

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145016	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Goldwater Care Bloomington		STREET ADDRESS, CITY, STATE, ZIP CODE 700 East Walnut Bloomington, IL 61701	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on observation, interview, and record review the facility failed to ensure a severely cognitively impaired resident (R6) did not exit the facility unnoticed (elopement). The facility failed to ensure staff were trained on exit door alarms and identifying residents at risk for elopement, supervise R6, assess elopement/wandering risk, develop and implement a care plan and interventions for wandering/exit seeking behaviors, identify triggers for exit seeking behaviors, and monitor departure alert device placement for three (R6, R7, R8) of three residents reviewed for elopement in the sample list of 11.</p> <p>Findings include:</p> <p>1.) R6's Nursing Note dated 7/2/2024 at 10:03 PM documents the following: At 8:10 PM the nurse (V14 Agency Licensed Practical Nurse (LPN)) received a call from an unidentified pedestrian reporting a resident (identified as R6) was walking in socks outside of the facility near the street, and R6 attempted to step onto the curb and tripped, causing R6 to fall and hit R5's head on the pavement. V14 went out the front door of the facility to the back parking lot and found a staff member and the pedestrian with R6, who was sitting on the cement next to the back stairwell. R6 receives Plavix (blood thinner) and R6 was sent to the emergency room . R6's family was notified that R6 had eloped from the facility (left unnoticed.) V14 found R6's wheelchair sitting in the middle of the therapy room with the therapy doors open and the alarm sounding. V14 last observed R6 self propelling his wheelchair on the long hallway of the East wing during V14's medication pass.</p> <p>R6's Admission Minimum Data Set (MDS) dated [DATE] documents R6 has severe cognitive impairment. R6's Care Plan dated 6/7/24 documents R6 is at risk for elopement and wanders related to disorientation to place, exit seeking, and impaired safety awareness; and includes interventions dated 6/7/24 for departure alert device, check placement every shift and functioning per facility policy; offer diversions, structured activities, food, conversation, television, and books to distract R6 from wandering; identify patterns of wandering to determine if it is purposeful, aimless, or escapist, or if R6 is looking for something and intervene as appropriate.</p> <p>R6's Behavior Tracking dated 6/5/25-7/2/24 documents 6/23/24 as the only day that R6 has wandered, and does not identify wandering/exit seeking as a targeted behavior or specific interventions to address/prevent this behavior. R6's care plan and behavior tracking does not identify family visiting as a trigger for R6's exit seeking/wandering or interventions to implement after family visits.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R6's Wandering Risk assessment dated [DATE] documents a departure alert device was placed on R6 and R6 is in common areas for safety and observation. R6's Elopement Risk and Community Survival Skills assessment dated [DATE] documents R6 has dementia, the physical ability to leave the facility, history of wandering and elopement attempts, and verbalizes intent to leave the facility. This assessment documents R6 is not able to verbalize how to move/navigate/negotiate safely on community streets (such as crossing safely, maintaining safe distance from cars, use of sidewalks, safely/carefully propel wheelchair); and R6 is considered at risk for elopement and should be placed on the Elopement Risk Protocol and care planned.</p> <p>R6's Nursing Notes document the following: R6's departure alert device was not in place on 6/12/24, 6/14/24, 6/19/24, and 6/30/24. On 6/12/24 at 6:47 AM R6 was awake until 4:30 AM with increased confusion and wandering behaviors. R6 had a departure alert device in place and frequently self propels in wheelchair throughout the halls and units. R6 does not follow instructions and is unable to be redirected without one to one attention from staff for the majority of the shift. On 7/2/24 at 1:44 AM R6 became combative, hitting, and yelling at staff when staff tried to redirect R6 from going to the other side of the building.</p> <p>On 7/3/24 between 11:50 AM and 11:58 AM the exit doors located at the end of the East hall near therapy and in the therapy gym led to a stairwell and an elevator to reach the ground floor near the parking lot and east entrance of the facility, which was near the street.