| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065239 | A. Building<br>B. Wing | 06/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| San Luis Care Center | 240 Craft Dr<br>Alamosa, CO 81101 |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>48112<br><br>Based on record review and interviews, the facility failed to inform one (#39) of three residents reviewed for beneficiary notices and appeal rights out of 21 sample residents of changes in their services covered by Medicare in a timely manner.<br><br>Specifically, the facility failed to:<br><br>-Obtain a signature from the resident's authorized representative on liability notices for Resident #39, who had memory impairments; and,<br><br>-Provide written notification of Medicare Non-Coverage letters to the resident's representative of Medicare-covered services ended for Resident #39.<br><br>Findings include:<br><br>I. Facility policy<br><br>The Denial or End of Benefits policy, revised 7/11/23, was provided by the nursing home administrator (NHA) on 6/19/24 at 10:40 a.m. It revealed in pertinent part,<br><br>The Denial or End of Benefits process is in place to help the resident and family understand<br><br>their options and needs they might have regarding their care.<br><br>Upon end of coverage under Medicare, the resident and family will receive notice that specifically states the reason for non-coverage. The NOMNC (Notice of Medicare Non Coverage), Form CMS-10123, is given to all Medicare beneficiaries at least two days before the end of a Medicare-covered Part A stay or when all of Part B therapies are ending. The NOMNC informs the beneficiaries of the right to an expedited review by a Quality Improvement Organization.<br><br>II. Record review<br><br>A. Resident #39<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident #39's electronic medical record (EMR) revealed the resident had short-term and long-term memory deficits through staff assessment.<br><br>The EMR revealed Resident #39 was discharged from Medicare Part A funded therapy services on 1/25/24.<br><br>-The NOMNC notice was signed by the resident's representative on 1/25/24, the same day Resident #29's Medicare Part A benefits ended. The resident continued to live in the facility.<br><br>The medical record revealed Resident #39 was restarted on Medicare Part A funded therapy services on 4/13/24. Resident #39 was discharged from Medicare Part A funded therapy services on 4/26/24. The resident signed the NOMNC on 4/24/24 The skilled nursing facility advanced beneficiary (SNF ABN) was provided to the resident. The resident printed their name and ask her in the signature line of the patient or authorized representative section.<br><br>-A review of the resident's EMR revealed the resident's representative was not provided notice to indicate Resident #39's Medicare part A services were ending, given the estimated cost of services the resident would incur if they choose to pay out of pocket to continue services, the reason why Medicare was no longer continuing to pay for the particular service and the information to appeal if desired.<br><br>III. Staff interviews<br><br>The social services director (SSD) was interviewed on 6/19/24 at 9:48 a.m. The SSD said she started working at the facility in January 2024. The SSD said she and the minimum data set coordinator (MDSC) were responsible for notifying the resident or resident's representative when the Medicare benefits were ending. The SSD said when a resident's Medicare services were going to end, she would schedule a family meeting to review when the benefits would end. The SSD said during the meeting, the resident's representative signed the NOMNC if the resident was unable to sign the form. The SSD said the resident's representative was provided the NOMNC form and the SSD explained the appeal process. The SSD said the resident or resident's representative told the SSD if they wanted to appeal during the meeting. The SSD said she did not document when she contacted the family to schedule the meeting, the outcome of the meeting or if the NOMNC and SNF ABN were provided and signed by the resident or resident's representative. The SSD said she needed to better document the NOMNC process so it was clear the resident or resident's representative was notified, options were explained and the outcome was determined.<br><br>The SSD said she was familiar with Resident #39 and her Medicare part A services. The SSD said she had Resident #39 sign the NOMNC and ABN on 4/24/24. The SSD said she went to the resident's room to explain the NOMNC and SNF ABN. The SSD said the resident appeared alert and oriented. The SSD said after she talked to the resident, she contacted the resident's representative over the phone. The SSD said she did not have it documented when the representative was notified and she did not know if the NOMNC and SNF ABN form were provided to the resident's representative in person or by mail. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112<br><br>Based on record review and interviews, the facility failed to develop a comprehensive care plan for one (#18) of three residents out of 21 sample residents for services to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being that included measurable objectives and timeframes.