| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075326 | A. Building<br>B. Wing | 11/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Evergreen Center for Health & Rehabilitation | 205 Chestnut Hill Road<br>Stafford Springs, CT 06076 |

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) |
|---|---|
| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721<br><br>Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 2 sampled residents (Resident #194) reviewed for abuse, the facility failed to implement policies that ensured allegation(s) of feeling unsafe and being fearful of retaliation were reported. The findings include:<br><br>Resident #194's diagnoses included acute embolism of the deep veins on the left lower extremity and anxiety disorder.<br><br>The Nursing Admission assessment dated [DATE] identified Resident #194 was cognitively intact and had no activity of daily living/mobility impairments.<br><br>The Resident Care Plan dated 11/12/24 identified Resident #194 had a history of depression and with interventions that directed administering medications as ordered and to monitor/report signs of depression, repetitive anxiousness/tearfulness.<br><br>a. Physician's orders dated 11/13/24 directed Ativan 0.5 MG every 12 hours as needed for anxiety.<br><br>The Medication Administration Record (MAR) dated 11/16/24 identified that Ativan 0.5 Milligrams (MG) was administered to Resident #194 at 8:28 PM by Licensed Practical Nurse, LPN #5.<br><br>An interview with Resident #194 on 11/18/24 at 11:40 AM identified on 11/16/24 during the 3:00 PM -11: 00 PM shift, her/his assigned nurse, LPN #5 attempted to administer her/his prescription Ativan earlier than preferred.<br><br>Instead of removing the medication, the medication was instead left at the bedside. After returning from the bathroom, the medication was no longer at the bedside table where it was last observed. Resident #194 requested the medication a second time and received the medication 45 minutes after the request. LPN #5, according to Resident #194 stated, This will not happen again. The incident left Resident #194 feeling threatened that LPN #5 may poison her/him in retaliation of not believing her/him about the unaccounted medication. Resident #194 further identified she/he reported the incident to Nurse Aide, NA #7 who gave assurances she would not let anything bad happen to her/him.<br><br>b. Physician's orders dated 11/13/24 directed Eliquis (2) tablets or 10 MG twice daily for deep vein thrombosis (DVT) until 11/16/24.<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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The physician's orders dated 11/17/24 directed Eliquis (1) tablet or 5 Mg twice daily for DVT.<br><br>The Medication Administration Record (MAR) dated 11/16/24 identified Eliquis 10 Mg was last administered at 8:00 PM.<br><br>The MAR dated 11/17/24 identified Eliquis 5 MG was started at 8:00 AM.<br><br>An interview with Resident #194 on 11/18/24 at 11:40 AM identified on 11/17/24 during the 3:00 PM - 11:00 PM shift, LPN #5 administered and a new dose of anticoagulant medication. Resident #194 questioned the dose as s/he was concerned the dose was more than what was prescribed. Resident #194 felt threatened after alleging LPN #5 told her/him that unless Resident #194 wanted a blood clot, s/he would need to take the medication. The second incident left Resident #194 feeling threatened by LPN #5 and fearful of a blood clot, so s/he took the medication. Resident #194 reported the second incident to NA #7 who told him/her the incident should not have happened.<br><br>An interview with NA #7 on 11/21/24 at 11:36 AM identified she was the assigned Nurse Aide for Resident #194 on 11/16/24 and 11/17/24 during the 3:00 PM to 11:00 PM shift. NA#5 identified Resident #194, was tearful and upset and did report to her that s/he was fearful for her/his own safety, fearful of retaliation and fearful of being poisoned after requesting an additional dose of Ativan when the dose at her/his bedside was unaccounted for and for questioning her/his dose of the blood thinner adding LPN #5 could be harsh. NA #7 did report to LPN #5 that Resident #194 was upset but was unable to recall if she had reported Resident #194 feeling unsafe and fearful of retaliation. NA #7 further identified that anything that was reported was done at the nurse station and in the presence of the Nursing Supervisor, RN #5 who had an office nearby, so therefore did not report directly to her.<br><br>An interview with the Director of Nursing, DNS on 11/21/24 11:45 AM identified she should be notified of any allegations of mistreatment and confirmed she was not notified at any time over the weekend of any staff to resident allegations of mistreatment pertaining to Resident #194. The DNS identified she would expect staff to follow policies for a resident reported allegation of mistreatment.<br><br>An interview with Registered Nurse (RN #5) on 11/21/24 at 12:25 PM identified she was the assigned nursing supervisor on 11/16/24 and 11/17/24 during the 3:00 PM to 11:00 PM shift. RN #5 identified that she was made aware of a missing dose of Ativan presumed to have dropped on the floor and cosigned a second dose to be administered to Resident #194. RN #5 further identified she was not notified at any time over the weekend Resident #194 was fearful for her/his safety and fearful of retaliation.<br><br>A review of the facility policy for Abuse dated 12/2023 directed actions to take when any allegation of abuse, mistreatment, neglect or misappropriation of resident property is observed, reported or suspected by any employee. This would include immediately separating the resident from the alleged abused and notifying the administrative staff or nursing supervisor on duty of the alleged abuse. |

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| F 0637<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Assess the resident when there is a significant change in condition<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046<br><br>Based on review of clinical record reviews and staff interview for 3 of 4 residents reviewed for hospice ( Residents # 12, # 91, the facility failed to ensure staff coded the resident's MDS assessment to accurately reflect the significant change in status. The findings include:<br><br>1. Resident #12 ' s diagnosis included dementia, and heart failure.<br><br>Resident #12 ' s quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #12 had severe cognition impairment.<br><br>Resident #12 elected Hospice services on 11/5/2024.<br><br>The care plan dated 11/6/2024 indicated to coordinate palliative care services with hospice initiated 11/5/2024 Intervention included in part to collaborate with the hospice provider to ensure a review of the effectiveness of the plan of care and services provided.<br><br>Although the facility started a Significant Change in Status MDS assessment with assessment reference date (ARD) 11/18/2024 was not completed as of 11/21/2024 (so far 3 days late).<br><br>2. Resident #91's diagnoses included Alzheimer's disease and palliative care.<br><br>Resident #91 elected hospice services on 12/18/2023.<br><br>The care plan dated 12/27/2023 indicated hospice services related to end stage dementia. Interventions in part directed to honor choices and coordinate care for resident ' s comfort.<br><br>The Significant Change in Status MDS assessment dated [DATE] indicated Resident #91 had severe cognitive impairment and was receiving hospice services. The completion date of the MDS assessment was 1/3/2024 (2 days late).<br><br>3. Resident #101's diagnosis included dementia and palliative care.<br><br>Resident #101 elected hospice services on 2/18/2024 .<br><br>The Significant Change in Status Minimum Data Set assessment dated [DATE] indicated Resident #101 was severely cognitively impaired and receiving hospice services. The MDS assessment was completed on 3/5/2024 (2 days late).<br><br>An interview, clinical record review, and review of the Resident Assessment Instrument manual (RAI) on 11/21/2024 at 1:55 PM with RN #6 the MDS Director identified she/he was not aware/trained regarding the need to complete a significant change MDS 14 days after the date of determination of a significant change. RN #6 identified her/his understanding was the facility had 14 days after the Assessment reference date was set to complete the MDS. Resident #12, #91 and #101's significant change MDS assessments were completed late.<br><br>(continued on next page) |

