| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075381 | A. Building<br>B. Wing | 07/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Water's Edge Center for Health & Rehab | 111 Church Street<br>Middletown, CT 06457 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117<br><br>Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 residents (Resident #78 and 101), for Resident #78, reviewed for elopement, the facility failed to notify the resident representative and physician when the resident eloped from a secure locked unit, and for Resident #101, reviewed for infection, the facility failed to give prompt notification to the resident representative and physician when the resident had a change in condition. The findings include:<br><br>1. Resident #78 was admitted to the facility in December 2021 with diagnoses that included dementia and traumatic brain injury.<br><br>A fall risk evaluation, done upon admission in 12/2021, identified Resident #78 was at high risk to fall due to a history of multiple falls prior to admission and use of multiple sedative, cathartic, and psychotropic medications.<br><br>An elopement evaluation on admission, dated 12/2021, identified Resident #78 was at high risk for elopement due to a physical ability to leave the facility, cognitive impairment, inability to make informed decisions about leaving the facility, and disorientation. Resident #78 had a wander guard device placed.<br><br>The care plan dated 4/18/24 identified Resident #78 had impaired cognitive thought processes due to dementia that included inattention and disorganized thinking and was at risk for elopement and wandering. Interventions included to keep the resident's routine as consistent as possible to decrease confusion and the use of a wander guard device. Further, the care plan indicated the resident was at risk to fall.<br><br>The physician's orders dated 6/1/24 directed behavior monitoring for elopement every shift, and the use of a wander guard, check for expiration date every 7 days and check for function every 11:00 PM - 7:00 AM shift and as needed.<br><br>Review of facility documentation identified Resident #78 resided on the 4th floor, a secured locked unit.<br><br>The quarterly MDS assessment dated [DATE] identified Resident #78 had severely impaired cognition.<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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The nurse's note dated 6/25/24 at 12:36 PM, written by the RN Supervisor (RN #3), entered as a late entry on 6/28/24 identified that Resident #78 wandered off the unit and was found on the 1st floor near the kitchen area. (This is in conflict with security camera footage that identified Resident #78 left the 4th floor via a stairwell to the 1st floor unsupervised from 8:11 PM - 8:26 PM, not 12:36 PM.)<br><br>The nurse's note dated 6/26/24 by LPN #12 identified Resident #78 had been placed on every 15-minute checks for the 3:00 PM - 11:00 PM shift only however the clinical record failed to identify any documentation related to 15-minute checks being completed.<br><br>The nurse's note dated 6/28/24 at 2:00 PM by LPN #3 identified Resident #78 had been observed in the lobby (1st floor) by staff.<br><br>Review of the clinical record failed to reflect that Resident #78's representative was notified of the attempted elopement on 6/25/24.<br><br>Interview with RN #3 on 7/2/24 at 9:11 AM identified he was the RN Supervisor on 6/25/24 during the 3:00 PM - 11:00 PM shift. RN #3 identified that Resident #78 was found on the 1st floor of the near the kitchen on 6/25/24 at approximately 9:00 PM by NA #5. RN #3 identified he was notified of the incident by LPN #7, who was assigned to Resident #78.<br><br>Interview with APRN #2 on 7/2/24 at 9:45 AM identified she was not notified that Resident #78 was able to exit the secured locked unit on 6/25/24 and indicated she should have been notified. APRN #2 indicated she was notified that Resident #78 had an elopement attempt on 6/28/24, as staff reported that Resident #78 was able to leave the secured unit, but was found in the building. (This is in conflict with the surveillance video that showed Resident #78 exiting the front door and being [NAME] back into the facility by RN #1).<br><br>Interview with LPN #7 on 7/2/24 at 12:54 PM identified she was the nurse assigned to Resident #78 on 6/25/24 during the 3:00 PM - 11:00 PM shift and she was notified by NA #5 that Resident #78 was found on the 1st floor near the kitchen around 9:00 PM. LPN #7 identified she notified RN #3 of the situation. LPN #7 identified she did not notify any other facility staff, including maintenance staff, of the issue with Resident #78's wander guard, since she felt notification to RN #3 was sufficient. LPN #7 identified she did not document the residents elopement behaviors or the attempted elopement incident on 6/25/24 as she also felt this was addressed by her notification to RN #3.<br><br>Interview with the Receptionist on 7/2/24 at 10:00 AM identified she was assigned to work the reception desk on 6/28/24 and was also assisting with admissions. The Receptionist identified she witnessed RN #1 walking a resident back into the building and that she was told the resident had a wander guard on, but it did not alarm or lock the exit doors.<br><br>Interview with the Administrator on 7/2/24 at 10:12 AM identified he was aware Resident #78 had 2 incidents involving leaving the secured unit on the 4th floor to the 1st floor on 6/25/24 and 6/28/24. The Administrator identified he had reviewed the security footage following the 6/28/24 attempt when he was made aware of an additional attempt on 6/25/24, 3 days prior. The Administrator identified that with both attempts, Resident #78 remained in the building and did not leave the lobby area (This is in conflict with the surveillance video that showed Resident #78 exiting the front door and being [NAME] back into the facility by RN #1).<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with RN #1 (IP Nurse) on 7/2/24 at 11:23 AM identified that he was leaving the facility for an appointment sometime between 10:30 AM - 11:00 AM on 6/28/24 and although he did not see the resident exit the facility, he saw Resident #78 outside of the facility. RN #1 identified he had observed Resident #78 standing approximately 5 feet from the outside exit doors of the facility on a sidewalk.<br><br>Interview with the Maintenance Technician on 7/2/24 at 11:27 AM identified he was outside the facility working in the parking lot approximately 15 feet from the outside entrance doors on 6/28/24 when he saw RN #1 pull his vehicle up to the sidewalk near the entrance and saw a resident standing in the walkway. The Maintenance Technician identified he saw the resident there prior to RN #1 pulling up. The Maintenance Technician identified he saw RN #1 park his vehicle, get out, and walk Resident #78 back into the building. The Maintenance Technician identified he did not know Resident #78 was able to exit the building with a wander guard, or that the resident was able to leave the secured unit, until he was notified later that day.<br><br>The facility policy on elopement directed that residents of the facility would be accounted for at all times, and any resident identified as missing would require protocol that would include to announce a designated code alert for a missing person and initiate a missing person report; assign staff to begin an organized search of the facility and grounds, and notify the DNS, Administrator, provider, and resident representative.<br><br>The facility policy on 1:1 monitoring directed that a licensed nurse, the DNS, and/or the Administrator was responsible to place a resident on 1:1 observation if the safety of the resident was at risk. The policy further directed that facility guidelines for 1:1 observation included unsafe wandering or exit seeking behavior on or off the unit. The policy further directed that staff members were responsible to report any resident behaviors that posed a potential for harm to the resident, and the person who becomes aware of the situation was to stay with the resident and call for assistance, and that the licensed nurse was to evaluate the resident and ensure that the resident was not left alone and assign a designated person to monitor the resident 1:1. The policy also directed the DNS/Administrator, attending physician, and resident representative would be notified and that staff responsible for the resident would be educated by the licensed nurse on 1:1 observation.<br><br>The facility policy on change of condition directed that the facility would inform the resident's healthcare provider and the resident representative when there was a change in the resident's condition, and this would include an incident involving the resident that may result in injuries or require medical treatment. The policy further directed that per state regulations, the licensed nurse would notify the resident, attending physician, and resident representative of the change of condition, and all attempts would be documented.<br><br>2. Resident #101 was admitted to the facility with diagnoses that included dementia, hypertension, and stroke.<br><br>The annual MDS dated [DATE] identified Resident #101 had moderately impaired cognition and required touching assistance with personal hygiene and moderate assistance with transfers and ambulation.<br><br>The care plan dated 6/21/24 identified the resident has impaired balance and impaired cognition. Interventions included providing assistance of 1 with a rolling walker for transfers, ambulation, and personal hygiene.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The nurses note, written by LPN #8 (an agency nurse), on 6/22/24 at 10:32 PM identified Resident #101 complained of eye discomfort to both eye lids, and the eye lids were red and puffy. LPN #8 applied a cool compress to each eye with effect.<br><br>A physician's order dated 6/25/24 directed to apply Erythromycin (antibiotic) Ophthalmic Ointment 5mg/gm, instill 1 ribbon in both eyes every 8 hours for 5 days, and Lotrisone (steroid and fungal medication) cream 1 - 0.05% apply to bilateral hands topically every day and evening for 10 days for rash.<br><br>Initial Interact Change of Condition Form completed by LPN #9 dated 6/25/24 at 2:51 PM identified Resident #101 was noted to have redness of the left eye sclera, complains of itchiness and grittiness, and both hands palm side were dry with a rash and pink in color. The APRN was notified on 6/25/24 at 1:00 PM and ordered Lotrisone cream to both hands and Erythromycin ointment to both eyes for 5 days for diagnosis of conjunctivitis. Resident representative left a message to return the call for update.