

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Polaris Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21 W Clarke Avenue Milford, DE 19963	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>46988</p> <p>Based on observations, interviews and record review, it was determined that for three (R7, R23 and R57) out of three sampled residents reviewed for dignity, the facility failed to promote care in a manner and environment that maintained or enhanced their dignity and respect. Findings include:</p> <p>1. Review of R7's clinical record revealed:</p> <p>2/23/24 - R7 was admitted to the facility.</p> <p>4/10/24 10:08 AM - An observation of E33 (CNA) and E34 (CNA) in room with R7 providing care with door open. R7's unclothed, lower body from thigh down to feet was able to be observed from open door.</p> <p>4/10/24 10:50 AM - An interview with E33 and E34 confirmed that care was completed with the door open leaving R7 exposed to the hallway.</p> <p>2. Review of R23's clinical record revealed:</p> <p>5/24/23 - R23 was admitted to the facility.</p> <p>4/11/24 10:17 AM - An observation of E35 (CNA) in room with R23 providing care with the door open. R23's care occurred till 10:27 AM. R23's unclothed, lower body from thigh down to feet was able to be observed from hallway.</p> <p>4/11/24 10:28 AM - An interview with E35 confirmed that R23's care was completed with door open and R23's unclothed body was exposed to the hallway.</p> <p>47142</p> <p>3. Review of R57's clinical record revealed:</p> <p>7/13/23 - R57's quarterly MDS documented that R57 had a documented BIMS score of 15, revealing an intact cognitive state and was totally dependent of two staff for toilet use. R57 had impairments on both sides for upper and lower extremities.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11/13/23 - A facility incident report documented that on 11/11/23 at 6:45 AM, E16 (former CNA) was argumentative with R57 when E16 came into R57's room to change her.</p> <p>11/20/23 - A facility follow-up report documented that it was determined that E16 did speak inappropriately to R57.</p> <p>11/27/23 - E16 was terminated from the facility.</p> <p>4/10/24 9:39 AM - An interview with E12 (Agency RN) revealed that she went into R57's room to help E16 to perform care. E16's tone became hostile towards R57. E12 was not able to recall the words exchanged but stated that E16 and R57 were talking back and forth during which time E16's tone went from a normal tone of 1 to a 10. E12 stated, she stepped in and said to E16 that she cannot talk to the resident that way.</p> <p>4/10/24 12:09 PM - An interview with R57 revealed that on the morning of 11/16/23 at approximately 6:50 AM, E16 was in the room and woke R57 up due to a noise. R57 asked E16 if she was going to change her. R57 stated, [E16] began to get loud and asked her, do you want to be changed? R57 then replied, Yes, I do. At that point [E16] turned her head to the nurse and said, do you hear this? E12 said, she heard [E16]. E16 was asking R57 in a loud and aggressive manner, do you need to be changed because I got to go Are you refusing to be changed? I need to go. E12 had told E16 that the patient is always right. While E16 and E12 was proceeding to change R57, E16 kept telling me to be quiet, because I kept saying it was a problem. Then E16 told E12 that R57 did not like her and R57 said, I don't have a problem with anyone, I don't know her. Afterwards, R57 stated she was upset and crying. R57 stated she has not had any issues with other staff since.</p> <p>4/11/24 8:48 AM - An interview with E17 (former DON 1) revealed that E16 denied speaking inappropriately to the resident but E12 did corroborate what R57 had reported.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>47114</p> <p>Review of the facility policy titled, Change in a Resident's Condition or Status last dated 2/2021 documented . 1. Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status, changes in level of care, billing/payments, resident rights, etc.</p> <p>Review of R8's clinical record revealed:</p> <p>7/1/21 - R8 was admitted to the facility with a diagnosis including but not limited to hypertension, stroke, left side weakness and depression.</p> <p>1/5/24 - Review of the facilities diet requisition form revealed R8 was on a regular textured diet and thin liquids.</p> <p>2/15/24 12:47 PM - A physician's order written by E4 (MD) for R8 documented . 1. Regular diet dysphagia mechanical soft texture thin liquids consistency. Patient may have regular pleasure foods.</p> <p>2/15/24 1:25 PM A plan of care note written by E14 (RD) revealed that R8's diet was downgraded for safety. In addition, a facility diet requisition form revealed R8's diet was changed to dysphagia mechanical soft texture on 2/15/24.