

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Medallion Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 E Bijou St Colorado Springs, CO 80909	

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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853</p> <p>Based on observations, record review and interviews, the facility failed to ensure residents were treated with respect and dignity for two (#4 and #5) of five residents reviewed out of 33 sample residents by providing care in a dignified, respectful and individualized manner.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure staff knocked or announced themselves prior to entering Resident #4's room; and, -Ensure Resident #5 was provided with timely incontinence care when requested. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Dignity and Respect policy, dated April 2024, was provided by the nursing home administrator (NHA) on 8/15/24 at 9:12 p.m. It read in pertinent part,</p> <p>It is the policy of this facility that all residents be treated with kindness, dignity and respect.</p> <p>Residents will be appropriately dressed in clean clothes arranged comfortably on their persons, and be well groomed.</p> <p>Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the resident from passers-by.</p> <p>Staff members shall knock before entering the residents' room.</p> <p>II. Resident #4</p> <p>A. Resident status</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #4, age 82, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with diabetic peripheral angiopathy (narrowing of the arteries decreasing blood flow), chronic kidney disease, heart failure, chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), major depressive disorder and anxiety.</p> <p>The 7/13/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She could hear adequately, was able to understand others and made herself understood.</p> <p>B. Resident observations and interview</p> <p>On 8/13/24 at 10:35 a.m. certified nurse aide (CNA) #1 entered Resident #4's room without knocking or announcing herself. CNA #1 walked into the room and delivered hot tea to Resident #4. Resident #4 said staff did not always knock. She said sometimes the staff came into her room and did not even speak to her.</p> <p>On 8/13/24 at 1:52 p.m. CNA #1 entered Resident #4's room without knocking. CNA #1 took the resident's lunch plate cover from the room and left without speaking to the resident or her roommate.</p> <p>On 8/15/24 at 1:21 p.m. CNA #2 entered Resident #4's room without knocking. She delivered the lunch tray to Resident #4's roommate, sat it on the bedside table and left without speaking to either resident.</p> <p>C. Staff interviews</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 8/15/24 at 3:19 p.m. LPN #1 said staff should knock and announce themselves prior to entering a residents' room. She said staff should let the resident know who they were and what they were going to do.</p> <p>The director of nursing (DON) was interviewed on 8/15/24 at 5:45 p.m. The DON said staff should knock and announce themselves before entering a residents' room.</p> <p>III. Resident #5</p> <p>A. Resident status</p> <p>Resident #5, age 68, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included type 2 diabetes mellitus, chronic respiratory failure, hypertension (high blood pressure), chronic obstructive pulmonary disease and bipolar disorder (a mental illness causing severe mood swings).</p> <p>The 7/25/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She was dependent on staff for transfers and toileting hygiene. She was frequently incontinent of urine.</p> <p>B. Resident observations and interview</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/13/24 at 1:12 p.m. Resident #5 told an unidentified CNA that she needed her brief changed before she went to the music program that started at 2:00 p.m. Resident #5's husband assisted the resident to her room and turned the call light on.</p> <p>During a continuous observation on 8/13/24, beginning at 1:17 p.m. and ending at 1:40 p.m. the following was observed:</p> <p>At 1:17 p.m. CNA #5 went into Resident #5's room and turned off the call light. CNA #5 said she had to help another resident and would be back.</p> <p>At 1:28 p.m. CNA #5 was pushing a mechanical lift into another resident's room.</p> <p>At 1:30 p.m. CNA #2 was picking up lunch trays from two residents' rooms.</p> <p>At 1:40 p.m. Resident #5's husband came into the hall and told CNA #5 that the staff ran out of time and Resident #5 needed to go to the activity program. The resident's husband assisted Resident #5 to the activity program without having her brief changed.</p> <p>-Resident #5 had waited 28 minutes for CNA #5 to return to her room to provide her assistance.</p> <p>At 3:07 p.m. Resident #5 returned from the activity and went into her room. She turned on her call light.</p> <p>-Resident #5 had been in a wet brief for one hour and 55 minutes after informing a staff member she needed her brief changed.</p> <p>At 3:08 p.m. registered nurse (RN) #2 went to Resident #5's room. RN #2 left, did not turn off the call light and retrieved the mechanical lift. CNA #2 and RN #2 took the mechanical lift into Resident #5's room. RN #2 said they were going to lay Resident #5 down and change her.</p> <p>Resident #5 was interviewed on 8/14/24 at 11:23 a.m. Resident #5 said she was upset when she did not get her brief changed before she went to the music program activity on 8/13/24. She said she was uncomfortable sitting in the wet brief during the program.</p> <p>C. Staff interviews</p> <p>CNA #5 was interviewed on 8/15/24 at 3:42 p.m. CNA #5 said if a resident was incontinent, staff should check on them every two hours and change their brief if needed. CNA #5 said Resident #5 used her call light when she needed to be changed but sometimes she forgot so the staff needed to check on her. CNA #5 said it was important to change incontinent residents frequently to prevent skin breakdown.</p> <p>The DON was interviewed on 8/15/24 at 5:45 p.m. The DON said residents should be checked on for incontinence care at a minimum of every two hours. The DON said it was a priority for CNAs to change an incontinent resident before picking up room trays.</p> <p>48114</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** 48114</p> <p>Based on observations, record review and interviews, the facility failed to provide reasonable accommodations necessary to accommodate mobility and accessibility in the resident's environment for one (#8) of one resident reviewed out of 33 sample residents.</p> <p>Specifically, the facility failed to ensure Resident #8's call light was consistently accessible to her.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Call Lights Accessibility and Timely Response policy and procedure, undated, was provided by the nursing home administrator (NHA) on 8/15/24 at 9:12 p.m. It read in pertinent part, The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance.</p> <p>Call lights will directly relay to a staff member or centralized location to ensure appropriate response.</p> <p>All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light.</p> <p>All residents will be educated on how to call for help by using the resident call system.</p> <p>Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system.</p> <p>Staff will ensure the call light is within reach of the resident and secure, as needed.</p> <p>II. Resident #8</p> <p>A. Resident status</p> <p>Resident #8, age 83, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease and dementia.</p> <p>The 7/20/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of two out of 15. She was dependent on staff assistance with toileting hygiene, upper and lower body dressing, putting on/taking off footwear, sitting to lying, lying to sitting on side of bed, sitting to standing, chair to bed/bed to chair transfers and toileting transfers.</p> <p>III. Resident interview and observations</p> <p>(continued on next page)</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>Resident #8 was interviewed on 8/12/24 at 3:30 p.m. Resident #8 said she did not know where her call light was.</p> <p>-Resident #8's call light was on the floor at the foot of her bed.</p> <p>On 8/13/24 at 9:35 a.m. an unidentified staff member entered Resident #8's room. The resident's call light was on the floor at the foot of her bed.</p> <p>At 9:41 a.m. the unidentified staff member exited Resident #8's room. The resident's call light was still on the floor.</p> <p>-The unidentified staff member did not pick the call light up off of the floor and place it within reach of Resident #8 while in the resident's room.</p> <p>During a continuous observation on 8/13/24, beginning at 1:45 p.m. and ending at 4:52 p.m., the following was observed:</p> <p>At 1:45 p.m. an unidentified staff member entered Resident #8's room and closed the door.</p> <p>At 1:47 p.m. the unidentified staff member exited Resident #8's room and the call light was located on the floor at the foot of the resident's bed.</p> <p>-The unidentified staff member did not pick the call light up off of the floor and place it within reach of Resident #8 while in the resident's room.</p> <p>At 2:29 p.m. an unidentified staff member entered the resident's room. Resident #8 was lying down in her bed and her call light was on the floor at the foot of her bed.</p> <p>-The unidentified staff member did not pick the call light up off of the floor and place it within reach of Resident #8 while in the resident's room.</p> <p>At 4:12 p.m. an unidentified staff member entered the resident's room. The resident was lying down in bed and her call light was on the floor at the foot of her bed.</p> <p>-The unidentified staff member did not pick the call light up off of the floor and place it within reach of Resident #8 while in the resident's room.</p> <p>At 4:48 p.m. an unidentified staff member entered Resident #8's room and closed the door.</p> <p>At 4:52 p.m. the unidentified staff member exited the room. The resident was lying in her bed and the call light was located on the floor at the foot of her bed.</p> <p>-The unidentified staff member did not pick the call light up off of the floor and place it within reach of Resident #8 while in the resident's room.</p> <p>On 8/14/24 at 9:31 a.m. an unidentified staff member entered Resident #8's room. The resident was in bed lying down and her call light was located on the floor at the foot of her bed.</p> <p>(continued on next page)</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>LPN #2 said the call light should never be placed on the floor where it was out of reach for the resident. She said if the call light was on the floor or out of reach then the resident could not call for help and that could be a problem. She said any staff who went into Resident #8's room should have picked up her call light and put it within reach.</p> <p>LPN #2 said she was not sure if Resident #8 was able to use her call light. She said she thought Resident #8 might not have been able to use her call light due to her cognition.</p> <p>The director of nursing (DON) was interviewed on 8/15/24 at 6:02 p.m. The DON said the call light needed to be within reach when a resident was in bed and within reach while a resident was in a chair where the resident could reach it safely. She said if the call light was not within reach, the staff needed to move it so that it was within reach. She said the staff should be checking at least every hour to ensure the call light was within reach. She said the call light should never be on the floor.</p> <p>The DON said Resident #8 could use her call light but chose not to and would yell out for help instead. She said Resident #8 kicked the call light off her bed. She said the staff should be doing rounding and checking on those things to make sure the call light was within reach for all of the residents.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185</p> <p>Based on observations, record review and interviews, the facility failed to honor resident choices for four (#7, #59, #4 and #23) of six residents out of 33 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure Residents #59, #7 and #4 received bathing according to their comprehensive choice and plan of care; and, -Ensure Resident #23 was provided assistance to be able to hear his television when he had a conflict with his roommate. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Resident Rights policy and procedure, revised April 2022, was provided by the nursing home administrator (NHA) on 8/15/24 at 9:15 p.m. It revealed in pertinent part, It is the policy of this facility that all resident rights be followed per state and federal guidelines as well as other regulatory agencies.</p> <p>To be treated with consideration, respect, and full recognition of his or her dignity and individuality.</p> <p>II. Resident #59</p> <p>A. Resident status</p> <p>Resident #59, age 72, was admitted on [DATE] and readmitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included Parkinson's disease.</p> <p>The 8/7/24 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. He required partial or moderate assistance with activities of daily living.</p> <p>B. Resident interview</p> <p>Resident #59 was interviewed on 8/13/24 at 10:07 a.m. He said had only received one shower since he had been admitted to the facility. He said he usually showered multiple times a week when he was home. He said he was only offered two showers per week when he was admitted .</p> <p>Resident #59 said he was frustrated because he was promised he would receive two showers per week and the facility had not honored that promise.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>C. Record review</p> <p>The self-care deficit care plan, initiated on 7/12/24, documented Resident #59 had a self-care performance deficit due to a diagnosis of Parkinson's disease. It indicated that the resident required the assistance of one to two staff members for bathing.</p> <p>The July 2024 certified nurse aide (CNA) shower task documentation revealed Resident #59 did not receive bathing between his admission on 7/11/24 to 7/18/24, when the resident returned to the hospital. The documentation indicated the resident refused bathing on one occasion on 7/17/24.</p> <p>-Resident #59 should have received two showers during that one week timeframe in July 2024.</p> <p>The August 2024 CNA shower task documentation revealed Resident #59 received bathing once, on 8/4/24, between 8/1/24 to 8/15/24.</p> <p>-Resident #59 should have received four showers during the two week timeframe in August 2024.</p> <p>III. Resident #7</p> <p>A. Resident status</p> <p>Resident #7, age 88, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included heart failure, chronic respiratory failure with hypoxia, type 2 diabetes, unsteadiness on feet and pain in the left knee.</p> <p>The 7/13/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was dependent upon staff for bathing assistance and partial to moderate assistance with toileting and dressing.</p> <p>B. Resident interview</p> <p>Resident #7 was interviewed on 8/12/24 at 2:51 p.m. Resident #7 said she was frustrated because she had not been receiving showers according to the established schedule. She said she was supposed to receive a shower on Mondays and Thursdays but she did not always get them. She said the facility had recently changed the shower aides schedule and ever since, she said she had not been receiving her showers.</p> <p>C. Record review</p> <p>The Kardex (a tool utilized to enable staff to provide consistent care) documented Resident #7 should receive showers on Tuesday and Friday evenings. The resident required substantial to maximum assistance of staff for bathing.</p> <p>-However, according to Resident #7, her showers were supposed to be on Mondays and Thursdays (see resident interview above).</p> <p>The June 2024 CNA shower task documentation revealed Resident #7 only received a shower on four occasions (6/3/24, 6/6/24, 6/13/24 and 6/27/24) out of eight opportunities, missing four showers.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The July 2024 shower documentation revealed Resident #7 only received a shower on five occasions (7/4/24, 7/8/24, 7/11/24, 7/22/24 and 7/29/24) out of nine opportunities, missing four showers.</p> <p>The August 2024 shower documentation, from 8/1/24 to 8/15/24, revealed Resident #7 only received a shower on two occasions (8/5/24 and 8/12/24) out of four opportunities, missing two showers.</p> <p>IV. Resident #4</p> <p>A. Resident status</p> <p>Resident #4, age 82, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included type 2 mellitus diabetes with diabetic peripheral angiopathy (narrowing of the arteries decreasing blood flow), chronic kidney disease, heart failure, chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), major depressive disorder and anxiety.</p> <p>The 7/13/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She could hear adequately, was able to understand others and made herself understood. Resident #4 was dependent on staff for bathing and did not reject care during the assessment period.</p> <p>B. Resident interview</p> <p>Resident #4 was interviewed on 8/15/24 at 9:17 a.m. Resident #4 said a CNA offered her a shower on 8/14/24 but she declined due to her recent surgery. She said the CNA did not offer her a bed bath.</p> <p>C. Record review</p> <p>The activities of daily living (ADL) care plan, initiated 10/17/18, indicated Resident #4 required substantial assistance with bathing and two-person assistance to transfer her into a shower chair. Resident #4 preferred showers.</p> <p>The behavior care plan, initiated 8/29/17, revealed Resident #4 would refuse showers at times. Interventions included leaving and returning five to 10 minutes later and offering care again.</p> <p>The CNA task shower documentation in Resident #4's electronic medical record (EMR) revealed Resident #4 was to have a shower every Wednesday.</p> <p>The CNA shower task documentation was reviewed from 4/1/24 through 8/14/24. The documentation revealed the following:</p> <ul style="list-style-type: none"> -Resident #4 received a shower on two out of four Wednesdays in April 2024; -Resident #4 received a shower on two out of five Wednesdays in May 2024; -Resident #4 received a shower on two out of four Wednesdays in June 2024; -Resident #4 received a shower on three out of five Wednesdays in July 2024; and, <p>(continued on next page)</p>

