and IDT review of weight loss should have been conducted.</p> <p>On 9/20/24 at 0912 hours, a concurrent interview and medical record review for Resident 13 was conducted with the DON. The DON verified and acknowledged the above findings.</p> <p>Cross reference to F656, example #1.b and F849, example #1.a.</p> <p>39683</p> <p>2. Medical record review for Resident 35 was initiated on 9/17/24. Resident 35 was readmitted to the facility on [DATE].</p> <p>Review of Resident 35's Weight Change Note dated 8/8/24, showed the resident was steadily losing weight and the RD had recommended weekly weights for four weeks.</p> <p>Review of Resident 35's physician's order dated 8/9/24, showed to monitor the resident's weights weekly for four weeks.</p> <p>Review of Resident 35's Weights and Vitals Summary dated 9/20/24, showed the following:</p> <ul style="list-style-type: none"> - On 7/4/24, a weight of 101 pounds. - On 8/6/24, a weight of 96 pounds. - On 9/6/24, a weight of 95 pounds. <p>There were no weekly weights recorded after 8/6/24.</p> <p>On 9/20/24 at 1337 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the RD recommendations were provided to the DON and distributed to the Nursing Supervisors to carry out and follow up with the physician. The DON stated the weekly weight orders should be communicated to the RNA, so they would know to weigh the resident weekly. The DON reviewed Resident 35's weight order and weight entries and verified the weekly weights were not completed as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Medical record review for Resident 4 was initiated on 9/17/24. Resident 4 was readmitted to the facility on [DATE].</p> <p>Review of Resident 4's Dietary/RD note dated 8/21/24, showed an IDT weight meeting was held for the resident's weight loss, and the RD recommended weekly weights for four weeks.</p> <p>Review of Resident 4's physician's order dated 8/23/24, showed an order to monitor weights weekly for four weeks.</p> <p>Review of Resident 4's Weights and Vitals Summary dated 9/20/24, showed the following:</p> <ul style="list-style-type: none"> - On 8/6/24, a weight of 165 pounds. - On 9/6/24, a weight of 168 pounds. - On 9/12/24, a weight of 165 pounds. <p>There were no weekly weights done as per the 8/23/24 order until 9/6/24.</p> <p>On 9/20/24 at 1337 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the RD recommendations were provided to the DON and distributed to the Nursing Supervisors to carry out and follow up with the physician. The DON stated the weekly weight orders should be communicated to the RNA, so they would know to weigh the residents weekly. The DON reviewed Resident 4's order for weekly weights and weight entries and verified weekly weights were not completed as ordered. The DON stated the resident should have been weighed within 24 hours of the order date, then every seven days from that first weekly weight. The DON stated the order was discontinued on 9/1/24, when the resident was transferred to the acute care hospital and was reordered when they returned on 9/4/24. The DON stated the resident missed two weekly weights.</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>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care for five of six final sampled resident (Residents 2, 4, 27, 72, and 442) and one nonsampled resident (Resident 12) reviewed for respiratory care and services.</p> <p>* The facility failed to ensure the physician's order for oxygen therapy was followed for Resident 442. In addition, the facility failed to clarify the physician's order when the order did not show how high the oxygen could be titrated for Resident 442.</p> <p>* Resident 12's oxygen concentrator was observed in the hallway, and the door was closed with compressing oxygen tubing. This failure posed the risk of Resident 12 not receiving her oxygen.</p> <p>* Resident 27 was not administered continuous oxygen as ordered by the physician.</p> <p>*The facility failed to ensure Resident 72's oxygen titration order included the parameter for the oxygen to be titrate up to.</p> <p>* The facility failed to ensure there was a physician's order for the administration of oxygen for Resident 2. In addition, the facility failed to ensure the licensed nurse documented Resident 2's change of condition when the resident had low oxygen saturation level at 89%.</p> <p>* Resident 4's suction machine and two suction machine canisters were observed on the floor.</p> <p>These failures had the potential to negatively affect the residents' medical conditions.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Oxygen Administration revised October 2010 showed to verify the physician's order for the procedure and to review the physician's order or facility protocol for oxygen administration. Under the section for documentation showed after completing the oxygen setup or completion, the information should be recorded in the resident medical record which included the reason for PRN (as needed) administration.</p> <p>1. On 9/17/24 at 1018 hours, and 9/18/24 at 1237 hours, Resident 442 was observed receiving oxygen through nasal cannula at 4 liters per minutes.</p> <p>Medical record review for Resident 442 was initiated on 9/17/24. Resident 442 was admitted to the facility on [DATE].</p> <p>Review of the Resident 442's Physician Order Summary dated 9/9/24, showed an order for oxygen to titrate to start at 3 liters per minute through nasal cannula to maintain oxygen saturation level above 88-89% for diagnosis chronic obstructive pulmonary disease. Further review of the Physician Order did not show for the parameters on how high the oxygen could be titrated.</p> <p>(continued on next page)</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>Review of Resident 442's MAR for September 2024 showed no documented evidence if Resident 442 had oxygen saturation level less than 88 % requiring the titration of the oxygen.