</p> <p>4/9/24 12:07 PM - An interview with E13 (LPN) revealed that if a resident's diet had changed nursing would notify the contact person.</p> <p>4/9/24 2:37 PM - During an interview E14 revealed, I downgraded R8's diet texture, but did not notify R8's contact person of the change. In addition, E14 said, I assumed that nursing would have notified R8's contact person.</p> <p>4/9/24 3:00 PM - Further review of R8's clinical record lacked evidence that R8's contact person was notified R8's diet texture had been downgraded from regular textured food to an altered regular mechanical textured diet.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>32810</p> <p>Based on observation, record review and interview it was determined that for two (R131 and R57) out of 40 initial pool residents screened the facility failed to ensure that the residents call bell was in reach and that the resident was capable of using it. Findings include:</p> <p>The facility policy on the resident call system last updated September 2022 indicated, Each resident is provided with a means to call staff directly for assistance .The resident call system remains functional at all times. If the resident has a disability that prevents him/her from using the call system an alternative means of communication that is usable for the resident is provided and documented in the care plan.</p> <p>1. Review of R131's clinical record revealed:</p> <p>3/25/24 - R131 was admitted to the facility with multiple diagnoses including spinal injury.</p> <p>3/25/24 9:52 PM - A nurse's note documented, R131 was, Alert and oriented and able to make needs known a quadriplegic and requires maximum assistance of two .Resident a quadriplegic and unable to sign paperwork.</p> <p>3/25/24 - The admission evaluation assessment documented R131 unable to use the call light/call bell.</p> <p>4/1/24 - An admission MDS assessment documented R131 had impairments to all extremities and an active diagnosis of quadriplegia (paralysis of all four limbs).</p> <p>During the intial pool screening on 4/7/24 at 9:29 AM, R131 was observed with a standard push button call bell fastened to the fitted sheet, shoulder height, close to the side rail and a metal bell on the farthest end of the over bed table. R131 confirmed both bells were out of reach and that he was unable to use either call bell. R131 stated, I talked to someone and every aide, I'm paralyzed they gave me this bell I'm unable to use either one. I can use a large round soft touch bell if placed by my chin or head. That's what I had at the last nursing home. R131 confirmed that staff checked on him regularly.</p> <p>During an interview on 4/7/24 at 12:30 PM, E28 (RN) unit manager was asked if there were any soft touch call bells in the facility. E28 was unsure and explained she would have maintenance look. E28 then accompanied the surveyor to R131's room, and confirmed the resident was unable to use the current call bells in the room.</p> <p>During an interview on 4/7/24 12:51 PM, E28 (RN) unit manager provided the surveyor with an invoice dated 3/27/24 for the order of a touch and breath call bell system. E28 was asked if leadership was aware that R131 was unable to use the call bell system currently in his room. E28 stated, I don't think management knew but someone knew because we ordered it. I will have maintenance put it in. E28 could not confirm when the touch and breath call bell systems were delivered to the facility.</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4/7/24 1:05 PM - E28 (RN) unit manager and E9 (ICP) were observed entering R131's room with call bell equipment.</p> <p>During an interview on 4/7/24 at 1:36 PM, R131 was able to return demonstrate ability to use breath call bell system, and confirmed satisfaction.</p> <p>During an interview on 4/10/24 at 11:07 AM, E1 (NHA) was unable to provide documentation regarding delivery of the breath call bell system. E1 stated, We didn't sign for it but it was here on Sunday.</p> <p>During an interview on 4/10/24 at 12:06 PM, E2 (DON) reported that if a resident was assessed as unable to use the standard push button call bell, I would expect them to report that to their supervisor and then the supervisor get in contact with maintenance. Which they did and we didn't have a breath call bell and maintenance ordered it. E2 was unable to confirm the date of delivery of the breath call bell.</p> <p>39058</p> <p>2. Review of R57's clinical record revealed:</p> <p>10/11/22 - R57 was readmitted to the facility with diagnoses including but not limited to quadriplegia, spinal muscular atrophy, morbid obesity and tracheostomy.</p> <p>1/18/24 - MDS quarterly documented R57 as totally dependent.</p> <p>4/7/24 1:00 PM - An observation and interview with R57 revealed the sip and puff (type of call bell) was next to the bed in a position that R57 was unable to use.