<br><br>The care plan dated 6/25/24 identified Resident #101 had a new diagnosis of conjunctivitis. Interventions included giving ointments/drops per the physician orders and preventing the spread of infection by good handwashing before and after treating eyes.<br><br>Review of the progress notes dated 6/22/24 to 7/2/24 failed to reflect the responsible party had been notified of the eye discomfort, or new orders for the Erythromycin or Lotrisone.<br><br>Interview with Resident #101 on 6/30/24 at 7:35 AM indicated that his/her eyes were itchy and have bothered him/her for 2 - 3 weeks and that the nurses have been informed many times during that timeframe. Resident #101 indicated that finally, a couple days ago, the nurse looked at it and he/she received new eye drops that are helping.<br><br>Interview with the DNS on 7/2/24 at 6:45 AM indicated that a when the resident had a change of condition, the resident representative should immediately have been notified by the charge nurse or supervisor, and that notification must be documented. The DNS indicated that if only a message was left the nurse must continue to try and reach the resident representative and if after multiple attempts nursing cannot reach the residents representative then nursing will get the social worker involved to try to reach the resident representative. The DNS indicated that the nurses must document all the attempts to reach the resident representative to update them. After review of the clinical record, the DNS indicated that she did not see in the APRN or nursing notes that Resident #101's representative had been notified of the change of condition from 6/22/24 and on 6/25/24. The DNS indicated that nursing had only left one message and did not try again. The DNS indicated that it is not documented that the resident representative was updated regarding the Lotrisone cream for the hands or the antibiotic eye ointment from 6/22/24 - 7/2/24.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with Person #2 on 7/2/24 at 7:53 AM indicated that RN #2 had just called and he/she was notified that Resident #101 had a diagnosis of conjunctivitis and was getting treated with eye drops. Person #2 indicated that on 6/2/24 he/she had visited Resident #101 and Resident #101 was complaining that both eyes were itchy. Person #2 indicated at that time he/she had notified the charge nurse on that day 6/2/24. Person #2 questioned if the conjunctivitis was contagious, and that RN #2 did not explain that to him/her. Person #2 indicated that she was not aware prior to today of the diagnosis of conjunctivitis and the antibiotic eye drops but he/she had known that Resident #101 was complaining about his/her eyes red and itchy since the party on 6/2/24.<br><br>Interview with the DNS on 7/2/24 at 9:53 AM indicated that the nurse, LPN #8, was an agency nurse. The DNS indicates that on the 6/22/24 note, LPN #8 wrote regarding the change in condition that LPN #8 should have notified the RN supervisor to do an assessment that would have been documented and then notify the physician and the resident's representative on 6/22/24. The DNS indicated that LPN #9 had notified the APRN on 6/25/24 (3 days later) and only left a message for the resident representative. After review of the clinical record, the DNS indicated that the APRN/MD were not notified on 6/22/24 of the change in condition and the resident's representative was not notified on 6/22/24 or on 6/25/24 of the change of condition of the eyes and hands or the new orders.<br><br>Although attempted, an interview with LPN #8 was not obtained.<br><br>Review of the facility Change of Condition Notification Policy identified the facility will inform the resident, residents' representative when there is a change in condition. The purpose is to ensure the change of condition was evaluated and documented properly and that it was reported to the healthcare provider and resident representative. The licensed nurse per state regulations conducts a complete physical and mental evaluation and documents the findings in the medical record. The licensed nurse per state regulations notifies the resident, the attending physician, and the resident representative of the change in condition. If unable to reach the residents representative repeated attempts will be made to reach the residents representative until successful. The nurse will document all attempts noting the date and time of the attempts.<br><br>46040 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293<br><br>Based on observation, review of facility documentation, job descriptions, and interviews for 5 of 5 units, the facility failed to ensure the environment was clean, sanitary, maintained in good repair and homelike. The findings included:<br><br>Review of the maintenance repair log dated 4/2/24 through 6/28/24 failed to reflect documentation regarding the condition of resident rooms.<br><br>Review of the environmental rounds worksheet for infection prevention dated 6/26/24 and the random environmental rounds form dated 6/27/24 identified rounds were completed by RN #1. The environmental rounds worksheet for infection prevention and the random environmental rounds form failed to reflect documentation of the condition of resident rooms.<br><br>Observations on 7/2/24 at 1:20 PM through 2:40 PM, and on 7/2/24 at 2:45 PM through 3:00 PM with the Director of Maintenance, and the ADNS identified the following:<br><br>a. Damaged, missing and/or broken floor tiles in the bedroom on the 3rd floor, A Wing, in room [ROOM NUMBER], and on the 3rd floor, B Wing, in rooms 317, 329, and both elevators.<br><br>b. Damaged, yellow stained floor tiles in the bathroom on the 3rd floor, A Wing, in rooms 303, 305, and on the 3rd floor, B Wing, in rooms 330, and 331.<br><br>c. Damaged, stains, chipped and/or marred bedroom walls, and/or bedroom wallpaper, and bathroom walls, on the 2nd floor, A Wing, in rooms [ROOM NUMBER]. On the 2nd floor, B Wing, in rooms 215, 221, 222, 223, Resident Lounge, and 226. On the 3rd floor, A Wing, in rooms 301, 303, 304, 305, 306, 307, 308, hallway, and 310. On the 3rd floor, B Wing, in rooms 314, 316, 318, 319, 320, 321, 322, 324, 330, 331, and the Shower Room. On the 4th floor in rooms 414, 417, 418, 421, hallway, 425, Recreation Area on the 4th floor.<br><br>d. Damaged, dirty and/or missing cove base in bedroom and bathroom on the 3rd floor, A Wing, in rooms 303, and on the 3rd floor, B Wing, in rooms [ROOM NUMBER].<br><br>e. Stains, dirt, debris, discoloration and/or wax build up on the floor bedrooms on the 3rd floor, A Wing, in rooms 306, 307, 310, 311, 312, and 313. On the 3rd floor, B Wing, in rooms 314, 315, 316, 318, 319, 320, 323, 324, 328, and 330.<br><br>f. Stains, dirt, debris, discoloration and/or wax build up on the floor in the bathroom on the 3rd floor A Wing, in room [ROOM NUMBER]. On the 3rd floor, B Wing, in rooms 314, 317, 321, 323, and 324.<br><br>g. Damaged, peeling, and/or brown stains on bedroom and bathroom ceiling, on the 2nd floor, A Wing, in rooms [ROOM NUMBER]. On the 3rd floor A Wing in rooms 301. On the 4th floor in the Recreation Area.<br><br>h. Damaged, rusty, and/or stain air conditioner on the 4th floor in room [ROOM NUMBER].<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | i. Damaged, torn, and/or stained carpet on the 2nd floor hallway. The 3rd floor, A/B Wing hallway in the corridor at the elevator area. On the 3rd floor B Wing hallway. On the 4th floor Recreation Area, and the 4th floor corridor at the elevator area.<br><br>j. Damaged, peeling, and/or stained bed footboard in bedroom on the 3rd floor, A Wing, in rooms 310, and 312. On the 3rd floor, B Wing, in room [ROOM NUMBER].<br><br>k. Damaged, off-track, and/or stains privacy curtain in bedroom on the 3rd floor, A Wing, in rooms 301, and 304. On the 3rd floor, B Wing, in rooms 321, and 329.<br><br>l. Damaged, torn, and/or broken bathroom cabinet in room on the 3rd floor, A Wing, 303, and on the 3rd floor, B Wing, in room [ROOM NUMBER].<br><br>m. Damaged, broken, peeling, and/or missing dresser, and/or nightstand drawer knob in bedroom on 3rd floor on the B Wing in rooms 315 (2nd drawer handle off), and 320 (2nd drawer damaged).<br><br>n. Damaged and/or marred door frame, door in bedroom and/or bathroom on the 3rd floor in rooms 317, and 321.<br><br>Interview with the Director of Maintenance on 7/2/24 at 3:00 PM identified he has been employed by the facility since November 2023. The Director of Maintenance indicated he was aware of some of the issues. The Director of Maintenance indicated he and the maintenance staff are trying to repair some of the damaged walls in the bedrooms and bathrooms. The Director of Maintenance indicated the maintenance department is trying to repair and fix one wing at a time. The Director of Maintenance indicated he does make rounds but did not document when he made rounds or his findings.<br><br>Interview with the ADNS on 7/2/24 at 3:19 PM identified she was not aware of the resident bedroom floors with stains, dirt, debris, discoloration and/or wax build up on the floors, and the privacy and window curtains dirty with brown stains. The ADNS indicated she will discuss the issues with the DNS, the Housekeeping Director, and RN #1. The ADNS indicated an in-service will be given to the housekeeping staff, and the nursing department.<br><br>Interview with the DNS on 7/3/24 at 4:00 PM identified she was not aware of the issues. The DNS indicated that going forward there will be a meeting with the Director of Maintenance, the Director of Housekeeping, and RN #1 regarding the expectation of a home like environment.<br><br>Although attempted, an interview with RN #1 and the Director of Housekeeping was not obtained.<br><br>Review of the facility Infection Preventionist position description identified the Infection Preventionist (IP) serves as the facility's Infection Prevention and Control Officer and functions as a practitioner, resource, consultant, educator, and facilitator for all staff in all departments focusing on the following areas: Infection Prevention & Control Activities<br><br>Outcome & process Surveillance<br><br>Outbreak Management & Reporting Requirements<br><br>Employee Health<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | To maintain a safe environment for facility residents and personnel.<br><br>Review of the facility infection prevention rounds identified each center will have an effective Infection Control/Environmental Rounds Program in place. Rounds will be conducted monthly by the Infection Prevention Committee and appropriate department heads.<br><br>Review of the Janitor/Custodian position description identified responsible for performing routine tasks to ensure the cleanliness of assigned areas of the facility.<br><br>Review of the facility housekeeper position description identified responsible for performing routine tasks to ensure the cleanliness of assigned areas of the facility.<br><br>Review of the facility engineering personnel/maintenance worker position description identified repairs and maintains the facility's equipment and buildings. |