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| F 0637<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | The RAI manual indicated an election or discontinuation of Hospice services determines the need for a significant change in status MDS to be completed.<br><br>The RAI manual also indicated the MDS completion date must be no later than 14 days after the determination that the criteria for a significant change in status assessment were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than. |

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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** 46046<br><br>Based on clinical record reviews, review of policy and interviews for 1 of 1 resident reviewed for urinary catheter (92), the facility failed to ensure staff developed a comprehensive care plan related to the urinary tract condition and urinary catheter and for 1 of 1 sampled resident (Resident #76) reviewed for Communication/ Sensory, the facility failed to create person centered care plan to reflect sensory needs. The findings included:<br><br>1. Resident #92's diagnosis included Benign Prostatic Hypertrophy.<br><br>The admission comprehensive Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #92 was cognitively intact and used intermittent and indwelling catheterization for urinary elimination.<br><br>A progress note dated 9/20/2024 at 10:36 PM indicated in part Resident #92 was admitted at 6:30 PM and had an indwelling urinary catheter removed at the hospital at 11:00AM. The note further indicated orders directed to continue the voiding trial for the next 3 days.<br><br>The progress notes dated 9/21/2024 at 10:45 PM indicated a post void residual of 482 cc urine was noted and straight catheterization was needed and drained 500 cc urine. The progress note dated 9/23/24 at 6:48 AM indicated an indwelling catheter was inserted due to 500 cc being obtained. A physician's order indicated reinserting the indwelling catheter if residual was greater than 350 cc.<br><br>On 11/22/24 9:56 AM interview and record review with the Director of Nursing Services (DNS), the Assistant Director of Nursing Services (ADNS) and the Corporate RN #4 indicated not being able to find any care plan indicating Resident #92's difficulty urinating on own and the interventions that were ordered and provided by the nursing staff. The DNS indicated she would contact the MDS Coordinator (RN #6).<br><br>An interview and record review of the (MDS) on 11/22/24 at 10:20 AM with RN #6 indicated. The comprehensive admission assessment indicated the use of a urinary catheter, and the Care Assessment Area of urinary incontinence was triggered which indicated the facility was to proceed with care planning this care area. However, this was not done due to an oversight.<br><br>The facility policy labeled Baseline/Comprehensive Person-Centered Care Plan (CPCCP) indicated in part the comprehensive Person-Centered Care plan will be developed after the completion of the comprehensive assessment (MDS). The policy further indicated the CPCCP will be kept current by all disciplines on an ongoing basis and the disciplines would be responsible for updating the care plan when a new problem requires that discipline to intervene.<br><br>2. Resident #76's diagnoses included Cognitive Communication deficit and Anxiety.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #76 as cognitively intact, and requires set-up assistance with eating, supervision/touching assistance for personal hygiene and moderate assistance for upper body dressing. The MDS further indicated Resident #76 has moderate difficulty hearing and wears hearing aids.<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 care plan dated 10/30/24 did not include Resident #76 communication/ sensory nor did it reflect any interventions.<br><br>A nurse's note dated 9/3/24 identified Resident # 76 was seen by the facility vendor audiologist today who recommended that patient receive new hearing aids, and the vendor will be ordering them.<br><br>Interview with Resident #76 on 11/18/24 at 12:16 PM identified Residents #76 was having difficulties hearing. He/she reported his/her hearing aid was malfunctioning and the facility was aware of the concern.<br><br>Interview with DNS on 11/20/24 at 10:39 AM identified the Interdisciplinary Team are responsible for updating the care plan. DNS was unable to locate the care plan and interventions for hearing deficit. The DNS identified the expectation is that care plans are customized and updated to meet the needs of residents.<br><br>49100 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100<br><br>Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 sampled resident (Resident #342) reviewed for Comprehensive Resident Centered Care Plan, the facility failed to update the resident's care plan to reflect resident preferences. The findings include:<br><br>Resident # 342's diagnoses included Acute Embolism and Thrombosis, Paraplegia and anxiety disorder.<br><br>The admission Minimum Data Set assessment dated [DATE] identified Resident #342 was cognitive intact and required maximum assistance upper and lower body dressing and bathing.<br><br>The care plan dated 11/7/24 did not reflect Resident #342 preferences on how to be addressed.<br><br>The Grievance Log dated 11/11/24 at 8:00 AM indicated Resident #342 was not happy with how a staff member called him/her using his/her first name.<br><br>A nurse's note dated 11/11/24 at 2:22 identified Resident # 342 expressed care concern, The note further indicated concerns were resolved by management.<br><br>An Interview with RN #3 on 11/21/24 at 10:36, identified identified she/he should have put in the special instruction to update the resident's care plan to reflect the resident's preference. We go by word of mouth, but it should be in there for other staff that might not have taken care of the resident RN#3 identified she/he did not add the information to the care plan because she/he forgot<br><br>An interview with NA # 8 on 11/22/24 at 12:21 PM identifed she went to introduce herself to Resident #342 and to provide care, which lasted about 40 minutes. She reported that during that time, Resident # 342 was expressing concerns regarding another staff, however, she did not engage beyond asking residents presence for care. NA #8 reported after providing care she was told that she was taken off Residents #342 assignment and received an in-service.<br><br>Facility Baseline/Comprehensive Person-Centered Care Plan indicates, in part, the care plan will be kept current by all disciplines on an ongoing basis. Disciplines will be responsible for updating the care plan when there is a new problem that requires that discipline to intervene. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721<br><br>Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 4 sampled residents (Resident #194) reviewed for abuse, the facility failed to ensure medications were administered according to professional standards of practice and for 1 of 5 resident who required assistance with medication administration (Resident # 74), the facility failed to follow the five rights when administering the resident's medication. The findings included:<br><br>1. Resident #194's diagnoses included acute embolism of the deep veins on the left lower extremity and anxiety disorder.<br><br>The Nursing Admission assessment dated [DATE] identified Resident #194 was cognitively intact and had no activity of daily living/mobility impairments.<br><br>The Resident Care Plan dated 11/12/24 identified Resident #194 had a history of depression and with interventions that directed administering medications as ordered and to monitor/report signs of depression, repetitive anxiousness/tearfulness.<br><br>Physician's orders dated 11/13/24 directed Ativan 0.5 MG every 12 hours as needed for anxiety.<br><br>The Medication Administration Record (MAR) dated 11/16/24 identified that Ativan 0.5 Milligrams (MG) was administered to Resident #194 at 8:28 PM by Licensed Practical Nurse, LPN #5.<br><br>An interview with Resident #194 on 11/18/24 at 11:40 AM identified on 11/16/24 during the 3:00 PM -11: 00 PM shift, her/his assigned nurse, LPN #5 attempted to administer her/his prescription Ativan earlier than preferred. Instead of removing the medication, the medication was instead left at bedside. After returning from the bathroom following evening personal care, the medication was no longer at the bedside table where it was last observed. Resident #194 subsequently requested the medication a second time and finally received the medication 45 minutes after the request.