</p> <p>4/7/24 1:44 PM - An observation of E37 (CNA) leaving the room with R57's lunch tray and the sip and puff was next to the bed in a position that R57 was unable to use.</p> <p>4/7/24 1:53 PM - During an observation and interview with E36 (Respiratory Therapist) it was confirmed that the resident did not have her sip and puff, but she would be able to call out for help.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>44706</p> <p>Based on record review and interview, it was determined that for one (R287) out of three residents reviewed for discharge the facility failed to provide R286 the Notice to Medicare Provider Non-Coverage (NOMIC) form before services were terminated. Findings include:</p> <p>R287's clinical record revealed:</p> <p>3/20/24 R287 was discharged to home.</p> <p>4/11/24 approximately 10:30 AM - During an interview, E1 (NHA) confirmed that the NOMIC form was not provided to R287. As part of R287's resident rights, the NOMIC form notifies the beneficiary of his or her right to an expedited review of the service termination.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>

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<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32810</p> <p>Based on observation and interview it was determined that for one (room [ROOM NUMBER]) out of 59 rooms observed the facility failed to ensure cleanliness. Findings include:</p> <p>During daily observations of resident rooms the following was observed in room [ROOM NUMBER] :</p> <p>4/7/24 10:53 AM - Three circular large brown stains on the fitted sheet of a occupied bed. A large circular dried pooling of the same brown liquid on the floor.</p> <p>4/8/24 2:34 PM - The fitted was sheet clean. The large brown circular stain remained on floor also two pieces of balled paper napkins.</p> <p>4/9/24 9:04 AM - A large brown circular stain remains on floor and the balled paper napkins were no longer present.</p> <p>During an interview on 4/9/24 at 9:40 AM, E10 (housekeeper) confirmed the stain on the floor of room [ROOM NUMBER]. E10 stated, There are three total housekeepers every day and a floor technician mainly to take care of the floors, trash, and common areas. Housekeepers sweep and mop everyday.</p> <p>During an observation on 4/9/24 at 1:56 PM, the large brown circular stain remained on the floor of room.</p> <p>During an observation on 4/11/24 at 10:00 AM, the stain was no longer present.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>32810</p> <p>Based on record review and interview it was determined that for one (R53) out of three residents reviewed for abuse the facility failed to recognize and immediately report an allegation of abuse. Findings include:</p> <p>The facility policy on Abuse, last updated April 2021 indicated that staff, Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Investigate and report any allegations within timeframe's required by federal requirements.</p> <p>3/25/24 - The facility reported an incident to the State Agency that alleged, On 3/21/24 there was a disagreement between roommates and a room change was recommend by the on call nurse for that shift.</p> <p>4/11/24 9:00 AM - Review of the facility incident report and investigations revealed a statement dated 3/12/24 written by E24 (LPN) that documented, [R17] said he threw soda cans at [R53] and called him an asshole and a retard I heard [R53's] wife yelling but I am not sure what was said I heard both residents yelling at each other. Another statement dated 3/21/24 written by E25 (RN) documented, [R17] agreed that he called his roommate a retard and initiated incident and he also accepted that he threw soda cans against curtain which were lying on the floor between bed a and bed b.</p> <p>During an interview on 4/11/24 at 9:18 AM, E23 (RN supervisor) stated, I was called that night by the nurse and asked to move the residents. They told me that they had gotten into an argument and they were yelling at each other. E23 explained she was not aware that R17 threw the soda can at R53.</p> <p>During an interview on 4/11/24 9:25 AM, E2 (DON) confirmed that the resident to resident incident between R53 and R17 was not recognized as an allegation of abuse and therefore not immediately reported. E2 stated, I was made aware the 22nd when I saw the statements, I verified it with the supervisor. It [soda-can] hit the curtain. E2 clarified that because the soda can didn't hit R53 that the incident was not recognized as allegation of abuse and not immediately reported.</p> <p>During an interview on 4/11/24 11:20 AM, R53 stated that R17, Threw a soda can at me and my wife .He threatened me and called my Wife me an ass-hole got me and my Wife wet [with soda] so me and my wife screamed, the nurses came in and he got moved.