</p> <p>On 9/18/24 at 1240 hours, a concurrent observation, interview and medical record review for Resident 442 was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings and stated Resident 442 received continuous oxygen at 4 liters per minute through nasal cannula. The MDS Coordinator reviewed the records and stated there was no documented evidence if Resident 442 required titration of the oxygen and when the facility titrated the oxygen to 4 liters per minute. The MDS Coordinator acknowledged there should have been documented evidence when the oxygen was titrated to 4 liters per minute and the reason requiring oxygen titration.</p> <p>On 9/18/24 at 1246 hours, a concurrent interview and medical record review for Resident 442 was conducted with the DON. The DON verified the above findings and stated there should have been documented evidence when the oxygen was titrated to 4 liters per minute and the reason requiring oxygen titration for Resident 442. The DON further stated the physician's order should clarify how high the oxygen could be titrated for Resident 442.</p> <p>35346</p> <p>2. On 9/17/24 at 1004 hours, Resident 12's oxygen concentrator was observed to be on and in the hallway outside Resident 12's room. The room's door was observed closed and compressing Resident 12's oxygen tubing.</p> <p>Medical record review for Resident 12 was initiated on 9/17/24. Resident 12 was readmitted to the facility on [DATE].</p> <p>Review of Resident 12's H&P examination dated 11/6/23, showed Resident 12's diagnoses included anoxic brain injury, debility, and respiratory failure. Resident 12 was dependent on oxygen for her breathing needs.</p> <p>Review of Resident 12's MAR for September 2024 MAR, showed a physician's order dated 7/11/24, for Resident 12 to be administered with oxygen via nasal cannula continuously for diagnosis chronic obstructive pulmonary disorder.</p> <p>On 9/19/24 at 0835 hours, Resident 12's oxygen concentrator was observed to be on and in the hallway outside Resident 12's room. The room's door was observed closed and compressing Resident 12's oxygen tubing. LVN 3 verified the findings.</p> <p>39683</p> <p>3. Medical record review for Resident 27 was initiated on 9/17/24. Resident 27 was readmitted to the facility on [DATE].</p> <p>Review of Resident 27's Order Summary Report dated 9/19/24, showed the following orders:</p> <p>- An order dated 9/1/24, to administer oxygen 2-3 liters per minute via nasal cannula continuously.</p> <p>(continued on next page)</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>- An order dated 9/1/24, to administer oxygen at 10 liters per minute PRN to keep oxygen saturation level above 90%.</p> <p>Review of Resident 27's MAR for September 2024 showed the resident received routine oxygen at 2-3 liters per minute continuous. The document also showed the resident did not receive any additional supplemental oxygen, up to 10 liters per minute as needed.</p> <p>On 9/18/24 at 0936 hours, Resident 27 was observed lying in bed, on room air, without supplemental oxygen. There was no nasal cannula in place and the oxygen concentrator (oxygen delivery equipment) was turned off.</p> <p>On 9/18/24 at 0953 hours, LVN 5 was observed standing with the medication cart in Resident 27's doorway. Resident 27 was observed on room air.</p> <p>On 9/18/24 at 1113 hours, an observation, interview, and concurrent medical record review were conducted with LVN 5. LVN 5 reviewed Resident 27's physician's orders and stated the resident had an order for continuous oxygen at 2-3 liters per minute via nasal cannula, as well as a PRN order for up to 10 liters per minute. When asked how much oxygen the resident was currently on, the LVN stated they had not yet checked that day. LVN 5 proceeded to Resident 27's bedside and verified the resident was not receiving supplemental oxygen. LVN 5 then placed the resident on oxygen at 3 liters per minute. LVN 5 checked the resident's oxygen saturation level with a pulse oximeter showing a reading of 84%, and stated that was a low reading. LVN 5 then increased the resident's oxygen to 6 liters per minute.</p> <p>On 9/19/24 at 1028 hours, Resident 27 was observed with oxygen 7 liters per minute via nasal cannula being administered.</p> <p>On 9/19/24 at 1045 hours, an observation and interview were conducted with LVN 1. LVN 1 stated Resident 27 was on oxygen at 7 liters per minute, and the resident had a PRN order to administer oxygen up to 10 liters per minute.</p> <p>On 9/19/24 1331 hours, an interview and concurrent record review were conducted with RN 2. RN 2 verified Resident 27's administration record for September 2024 showed the resident was administered their routine oxygen at 2-3 liters per minute and did not receive PRN oxygen up to 10 liters per minute.</p> <p>51539</p> <p>3. Medical record review for Resident 2 was initiated on 9/17/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. The resident's admission diagnoses included chronic obstructive pulmonary disease (COPD-a medical condition/lung disease which makes it difficult for the person to breathe) with acute exacerbation (sudden worsening of symptoms)</p> <p>On 9/17/24 at 1019 hours, Resident 2's oxygen concentrator was turned on and the resident was receiving 2L/min of oxygen via nasal cannula.</p> <p>Review of Resident 2's physician's orders did not show an order to administer oxygen.</p> <p>(continued on next page)</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>On 9/18/24 at 1113 hours, an observation and concurrent interview and medical record review for Resident 2 was conducted with LVN 6. Resident 2's oxygen concentrator was turned on and the resident was receiving 2L/min of oxygen via nasal cannula. LVN 6 verified Resident 2 was receiving oxygen at 2L/min via nasal cannula. When asked why Resident 2 was receiving oxygen, LVN 6 stated the resident's status was one day up and one day down. Resident 2's physician's orders were reviewed by LVN 6 who verified there was no order currently for Resident 2 to receive oxygen. LVN 6 stated the resident's oxygen saturation level this morning at around 0800 hours, was 89%. LVN 6 stated she repositioned and reassessed Resident 2, and spoke to Resident 2's physician at 0830 hours. However, LVN 6 verified there was no current order to administer oxygen continuously or PRN and there was no documentation of the resident's COC in the resident's medical record.