</p> <p>On 7/3/24 at 11:26 AM R6 was sitting in a wheelchair near the East nurse's station and there was no departure alert device on R6 or R6's wheelchair. On 7/13/24 at 11:46 AM R6 was unable to state the facility's name or how long R6 has lived in the facility. R6 recalled leaving the facility last evening, but was unable to provide details.</p> <p>On 7/3/24 at 1:44 PM the door alarm computer system, viewed and confirmed with V22 Maintenance Director, showed the therapy gym door alarm was activated on 7/2/24 at 7:56 PM.</p> <p>On 7/3/24 at 11:30 AM V13 Certified Nursing Assistant (CNA) confirmed a departure alert device was not on R6 or R6's wheelchair. V13 stated R6 does not wear a departure alert device. V13 stated R6 wanders around the building and has tried to go out exit doors, we try to give R6 something to do such as reading the newspaper, but it is hard to keep R6 occupied.</p> <p>On 7/3/24 at 11:27 AM V12 CNA stated R6 self propels his wheelchair and wanders, but does not wear a departure alert device. V12 stated the list of residents with departure alert devices is kept behind the nurses station. This list, dated 3/13/24, was viewed with V12 at the East nurse's station and did not include R6. R7 and R8 were included on the list.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/3/24 between 11:33 AM and 11:44 AM V18 (R6's Family) stated V18 was notified last evening that R6 was found outside of the facility in the parking lot. V18 stated if R6 had gotten to the street, R6 could have been hit by a car. V18 stated R6 has been in the facility for approximately one month after being hospitalized for a stroke. V18 stated R6 sees his family leave and then talks about going home and does not remember things after you tell him. V18 stated staff try to distract R6 when family leaves and a lot of times V19 Wound Nurse takes R6 with V19 during V19's medication pass. V18 stated last night there was a newer nurse working who was not familiar with R6. V18 stated about a month ago V20 Social Services Director reported R6 had tried to go through an exit door at the end of a hallway and a departure alert device was placed on R6, but V18 has not seen the device being used.</p> <p>On 7/3/24 between 11:48 AM and 11:58 AM V2 Director of Nursing confirmed the departure alert device list had not been updated since March 2024 and social services is responsible for applying the departure alert device and updating the list.</p> <p>On 7/3/24 at 12:11 PM V20 Social Services Director stated V20 used to maintain the departure alert device list, but activity staff were suppose to be updating the list. V20 confirmed this list should have been updated to include R6. V20 stated this device was applied after R6 sounded an exit door, this was updated on R6's care plan on 6/7/24, and is still a current intervention.</p> <p>On 7/3/24 at 12:26 PM V21 CNA stated R6 wanders daily, has tried to go out the exit doors at the end of the halls, and a few nights ago became combative when staff tried to stop R6 from leaving the East wing. V21 stated the nurses should document the behaviors as well as the CNAs as part of their charting. V21 stated R6's exit seeking is triggered when R6's family leaves after visiting and R6 tries to go with his family, causing R6 to get upset and agitated. V21 stated R6 requires close supervision and gets up on his own to walk. V21 stated R6 needs to be in a locked facility and V21 does not feel that R6 or R7 are appropriate for this facility since R7 also sounds door alarms.</p> <p>On 7/3/24 at 1:11 PM V14 Agency LPN stated 7/2/24 was V14's first time working at the facility and V14 was only told in report that R6 wanders the hallways and sits by the nurses station. V14 stated no one had told V14 that R6 was an elopement risk. V14 stated that night V14 last saw R6 in his wheelchair facing the nurses station at 7:30 PM while V14 was passing medications. V14 stated at 8:10 PM V14 received a telephone call from an unidentified pedestrian who witnessed R6 walking near the road/parking lot and R6 fell and hit his head on the concrete. V14 confirmed staff were not aware that R6 had left the facility prior to this telephone call. V14 stated V14 was found sitting on the cement step near the stairwell/elevator entrance. V14 did not recall R6 wearing a departure alert device. V14 stated there were two CNAs working the East wing with V14 when R6 eloped, and none of these staff were familiar with the East wing. V14 stated at the time of R6's elopement there were three door alarms sounding, including the therapy gym door and the hall exit door near therapy, believed to be triggered by caregivers of other residents. V14 stated these alarms sound similar to call lights, so V14 was unsure which sound was a door alarm. V14 stated it was frustrating that none of the staff from the [NAME] wing came to answer the door alarms.