<br><br>An interview with LPN #5 on 11/19/24 at 1:34 PM identified she was the assigned nurse for Resident #194 on 11/16/24 during the 3:00 PM to 11:00 PM shift. LPN #5 identified on 11/16/24, she prepared Resident #194's dose of Ativan. However, when she went to administer the medication, Resident #194 informed LPN #5 it was too early. LPN #5 left the medication at the bedside for Resident #194 while she attended to other responsibilities. LPN #5 returned sometime later, and the medication cup was empty. Resident #194 reported she/he had not taken the medication. LPN #5 looked for the medication on the floor and in the garbage but was unable to locate the medication. A second dose of the Ativan was subsequently prepared and administered to Resident #194. LPN #5 identified she was at fault for leaving the medication at Resident #194's bedside.<br><br>An interview with the Director of Nursing Services on 11/21/24 at 11:45 AM identified no medications should be left at the bedside and indicated she would expect that medications be administered according to policy.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the facility policy for Medication Pass dated 10/2024 directed to always observe the resident until they have swallowed the medications administered. Do not leave the medication at the bedside or table.<br><br>2. Resident #74 's diagnoses included Type 2 diabetes mellitus, hypothyroidism, and Parkinson's disease.<br><br>A physician's order dated 8/24/24 directed to administer 2 tablets of Metformin HCL ( anti-diabetic medication) extended release oral tablet 500 MG.<br><br>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #74 was cognitively intact and required partial assistance with personal hygiene, toileting, and substantial assistance with showering.<br><br>The Resident Care Plan with a revision date of 9/25/24 identified Resident #74 had a self-care deficit. Interventions included assistance with activities of daily living and personal hygiene.<br><br>Observations on 11/20/24 at 8:30 AM, identified LPN #1 poured 1 tablet of Metformin HCL ER oral tablet 500 MG.<br><br>Interview with LPN #1 on 11/20/24 at 8:35 AM identified she poured the incorrect dose and was not familiar with the resident as she does not usually work on that wing. LPN #1 further indicated she stated should have read the physician's order more carefully.<br><br>Review of the Medication Pass policy dated 10/2018, and presently active, directed, in part, medications are administered safely, and timely per the physician's orders.<br><br>.<br><br>48792 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14448<br><br>Based on clinical record reviews, facility documentation, review of policy and staff interviews 1 of 2 residents reviewed for limited range of motion (Resident #27), the facility failed to ensure physical therapy was made aware of a resident's change in condition regarding the comfort and fit of a prosthetic device for 1 of 1 resident who utilized a Foley catheter, the facility failed to document the diagnosis for the utilization of urinary catheter and for 1 of 4 resident (Resident # 135) reviewed for abuse, the facility failed to assess the resident's left lower hand bruise area according to facility practice and The findings included:<br><br>1. Resident #27's diagnoses Cerebrovascular Accident and amputations. The annual MDS assessment dated [DATE] identified Resident #27 was cognitively intact and used limb prosthetics.<br><br>A care plan dated 10/9/2024 indicated Resident #27 had a history of amputation. Interventions included applying bilateral lower extremity prosthesis per physician's order and to assist resident as needed with application. Additional interventions included referring to physical therapy or occupational therapy for any changes in wearing tolerance, schedule, or skin integrity.<br><br>A physical therapy note dated 10/11/2024 recommended continuing bilateral lower extremity prostheses per resident for dignity/appearance.<br><br>On 11/19/2024 an observation in Resident #27's room identified signs over the head of the bed with instructions on applying prosthetic devices. The resident prosthetic devices were noted behind the entry door. Resident # 27 indicated to surveyor staff did not offer to put on her/his prosthetic devices and she/he did not recall when she/he had the prosthetic devices on last.<br><br>A review of the NA care card instructed to assist with orthotic devices on with AM care and off when resident requests.<br><br>A review of the NA flow sheets from 10/24/2024 through 11/19/2024 identified staff had applied the orthotic devices on four occasions: 10/25/2024, 11/3/2024, 11/17/2024, and 11/18/2024.<br><br>Additionally, the NA Flowsheet indicated Resident #27 had refused his/her orthotic devices 17 times between 10/24/2024 and 11/19/2024. A review of nursing notes from 10/1/2024 to 11/19/2024 failed to identify the resident refusal of orthotic devices.<br><br>On 11/20/2024 at 12:02 PM, an interview with NA # 9 identified Resident #27 had refused the application of bilateral prosthetic devices because the prostheses they were uncomfortable. NA#9 indicated that on 11/19/2024 she offered to help with the application of the prosthetic devices but that on 11/20/2024 she had overlooked offering to apply the prostheses. Additionally, NA #9 indicated she would document refusals in the electronically medical record but would sometimes also alert the nurse.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Evergreen Center for Health & Rehabilitation | 205 Chestnut Hill Road<br>Stafford Springs, CT 06076 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 11/20/2024 at 12:10 PM an interview with LPN #8 identified Resident #27 had been offered to wear the bilateral prosthetic devices in the past but the resident had refused to wear them because the prostheses were uncomfortable. LPN #8 indicated that the last time she/he had worn the prostheses was a couple of weeks ago and she/he did not know if the resident had refused or had been offered the prostheses with AM care on 11/20/2024.<br><br>On 11/20/2024 at 1:15 PM, an interview with Physical Therapist ( PT #2) identified Resident #27's prostheses were not ordered for functionality but rather for appearance and dignity. A review of the medical record with PT #2 failed to identify an order for bilateral prostheses and the last order had been placed on 4/12/2024 and discontinued on 9/20/2024 when the resident was hospitalized . PT#2 further indicated that the physician's order should have been reactivated or reordered when the resident returned from the hospital. PT#2 identified that she was aware that Resident #27 did not want to wear the prostheses but indicated that she was not aware that the prostheses were uncomfortable. PT #2 indicated that if she had been aware Resident # 27's was refusing the prostheses due to discomfort, she would have evaluated the prostheses, and if the issue could not be resolved by the physical therapy department, then the vendor of the prostheses would have been notified for an evaluation.<br><br>On 11/20/2024 at 2:00 PM, an attempt to reach NA#11 who documented application of Resident #27's prostheses on 11/17/2024 was unsuccessful.<br><br>On 11/20/2024 at 2:05 PM an interview with NA#10 identified she documented the application of Resident #27's prostheses on 11/18/2024 in error because she do not recall applying Resident #27's prostheses on 11/18/2024. Furthermore, NA#10 indicated the resident sometimes refuses the prostheses because the device caused discomfort.<br><br>Although requested, the facility did not have a policy for the application of prostheses.<br><br>2. Resident #92's diagnosis included Benign Prostatic Hypertrophy ( BPH).<br><br>A physician's order dated 9/20/2024 indicated an indwelling urinary catheter was removed on 9/20/2024 at 11 :00 AM and if Resident #92 does not urinate in 6 hours to perform a bladder scan or straight catheterize. If the residual urine in the bladder after urinating on own Post Void Residual (PVR) is >350 cc to reinsert a urinary catheter and indicated the order was in effect for 3 days.<br><br>The admission comprehensive Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #92 was cognitively intact and used intermittent and indwelling catheterization for urinary elimination.