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>32810</p> <p>Based on on record review and interview it was determined that for one (R42) out of five residents reviewed for medication review the facility failed to ensure accuracy of the MDS assessment. Findings include:</p> <p>Review of R42's clinical record revealed:</p> <p>5/9/23 - R42 was admitted to the facility.</p> <p>5/15/23 - An admission MDS assessment for R42 documented that the cognitive, behaviors, mood and pain level sections, were not assessed.</p> <p>During an interview on 4/9/24 at 1:22 PM, E15 (Director of Reimbursement Services) confirmed the finding. E15 stated, it was missed, we didn't get to it. [R42] should've been interviewed.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>47114</p> <p>Based on interview, and record review it has been determined that for one (R68) out of one resident reviewed for PASARR, the facility failed to ensure a referral for a new PASARR Level I and II screening occurred by or before the 60th day. R68 was remained in the facility beyond the authorization timeframe. Findings include:</p> <p>A facility policy and procedure titled, Admission Criteria, documented . 1. All new admissions and readmissions are screened for mental disorders, intellectual disabilities or related disorders per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process.</p> <p>Review of R68's clinical record revealed:</p> <p>7/26/23 - A review of R68's PASARR Level I screen outcome revealed an approval period of 60 days for R68 a resident with a mental health disability in the nursing facility.</p> <p>8/30/23 - R68 was admitted to the facility with diagnoses including but not limited to bipolar disorder, anxiety disorder and major depressive disorder.</p> <p>11/6/23 - A review of R68's PASARR Level I screen outcome determination revealed R68 was referred for a PASARR Level II for a confirmed mental health disability. Additionally, R68's PASARR Level I screen was not done within the required authorization timeframe; by or before the 60th day.</p> <p>11/13/23 - A review of R68's PASARR Level II determination revealed: short term approval without specialized services with an approval end date of 3/12/24.</p> <p>4/9/24 1:41 PM - During an interview E15 (DRS) confirmed R68's PASARR Level I screen had not occurred by or before the 60th day. In addition, E15 confirmed R68's PASARR Level II's approval ended 3/12/24.</p> <p>4/11/24 12:58 PM - During an interview E1 said, [R68] was supposed to be discharged and had not been.</p> <p>The facility failed to coordinate the PASARR screening process for a resident with a mental health disability within the determined short term approval period as required.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>32810</p> <p>Based on record review and interview it was determined that for one (R42) out of five residents reviewed for medication review the facility failed to develop a care plan to address the residents use of an anticoagulant. Findings include:</p> <p>Review of R42's clinical record revealed:</p> <p>5/9/23 - R42 was admitted to the facility.</p> <p>5/9/23 - A physicians order was written for R42 to receive an anticoagulant medication one tablet by mouth two times a day for blood clot prevention.</p> <p>5/15/23 - An admission MDS assessment documented R42 received anticoagulant medication.</p> <p>2/15/24 - A quarterly MDS assessment documented R42 received anticoagulant medication.</p> <p>Review of R42's care plans lacked evidence that care plan was created that addressed the residents use of an anticoagulant medication.</p> <p>During an interview on 4/9/24 at 1:25 PM E15 (Director of Reimbursement Services) confirmed the finding.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>40260</p> <p>Based on record review and interview, it was determined that for four (R33, R45, R55, and R75) out of twenty-three (23) sampled residents, the facility failed to have input from all required interdisciplinary team (IDT) members at the residents' care plan meetings. Findings included:</p> <p>1. Review of R33's clinical record revealed:</p> <p>7/31/20 - R33 was admitted to the facility.</p> <p>4/9/24 - A review of quarterly care plan meetings for 12/13/23 and 3/6/24 lacked evidence of input from the Physician and the CNA.</p> <p>2. Review of R45's clinical record revealed:</p> <p>6/13/23 - R45 was admitted to the facility.</p> <p>4/9/24 - A review of quarterly care plan meetings for 1/3/24 and 4/3/24 lacked evidence of input from the Physician and the CNA.</p> <p>3. Review of R55's clinical record revealed:</p> <p>8/24/22 - R55 was admitted to the facility.</p> <p>4/9/24 - A review of quarterly care plan meeting for 12/20/23 lacked evidence of input from the Physician, nurse and the CNA. A review of the quarterly care plan meeting for 3/24/24 lacked evidence of input from the Physician and CNA.