<br><br>Specifically, the facility failed to develop an activities care plan focus for Resident #18.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Activities Progress Notes policy, revised 9/21/23, was provided by the nursing home administrator (NHA) on 6/19/24 at 12:11 p.m. It read in pertinent part,<br><br>Progress notes are written at least every 90 days from the date of the last progress note. These notes will include the status of activity problems, needs and concerns identified in the care plan, a description of the resident's progress towards achieving care plan goals, the documentation of specific recreation approaches in the care plan and the evaluation of approaches toward achieve goals and changes to be incorporated into the care plan based on evaluation information.<br><br>II. Resident #18<br><br>A. Resident status<br><br>Resident #18, age greater than 65, was admitted on [DATE]. According to the June 2024 computerized physician order (CPO), diagnoses included Alzheimer's disease, depression, anxiety and difficulty in walking.<br><br>The 3/19/24 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of five out of 15. He was dependent on showering and used a walker.<br><br>B. Record review<br><br>The 12/29/23 initial baseline care plan was reviewed.<br><br>-An activity focus area was not included in the initial baseline care plan.<br><br>-A review of Resident #18's comprehensive care plan, revised 3/22/24, did not reveal person centered activity preferences and interventions to meet the residents recreational needs and goals.<br><br>D. Staff interviews<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The activities director (AD) was interviewed on 6/19/24 at 11:20 a.m. The AD said she was responsible for creating the resident's recreation care plans. She said she had only implemented two activity care plans since she started in January 2024.<br><br>The AD said she did not create an activity specific care plan for Resident #18 because he participated in group activities and conversed with residents and staff. The AD said she created care plans when residents did not participate in activities and isolated themselves.<br><br>The nursing home administrator (NHA) was interviewed on 6/19/24 at 11:35 a.m. The NHA said all residents should have an activities care plan. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112<br><br>Based on observations, record review and interviews, the facility failed to provide an effective pain management regimen in a manner consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals for two (#3 and #25) of three residents out of 21 sample residents.<br><br>Specifically, the facility failed to:<br><br>-Offer non-pharmacological interventions for pain management for Resident #3 and Resident #25; and,<br><br>-Ensure the location of pain was identified when administering pain medications for Resident #3 and Resident #25.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Pain Assessment and Management policy, revised 9/12/23, was provided by the nursing home administrator (NHA) on 6/19/24 at 11:24 a.m. It revealed in pertinent part,<br><br>The facility will address and treat the underlying causes of pain, to the extent possible and develop and implement both non-pharmacological and pharmacological interventions and approaches to pain management.<br><br>Identify and use specific strategies for preventing or minimizing different levels or sources of pain based on the resident-specific assessment.<br><br>II. Resident #3<br><br>A. Resident status<br><br>Resident #3, age 75, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included systemic lupus erythematosus (a chronic autoimmune disease that causes the body's immune system), hemiplegia (paralysis on one side) and hemiparesis (weakness or inability to move one side of the body) following cerebral infarction (a stroke) affecting the right dominant side, falling, chronic kidney disease, bipolar disorder, schizophrenia, hallucinations and unsteadiness on feet.<br><br>The 3/29/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview mental status (BIMS) score of 15 out of 15. She required set-up assistance with toileting, dressing and personal hygiene. She required partial assistance with showering.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The assessment indicated she received as needed pain medications and non-medication interventions for pain management. She had pain almost constantly which interfered with day to day activities almost constantly. She described her pain as an 8 on a pain scale of 1-10.<br><br>-However, a review of the resident's electronic medical record (EMR) did not reveal non-medication interventions for pain management were consistently offered.<br><br>B. Resident interview<br><br>Resident #3 was interviewed on 6/17/24 at 9:43 a.m. She said at the time of the interview, she was in pain. Resident #3 said on a pain scale from 1-10, she rated her pain as an 8. She said she took Tylenol and the last time she took Tylenol was last night (6/16/24). She said watching television, listening to music, seeing family and lying down helped alleviate her pain. She said she had a bad fall about two months ago. She hit her head and she went to the hospital for 19 stitches. Resident #3 said her head hurt after the bad fall.