</p> <p>On 9/18/24 at 1129 hours, LVN 6 rechecked Resident 2's oxygen saturation level and noted at 97% with the administration of 2L/min of oxygen. LVN 6 stated she would take off the resident's oxygen.</p> <p>4. Medical record review for Resident 72 was initiated on 9/17/24. Resident 72 was admitted to the facility on [DATE]. The resident's admission diagnoses included chronic obstructive pulmonary disease with acute exacerbation.</p> <p>Review of Resident 72's Order Summary Report for September 2024 showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 8/12/24, to change oxygen humidifier and nasal cannula and tubing every week on Friday and PRN (label with date) every night shift. - dated 8/12/24, to monitor oxygen saturation level every shift. Notify MD if oxygen is less than 92% every shift - dated 9/18/24, to titrate oxygen to start at 2L/min via nasal cannula to maintain oxygen saturation level at 88-89% as needed. <p>On 9/20/24 at 1044 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the above orders. RN 1 stated Resident 72 was transferred to the hospital on 8/9/24, and returned to the facility on [DATE]. RN 1 verified at the time the resident was readmitted to the facility, there was no order for oxygen administration because Resident 72 did not need it, the oxygen saturation levels were OK, and the order to change humidifier, nasal cannula and tubing should have been discontinued. When asked for the reason why an oxygen order for Resident 2 was received on 9/18/24, to titrate to start at 2L/min via nasal cannula to maintain oxygen saturation at 88-89%, RN 1 stated she did not know why and Resident 72 did not need it. RN 1 also verified the oxygen order should have included a specific parameter as to how much they cloud titrate the oxygen. RN 1 verified the oxygen order dated 9/18/24, was obtained by LVN 6; however, there was no documentation as to why the physician was contacted to obtain the oxygen order. RN 1 stated there should have been documentation in Resident 72's progress notes.</p> <p>50127</p> <p>5. Medical record review for Resident 4 was initiated on 9/17/24. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>(continued on next page)</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>On 9/18/24 at 0954 hours, an observation and concurrent interview was conducted with LVN 6. Resident 4 was in bed. Resident 4's suction machine and two suction machine canisters were in a clear plastic bag on the floor to the right side of Resident 4's bed. LVN 6 verified the findings and stated the suction machine and two canisters should not be stored on the floor and needed to be disinfected before placing it on Resident 4's bedside table in the event Resident 4 needed to be suctioned.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346</p> <p>Based on interview and medical record review, the facility failed to ensure one of three final sampled residents (Resident 62) reviewed for pain management had the pain medication orders to include clear indication for use as evidenced by:</p> <p>* Resident 62 had the orders for acetaminophen (analgesic) and hydrocodone-acetaminophen (opioid analgesic) with the same pain levels for use. This failure posed the risk of the resident's pain not being managed appropriately.</p> <p>Findings:</p> <p>Medical record review was initiated for Resident 62 on 9/17/24. Resident 62 was admitted on [DATE].</p> <p>Review of Resident 62's admission MDS dated [DATE], showed Resident 62 had severe cognitive impairment.</p> <p>Review of Resident 62's MAR for September 2024 showed an order dated 7/22/24, for acetaminophen for pain levels mild to severe (levels of 1-10, on a 0-10 pain scale, with 0=no pain and 10=worst pain) and order dated 6/15/24, for hydrocodone-acetaminophen for moderate to severe pain (levels of 4-10).</p> <p>On 9/20/24 at 1408 hours, concurrent interview and medical record review was conducted with LVN 4. LVN 4 verified Resident 62 had the above pain medications ordered. LVN 4 verified on 9/18/24, Resident 62 had a pain level of 5 and was administered acetaminophen. LVN 4 stated Resident 62 should have been administered hydrocodone-acetaminophen for a pain level of 5. LVN 4 verified the acetaminophen and hydrocodone-acetaminophen medication orders did not have a clear indication to use related to Resident 62's pain levels.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346</p> <p>Based on observation, interview and facility P&P review, the facility failed to ensure the medications were administered according to the facility's P&P for one nonsampled resident (Resident 59). This failure posed the risk of Resident 59's medications not being administered according to accepted practices.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Administering Medications through an Enteral Tube revised 11/18 showed steps to administer G-tube medications included removing the plunger from the syringe prior to pouring the medications into the syringe barrel. Further steps include to flush the G-tube with water prior to administering medications and also in between administering medications.</p> <p>On 9/19/24 at 0820 hours, a concurrent medication administration observation for Resident 59 and interview was conducted with LVN 3. LVN 3 was observed using the syringe and plunger to push the first medication, then second medication into Resident 59's G-tube. LVN 3 failed to flush Resident 59's G-tube with 50 ml of water prior to administering Resident 59's medications and in between the first and second medications. After LVN 3 finished administering all of Resident 59's medications, an interview was conducted with LVN 3. LVN 3 acknowledged the findings.