<br><br>A progress note dated 9/20/2024 at 10:36 PM indicated in part Resident #92 was admitted at 6:30 PM and had an indwelling urinary catheter removed at the hospital at 11:00 AM. The note further indicated physician's orders directed to continue the voiding trial for the next 3 days.<br><br>The progress notes dated 9/21/2024 at 10:45 PM identified a post void residual of 482 cc urine was noted and straight catheterization was needed. The resident drained 500 cc urine after catherization. The note dated 9/23/24 at 6:48 AM indicated an indwelling catheter was inserted due to 500 cc was obtained and the order indicated to reinsert the indwelling catheter if residual was greater than 350 cc.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A physician's order dated 9/23/2024 directed an indwelling urinary catheter size 16 French with 10 cc balloon to. be kept to straight drainage for urinary retention.<br><br>On 11/22/24 09:56 AM during an interview and record review with the Director of Nursing Services (DNS), the Assistant Director of Nursing Services (ADNS) and the Corporate Nurse RN #4 identified they could not find a diagnosis to support the use of an indwelling catheter in the electronic or paper chart or in the Physician's History Examination and physical, APRN notes or in the hospital transfer paperwork. The DNS did indicate a diagnosis to support the use should have been written.<br><br>3. Resident # 135 was admitted to the facility on [DATE]. The resident diagnoses included hypothyroidism, hyperlipidemia, hypertension, fall, osteoarthritis left hip and knee and Transient Ischemic Attack (TIA).<br><br>The hospital discharge summary dated 9/15/24 identified a history of stroke, left side weakness and indicated the patient presented in Emergency Department (ED) for left leg pain. However, studies showed no fracture. Patients ambulate with a walker but have difficulty due to left foot pain. Additionally, noted a need rehabilitation. The patient presents with significant impairment of mobility due to recent fall. The patient will require short term stay rehabilitation secondary to unsafe discharge to home at this time. Patient reported that she/he fell 12 hours prior to ED admission secondary to tripping and falling. Patient noted with bruise on the dorsal aspect of left foot and reports worsening of swelling on lower aspect of leg, denies any injury to head or loss of consciousness, no headaches. X ray of left foot dated 9/13/24 noted bones are well mineralized and identified degenerative changes due to osteoarthritis.<br><br>The care plan, dated 9/16/24 for Deficit in Self Care Function related to decreased mobility and osteoarthritis. Interventions included: assistance of 1 person for bathing /showers, assistance of 1 person for dressing and toileting.<br><br>The admission Minimum Data Set ( MDS) assessment dated [DATE] identified the resident as cognitively intact and had no memory problems, upper and lower extremity impairment on one side, utilization of a cane and wheelchair for mobility.<br><br>The physician's order dated 10/2/24 noted toileting assistance of 1 person.<br><br>A review of the Reportable Event dated 10/12/24 identified the resident stated a nurse aide grabbed her/his hand and feet to transfer her/him to the wheelchair. The resident stated she/he noticed a bruise on her/his right hand the following day and noted no complaints of pain or discomfort identified.<br><br>The facility investigation dated 10/12/24 identified the resident rang the call bell for assistance to use the bathroom. The resident stated that the NA helped her/her to a sitting position then the NA grabbed her/his hand and feet to transfer the resident to wheelchair. The resident stated s/he had no pain but noticed a bruise on her/his left lower hand the following day. A body audit conducted, and bruise was noted on the resident's left lower hand. Another small bruise was noted above the same hand. However, the resident stated the second bruise was old. The care plan updated to provide two staff members for care. The facility investigation identified the facility could not substantiate the abuse.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Health Status Note dated 10/15/2024 at 4:58 PM identified the resident stated a Nurse Aide (NA # 9) grabbed her/his hand and feet to transfer the resident to the wheelchair. Resident # 135 stated she/he had no pain but noticed a bruise on her/his left lower hand the following day. A body audit was conducted, and a bruise was noted on the resident's left lower hand and a smaller bruise was noted proximally. The Advanced Practice Registered Nurse (APRN) was updated, family was in house/at bedside and was aware.<br><br>A review of the Reportable Event (RE) dated 10/15/24 identified the resident indicated a Nurse Aide (NA # 9) had helped her/him to bed around 7:00 PM during the 11-7 AM shift, the resident rang the call bell for assistance to use the bathroom. Resident# 135 stated NA # 9 helped her/him to a sitting position then NA # 9 grabbed her/his hand and feet to transfer the resident to the wheelchair. Resident # 135 denied any pain but was noted with a bruise on her/his left lower hand the following day. A body audit was conducted, and a bruise was noted on the resident's lower hand. Action taken for the incident two staff members for care. The NA #9 was placed on suspension pending further investigation.<br><br>A review of the electronic clinical record for Resident # 135 from 9/13/24 to 10/12/24 identified no bruise on the resident's body during skin audits until 10/15/24. The clinical record also failed to identify the size of the bruise area on the resident's left lower arm.<br><br>Interview with the ADNS and the DNS on 11-21-24 at 10:40 AM identified the incident<br><br>Identified over the weekend of 10/12/24 identified the resident stated on the 3-11 PM the incident occurred. We came on Tuesday 10/15/24 and it was reported to us that the physical therapist had a session with the resident and saw the area. The therapist asked what happened and that is when the resident told therapist what happened. The rehabilitation therapist then reported the incident to the nurse. On 10/12/24 the resident required assistance with care and had to wait 45 minutes. The resident was noted to be helped to bed roughly causing bruising.<br><br>Interview with RN # 3 ( supervisor ) on 11/21/24 at 2:41 PM identified she was made aware on the 3-11 PM shift on 10/14/24 by the nurse on duty ( LPN # 13) that a family member not part of patient care was upset about the care the Resident # 135 received on the 11- 7 AM shift. RN # 3 indicated the family member had left therefore she did not speak to the family member. RN # 3 further indicated LPN # 13 or NA # 9 did not mention anything about a bruise but she did say maybe NA # 9 should not take care of the resident. RN #3 indicated she reported the concern the ADNS who was the Acting DNS on 10/14/24 who indicated she ( ADNS) would follow up with NA # 9. RN # 3 indicated because she was not made aware of any bruise she did not assess the resident after family member concern after care.<br><br>The ADNS on 11/21/24 at 3:30 PM identified the facility practice is to assess any bruise on resident for size, color and pain and document in the clinical record.<br><br>46046<br><br>48880 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880<br><br>Based on clinical record review, observations, resident interviews, and staff interviews for 1 of 3 residents reviewed for pressure ulcers (Resident #6), the facility failed to ensure the resident was turned using the appropriate offloading device per the plan of care. The findings include:<br><br>Resident #6 was admitted to the facility on [DATE]. The residents' diagnoses included diabetes mellitus diabetic neuropathy, and Peripheral Vascular Disease (PVD). The admission MDS assessment dated [DATE] identified Resident #6 as cognitively intact and noted the resident required partial/moderate assistance to roll left and right. The MDS assessment also indicated that the resident was at risk for pressure ulcers but did not have an unhealed pressure ulcer at the time of admission.<br><br>A nursing note dated 11/8/2024 identified Resident #6 had an open area to the right buttocks and that the provider, wound nurse, and responsible party were made aware.