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident #4 received a shower on one out of two Wednesdays in August 2024.</p> <p>-From 4/1/24 through 8/14/24, Resident #4 received 10 showers out of 20 opportunities for a shower.</p> <p>The CNA shower task documentation further revealed Resident #4 refused her shower five times and there was no documentation regarding whether or not a shower occurred on five occasions from 4/1/24 through 8/14/24.</p> <p>-Review of Resident #4's nurse progress notes revealed no documentation from 4/1/24 through 8/14/24 to indicate the resident refused her shower on the five dates the documentation was left blank, the reason for the five shower refusals or if the resident was reapproached at a later time when she refused her shower.</p> <p>V. Staff interviews</p> <p>CNA #6 was interviewed on 8/15/24 at 3:53 p.m. CNA #6 said she offered Resident #4 a shower on 8/14/24 but Resident #4 declined. CNA #6 said she forgot to chart the refusal for 8/14/24 and that was why the charting was blank. CNA #6 said Resident #4 preferred a shower one time per week. She said sometimes she did not feel good and did not want a shower. CNA #6 said if the resident refused her shower, she would offer one the next day or on Saturdays.</p> <p>CNA #3 was interviewed on 8/15/24 at 5:20 p.m. CNA #3 said the facility used to have two shower aides but currently only had one. She said the facility had recently changed their hours from eight hour shifts five days per week to 10 hour shifts three days per week. She said she found the schedule change made it very difficult to provide showers to all the residents.</p> <p>CNA #3 said the shower aides were the staff members who provided showers to the residents. She said the floor CNAs did not provide showers. She said the other shower aide was injured so she had been the only shower aide for the past few weeks. CNA #3 said she tried her best to get to all of the residents' showers but sometimes she was not successful.</p> <p>The director of nursing (DON), the NHA and the clinical consultant (CC) were interviewed on 8/15/24 at 5:44 p.m. The DON said the facility employed two shower aides to provide all the resident showers throughout the facility. She said she had recently changed the shower aide schedule from eight hours five days per week to three days per week for 10 hours per day. She said she changed the shower aide schedules to address the staffing needs.</p> <p>The DON said the shower aides should document which residents did not receive a shower and provide that list to the nurse at the end of their shift. She said if a resident did not receive a shower, that resident should receive a shower the next day.</p> <p>The DON said she was aware the showers were not being completed according to the shower schedule. She said the shower schedule was a work in progress.</p> <p>The NHA said the facility would look at the shower aide schedule again to see if another alteration needed to be made to ensure residents were receiving their showers per their preferences.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>48114</p> <p>VI. Resident #23</p> <p>A. Resident status</p> <p>Resident #23, age 71, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included hemiplegia and hemiparesis (impaired communication between the brain and muscles) and chronic systolic (congestive) heart failure.</p> <p>The 2/2/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He was dependent on staff assistance for showering/bathing himself, lower body dressing, putting on/taking off footwear, lying to sitting, sitting to stand, chair to bed and bed to chair transferring and tub/shower transferring.</p> <p>B. Resident interview</p> <p>Resident #23 was interviewed on 8/14/24 at 8:49 a.m. Resident #23 said his roommate kept the television on all the time and it was loud. He said he could not hear his television and could not sleep due to the noise level. He said he talked to staff about the problem and was informed that if he filed a grievance then he would need to move to a different room. He said the facility staff did not provide any other solutions for the problem and told him he would have to deal with it.</p> <p>Resident #23 was interviewed on 8/15/24 at 11:55 a.m. Resident #23 said when his roommate had his television on loud then he would turn the volume up on his television so that he was able to hear. He said it was a constant problem that he dealt with every day. He said the facility staff did not offer to provide headphones or address the situation.</p> <p>C. Record review</p> <p>The care plan for psychosocial needs, revised 5/13/24, revealed Resident #23 had the potential for psychosocial well-being problems related to a recent disagreement with another resident in the facility. Interventions included consulting with psychiatric services, which the resident declined, encouraging the resident to attend activities and meals in the dining room and social services to provide psychosocial check-ins as needed.</p> <p>A progress note dated 4/27/24 documented Resident #23 had a noise complaint made by the resident's roommate. The registered nurse (RN) went into Resident #23's room and asked him if he could turn down his music to a respectable level. Resident #23 proceeded to turn up his music. The resident's roommate then turned up his television louder than the music. Resident #23 was asked two more times by the assigned certified nurse aide (CNA) as well as the assigned RN to turn the music down and Resident #23 did not comply.</p> <p>-The nursing progress note did not document any interventions put into place to address the noise level concerns for either resident.</p> <p>D. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The social services director (SSD) was interviewed on 8/15/24 at 3:32 p.m. The SSD said she was responsible for handling problems/concerns between residents but she said she got other staff/administrators involved when needed.</p> <p>The SSD said it was not the facility protocol to move someone to a different room when there was a problem/concern between roommates. She said moving someone was not the only solution and other interventions could be implemented. She said she could get the resident headphones to help with the noise complaint. She said she was not informed about the concern between the two roommates.</p> <p>The SSD said she would reeducate staff and let them know if there were any problems/concerns between roommates to notify social services. She said she would follow up with Resident #23 regarding his concern with the noise of his roommate's television.</p> <p>LPN #1 was interviewed on 8/15/24 at 5:06 p.m. LPN #1 said said Resident #23's roommate had brought up concerns about Resident #23's television noise. She said that before both residents got into bed she reminded both of them to be mindful of each other's environment. She said both residents were hard of hearing.</p> <p>LPN #1 said it had never been discussed that Resident #23 would have to move rooms. She said moving rooms was not a solution to the problem. She said if there were any threatening behaviors, that would warrant a room move but a noise complaint would not warrant a room move. She said she was not sure where Resident #23 would have gotten the information about needing to move. She said it was not standard practice to move someone for a noise complaint.</p> <p>CNA #4 was interviewed on 8/15/24 at 5:20 p.m. CNA #4 said he was aware of television volume concerns between Resident #23 and his roommate. He said he had gone into the room on occasions and turned down the volume.</p> <p>The SSD was interviewed a second time on 8/15/24 at 6:00 p.m. She said she spoke with Resident #23 and his roommate. She said she provided headphones to Resident #23's roommate. She said he was agreeable to use the headphones to solve the problem with the noise level of the television.</p> <p>The DON was interviewed on 8/15/24 at 6:48 p.m. The DON said Resident #23's roommate should have been offered headphones since he liked to listen to his television loudly.</p> <p>The DON said moving residents out of their room was not the process or protocol. She said staff should be mediators, help residents and involve social services when needed.</p> <p>50853</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>38185</p> <p>Based on record review and interviews, the facility failed to ensure prompt action was taken upon the filing of a grievance of a group.</p> <p>Specifically, the facility failed to make prompt efforts to resolve resident grievances about a variety of concerns, including grievances not being answered in a timely manner, staffing shortages with provision of timely care and responding to resident call lights.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Grievance policy and procedure, revised August 2024, was provided by the nursing home administrator (NHA) on 8/15/24 at 9:14 p.m. It read in pertinent part, It is the policy of this facility to establish a grievance process to address resident concerns without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, other concerns regarding their facility stay and make prompt efforts to resolve grievances the resident may have.</p> <p>The facility's grievance official is responsible for overseeing the grievance process, receiving and tracking grievances; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident, if requested and coordinating with state and federal agencies as necessary.</p> <p>The grievance official evaluates and investigates the concern and takes immediate action to resolve the concern and prevent further potential violations of any resident's right while the alleged violation is being investigated.</p> <p>The grievance official or designee responds to the individual expressing the concern within three working days of the initial concern to acknowledge receipt and describe steps taken toward resolution.</p> <p>II. Resident group interview</p> <p>Six alert and oriented residents (#23, #17, #22, #52, #1 and #3) who regularly attended the resident council meetings were interviewed on 8/14/24 at 10:08 a.m. The residents were identified as alert and oriented through facility and assessment.</p> <p>The group of residents said they had turned in grievances and the staff did not get back to them regarding the concerns. The residents said they were unhappy with the staff shortages, especially the certified nurse aides (CNA).</p> <p>The group of residents said the facility needed more staff, especially during the hours of 2:00 p.m. to 10:00 p. m. and on the weekends. The group of residents said most days they only had one CNA working the hallways.</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 - Some</p>	<p>Resident #22 said he was told that the facility did not use agency staff.</p> <p>The group of residents all discussed how long they had had to wait for call lights to be answered by staff. The group of residents said when they turned on their call lights, staff should be coming into their rooms to find out what was going on. The group of residents said most days the staff just walked by and ignored their call lights.</p> <p>Resident #23 and Resident #17 said they had had a couple of accidents where they had an incontinence episode because the staff did not answer their call light in a timely manner.</p> <p>The group of residents said they had had to wait 20 to 30 minutes before staff would respond to their call lights. The group of residents said the facility needed extra CNAs to walk the halls and help the residents.</p> <p>III. Additional resident interviews</p> <p>Resident #7, who was cognitively intact based on facility assessment, was interviewed on 8/12/24 at 2:51 p. m. Resident #7 said it took a long time for call lights to be answered at the facility. She said when she activated her call light, the staff would talk to her roommate first, even though she was the one who had activated the call light. She said it took even longer for the staff to attend to her needs because of that.</p> <p>Resident #7 said the staff would often enter her room, turn off her call light, ask her what she wanted and then say they would return. However, she said staff would not come back. She said she felt like the staff did not care about the residents. She said there had been a lot of recent turnover with the nursing staff and the new staff did not care like the other staff had.</p> <p>Resident #7 said she had expressed her concerns to the nursing staff during care conferences and her family had brought it up to management staff. She said the facility staff had not followed up on her concerns and she felt they were not being addressed.</p> <p>Resident #14, who was cognitively intact based on facility assessment, was interviewed on 8/12/24 at 3:21 p. m. Resident #14 said she let the facility staff know her concerns constantly but felt they did not care and her concerns were not addressed. She said an example was the call lights. She said it would take between 30 minutes to over an hour to get the call light answered, especially on the weekends. She said she had sat in her dirty brief for over an hour at times waiting for someone to come in and provide her assistance.</p> <p>Resident #14 said she had expressed her concerns to the director of nursing (DON) on multiple occasions, however, she said the problems never got any better. She said she did not think the DON liked her very much and would disregard any of her concerns.</p> <p>Resident #14 said there had been a lot of nursing staff turnover recently and she felt the environment at the facility was not a caring environment.</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 - Some</p>	<p>Resident #14 said, that morning (8/12/24), the nursing staff did not wake her up in time for breakfast. She said by the time she woke up, the CNA told her breakfast was over and she could not have anything. She said she ate cereal and a banana every morning for breakfast. She said her favorite CNA, who was working another hallway, entered her room around 10:15 a.m. to see how she was doing. She said that CNA, after being told the resident did not have breakfast, went to the kitchen and got her cereal and a banana. She said this particular CNA was rare and was one of the only staff members who truly cared about the residents.</p> <p>Resident #14 said she had written up a lot of grievances. She said she turned them into the nursing staff or the DON and then would not hear any follow up. She said her concerns were never addressed.</p> <p>Resident #36, who was cognitively intact based on facility assessment, was interviewed on 8/13/24 at 9:38 a.m. Resident #36 said he felt the nursing staff at the facility did not care about the residents. He said when he would voice a concern, he felt like it fell on deaf ears. He said he had expressed his concerns a lot and did not feel like the facility tried to resolve them.