</p> <p>Medical record review for Resident 59 was initiated on 9/19/24. Resident 59 was readmitted to the facility on [DATE], with post status G-tube placement.</p> <p>Review of Resident 59's September 2024 MAR showed an order dated 9/10/24, to flush G- tube with 30 ml before and after medication.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents (Residents 2 and 7) reviewed for psychotropic medications (medication affecting brain activities associated with mental processes and behavior) was free from unnecessary psychotropic medications.</p> <p>* The facility failed to ensure Resident 7's behavior manifestation and side effects were monitored accurately for the use of risperidone (an antipsychotic medication used for mental illness that causes disturbed or unusual thinking).</p> <p>* The facility failed to ensure the PRN order for lorazepam (antianxiety medication)was limited to 14 days for Resident 2.</p> <p>These failures posed the risk of unnecessary medications for these residents and negatively affects the residents' health and well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Psychotropic Medication Use dated 7/2022 showed the drugs in the categories considered psychotropic medications are subject to prescribing, monitoring, and review requirements specific to antipsychotics. Residents receiving psychotropic medications are monitored for adverse consequences including anticholinergic, cardiovascular, metabolic, neurologic, and psychosocial effects.</p> <p>Medical record review for Resident 7 was initiated on 9/19/24. Resident 7 was admitted to the facility on [DATE].</p> <p>Review of Resident 7's H&P examination dated 6/17/24, showed the resident had the capacity to understand and make decisions.</p> <p>Review of Resident 7's Order Summary Report dated 9/19/24, showed an order dated 7/26/24, for risperidone 0.5 mg tablet by mouth at bedtime for schizoaffective disorder manifested by racing thoughts.</p> <p>Review of Resident 7's MARs for June, July, and August 2024 showed the following:</p> <p>* The June 2024 MAR showed the following physician's orders:</p> <ul style="list-style-type: none"> - dated 6/17/24, to administer risperidone 0.5 mg at HS for schizoaffective Disorder manifested by injury to self (Suicidal ideation). - dated 6/15/24, to monitor behavior(s) of refusing care every shift for use of risperidone. <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>However, Resident 7's June 2024 MAR failed to show the monitoring of side effects for risperidone medication use.</p> <p>* The July 2024 MAR showed the following physician's order:</p> <p>- dated 7/26/24, to administer risperidone 0.5 mg at bedtime for schizoaffective disorder manifested by racing thoughts .</p> <p>However, Resident 7's July 2024 MAR failed to show the monitoring of the side effects for risperidone medication use and monitoring of the resident's behavior manifestation.</p> <p>* The August 2024 MAR showed the following physician's order:</p> <p>- dated 7/26/24, to administer risperidone 0.5 mg at bedtime for schizoaffective disorder manifested by racing thoughts .</p> <p>However, Resident 7's August 2024 MAR failed to show for the monitoring of the side effects for risperidone and behavior manifestation of racing thoughts</p> <p>In addition, review of Resident 7's September 2024 MAR failed to show the monitoring of the side effects for risperidone and behavior manifestation of racing thoughts.</p> <p>On 9/19/24 at 1444 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified Resident 7 received risperidone 0.5 mg at bedtime for schizoaffective disorder manifested by racing thoughts. LVN 2 stated Resident 7 was not currently being monitored for the manifestation of the behavior of racing thoughts and side effects for the use of the risperidone medication. LVN 2 stated the behavior and side effects monitoring should have been completed for the residents receiving antipsychotic medications.</p> <p>On 9/19/24 at 1617 hours, an interview and concurrent medical record review with RN 1 was conducted. RN 1 verified Resident 7's Psychoactive Summary form showed risperidone 0.5 mg at bedtime for schizoaffective disorder for the behavior manifestation of racing thoughts. RN 1 verified the behavior manifestation was inaccurate based on the specific behavior manifestation for the risperidone medication as ordered in June 2024.</p> <p>44175</p> <p>2. Review of the facility's P&P titled Psychotropic Medication Use dated July 2022 showed psychotropic medication are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. Further review of the P&P showed the PRN order for psychotropic medication are limited to 14 days. The P&P also showed for psychotropic medication that are not antipsychotic and if prescriber or attending physician believes it is appropriate to extend the PRN medication beyond 14 days, he or she will document the rational for extending the use and include the duration for the PRN order.</p> <p>Medical record review for Resident 2 was initiated on 9/20/24. Resident 2 was admitted to the facility on [DATE] and was readmitted on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 2's Physician Order Summary dated 7/28/24 showed an order for lorazepam 0.5 mg every six hours as needed. Further review of the order did not show an end date for lorazepam use.</p> <p>Further review of Resident 2's medical record did not show a documented reason for the extension of lorazepam beyond 14 days.</p> <p>On 9/20/24 at 1421 hours, a concurrent interview and medical record review for Resident 2 was conducted with the DON. The DON verified the above findings and stated the PRN order for psychotropic medication should only be limited to 14 days, if the resident required medication more than 14 days, then there should have been a documented reason for extension of the PRN psychotropic medication. The DON was not able to show the documented reason for extension of the lorazepam medication for Resident 2 beyond 14 days.</p>