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| F 0625<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117<br><br>Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #4) reviewed for hospitalization , the facility failed to ensure the resident or resident representative received the bed hold notice for a bed hold prior to being transferred to the hospital 4 times. The findings include:<br><br>Resident #4 was admitted to the facility on [DATE] with diagnoses that included bowel obstruction, and anemia.<br><br>The annual MDS dated [DATE] identified Resident #4 had intact cognition.<br><br>A census form identified Resident #4 was sent to the hospital on 1/15,, 2/7, 4/8, and 4/24/24.<br><br>Interview with the ADNS on 7/1/24 at 8:52 AM indicated that the bed hold notice, for Resident #4, was signed by the resident at admission only. The ADNS indicated that nursing does not give the bed hold notice to the resident or resident representative when the resident is sent to the emergency room , because it was signed once at admission.<br><br>Interview with the DNS on 7/1/24 at 2:05 PM indicated the RN Supervisor is responsible to send the bed hold notice with the residents when they go to the hospital, however, although they are also responsible for making copies of all discharge paperwork, including the bed hold notice, prior to the resident leaving the facility, it had not been done for Resident #4's hospitalization s on 1/15, 2/7, 4/8, or 4/24/24.<br><br>Review of the facility Bed Hold Policy identified to provide written notice of the bed hold policy to the resident and resident representative at the time of transfer out of the facility regardless of payor source. Also, to secure a private payer source, if applicable, to ensure a bed is reserved and available upon the resident's return. When a resident is transferred out of the facility to a hospital or on a therapeutic leave, a facility representative will provide the resident and/or representative with a written Bed Hold Policy Notice and Authorization Form regardless of payer source. During the transfer the resident will be provided with a copy of the form, and a copy will be maintained in the residents' medical record and a copy of the form will be given to the business office. |

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| | 075381 | A. Building<br>B. Wing | 07/03/2024 |

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| Water's Edge Center for Health & Rehab | 111 Church Street<br>Middletown, CT 06457 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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** 42117<br><br>Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #91) reviewed for skin conditions, the facility failed to monitor the resident for scratching/itching behaviors and utilize a prn anti itch medication as needed and for 1 resident (Resident #101), who had complaints of eye discomfort and had orders for compression stockings, the facility failed to ensure the resident was assessed by a registered nurse when the eye discomfort was noted and staff failed to apply compression stockings according to the physician's order. The findings include:<br><br>1. Resident #91 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, right dominant side hemiplegia, and contractures of the right hand, elbow, knee, ankle, and foot.<br><br>A physician's order dated 12/4/23 directed to apply [NAME] External lotion 0.5 - 0.5% topically to trunk and legs every evening shift for dry skin.<br><br>A physician's order dated 4/2/24 directed to apply Triamcinolone Acetonide external lotion 0.1% to affected itchy areas topically, every 8 hours, as needed for itchiness.<br><br>The June 2024 TAR and MAR identified the Triamcinolone Acetonide external lotion had not been applied to Resident #91's affected itchy areas.<br><br>The annual MDS dated [DATE] identified Resident #91 had moderately impaired cognition, was dependent with toileting, hygiene and bathing, required a moderate assist with personal hygiene, and required a skin treatment which included applications of ointments or medications.<br><br>The care plan dated 6/25/24 identified Resident #91 had an alteration in skin integrity (non-pressure) related to pruritus and eczema. Interventions included providing treatment as ordered, updating the physician or APRN with changes, and updating the resident representative as needed.<br><br>The total body skin assessment dated [DATE] identified Resident #91's skin had good elasticity, skin color was normal for ethnic group, temperature was warm (normal), moisture was normal, condition was dry, and there were zero new wounds.<br><br>Observation and interview with LPN #5 on 7/1/24 at 9:00 AM identified Resident #91 sitting up in bed with a white sheet covering his/her lower extremities; the sheet was noted to have an area with a dried red fluid stain, resembling blood. LPN #5 indicated that Resident #91 had a history of dry, itchy skin affecting both legs and one of his/her behaviors was itching the affected areas. LPN #5 indicated that Resident #91 identified that the [NAME] lotion usually helps with itchy skin, but he/she requires constant reminding and education not to scratch the affected areas.<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 - Few | Observation with the Wound Nurse (RN #1) on 7/1/24 at 9:20 AM identified Resident #91 had multiple areas at various stages of healing, on his/her upper and lower extremities, including open areas with a dried fluid resembling blood and dried red fluid under some of his/her fingernails. Resident #91 identified that he/she had been itchy for the last month and had been increasingly scratching his/her arms and legs for the past week, using his/her fingernails, toenails, and heels to scratch. Resident #91 indicated that he/she thinks the detergent used to launder the sheets may be causing an increase in itchiness; Resident #91 could not recall if he/she had told the nursing staff of the increase in itching. RN #1 indicated that he would have the nurse aide wash Resident #91, begin a facility accident and incident investigation, and have the daytime nursing unit manager notify the APRN.<br><br>Interview and review of the clinical record with the Nursing Unit Manager (RN #6) on 7/1/24 at 12:18 PM identified that she notified the APRN of Resident #91's change in condition, new orders were obtained, and the resident would be followed by the skin and wound team. RN #6 further indicated that Resident #91 has scratching behaviors; the clinical record failed to identify that the nursing staff was monitoring for scratching behaviors; RN #6 indicated that she would expect to see documentation for the behaviors. RN #6 identified that the nursing staff reported using the Triamcinolone Acetonide external lotion to the affected areas and that she observed the medication bottle to be nearly empty, but the clinical record did not provide documentation that the cream was applied from 6/1/24 through 6/30/24. RN #6 indicated that she would expect that the nurses document every time a PRN medication is given and that she would provide education to the nurses on her unit that the expectation is that PRN medications are documented with every administration.<br><br>Interview and review of the clinical record with the DNS on 7/2/24 at 12:46 PM identified that Resident #91 was care planned for chronic skin conditions, pruritus and eczema but not for scratching or itching behaviors. The DNS further identified that if there is a new behavior the nurses should write a note indicating the behavior, notify the provider and family, create a care plan, and begin behavior monitoring. The DNS indicated that since Resident #91 has chronic skin issues, there is already a treatment in place, but if the conditions worsened, she would expect the nurse aide to notify the licensed staff, and the nurse should conduct an assessment, notify the provider and family, and update the care plan.<br><br>Interview with NA #6 on 7/2/24 at 1:16 PM identified that Resident #91 had recently reported having itchy skin within the last week and that she notified the nurse, but she could not recall the specific day that the resident complained of itchiness or the nurse that she notified. NA #6 further identified that when Resident #91 reports being itchy, the resident will scratch at the area a lot.<br><br>Interview with LPN #11 on 7/2/24 at 1:22 PM identified that she has provided care for Resident #91 many times and that when the resident has periods of pruritus he/she will scratch a lot and that she was unaware of behavior monitoring for scratching, but she does apply the [NAME] lotion per the physician's order.<br><br>Although requested a facility policy for behavior monitoring was not provided.<br><br>Although requested a facility policy for nursing documentation was not provided.<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 - Few | The facility's Change of Condition notification policy directs the that the facility must inform the resident, consult with the resident's healthcare provider, and if known the resident's legal representative or family member when there is: an incident involving the resident which may result in an injury or requires medical treatment; a significant change in physical, mental, or psychosocial status; a need to alter treatment; a decision to transfer or discharge the resident from the facility.<br><br>2. Resident #101 was admitted to the facility with diagnoses that included dementia, hypertension, and stroke.<br><br>A physician's order dated 6/3/24 directed to apply compression stockings to bilateral lower extremities every day for edema and keep legs elevated at all times when seated.<br><br>The APRN #2 progress note dated 6/3/24 identified that Resident #101 had a trace of bilateral lower extremity edema with recommendations that included to continue compression stockings and a low sodium diet.<br><br>The annual MDS dated [DATE] identified Resident #101 had moderately impaired cognition, required touching assistance with personal hygiene, moderate assistance with transfers and ambulation, required moderate assistance with lower body dressing and putting on and off footwear.