</p> <p>Resident #36 said he had expressed on multiple occasions his frustration with his medications being administered late. He said the nursing staff would answer his call light and say they would be back but then not return. He said he would often find the staff sitting in the computer room on their cell phones and call lights would be going off in the hallway.</p> <p>Resident #59, who was cognitively intact based on facility assessment, was interviewed on 8/13/24 at 10:07 a.m. Resident #59 said the facility took a long time to answer the call lights. He said sometimes he would wait for longer than 30 minutes. He said he had expressed his frustration to the therapy department and the nursing staff.</p> <p>Resident #59 said he had been living with Parkinson's disease for a long time. He said a side effect of the disease that he dealt with every day was hand tremors. Resident #59 said he had never experienced this bad of hand tremors. He said the facility had not been administering his medication appropriately. Resident #59 said his hand tremors had been worse since he was admitted to the facility. He said he had expressed his frustration to the nursing staff. He said the facility had never followed up with him regarding his concerns.</p> <p>Cross reference F760: the facility failed to ensure Resident #59's Parkinson's medications were administered according to the manufacturer's guidelines.</p> <p>IV. Staff interviews</p> <p>CNA #1 was interviewed on 8/15/24 at 11:08 a.m. CNA #1 said she had worked in the facility for a long time. She said when a resident voiced a concern, if she was able to handle it herself, she would, otherwise she said she would tell the nurse on duty. She said she was aware the facility had a grievance policy, however, she was not sure what it entailed. CNA #1 said she had never filled out a grievance form for a resident.</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 - Some</p>	<p>The social services director (SSD) and the social services consultant (SSC) were interviewed together on 8/15/24 at 3:02 p.m. The SSD said the social services department was responsible for reviewing the grievances, distributing them to the appropriate department and ensuring follow-up occurred with the resident. She said each department was responsible for addressing the grievance with the resident.</p> <p>The SSD said the amount of grievances received had gone up in the last three months. She said she had not seen an improvement yet, but was working to make sure the grievances were addressed timely for the residents.</p> <p>The SSD said she had received a lot of grievances related to call light response times, especially on the weekends. She said the grievances documented that residents were waiting a long time for call lights to be answered. She said the residents had voiced concerns over call light wait times during meals.</p> <p>The SSD said she did not know what the response was for the call light grievances or if the residents were satisfied with the response.</p> <p>The SSD said the facility had implemented ambassador rounds for all the department heads. She said the department head was responsible for meeting with their list of assigned residents three times per week and turning in a form every Friday about the resident rounds.</p> <p>The SSD said the ambassador rounds did not formally follow up with written grievances for any concerns. She said she was not aware of what happened to any resident concerns documented on the ambassador round forms.</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 8/15/24 at 5:06 p.m. LPN #1 said she had never filled out a grievance form for a resident. She said she knew the grievance form went through a chain of command but did not know what department received the grievance forms. She said she did not know the facility's policy for grievances. She said she thought grievances should be addressed within 24 to 48 hours.</p> <p>The director of nursing (DON), the NHA and the clinical consultant (CC) were interviewed together on 8/15/24 at 5:44 p.m. The DON said grievances were filed through the ambassador rounds, from an individual resident or from the resident council meeting. She said any staff member who was told a concern by a resident should fill out a grievance form and turn it into the social services department.</p> <p>The DON said each grievance should be investigated within 72 hours of the form being completed. She said each grievance should have a plan developed to address the concern and follow up with the resident to ensure their satisfaction.</p> <p>The DON said the residents had voiced their concerns over call light response times. She said she felt like the residents only wanted their favorite CNAs to answer the call light and would not allow other staff to assist them.</p> <p>The NHA said she had recently implemented the ambassador rounds to assist with resident concerns.</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 - Some</p>	<p>The DON said she felt the residents saying they felt some of the staff did not care was unfair because she had tried to change the culture of the facility. However, she said she could not point to anything specific she had done to change the culture.</p> <p>The NHA was interviewed again on 8/15/24 at 7:08 p.m. The NHA said the ambassador rounds were non-existent when she first started at the facility a couple of months prior. She said the department heads had not completed grievance forms for resident concerns that they were documenting on the ambassador rounds. She said that was an oversight in direction that she would fix.</p> <p>The NHA said she felt that receiving grievances was not a bad thing, but pointed to areas where the facility could improve. She said she thought the rest of the department heads did not feel the same way. She said she was trying to change that mindset.</p> <p>The NHA said she thought the culture at the facility needed a change but she was not sure what that change would entail just yet. She said she had been trying to come up with different ideas for the staff to change their mindset.</p> <p>The NHA said all grievances should be followed up on to ensure the facility staff were doing everything they could to do right by the residents.</p> <p>48114</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114</p> <p>Based on observations and interviews, the facility failed to provide a clean, comfortable and homelike environment for residents.</p> <p>Specifically, the facility failed to ensure resident rooms, bathrooms and hallways received necessary maintenance repairs.</p> <p>Findings include:</p> <p>I. Observations and resident interviews</p> <p>On 8/12/24 at 10:24 a.m. the corner edge of the sink in room [ROOM NUMBER] was chipped. The left side of the sink had a chipped piece missing. The side wood panel to the sink was chipped on the right side.</p> <p>On 8/12/24 at 1:14 p.m. the dresser next to the bed in room [ROOM NUMBER] was missing both of the drawer fronts that had handles to open the drawers. The drawer front to the bottom drawer</p> <p>The resident who resided in room [ROOM NUMBER] reported that the dresser drawer had been broken for a while.</p> <p>On 8/12/24 at 3:20 p.m. room [ROOM NUMBER]'s window curtain on the left side was disconnected from five hooks.</p> <p>A family member of the resident who resided in room [ROOM NUMBER] said the curtain had been disconnected for two weeks.</p> <p>On 8/14/24 at 2:30 p.m. the door going into the dining room down across from room [ROOM NUMBER] had missing baseboards and trim around all of the edges of the door.</p> <p>On 8/14/24 at 2:32 p.m. one ceiling tile in room [ROOM NUMBER] had a brown water stain on it.</p> <p>In the bathroom of room [ROOM NUMBER], behind the toilet, there was a part of the wall that had been patched and needed to be painted.</p> <p>On 8/14/24 at 2:33 p.m. room [ROOM NUMBER] had two ceiling tiles that were discolored and brown.</p> <p>In the bathroom in room [ROOM NUMBER], the wall behind the toilet had a part of the wall that had been patched and needed to be painted. The bathroom wall on the left side as one exited the bathroom was chipped. The side panel on the sink was chipped.</p> <p>One of the dresser drawers that were built into the wall in room [ROOM NUMBER] were chipped on the left side.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Medallion Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 E Bijou St Colorado Springs, CO 80909	
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In room [ROOM NUMBER], one of the residents who resided in the room had a fan that was attached to the wall by the head of the bed that was coming off the wall. The resident said she was afraid the fan was going to come off the wall and hit her in the head.</p> <p>The same resident's light fixture at the head of the bed in room [ROOM NUMBER] was missing the light cover.</p> <p>On 8/14/24 at 2:35 p.m. room #S2 had two ceiling tiles that were stained brown.</p> <p>On 8/14/24 at 2:36 p.m. room #S1 had one ceiling tile with a white circular stain.</p> <p>On 8/14/24 at 2:37 p.m. the hallway between room #S2 and room #S1 had three stained ceiling tiles that were brown.</p> <p>On 8/14/24 at 2:38 p.m. the floor down the Silverthorn unit was removed and covered up with flooring paper and tape.</p> <p>On 8/14/24 at 2:40 p.m. at the main entrance of the facility there were six ceiling tiles that had brown stains on them.</p> <p>On 8/15/24 at 4:03 p.m. the ceiling in the [NAME] hallway shower room had approximately five inches of paint that was peeling off by the toilet.</p> <p>The wall by the sink in the [NAME] shower room was patched but needed to be painted.</p> <p>II. Staff interviews</p> <p>An environmental tour was conducted on 8/15/24 at 4:17 p.m. with the maintenance director (MTD) and the above concerns were observed. The MTD said staff should be putting in work orders when they noticed something was broken. He said the facility utilized an electronic work system to track needed repairs. He said the facility staff also verbally let him know what needed to be repaired. He said the receptionist or the maintenance staff put the work orders into the electronic work system. He said most of the facility staff did not have access to the electronic work system. He said all of the maintenance staff knew how to put a work order into the electronic work system.</p> <p>The MTD said he did a walk through with new employees to show them the facility. He said he did a morning walk through every day he was working. He said the walk through usually took him 30 to 40 minutes to complete. He said he would do a walk through by himself or with two of his technicians that worked with him. He said he would take notes on what needed to be repaired. He said every Monday and Wednesday he did a building inspection where he checked the water temperature, air temperature and fans in the bathroom.</p> <p>The MTD said if he found any issues during the building inspection he would let the nursing home administrator (NHA) know. He said the NHA did a walk through the building with him once a week. He said the last time he did a walk through with the NHA was on Monday 8/12/24. He said they noticed the ceiling tiles were stained and needed to be repaired. He said he replaced the ceiling tiles three to four times a year.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The MTD said when there was an empty resident room his staff would do a whole remodel and find out what needed to be fixed and repaired before another resident was admitted to the room.</p> <p>The MTD said work orders could take a while to get approved depending on how much it cost to fix the issue. He said anything that cost over 2500 dollars had to be approved by the NHA and the corporate office prior to him fixing it. He said the approval process could take one week, three weeks or even one month He said if he was working on a big project he needed to get two separate quotes from contractors and then the corporate office decided who they were going to use. He said he had gotten one quote for the floor down the S hallway and was waiting on another quote before he could send it off for approval. He said he did not know how long it would be before the floor would be replaced down the S hallway.</p>

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<p>F 0585</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 voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853</p> <p>Based on record review and interviews, the facility failed to ensure one (#4) of three residents out of 33 sample residents was provided prompt efforts by the facility to resolve grievances.</p> <p>Specifically, the facility failed to provide a resolution to Resident #4's grievance, which he had communicated to staff on multiple occasions, regarding the resident's care.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Grievance policy and procedure, revised August 2024, was provided by the nursing home administrator (NHA) on 8/15/24 at 9:14 p.m. It read in pertinent part, It is the policy of this facility to establish a grievance process to address resident concerns without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, other concerns regarding their facility stay and make prompt efforts to resolve grievances the resident may have.</p> <p>The facility's grievance official is responsible for overseeing the grievance process, receiving and tracking grievances; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident, if requested and coordinating with state and federal agencies as necessary.</p> <p>The grievance official evaluates and investigates the concern and takes immediate action to resolve the concern and prevent further potential violations of any resident's right while the alleged violation is being investigated.</p> <p>The grievance official or designee responds to the individual expressing the concern within three working days of the initial concern to acknowledge receipt and describe steps taken toward resolution.</p> <p>II. Resident #4</p> <p>A. Resident status</p> <p>Resident #4, age 82, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with diabetic peripheral angiopathy (narrowing of the arteries decreasing blood flow), chronic kidney disease, heart failure, chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), major depressive disorder and anxiety.</p> <p>The 7/13/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She could hear adequately, was able to understand others and made herself understood.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>B. Resident interview</p> <p>Resident #4 was interviewed on 8/13/24 at 10:33 a.m. Resident #4 said she filed a grievance right before she went to the hospital on 8/5/24. Resident #4 said a certified nurse aide (CNA) was unfamiliar with her care and did not know how to transfer her with the sit to stand mechanical lift. Resident #4 said the CNA left the room to get another staff member to help her and was gone for 30 minutes. When the CNA returned, Resident #4 said she was upset because she had waited so long. She said the CNA argued with her and spoke in a disrespectful manner. Resident #4 said she wrote out a grievance and gave it to her regular CNA to give to the NHA.</p> <p>C. Record review</p> <p>A nursing progress note, dated 8/3/24 at 3:46 p.m., documented Resident #4 said a CNA was incompetent to care for her.</p> <p>-The progress note did not indicate a grievance was filed by the resident.</p> <p>On 8/14/24 at 4:30 p.m. the NHA provided a grievance form dated 4/5/24, regarding call light times. The facility follow-up was educating staff and monitoring of call light times.</p> <p>On 8/15/24 at 5:45 p.m. the NHA provided an additional grievance form, dated 8/5/24 which noted an investigation was started upon review of a progress note from 8/3/24 related to Resident #4. The follow-up action on the grievance form indicated Resident #4 was spoken to regarding the importance of skin hygiene and teaching new CNAs her preferences for care.</p> <p>-The grievance did not address Resident #4's concern of the CNA arguing with her and speaking to her in a disrespectful manner. The resident's name was not on the grievance form and the section for the resident's concern was blank.</p> <p>III. Staff interviews</p> <p>The director of nursing (DON) was interviewed on 8/15/24 at 5:45 p.m. The DON said grievances came through staff rounding with the residents, individual resident concerns and through reports from a CNA or other staff member. She said grievances had to be followed up on by the manager of the department the concern pertained to within three days. She said the grievance was supposed to have some sort of resolution that was satisfactory for the resident.