

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Alden Debes Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 550 South Mulford Avenue Rockford, IL 61108	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident remained free from resident-to-resident abuse for two of two residents (R30, R58) reviewed for abuse in the sample of 38.</p> <p>Findings include:</p> <p>R30's Admission Record, provided by the facility on 6/27/24, showed he had diagnoses including schizophrenia, bipolar disorder, cataract-unspecified, and cognitive communication deficit. R30's facility assessment dated [DATE] showed he was cognitively intact, had behaviors that were not directed towards others, and had hallucinations. The assessment showed R30 needed supervision or touching assistance with walking.</p> <p>R58's Admission Record, provided by the facility on 6/27/24, showed he had diagnoses including schizoaffective disorder, generalized anxiety disorder, metabolic encephalopathy (a brain condition caused by a chemical imbalance in the blood due to an illness or organ dysfunction), and cognitive communication deficit. R58's facility assessment dated [DATE] showed he had moderate cognitive impairment, had verbal behaviors directed towards others, had hallucinations and delusions. The assessment showed R58's behaviors significantly intruded on the privacy or activity of others and significantly disrupted care or living environment. The assessment showed R58 needed supervision or touching assistance with walking.</p> <p>On 6/25/24 at 10:22 AM, R30 was observed walking up and down the hall repeatedly on the A unit behavioral wing of the facility. R30 did not stop or reply when this surveyor greeted him and tried initiating a conversation.</p> <p>On 6/25/24 at 12:29 PM, R58 was in the dining room, sitting at a table. R58 would yell out occasionally and sang I will put a gun against your head, pull the trigger now your dead. At 12:58 PM, R58 got up from his chair and said loudly Warning. Get out of my way. Staff moved over to let R58 through. R58 walked up the hall. A minute later, R58 came back down the hall and said Hey, where is my room? Staff told R58 they would show him where his room was. The staff member said, Remember you were moved? R58 said he knew, but he could not find his room.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145142	If continuation sheet Page 1 of 19

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R58's Progress note dated 6/9/24 showed Writer made aware from activity staff that she believed the resident (R58) had just hit another resident that had fallen to the ground, The Progress note showed a counselor reviewed the facility cameras and saw that as a peer was walking by, R58 shoved him, and then punched him in the face causing that peer to fall to the ground. The note showed R58 then stood over peer watching him before going into the TV room. The note showed when R58 was asked why he hit his peer, R58 denied hitting peer, even after being told that it was on camera and staff witnessed the event. R58 was removed from the area and placed on 15-minute checks. Psychiatric services were called, and an order was given to send R58 out for evaluation related to physical aggression initiated.</p> <p>R30's Progress note dated 6/9/24 showed Writer made aware resident had fallen .Writer then made aware that resident (R30) was walking up the hall and was hit unprovoked by a peer causing him to fall to the ground .Related to punch, resident unable to give description related to aphasia (difficulty talking) .resident skin assessment clear .No signs or symptoms of pain or injuries noted.</p> <p>On 6/27/24 at 11:18 AM, V20 (Activity Aide) said she was at the nurse's station and heard a commotion behind her. She turned and saw R30 on the floor. V20 said she told V22 (Certified Nursing Assistant-CNA) that R30 was on the floor. V20 said she and V22 asked R30 what happened. He (R30) kept saying nothing, nothing, nothing. V20 said V22 and V21 (Licensed Practical Nurse-LPN) checked the cameras and told her that R58 hit R30. V20 said she is not aware of any previous incidents between R58 and R30. V20 said R58 is quite verbally aggressive. V20 said R58 is loud, and his voice is jarring. He will scream out.