<br><br>The care plan dated 6/21/24 identified the resident has impaired balance and impaired cognition. Interventions included providing assistance of 1 with a rolling walker for transfers, ambulation, and personal hygiene. Additionally, the resident has impaired circulation related to dependent edema. Resident #101 was to elevate legs when resting and nursing to inspect for changes of redness, purple tinge, weeping, edema, and puffiness.<br><br>a. The nurses note, written by LPN #8 (an agency nurse), on 6/22/24 at 10:32 PM identified Resident #101 complained of eye discomfort to both eye lids, and the eye lids were red and puffy. LPN #8 applied a cool compress to each eye with effect.<br><br>A physician's order dated 6/25/24 directed to apply Erythromycin (antibiotic) Ophthalmic Ointment 5mg/gm, instill 1 ribbon in both eyes every 8 hours for 5 days, and Lotrisone (steroid and fungal medication) cream 1 - 0.05% apply to bilateral hands topically every day and evening for 10 days for rash.<br><br>Initial Interact Change of Condition Form completed by LPN #9 dated 6/25/24 at 2:51 PM identified Resident #101 was noted to have redness of the left eye sclera, complains of itchiness and grittiness, and both hands palm side were dry with a rash and pink in color. The APRN was notified on 6/25/24 at 1:00 PM and ordered Lotrisone cream to both hands and Erythromycin ointment to both eyes for 5 days for diagnosis of conjunctivitis. Resident representative left a message to return the call for update.<br><br>The care plan dated 6/25/24 identified Resident #101 had a new diagnosis of conjunctivitis. Interventions included giving ointments/drops per the physician orders and preventing the spread of infection by good handwashing before and after treating eyes.<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 - Few | Interview with the DNS on 7/2/24 at 6:45 AM indicated that when the resident had a change of condition (eye discomfort), the resident representative should immediately have been notified by the charge nurse or supervisor, and that notification must be documented. The DNS indicated that if only a message was left the nurse must continue to try and reach the resident representative and if after multiple attempts nursing cannot reach the residents representative then nursing will get the social worker involved to try to reach the resident representative. The DNS indicated that the nurses must document all the attempts to reach the resident representative to update them. After review of the clinical record, the DNS indicated that she did not see in the APRN or nursing notes that Resident #101's representative had been notified of the change of condition from 6/22/24 and on 6/25/24. The DNS indicated that nursing had only left one message and did not try again. The DNS indicated that it is not documented that the resident representative was updated regarding the Lotrisone cream for the hands or the antibiotic eye ointment from 6/22/24 - 7/2/24.<br><br>Interview with the DNS on 7/2/24 at 9:53 AM indicated that the nurse, LPN #8, was an agency nurse. The DNS indicated that on 6/22/24, LPN #8 should have notified the RN Supervisor of the resident's complaints of eye discomfort so the RN Supervisor could complete an assessment.<br><br>Review of the clinical record dated 6/22/24 to 7/2/24 failed to reflect that a registered nurse completed an assessment of the resident's eyes after the resident complained of eye discomfort to both eye lids, and the eye lids were red and puffy.<br><br>Although attempted, an interview with LPN #8 was not obtained.<br><br>b. Observation on 6/30/24 at 7:25 AM identified Resident #101 was lying in bed wearing blue grippy socks. At 8:10 AM and 10:00 AM Resident #101 was sitting in a recliner chair with wearing blue grippy socks without the benefit of the ted stocking. Resident #101 bilateral lower legs were puffy over the top edge of the blue grippy sock.<br><br>Interview with LPN #6 on 6/30/24 at 11:17 AM indicated that Resident #101 had a physician order for the elastic stockings. LPN #6 noted after lifting the sheet covering Resident #101's legs the elastic stockings were not on. LPN #6 indicated that she did not have any elastic stockings in Resident #101's room but would get a new pair of elastic stockings and would apply them. LPN #6 and surveyor noted Resident #101 had ankle and lower leg edema. LPN #6 indicated that Resident #101 would usually put his/her own elastic stockings on, but today she will assist Resident #101. LPN #6 indicated that the nurses or the nurse aides were responsible to apply the elastic stockings before a resident gets out of bed in the morning before the resident's edema starts, but Resident #101 sometimes gets him/herself up and will put on own elastic stockings. LPN #6 offered to put on the elastic stockings and Resident #101 agreed. LPN #6 indicated that she had 2 sizes on her treatment cart, a small pair and a large pair so she will try the small pair on Resident #101.<br><br>Observation on 7/2/24 at 8:15 AM identified Resident #101 sitting upright in recliner chair only wearing blue grippy socks without the benefit of elastic stockings.<br><br>Observation on 7/2/24 at 9:00 AM identified Resident #101 was sitting upright in a recliner chair without the elastic stockings.<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 - Few | Interview with NA#3 on 7/2/24 at 9:05 AM indicated that the nurse aides were responsible to put on the elastic stocking prior to getting the resident out of bed every morning. NA #3 indicated that she had gotten Resident #101 washed and dressed prior to breakfast but was unable to recall the time. NA #3 indicated that she knew that Resident #101 needed elastic stocks but that she thought she needed a new pair. NA #3 opened Resident #101 top draw of nightstand and indicated there was a new /clean pair in the nightstand and she had not looked there prior. After surveyor inquiry NA #3 indicated that she would put the elastic stockings on Resident #101.<br><br>Interview with LPN #9 on 7/2/24 at 9:11 AM indicated as the charge nurse of the unit she was responsible to put the elastic stockings on Resident #101 prior to Resident #101 getting out of bed this morning, but she did not do it because she went right to starting the blood sugars and vital signs for the other residents and then started her medication pass. LPN #9 indicated the physician order for the elastic stockings were on her treatment administration record and she was responsible to sign off on it daily in the morning. LPN #9 indicated that she doesn't know why she did not do it before Resident #101 got out of bed except that she got busy with the medication pass.<br><br>Interview with LPN #6 on 7/2/24 at 9:13 AM indicated that she was the treatment nurse and was responsible for the treatments on all the units and at 7:30 AM she looked in on the resident, who was sleeping, and she did not want to wake the resident up. LPN #6 indicated she had been busy doing other treatments and did not have time to get back to Resident #101. LPN #6 indicated ideally, she needed to put on the elastic stockings prior to Resident #101 getting out of bed every morning. LPN #6 indicated that NA #3 was putting on the ted stocking right now.<br><br>Interview with RN #2 on 7/2/24 at 9:29 AM indicated that elastic stockings are to be put on a resident before a resident gets out of bed every morning. RN #2 indicated that the charge nurse or the treatment nurse, when they have one, was responsible to put the elastic stockings on prior to the resident getting out of bed. RN #2 indicated that if a resident refused the stockings, the charge nurse must document that on the treatment administration record and in a progress note and update the MD/APRN and the family. RN #2 indicated that he was not aware that the elastic stockings had not been put on Resident #101 prior to him/her getting out of bed.<br><br>Interview with APRN #2 on 7/2/24 at 9:45 AM indicates that Resident #101 has the physician order for the elastic stockings due to having swelling in bilateral lower legs and ankles from cardiac issues. APRN #2 indicated that her expectations was the nurses would follow the physicians orders and protocols for the elastic stockings and that if the physicians orders were not being followed the nurse would update her.<br><br>Interview with the ADNS on 7/2/24 at 3:02 PM indicated that the physician or APRN would write down what size of ted stockings belong on the resident as part of the order. ADNS indicated that the nurses were responsible to make sure the elastic stockings were on a resident prior to getting out of bed daily.<br><br>Interview with the DNS on 7/2/24 at 3:30 PM indicated that the compression stockings were to be put on Resident #101 prior to getting out of bed each day. The DNS indicated that there was not a policy regarding the compression stockings.<br><br>Review of the compression stocking packaging identified the purpose was to provide mild compression and protect fragile skin.<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 - Few | Although requested, a facility policy on compression stocking was not provided.<br><br>46040 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<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** 46040<br><br>Based on observation, record review and interviews for 1 of 4 residents (Resident #78) who was on a secured locked unit and wore a wander guard, the facility failed to ensure the residents wander guard was changed when it expired, failed to investigate and implement interventions after Resident #78 was able to exit the secured locked unit on [DATE]; and failed to provide adequate supervision and devices to prevent the resident from exiting the secured locked unit on [DATE] when the resident accessed the elevator on the 4th floor, (secured locked unit), took the elevator to the 1st floor, and walked out the front door unsupervised. These failures resulted in a finding of Immediate Jeopardy. The findings include:<br><br>Resident #78 was admitted to the facility in [DATE] with diagnoses that included dementia and traumatic brain injury.<br><br>A fall risk evaluation, done upon admission in ,d+[DATE], identified Resident #78 was at high risk to fall due to a history of multiple falls prior to admission and use of multiple sedative, cathartic, and psychotropic medications.<br><br>An elopement evaluation on admission, dated ,d+[DATE], identified Resident #78 was at high risk for elopement due to a physical ability to leave the facility, cognitive impairment, inability to make informed decisions about leaving the facility, and disorientation. Resident #78 had a wander guard device placed.