</p> <p>The DON said Resident #4 had a history of self-sabotaging and not allowing care if she thought the CNA did not know how to care for her. The DON said the resident would say the staff were incompetent. She said Resident #4 did not tell the staff how she wanted them to care for her. The DON said they had tried to train other staff how to care for Resident #4 but she still preferred only certain staff.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853</p> <p>Based on observation and interviews, the facility failed to ensure that professional standards of practice were followed during medication administration for one (#4) of one resident reviewed out of 33 sample residents.</p> <p>Specifically, the facility failed to ensure medications were not left at Resident #4's bedside.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Medication Administration policy, dated January 2023, was provided by the nursing home administrator (NHA) on 8/15/24 at 9:12 p.m. It read in pertinent part,</p> <p>Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so.</p> <p>Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing care center.</p> <p>Residents are allowed to self-administer medications when specifically authorized by the prescriber, the nursing care center's interdisciplinary team (IDT), and in accordance with procedures for self-administration of medications and state regulations.</p> <p>The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the medication administration record (MAR), and action is taken as appropriate.</p> <p>II. Resident #4</p> <p>A. Resident status</p> <p>Resident #4, age 82, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with diabetic peripheral angiopathy (narrowing of the arteries decreasing blood flow), chronic kidney disease, heart failure, chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), major depressive disorder and anxiety.</p> <p>The 7/13/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She could hear adequately, was able to understand others and made herself understood. She was independent with eating and drinking.</p> <p>B. Observations and interview</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/15/24 at 9:17 a.m. Resident #4 was in bed in her room. There were two cups of pills on her bedside table. One cup contained seven pills and the other cup contained two pills, one of the pills was broken in half. Resident #4 said she asked for fresh ice water to take her seven pills this morning but no one had brought her any so she was unable to take her medications.</p> <p>Resident #4 said the cup containing two pills was from last night (8/14/24). Resident #4 said the night nurse delivered the pills to her but did not return to see if she had taken the medications.</p> <p>C. Record review</p> <p>The self-administration of medication evaluation, completed on 8/12/24 (during the survey), revealed Resident #4 was able to self-administer medication.</p> <p>-A review of Resident #4's electronic medical record (EMR) did not reveal a physician's order for the resident to self-administer oral medications.</p> <p>-A review of Resident #4's comprehensive care plan did not reveal documentation regarding the resident's ability to self-administer medications.</p> <p>A review of the August 2024 medication administration record (MAR) indicated licensed practical nurse (LPN) #3 administered cetirizine HCl 5 milligrams (mg) and calcium carbonate with vitamin D 600 mg-400 mg at 11:04 p.m. on 8/14/24.</p> <p>D. Staff interviews</p> <p>LPN #1 was interviewed on 8/15/24 at 9:17 a.m. LPN #1 said she delivered medications to Resident #4 that morning (8/15/24). LPN #1 said the nurses left Resident #4's medication at her bedside and she took her medication when she was ready. LPN #1 said she checked in with the resident about two hours after she gave the resident the medication cup to see if the resident had taken the medication. LPN #1 said Resident #4 did not ask for fresh ice water when she delivered her medication that morning. LPN #1 said she only delivered one medication cup containing seven pills.</p> <p>LPN #1 said she did not see the other medication cup containing two pills when she delivered Resident #4's morning medications but she said the medications must have been from the previous night. LPN #1 said she would document that the resident did not take the two pills and dispose of the medications. LPN #1 said she would get fresh ice water for Resident #4 and make sure she took her morning medications.</p> <p>The director of nursing (DON) was interviewed on 8/15/24 at 6:23 p.m. The DON said medications could be left at the bedside if a resident was independent and had been assessed to safely self-administer their medications. The DON said if the nurse left medications at the bedside, the nurse should go back and check with the resident before the end of their shift to make sure the resident took the medications.</p> <p>E. Facility follow up</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/15/24 at 5:45 p.m. the DON provided a copy of a counseling notice, dated 8/15/24 (during the survey), for LPN #3. The notice indicated LPN #3 received a written warning via telephone for documenting medications as administered on the evening of 8/14/24 without verifying the medication was taken by the resident. The counseling notice was signed by the DON.</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185</p> <p>Based on record review and interviews, the facility failed to develop and implement effective discharge planning for one (#59) of two residents reviewed for discharge planning out of 33 sample residents.</p> <p>Specifically, the facility failed to develop and implement a collaborative discharge plan that involved Resident #59's discharge goals.</p> <p>Findings include:</p> <p>I. Resident #59</p> <p>A. Resident status</p> <p>Resident #59, age 72, was admitted on [DATE] and readmitted on [DATE]. According to the August 2024 computerized physician orders (CPO), the diagnoses included Parkinson's disease.</p> <p>The 8/7/24 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. He required partial or moderate assistance with activities of daily living.</p> <p>B. Resident interview</p> <p>Resident #59 was interviewed on 8/13/24 at 10:07 a.m. Resident #59 said he was admitted to the facility for short-term rehabilitation. He said his goal was to move back to the community. He said his previous living arrangement was with a family member who had passed away and he was not sure if he was able to return.</p> <p>Resident #59 said the facility staff had not asked him what his discharge plan goal was except for when he was first admitted . He said he did not feel like anyone was working toward a goal of him discharging but were instead planning on him staying at the facility under long-term care services.</p> <p>Resident #59 said he was aware of his limitations with Parkinson's disease, but he wanted to be as independent as possible for as long as possible, which included his living situation. He said facility staff had not developed goals with him for discharge or provided him different options for when he would return to the community.</p> <p>Resident #59 said he did not want to stay at the facility for long-term care. He said he had never told the facility staff he wanted to stay, but he felt that they were planning to do whatever they wanted without consulting him.</p> <p>C. Record review</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 8/8/24 social services assessment documented the resident previously lived alone with a family member who had passed away. It indicated that a family member was the resident's only support, however, the resident was still in touch with his brother-in-law.</p> <p>The social services assessment documented the resident had a discharge plan of long-term care placement at the facility.</p> <p>-The assessment did not document the resident's wish to return to his previous living situation, nor did it provide any documentation or follow-up with the brother-in-law to determine if the resident living with the brother-in-law was a viable option.</p> <p>-A review of the resident's comprehensive care plan did not reveal documentation that a care plan had been developed with the resident's discharge goals and any interventions to assist the resident in achieving those goals.</p> <p>-A review of the resident's electronic medical record (EMR) did not reveal documentation that active discharge planning had been conducted for Resident #59.</p> <p>II. Staff interviews</p> <p>The social services director (SSD) and the social services consultant (SSC) were interviewed on 8/15/24 at 3:02 p.m. The SSD said social services was responsible for discharge planning.</p> <p>The SSC said discharge planning was fluid and should begin at the resident's admission and continue throughout their stay at the facility. She said the comprehensive care plan should include the resident's discharge goals and interventions to assist the resident to achieve those goals.</p> <p>The SSD said the discharge goals were obtained during the initial social services assessment when the resident was admitted to the facility. She said from there, the comprehensive care plan would be developed within the first seven days of the residents' admission.</p> <p>The SSC said the least restrictive goal was the initial plan and development of that plan would lead to achievement or alteration of the goals.</p> <p>The SSD said Resident #59 planned to remain at the facility for long-term care. She said she had documented that on the social services assessment. She said she did not know the resident wanted to return to his previous living arrangement or a possible assisted living. She said she had not provided Resident #59 with any discharge alternatives other than long-term care.</p> <p>The SSD confirmed she had not developed a discharge care plan within the comprehensive plan of care. She said that should have been developed immediately following the completion of the social services assessment.</p> <p>The SSD said she would meet with Resident #59 and provide him with alternative discharge options and a list of different assisted living communities. She said she would develop his discharge plan and interventions to reach his goals.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The SSD was interviewed again on 8/15/24 at 5:11 p.m. The SSD said she went to Resident #59's room to speak about his discharge goals, however the resident said he had a migraine and asked if she could visit later. She said she set up a care conference to discuss his discharge goals for the following week.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114</p> <p>Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and personal hygiene for three (#18, #45 and #5) of three residents reviewed for assistance with ADLs out of 33 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure Resident #18 and #45's fingernails were trimmed and clean; and, -Ensure Resident #5 received staff assistance with getting dressed. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Activities of Daily Living (ADLs) policy and procedure, dated October 2022 was received by the nursing home administrator (NHA) on 8/15/24 at 9:12 p.m. It read in pertinent part, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable.</p> <p>Care and services will be provided for the following activities of daily living, bathing, dressing, grooming and oral care.</p> <p>The facility will provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment.</p> <p>A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>The facility will maintain individual objectives of the care plan and periodic review and evaluation.</p> <p>II. Resident #18</p> <p>A. Resident status</p> <p>Resident #18, age 78, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included chronic kidney disease stage four and dementia.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The 8/26/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He required set up or clean up assistance with eating, oral hygiene, showering/bathing self, upper and lower body dressing, putting on/taking off footwear and personal hygiene.</p> <p>B. Observations and resident interview</p> <p>Resident #18 was interviewed on 8/12/24 at 10:30 a.m. Resident #18 said his fingernails were long and the staff did not cut them when he received his showers. He said he wanted his fingernails cut. He said he did not know the last time his fingernails were trimmed.</p> <p>Resident #18's fingernails extended past the tip of his fingers and had brown matter underneath them. He had fingernail clippers on his dresser and he said they were too small and did not work for him.</p> <p>C. Record review</p> <p>The ADLs care plan, revised on 6/1/23, documented Resident #18 had an ADL self care performance deficit related to impaired mobility/cognition due to dementia, chronic renal failure with hypoxia. Interventions included conversing with the resident while providing care, explaining all procedures/tasks before starting, praising all efforts at self-care and encouraging the resident to discuss feelings about self-care deficits.</p> <p>-The care plan did not include information regarding the resident's nail care.</p> <p>-A review of the certified nurse aide (CNA) task documentation for nail care (reviewed from 7/12/24 to 8/15/24) revealed there was no documentation indicating the resident had received nail care during that time period.</p> <p>III. Resident #45</p> <p>A. Resident status</p> <p>Resident #45, age 76, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included Alzheimer's disease, dementia and stage four chronic kidney disease.</p> <p>The 7/3/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of seven out of 15. He was dependent on staff assistance with toileting hygiene, showering/bathing, upper and lower body dressing and putting on/taking off footwear. He required set up or clean-up assistance with personal hygiene.</p> <p>B. Observation and resident interview</p> <p>Resident #45 was interviewed on 8/12/24 at 1:17 p.m. Resident #45 said his fingernails were long and had not been trimmed since his admission. He said staff had never offered to trim his nails. He said he would like his fingernails to be trimmed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #45's fingernails extended past the tip of his fingers and he had brown matter underneath all of his nails.</p> <p>C. Record review</p> <p>The ADL care plan, revised 6/24/24, documented Resident #45 had an ADL self care performance deficit. Interventions included encouraging the resident to discuss feelings about self-care deficits, encouraging the resident to participate to the fullest extent possible with each interaction and providing maximum assistance of one to two people for personal hygiene.</p> <p>-The care plan did not include information regarding the resident's nail care.</p> <p>-A review of the CNA task documentation for nail care (reviewed from 7/12/24 to 8/15/24) revealed there was no documentation indicating the resident had received nail care during that time period.</p> <p>D. Staff interviews</p> <p>CNA #1 was interviewed on 8/15/24 at 10:34 a.m. CNA #1 said the CNAs and shower aides were responsible for cutting the residents' fingernails. She said the residents' fingernails should be cut once a week or every other week. She said the best time to cut the residents' fingernails was during their showers. She said she did not know the last time Resident #18 and Resident #45 had their fingernails trimmed.</p> <p>CNA #1 said Resident #18's and Resident #45's fingernails needed to be cut. She said she did not know why both residents had not had their fingernails cut recently. She said both of the residents should have had their fingernails cut before they got that long.</p> <p>Licensed practical nurse (LPN) #2 was interviewed on 8/15/24 at 11:33 a.m. LPN #2 said if the resident was not diabetic that the CNAs could cut the residents' fingernails. She said if the resident was diabetic then the nurses were responsible for cutting the residents' fingernails. She said she did not know how often the residents' fingernails should be cut. She said the best time for the residents to have their fingernails cut was when they were taking a shower.