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/3/24 at 1:48 PM V15 CNA stated we were swamped last night on the East side, there were lots of families visiting and requests for care needs. V15 stated there was a fairly new CNA and an agency nurse working the East wing with V15. V15 stated there were a lot of call lights going off and V15 did not know the difference between the sounds of call lights and door alarms. V15 stated V15 noticed there was an unidentified family member at the front entrance at 8:08 PM who reported that a resident (R6) was outside and had fallen. V15 stated V15 had only worked on the East side twice and was unsure which residents were high risk for elopement and needed to be watched closely. V15 stated V15 last observed R6 with the nurse around 7:00 PM.</p> <p>On 7/3/24 at 2:08 PM V16 CNA stated V16 was hired at the end of May 2024, V16 was not as familiar with the East wing and R6 admitted after V16's East wing orientation. V16 stated V16 was pulled to work R6's unit at 7:00 PM on 7/2/24. V16 confirmed there was one nurse and another CNA working on the East wing at that time. V16 stated V16 was getting residents ready for bed and heard an alarm that sounds similar to a call light, which was confusing. V16 stated V16 checked the therapy hall and camera and did not see any residents, and V16 thought family had set off a door alarm. V16 stated the alarm panel is vague and doesn't specify which door, it just said East/Therapy door, which is difficult to determine which door is alarming. V16 stated it would have been helpful to know the layout of the building and exit doors. V16 stated V16 asked V14 and V15 about the sounding alarm, and they didn't know what it was either. V16 stated V16 last saw R6 close to 8:00 PM with V14 LPN, and R6's wheelchair was found in the therapy gym which is the door R6 went out. V16 stated V16 was unaware that the therapy gym had an exit door and the gym is supposed to be locked at night. V16 was asked how V16 knows which residents are at high risk for elopement, and V16 replied we just rely on staff to give report. V16 stated It was a bit chaotic that night because none of us working on East were family with that unit.</p> <p>On 7/3/24 at 3:22 PM V17 CNA stated V17 arrived to work on 7/2/24 at 8:23 AM and the assigned nurse and CNAs were outside with R6 who was found on the east side of the building near the stairs. V17 stated R6's wheelchair was found in the therapy gym and the gym door alarm was sounding. V17 stated R6 was not wearing a departure alert device, because the device sounds another alarm when the resident is close to the door, and that alarm was not sounding. V17 stated R6 is very active and sundowns (increased behaviors in the afternoon/evenings), and had one to one supervision when V17 previously worked the East wing. V17 stated V17 had not received any training on identifying residents at risk for elopement or on the facility's door alarms. V17 stated prior to R6's elopement, V16 was not aware that R6 was at risk for elopement.</p> <p>2.) On 7/3/24 at 12:42 PM V23 LPN stated R7 wears a departure alert device and the nurses are responsible for checking and documenting this device placement.</p> <p>On 7/3/24 at 12:59 PM R7 was not wearing a departure alert device and R7's wheelchair did not contain this device, verified with V6 CNA.</p> <p>The facility's Departure Alert Device list dated 3/13/24 includes R7 and R8. The facility's Departure Alert Device binder provided by V20 Social Services Director, includes exit seeking profiles for R7 and R8 who use the device.</p> <p>R7's MDS dated [DATE] documents R7 has severe cognitive impairment and wandered four to six days during the seven day review period. R7's Care Plan dated 5/7/24 documents R5 wanders related to Alzheimer's Disease/Dementia and does not include an intervention for a departure alert device.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on observation, interview, and record review the facility failed to ensure narcotic pain medication was obtained to be given as ordered resulting in R5 experiencing uncontrolled pain for 24 hours. The facility also failed to timely administer requested pain pain medication for one (R5) of five residents reviewed for medications in the sample list of 11.