<br><br>The care plan dated [DATE] identified Resident #78 had impaired cognitive thought processes due to dementia that included inattention and disorganized thinking and was at risk for elopement and wandering. Interventions included to keep the resident's routine as consistent as possible to decrease confusion and the use of a wander guard device. Further, the care plan indicated the resident was at risk to fall.<br><br>The care card, not dated, identified that Resident #78 was to have appropriate footwear on including non-skid socks and non-skid soles on shoes/sneakers while ambulating and non-skid socks on at bedtime.<br><br>A psychiatric note dated [DATE] identified that staff had reported Resident #78 had periods of exit seeking behaviors and difficulty with redirection, the resident was cognitively impaired, was confused, was alert to person only, had confabulatory speech, had delusions that included confabulatory false fixed ideations, had poor insight, poor judgement, and impaired short-term memory and poor long term memory.<br><br>A psychiatric note dated [DATE] identified Resident #78 had poor insight and judgement.<br><br>The physician's orders dated [DATE] directed behavior monitoring for elopement every shift, and the use of a wander guard, check for expiration date every 7 days and check for function every 11:00 PM - 7:00 AM shift and as needed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of facility documentation identified Resident #78 resided on the 4th floor, a secured locked unit.<br><br>Review of the March, April and [DATE] MARs identified Resident #78's wander guard had been checked for expiration by licensed staff weekly, however, documented on the MARs was an expiration date of [DATE] for the wander guard.<br><br>The quarterly MDS assessment dated [DATE] identified Resident #78 had severely impaired cognition.<br><br>Review of the [DATE] MAR identified Resident #78's wander guard had been checked for expiration by licensed staff on [DATE], [DATE], [DATE], and [DATE], however, documented on the MAR was an expiration date of [DATE] for the wander guard (8 months expired).<br><br>The nurse's note dated [DATE] at 12:36 PM, written by the RN Supervisor (RN #3), entered as a late entry on [DATE] identified that Resident #78 wandered off the unit and was found on the 1st floor near the kitchen area. (This is in conflict with security camera footage that identified Resident #78 left the 4th floor via a stairwell to the 1st floor unsupervised from 8:11 PM - 8:26 PM, not 12:36 PM.)<br><br>Although Resident #78 eloped the 4th floor secured unit during the 3:00 PM - 11:00 PM shift on [DATE], LPN #7 documented no elopement behaviors during the 3:00 PM - 11:00 PM shift on the MAR.<br><br>Review of the clinical record failed to identify documentation regarding how Resident #78 was able to leave the secured unit or new interventions to monitor the resident's location on or following the [DATE] elopement from the secured locked unit on the 4th floor to the 1st floor on [DATE].<br><br>The nurse's note dated [DATE] by LPN #12 identified Resident #78 had been placed on every 15-minute checks for the 3:00 PM - 11:00 PM shift only however the clinical record failed to identify any documentation related to 15-minute checks being completed.<br><br>In a 2nd elopment in 3 days, the nurse's note dated [DATE] at 2:00 PM by LPN #3 identified Resident #78 had been observed in the lobby (1st floor) by staff. The note further identified that Resident #78's wander guard was replaced, and Resident #78 was placed on 1:1 observation from 7:00 AM - 11:00 PM and every 15-minute checks from 11:00 PM - 7:00 AM.<br><br>Interview with RN #3 on [DATE] at 9:11 AM identified he was the RN Supervisor on [DATE] during the 3:00 PM - 11:00 PM shift. RN #3 identified that Resident #78 was found on the 1st floor near the kitchen on [DATE] at approximately 9:00 PM by NA #5 but could not identify how Resident #78 was able to leave the secured unit. RN #3 identified he was notified of the incident by LPN #7, who was assigned to Resident #78. RN #3 identified the wander guard should have been changed at time it expired on [DATE], and that it should have been changed following the 1st elopement attempt on [DATE] as the wander guard can malfunction or lose battery function if not changed timely.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview with LPN #7 on [DATE] at 12:54 PM identified she was the nurse assigned to Resident #78 on [DATE] during the 3:00 PM - 11:00 PM shift. LPN #7 identified that she was in another resident's room administering medications when she was notified by NA #5 that Resident #78 was found on the 1st floor near the kitchen around 9:00 PM. LPN #7 identified that Resident #78 had not been exit seeking during her shift, and that she spoke with Resident #78 and asked Resident #78 if he/she knew the code to leave the secured unit, which the resident did not. LPN #7 brought Resident #78 to the exit doors by the elevators, checked the function of the wander guard by entering the 4th floor elevator with Resident #78, and the alarm box for the wander guard did beep, however, the elevator did not lock and allowed LPN #7 and Resident #78 to operate the elevator to the 1st floor and then back up to the unit. LPN #7 identified that while the elevators did not lock, since the alarm beeped, LPN #7 did not check further into the actual wander guard Resident #78 was wearing to see if there were any issues with the it, including the expiration date, since the beep would mean the wander guard was functioning, even if the elevators did not lock. LPN #7 identified she notified RN #3 of the situation and was told by RN #3 he contacted the DNS that Resident #78 was to be placed on 1:1 monitoring. LPN #7 identified she did not complete 1:1 monitoring of Resident #78's location during her shift and was unable to identify who was assigned to complete the 1:1 monitoring. LPN #7 identified she did not notify any other facility staff, including maintenance staff, of the issue with Resident #78's wander guard, since she felt notification to RN #3 was sufficient. LPN #7 identified she did not document the residents elopement behaviors or the attempted elopement incident on [DATE] as she also felt this was addressed by her notification to RN #3.<br><br>Interview with LPN #3 on [DATE] at 11:55 AM identified she was the charge nurse assigned to Resident #78's secured unit on [DATE] when the resident exited the unit unsupervised. Resident #78 was able to get off of the secured unit by following visitors to the elevator, which should have locked once Resident #78 attempted to use it, but Resident #78's wander guard was not working properly, and did not lock down the elevator, allowing the resident to leave the secured unit. LPN #3 identified that Resident #78's wander guard worked in some areas of the facility and not others, based on the investigation by LPN #3 and the DNS, but LPN #3 did not identify the specific areas that the wander guard failed to work. LPN #3 identified that the wander guard did not work to lock down the elevator on the secured locked unit, and Resident #78 was able to leave the unit. Further, LPN #3 identified the wander guard had expired in [DATE] and she changed it after the incident on [DATE]. LPN #3 identified that wander guards should be changed upon expiration.<br><br>Interview with the Receptionist on [DATE] at 10:00 AM identified she was assigned to work the reception desk on [DATE] and was also assisting with admissions. The Receptionist identified she witnessed RN #1 walking a resident back into the building and that she was told the resident had a wander guard on, but it did not alarm or lock the exit doors.<br><br>Interview with the Administrator on [DATE] at 10:12 AM identified he was aware Resident #78 had 2 incidents involving leaving the secured unit on the 4th floor to the 1st floor on [DATE] and [DATE]. The Administrator identified he had reviewed the security footage following the [DATE] attempt when he was made aware of an additional attempt on [DATE], 3 days prior. The Administrator identified that with both attempts, Resident #78 remained in the building and did not leave the lobby area (This is in conflict with the surveillance video that showed Resident #78 exiting the front door and being [NAME] back into the facility by RN #1).<br><br>A request was made by this surveyor to review the security footage of the [DATE] and [DATE] incidents. The footage was observed with the Administrator identified the following:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observation of the security camera footage on [DATE] identified the following:.<br><br>-At 8:10 PM Resident #78 walking toward the end of the 4th floor secured unit.<br><br>At 8:13 PM Resident #78 walking down a flight of stairs located in the 1st floor stairwell. Resident #78 turns around to walk back up the stairs.<br><br>At 8:16 PM Resident #78 is walking down the flight of stairs in the stairwell and exits the stairwell walking through a hallway on the 1st floor and towards to the main elevators.<br><br>-At 8:18 PM Resident #78 pressed the up button and entered the elevator.<br><br>At 8:24 PM Resident #78 walked out of the elevator on the 1st floor and through a set of double doors where the facility laundry and kitchen areas are located.<br><br>-From 8:24 PM - 8:26 PM Resident #78 remained out of camera view in the laundry and kitchen areas.<br><br>-At 8:26 PM NA #5 was seen entering the double doors in the laundry and kitchen areas and escorted Resident #78 towards the elevator and back to the 4th floor at 8:27 PM.<br><br>Based on review of this security camera footage, Resident #78 was able to leave the 4th floor and was unsupervised in the facility from 8:11 PM - 8:26 PM, a total of 15 minutes.<br><br>Observation of the security camera footage on [DATE] identified the following:.<br><br>At 10:39 AM Resident #78 was seen standing at the 4th floor doors that give access to the elevator. A visitor exited the elevator to the 4th floor unit.<br><br>-At 10:40 AM Resident #78 pressed the down button for the elevator and entered the elevator after the doors opened.<br><br>-At 10:41 AM Resident #78 was observed exiting the 1st floor elevator and walked towards the lobby.<br><br>-At 10:41 AM the Receptionist is seated at the reception desk, within direct eyesight of the exit door (approximately 6 feet) and the HR Director and Administrator are standing to the side of the reception desk facing the area of the front entrance.<br><br>-At 10:41AM Resident #78 was seen walking towards the front entrance, directly passing the Receptionist, Administrator, and HR Director, through the initial exit door which did not appear to lock or alarm, and into the vestibule.