<br><br>A care plan dated 11/8/2024 identified Resident #6 had a facility-acquired stage 2 pressure ulcer on the right buttocks. Interventions included repositioning the resident every 2 hours in the bed with positioning wedges (positioning aids used to alleviate pressure).<br><br>A wound specialist's note dated 11/14/2024 identified Resident #6 had a stage 2 pressure ulcer that measured 0.9 Centimeters (cm) x 1.1 cm x 0.1 cm. Recommendations were to apply barrier cream to the wound and reposition the resident every 2 hours.<br><br>On 11/18/2024 at 1:32 PM, an observation was made of Resident #6 laying supine in bed with the head of the bed elevated. An interview with Resident #6 indicated she/he could not turn her/himself and she/he would need to call staff for help. Resident #6 indicated that if she/he would not call for help, she/he would be stuck in one position.<br><br>On 11/21/2024 at 12:40 PM, an interview with NA #9 indicated she was not sure if Resident #6 was able to turn by her/himself in the bed and indicated she did not have to turn the resident in the morning. NA#9 indicated she was told in report Resident # 6 needed the assistance of 1 staff member, but she would refer to the aide care card for more information. A review with NA #9 nurse aide care card identified the resident required turning every 2 hours with a wedge. NA#9 indicated she did not see a wedge in the resident's room and indicated pillows could be used for positioning.<br><br>On 11/21/2024 at 12:53 PM an interview with LPN#9 indicated she was a float nurse, and she did not get any report regarding the residents positioning needs. LPN#9 further indicated she would reference the care plan and care card for information of the type of care the resident needs.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/21/2024 at 1:03 PM, an observation with RN #7 identified two green wedges in the resident's closet. Additionally, both the wound specialist and the wound nurse, LPN# 10, were in the room preparing supplies to assess Resident #6's wound. RN #7 asked Resident #6 if she/he knew where the wedges were being stored in her/his closet; Resident #6 then indicated she/he could not recall who placed the wedges in the closet and indicated no staff member had used the wedges to position her/him (Resident #6). An attempt to interview the wound specialist at the time was unsuccessful as the wound specialist declined to answer questions, indicating she had several residents to see in other buildings.<br><br>On 11/22/2024 at 11:51 AM, an interview with the Wound Care Nurse, LPN #10 identified the rationale for initiating the nursing intervention of a positioning wedge was to help offload pressure from the stage 2 pressure ulcer. LPN #10 indicated that using a pillow for positioning could be an alternative to using a wedge but that a wedge would provide a more effective turn. LPN #10 also identified on 11/21/2024 (after surveyor inquiry), Resident #6 expressed to her Resident # 6 did not like using the wedge and indicated the resident would be provided an air mattress.<br><br>Although requested, the facility did not have a policy for the use of positioning wedges and air mattresses. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792<br><br>Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident # 136) reviewed for accidents, the facility failed to provide the necessary supervision to prevent a resident from eloping. The findings include:<br><br>Resident #136 's diagnoses included hemiplegia and hemiparesis, TIA, and Cerebral Infarction.<br><br>The Resident Care Plan dated 9/25/24 identified Resident #136 had a deficit in self-care. Interventions included to provide assist of 1 for eating, toileting and self-care.<br><br>A physician's order dated 9/25/24 directed assistance with all self-care activities.<br><br>The admission Minimum Data Set assessment dated [DATE] identified Resident #136 was severely cognitively impaired and noted dependence for all activities of daily living and personal care.<br><br>A nurse's note dated 11/19/24 at 6:59 PM identified Resident #136 was seen by staff outside the front door self-propelling in his/her wheelchair. Resident # 136 was alert and confused. An elopement assessment was completed, and a wander guard was placed on Resident # 136 right ankle.<br><br>On 11/20/24 during an interview with Occupational Therapist (OT#1) at 9:00 AM identified she had discharged Resident # 136 from OT on 11/19/24 in the morning as the resident had reached his/her goals. OT #1 further stated that on 11/19/24 was the first time that she had seen the resident able to self-propel in the wheelchair.<br><br>On 11/20/24 during an interview with Physical Therapist (PT #1) at 9:15 AM the resident was able to use his/her feet to propel himself/herself for very short distances in the gym. PT #1 also indicated Resident # 136 usually did not get very far due to his/her deficits. Upon admission Resident # 136 was totally dependent. PT#1 was aware the resident had eloped on 11/19/24 and had no idea how that happened as PT had never seen the resident self- propel more than a few feet.<br><br>An interview on 11/20/24 with Receptionist #1 at 9:45 AM indicated she works until 3:00 PM and was not at work when Resident #136 eloped. Receptionist # 1 stated that there is a binder at the desk that contains pictures of the residents who are at risk for elopement. She identified that she would consult the binder if a resident was in the lobby she did not normally see in the lobby, to identify if the resident was an elopement risk. She confirmed that Resident #136 had not tried to elope prior to 11/19/24.<br><br>On 11/20/24 during an interview with NA #1 at 10:30 AM identified she usually takes care of Resident #136. NA # 1 stated Resident # 136 has been able to self-propel in the wheelchair for the past 2 weeks, so she makes sure she knows where the resident is located at all times. She left at 3:30 PM on 11/19/24 and prior to leaving she toileted the resident. NA #1 further indicated she last saw Resident # 136 in the common area visiting with family.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 11/20/24 Interview with DNS at 11:00 AM identified Resident #136 had recently been able to self-propel in the wheelchair. At 4:40 PM on 11/19/24 Resident # 136 was found right outside the door by a staff member. The receptionist left the desk, and it was during that time the resident propelled out the door. The DNS identified that this was the first time Resident #136 tried to elope. The DNS also stated that the facility does not have any recorded video or cameras. However, the DNS thinks Resident # 136 was out of the building for just a few minutes. The Admissions Director and the Unit Secretary were talking in the office and saw the resident out the window as soon as he/she wheeled her/himself outside. Resident # 136 was quickly returned to the building.<br><br>On 11/20/24 during an interview with Receptionist #2 at 11:45 AM, I identified she was working the evening the resident eloped however, she was not at the desk when it happened. Receptionist # 2 stated that she only asks for coverage of the front desk if she is leaving for her break, if she leaves to use the restroom she does not ask for coverage as she is gone for just a few minutes. Receptionist # 2 identified the resident was outside for less than a minute, she heard someone talking to Resident # 136 and asking the resident if she/he needed help getting over the bump by the door. A few seconds later she exited the facilities and saw staff bringing the resident into the building. Receptionist #2 identified that she is aware of all residents that are at risk for elopement as she creates the list daily based on information, she receives from the nursing supervisor. Resident #136 had never attempted to elope before to her knowledge.<br><br>An interview on 11/20/24 with NA #2 at 11:55 AM identified she had taken care of resident on 11/19/24 and last saw the resident at 3:45 or 4:00 PM. NA # 2 stated the resident was at the nursing desk and was calm. Resident # 136 usually sits out at the desk talking to staff or watching television. NA #2 stated she did not see the resident leave the floor as she was in another resident's room providing care. Since Resident #136 was not 1:1, she began her assignment. NA # 2 also stated she did not know about the elopement until the resident was returned to the floor around 4:30 PM. NA #2 also identified this as the first time the resident eloped and upon Resident # 136's return to the building the resident was calm.