</p> <p>4/10/24 9:25 AM - In an interview, E6 (CNA) stated that CNA's do not participate in care plan meetings, and they do not provide input. The higher ups meet with residents.</p> <p>4/10/24 9:40 AM - In an interview, E7 (CNA) stated that when working on a different unit, she would ask to participate in resident care plan meetings. While not invited, E7 stated she would contribute. E7 stated she took it upon herself to participate in the other unit where E7 said she worked closely with the nurses.</p> <p>4/10/24 1:02 PM - In an interview, E1 (NHA) stated that the medical provider participates by entering new orders. CNA's have contact with nurses all the time and provide input in this manner, but she acknowledged she has no way of proving CNA involvement.</p> <p>4/10/24 2:07 PM - In an interview, E8 (CNA) stated that CNA's do not attend care plan meetings unless resident specifically requests that the CNA be present. CNA's are informed after the care plan meeting if there are changes.</p> <p>46988</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Review of R75's clinical record revealed:</p> <p>3/8/24 - R75 was admitted to the facility.</p> <p>4/3/24 - A review of R75's care plan meeting lacked evidence of input from a CNA, dietary, activities, and the medical director.</p> <p>4/10/24 1:02 PM - An interview with E1 (NHA) confirmed that the care plan meeting lacked evidence of the necessary members for input.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>47142</p> <p>Based on observations, interviews and record review, it was determined that for two (R24 and R57) out of four residents reviewed for position and mobility, the facility failed to turn and reposition the resident in accordance with professional standards of practice to prevent skin breakdown. Findings include:</p> <p>1. Review of R24's clinical record revealed:</p> <p>11/19/23 - R24 was readmitted to the facility with diagnoses including but not limited to hypoxic ischemic encephalopathy, anoxic brain damage and persistent vegetative state.</p> <p>9/3/23 - An annual MDS assessment documented that R24 was totally dependent for turning and repositioning with two person physical assist. R24 had impairments on both sides for upper and lower extremities.</p> <p>3/4/24 - A nursing Braden Scale documented R24 with a score of 10 (10 - 12 is considered high risk of skin breakdown).</p> <p>3/14/24 - A care plan for R24 last included to turn and reposition at least every two hours while in bed.</p> <p>On the following dates and times, R24 was observed lying in bed on her back with the head of the bed upright at approximately a 45 - 60-degree angle while R24's wedges were observed in the room on a chair on 4/8/24: 8:22 AM, 9:35 AM, 10:38 AM, 11:40 AM, 12:15 PM and 2:01 PM.</p> <p>R24 was observed lying in bed on her back for four hours without any turning.</p> <p>4/9/24 11:25 AM - During an interview, E8 (CNA) stated R24 sits up with a pillow under one of her shoulders.</p> <p>4/9/24 11:45 AM - During an interview, E18 (CNA) stated R24 gets turned side to side every 2 hours using positioning wedges.</p> <p>The facility failed to ensure that R24 was turned and repositioned every two hours.</p> <p>2. Review of R57's clinical record revealed:</p> <p>10/11/22 - R57 was readmitted to the facility with diagnoses including but not limited to quadriplegia, spinal muscular atrophy, morbid obesity and tracheostomy.</p> <p>7/13/23 - A quarterly MDS assessment documented that R57 was totally dependent for turning and repositioning with two person physical assist. R57 had impairments on both sides for upper and lower extremities.</p> <p>12/1/23 - R57's care plan included to turn and reposition at least every two hours while in bed.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1/13/24 - A nursing Braden Scale documented R57 with a score of 11 (10 - 12 is considered high risk of skin breakdown).</p> <p>1/18/24 - R57's quarterly MDS assessment documented that R57 had a documented BIMS score of 15, revealing an intact cognitive state and was dependent on staff to turn side to side.</p> <p>On the following dates and times, R57 was observed lying in bed on her back with the head of the bed at approximately a 30-degree angle on 4/8/24: 8:20 AM, 9:37 AM, 10:41 AM, 11:50 AM and 12:16 PM.</p> <p>R57 was observed lying in bed on her back for four hours without any turning.</p> <p>4/9/24 11:25 AM - During an interview, E8 (CNA) stated R57 is turned to the left and right with pillows, one on each side.</p> <p>4/9/24 11:45 AM - During an interview, E18 (CNA) stated that she has not seen R57 on her side, that she is always on her back. R57 has wedges for her legs, but she is always on her back.</p> <p>4/10/24 12:49 PM - During an interview, R57 stated that the staff do not turn her from left to right, that she stays laying on her back.</p> <p>The facility failed to ensure that R57 was turned and repositioned every two hours.