<br><br>-At 10:42 AM RN #1 was seen entering the facility with Resident #78.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview with the Administrator immediately following the security camera footage identified that on [DATE], Resident #78 was able to access a back stairwell outside of camera view, descend 4 flights of stairs, and accessed the 1st floor. The Administrator identified that the 4th floor unit has 3 access stair wells, all secured by the wander guard system. The Administrator also identified while he reviewed the camera footage at the time of the [DATE] incident, he did not realize that that Resident #78 had gotten outside the building. The Administrator further identified that Resident #78's wander guard failed, which allowed him/her to be able to access the stairwell on the 4th floor on [DATE] as well as leave the building on [DATE].<br><br>Areas that Resident #78 had access to when the resident eloped the 4th floor on [DATE] and when he/she eloped the facility on [DATE] included the following.<br><br>On the 1st floor, the resident had access to the kitchen area, oxygen storage area, maintenance area, and nursing supply storage and equipment storage areas. The kitchen area included a large walk-in refrigerator and freezer, large industrial gas burner stove/ovens and dishwasher areas with sanitizing chemicals. The 1st floor also included the location of the maintenance office with equipment. In addition, the 1st floor has a total of 8 separate exit doors. The 1st floor also had 3 additional access points to the facility basement, which include the facility boiler room, the laundry room, the electrical room, and main mechanical room.<br><br>When the resident eloped the facility on [DATE], the resident had access to the facility parking lot which provided direct access to 2 city roads, and the main access road was visible from the parking lot. The facility is also located in close proximity to a large parking lot used for medical offices, a private school, and a church.<br><br>Interview with RN #1 (IP Nurse) on [DATE] at 11:23 AM identified that he was leaving the facility for an appointment sometime between 10:30 AM - 11:00 AM on [DATE] and although he did not see the resident exit the facility, he saw Resident #78 outside of the facility. RN #1 identified he had observed Resident #78 standing approximately 5 feet from the outside exit doors of the facility on a sidewalk.<br><br>Interview with the Maintenance Technician on [DATE] at 11:27 AM identified he was outside the facility working in the parking lot approximately 15 feet from the outside entrance doors on [DATE] when he saw RN #1 pull his vehicle up to the sidewalk near the entrance and saw a resident standing in the walkway. The Maintenance Technician identified he saw the resident there prior to RN #1 pulling up. The Maintenance Technician identified he saw RN #1 park his vehicle, get out, and walk Resident #78 back into the building. The Maintenance Technician identified he did not know Resident #78 was able to exit the building with a wander guard, or that the resident was able to leave the secured unit, until he was notified later that day.<br><br>Review of the clinical record failed to reflect that every 15-minute checks or 1:1 monitoring had been initiated after Resident #78 was able to exit the 4th floor secured locked unit on [DATE].<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the user manual for the Advantage 1000DE system, the wander guard system used by the facility, directed that the transmitter should have an annual battery change, and that once the expiration date of the transmitter had been reached, they would not be repaired or have the warranty extended. The manual also directed that the advanced security mode feature allowed for doors attached to the system to remain locked when a monitored resident with a transmitter approached. The manual directed that when a resident with a transmitter was in range of the system, any doors connected to the system would lock and be accompanied by a beep.<br><br>The facility policy on the Wander Guard Secure Care Alarm directed that residents identified as an elopement risk would have a wander guard applied to ensure their safety and directed that the device would be checked for placement every shift, function once daily and expiration and/or battery life weekly and these would be documented in the TAR. The policy further directed that any device that had expired or malfunctioned would be discarded or replaced.<br><br>The facility policy on elopement directed that residents of the facility would be accounted for at all times, and any resident identified as missing would require protocol that would include to announce a designated code alert for a missing person and initiate a missing person report; assign staff to begin an organized search of the facility and grounds, and notify the DNS, Administrator, provider, and resident representative.<br><br>The facility policy on environment of care related to the Alzheimer's Special Care Unit (located on the 4th floor) directed that the facility Wander Guard system was worn by residents who were determined to be high risk of elopement from the unit, and that the system would not allow exit from the facility's entrances and exits.<br><br>The facility policy on 1:1 monitoring directed that a licensed nurse, the DNS, and/or the Administrator was responsible to place a resident on 1:1 observation if the safety of the resident was at risk. The policy further directed that facility guidelines for 1:1 observation included unsafe wandering or exit seeking behavior on or off the unit. The policy further directed that staff members were responsible to report any resident behaviors that posed a potential for harm to the resident, and the person who becomes aware of the situation was to stay with the resident and call for assistance, and that the licensed nurse was to evaluate the resident and ensure that the resident was not left alone and assign a designated person to monitor the resident 1:1. The policy also directed the DNS/Administrator, attending physician, and resident representative would be notified and that staff responsible for the resident would be educated by the licensed nurse on 1:1 observation. |

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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** 42117<br><br>Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 (Resident #289) reviewed for pain management, the facility failed to ensure the residents pain management needs were met. The findings include:<br><br>Resident #289 was admitted to the facility on [DATE] with diagnoses that included fractured kneecap, polymyalgia rheumatica, fibromyalgia, and gout.<br><br>The baseline care plan dated 6/26/24 identified pain management related to arthritis. Interventions included resident needed assistance of 2 for bed mobility and using a mechanical lift for transfers. Additionally, administer medications per physician orders, anticipate the resident's need for pain relief, and respond immediately to any complaints of pain.<br><br>The Brief Interview for Mental Status dated 6/26/24 identified Resident #289 had intact cognition.<br><br>A physician's order, from MD #1, dated 6/29/24 directed to give a one-time dose of Acetaminophen 650 mg tablet for pain.<br><br>The MAR dated 6/29/24 identified Resident #289 had received the one-time dose of Acetaminophen 650 mg at 1:55 PM. Further, the MAR dated 6/29/24 identified that Resident #289 had pain level of a zero out of 10 on the 7:00 AM to 3:00 PM shift, pain level of a 6 out of 10 on 3:00 PM to 11:00 PM shift, and pain level of a 4 out of 10 on 11:00 PM to 7:00 AM shift.<br><br>Interview with Resident #289 on 6/30/24 at 7:31 AM indicated that he/she had requested Tylenol for pain last night and he/she believes the pain is from the edema or gout in his/her left ankle/leg. Resident #289 indicated that the day nurse had given him/her only 1 tablet of Acetaminophen and it helped but when he/she had asked at bedtime was informed he/she could not have it. Resident #289 indicated that he/she had asked LPN #10 and was informed that the Acetaminophen order was a one-time order, and it could not be given again. Resident #289 indicated that he/she was in pain and was upset that he/she could not get Acetaminophen last night for the pain which would have helped him/her sleep. Resident #289 indicated that he/she was up most of the night with the pain. Resident #289 indicated how hard is it to get one tablet of Tylenol.<br><br>A physician order dated 7/1/24 directed to give Acetaminophen 975mg every 8 hours for 14 days.<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 | Interview with LPN #10 on 7/2/24 at 11:32 AM indicated he worked on that unit Saturday 3:00 PM to 11:00 PM and he was down the hallway near Resident #289's room and he could hear Resident #289 moaning and groaning. LPN #10 indicated that he left the medication cart and entered Resident #289's room and he/she indicated his/her legs were killing him/her had seen the physician's orders for a one-time order for Acetaminophen and it had already been given earlier in the day. LPN #10 indicated he had informed Resident #289 that he was not able to give another dose of Acetaminophen because he did not have an order. LPN #10 indicated that Resident #289 did not have a prn (as needed) pain medication to give. LPN #10 indicated that he had put Resident #289's request for Acetaminophen in the APRN book at the nurse's station and informed the RN supervisor, RN #5, sometime after 7:00 PM. LPN #10 indicated he did not document regarding Resident #289's pain and need for additional Acetaminophen, he just put it in the APRN's book.<br><br>Interview with APRN #2 on 7/2/24 at 11:48 AM indicated that she was not on call over the weekend. APRN #2 indicated that over the weekend the nurse documented in the APRN communication book that Resident #289 was requesting Acetaminophen for pain. APRN #1 indicated after MD #1 has seen Resident #289 he had asked her to put in the order for the Acetaminophen scheduled for 14 days for pain.