</p> <p>On 6/27/24 at 11:38 AM, V23 (Behavioral Counselor on A unit) said he was in his office when the incident happened on 6/9/24 between R30 and R58. V23 said the incident happened right outside the resident lounge area, in the hallway. V23 said R30 paces up and down the hall. R58 went into the lounge area and as he was coming out R30 and R58 met. V23 said R58 does not like people in his space. V23 said he thinks R58 thought R30 was in his space. V23 said R58 pushed R30, and then hit him in the neck or face. V23 said it wasn't like a punch to the face, more like hitting R30 with his arm, making him (R30) lose his balance.</p> <p>On 6/27/24 at 11:44 AM, V21 (LPN) said she was the nurse on duty on 6/9/24 when the incident happened between R30 and R58. V21 said she did not see the actual incident. V21 said she reviewed the camera. V21 said R30 was walking up the hallway and R58 was coming down the hallway. V21 said R58 had not been agitated prior to the incident. V21 said she did not understand why, but R58 hit R30. V21 said she could not tell where R58 hit R30 at. V21 said she did an assessment on R30 and did not see any red marks or bruising on R30's buttocks, neck, face, or chest. V21 said R30 was not able to explain what happened, and R58 claimed he did not do anything.</p> <p>On 6/27/24 at 11:54 AM, V23 (Behavioral Counselor Unit A) said he did not see any injuries on R30 after the incident and R30 did not complain of pain anywhere. V23 said R58 has poor insight. V23 said he could not get R58 to tell him why he did that. V23 said R58 can be impulsive. V23 said R58 had a previous small altercation with another resident one or two years ago. V23 said it was the other resident that was being aggressive. Staff intervened and the residents were separated. V23 said R58 is bipolar and when he is in the manic phase, he is loud and impulsive. V23 said he is not aware of any other altercations/incidents with R58.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/27/24 at 12:13 PM, V14 (Behavioral Unit Coordinator) provided an incident dated 10/16/2022 where another resident was walking out of the dining room. R58 unexpectedly turned and made open handed contact with the other resident on the back. V14 said she thinks it was just R58 saying hi buddy to the other resident. V14 said they (the facility) even debated on whether to send it in as an incident because it wasn't like R58 was agitated or being physically inappropriate. V14 said R58 said he was just saying hi to the other resident. V14 said she thinks it was just R58 not respecting the other resident's boundaries. V14 said there have not been any other reportable incidents since 2019, at least involving R58.</p> <p>R58's Progress notes were reviewed from 3/1/24 through 6/26/24. The notes showed on 3/4/24 R58 was behavioral, presenting with agitation and mania as evidenced by yelling, cursing at staff, being verbally inappropriate and pacing up and down the hallway throughout the morning shift. R58 cycled between being redirectable and difficult to redirect. R58's progress note dated 3/8/24 showed R58 became behavioral when another resident accidentally ran over his foot with his wheelchair. R58 raised his fist as if to hit the other resident. The note showed the residents were immediately separated and redirected. The notes from 3/8/24 showed around two hours later, R58 became aggressive towards a staff member, asking staff if the individual wanted to fight and threatening the staff member. R58's Progress notes showed on 3/13/24 R58 was displaying inappropriate language, yelling at staff, and disrupting breakfast. The note showed one of the counselors spoke with R58 and was able to settle him down and redirect him. The same day at 10:20 AM R58's Progress note showed R58 was displaying inappropriate socially, delusional thinking, and was aggressive with staff members several times. R58's progress notes showed on 3/16/24 R58 was being verbally aggressive and inappropriate towards staff. R58 continued yelling and disturbing the unit and proved difficult to redirect. Progress note dated 3/30/24 showed R58 was yelling and cussing at staff and peers. R58's progress notes showed many other dates where he displayed behaviors of yelling, cursing, making inappropriate comments and gestures at staff, urinating in the garbage can and on the floor, being difficult or unable to redirect at times. The notes showed on 5/12/24 R58 threatening staff periodically, telling them not to touch him or he will inflict physical harm to them. R58 was able to be redirected but remained agitated and continued to raise his voice.