</p> <p>LPN #2 said Resident #45 could not cut his own fingernails because he had vision impairments. She said Resident #18 was not able to cut his own fingernails. She said all of the residents should have received assistance cutting their nails and should not cut them on their own. She said did not know when the last time Resident #18 and Resident #45 had their fingernails cut. She said both residents should have had their fingernails cut. She said she did not know why both residents' fingernails were not cut.</p> <p>The director of nursing (DON) was interviewed on 8/15/24 at 6:44 p.m. The DON said the CNAs, shower aides and nurses could cut the residents' fingernails. She said if the resident was diabetic a nurse needed to cut the fingernails. She said residents' fingernails should be cut when they were long, sharp or dirty and when they requested it. She said during shower times the residents' fingernails should be checked and cut if needed.</p> <p>The DON said she did not know when the last time Resident #18 and Resident #45 had their fingernails cut. She said she would provide education to the staff about checking and cutting fingernails.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>50853</p> <p>IV. Resident #5</p> <p>A. Resident status</p> <p>Resident #5, age 68, was admitted on [DATE]. According to the August 2024 computerized CPO, diagnoses included type 2 diabetes mellitus, chronic respiratory failure, hypertension (high blood pressure), chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems) and bipolar disorder (a mental illness causing severe mood swings).</p> <p>The 7/25/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She was dependent on staff for transfers, dressing and toileting hygiene.</p> <p>The 4/24/24 MDS assessment indicated it was very important for Resident #5 to choose which clothes to wear.</p> <p>B. Resident observations and interview</p> <p>On 8/14/24 at 11:22 a.m. Resident #5 was sitting in her wheelchair in her room wearing a hospital gown. Resident #5 said the staff did not have time to get her dressed this morning (8/14/24) and she went to the dining room for breakfast in a hospital gown. Resident #5 said she usually got dressed in her clothes in the morning, which was what she preferred to do. She said she would go to lunch in her hospital gown because it was too much trouble to get dressed now that she was up.</p> <p>At 12:34 p.m. Resident #5 was sitting in her wheelchair in the dining room for lunch wearing a hospital gown.</p> <p>C. Record review</p> <p>The activities of daily living (ADL) care plan, initiated 2/14/24, revealed Resident #5 required substantial assistance from one staff member to get dressed and she preferred to go to the dining room for meals.</p> <p>-The care plan did not indicate she preferred to wear a hospital gown when out of bed.</p> <p>-The CNA documentation (8/1/24 to 8/14/24) did not indicate the resident refused to get dressed on 8/14/24.</p> <p>D. Staff interviews</p> <p>The DON was interviewed on 8/15/24 at 6:13 p.m. The DON said residents should be given a choice of what they wanted to wear each day. She said residents should receive assistance getting dressed in personal clothing unless it was their preference not to. The DON said she did not know why Resident #5 was not dressed in the clothes she preferred to wear on 8/14/24.</p>		

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<p>F 0684</p> <p>Level of Harm - 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** 50853</p> <p>Based on record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for one (#4) of two residents reviewed out of 33 sample residents.</p> <p>Resident #4 was admitted on [DATE] for long term care with diagnoses of type 2 diabetes with diabetic peripheral angiopathy (narrowing of the arteries decreasing blood flow), chronic kidney disease, heart failures, chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), major depressive disorder and anxiety.</p> <p>On 7/12/24 Resident #4 struck her right lower leg on the side of her metal bed frame when she was maneuvering her electric wheelchair near her bed, causing a hematoma (bruise) to her leg. The resident reported the injury was very painful. On 7/15/24 the facility obtained an x-ray of the resident's right lower extremity, which was negative.</p> <p>The facility failed to consistently document observations of the resident's injury.</p> <p>On 7/22/24 the resident reported increased pain and swelling, the nurse practitioner (NP) ordered ice three times a day to the area.</p> <p>On 7/29/24 the wound doctor (WD) visited the resident for a different wound. The WD did not see or assess the resident's wound to her right lower extremity.</p> <p>Due to the facility's failure to consistently monitor and document the status of the resident's wound, the resident was sent to the emergency department on 8/5/24 for increased swelling and pain.</p> <p>At the hospital, Resident #4 was diagnosed with cellulitis to the right lower extremity and she had an increased white blood cell count. The resident had surgery to drain and clean out the right leg wound which had become infected and required treatment with intravenous (IV) antibiotics.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Skin and Wound Monitoring policy, dated January 2022, was provided by the nursing home administrator (NHA) on 8/15/24 at 9:12 p.m. It read in pertinent part,</p> <p>A licensed nurse will assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident. This</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>assessment/evaluation should include but not be limited to: measuring the skin injury; staging the skin injury (when the cause is pressure); describing the nature of the injury (pressure, stasis, surgical incision); describing the location of the skin alteration; describing the characteristics of the skin alteration; describing the progress with healing, and any barriers to healing which may exist; and, identifying any possible complications or signs/symptoms consistent with the possibility of infection.</p> <p>Weekly skin checks will be conducted by a licensed nurse. All residents will have a head to toe skin check performed at least weekly by a licensed nurse. The licensed nurse should document the findings.</p> <p>II. Resident #4</p> <p>A. Resident status</p> <p>Resident #4, age 82, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with diabetic peripheral angiopathy, chronic kidney disease, heart failure, chronic obstructive pulmonary disease , major depressive disorder and anxiety.</p> <p>The 7/13/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She could hear adequately, was able to understand others and made herself understood.</p> <p>B. Resident interview</p> <p>Resident #4 was interviewed on 8/13/24 at 10:33 a.m. Resident #4 said she returned from the hospital yesterday (8/12/24). She said she had an infection in her leg that required surgery. Resident #4 said about a month ago (July 2024), she hit her leg on her bed frame when she was trying to maneuver her electric wheelchair in her room. She said there were no staff around and she was trying to get to her call light, which was on the floor. She said her leg started swelling and hurting right away. Resident #4 said an x-ray was done a couple of days later and there was no fracture so the staff stopped monitoring her leg.</p> <p>Resident #4 said the swelling continued to worsen and the area became warm and painful. Resident #4 said she was told by the nurses she just needed to ice the area to decrease the swelling. Resident #4 said after a few weeks, a red bump formed on top of the swollen area of her leg. She said when this occurred, the nurse called the doctor and was concerned about a blood clot. She said when her leg started draining, the facility decided to send her to the hospital.</p> <p>C. Record review</p> <p>The 7/12/24 incident report, completed by the director of nursing (DON), revealed Resident #4 hit her right leg on the metal part of her bed frame while maneuvering her electric wheelchair in her room. The report documented she obtained a large hematoma with red, blue and purple discoloration. The resident reported the leg was very painful.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The DON applied ice to the area and instructed the resident to elevate her leg in the recliner. The physician was notified.</p> <p>The 7/15/14 interdisciplinary team (IDT) progress note indicated x-rays were obtained of the resident's right leg which were negative for a fracture. The note documented the IDT recommended therapy to evaluate the resident's environment and assess the resident's electric wheelchair for safety.</p> <p>According to the nurse progress notes, alert charting (charting done when a resident's condition needs to be monitored) was initiated after the incident on 7/12/24.</p> <p>-However, there were no progress notes documented on 7/13/24 or 7/14/24 to indicate the injury was assessed or was being monitored.</p> <p>The 7/15/2024 alert charting indicated it was the third day of the skin alteration to the resident's right lateral (outside) lower extremity. The area had a dark purple discoloration to the mid-outer calf with an indentation to skin proximal to the ankle with a possible hematoma above the indentation. The resident reported the area was tender to soft touch. An x-ray was completed that morning and the results were pending.</p> <p>The 7/16/24 alert charting indicated it was the fourth day of the skin alteration to the right lateral lower extremity. The area was dark purple discoloration to the mid-outer calf. There was an indentation to the skin proximal to the ankle with a possible hematoma above the indentation. The resident reported the area was tender to soft touch. The x-ray results were negative for fractures.</p> <p>The 7/17/24 alert charting indicated the resident had a skin alteration of a left calf hematoma due to hitting her leg on her bed frame while in an electric wheelchair. The nurses were monitoring for signs and symptoms of infection, pain to sight, or complications every shift for the hematoma to the left lower extremity for three days. There were no signs or symptoms of infection to the resident's left calf. The resident did not have complaints of pain.</p> <p>-However, the resident sustained an injury to her right leg, not the left leg (see record review above and DON interview below).</p> <p>-A review of the resident's electronic medical record (EMR) did not reveal any documentation from 7/18/24 to 7/21/24 regarding the status of the resident's right leg injury.</p> <p>The 7/22/24 nursing progress note documented the nurse practitioner (NP) was notified of increased swelling in Resident #4's right lower leg.</p> <p>The 7/23/24 NP progress revealed the NP visited Resident #4 at the facility. The NP note documented Resident #4 said her leg had decreased in swelling since 7/22/24 but she still had discomfort to the touch. The NP ordered ice to the area three times a day for three days, to encourage elevation and continue to monitor the area.</p> <p>-A review of the residents EMR did not reveal any additional nursing documentation to indicate the staff were monitoring the status of Resident #4's leg from 7/23/24 to 8/4/24.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The 7/29/24 wound doctor (WD) progress note documented the WD visited Resident #4 for continued monitoring of a wound in her groin area.</p> <p>-The WD note did not document that the WD examined the resident's injury to her right lower extremity.</p> <p>The 8/5/24 nursing progress note, documented at 8:24 a.m., indicated a phone call was received from the NP with orders for a Doppler (an ultrasound test showing blood flow), to start Keflex (an antibiotic) for possible cellulitis (skin infection) and tramadol (an oral pain medication) for the resident's pain in her leg.</p> <p>The 8/5/24 nursing progress note, documented at 9:31 a.m., indicated the nurse placed a call to Resident #4's physician at 6:40 a.m. regarding the pain to her right lower leg approximately at the mid-calf. The area was red, warm and slightly elevated. The nurse requested a Doppler to rule out deep venous thrombosis (DVT - a blood clot).</p> <p>The 8/5/24 nursing progress note, documented at 1:39 p.m., indicated there was no evidence of a DVT in the resident's right lower extremity according to the Doppler test.</p> <p>The 8/5/24 nursing progress note, documented at 3:00 p.m., indicated the NP was called and notified the hematoma on Resident #4's right lower extremity had opened and was draining.</p> <p>The 8/5/24 nursing progress note, documented at 4:52 p.m., indicated Resident #4 was sent to the hospital emergency department for possible incision and drainage of a right lower extremity hematoma with bloody drainage and a foul smell.</p> <p>The 8/5/24 nursing progress note, documented at 5:28 p.m., revealed Resident #4 left the facility by emergency transport.</p> <p>The 8/5/24 hospital admission record revealed Resident #4 was diagnosed with cellulitis of the right lower limb, a cutaneous (on the skin) abscess of the right lower limb, local infection of the skin and subcutaneous (under the skin) tissue and an elevated white blood cell count of 13.6 (normal range is 4 to 11).</p> <p>The hospital physician's note indicated, upon admission, Resident #4 had a large area of fluctuant (fluid filled) swelling over the anterior pretibial (front of shin bone) space of the right lower leg. It was tender to palpation (touch). There was erythema (redness) with increased skin temperature. The area measured 14 centimeters (cm) length by 10 cm width by two cm depth. There was bloody, malodorous (foul smelling) and copious (large amounts) drainage. Resident #4 was complaining of pain to the right lower extremity which she rated at an 8 out of 10 and described as sharp in nature. The resident said she had been feeling poorly over the last several days.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The hospital documentation indicated Resident #4 had surgery overnight for the wound incision and drainage, which was completed at 12:44 a.m. on 8/6/24. She was started on IV antibiotics. The resident returned to the operating room on 8/7/24 for removal of packing, wound re-evaluation and excisional debridement (cutting away of dead tissue) of the wound cavity and repacking. The culture of the wound determined it was infected with multi-drug resistant Escherichia coli (a common bacteria normally found in feces that can infect wounds). On 8/9/24, Resident #4 returned to the operating room for a wound washout and complex wound closure with drain placement. The wound size was 8 cm length by 7 cm width by 2 cm depth.</p> <p>III. Staff interviews</p> <p>The NP was interviewed on 8/16/24 at 3:07 p.m. The NP said she was aware of the injury on Resident #4's leg. The NP said she received a phone call on 7/22/24 from the facility regarding increased swelling in the resident's leg. The NP said she visited Resident #4 on 7/23/24. The NP said the leg did not show signs of infection at that time and she ordered ice to the area. The NP said she received another phone call from the facility on 7/30/24 regarding Resident #4 having increased pain in her leg. She said the resident did not want to take narcotics so she did not order any new medication. The NP said the nurses at the facility should have been monitoring the injury daily and documenting the status.</p> <p>The DON was interviewed on 8/15/24 at 6:36 p.m. The DON said the nurses should have continued to monitor Resident #4's leg until the injury was resolved. The DON said the NP did see Resident #4 on 7/23/24 and ordered ice to the area. The DON said the nurses should have documented their observations of the wound. The DON said there were no signs or symptoms of infection until right before the resident's hospitalization but this was not documented (see record review above).</p> <p>IV. Facility follow-up</p> <p>A chart review was received from the NHA on 8/19/24 at 10:37 a.m. (after the survey). The review was performed by the medical director (MD). The MD confirmed Resident #4 was visited by the wound doctor on 7/29/24 who said he remembered seeing a lesion on the right lower leg but he did not include this observation in his progress note. The MD confirmed that Resident #4 was hospitalized for an infected hematoma on the right lower leg resulting from trauma occurring at the nursing facility.</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** 50853</p> <p>Based on observations, record review and interviews, the facility failed to ensure one (#39) of one resident out of 33 sample residents received the care and services necessary to meet their nutrition needs and to maintain their highest level of physical well-being.</p> <p>Specifically the facility failed to provide Resident #39 meal set-up assistance and implement nutritional interventions to prevent weight loss.