<br><br>An interview with the DNS and Regional Director on 11/20/24 at 1:10 PM identified the process when the receptionist must leave the desk is to put the phones on night mode and let the supervisor know. The DNS further indicated there was no expectation that anyone would cover the desk for bathroom breaks.<br><br>Review of the Elopement policy dated 3/23 currently in effect, directed, in part, Residents will be accounted for at all times. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046<br><br>Based on review of the clinical record, facility documentation, and interviews for 1 of 5 residents (Resident # 101) for Unnecessary Medication Review, the facility failed to ensure the pharmacist recommendations were provided to the physician for review and response. The findings include:<br><br>Resident #101's diagnosis included Post-Traumatic Stress Disorder (PTSD), and dementia with psychotic disturbance.<br><br>The Comprehensive Significant Change Minimum Data Set (MDS) assessment dated<br><br>8/8/2023 indicated Resident #101 had severe cognitive impairment.<br><br>The quarterly MDS assessment dated [DATE] indicated Resident #101 had severe cognitive impairment<br><br>A consultant progress note dated 2/21/2024 at 6:26 PM identified recommendations were made for the Prescriber to review the physician's order for Naloxone (Used to reverse overdose) when needed.<br><br>A consultant progress note dated 6/20/2024 at 8:32 AM and 7/21/2024 at 4:25 PM identified recommendations were made for the Prescriber for a recommendation to add a stop date for Clonazepam (Treatment of Panic disorder).<br><br>The quarterly MDS assessment dated [DATE] indicated Resident #101 had severe cognitive impairment.<br><br>However, review of the clinical record on 11/21/24 failed to reflect that the facility had addressed the 2/21/24 or acted upon and the 6/19/24 and 7/21/24 pharmacy recommendations were not addressed until 10/23/24.<br><br>An interview and record review on 11/21/24 at 10:23 AM with RN #4 (Corporate Nurse) identified she would call the pharmacy consultant to have a copy of the unsigned recommendations by the physician/APRN to be sent to the facility. RN #4 further indicated there was a transition of ownership in June 2024. However, pharmacy recommendations should be reviewed and signed by the physician, but she could not find at this time. RN #4 indicated pharmacy recommendations are kept in a binder and upon review of the recommendations noted sporadic entries. RN #4 initiate a call to the pharmacy consultant to obtain pharmacist recommendations made from 10/22/23 through 7/21/24.<br><br>The facility policy dated 5/2023 labeled Pharmacy Medication Review/Consultant Pharmacy Recommendations, indicated in part the pharmacist consultant will submit recommendation reports to the Director of Nursing Services (DNS) and follow up on the recommendations to verify that appropriate action had been taken or responded to within a reasonable time frame the completed pharmacy recommendations will be uploaded into the Electronic Medical Record. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046<br><br>Based on clinical record reviews and staff interviews for 2 of the 4 residents (Residents # 12 and # 91) reviewed for hospice, the facility failed to ensure the resident's hospice notes were complete. The findings include:<br><br>1. Resident #12 ' s diagnosis included dementia, and heart failure.<br><br>Resident #12 ' s quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #12 had severe cognition impairment.<br><br>Resident #12 elected Hospice services on 11/5/2024.<br><br>The care plan dated 11/6/2024 indicated to coordinate palliative care services with hospice initiated 11/5/2024 Intervention included in part to collaborate with the hospice provider to ensure a review of the effectiveness of the care and services provided.<br><br>2. Resident #91's diagnoses included Alzheimer's disease and palliative care.<br><br>Resident #91 elected hospice services on 12/18/2023.<br><br>The care plan dated 12/27/2023 indicated hospice services related to end stage dementia. Interventions included honor choices and coordinating care for residents' comfort.<br><br>An interview and review of the clinical record on 11/21/24 at 2:10 PM with the charge nurse LPN #7 of Residents # 12, and # 91 identified no certification records were found in the<br><br>clinical record for the residents. LPN #1 indicated she/he would call each residents Hospice provider to obtain the missing documentation. LPN#7 indicated hospice usually visit the facility and provides paperwork that is entered in each hospice binders. The binder also contains notes from the hospice nurse. |

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| | 075326 | A. Building<br>B. Wing | 11/22/2024 |

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| F 0850<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Hire a qualified full-time social worker in a facility with more than 120 beds.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14448<br><br>Based on clinical record review, facility documentation, review of policy and staff interviews for 1 of 4 resident (Resident # 135) reviewed for abuse, the facility failed to ensure the resident was seen by social service within three days after an allegation of mistreatment per facility practice and failed to report the allegation of mistreatment to other state agency. The findings include:<br><br>Resident # 135 was admitted to the facility on [DATE]. The resident diagnoses included hypothyroidism, hyperlipidemia, hypertension, fall, osteoarthritis left hip and knee and Transient Ischemic Attack (TIA).<br><br>The hospital discharge summary dated 9/15/24 identified a history of stroke, left side weakness and indicated the patient presented in Emergency Department (ED) for left leg pain. However, studies showed no fracture. Patients ambulate with a walker but have difficulty due to left foot pain. Additionally, noted a need rehabilitation. The patient presents with significant impairment of mobility due to recent fall. The patient will require short term stay rehabilitation secondary to unsafe discharge to home at this time. Patient reported that she/he fell 12 hours prior to ED admission secondary to tripping and falling. Patient noted with bruise on the dorsal aspect of left foot and reports worsening of swelling on lower aspect of leg, denies any injury to head or loss of consciousness, no headaches. X ray of left foot dated 9/13/24 noted bones are well mineralized and identified degenerative changes due to osteoarthritis.<br><br>The care plan, dated 9/16/24 for Deficit in Self Care Function related to decreased mobility and osteoarthritis. Interventions included: assistance of 1 person for bathing /showers, assistance of 1 person for dressing and toileting.<br><br>The admission Minimum Data Set ( MDS) assessment dated [DATE] identified the resident as cognitively intact and had no memory problems, upper and lower extremity impairment on one side, utilization of a cane and wheelchair for mobility.<br><br>The physician's order dated 10/2/24 noted toileting assistance of 1 person.<br><br>A review of the Reportable Event dated 10/12/24 identified the resident stated a nurse aide grabbed her/his hand and feet to transfer her/him to the wheelchair. The resident stated she/he noticed a bruise on her/his right hand the following day and noted no complaints of pain or discomfort identified.<br><br>The facility investigation dated 10/12/24 identified the resident rang the call bell for assistance to use the bathroom. The resident stated that the NA helped her/her to a sitting position then the NA grabbed her/his hand and feet to transfer the resident to wheelchair. The resident stated s/he had no pain but noticed a bruise on her/his left lower hand the following day. A body audit conducted, and bruise was noted on the resident's left lower hand. Another small bruise was noted above the same hand. However, the resident stated the second bruise was old. The care plan updated to provide two staff members for care. The facility investigation identified the facility could not substantiate the abuse.<br><br>(continued on next page) |