<br><br>Interview with MD #1 on 7/2/24 at 12:13 PM indicated that Resident #289 was admitted on [DATE] and he reviewed the resident's medical record and saw that the resident was on a prednisone taper. MD #1 indicated that he had received one phone call, and he gave a one-time order for a dose of Acetaminophen. MD #1 indicated that he did not receive any other calls over the weekend regarding Resident #289. MD #1 indicated when he saw Resident #289 on Monday 7/1/24, the resident complained of pain in his/her hip or leg, and he decided to schedule the Acetaminophen every 8 hours to help with the pain. MD #1 indicated that Resident #289 agreed and indicated that the Acetaminophen would help with the pain so he/she could participate in therapy. MD #1 indicated that he had only received 1 call and gave a 1-time dose of Acetaminophen and no other calls. MD #1 indicated that if Resident #289 was having pain on Saturday or Sunday the charge nurse could have called him any time and he would have given the additional orders for Acetaminophen if it worked for the resident's pain management. MD #1 indicated that he does not want any residents to be in pain. MD #1 indicated that his expectation is that when Resident #289 requested Acetaminophen for pain at bedtime, LPN #10 should have called him and he would have given an order for the Acetaminophen.<br><br>Interview with the DNS on 7/2/24 at 2:10 PM indicated when Resident #289 had complained of pain to LPN #10 and requested Acetaminophen from LPN #10, he should have informed the supervisor and the APRN of the need for pain medication right away. The DNS indicated that the charge nurse must follow up with the RN supervisor or the APRN/MD regarding getting pain medication so residents are not in pain.<br><br>Although attempted, an interview with RN#5 was not obtained.<br><br>Review of the Pain Management Policy identified it is the policy of the facility to monitor residents for symptoms of pain and when identified, provide a detailed pain evaluation, and develop a care plan to provide treatment and services to prevent, minimize, and alleviate pain. The overall goals of care of the resident with pain are prompt evaluation and diagnosis of the pain, evaluate the pain, and optimize the resident's ability to perform activities of daily living and participate in other activities. Consult the provider for any additional interventions when pain is not relieved by currently ordered treatment modalities and comfort measures. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117<br><br>Based on observation, review of the clinical record, facility documentation, facility policy, and interview for 1 resident (Resident #57) reviewed for dental services, the facility failed to provide the necessary assistance to the resident to ensure dentures that had been made for the resident were provided timely. The findings include:<br><br>Resident #57 was admitted to the facility with diagnoses that included dementia, stroke, hemiplegia, and diabetes.<br><br>A physician's order dated 7/20/21 directed to obtain a dental consult for dentures.<br><br>The Dental Consent Form dated 7/29/21 indicated consent was given and signed by Resident #57 for dental services to be provided.<br><br>A DDS (Doctor of Dental Surgery) note, written by DDS #1 dated 8/9/21 identified Resident #57 was informed that removal of dental roots would be necessary prior to dental fabrication, that dental x-rays are needed for further evaluation and prior authorization must be submitted to Medicaid for approval of dental fabrication.<br><br>The DDS note, written by DDS #1 dated 10/24/21 identified the x-ray evaluation revealed all natural teeth appear to be missing, however closer exam reveals several root tips. Recommendation to remove retained dental roots prior to fabrication of dentures.<br><br>The annual MDS dated [DATE] identified Resident #57 had moderately impaired cognition and touching assistance with toilet use, bathing, and putting on and off shoes.<br><br>The DDS note, written by DDS #1 dated 2/18/22 at 3:04 PM identified the resident is excited about moving forward with dental care. The resident was informed of the concern regarding the roots and after discussion, the decision was made for removal of the remaining roots. Medical clearance will be sought. Impressions were made and sent to the dental lab for fabrication of wax rims for bite registration. The resident will be scheduled once clearance is granted, and case returns from the dental lab.<br><br>The DDS note, written by DDS #1 dated 4/6/22 at 5:29 PM identified the resident was scheduled for removal of retained roots and insertion of new upper and lower denture, however, was notified that resident was out of the facility at an appointment so will reschedule. Dentures were delivered and secured in the dental clinic for insertion at the next visit.<br><br>The Dental Hygienist #1 note dated 6/15/22 at 3:31 PM identified that the resident was seen for routine oral exam. Resident #57 indicates that he/she prefers to wait for gastroenterology appointment before removal of the non-restorable teeth and then insertion of dentures.<br><br>The Dental Sign in Forms reviewed from 1/1/23 to 12/31/23 identified that dental services were in the facility 43 different days during 2023.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Dental Hygienist #1 note dated 5/10/23 at 7:31 PM indicated the resident was seen at request of nursing for examination and resident requested once his/her hip surgery was done he/she would like the dentures. Resident #57 will inform dental services when ready to schedule for consultation of the denture process fabrication and insertion.<br><br>The Dental Sign in Forms reviewed from 1/1/24 to 6/30/24 identified dental services were in the facility 18 different days during 2024.<br><br>The Dental Hygienist #1 note dated 6/21/24 at 10:29 PM identified that Resident #57 was in the dental book requesting to be seen for dentures. Years prior to this visit, this service started the fabrication of dentures.<br><br>Interview with Resident #57 on 6/30/24 at 10:58 AM indicates he/she has no teeth and over 2 years ago the dentist made a mold for dentures, and he/she never received them. Resident #57 thought because he/she had surgery on both hips maybe that might be the reason he/she had not received them. Resident #57 indicates that he/she was done with the surgeries since August 2023 almost a year ago. Resident #57 indicated that he/she had asked RN #2, Unit Secretary #1, and many other nurses about seeing dental services to get dentures many times in the last 6 months. Resident #57 indicated when he/she has spoken with staff that he/she felt that because it has been over 2 years that the dentist may have to make new molds because it has taken so long to get new dentures. Resident #57 indicates that he/she would really love to be able to chew food again.<br><br>Interview with RN #2 on 7/1/24 at 10:01 AM indicated he did not recall Resident #57 requesting to be seen by the dentist but he had heard recently that Resident #57 was on the list to be seen by dental the next time dental is in the facility. RN #2 indicated that he does not recall if Resident #57 was fitted for dentures. RN #2 indicated that in a morning report meeting about a month and a half ago he heard that Resident #57 was added to the dental list. RN #2 indicated that when a resident needs to be seen he will send a message to Unit Secretary #1 who is responsible to get residents on the dental list in a book. After clinical record review, RN #2 indicated that Resident #57 had left hip surgery on 3/28/23 and the right hip surgery on was 8/22/23.<br><br>Interview with Unit Secretary #1 on 7/1/24 at 10:04 AM indicated that she was only responsible to add names to the dental book when she is notified that a resident is requesting the dentist. Unit Secretary #1 indicted she does not follow up to make sure residents are seen or not. Unit Secretary #1 indicated that nursing will send a message through the electronic system PCC (point click care) messaging system. Unit Secretary #1 indicated that if anything needs to be done per dental, they will write a note in the electronic medical record, but the nurses were responsible to go in and see what was written, sometimes the hygienist will talk to the nurse. Unit Secretary #1 indicated that Resident #57 was only seen once this year and it was on 6/21/24. Unit Secretary #1 indicated that the dental hygienist comes in once a week. Unit Secretary #1 indicated that DDS #1 would only see residents if Hygienists #1 had recommended for her to see the resident. Unit Secretary #1 indicated that DDS #1 had last seen Resident #57 two years ago. Unit Secretary #1 indicated that she was notified that Resident #57 wanted to see the dentist on 5/31/24 but did not know why.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview with Unit Secretary #1 on 7/1/24 at 10:32 AM indicated that she does not follow up and read dental notes, but she has access to them in the electronic medical record. Unit Secretary #1 indicated that there was a dental note from 4/6/22 that indicated Resident #57's dentures were in the facility dental clinic and that resident had another appointment and had to cancel dentist and reschedule the dental appointment for the dentures. Unit Secretary #1 indicated that the resident was not at the hospital at that time just out for an appointment. Unit Secretary #1 indicated the last time Resident #57 was seen by the dentist was on 6/21/22 per the clinical record. Unit Secretary #1 indicated she does not keep tract when residents are seen by the dentist, she just adds resident's names in the book when she receives a message from nursing that someone needs to be seen. Unit Secretary #1 indicated that she does not tract the last time and how often residents were seen by the hygienist and dentist.<br><br>Interview with the DNS on 7/1/24 at 11:02 AM indicated that she did not know how often residents had to be seen by the dentist or the hygienist. The DNS indicated that if a resident wants to be seen or needs or be seen by a dentist that nursing gets the consent from the resident or resident representative and then it is put in the dental book on the units. The DNS indicated that the dental group were responsible to keep tract when resident's where due to be seen. The DNS indicated that the facility does not keep track of who or when residents need to be seen or to follow up whether or not a resident received their dentures.