</p> <p>R58's care plan initiated on 12/27/2019 showed he often yells out at random times during groups, leisure times, meals and medication times. R58's risk for abuse care plan, initiated 7/1/2019, showed he can be verbally and physically aggressive. R58's care plan initiated on 6/30/2020 showed he has displayed physically aggressive behaviors towards his staff and peers.</p> <p>The facility reported incident of 6/9/24, provided by the facility showed behavioral health resident (R58) exited a common area into the hallway of the unit and became aggressive towards a fellow behavioral health resident (R30). Physical contact was made. The residents were immediately separated. R58 was placed on one-to-one supervision until he was transported to a behavioral hospital for evaluation and staabilization of his acute schizoaggressive symptoms. The report showed no injuries were noted to R30.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's September 2020 Abuse policy showed This facility affirms the right of our residents to be free from abuse .This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members, or legal guardians, friends, or any other individuals. The policy identifies the definition of abuse as any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury .Willful means the individual acted deliberately, not that the individual must have intended the injury or harm .Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. The policy showed Prevention .d. As part of the social service assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals on a regular basis.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491</p> <p>Based on interview and record review, the facility failed to ensure nursing staff were documenting the resident's Physician, or Nurse Practitioner was notified when a resident's blood glucose levels were out of the parameters ordered by the physician for 1 of 1 resident (R133) reviewed for insulin medication use in the sample of 38.</p> <p>Findings include:</p> <p>R133's Admission Record, provided by the facility on 6/27/24, showed he had diagnoses including type II diabetes mellitus, schizoaffective disorder-depressive type, encephalopathy (a broad term for any brain disease that alters brain function or structure. Declining ability to concentrate, memory loss, personality changes, seizures, and twitching are common symptoms). R133's diagnoses also included generalized anxiety disorder, and adult failure to thrive. R133's facility assessment dated [DATE] showed he had moderate cognitive impairment and receives hypoglycemic medications including insulins. The assessment showed R133 did not have behaviors.</p> <p>R133's Medication Review Report, provided by the facility on 6/27/24, showed an order dated 11/14/23 for Blood glucose monitoring: As needed call physician for results less than 60 or greater than 400. The report showed in addition to orders for two oral antidiabetic medications (metformin and glipizide), R133 had orders for Levemir (a long-acting insulin) 10 units at bedtime, 25 units in the morning. The report showed an order dated 12/11/23 for Novolog (a short-acting insulin) per sliding scale, three times daily based on the results of the glucose testing. The order showed 400 or above give 12 units and call NP (Nurse Practitioner-V19).</p> <p>R133's Weights and Vitals Summary, printed by the facility on 6/26/24, showed R133's blood glucose levels were out of the parameters set by the Physician's order on the following dates:</p> <p>6/15/24: 55 mg/dL (milligrams per deciliter)</p> <p>6/14/24: 55 mg/dL</p> <p>6/12/24: 59 mg/dL at 5:31 PM and 423 mg/dL at 11:04 AM</p> <p>5/30/24: 455 mg/dL</p> <p>5/24/24: 470 mg/dL</p> <p>5/10/24: 427 mg/dL</p> <p>5/8/24: 52 mg/dL</p> <p>4/27/24: 58 mg/dL</p> <p>4/25/24: 46 mg/dL</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4/19/24: 52 mg/dL</p> <p>4/15/24: 453 mg/dL at 9:36 AM and 453 mg/dL at 9:44 AM</p> <p>4/3/24: 59 mg/dL</p> <p>4/1/24: 54 mg/dL</p> <p>3/29/24 43 mg/dL</p> <p>3/26/24: 36 mg/dL</p> <p>3/25/24: 54 mg/dL</p> <p>3/23/24: 47 mg/dL</p> <p>3/22/24: 54 mg/dL</p> <p>3/21/24: 443 mg/dL</p> <p>3/19/24: 496 mg/dL</p> <p>3/18/24: 453 mg/dL</p> <p>3/9/24: 417 mg/dL</p> <p>3/6/24: 59 mg/dL and</p> <p>3/5/24: 54 mg/dL</p> <p>R133's Nurse Progress Notes showed no documentation of V19 (Nurse Practitioner-NP) or R133's Physician being notified of R133's blood glucose levels on the following dates:</p> <p>6/12/24, 5/8/24, 4/27/24, 4/25/24, 4/19/24, 4/15/24, 4/3/24, 4/1/24, 3/29/24, 3/25/24, 3/22/24, and 3/5/24.