</p> <p>Findings include:</p> <p>On 7/2/24 at 12:06 PM R5 was sitting in a wheelchair in R5's room, and R5's left leg was in a cast. R5 stated R5 is waiting for requested pain medication that R5 had reported to V3 Certified Nursing Assistant (CNA) about 30 minutes ago. R5 stated R5 fractured R5's left ankle in two places prior to admitting to the facility. R5 stated at first the facility was not managing R5's pain, since the hospital hadn't sent prescriptions for pain medications R5 went an entire day without the ordered pain medication. R5 stated R5's leg hurt so bad that day that R5 was crying, and R5 rated the pain a 10 on a 0-10 scale.</p> <p>R5's ongoing Diagnoses List includes a diagnosis of displaced bimalleolar fracture of the left lower leg, subsequent encounter for closed fracture with routine healing. R5's Admission Minimum Data Set, dated dated [DATE] documents R5 is cognitively intact and during the last five days R5 had constant pain rated a 9 on a 0-10 scale that frequently affected sleep, therapy participation, and daily activities. R5's Care Plan dated 6/28/24 documents R6 has a fracture related to Osteoporosis and includes an intervention to administer pain medication as ordered.</p> <p>R5's Order Summary Report dated 6/18/24 includes orders for Norco (narcotic pain medication) 5-325 milligrams (mg) give one tablet by mouth every 6 hours as needed (PRN) for left ankle fracture, Acetaminophen Extra Strength Oral Tablet give 500 mg by mouth every 4 hours PRN for pain, and Tramadol Hydrochloride (narcotic pain medication) give 50 mg every 8 hours PRN for pain.</p> <p>R5's Pain assessment dated [DATE] at 11:24 PM documents R5 has left ankle pain related to recent fracture/surgery, rated as very severe almost constantly which almost constantly affects sleep and daily activities.</p> <p>R5's June 2024 Medication Administration Record (MAR) does not document between 6/18/24 and 6/19/24 R5 received any scheduled pain medication, or any PRN pain medication was administered other than Acetaminophen on 6/19/24 at 12:22 PM and Norco on 6/19/24 at 4:26 PM (almost 24 hours after R5's admission.) This MAR documents on 6/19/24 R5's pain was rated 6 at 12:00 AM, 7 at 6:00 AM, Not Applicable at 12:00 PM, 9 at 12:22 PM when PRN Acetaminophen was administered, 10 when PRN Norco was given at 4:26 PM, and 0 at 6:00 PM. This MAR documents Norco was given on 6/19/24 at 9:40 PM with pain rated 8; 6/20/24 at 3:40 AM for pain rated 6 and at 10:40 AM for pain rated 5. R5's July 2024 MAR documents PRN Tramadol 100 mg was given on 7/2/24 at 12:57 PM (over an hour after R5's request) for pain rated 5.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R5's Nursing Notes document the following: On 6/18/24 at 4:48 PM R5 admitted to the facility with left ankle pain. On 6/18/24 at 11:12 PM R5 had left ankle pain and R5 receives scheduled pain medication which is effective in managing R5's pain. On 6/20/2024 at 1:01 PM documents the following: R5's family called to discuss R5's pain medications and that Norco is ineffective. R5 was sent with unsigned prescriptions for pain medication from the hospital that were forwarded yesterday to the Nurse Practitioner for review. On 6/20/24 the electronically signed prescriptions were located in the bin containing electronic facsimiles (fax) and Oxycodone (narcotic) and Tramadol were ordered from pharmacy.</p> <p>There is no documentation in R5's medical record that attempts were made to notify the physician and obtain R5's ordered narcotic pain medication prior to 6/19/24.</p> <p>On 7/2/24 at 12:38 PM V4 MDS Coordinator stated R5 admitted late afternoon from the hospital and R5's narcotic prescriptions were not signed by a physician. V4 stated there wasn't a practitioner in the building to sign the prescriptions. V4 stated the facility has a medical group on call to contact to request prescription signatures and V4 was the nurse manager on call the day R5 admitted , V4 would have instructed the nurse to contact the medical group to sign R5's prescriptions. V4 confirmed attempts were not made to obtain R5's Norco until 6/19/24, and Tramadol and Oxycodone on 6/2024. V4 stated (R5's) pain increased unfortunately since we couldn't back track (change what happened).</p> <p>On 7/2/24 at 12:47 PM (45 minutes after R5's interview) V5 LPN stated V3 CNA reported earlier that R5 requested pain medication. V5 stated V5 has been busy with a new admission and hospital transfer and V5 forgot to administer R5's pain medication.