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The activities of daily living (ADL) policy, dated 2022, was provided by the nursing home administrator (NHA) on 8/15/24 at 9:12 p.m. It read in pertinent part, Care and services will be provided for the following activities of daily living eating to include meals and snacks.</p> <p>A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>II. Resident #39</p> <p>A. Resident status</p> <p>Resident #39, age 83, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included dementia without behavioral disturbance, type 2 diabetes mellitus, atherosclerotic heart disease (a build-up plaque in the arteries, restricting blood flow), lack of coordination, unspecified protein-calorie malnutrition, frontotemporal neurocognitive disorder (damage to the frontal and temporal lobes of the brain) and vitamin B-12 deficiency anemia.</p> <p>The 7/6/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of seven out of 15. Resident #39 was able to feed himself with set-up assistance and was prescribed a mechanically altered diet.</p> <p>B. Observations</p> <p>During a continuous observation on 8/14/24, beginning at 11:55 a.m. and ending at 1:12 p.m., Resident #39 was sitting at a table in the dining room, drinking a beverage from a regular glass.</p> <p>At 12:29 p.m. Resident #39's food was delivered. An unidentified staff member set the resident's plate above his beverage, which was sitting directly in front of the resident. He was not served a dessert.</p> <p>-The unidentified staff member did not hand the resident a utensil, napkin or ensure his plate was set directly in front of him.</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>Resident #39 picked up his fork and began eating his pureed food, reaching over his beverage. The resident dropped some food into his drink and attempted to fish it out with the fork. Resident #39 repeatedly put his fork in his drink.</p> <p>Resident #39 picked up the glass and drank some of his beverage and set the glass back in front of his plate. He continued reaching over the glass to eat his food. The registered dietitian (RD) was standing nearby observing residents and looking at her cellular phone.</p> <p>-The RD did not assist the resident with setting up his plate in a location where he could reach all of his food.</p> <p>At 12:35 p.m. Resident #39 dropped some pureed food from his fork onto the table. The resident attempted to pick the food up with his fork and eat it. He was attempting to reach the food on the far side of his plate, however he was unable to reach it, therefore the resident was only able to get small amounts of food on his fork.</p> <p>At 12:46 p.m. Resident #39 was attempting to get food out of his drink with his fork. He became distracted by another resident at his table and stopped eating.</p> <p>-The staff in the dining room did not notice or provide Resident #39 cueing to continue eating.</p> <p>At 12:53 p.m. Resident #39 leaned forward in his wheelchair to reach for the food on the far side of his plate but only got a small amount on his fork. The RD walked by but did not stop to assist him. Registered nurse (RN) #2 came into the dining room and looked over Resident #39's shoulder but did not offer to assist him.</p> <p>At 12:57 p.m. Resident #39 put down his fork and picked up his spoon. He leaned forward and reached for some more of the food on the far side of his plate. He continued this until he ate all the food within his reach, leaving the food that was around the far edge of the plate. The resident did not receive any dessert.</p> <p>At 1:06 p.m. the RD stopped at the table and talked to Resident #39's table mate. She did not offer to move Resident #39's plate closer to him.</p> <p>Resident #39 continued to lean forward in his wheelchair, reaching over his glass with his spoon. He was unable to reach more food and put the empty spoon into his mouth.</p> <p>At 1:12 p.m. certified nurse aide (CNA) #5, asked Resident #39 if he was going to eat anymore. She did not move his plate closer to him or move his glass out of the way so he could reach more food. Resident #39 did not respond to CNA #5. CNA #5 took his plate away. The plate had food remaining around the far edge from the 9:00 o'clock position to the 12:00 o'clock position. He had eaten approximately 75% of his meal. He did not receive a dessert.</p> <p>-The resident was observed attempting to eat without assistance for 41 minutes and did not eat 100% of his meal.</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>On 8/15/24 at 12:21 p.m. Resident #39 was observed eating lunch in the dining room with his plate directly in front of him. He had finished 100% of the meal and dessert. He continued putting the spoon on his plate and into his mouth, but there was no food left on the plate.</p> <p>The RD approached Resident #39 and asked him if he wanted more to eat. She brought another plate of food to him and he continued eating.</p> <p>C. Record review</p> <p>The self-care deficit care plan, initiated 1/20/22, documented Resident #39 had a self-care performance deficit related to impaired cognition and mobility due to dementia. The pertinent intervention included providing set-up to supervision assistance with eating.</p> <p>The nutritional care plan, revised on 7/31/24, documented Resident #39 had a nutritional problem related to diagnoses of dementia, dysphagia, protein calorie malnutrition and moderate cognitive impairment. He was at risk of malnutrition per the mini nutritional assessment (MNA) score and had a history of difficulty swallowing. The pertinent interventions included a nose cup (specialized cup to aid with swallowing), mechanically altered meal with thickened liquids, providing assistance with meals as needed and large portions per resident request.</p> <p>-The care plan did not specify how much assistance Resident #39 needed with meals.</p> <p>-There were no new nutrition interventions added to the care plan since 12/20/23, including since his recent weight loss (see weights below).</p> <p>According to the August 2024 CPO, the resident had a physician's order for a consistent carbohydrate (CCHO) diet, pureed texture with honey thick liquids, ordered 7/3/24.</p> <p>An evening snack was ordered on 10/24/22.</p> <p>-Review of the resident's electronic medical record (EMR) did not reveal any additional nutritional interventions that were implemented.</p> <p>The nutrition evaluation, dated 7/3/24, indicated Resident #39 was independent with eating, he was alert and oriented and was able to make his needs known. It indicated his usual meal intakes were 75-100%, his weight was stable and there were no new recommendations.</p> <p>-The resident's EMR did not reveal any further documentation from the RD regarding his weight trending downward and the 6.36% weight loss in just under four months (see weights below).</p> <p>Resident #39's weights were documented as follows:</p> <p>-On 4/11/24, the resident weighed 154.0 pounds (lbs);</p> <p>-On 5/2/24, the resident weighed 151.8 lbs;</p> <p>-On 6/5/24, the resident weighed 151.3 lbs;</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>-On 7/17/24, the resident weighed 148.0 lbs (6 lb weight loss, 3.9%); and,</p> <p>-On 8/1/24, the resident weighed 144.2 lbs (9.8 lb weight loss, 6.36%).</p> <p>Resident #39's documented weights revealed a gradual weight loss over the past four months with a total loss of 9.8 lbs.</p> <p>Review of the CNA charting (from 7/17/24 to 8/13/24) revealed Resident #39 had accepted an evening snack eight times in the past 28 days.</p> <p>Review of the CNA charting (from 7/1/24 to 8/14/24) revealed Resident #39 had a decrease in meal intakes beginning on 7/1/24. The meal intake documentation was as follows:</p> <p>-From 7/1/24 to 7/16/24, Resident #39 consumed an average of 76-100% of his meals 34% of the time;</p> <p>-From 7/17/24 to 7/31/24, Resident #39 consumed an average of 76-100% of his meals 26% of the time; and,</p> <p>-From 8/1/24 to 8/14/24, Resident #39 consumed an average of 76-100% of his meals 11% of the time.</p> <p>III. Staff interviews</p> <p>CNA #7 was interviewed on 8/15/24 at 2:00 p.m. CNA #7 said plates should be set directly in front of the residents so the residents could reach their meal. She said for residents who required set-up assistance, she would place the utensil in their hand and make sure they started eating.</p> <p>CNA #7 said the residents should be positioned correctly in their chairs. She said this was important to ensure the residents got adequate nutrition and did not choke.</p> <p>CNA #7 said Resident #39 required set-up assistance. She said she would hand him the spoon and make sure he started eating.</p> <p>The RD was interviewed on 8/15/24 2:15 p.m. The RD said if a resident required set-up assistance with meals, the staff should unwrap their silverware, hand them the napkin, cut up the food and offer the resident condiments. She said the amount of assistance needed varied with each resident.</p> <p>The RD said Resident #39 required set-up assistance. She said the facility staff needed to get his plate set up in front of him and monitor him in case he needed further assistance throughout the meal.</p> <p>The RD said Resident #39 had a steady weight decline over the past four months. She said it had not triggered on her radar yet, because it was not considered significant. She said additional nutritional interventions had not yet been put into place for the weight loss. She said she would recommend for Resident #39 to have double portions at every meal and she would add him to the nutrition at risk committee for review.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185</p> <p>Based on record review and interviews, the facility failed to ensure one (#59) of one resident out of 33 sample residents was free of significant medication errors.</p> <p>Specifically, the facility failed to ensure Resident #59 was administered medication in regular intervals for Parkinson's disease according to the manufacturer recommendations, which resulted in the resident experiencing increased tremors, a symptom of his Parkinson's disease.</p> <p>Findings include:</p> <p>I. Professional references</p> <p>According to the carbidopa/levodopa dosing instructions, retrieved from https://www.goodrx.com/carbidopa-levodopa/dosage on 8/14/24, A combination of two medications: carbidopa and levodopa. Levodopa replaces dopamine, which improves symptoms of Parkinson's disease. And carbidopa helps levodopa stick around longer in the body.</p> <p>If you miss a dose of carbidopa/levodopa, take the medication as soon as you remember. But if you remember when you're already close to taking your next dose, skip the missed one.</p> <p>Don't take more than one carbidopa/levodopa dose at a time. Doubling up on doses can be dangerous and lead to more side effects, such as movement problems and mood changes.</p> <p>Taking too much carbidopa/levodopa can be dangerous and increase your risk of side effects. These side effects may include low blood pressure, a fast heartbeat and confusion.</p> <p>According to carbidopa-levodopa dosing guidelines, retrieved from https://www.drugs.com/medical-answers/carbidopa-levodopa-3562239/ on 8/14/24, It is important to adhere to the schedule closely, and it is recommended that you take the medication at the same time each day.</p> <p>It may be best to take your first daily dose one to two hours before eating your first meal of the day.</p> <p>Taking carbidopa and levodopa soon after eating a meal that is high in fat and calories can elongate the time it takes for your body to absorb the medication and feel its effects. Eating lots of protein or acidic foods with the medication may also delay the onset of the medication's effects.</p> <p>The short-acting (immediate-release) formulation of carbidopa/levodopa takes effect within about 20 to 50 minutes.</p> <p>II. Facility policy and procedure</p> <p>The Medication Administration Times policy, undated, was provided by the nursing home administrator (NHA) on 8/12/24 at 12:00 p.m. It documented, The facility medication administration times are: 7:00 a.m. to 10:00 a.m., 11:00 a.m. to 2:00 p.m., 3:00 p.m. to 6:00 p.m. and 7:00 p.m. to 10:00 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>III. Resident #59</p> <p>A. Resident status</p> <p>Resident #59, age 72, was admitted on [DATE] and readmitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included Parkinson's disease.</p> <p>The 8/7/24 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. He required partial or moderate assistance with activities of daily living (ADL).</p> <p>B. Resident interview and observations</p> <p>Resident #59 was interviewed on 8/13/24 at 10:07 a.m. Resident #59 said he had been living with Parkinson's disease for a long time. He said a side effect of the disease that he dealt with every day was hand tremors.</p> <p>Resident #59 said he had never experienced this bad of hand tremors. He said the facility had not been administering his medication appropriately. He said he still had not received his morning medications that day (8/13/24). He said he had to stop his physical therapy that morning (8/13/24) because his hand tremors were so bad that it was difficult to walk with the walker.</p> <p>Resident #59 said his hand tremors had been worse since he was admitted to the facility. He said the facility was not administering his medications at the appropriate times and it was making his hand tremors worse. He said the facility would administer the medications after he ate. He said his Parkinson's medication should be administered an hour before he ate a meal.</p> <p>Resident #59 was observed sitting in his bed, with his legs over the side and feet on the ground. His hand tremors were significant. The resident was unable to still his hands.</p> <p>On 8/14/24 at 9:40 a.m. registered nurse (RN) #3 was observed administering Resident #59's medications RN #3 handed Resident #59 a cup of water to rinse his mouth after an inhaler. Resident #59 had significant hand tremors and spilled the cup of water onto his shirt. RN #3 offered to assist the resident with the water. Resident #59 agreed.</p> <p>RN #3 said she needed to go to the medication cart to get Resident #59 a straw since his tremors were so significant.</p> <p>As RN #3 was administering Resident #59's medication, the physical therapy assistant (PTA) entered the resident's room. Resident #59 said he was not able to participate in therapy for at least 30 minutes, until the medication had time to take effect and his tremors would reduce. The PTA left the room and said she would return later in the day.</p> <p>C. Record review</p> <p>The Parkinson's disease care plan, initiated on 7/11/24 and revised on 7/12/24, documented Resident #59 was on anti-Parkinson therapy. The interventions included administering the medications as ordered.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The August 2024CPO documented the following physician's order:</p> <p>Carbidopa-Levodopa 25-100 mg (milligrams), give two tablets by mouth four times a day for Parkinson's disease, ordered 7/31/24.</p> <p>The August 2024 medication administration record (MAR) documented the administration times for Resident #59's carbidopa-levodopa medication were as follows: in the morning, mid-day, evening 1 and evening 2.</p> <p>-The medication was not scheduled to be administered at a specific time.</p> <p>The August 2024 MAR detailed the following administrations of the carbidopa-levodopa medication:</p> <p>On 8/1/24, the medication was administered at 9:15 a.m., 11:50 a.m. (two hours and 35 minutes after the last dose), 3:56 p.m. (four hours and six minutes after the last dose) and 8:19 p.m. (four hours and 35 minutes after the last dose).</p> <p>On 8/2/24, the medication was administered at 10:18 a.m., 2:15 p.m. (four hours and three minutes after the last dose), 3:35 p.m. (one hour and 20 minutes after the last dose) and 11:12 p.m. (seven hours and 37 minutes after the last dose).</p> <p>On 8/3/24, the medication was administered at 8:25 a.m., 11:46 a.m. (three hours and 11 minutes after the last dose), 3:17 p.m. (three hours and 31 minutes after the last dose) and 11:52 p.m. (seven hours and 35 minutes after the last dose).</p> <p>On 8/4/24, the medication was administered at 8:59 a.m., 12:15 p.m. (three hours and 16 minutes after the last dose), 3:28 p.m. (three hours and 13 minutes after the last dose) and 8:58 p.m. (five hours and 30 minutes after the last dose).</p> <p>On 8/5/24, the medication was administered at 8:37 a.m., 12:05 p.m. (three hours and 28 minutes after the last dose), 3:51 p.m. (three hours and 46 minutes after the last dose) and 7:37 p.m. (three hours and 46 minutes after the last dose).