<br><br>C. Record review<br><br>The pain care plan, revised 3/13/24, revealed the resident had pain related to the disease process of lupus and headaches. Interventions included to attempt non-pharmacological interventions that included repositioning, use of pillows and wedges, reassurance, redirection, heat and ice.<br><br>-The care plan did not identify the location of her pain.<br><br>The 4/30/24 pain assessment revealed the resident had pain in the back of her head and her neck.<br><br>-The pain assessment did not identify what made the pain worse, the pain better, her acceptable level of pain, pharmacological and non-pharmacological interventions and their effectiveness.<br><br>The June 2024 CPO revealed the following physician's order for pain management:<br><br>Acetaminophen 325 milligrams (mg). Administer two tablets by mouth every four hours as needed for pain level 5-10 on a scale of 1-10, ordered 5/6/24.<br><br>Acceptable level of pain 5 out of 10. Location of pain: back, legs, headache, feet. Non-pharmacological interventions: repositioning, positive distractions and offering fluids and snacks, ordered 4/7/22.<br><br>The January 2024 medication administration record (MAR) revealed acetaminophen was administered 17 days out of 31 days.<br><br>-A review of the resident's EMR revealed non-pharmacological interventions were not offered on 13 out of 17 days when acetaminophen was administered.<br><br>The February 2024 MAR revealed acetaminophen was administered on 21 days out of 29 days.<br><br>-A review of the resident's EMR revealed non-pharmacological interventions were not offered on 14 out of 21 days when acetaminophen was administered.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The March 2024 MAR revealed acetaminophen was administered on 15 days out of 31 days.<br><br>-A review of the resident's EMR revealed non-pharmacological interventions were not offered on 13 out of 15 days when acetaminophen was administered.<br><br>The April 2024 MAR revealed acetaminophen was administered on 23 days out of 30 days.<br><br>-A review of the resident's EMR revealed non-pharmacological interventions were not offered on 17 out of 23 days when acetaminophen was administered.<br><br>The May 2024 MAR revealed acetaminophen was administered on 12 days out of 31 days.<br><br>-A review of the resident's EMR revealed the location of the pain was not identified on three days of the 12 days acetaminophen was administered and non-pharmacological interventions were not offered on five days of the 12 days acetaminophen was administered.<br><br>The June 2024 MAR (6/1/24 to 6/18/24) revealed acetaminophen was administered on 14 days out of 18 days.<br><br>-A review of the resident's EMR revealed the location of the pain was not identified on 12 days of the 18 days acetaminophen was administered and non-pharmacological interventions were not offered on 12 days of the 18 days.<br><br>III. Resident #25<br><br>A. Resident status<br><br>Resident #25, age 79, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included malignant neoplasm of the left kidney (kidney cancer), end-stage renal disease, dialysis, type II diabetes and atherosclerotic (plaque buildup in the walls of arteries) heart disease.<br><br>The 5/6/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was independent for oral hygiene, toileting, dressing and personal hygiene. She required supervision for showering and set-up assistance for eating.<br><br>The assessment indicated the resident was not on a pain medication regimen and did not receive non-medication interventions for pain. She did not have pain in the past five days.<br><br>B. Resident interview and observation<br><br>Resident #25 was interviewed on 6/17/24 at 2:07 p.m. Resident #25 said she had pain in two of her fingers on her left hand. She said she took Tylenol and the facility did not offer non-pharmacological interventions. She said she had surgery related to her dialysis port and she was not getting proper circulation on her left extremity. Resident #25 eyes squinted and she grimaced throughout the interview while she described the pain. Resident #25 had two band-aids on her left index finger and left middle finger. She had a bruise on her upper left arm located on the side closest to her chest.<br><br>C. Record review<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The pain care plan, revised 5/15/24, revealed the resident had pain in her abdomen, her head, fistula site and her left pointer finger. The pain was related to GERD (gastro esophageal reflux disease), dialysis, injury to her finger and osteoarthritis. Interventions included administering medication and treatments as ordered and the acceptable level of pain was 3 out of 10 using a numeric pain scale of 1-10.<br><br>-The care plan did not identify non-pharmacological interventions.<br><br>The initial pain assessment on 5/6/24 revealed the resident did not have pain in the past five days.