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>46988</p> <p>Based on observation, interview and record review it was determined that for one (R75) out of one resident reviewed for incontinence, the facility failed to respond to or provide services to restore bladder continence. Findings include:</p> <p>A facility policy titled, Urinary Continence and Incontinence assessment and management revised August 2022 stated the staff will appropriately screen for, and manage individuals with urinary incontinence. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible.</p> <p>Review of R75's clinical record revealed:</p> <p>3/8/24 - R75 was admitted to the facility.</p> <p>3/8/24 4:39 PM - A admission bowel and bladder continence evaluation documented R75 was incontinent.</p> <p>3/12/24 11:31 AM - Review of R75's bowel and bladder program evaluation revealed R75 was a candidate for scheduled prompted voiding.</p> <p>3/14/24 10:02 AM - An admission MDS revealed that R75 is frequently incontinent and a toileting program was not attempted.</p> <p>4/9/24 10:37 AM - - During an observation R75 stated, I need to use the bathroom. FM1 (Spouse) put the call bell on for assistance. E33 (CNA) entered the room at 10:50 AM.</p> <p>4/9/24 11:00 AM - An observation of E33 providing care confirmed that R75 was incontinent and that E33 did not offer or assist R75 with the urinal.</p> <p>4/9/24 12:00 PM - A review of the CNA task flow sheet revealed that E33 documented not applicable for bed pan and urinal use for R75.</p> <p>4/9/24 2:46 PM- During an interview FM1 revealed, staff did not assist R75 with toileting when the call light was on. FM1 also said, [R75] was continent of bowel and bladder when E31 (COTA) from therapy assisted him with toileting.</p> <p>4/10/24 8:52 AM - An interview with E32 (COTA) revealed R75 could voice when he has the urge to use the bathroom and had initiated the use of the bed pan and urinal for R75.</p> <p>4/10/24 10:50 AM - An interview with E33 (CNA) and E34 (CNA) revealed R75 was not able to sustain continence. E33 and E34 confirmed when assigned to R75 the urinal or bed pan had not been offered to promote continence.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4/10/24 11:46 AM - During an interview E28 (RN) confirmed the admitting nurse does the bowel and bladder evaluation. E28 revealed R75 is more alert at this time, and his care plan should have been updated with this change.</p> <p>4/11/24 8:15 AM - During an interview E31 (COTA) stated, [R75] is able to verbalize the need to use the toilet. E31 revealed that R75 is encouraged to use the bedpan and urinal during therapy. E31 said, I do not think that direct care staff is following the recommendation.</p> <p>4/11/24 8:30 AM - - During an interview E29 (Rehab. Director) stated, I spoke with nursing on 4/10/24 and requested staff use the bedpan and urinal for [R75].</p> <p>4/11/24 11:11 AM - An interview with E30 (RN UM) confirmed that upon admission all residents are placed on a every two hour continence check to verify continence and that is considered the facilities toileting program.</p> <p>4/11/24 11:54 AM - A review of the CNA task flow sheet for R75 lacked evidence of a every two hour continence check on admission.</p> <p>The facility failed to provide care and services that promoted maintaining and/or restoring continence.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>44706</p> <p>Based on observation, interview and record review, it was determined that for two (R3 and R66) out of two residents reviewed for respiratory care, the facility failed to provide respiratory care consistent with professional standards of practice. For R3, the facility failed to ensure the canister and tubing for suctioning had been changed. For R66, the facility failed to ensure the oxygen tubing and humidifier bottle were labeled. Findings include:</p> <p>1. 3/11/24 - R66 was admitted to the facility.</p> <p>3/17/24 - An admission MDS documented R66 was cognitively intact and had diagnoses that included Chronic obstructive pulmonary disorder (COPD) and hypoxic respiratory failure unspecified.</p> <p>A facility policy titled Oxygen Administration revised October 2010 included Oxygen tubing will be changed and dated weekly, refillable humidifiers will be dated and changed weekly, disposable humidifiers will be dated and discarded when empty.</p> <p>3/12/24 - A physician order included 4L via nasal cannula to maintain oxygen saturation greater than 92%.</p> <p>3/11/24 - 4/10/24 - Review of EMAR's lacked evidence that the oxygen tubing and the humidifier bottle were changed weekly.</p> <p>4/7/24 and 4/8/24 - Several random observations revealed that the oxygen tubing and humidifier bottle was not labeled and dated.</p> <p>4/8/24 9:20 AM - During an interview E11 (RN) confirmed that R66's oxygen tubing and humidifier bottle were not dated.