</p> <p>On 8/6/24, the medication was administered at 10:15 a.m., 3:05 p.m. (four hours and 50 minutes after the last dose), 4:36 p.m. (one hour and 31 minutes after the last dose) and 7:54 p.m. (three hours and 18 minutes after the last dose).</p> <p>On 8/7/24, the medication was administered at 9:50 a.m., 1:52 p.m. (three hours and 2 minutes after the last dose), 4:45 p.m. (two hours and 53 minutes after the last dose) and 7:46 p.m. (three hours and one minute after the last dose).</p> <p>On 8/8/24, the medication was administered at 8:53 a.m., 1:37 p.m. (four hours and 16 minutes after the last dose), 3:50 p.m. (two hours and 13 minutes after the last dose) and 8:21 p.m. (four hours and 29 minutes after the last dose).</p> <p>On 8/9/24, the medication was administered at 10:21 a.m., 2:17 p.m. (three hours and 56 minutes after the last dose), 5:39 p.m. (three hours and 22 minutes after the last dose) and 8:26 p.m. (two hours and 47 minutes after the last dose).</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/10/24, the medication was administered at 8:37 a.m., 12:42 p.m. (four hours and five minutes after the last dose), 3:17 p.m. (two hours and 25 minutes after the last dose) and 7:47 p.m. (four hours and 30 minutes after the last dose).</p> <p>On 8/11/24, the medication was administered at 8:29 a.m., 12:34 p.m. (four hours and five minutes after the last dose), 4:17 p.m. (three hours and 43 minutes after the last dose) and 9:12 p.m. (four hours and 55 minutes after the last dose).</p> <p>On 8/12/24, the medication was administered at 9:43 a.m., 11:37 a.m. (one hour and 44 minutes after the last dose), 2:37 p.m. (three hours after the last dose) and 7:23 p.m. (four hours and 46 minutes after the last dose).</p> <p>On 8/13/24, the medication was administered at 10:07 a.m., 12:07 p.m. (two hours after the last dose), 3:26 p.m. (three hours and 19 minutes after the last dose) and 10:25 p.m. (seven hours after the last dose).</p> <p>The August 2024 MAR, from 8/1/24 to 8/13/24, indicated the following:</p> <ul style="list-style-type: none"> -The medication was administered late, according to the facility medication administration times, on five occasions; -The medication was given in less than four hour intervals on 26 occasions; -The medication was given over a four hour interval on 12 occasions; and, -The medication was not administered consistently at the same time every day (see professional references above and pharmacist interview below). <p>IV. Staff interviews</p> <p>RN #3 was interviewed on 8/14/24 at 9:40 a.m. RN #3 said the facility had scheduled administration time frames of 7:00 a.m. to 10:00 a.m. for morning medications, 11:00 a.m. to 2:00 p.m. for mid-day medications, 3:00 p.m. to 6:00 p.m. for evening medications and 7:00 p.m. to 10:00 p.m. for nocturnal medications. She said medications should be administered during those time frames.</p> <p>RN #3 said Resident #59 had a diagnosis of Parkinson's disease. She said she had observed Resident #59 with significant hand tremors since his admission to the facility.</p> <p>RN #3 said Resident #59 was administered the carbidopa-levodopa medication due to the resident's diagnosis of Parkinson's disease. She said she administered the medications in the time frame indicated. She said she did not know if the medication should be administered at the same time every day or in a specific interval. She said she administered the medication when she was able.</p> <p>RN #3 said if the medication was administered outside the facility's designated time frame it was considered late and that was a medication error.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The pharmacist (PH) was interviewed on 8/15/24 at 10:37 a.m. The PH said Resident #59 had a diagnosis of Parkinson's disease and was prescribed carbidopa-levodopa medication to alleviate the symptoms of the disease. She said the symptoms of Parkinson's disease could include hand tremors.</p> <p>The PH said the facility had medication administration time intervals to administer medications. She said the intervals established at the facility were 7:00 a.m. to 10:00 a.m. for morning medications, 11:00 a.m. to 2:00 p.m. for mid-day medications, 3:00 p.m. to 6:00 p.m. for evening medications, and 7:00 p.m. to 10:00 p.m. for nocturnal medications.</p> <p>The PH said that carbidopa-levodopa should be administered in regular intervals and at the same time every day to promote consistent blood levels, ideally in four hour intervals. She said there should be several hours in between each dose. She said Resident #59 could experience a variation in side effects of Parkinson's disease if the medication was not given according to the administration guidelines.</p> <p>The PH said the facility was not administering Resident #59's carbidopa-levodopa medication appropriately. She said the facility should have scheduled the medication at a specific time to ensure the resident received the medication at the appropriate intervals in order to provide him with the appropriate blood levels of the medications to help with the side effects of his Parkinson's disease.</p> <p>The PH said it was possible for Resident #59 to experience an increase in hand tremors because the medication was not being administered in the appropriate intervals.</p> <p>The PH said she would contact the facility immediately and ensure the medication was scheduled at the same time every day and within four hour intervals.</p> <p>The PTA was interviewed on 8/15/24 at 12:35 p.m. The PTA said she had worked with Resident #59. She said Resident #59 had significant hand tremors. She said Resident #59 had experienced an increase in his hand tremors on 8/14/24 and she had to provide him with additional assistance.</p> <p>The PTA said Resident #59 got really frustrated when his hand tremors increased. She said she was the therapist that entered the room when the resident was taking his medications. She said she witnessed him spilling the water down the front of his shirt because of his hand tremors. She said Resident #59 was usually able to drink by himself.</p> <p>The director of nursing (DON), the NHA and the clinical consultant (CC) were interviewed on 8/15/24 at 5:44 p.m. The DON said the facility had designated medication administration times of 7:00 a.m. to 10:00 a.m. for morning medications, 11:00 a.m. to 2:00 p.m. for mid-day medications, 3:00 p.m. to 6:00 p.m. for evening medications, and 7:00 p.m. to 10:00 p.m. for nocturnal medications. She said medications not administered during those time frames were considered late and a medication error.</p> <p>The DON said Resident #59 had a diagnosis of Parkinson's disease and had significant hand tremors. She said carbidopa-levodopa should be administered at the same time every day and within four hour intervals. She said this was important to make sure blood levels were at the appropriate level to ensure the medication was effective.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON said Resident #59 was not being administered the carbidopa-levodopa medication according to the administration guidelines for the medication. She said she spoke with the PH and they scheduled the medication to be administered at specific times that day (8/15/24).</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853</p> <p>Based on observations and interviews, the facility failed to ensure medications and biologicals were properly stored and labeled in accordance with professional standards in two of three medication carts and one of one medication storage rooms.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure controlled medications were securely stored under double lock; -Ensure expired medications were removed from the medication carts and the medication storage room; and, -Ensure medications were labeled with an expiration date. <p>Findings include:</p> <p>I. Professional reference</p> <p>The United States Food and Drug Administration (USFDA) (2/8/21) Don't Be Tempted to Use Expired Medicines, was retrieved on 8/19/24 from https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines. It read in pertinent part, Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it.</p> <p>II. Facility policy and procedure</p> <p>The Storage of Medication policy, dated January 2024, was provided by the nursing home administrator (NHA) on 8/15/24 at 9:12 p.m. It read in pertinent part,</p> <p>Controlled medications should be stored separately from non-controlled medications. The access system (key, security codes) used to lock controlled medications, cannot be the same access system used to obtain the non-controlled medications.</p> <p>Outdated, contaminated, discontinued or deteriorated medications are immediately removed from stock and disposed of according to procedures for medication disposal.</p> <p>III. Observations</p> <p>On 8/14/24 at 4:35 p.m. the medication storage room was observed with the director of nursing (DON). The following items were found:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Four one ounce (oz) tubes of bacitracin ointment (first aid antibiotic) that expired in March 2024.</p> <p>The following personal medications were found in a plastic grocery bag in the medication room. The DON said a resident brought them in from home upon admission.</p> <p>-One three oz tube of Theragesic cream (pain relieving cream) that expired in December 2018;</p> <p>-One 1.8 oz tube of hemorrhoid cream that expired in July 2020;</p> <p>-One 5.5 oz tube of Neosporin ointment (first aid antibiotic) that expired in November 2014;</p> <p>-One 3.8 oz bottle of lidocaine hemorrhoid spray that expired in October 2023;</p> <p>-One bottle of Lexapro 10 milligrams (mg) (antidepressant medication) that expired on 6/1/24;</p> <p>-One bottle of hydrochlorothiazide 25 mg (diuretic medication) that expired on 5/17/24; and,</p> <p>-One bottle of lorazepam 0.5 mg, (a controlled anti anxiety medication) containing two tablets, that was not in a locked cabinet.</p> <p>On 8/15/24 at 1:00 p.m. the Aspen hall medication cart was observed with licensed practical nurse (LPN) #1. The following item was found:</p> <p>-One bottle of Pro-Stat (liquid protein supplement) 30 oz that expired on 7/31/24.</p> <p>On 8/15/24 at 1:44 p.m. the [NAME] hall medication cart was observed with registered nurse (RN) #1. The following items were found:</p> <p>-Three bottles of magic mouthwash with no expiration date on the pharmacy label; and,</p> <p>-One bottle of Systane lubricant dry eye relief 1.5 oz that expired in July 2024.</p> <p>IV. Staff interviews</p> <p>LPN #1 was interviewed on 8/15/24 at 1:00 p.m. LPN #1 said the night shift nurse checked the medication carts for expired medications, cleaned the carts and checked for loose pills. She said if a medication was expired, the night shift nurse removed it from the cart and placed it in the designated area in the medication room for expired medications.</p> <p>The DON was interviewed on 8/14/2024 at 4:45 p.m. The DON said if a resident brought medications from home, the medications should be reviewed with the doctor to determine if the resident was still taking them. She said if the medication had been discontinued or changed, the resident's family should take the medications home. The DON said medications brought from home should be checked for expiration dates. The DON said controlled medication should be secured under a double lock.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114</p> <p>Based on record review and interviews,, the facility failed to assist residents in obtaining routine or emergency dental services, as needed for two (#23 and #18) of four residents reviewed for dental services out of 33 sample residents.</p> <p>Specifically, the facility failed to ensure:</p> <ul style="list-style-type: none"> -Dental services were offered to Resident #23; and, -Resident #18 was provided dentures in a timely manner. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Dental Services policy and procedure, dated January 2020, was provided by the nursing home administrator (NHA) on 8/15/24 at 9:12 p.m. It read in pertinent part, It is the policy of this facility, in accordance with residents' needs, to promptly assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care.</p> <p>The dental needs of each resident are identified through the physical assessment and minimum data set (MDS) assessment processes and are addressed in each resident's plan of care.</p> <ul style="list-style-type: none"> -Oral/dental status shall be documented according to assessment findings. -Oral care and denture care shall be provided in accordance with identified needs and as specified in the plan of care. <p>The social services director (SSD) maintains contact information for providers of dental services that are available to facility residents at a nominal cost.</p> <p>The facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location.</p> <p>All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record.</p> <p>II. Resident #57</p> <p>A. Resident status</p> <p>Resident #23, age 71, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis (impaired communication between the brain and muscles) and chronic systolic (congestive) heart failure.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 2/2/24 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He was dependent on staff assistance with showering/bathing himself, lower body dressing, putting on/taking off footwear, lying to sitting, sitting to stand, chair/bed and bed/chair transferring and tub/shower transferring.</p> <p>The MDS assessment indicated the resident had no dental issues.</p> <p>-However, the resident had broken teeth (see resident observation and interview below).</p> <p>B. Resident interview and observation</p> <p>Resident #23 was interviewed on 8/12/24 at 10:30 a.m. Resident #23 said he had not seen the dentist since he was admitted to the facility. He said he would like to see the dentist because he would like his teeth to be fixed.</p> <p>An observation of Resident #23's mouth revealed the resident had a couple of broken teeth.</p> <p>C. Record review</p> <p>The nutrition care plan, revised 7/31/24, documented Resident #23 had potential nutritional problem related to urinary tract infection (UTI), congestive heart failure (CHF), failure to thrive, seizure disorder, acute on chronic respiratory failure, diabetes, edema and diuretic treatment, obesity per body mass index (BMI), poor dentition but resident declined diet texture downgrade, dietary noncompliance and fluid related significant weight gain.</p> <p>Interventions included diet as ordered by physician (regular, regular, thin), food preferences (chicken, beef, peanut butter) and honoring resident rights to make personal dietary choices and provide dietary education as needed.</p> <p>Review of the August 2024 CPO revealed the following physician's order:</p> <p>Resident may have doctor of dental surgery (DDS), ophthalmology, audio and podiatry care as needed, ordered 1/30/24.</p> <p>A 1/31/24 social services note documented the social worker met with Resident #23 and no immediate concerns were noted per the resident regarding vision or dental needs. However, Resident #23 told the social worker he should see a dentist at some point. The social worker would continue to follow and assist the resident as needed.</p> <p>a 4/30/24 social service quarterly note documented vision, dental, and hearing were not a concern for Resident #23 but he was open to getting dentures. The social worker would continue to follow and assist the resident as needed.</p> <p>III. Resident #18</p> <p>A. Resident status</p> <p>(continued on next page)</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #18, age 78, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included chronic kidney disease stage four and dementia.</p> <p>The 4/26/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He required setup or clean up assistance with eating, oral hygiene, showering/bathing himself, upper and lower body dressing, putting on/taking off footwear and personal hygiene.</p> <p>The MDS assessment revealed Resident #18 had no natural teeth or tooth fragments (edentulous).</p> <p>B. Resident interview</p> <p>Resident #18 was interviewed on 8/12/24 at 10:27 a.m. Resident #18 said he had no teeth and was promised a year ago (in 2023) the facility would help him get some dentures. He said he saw the dentist at the facility but still had not received dentures. The resident said he would like to get dentures.