<br><br>The June 2024 CPO revealed the following phsycian's orders for pain management:<br><br>Lidocaine-prilocaine 2.5% cream. Apply cream to fistula site topically one a day every Monday, Wednesday and Friday for pain control for fistula access. Apply cream to the fistula site 60-90 minutes prior to leaving for dialysis, ordered 5/10/24.<br><br>Acetaminophen 325 mg. Administer two tablets by mouth every four hours as needed for pain, ordered 5/3/24.<br><br>Acceptable level of pain: 3 out of 10, on a scale of 1-10. Location of pain: pointer finger, abdomen and head. Attempt non-pharmacological interventions prior to administering pain medications: rest, distraction and ice, ordered 5/3/24.<br><br>-The physician's order did not identify what type of pain the acetaminophen attempted to alleviate.<br><br>The May 2024 MAR revealed acetaminophen was administered on 12 days out of 29 days.<br><br>-A review of the nurse progress notes from May 2024 (5/3/24 - 5/31/24) revealed that the location of the pain was not identified on two days of the 12 days acetaminophen was administered.<br><br>- A review of the resident's EMR revealed non-pharmacological interventions were not offered on four days of the 12 days the acetaminophen was administered.<br><br>The June 2024 MAR (6/1/24 to 6/18/24) revealed acetaminophen was administered on four days out of 18 days.<br><br>-A review of the resident's EMR revealed that non-pharmacological interventions were not offered on two days of the four days the acetaminophen was administered.<br><br>IV. Staff interviews<br><br>Licensed practical nurse (LPN) #1 was interviewed on 6/18/24 at 4:21 p.m. LPN #1 said pain was assessed throughout her shift. She said interventions were based on what she knew about the resident's pain history, their facial expressions throughout the day and she monitored their effect throughout her shift. She said she documented when a resident had pain in the MAR and as a progress note.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LPN #1 was familiar with Resident #3 and Resident #25. She said Resident #3 had generalized pain in her legs, in her shoulders and she had headaches. She said Tylenol, repositioning, food and distraction helped alleviate her pain. She said she documented non-pharmacological interventions as a progress note.<br><br>LPN #1 said Resident #25 had pain on her left hand on her second and third finger. She said the resident had ulcers at the tip of each finger that were being treated. She said the ulcers were due to the fistula she had for dialysis treatments. She said Tylenol, repositioning and elevating her hand helped alleviate Resident #25's pain.<br><br>The director of nursing (DON) was interviewed on 6/18/24 at 4:49 p.m. The DON said a pain assessment was completed at the time of admission, then every six hours for three days. The DON said pain was assessed prior to each pain medication administration. The DON said the assessment covered the onset, presences, duration, characteristics, cause, locations and interventions. She said interventions were personalized to each resident. She said non-pharmacological pain interventions included resting, elevating the part of the body that was in pain and an activity to distract the resident from their pain. The DON said interventions were documented in the assessment and as a progress note.<br><br>The DON said she was familiar with Resident #3 and Resident #25. She said Resident #3 did not have pain that often and the location varied. The DON said Resident #3 had a lot of headaches. She said a quiet and dark environment helped alleviate Resident #3's pain.<br><br>The DON said she was not as familiar with Resident #25's pain because she was a new resident. She said Resident #25 had pain surrounding her fistula site used for dialysis. The DON said a cream helped the resident's pain for her fistula.<br><br>The DON said was not aware that non-pharmacological interventions were not consistently offered for Resident #3 and Resident #25.<br><br>V. Facility follow-up<br><br>The 6/18/24 DON's nurse progress note for Resident #25 revealed the nurse asked if the resident experienced pain frequently and the resident denied. The resident said she did not experience pain very often. The nurse asked the resident when she did have pain if she was provided with interventions and Tylenol. The resident said yes when she had pain she took Tylenol and at times elevated her hand. The nurse asked if those interventions and medications alleviated her pain and the resident said yes. The nurse asked the resident about her fingers that tended to bother her and cause her pain. The resident said yes, she had pain in her fingers, but over the past week the pain has not been too bad. The nurse asked if there was anything else the facility could do to address her pain and the resident said no. The nurse told the resident to make sure the hall nurse knew when she experienced pain so the nurse could address it. The resident verbalized understanding.<br><br>-However, the pain care plan was not updated and the acetaminophen physician's order was not updated. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112<br><br>Based on record review and interviews, the facility failed to ensure residents who (#25) required dialysis received dialysis services consistent with professional standards of practice for one (#25) of one resident reviewed for dialysis out of 21 sample residents.