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| F 0850<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Health Status Note dated 10/15/2024 at 4:58 PM identified the resident stated a Nurse Aide (NA # 9) grabbed her/his hand and feet to transfer the resident to the wheelchair. Resident # 135 stated she/he had no pain but noticed a bruise on her/his left lower hand the following day. A body audit was conducted, and a bruise was noted on the resident's left lower hand and a smaller bruise was noted proximally. The Advanced Practice Registered Nurse (APRN) was updated, family was in house/at bedside and was aware.<br><br>A review of the Reportable Event (RE) dated 10/15/24 identified the resident indicated a Nurse Aide (NA # 9) had helped her/him to bed around 7:00 PM during the 11-7 AM shift, the resident rang the call bell for assistance to use the bathroom. Resident# 135 stated NA # 9 helped her/him to a sitting position then NA # 9 grabbed her/his hand and feet to transfer the resident to the wheelchair. Resident # 135 denied any pain but was noted with a bruise on her/his left lower hand the following day. A body audit was conducted, and a bruise was noted on the resident's lower hand. Action taken for the incident two staff members for care. The NA #9 was placed on suspension pending further investigation.<br><br>A review of the electronic clinical record for Resident # 135 from 9/13/24 to 10/12/24 identified no bruise on the resident's body during skin audits until 10/15/24.<br><br>A review of the social services notes dated 10/12/24 through 11/21/24 failed to reflect that Resident # 135 had been seen by the social worker after an allegation of mistreatment.<br><br>Interview with Resident # 135 on 11/20/24 at 10:45 AM identified s/he called the front desk to ask for the nurse aide to come and help her/him. The nurse aide ( NA # 9) came to the room angry and said to me this is my break you have no right calling me on my break for anything. My roommate was asked to give a statement, but she/he stated she/he did not know what happened, I think she did not want to get involved that is ok I understand. The nurse aide ( NA # 9) helped me to get into bed and I noticed black and blue marks on my left arm. After the nurse aide left the next morning, I noticed my left arm was black and blue, but the arm has since healed. I never saw the nurse aide ( NA # 9) after the incident, I believe she/he was an agency nurse aide.<br><br>Interview with the ADNS and the DNS on 11-21-24 at 10:40 AM identified the incident<br><br>Identified over the weekend of 10/12/24 identified the resident stated on the 3-11 PM the incident occurred. We came on Tuesday 10/15/24 and it was reported to us that the physical therapist had a session with the resident and saw the area. The therapist asked what happened and that is when the resident told therapist what happened. The rehabilitation therapist then reported the incident to the nurse. On 10/12/24 the resident required assistance with care and had to wait 45 minutes. The resident was noted to be helped to bed roughly causing bruising. The resident did not report the incident on Sunday 10/13/24 but reported the incident following day. The resident stated she/he was fearful of retaliation that is why she/he did not report the incident over the weekend.<br><br>Interview with the Licensed Practical Nurse (LPN # 13) on 11-21-24 at 11:45 AM identified she was called to the room by the physical therapist who indicated Resident # 135 state on 10/12/24 she/he was in the wheelchair 10:00 AM to 6:00 PM and no one answered her/his call bell, so she/he called the front desk for assistance to get back into bed. Resident # 135 provided evidence of the telephone call on her/his cellular. The resident indicated while being rolled over on 10/12/24 during being put to bed, she/he noticed a pink area on the left forearm but did not call the nurse.<br><br>(continued on next page) |

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| F 0850<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 11-21-24 with NA # 9 in presence of Corporate Nurse Registered Nurse ( RN# 4) at 2:12 PM identified she/he passed out dietary trays and then picked them up. NA # 9 went on her break at 6:30 PM and came back at 7:00 PM because the nurse told her/him Resident # 135 wanted to go to bed. NA # 9 assisted the resident to transfer from the wheelchair to the bed by pulling the resident by the back of pants to assist with transfer because she/he did not have a gait belt on her/him. NA # 9 indicated Resident # 135 was heated because she/he had been in the wheelchair for 10 hours and wanted to go to bed. NA #9 further indicated she told Resident # 135 she has a right to have a break and denied handling the resident roughly. NA # 9 indicated the gait belt was at the nurse's station and she did not want to leave to get the gait belt because the resident was already mad, and she did not want to make her upset again.<br><br>Interview with the Social Worker #2 on 11-21-24 at 12:20 PM identified she found about Resident # 135 allegation abuse during morning report and cannot recall if she saw the resident three days to follow up after the notification . Social Worker also was unable to provide evidence that other state agency was made aware of Resident # 135 allegation of mistake secondary to her workload at the facility.<br><br>The facility Abuse Policy and Procedure dated 12/2023 notes in part abuse means the wilful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>46046<br><br>Based on review of the infection control program, observations, review of facility policy and staff interviews, the facility failed to ensure all staff members were knowledgeable in identifying residents requiring Enhanced Barrier Precautions (EBP) and proficient in utilizing proper personal protective equipment while providing care for residents requiring EBP. The findings included:<br><br>a. On 11/19/24 at 12:17 PM during the survey identified no enhanced barrier signs outside resident bedroom doors reported by surveyors.<br><br>On 11/20/24 at 6:18 AM an observation and interview with the 3rd shift charge nurse (LPN # 12) indicated the orange dots on the resident room plates outside the residents' rooms means that the resident is on enhanced barrier precautions and personal protective equipment (PPE) must be worn for extended periods of time or close contact like direct care and incontinent care. LPN #12 further indicated the PPE is in a bin on the linen cart supplied by the laundry department.<br><br>On 11/20/24 at 6:20AM an interview with NA#3 located on the second floor of the facility indicated no one on her/his assignment required PPE to be worn during care. NA #3 further indicated s/he would obtain PPE supplies in the supply room if they were not located in a bin outside the resident door. NA #3 further indicated no using any gown while proving care for any residents on her/his unit this past shift and indicated not knowing what the orange dots meant on the resident name plate outside the resident door. NA # 3 further indicates she/h would ask the nurse at the nurse's station the meaning of the dots. LPN #2 and LPN#3 were at the nurse's station and LPN #2 indicated the orange dot meant the resident required Enhanced Barrier Precautions (EBP) and a gown was needed when providing care. LPN #2 further indicated the nurse aides are made aware of what residents require EBP during the beginning of shift report/huddle. LPN #2 further indicated in-servicing would have been completed but working the overnight shift can make it difficult to accomplish. LPN #3, the charge nurse for NA#3 indicated there may have been some talk about EBP directed the use of a gown should be worn for the residents on NA #3's assignment while providing care. The nursing supervisor RN #1 came to the nurse's station and indicated the orange dots meant EBP indicated to wear gown gloves and mask when caring for the residents requiring the precautions and indicated it is difficult for the 3rd shift staff to attend in-servicing and that may be why the staff may not be aware of what to do.<br><br>An observation and interview on 11/20/2024 at 6:38 AM with charge nurse LPN #4 on the memory care unit indicated a gown, gloves, and mask need to be worn when providing care when there is an orange dot next to the name on the name plate outside the resident door.<br><br>On 11/20/2024 at 6:40 AM and observation and interview with NA #4 indicated not having any residents on his/her assignment (the low number end of the hall to the double doors and the other NA has all the rooms beyond the double doors) that required the use of a gown and mask in addition to wearing gloves for care.