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683</p> <p>Based on observation, interview, medical record review, and facility document review, the facility failed to ensure daily nutritional and special dietary needs, and preferences were provided for one of 21 final sampled residents (Resident 62) and two nonsampled residents (Residents 592 and 593).</p> <p>* Resident 592's lunch tray did not include gluten free pasta.</p> <p>* Resident 593's lunch tray did not include double portions.</p> <p>* Resident 62 did not have Ensure (supplement) to his lunch tray as per the physician's orders.</p> <p>These failures posed the risk for the residents' foods and nutritional needs not being met.</p> <p>Findings:</p> <p>1. Review of the facility's posted menu showed the lunch menu for 9/18/24, included chicken cacciatore with pasta, and broccoli and cauliflower with Italian green bean salad and cranberry crunch.</p> <p>a. Medical record review for Resident 592 was initiated on 9/18/24. Resident 592 was readmitted to the facility on [DATE].</p> <p>Review of Resident 592's Order Summary Report dated 9/18/24, showed a physician's order dated 9/8/24, for a non-gluten diet.</p> <p>On 9/18/24, during a concurrent lunch tray line observation and interview with the Corporate Dietary Supervisor, Resident 592's tray was pulled from the tray cart for observation. The resident's tray did not have a pasta alternative, the Corporate Dietary Supervisor stated they had prepared a gluten free pasta, but the staff forgot to put it on the resident's tray.</p> <p>b. Medical record review for Resident 593 was initiated on 9/18/24. Resident 592 was admitted to the facility on [DATE].</p> <p>Review of Resident 593's Order Summary Report dated 9/18/24, showed a physician's order dated 9/16/24, for a double portion for meals.</p> <p>On 9/18/24, during a concurrent lunch tray line observation and interview with the Corporate Dietary Supervisor, Resident 593's tray was pulled from the tray cart for observation. Review of Resident 593's lunch tray ticket showed, notes: double portions. The resident's tray had single portions, the Corporate Dietary Supervisor stated it was single portion servings and should have been double portions.</p> <p>50127</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Medical record review for Resident 62 was initiated on 9/18/24. Resident 62 was admitted to the facility on [DATE].</p> <p>Review of Resident 62's Order Summary Report dated 9/18/24, showed a physician's order dated 6/15/24, for may give Ensure with meals.</p> <p>Review of Resident 62's MAR dated 9/2024, showed an entry for may give Ensure with meals.</p> <p>Review of the Nutrition Risk assessment dated [DATE], showed the following:</p> <ul style="list-style-type: none"> - Section A1. Diet Order Regular Puree Supplement: Ensure with meals. - Section J15. Accepting Ensure to help with weight gain goals. - Section J17. Underweight related to poor intake as evidenced by Body Mass Index of 18.6. <p>Review of Resident 62's Plan of care showed a care plan problem for at risk for weight loss, malnutrition, and dehydration dated 6/3/24, and revised 9/13/24. The goal included Resident 2 would receive adequate hydration and nutrition.</p> <p>On 9/17/24 at 1209 hours, an observation and concurrent interview and medical record review was conducted with the IP. Resident 62 was in sitting in the dining room eating his lunch. Resident 62 stated he only received Ensure sometimes, and not with every meal. The IP verified Resident 62 did not have Ensure on his lunch tray and stated Resident 62 should have the Ensure with every meal to make sure the resident received. The IP verified Resident 62 had a physician's order to receive Ensure with every meal.</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>39683</p> <p>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed when:</p> <ul style="list-style-type: none"> * The food and beverages in the walk-in refrigerator were not discarded by the use-by date. * The appropriate hair restraints were not worn by four staff in the kitchen (The DSS, Cooks 1 and 2, and the Maintenance Supervisor). * One uncovered bucket of cleaning chemical was stored next to two containers of broth base and one container of oil. * The cooking utensils, cutting boards did not have cleanable surfaces. * One rubber spatula had white residue on the spatula and handle. * 12 baking sheets had black residue. * The trash can lid was on top of the handwashing sink * One dry goods bin with white granulated powder was unlabeled. * Two dry goods scoops, with powdery white residue, were on the food preparation counter * Two oven mitts were discolored and had frayed edges. <p>These failures had the potential to result in foodborne illnesses for the residents receiving kitchen services.</p> <p>Findings:</p> <p>Review of the facility matrix dated 9/17/24, showed 89 of 92 residents consumed food prepared in the kitchen.</p> <p>1. According to the USDA Food Code 2022 Annex 6 Food Processing Criteria, (F) Recommendations for Safe Curing of Meat and Poultry, (3) HACCP (Hazard Analysis and Critical Control Point: food safety management system that aims to reduce the risk of foodborne illness by identifying and controlling potential problems before they occur) (b) Raw Material Handling (i) Thawing must be monitored and controlled to ensure thoroughness and to prevent temperature abuse. Improperly thawed meat could cause insufficient cure penetration. Temperature abuse can cause spoilage or growth of pathogens.</p> <p>a. On 9/17/24 at 0803 hours, a concurrent observation and interview were conducted with the DSS. Inside the walk-in refrigerator, the following items were observed:</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>- A sealed package of beef, undated and unlabeled as to when it was placed in the refrigerator.</p> <p>- A 20-pound box of diced chicken, undated and unlabeled as to when it was placed in the refrigerator.</p> <p>The DSS stated the beef and chicken packages should have been labeled and dated when they were removed from the freezer for thawing.