</p> <p>C. Record review</p> <p>The care plan for dentition, revised 6/7/22, documented Resident #18 had the potential for impaired dentition as he was edentulous and did not have dentures because he had lost them. Interventions included coordinating arrangements for dental care, transportation as needed/as ordered, monitoring/documenting/reporting to the medical doctor (MD) as needed (PRN) signs/symptoms of oral/dental problems needing attention, teeth missing, loose, broken, eroded, or decayed and providing mouth care as per activities of daily living (ADL) personal hygiene.</p> <p>Review of the August 2024 CPO revealed the following physician's order:</p> <p>Resident may have doctor of dental surgery (DDS), ophthalmology, audio and podiatry care as needed, ordered 5/19/22.</p> <p>A dental note dated 8/23/23 documented Resident #18 was seen by the dentist. The dentist documented a pre-authorization would be obtained for full upper and full lower dentures. The resident would have dental impressions for full upper and lower dentures taken on his next dental visit.</p> <p>A quarterly social services assessment, dated 11/1/23, documented Resident #18 was up to date with his vision and dental care. The social worker would continue to follow and assist the resident with support.</p> <p>A quarterly social services assessment, dated 2/2/24, failed to reveal documentation that Resident #18 had been offered dental care services.</p> <p>A quarterly social services assessment, dated 4/24/24, failed to reveal documentation that Resident #18 had been offered dental care services</p> <p>A quarterly social services assessment, dated 7/24/24, failed to reveal documentation that Resident #18 had been offered dental care services.</p> <p>IV. Staff interviews</p> <p>(continued on next page)</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Certified nurse aide (CNA) #1 was interviewed on 8/15/24 at 10:08 a.m. CNA #1 said she did not know the process for follow up visits or recommendations from the dentist. She said she would give any information to management. She said Resident #18 had his natural teeth. She said Resident #18 had no concerns with his food and he was independent with all his meals. She said Resident #18 had not voiced any concerns about his teeth.</p> <p>-However, Resident #18 did not have any natural teeth (see record review and resident interview above).</p> <p>CNA #1 said if a resident reported any oral/dental pain or lost or damaged dentures she would notify the nurse.</p> <p>Licensed practical nurse (LPN) #2 was interviewed on 8/15/24 at 11:35 a.m. LPN #2 said if a resident reported having any problems with their teeth she would notify the assistant director of nursing (ADON) and see about getting a dental appointment made for the resident. She said if a resident reported any oral/dental changes she would report it to the ADON so that they could make a dental appointment.</p> <p>LPN #2 said the dentist came to the facility and was there every few months. She said Resident #18 had seen the dentist but she did not know when he was last seen. She said she would have to follow up with the ADON.</p> <p>The social service director (SSD) was interviewed on 8/15/24 at 3:10 p.m. The SSD said she was in charge of arranging ancillary services, including dental services for the residents. She said if residents requested to be seen by the dentist then they would be seen. She said seeing the dentist was offered upon admission. She said she let the residents know what services were offered. She said the dentist came to the facility to see residents. She said she did not know that Resident #23 and Resident #18 needed to be seen by the dentist. She said she had no idea when Resident #18 or Resident #23 were last seen by the dentist. She said the facility had not been getting the records from the dentist and had requested the records for the last three months.</p> <p>The SSD said the dentist was at the facility in July 2024 and the dental hygienist would be coming in September 2024. She said the dentist and the dental hygienist alternated visits with each other and came to the facility every other month. She said ancillary services were offered every three months in care conferences. The SSD said residents could also request to be placed on a list to be seen the next time the dentist or the dental hygienist were in the facility.</p> <p>The SSD said residents should be seen by the dentist annually for dental care and every six months for hygiene care. She said residents could be seen more frequently or less frequently depending on their dental needs and the recommendations of the dental provider.</p> <p>The SSD said Resident #18 was on the list to be seen in September 2024. She said Resident #18 was last seen by the dentist on 8/23/23. She said she did not know if Resident #18 had received dentures or if anyone had followed up with him about the dentures since his last visit in August 2024. She said she would follow up on the services for Resident #18.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The SSD said if Resident #23 had requested to be seen by the dentist he should have been seen. She said upon admission residents were offered to be seen by the dentist. She said she did not know Resident #23 wanted to be seen by the dentist. She said she did not know if he had ever been seen by the dentist. She said she would be following up with the resident about dental services and get him on the list to be seen.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853</p> <p>Based on observations and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on one of three units.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure housekeeping staff disinfected high touch surfaces (call lights, door handle and light switches) in resident rooms; -Ensure surface disinfectant dwell times (the amount of time a disinfectant needs to remain wet on a surface to effectively kill germs) were followed; -Ensure areas were cleaned from clean areas to dirty areas; and, -Ensure hand hygiene was performed appropriately during the cleaning of residents' rooms. <p>Findings include:</p> <p>I. Professional reference</p> <p>According to The Centers for Disease Control (CDC) Environment Cleaning Procedures (3/19/24), retrieved on 8/20/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html#,</p> <p>High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility.</p> <p>Common high-touch surfaces include:</p> <ul style="list-style-type: none"> -bedrails; -IV (intravenous) poles; -sink handles; -bedside tables; -counters; -edges of privacy curtains; -patient monitoring equipment (keyboards, control panels); <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-call bells; and,</p> <p>-door knobs.</p> <p>Proceed From Cleaner to Dirtier</p> <p>Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include:</p> <p>-During terminal cleaning, clean low-touch surfaces before high-touch surfaces;</p> <p>-Clean patient areas (patient zones) before patient toilets; and,</p> <p>-Within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone.</p> <p>II. Manufacturer's recommendations</p> <p>The Ecolab product specification document for Peroxide multi-surface cleaner and disinfectant was provided by the housekeeping manager (HM) on 8/15/24 at 5:15 p.m. It read in pertinent part:</p> <p>Treated surfaces must stay wet for 90 seconds for use as a sanitizer. For bactericidal or virucidal use, the solution should stay wet on the surface for five minutes before wiping.</p> <p>III. Facility policy</p> <p>The Room and Bathroom Cleaning policy, not dated, was provided by the nursing home administrator (NHA) on 8/15/24 at 9:12 p.m. It read in pertinent part,</p> <p>It is the policy of this facility to establish policies, procedures and guidelines to provide a clean and sanitary environment for residents, staff and visitors in order to prevent cross contamination and transmission of healthcare-associated infections (HAI).</p> <p>Employees are required to use standard precautions when handling body fluids, excretions, secretions and contaminated equipment or environmental surfaces. Standard precautions refers to infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status and includes hand hygiene, use of gloves, gown, mask, eye protection or face shield.</p> <p>Working from clean areas to dirty areas:</p> <p>-Remove soiled linen from floor, wipe up any spills and remove waste;</p> <p>-Clean door handle, frame and light switch;</p> <p>-Clean wall attachments (if applicable);</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Medallion Post Acute Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1719 E Bijou St Colorado Springs, CO 80909	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Clean inside and outside the sink, sink faucets and mirror. Wipe plumbing under the sink. Apply disinfectant to interior of sink and allow sufficient contact time with disinfectant according to manufacturer's recommendation. Rinse sink and dry fixtures;</p> <p>-Clean all dispensers and frames;</p> <p>-Clean call bell and cord;</p> <p>-Clean support railings, ledges and shelves;</p> <p>-Clean shower/tub faucets, walls and railing, scrubbing as required to remove soap scum. Inspect grout for mold, apply disinfectant to interior surfaces of shower/tub, including soap dish, faucets and shower head. Allow sufficient contact time for disinfectant according to manufacturer's recommendations. Rinse and wipe dry. Inspect shower curtain and replace as required; and,</p> <p>-Clean entire toilet including handle and underside of flush rim. Apply disinfectant and allow sufficient contact time according to manufacturer's recommendations.</p> <p>IV. Observations</p> <p>On 8/15/23 at 9:55 a.m. housekeeper (HSK) #1 was observed cleaning a double occupancy room on the [NAME] unit.</p> <p>HSK #1 entered the resident room without donning gloves. She took the disinfectant cleaner into the bathroom and sprayed the toilet and grab bars with the disinfectant. She said she let the disinfectant remain on the surface for five minutes.</p> <p>HSK #1 got her broom and dustpan from her cart. She emptied the trash (without wearing gloves) then swept the floor on side two of the room with the broom, swept under the bed and around the resident's wheelchair, then moved the recliner and swept behind it. HSK #1 proceeded to side one of the room and swept the floor.</p> <p>HSK #1 put a glove onto her right hand. She took a rag in her gloved hand, wiped the toilet from the top of the tank to the seat and base and wiped the floor area around the toilet. She put the dirty rag into her left, ungloved hand, took the toilet cleaning brush with her gloved hand and cleaned the inside of the toilet.</p> <p>HSK #1 got a clean rag and wiped the bathroom grab bars without changing her glove or performing hand hygiene. She removed the glove, obtained a mop and mopped the bathroom floor.</p> <p>-HSK #1 did not perform hand hygiene after removing the glove.</p> <p>HSK #1 obtained a clean rag from her cart (without performing hand hygiene) and went back to side two of the room.</p> <p>HSK #1, without performing hand hygiene or applying a new pair of gloves, used the disinfectant cleaner to spray the windowsill and wiped it with her rag immediately. She sprayed and cleaned the sink area, wiping off the disinfectant immediately.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-HSK #1 did not allow the disinfectant to remain wet on the surfaces for the manufacturer recommended dwell time.</p> <p>HSK #1 put the dirty rag she used to clean the windowsill and sink area over her shoulder and mopped the floor under the window, under the bed and towards side one of the room. She cleaned the television and stand.</p> <p>-HSK #1 did not clean the high touch surfaces in the room, such as the call light cord, over the bed table, door handles or light switches.</p> <p>HSK #1 took the mop with the same mop head and mopped the floor on side one of the room.</p> <p>-HSK #1 did not perform hand hygiene before moving to side one of the room.</p> <p>HSK #1 sprayed the disinfectant cleanser on the over the bed table and wiped it off immediately. She sprayed the sink area with disinfectant and wiped it off immediately. She cleaned the television stand.</p> <p>-HSK #1 did not allow the disinfectant to remain wet on the surfaces for the manufacturer recommended dwell time.</p> <p>HSK #1 finished cleaning the room by mopping the entryway and partially into the hall. HSK #1 removed the dirty mop head but did not perform hand hygiene prior to moving to clean the next room.</p> <p>At 10:18 a.m. HSK #1 moved her cart in front of a single occupancy room on the [NAME] unit to begin cleaning that room.</p> <p>-HSK #1 did not perform hand hygiene or don a pair of gloves prior to entering the room and picking up trash from the floor.</p> <p>Without performing hand hygiene, HSK #1 proceeded to straighten items on the resident's nightstand and over the bed table. HSK #1 emptied the trash from the bathroom and took all the trash to the housekeeping cart in the hallway. She obtained a rag, toilet cleaner spray and brush.</p> <p>Without performing hand hygiene, HSK #1 put a glove on her right hand and sprayed the entire toilet, grab bars, shower chair and pull down seat in the shower with disinfectant cleaner. She said she would sweep the bedroom floor while the disinfectant sat on the surfaces for five minutes.</p> <p>HSK #1 took the broom and swept under the bed, around the room, under the sink area, and the entry area in front of the bathroom. She swept the bathroom and the rest of the entry area and out into the hall. She returned the broom to the cart, removed the glove and sanitized her hands.</p> <p>HSK #1 donned a glove on her right hand, took a clean rag and cleaned the toilet from top to bottom with her gloved hand. She used a clean rag and cleaned the hand rails by the toilet with the same glove on her right hand. She wiped the shower hand rails, shower chair and fold down seat in the shower. HSK #1 did not clean the shower walls or the shower floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>HSK #1 left the room to fill her mop with disinfectant. When she returned, she mopped part of the bathroom then cleaned the toilet with the toilet brush without donning gloves on either hand. She mopped the remainder of the bathroom.</p> <p>-HSK #1 did not perform hand hygiene after cleaning the toilet. She went to the bedroom and cleared personal items off of the counter around the sink. She sprayed the counter and sink with disinfectant cleaner and wiped it off immediately with a clean rag.</p> <p>-HSK #1 did not allow the disinfectant to remain wet on the surfaces for the manufacturer recommended dwell time.</p> <p>HSK #1 moved the resident's personal items (briefs, hanger, and hospital bags containing wipes) from a side table into the closet. She sprayed and wiped the side table with disinfectant cleaner.</p> <p>-HSK #1 did not perform hand hygiene after cleaning the toilet and prior to touching the resident's personal belongings.</p> <p>HSK #1 obtained her mop with a clean mop head and started mopping the floor under the bed. She picked up the telephone (without performing hand hygiene) to move the cords out of the way of her mop. She mopped under and around the furniture and then out of the room.</p> <p>-HSK #1 did not wipe down high touch surfaces such as the call light, door knobs or light switches.</p> <p>-HSK #1 did not clean the telephone after touching it with dirty hands.</p> <p>V. Staff interviews</p> <p>HSK #1 was interviewed on 8/15/24 at 10:37 a.m. HSK #1 said she only needed to wear gloves when cleaning the bathroom. She said she sanitized her hands when taking her gloves off. She said she cleaned the bathroom first and then the rest of the room.</p> <p>-However, HSK #1 was observed cleaning the bathroom in both rooms prior to cleaning the residents' rooms and did not perform appropriate hand hygiene during the room cleanings (see observations above).</p> <p>The infection preventionist (IP) was interviewed on 8/15/24 at 4:08 p.m. The IP said housekeepers should clean resident rooms from the cleanest part to the dirtiest part. She said bathrooms should be cleaned last. The IP said housekeepers should wear gloves when cleaning resident rooms and they should treat each side of the room separately. The IP said high touch surfaces should be cleaned at least daily.</p> <p>The HM was interviewed on 8/15/24 at 4:47 p.m. The HM said when cleaning residents' rooms, the housekeepers should spray disinfectant cleaner on high touch surfaces and let it sit for five minutes to kill all bacteria and viruses.</p> <p>(continued on next page)</p>		

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