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p> <p>47114</p> <p>2. Review of R3's clinical record revealed:</p> <p>8/25/22 - R3 was admitted to the facility with diagnoses including but not limited to acute respiratory failure, difficulty swallowing and hypertension.</p> <p>11/28/23 5:20 PM - A physician's order documented . 1. Tracheostomy care change oxygen tubing, canister and humidifier bottle one time a day every Monday and as needed.</p> <p>4/7/24 10:08 AM - R3 was observed sitting in the wheelchair in her room, further observations revealed that R8's tracheal suction machine equipment had not been changed, the suction canister had thick secretions and had a date of 1/26/24 and tubing for the suction equipment was not dated.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4/8/24 12:34 PM - Day 2 observations revealed R3's tracheal suction machine equipment had not been changed and the canister contained the same thick secretions as observed and dated 1/26/24.</p> <p>4/9/24 12:59 PM - During an interview and observation E13 (LPN) confirmed R3's suction machine equipment had not been changed and the suction canister contained secretions and was dated 1/26/24. E13 stated, I'm not sure why it has not been changed, but I will change it.</p> <p>The facility failed to provide R3 with respiratory care as required by a physicians order in changing tracheostomy care equipment routinely and as needed.</p> <p>These findings were reviewed at the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>32810</p> <p>Based on record review and interview it was determined that for one (R42) out of five residents reviewed for medication review the facility failed to ensure pharmacist recommendations were reviewed by the attending physician. Findings include:</p> <p>The facility policy for MRR's last updated May 2019, indicated The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it.</p> <p>2/5/224 11:47 - A Pharmacist Consultant Note documented, Medication Regimen Reviewed: Recommendations Made.</p> <p>Review of R42's 2/5/24 MRR revealed a lack of physician response to the recommendations to evaluate and consider discontinuing use of vitamin c and to consider switching timeframe of laxative.</p> <p>During an interview on 4/10/24 at 1:07 PM, E1 (NHA) confirmed the facility was unable to locate a physician response to the February 2024 MRR.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>32810</p> <p>Based on record review and interview it was determined that for one (R42) out of five residents reviewed for medication review the facility failed to complete AIMS testing every six months for a resident on antipsychotic medications. Findings include:</p> <p>The facility policy on psychotropic medication use, last updated July 2022 indicated, Psychotropic medication is any medication that affects brain activity associated with mental processes and behaviors. Psychotropic medications are monitored with AIMS testing as required.</p> <p>Review of R42's clinical record revealed:</p> <p>7/18/23 - A physicians order was written for R42 to receive an antipsychotic medication daily.</p> <p>7/18/23 - R42 received an AIMS test assesment for side effects related to antipsychotic medication use.</p> <p>7/2023 - A care plan for use of antipsychotic medications included the intervention for - AIMS testing per facility protocol.</p> <p>4/10/24 - Review of R42's clinical revealed AIMS testing had not been completed for R42 in nine months.</p> <p>During an interview on 4/11/24 at 8:30 AM, E3 (ADON) confirmed the findings.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 (NHA) and E2 (DON).</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39058</p> <p>Based on observation it was determined that the facility failed to ensure that all nourishment refrigerators were maintained in a sanitary condition and food is stored safely to prevent food-borne illness. Findings include:</p> <p>1. 4/7/24 8:45 AM -The following was observed in the Reserve Unit nourishment refridgerator:</p> <ul style="list-style-type: none"> -Boost dated 10/17/23. -Sandwich in green and white wrapper dated 2/21. -Brown paper bag unmarked. -Partially eaten pretzel salad undated. -Cheese doodles opened unlabeled. -Salad dressing dated 9/8/23. <p>4/7/24 9:47 AM - The above was confirmed and removed from the refridgerator by E38 (Supervisor).</p> <p>38302</p> <p>2. 4/8/24 - The nourishment refrigerated adjacent to the small dining room in the Riverside unit had a large semi-dried spill of orange liquid on the middle and bottom shelves of the door, and the full-sized refrigerator located in that same dining room contained an undated unlabeled small plastic food storage bowl of leftover food.</p> <p>These findings were reviewed during the exit conference on 4/11/24 at 2:26 PM with E1 and E2 (DON).</p>