<br><br>Specifically, the facility failed to:<br><br>-Ensure the physician's order for Resident #25' s fistula care was followed; and,<br><br>-Ensure the physician was notified when Resident #25' s fistula site healed.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Hemodialysis Offsite policy, revised 8/23/23, was provided by the nursing home administrator (NHA) on 6/17/24 at 11:21 a.m. It read in pertinent part,<br><br>The facility should provide immediate monitoring and documentation of the status of the resident' s access site upon return from the dialysis treatment to observe for bleeding or other complications.<br><br>Notify the physician of any change in mental or physical status.<br><br>II. Resident #25<br><br>A. Resident status<br><br>Resident #25, age 79, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included malignant neoplasm of left kidney (kidney cancer), end-stage renal disease, dialysis, type II diabetes mellitus and atherosclerotic (plaque buildup in the walls of arteries) heart disease.<br><br>The 5/6/24 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 was independent with oral hygiene, toileting, dressing and personal hygiene. She required supervision with showering and set-up assistance for eating.<br><br>The assessment revealed the resident was receiving dialysis while she resided at the facility.<br><br>B. Record review<br><br>The dialysis care plan, revised 5/3/24, revealed the resident received dialysis treatment related to stage four kidney disease.<br><br>(continued on next page) |

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|---|---|---|---|
| | 065239 | A. Building<br>B. Wing | 06/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| San Luis Care Center | 240 Craft Dr<br>Alamosa, CO 81101 |

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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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The chronic renal failure care plan, revised 5/16/24, revealed the resident had chronic renal failure related to end-stage disease and malignant neoplasm of the left kidney. Interventions included giving medications and supplements as ordered.<br><br>-A review of the dialysis and chronic renal failure care plans revealed there were no interventions for the skin treatment and monitoring of the fistula site (access site for dialysis).<br><br>The 6/6/24 skin assessment revealed the resident had bruises on her left upper arm dialysis shunt site.<br><br>The 6/13/24 skin assessment revealed the resident had bruises on her left upper arm shunt site.<br><br>The June 2024 CPO revealed the following treatment orders related to the resident' s fistula site:<br><br>-Left fistulogram. Apply antibiotics and band-aid until healed to the left upper arm, monitor for signs and symptoms of infection. Complete every day shift for wound, ordered 6/6/24 and discontinued on 6/8/24.<br><br>-Left fistulogram. Apply antibiotics and band-aid until healed to the left upper arm, monitor for signs and symptoms of infection. Complete every day shift for wound, ordered 6/8/24.<br><br>-The physician' s orders failed to indicate what antibiotic to apply to the fistula site.<br><br>-Review of the resident' s June 2024 medication administration record (MAR) revealed the treatment to the fistula site was not completed on 6/13/24, 6/14/24, 6/15/24 and 6/16/24.<br><br>-Review of Resident #25' s electronic medical record (EMR) did not reveal the physician was notified when the physician' s order was not followed from 6/13/24 to 6/16/24.<br><br>III. Staff interviews<br><br>Licensed practical nurse (LPN) #1 was interviewed on 6/18/24 at 4:21 p.m. LPN #1 said when a resident received dialysis care she monitored the resident' s vital signs and weight before and after her shift. LPN #1 said she also monitored the fistula site for any changes or abnormalities.<br><br>LPN #1 said she had worked with Resident #25. She said Resident #25 had a fistula on her left arm for dialysis. She said antibiotics and a band aid were applied until she noticed a scab had formed. LPN #1 said she did not follow the physician' s order because a scab was nature' s version of a band-aid. She said she monitored the site daily for signs and symptoms of infection. She said she did not notify the physician when she did not use antibiotic cream and a band aid when the scab developed .<br><br>The director of nursing (DON) was interviewed on 6/18/24 at 4:49 p.m. The DON said when a resident received dialysis care the nursing staff monitored fluid intake and urine output, weight, blood sugar and the dialysis access site.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The DON said she was familiar with Resident #25 and her dialysis treatment. She said she was not aware that the physician was not notified when a scab appeared on the resident' s left upper arm near the fistula site. She said the licensed nursing staff needed to notify the physician when the order was not followed so the physician could provide further orders if needed. The DON said the nursing staff documented when a physician was notified about skin and dialysis care as a progress note.<br><br>V. Facility follow up<br><br>The June 2024 CPO was updated on 6/19/24 at 8:25 a.m. with the following order:<br><br>-Monitor for signs and symptoms of infection to the resident' s left upper extremity. Scab in place, discontinue order when the scab is gone. Complete every shift for scab monitoring. Discontinue when healed, ordered 6/19/24.<br><br>-However, the dialysis and chronic renal failure care plan were not updated with interventions for the skin treatment at the fistula site. |