</p> <p>On 7/2/24 at 1:58 PM V6 CNA stated R5 was in a lot of pain the night R5 admitted to the facility. V6 stated R5 called to request pain medication, R5 was in a lot of pain, and the nurse didn't have the pain medication because it hadn't been delivered. V6 stated R5 did not get out of bed that evening, we tried ice packs, and R5 required assistance of two staff for bed mobility due to the amount of pain R5 was in. V6 stated R5 had facial expressions of pain and tears in R5's eyes.</p> <p>On 7/2/24 at 2:35 PM V2 Director of Nursing stated the hospital is suppose to send prescriptions electronically signed which are sent to pharmacy and then pharmacy will dispense the medication. V2 stated the nurses should look at the hospital discharge orders and enter the orders onto the order list that is sent to pharmacy, and then the pharmacy is suppose to reach out to the facility to notify us if they don't have a signed prescription. V2 stated the nurse is then responsible for notifying the physician to obtain the signed prescription, the facility has a Nurse Practitioner who rounds daily who is available to sign prescriptions, and that should not have happened (referring to R5's lack of pain medication). On 7/3/24 at 9:18 AM V2 stated V2 expects the nurses to administer pain medication as soon as possible when requested, and it should be a priority.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/2/24 at 2:45 PM V8 Pharmacist stated R5's Norco prescription was faxed to the pharmacy on 6/19/24 at 2:37 PM and two tablets were pulled from the backup medication supply. V8 stated R5's Norco was not previously obtained from the backup medication supply due to the pharmacy not having a valid signed prescription for the medication. V8 stated on 6/18/24 at 6:10 PM the facility faxed electronic prescriptions to the pharmacy for R5's narcotic pain medications that were not signed by a physician. V8 stated V8 notified R5's physician's office at 9:19 AM on 6/19/24 to request signed prescriptions for R5's Norco, Oxycodone, and Tramadol orders, and had not gotten a response by 12:26 PM so V8 contacted the office again and was informed the physician would be rounding at the facility that day. V8 stated the pharmacy received R5's Oxycodone and Tramadol signed prescriptions on 6/19/24 at 4:42 PM and the medications were dispensed on 6/20/24 since the fax was received after 4:00 PM. V8 stated the medications can be delivered the same day if the facility calls to request it and the facility can contact the after hours pharmacy to obtain medications. V8 stated neither Tramadol or Oxycodone were pulled from the backup medication supply. V8 confirmed there is no documentation that the facility contacted the after hours pharmacy to obtain R8's Oxycodone or Tramadol.</p> <p>On 7/3/24 at 9:39 AM V9 Nurse Practitioner was asked what are the potential consequences for R5 going without pain medication for 24 hours. V9 stated besides discomfort, it could cause increased heart rate and blood pressure. V9 stated it is more so unfortunate for (R5) to experience the pain when going 24 hours without pain medication, and the pharmacy doesn't always send medications quickly. V9 stated R5's pain is effectively managed now with Tramadol and scheduled Acetaminophen and the first few days R5 was using pain medication quite frequent, which was probably due to R5 trying to catch up on the pain.</p> <p>The facility's backup medication supply list includes Norco 5-325 mg and Tramadol 50 mg.</p> <p>The facility provided pharmacy policy titled Controlled Substance Prescriptions, dated 2018, documents a signed written prescription must be obtained in order to dispense controlled medications. The facility provided pharmacy policy titled Emergency Pharmacy & Emergency Kits, dated 2018, documents the emergency pharmacy is available 24 hours per day for emergency needs through the emergency medication supply or by special order from the pharmacy. Once orders are verified and prescriptions are verified for controlled medications, the nurse can remove the required medication from the emergency supply and if the medication is not available in this supply the nurse should contact the after hours emergency pharmacy if necessary.</p> <p>The facility's Pain Assessment policy dated 7/6/18 documents medications will be administered when requested, assess pain control effectiveness when PRN medication is administered and during medication administration, and notify the physician when there is inadequate pain control. This policy documents pain interventions will be balanced with adequate response in order to provide comfort, maintain functional status, and in accordance with the resident's wishes and plan of care.</p>		