<br><br>Interview with Dental Hygienist #1 on 7/1/24 at 11:25 AM indicated that the facility has to get consent for dental services prior to being seen. Dental Hygienist #1 indicated that dental needs to see residents on a regular basis. Dental Hygienist #1 indicated that he does a quarterly audit by using the facility census and if a resident is not in his system, he puts the residents name on a list and gives the list, for who needs consents, to Unit Secretary #1. Dental Hygienist #1 indicated that resident need to be seen once a year for exam and cleaning, but they are allowed to receive cleanings 2 times a year. Dental Hygienist #1 indicated that he documents in their system and copies into the resident clinical record when residents are seen or if they refuse. Dental Hygienist #1 indicated that for Resident #57, they had to get prior authorization for dentures, and they have to wait for a hard copy of approval from Medicaid, then the dentist takes impression then 2 - 3 weeks later, the resident will get a first trial fitting, and then another fitting in 2 - 3 weeks for the final impression and delivery. Dental Hygienist #1 indicated that on 4/6/22 Resident #57 had a lot of medical issues. Dental Hygienist #1 indicated in March 2023 Resident #57 had a hip replacement and recommendation is not to do any procedures for 6 - 8 months after a hip replacement. Dental Hygienist #1 indicated that he did not see Resident #57 from 5/10/23 - 6/21/24. Dental Hygienist #1 indicated that he saw Resident #57 on 6/21/24 because he/she was in the dental book to be seen. Dental Hygienist #1 indicated that the DDS #1 comes at least once a month sometimes 2 times a month into the facility. Dental Hygienist #1 indicated that he does not know why he did not see Resident #57 for over a year except that Resident #57 had not asked to be seen. Dental Hygienist #1 indicated that the last time he had seen Resident #57 prior was 9/15/22 for a routine exam. Dental Hygienist #1indicated that he and DDS #1 were waiting for Resident #57 to ask to be seen to get the dentures.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075381 | A. Building<br>B. Wing | 07/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Water's Edge Center for Health & Rehab | 111 Church Street<br>Middletown, CT 06457 |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview with DDS #1 on 7/1/24 at 12:45 PM indicated that she had already spoken with Dental Hygienist #1 and reviewed the record prior to returning call. DDS #1 indicated that she goes into the facility at least once a month or more often based on the need of the residents. Dental Hygienist #1 indicated all her documentation was in the electronic medical record for when a resident was seen for each visit. DDS #1 indicated they check the dental book as soon as they come into the facility to see who needs to be seen and they have a list of scheduled routine visits. DDS #1 indicated she prioritizes who needs to be seen and documents in the resident's electronic [NAME] record. DDS #1 indicated for Medicaid residents, they only are required to be seen for a yearly exam, but we try to see then 2 times a year and if a resident was a denture wearer they get a soft tissue exam once a year. DDS #1 indicated she was responsible for the denture process. DDS #1 indicated for Resident #57 first visit is an assessment and if we are going to make dentures and let resident or facility know, then get prior authorization request that at most takes 4 - 6 weeks to get, then she does the initial impression and sends to a lab which could take 4 - 6 weeks, third visit is insertion of the denture. DDS #1 indicated taking impressions is an invasive procedure and indicated she had made dental impressions for Resident #57 on 2/18/22. Further, it could take up to 2 - 3 weeks week or longer to get the denture back. DDS #1 indicated everything would be in the notes. DDS #1 indicated on 3/14/22 she did the bite registration but there is no note in Resident #57's electronic medical record. DDS #1 indicated she saw Resident on 6/15/22 and a note stated cleared by medical to have root tips taken out but preferred to wait until after gastroenterology appointment. DDS #1 indicated nursing never communicated with when the appointment was planned so we could do the root tip removal. DDS #1 indicated she expected that someone in nursing would have read her notes and notified her but that did not occur. DDS #1 indicated that Resident #57 could tell nursing to have dental come back. DDS #1 indicated she then found out the resident had hip replacement and 5/10/23 the resident was in book and requested to be seen. DDS #1 indicated once the next hip was done he will then take care of denture needs. DDS #1 indicated after hip surgery there are no guidelines for Resident #57 not to be seen but we need to be concerned regarding infection and we might wait 6 months. DDS #1 indicated we did not hear anything from nursing until 6/21/24 when resident was seen. DDS #1 indicated from 5/10/23 to 6/21/24 we were waiting for Resident #57 to let us know he/she wanted to be seen. DDS #1 indicated Resident #57 was not a priority. DDS #1 indicated ideally it would have been nice if we had seen Resident #57 for his/her dentures, but Resident #57 did not let us know. DDS #1 indicated that Resident #57 did not receive the dentures completed as in the note dated 4/6/22 yet, but she will begin the process of removing the root tips at the facility and trial the dentures that were already made on 4/6/22 and are at the facility because they should still fit.<br><br>Review of the Dental Services Policy identified it was the facility that was responsible to provide an outside resource, routine, and emergency dental services to meet the needs of each resident: assistance for dental care upon the resident's/resident's representative's request. The facility will also assist with providing transportation as needed. Documentation of dental visits will be maintained in the resident's electronic medical record. In the event there is a delay in obtaining a dental appointment, the facility will document the reason for the delay and what measures were out in place to ensure the resident can eat and drink adequately while awaiting dental services. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>15802<br><br>Based on observation, review of facility policy and interviews, the facility failed to serve food at safe and palatable temperature. The findings include:<br><br>Observation and test tray on 7/1/24 at 12:38 PM identified the Surveyor and FSD followed the cart to the 4th floor dining room and temped the test tray as the last meal left on the cart.<br><br>The temperature of the main entree turkey was 124 degrees F and the peas temped at 127 degrees F.<br><br>The FSD identified she has no explanation of why temps are dropping and indicated the meals are plated on a warming tray. The FSD indicated the food was delivered to the pantry, quick cut ups were made, and the nurse aides delivered the trays relatively quickly.<br><br>The facility guidelines for hot foods indicate the holding temperature for hot foods is 140 degrees F or higher.<br><br>The facility policy indicates that foods are in the danger zone when the temperature is below 135 degrees F and to take action if the temperature is not within acceptable range which may include but not limited to: cook, reheat, cool, or discard. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>43032<br><br>Based on observation, review of facility policy and interviews, the facility failed to store food under sanitary conditions and distribute meals at a desired palatable temperature. The findings include:<br><br>An initial walk through of the kitchen on 6/30/24 at 6:54AM with the Food Service Director (FSD) identified empty trash bags on the counter tops near food, empty boxes of hot cereal on counter tops, hot uncooked cereal boxes opened and undated, a discarded worn latex glove near food mixer, box of Nilla wafers opened and undated, a rack with unused disposable lids on the top shelf near unused garbage bags, and the lower shelf of the same rack contained a tray clean coffee mugs with what the FSD described as an open box of previously shipped items on top, with a soiled orange safety cone partially underneath the rack.<br><br>The shelves identified a large bag of cocoa powder, opened and undated, and 3 cans of gravy significantly dented. The lower portion of the freezer exterior was unclean. The freezer interior identified a 30lb box of frozen strawberries, and 10lb box of chicken quarters; bagged in their respective box, opened, undated and not covered with the appearance of ice covered and freezer burn. Also identified was an insulated bag with 2 small boxes of ice cream. The FDS identified the ice cream did not belong to the residents, were used by one of the facility's departments for employee incentives and she further identified they should have been stored in the employee refrigerator. The freezer also contained one 500ml bottle of spring water which was frozen which the FSD identified was not for resident's use. The freezer flooring was also soiled with miscellaneous debris. The refrigerator identified several sandwiches which were undated, however the FSD identified they were made that morning, a sleeve of turkey meat thawing with an obvious tear in the plastic wrapping, pancakes which were dated 6/10/24 which were discarded.<br><br>The FSD on 7/2/24 at 10:40AM identified the kitchen had been short staffed and although she had a cleaning schedule, it was difficult to address the concerns identified. She further identified that it is her expectation that as staff opens a container in either the refrigerator or freezer that the container is dated, and the remaining contents are stored appropriately.<br><br>Interview with the DNS and Administrator 7/2/24 at 4:15 PM identified it is their expectation that the kitchen is cleaned, and items are stored in a sanitary manner.<br><br>The policy for food storage indicates that food from non-approved sources should not be stored in the kitchen (i.e., staff food, goods brought by families or friends from home or another food establishment, etc.). The policy further states that refrigerated foods, ready-to-eat food prepared on site that is held longer than 24 hours should be properly labeled with the common name, the preparation date (day 1) and use-by-date (maximum of 7 days, if held at an internal temperature of 41degrees or below including the date of preparation). The policy states for damaged food products that are identified as an unacceptable product not discovered until the delivery driver has left the premises, the items are to be kept in a separate area away from usable stock. Also, the storeroom walls and floors are solid, cleanable, in good repair and rodent proof.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The policy for Sanitation of Kitchen, Food Service Equipment & Work Surfaces dated 2/22 identified the food service equipment and surfaces (stationary and mobile) are cleaned. Food contact surfaces of stationary foodservice equipment and work surfaces are cleaned and sanitized to minimize the risk of pathogen and chemical food contamination. Cleaning schedules will be posted for all cleaning tasks and staff will initial the tasks as completed. |