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | b. An observation and interview with NA #5 on 11/20/2024 at 6:45 AM noted her/him coming out of a room with an orange dot has a mask and gloves no gown), NA # 5 removed gloves and use hand sanitizer after being asked the meaning of the orange dot. NA # 5 indicated the orange dot next to a resident's name was the type of precautions needed. NA #5 indicated Resident # 91 was totally dependent on care requiring incontinent care and indicated neither resident in the room required the use of a gown during care.<br><br>On 11/20/2024 at 7:05 AM an interview with the Staff Development Coordinator, RN #8 indicated in-servicing of the staff regarding EBP was conducted by and the Infection Preventionist, RN #2 and would locate the information for review.<br><br>On 11/20/2024 the facility provided a list of 57 residents located throughout the facility that required enhanced barrier precautions.<br><br>On 11/22/2024 at 11:50 AM and interview and review of facility documents with RN #8 indicated NA #3 had in-service training regarding EBP on 4/12/2024 per the facility EBP in-servicing attendance sheet. However, NA #5 was not found to have attended EPB in-service training. RN #8 indicated the 2 nurse aids were spoken to regarding the occurrences.<br><br>An interview on 11/22/2024 at 2:00PM with the Infection Preventionist RN # 2 indicated no signage is required outside the resident rooms as visitors are not expected to provide high risk direct care so visitors do not need to know about EBP but, in the event a visitor or family member indicated that they wanted to assist the resident with a high-risk care activity the visitor would be provided 1:1 training by RN # 2 or another staff member.<br><br>The facility policy labeled Precautions to Prevent Infection, indicated in part enhanced barrier precautions is an approach of targeted gown and glove use during high contact resident care activities designed to reduce transmission of Staphylococcus Aureus and Multidrug Resistant Organisms (MDRO's) when contact precautions do not apply. The policy further indicated residents found at risk for EBP are those infected or colonized with a Center for Disease Control (CDC) novel or targeted MDRO when contact precautions do not apply and those with indwelling medical devices and or wounds even if not known to be infected or colonized with a MDRO. The policy indicated high risk resident care activities included dressing bathing, showering, transferring, proving hygiene, changing linens, briefs or assisting with toileting, device care or use of a device and wound care or dressing changes. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>46046<br><br>Based on observations, review of facility policy and staff interviews, the facility failed to ensure staff followed the hot water temperature monitoring requirements by checking and logging the mixing valve daily, testing to be done at different times throughout the month at varied testing locations and weekly calibration of the tester and recording the results to ensure a safe environment. The findings include:<br><br>An observation on 11/18/24 at 10:40 AM in the memory care unit Resident #46's bathroom faucet hot water temperature was 124.4 degrees Fahrenheit (F.), (Centers for Medicare and Medicaid's acceptable temperature was below 120 degrees F.)<br><br>An observation on 11/18/2024 at 10:55 AM identified Resident #95's bathroom faucet (at the opposite end of the unit) the hot water temperature was 129.4 degrees F. (10.4 degrees above acceptable hot water temperature).<br><br>On 11/18/2024 at 11:10 AM Charge Nurse LPN #7 notified of hot water temperatures that were found to be elevated and maintenance was notified to come to the unit.<br><br>On 11/18/2024 at 11:25 AM an observation and interview with Maintenance Worker #1 who was made aware of the hot water temperature findings and re-temperatures with the facility thermometer were made in Resident #46 and #95's bathroom faucets were 124.1 degrees F. and 127 degrees F which were noted to be (5.1- and 8.0-degrees F. above acceptable hot water temperatures). Maintenance Worker #1 indicated the hot water temperature results were too high and communicated the temperatures to Maintenance Worker #2 who indicated he/she would turn down the mixing valve so the temperature would not climb any higher.<br><br>An interview with the Director of Maintenance on 11/18/24 at 11:35 AM upon receiving an update of the excessive hot water temperature status by the surveyor, s/he radioed Maintenance Workers #1 and #2 to request the water temperature logs. When asked how the residents on the memory care unit would be kept residents safe from using excessively hot water, s/he indicated the system would be flushed to cool temperatures down and she/he would turn off the hot water to the unit until water temperatures were safe. The Director of Maintenance agreed to supply the water temperature logs, the facility water temperature monitoring policy and by 3:00 PM a written plan of how the facility would monitor the situation over the next 24 hours.<br><br>An interview on 11/18/24 at 11:40 AM with the Administrator informing him/her of the elevated hot water temperature and a request for a written plan of the process for resolving the issue. A plan on how the facility would be keep residents safe from the hot water was requested along with the facility policy and the temperature logs. The Administrator called the Maintenance Director to obtain the logs.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 11/18/2024 at 2:00 PM and interview and facility document review with the Director of Maintenance indicated the water temperatures were taken daily in 3 resident room locations and found to be within acceptable range including 11/18/2024. The Director of Maintenance further indicated the time temperatures were taken is not documented on the log, but the temp had been taken early AM upon start of the shift. The Director of Maintenance further indicated the time of day the testing was done was not varied as it should have been. The Director of Maintenance indicated the vendor replaced the hot water valve and she/he would provide updated temperature monitoring on 11/19/2024.<br><br>On 11/18/2024 at 3:00-3:15 PM an interview and facility document review with the Administrator identified the facility policy the Maintenance Director provided to him/her indicated the prior owner did not have a policy for monitoring of hot water temperature logs. Review of the facility policy with the Administrator indicated the Director of Maintenance did not have evidence of checking and logging the mixing valve daily, evidence testing was done at different times throughout the month at varied testing locations (ex. including shower rooms) and no weekly calibration of the tester with documentation of the results. The Administrator further provided the plan for monitoring the hot water temperatures over the next 24 hours along with training of the nursing staff regarding their role in providing resident care with no available hot water and monitoring the hot water temperatures when the maintenance personnel was not in the building overnight.<br><br>On 11/19/24 at 2:14 PM an interview and facility document review with the Director of Maintenance identified current hourly hot water temperatures were within acceptable limits since the replacement of the hot water valve. The Director of Maintenance further indicated that a final log would be provided on 11/20/2022 once monitoring is completed.<br><br>The facility policy labeled Engineering Management : Hot Water Temperature Requirements indicated in part; daily hot water temperatures would be taken and recorded in 3 locations throughout the building and recorded, the temperature readings would be taken with a calibrated tester and recorded on the daily water temperature log, the mixing valve gauge would be checked and logged daily, time of the tests were to be at different hours throughout the month, the tester wil be calibrated weekly and recorded as to manufacture's specifications and sample rooms would include shower rooms, utility rooms kitchenettes and other spaces as well as resident's rooms. The policy further indicated any reading over the state's maximum temperature level requires the hot water to be shut off immediately with notification to nursing the administrator and temperature readings taken on an hourly basis for 24 hours through the following day after correction/repairs are completed. |