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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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on observation, interview, and record review the facility failed to sufficiently staff nurses and Certified Nursing Assistants for 10 (R1, R2, R3, R4, R5, R6, R7, R9, R10, R11) of 11 residents reviewed for staffing in the sample list of 11. This failure has the potential to affect all 72 residents residing in the facility.</p> <p>Findings include:</p> <p>The Facility's Facility assessment dated [DATE]-[DATE] documents an average daily census of 68 residents and staffs based on resident population and their needs for care/support. This assessment includes a staffing plan for 10 nurses per day and 21 nurse aides per day.</p> <p>The facility's Midnight Census Report dated 7/1/24 documents 72 residents reside in the facility, R1-R6 and R11 reside on the East wing and R7-R10 reside on the [NAME] wing.</p> <p>The facility's Daily Assignment Sheet dated 6/18/24-7/2/24 document two Certified Nursing Assistants (CNAs) were assigned to East Wing on two days for dayshift and four days for evening shift, and one nurse was assigned daily for the East Wing. The Daily Assignment Sheet dated 5/26/24 documents two CNAs were assigned East Wing for day/evening shifts and [NAME] wing on evening shift.</p> <p>The Resident Council Minutes dated 2/6/24 and 3/5/24 document concerns with call light timeliness and beds not being made. The Resident Council Minutes dated 4/2/24 documents concerns of call light times and not having showers for two weeks due to staffing issue. The Resident Council Minutes dated 5/14/24 documents concerns of call light wait times.</p> <p>1.) On 7/2/24 between 9:15 AM and 11:45 AM V5, Licensed Practical Nurse (LPN), was the only nurse working on the East wing of the facility. On 7/3/24 at 9:36 AM V11 LPN was the only nurse working on the East wing.</p> <p>On 7/2/24 at 10:35 AM V5 was administering medications on R1's, R2's, and R5's hallway. V5 stated V5 is assigned to 25 residents, there is an hour window to give medications before/after the scheduled time, and V5 is behind with medication administration today. On 7/2/24 at 11:45 AM V5 stated V5 did not complete the East wing 8:00 AM medication pass until 10:00 AM-10:30 AM. V5 stated V5 has been having difficulty getting the medications administered timely since the facility changed to having only one nurse on the East wing, and due to not having a routine since V5 is an agency nurse.</p> <p>On 7/2/24 at 9:31 AM R1 stated R1 has not been getting R1's bedtime medications on time and therefore it takes R1 awhile to fall asleep. R1 stated there have been a few nights where R1 didn't call staff to provide incontinence cares and R1 was left incontinent during the night.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 7/2/25 at 12:06 PM R5 was eating lunch in R5's room and R5's left leg was in a cast. R5 stated R5 often doesn't get Reglan (gastric reflux medication) before R5's meals as it should be given, and R5 has not yet received the noon dose. R5 stated a few times R5 had to wait until midnight for R5's bedtime medications to be given. R5 stated R5 is waiting for requested pain medication that R5 had reported to V3 Certified Nursing Assistant (CNA) about 30 minutes ago. R5 stated R5 fractured R5's left ankle in two places prior to admitting to the facility.</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documents R1 is cognitively intact. R1's Concern/Complement Forms dated 5/28/24 and 6/19/24 document R1's bedtime medications are not administered timely. R1's May-July 2024 Medication Administration Audit Reports document 31 doses of Eliquis (anticoagulant) were given at least 90 minutes late. These reports document R1's daily scheduled medications are frequently given over 90 minutes late.</p> <p>R2's June 2024 and July 2024 Medication Administration Audit Reports document 41 doses of Lyrica (pain medication) and 24 doses of Levetiracetam (seizure medication) were given at least 90 minutes late. These reports document R2's daily scheduled medications are frequently given over 90 minutes late.</p> <p>R3's June 2024 and July 2024 Medication Administration Audit Reports document R3's daily medications were given over 90 minutes late on 20 days between 6/1/24 and 7/2/24.</p> <p>R4's June 2024 and July 2024 Medication Administration Audit Reports document R4's daily medications were given over 90 minutes late on 10 days between 6/21/24 and 7/2/24.