</p> <p>b. On 9/17/24 at 0803 hours, a concurrent observation and interview were conducted with the DSS. Inside the walk-in refrigerator, the following items were observed:</p> <p>- A container labeled as gelatin with a use-by date of 9/12/24.</p> <p>- A container labeled as grape juice with a use-by date 9/14/24.</p> <p>The DSS also stated the gelatin and grape juice should have been discarded as per their use-by date.</p> <p>2. According to the USDA Food Code 2022, Section 2-402.11 (A), Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils.</p> <p>On 9/17/24 at 1504 hours, a concurrent interview and kitchen observation was conducted with the Maintenance Supervisor and [NAME] 2.</p> <p>-The Maintenance Supervisor was observed on a step stool, over the coffee machine, with parts disassembled while working on the machine. The Maintenance Supervisor was observed with a hair net on; however, the Maintenance Supervisor's ponytail was not tucked in to the hair net and was hanging down.</p> <p>- [NAME] 2 was observed without a covering for his facial hair.</p> <p>On 9/18/24 at 1003 hours, a concurrent puree food preparation observation and interview was conducted with the Corporate Dietary Supervisor. The DSS was observed walking from the back office to the stove, puree preparation area without a facial hair restraint for his beard. The Corporate Dietary Supervisor verified the finding and stated hair should be restrained.</p> <p>3. According to the USDA Food Code 2022, Section 3-304.14 (E), chemical sanitizing solutions in which wet wiping cloths are held between uses shall be stored off the floor and used in a manner that prevents contamination of food and equipment.</p> <p>On 9/17/24 at 1504 hours, a concurrent interview and observation were conducted with the Corporate Dietary Supervisor. A red bucket contained liquid and a rag was observed on the bottom shelf next to two containers of broth base and one container of cooking oil. The Corporate Dietary Supervisor stated it was quaternary ammonium compounds solution (a chemical that cleans and disinfects).</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>4. According to the USDA Food Code 2022 Annex 3 Section 4-201.11 Equipment and Utensils showed, Equipment and utensils must be designed and constructed to be durable and capable of retaining their original characteristics so that such items can continue to fulfill their intended purpose for the duration of their life expectancy and to maintain their easy cleanability. If they cannot maintain their original characteristics, they may become difficult to clean, allowing for the harborage of pathogenic microorganisms, insects, and rodents.</p> <p>On 9/17/24 at 1504 hours, a concurrent kitchen observation and interview were conducted with the Corporate Dietary Supervisor. The following items were observed:</p> <ul style="list-style-type: none"> - One slotted spoon with a melted black handle - Four spatulas with melted handles - One black scoop with a melted handle <p>The Corporate Dietary Supervisor verified the findings.</p> <p>5. According to FDA Food Code 2022, 4-601.11, Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood-contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>On 9/17/24 at 1504 hours, a concurrent kitchen observation and interview was conducted with the Corporate Dietary Supervisor. The following items were observed:</p> <ul style="list-style-type: none"> - 12 baking sheet pans with black greasy residue - A rubber spatula with white residue on the spatula end and handle. - Two dry scoop cups on the counter, with white powdery residue. - Two oven mitts with dark buildup and frayed edges. - Two white cutting boards with visible black markings. <p>The Corporate Dietary Supervisor verified the findings.</p> <p>6. According to FDA Food Code 2022, Section 4-501.12, Cutting Surfaces, surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces.</p> <p>On 9/17/24 at 1504 hours, a concurrent kitchen observation and interview was conducted with the Corporate Dietary Supervisor. A red cutting boards with a scored surface from use was observed. The Corporate Dietary Supervisor verified the finding.</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>7. According to the USDA Food Code 2022, 5-204.11 Handwashing Sinks, hands are a common vehicle for the transmission of pathogens to foods and can become soiled with a variety of contaminants during routine operations. The transfer of contaminants can be limited by providing food employees with handwashing sinks that are properly equipped and conveniently located. Handwashing sinks that are blocked by portable equipment or stacked full of soiled utensils and other items, are rendered unavailable for employee use. Nothing must block the approach to a handwashing sink thereby discouraging its use, plus it must be kept clean and well stocked with soap and sanitary towels to facilitate frequent use.</p> <p>On 9/20/24 at 0827 hours, a concurrent kitchen observation and interview was conducted with the Maintenance Supervisor. Upon entering the kitchen, the lid of a portable trash receptacle was observed on top of the handwashing sink and wheeled trash receptacle. Two kitchen staff were discarding food items into the trash receptacle. The Maintenance Supervisor stated the trash can lid should not be on top of the hand washing sink.</p> <p>8. On 9/17/24 at 1504 hours, a concurrent kitchen observation and interview was conducted with the Corporate Dietary Supervisor. A bulk bin with a white granulated powder was observed, unlabeled.</p> <p>The Corporate Dietary Supervisor stated it was the thickener and the bin should be labeled with its contents.</p>		