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.<br><br>31820<br><br>Based on record review and staff interviews, the facility failed to conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during day-to-day operations.<br><br>Specifically, the facility:<br><br>-Failed to update the facility assessment annually;<br><br>-Failed to include all current diagnoses the facility currently cared for; and,<br><br>-Failed to develop a facility assessment which included staff education and staff competencies.<br><br>Findings include:<br><br>I. Facility assessment<br><br>The facility assessment was provided by the nursing home administrator (NHA) on 6/17/24 at 11:25 a.m. It was updated on 2/27/23 and reviewed by the quality assurance performance improvement (QAPI) committee on 2/28/23.<br><br>The facility assessment failed to include the following:<br><br>-Diagnoses of current residents including intermittent explosive disorder (mental disorder that causes sudden, impulsive and aggressive outbursts) , schizophrenia (mental illness causing episodes of psychosis), anxiety, seizures and methicillin resistant Staphylococcus aureus (MRSA);<br><br>-Include staff competencies that were necessary to provide the level and types of care needed for the resident population or include the staff training program to ensure any training needs are met for all new and existing staff; and,<br><br>-Include staff trainings/education necessary to provide the level and types of support and care needed for the resident population.<br><br>The NHA provided information regarding resident specific care needs on 6/18/24 at 3:16 p.m. which included the following:<br><br>-Four individuals needed a two-person lift;<br><br>-13 residents receiving respiratory care;<br><br>-Four residents receiving insulin; and,<br><br>-11 residents were on a specialized diet.<br><br>(continued on next page) |

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -The facility assessment did not include these specialized resident specific care needs.<br><br>II. Staff interviews<br><br>The NHA was interviewed on 6/19/24 at 9:00 a.m. The NHA said she was not aware the facility assessment was not current. The NHA reviewed the facility assessment and said it did not identify current diagnoses for some of the residents the facility was caring for at that time.<br><br>The NHA reviewed the facility assessment and said the assessment did not have specific training staff needed to help care for the residents at the facility. She said the facility assessment should reflect the needs of the residents.<br><br>The NHA said she and the interdisciplinary team would review the facility assessment and create a new one. The NHA said the current facility assessment was missing current diagnoses of residents in the facility and staff training and competencies necessary for the care of the residents and would be updated to ensure the training and education programs would cover the residents' needs. She said it was important to have a complete assessment to provide for the residents in the facility. |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>31820<br><br>Based on record review and interviews, the facility failed to ensure in-service training for certified nurse aides (CNA) consisted of annual training for dementia management and/or annual abuse training for three of five CNAs reviewed.<br><br>Specifically, the facility:<br><br>-Failed to ensure CNA #3 and CNA #5 received annual dementia management training;<br><br>-Failed to ensure CNA #1 received annual abuse training; and,<br><br>-Failed to ensure CNA #5 received 12 hours of annual training.<br><br>Findings include:<br><br>I. Record review of insufficient in-service training in the last 12 months for three CNAs<br><br>CNA #1 was hired on 9/7/22. She had not had annual abuse training in the past 12 months.<br><br>CNA #3 was hired on 5/3/23. She had not had annual dementia management training in the past 12 months.<br><br>CNA #5 was hired on 1/13/22. She had not had annual dementia management training or 12 hours of training in the past 12 months.<br><br>II. Interview<br><br>The director of nursing (DON) and staff development director (SDC) were interviewed together on 6/18/24 at 5:20 p.m. The SDC said she could not find documentation that the facility had provided annual abuse and/or dementia management training and 12 hours of training for CNA #1, #3, and #5 in the past 12 months. She said all CNAs providing care should be trained on abuse and dementia management as well as receive 12 hours annually of training in order to provide appropriate care for the facility ' s residents. |