</p> <p>R5's MDS dated [DATE] documents R5 is cognitively intact. R5's June 2024 and July 2024 Medication Administration Audit Reports document 13 doses of Reglan, 12 doses of Insulin Lispro, and seven doses of Levetiracetam were given at least 90 minutes late. R5's July 2024 Medication Administration Record documents PRN (as needed) Tramadol 100 mg was given on 7/2/24 at 12:57 PM (over an hour after R5's request) for pain rated 5. These reports document R5's daily scheduled medications are frequently given over 90 minutes late.</p> <p>On 7/27/24 between 11:27 AM and 3:22 PM V5, V7, V10 LPNs and V17 CNA were interviewed. V7 LPN stated V7 there is only one nurse assigned to East wing, and V7 often started medication administration for East wing at 6:30 PM and would not be finished until 10:00 PM. V7 stated the [NAME] wing could use more CNAs on night shift, because the residents weren't always getting changed timely. At 12:47 PM (45 minutes after R5's interview) V5 LPN stated V3 CNA reported earlier that R5 requested pain medication. V5 stated V5 has been busy with a new admission and hospital transfer, and V5 forgot to administer R5's pain medication. V10 LPN stated V10 stated nurses have an hour window to administer medications and V10 usually has to start evening medication pass two hours early in order to finish on time, which is difficult to do. V10 states one nurse on East is not enough making it difficult to get medications administered timely. V10 stated we work with two CNAs on East which seems to be enough during the night, but not enough during the busier time of 6:00 PM to 10:00 PM when residents want to go to bed. V17 CNA stated V17 has staffing concerns and feels the facility is understaffed. V17 stated residents aren't being changed and are soaking wet with urine when V17 has arrives for V17's evening shifts.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 7/2/24 at 2:32 PM V2 Director of Nursing stated the facility staffs one nurse on the East wing on day and evening shifts, and that wing used to have 2 nurses assigned. V2 stated for dayshift the facility staffs three CNAs on East and four on West, and then evening shift drops down to three CNAs on [NAME] and two on East. V2 stated CNA and nurse shifts are 6:00 AM-6:00 PM and 6:00 PM-6:00 AM.</p> <p>2.) R6's Admission MDS dated [DATE] documents has severe cognitive impairment. R6's Care Plan dated 6/7/24 documents R6 is at risk for elopement and wanders related to disorientation to place, exit seeking, and impaired safety awareness.</p> <p>R6's Nursing Note dated 7/2/2024 at 10:03 PM documents the following: At 8:10 PM the nurse (V14 Agency LPN) received a call from an unidentified pedestrian reporting a resident (identified as R6) was walking in socks outside of the facility and near the street, and witnessed R6 attempt to step onto the curb and tripped, causing R6 to fall and hit R6's head on the pavement. R6's family was notified that R6 had eloped from the facility (left unnoticed.) V14 found R6's wheelchair sitting in the middle of the therapy room with the therapy doors open and the alarm sounding.</p> <p>On 7/3/24 between 1:11 PM and 3:22 PM V14 Agency LPN, V15, V16, V17 CNAs were interviewed. V14 Agency LPN stated V14 and two CNAs were assigned to the East wing (R6's unit) on 7/2/24 when R6 eloped from the facility, which is not enough staff when you have a resident, like R6, who needs one to one supervision. V15 CNA stated we were swamped last night on the East side, there were lots of families visiting and requests for care needs. V15 confirmed there was one nurse and two CNAs assigned to the East wing between 6:00 PM and 8:00 PM. V15 stated I don't feel one nurse and two CNAs is enough staff for the East side. That side is very busy and we are constantly in rooms and answering call lights. V16 CNA stated was pulled to work R6's unit at 7:00 PM on 7/2/24, and confirmed there was one nurse and another CNA working on the East wing at that time. V16 stated V16 does not feel the facility has enough staff, two CNAs for each wing is not enough, especially with having residents who wander. V16 stated R7 wanders to the lobby and doesn't always have a sitter, R9 and R10 also wander. V17 CNA stated V17 arrived to work on 7/2/24 at 8:23 AM and there was no staff present on the East wing. V17 stated the assigned nurse and CNAs were outside with R6, and R11 was walking towards the front exit door. V17 stated R6 is very active and sundowns (increased behaviors in the afternoon/evenings) and had one to one supervision when V17 previously worked the East wing. V17 stated V17 is very concerned about the facility's staffing and it seems that they are understaffed. V17 stated the East nurse is overloaded with passing medications and can't help much with anything else. V17 stated there are not enough staff on the East wing to deal with resident behaviors and residents who need someone to sit with them for one to one supervision.