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<p>F 0814</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>39683</p> <p>Based on observation and interview, the facility failed to dispose and store trash in a sanitary manner. This failure posed a threat for pest contamination.</p> <p>Findings:</p> <p>According to the US Food Code 2013, 5-501.113, Covering Receptacles, receptacle units for refuse shall be kept covered with tight fitting lids after they are filled.</p> <p>On 9/20/24 at 0827 hours, an observation of the facility's trash dumpsters and recycling bin was conducted with the Maintenance Supervisor. The following was observed:</p> <ul style="list-style-type: none"> - One of one recycling bin was observed with flattened cardboard boxes piled above the rim of the bin, preventing the lids from closing properly. - Two of two trash dumpsters were observed with black trash bags preventing the lids from closing properly. <p>The Maintenance Supervisor stated the trash and recycle bin lids should be closed fully, and not propped up, to prevent pests from getting into the bins.</p>

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49780</p> <p>Based on interview, medical record review, and the facility document review, the facility failed to ensure one of three nonsampled residents (Resident 45) reviewed for arbitration, who had no mental capacity to understand the terms of the facility's binding arbitration agreement (an agreement that allows parties to resolve disputes and lawsuits privately rather than going to the court) did not sign the Arbitration Agreement. This failure posed the risk for the resident to not have a clear understanding of the arbitration process.</p> <p>Findings:</p> <p>Medical record review for Resident 45 was initiated on 9/20/24. Resident 45 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 45's MDS - Section C dated 6/6/24, showed the resident's BIMS score was 6 which meant he had severe cognitive impairment.</p> <p>Review of the Arbitration Agreement showed a notice: by signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See article 1 of this contract was signed by Resident 45 on 7/22/24.</p> <p>Review of Resident 45's H&P examination dated 7/23/24, showed the resident did not have the capacity to make medical decisions.</p> <p>On 9/20/24 at 0933 hours, an interview was conducted with the Admission Director. The Admissions Director stated Resident 45 was confused lately, and he had explained to Resident 45 about the Arbitration Agreement before; however, he was not sure if Resident 45 understood everything. The Admissions Director also stated he should not have let Resident 45 sign the Arbitration Agreement.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44175</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for two of two final sampled residents reviewed for hospice services (Residents 2 and 13).</p> <p>* The facility failed to ensure the hospice was notified regarding significant weight loss for Residents 2 and 13.</p> <p>* The facility failed to ensure Resident 2 received the hospice nursing visits two times per week as per the plan of care.</p> <p>These failures posed the risk for delays in the communication between the hospice provider and the facility which may affect resident care.</p> <p>Findings:</p> <p>1. Review of the facility's P&P titled Weight Assessment and Intervention dated May 2023 showed the resident weights are monitored for undesirable or unintended weight loss or gain. The P&P showed the suggested parameters:</p> <p>a). 1 months- 5% weight loss is significant, greater than 5% is severe;</p> <p>b). 3 month- 7.5% weight loss is significant; greater than 7.5% is severe; and,</p> <p>c). 6 months- 10% weight loss is significant; greater than 10% is severe.</p> <p>Review of the facility P&P titled Hospice Program revised 7/2017 showed hospice services are available to the residents at the end of life. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident needs. These responsibilities include notifying the hospice about a significant change in the resident's physical, mental, social, or emotional status.</p> <p>a. Medical record review for Resident 13 was initiated on 9/18/24. Resident 13 was admitted to the facility on [DATE].</p> <p>Review of Resident 13's Weight Change Note dated 9/13/24, at 2041 hours, showed Resident 13's weights on following dates:</p> <p>- on 3/4/24, 116 pounds;</p> <p>- on 6/4/24, 117 pounds;</p> <p>- on 8/6/24, 105 pounds; and,</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 9/6/24, 103 pounds.</p> <p>Further review of Resident 13's Weight Change Note showed Resident 13 had 12 % weight loss in 3 months and 11.2% weight loss in 6 months.</p> <p>Review of Resident 13's Physician Order Summary dated 4/19/24 showed to admit Resident 13 to hospice services on a routine level of care.</p> <p>Review of Resident 13's medical record did not show the hospice was notified for the above weight changes.</p> <p>On 9/20/24 at 0859 hours, a concurrent interview and medical record review for Resident 13 was conducted with RN 1. RN 1 verified the above finding. RN 1 stated Resident 13 had a significant weight change identified on 9/13/24. RN 1 verified this was a change of condition for the Resident 13 and the hospice should have notified.</p> <p>On 9/20/24 at 0912 hours, a concurrent interview and medical record review for Resident 13 was conducted with the DON. The DON verified and acknowledged the above findings.</p> <p>Cross references to F656 example #1.b and F692, example #1.</p> <p>51539</p> <p>b. Medical record review for Resident 2 was initiated on 9/17/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of the Order Summary Report for September 2024 showed an order dated 7/29/24, to admit the resident to the hospice services for a routine care level.</p> <p>Review of Resident 2's monthly weight record in the PCC log showed the following:</p> <ul style="list-style-type: none"> - The resident had a six pounds weight loss in a month from 110 lbs in August to 104 lbs in September 2024 which was a significant weight loss of 5.45% in a month. - The resident had 32 weight loss in six month (from 136 lbs in March to 104 lbs in September 2024, 23.5% weight loss in 6 months). <p>Further review of Resident 2's medical record showed no documented evidence the hospice services was informed of the resident's significant weight loss.