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on observation, interview, and record review the facility failed to ensure medications were administered timely as ordered resulting in repeated significant medication errors for two (R2, and R5) of five residents reviewed for medications in the sample list of 11.</p> <p>Findings include:</p> <p>On 7/2/24 between 9:15 AM and 11:45 AM V5 Licensed Practical Nurse (LPN) was the only nurse working on the East wing of the facility. On 7/3/24 at 9:36 AM V11 LPN was the only nurse working on the East wing. On 7/2/24 at 10:35 AM V5 was administering medications on R1's, R2's, and R5's hallway. V5 stated V5 is assigned to 25 residents, there is an hour window to give medications before/after the scheduled time, and V5 is behind with medication administration today. On 7/2/24 at 11:45 AM V5 stated V5 did not complete the East wing 8:00 AM medication pass until 10:00 AM-10:30 AM. V5 stated V5 has been having difficulty getting the medications administered timely since the facility changed to having only one nurse on the East wing, and due to not having a routine since V5 is an agency nurse. V5 stated if the late medication is a ordered more frequently than daily V5 saves that resident for last at the time of the scheduled medication pass, and V5 should have been notifying the physician.</p> <p>1.) R2's June 2024 and July 2024 Medication Administration Audit Reports document the following: Lyrica (pain medication) 50 mg is scheduled to be given at 8:00 AM, 2:00 PM, and 8:00 PM, and was administered over 90 minutes late for 37 doses in June and four doses in July. Levetiracetam (seizure medication) 1000 mg is scheduled to be given at 8:00 Am and 1500 mg at 4:00 PM, and was administered over 90 minutes late for 22 doses in June and two doses in July. On 7/2/24 R2's 8:00 AM medications were administered between 10:01 AM and 10:03 AM.</p> <p>2.) On 7/2/25 at 12:06 PM R5 was eating lunch in R5's room. R5 stated R5 often doesn't get Reglan (gastric reflux medication) before R5's meals as it should be given, and R5 has not yet received the noon dose. R5 stated a few times R5 had to wait until midnight for R5's bedtime medications to be given.</p> <p>R5's MDS dated [DATE] documents R5 is cognitively intact.</p> <p>R5's June 2024 and July 2024 Medication Administration Audit Reports document the following: Reglan 5 mg is scheduled to be given at 7:30 AM, 11:30 AM, and 4:30 PM. 10 doses of Reglan were given over 90 minutes late in June, three in July, with some doses being given within 15 minutes of the next scheduled dose. Reglan was administered at 12:57 PM on 7/2/24. Insulin Lispro 10 units is scheduled to be given at 8:00 AM, 11:00 AM, and 5:00 PM. 10 doses were given over 90 minutes late in June, and two doses in July. Insulin Lispro was given on 6/21/24 at 12:51 PM and 5:48 PM. Levetiracetam 500 mg is scheduled to be given at 8:00 AM and 8:00 PM. Six doses of Levetiracetam were given over 90 minutes late in June, including one at 11:40 PM, and two doses in July.</p> <p>R5's June 2024 Medication Administration Record documents R5's blood glucose level was 51 (significantly low) on 6/21/25 at 5:00 PM.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/27/24 at 11:27 AM V7 LPN stated V7 often started medication administration for East wing at 6:30 PM and would not be finished until 10:00 PM.</p> <p>On 7/2/24 at 1:00 PM V10 LPN stated V10 stated nurses have an hour window to administer medications and V10 usually has to start evening medication pass two hours early in order to finish on time, which is difficult to do.</p> <p>On 7/2/24 at 2:32 PM V2 Director of Nursing stated the facility staffs one nurse on the East wing on day and evening shifts, and that wing used to have 2 nurses assigned. V2 stated V2 thinks it was better when the facility had their own nurses staffed on that unit and we are working on getting contracted nurses to help with consistency.</p> <p>The facility provided pharmacy policy, undated and titled, Medication Administration General Guidelines, documents medications are to be given within one hour before/after the scheduled time, unless otherwise ordered; and there should be a documented explanatory note when medications are not given at the ordered time.</p>