</p> <p>On 9/20/24 at 1428 hours, an interview and concurrent medical record review was conducted with the DON. When asked regarding the notification of significant changes to the hospice, the DON stated the nursing supervisor contacted the hospice of any changes. However, the DON was not able to provide documentation showing the hospice was notified regarding significant weight loss identified for one month and six month for Resident 2.</p> <p>49780</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the facility's P&P titled Hospice Program revised 7/2017 showed the facility has the responsibility to coordinate with the hospice representative to meet the resident's personal care and nursing needs and to ensure that the level of care provided appropriately based on the resident's needs.</p> <p>Medical record review for Resident 2 was initiated on 9/20/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 2's Order Summary Report showed the resident was admitted to Hospice Provider A on 7/29/24.</p> <p>Review of Hospice Provider A's Integrated Hospice and Facility Plan of Care for Resident 2 showed the frequency for the hospice nurse visit was two times per week for assessment and case management.</p> <p>Review of Resident 2's Staff Sign-In Sheet from Hospice Provider A showed the following visits were conducted by the hospice nurses:</p> <ul style="list-style-type: none"> - on 7/29/24, by Hospice RN 1 - on 8/1/24, by Hospice RN 1 - on 8/12/24, by Hospice RN 1 - on 8/20/24, by Hospice RN 1 - on 8/22/24, by Hospice RN 1 - on 9/3/24, by Hospice RN 1 - on 9/10/24, by Hospice LVN 1 - on 9/13/24, by Hospice RN 1 - on 9/17/24, by Hospice LVN 1 <p>Review of the Hospice Provider A's Staff Sign-in Sheet for Resident 2 showed the frequency of twice a week visits for resident assessment and case management from hospice licensed nurses was not followed.</p> <p>On 9/20/24 at 1449 hours, an interview and concurrent Hospice document review was conducted with LVN 3. LVN 3 verified the hospice licensed nurses did not visit Resident 2 two times per week as shown on the plan of care.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>35346</p> <p>The facility failed to ensure the equipment was maintained in the safe operating condition when:</p> <ul style="list-style-type: none"> * The facility's freezer compartments had ice buildup for two of two medication refrigerators. * One of one ice machines had black tape, a non-cleanable surface, and brownish-red residue inside. <p>These failures had the potential to affect the resident's health and well-being.</p> <p>Findings:</p> <p>1. On 9/18/24 at 1025 hours, a concurrent observation and interview was conducted with RN 1. Station 2 medication refrigerator inspection showed ice buildup. RN 1 verified the freezer compartment for the medication refrigerator in Station 2 had ice buildup.</p> <p>On 9/18/24 at 1110 hours, a concurrent observation and interview was conducted with RN 2. Station 1 medication refrigerator inspection showed ice buildup. RN 2 verified the freezer compartment for the medication refrigerator in Station 1 had ice buildup.</p> <p>39683</p> <p>2. On 9/20/24 at 0827 hours, a concurrent observation and interview was conducted with the Maintenance Supervisor and Corporate Dietary Supervisor. During an inspection of the ice machine, the Maintenance Supervisor removed two of the ice machine side panels, where the following was observed:</p> <ul style="list-style-type: none"> - Black duct tape on the plastic ice harvester curtain. - Reddish-brown residue on a gray water pipe. - Reddish-brown residue on a white insulated wire. <p>The Maintenance Supervisor stated the black tape was applied approximately a year ago by an outside vendor to repair a crack in the plastic. The Corporate Dietary Supervisor wiped the wire with a clean paper towel and verified some of the residue transferred onto the paper towel. The Corporate Dietary Supervisor stated the ice machine needed to be cleaned.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>39683</p> <p>Based on observation and interview, the facility failed to ensure the facility was free of pests in one resident's room, and the kitchen.</p> <p>* A fly was observed in Resident 10's room and on their uncovered cup of milk and on the opening of their bedside insulated water mug.</p> <p>* A fly was observed in the kitchen on multiple occasions over two days, by the coffee machine, puree food preparation and tray line areas.</p> <p>These failures had the potential for transmission of foodborne illness to the residents.</p> <p>Findings:</p> <p>1. On 9/17/24 at 1504 hours, during a kitchen observation, a fly was observed flying around by the coffee makers, then the stove area.</p> <p>On 9/18/24 at 1003 hours, during the puree food preparation observation, a fly was observed flying around the kitchen by the preparation and tray line area.</p> <p>On 9/18/24 at 1157 hours, a tray line observation in the kitchen was conducted. During the facility's lunch tray line, a fly was observed on a covered loaf of bread. The Corporate Dietary Supervisor verified the observation of fly.</p> <p>2. On 9/17/24 at 1245 hours, Resident 10 was observed lying in bed with a fly observed flying around the room, the fly then landed on an unoccupied bed in the same room. The room's window was open approximately six inches, and there was no screen in place. CNA 2 brought Resident 10's lunch tray and placed it on the resident's tray table. CNA 2 verified the fly and the open window without a screen. CNA 2 then closed the window.</p> <p>On 9/17/24 at 1302 hours, a fly was observed flying around Resident 10's lunch tray. The fly landed on the rim of Resident 10's cup of milk, then flew and landed on the top opening of Resident 10's insulated drinking mug. CNA 2 entered the room, observed the fly on the resident's water mug, and verified it was the resident's water.</p>		