</p> <p>On 6/27/24 at 9:25 AM, V2 (Director of Nursing-DON) said the nurses have been reporting R133's blood sugar levels to V19 (Nurse Practitioner-NP). V2 said the nurses are just not documenting that they have reported it. V2 said if the nurses are reporting R133's blood sugar levels to V19, they should be documenting it. V2 said without the nurse documenting that they reported it, there is no way to know for sure that it was reported to V19 or R133's Physician. V2 said it is important to report so that V19 is aware and can guide them as to what steps should be taken. So they can get new orders on how to proceed.</p> <p>On 6/27/24 at 9:58 AM, V19 (NP) said she knows R133 very well. V19 said R133 is on hospice, and he gets to eat what he wants. He is a brittle diabetic. V19 said when we (the facility) decrease his insulin dose, he goes higher. If we overcorrect, he goes low. V19 said R133 tends to swing pretty far if we make a change in his medications for his diabetes.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R133's care plan, initiated on 3/20/22, showed he has the potential for hypo/hyperglycemic reactions secondary to diagnosis of diabetes mellitus. The care plan showed blood glucose monitoring as ordered. Report results that are outside of ordered parameters to MD (Doctor). Monitor/document report to MD as needed signs and symptoms of hypoglycemia.</p> <p>The facility's 5/28/2020 policy and procedure titled Assure Platinum Blood Glucose Monitoring showed 13. Notify Physician if results are outside of parameters given.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042</p> <p>Based on observation, interview and record review the facility failed to ensure care was provided for a resident's right hand contracture and nails for 1 of 1 residents (R32) reviewed for activities of daily living in the sample of 38.</p> <p>Findings include:</p> <p>On 6/25/24 at 9:59 AM, R32 was sitting up in a low bed with a mat on the floor to her right side of the bed. R32's right hand was contracted with a long, slightly curved thick nail on her right thumb. R32 stated staff do not clean her right hand. R32 stated her nails hurt and were cutting into her hand.</p> <p>On 6/26/24 at 7:51 AM, R32 was in bed and V9 CNA (Certified Nursing Assistant) was providing morning care and incontinence care for the resident. R32's right hand was contracted with a long, slightly curved thick nail on her right thumb. V9 stated R32's nail was so thick that it is hard to cut that nail. V9 stated she did not think regular nail clippers would cut the nail. V9 stated the nurse's have to cut R32's nails. V9 stated R32's right hand is contracted and that she refused to have it cleaned today. V9 stated R32 has the right to refuse and she does what she can. V9 stated she takes care of R32 9 days out of a 14 day pay period.</p> <p>On 6/27/24 at 7:34 AM, R32 was sitting up in a low bed with a mat on the floor to her right side of the bed. R32's right hand was contracted with a long, slightly curved thick nail on her right thumb.</p> <p>On 6/27/24 at 9:13 AM, V2 DON (Director of Nursing) stated, R32 refuses a lot of care. R32 doesn't let people sometimes take care of her. Naturally she is clean so we are able to provide care; staff should re-approach later when care is refused. V2 stated no one has talked to her about her nails in a very long time.</p> <p>On 6/27/24 at 11:00 AM, V2 DON (Director of Nursing) stated R32's nail was cut today. V2 stated she discontinued the order today for the nurse's to cut R32's nails weekly because it should have never been in there. V2 stated the order had been in there for the nurse's to cut R32's nails before today. V2 stated she did not know how often the nurses were documenting that they had cut R32's nails; she would have to look.</p> <p>The TAR (Treatment Administration Record) dated June 2024 showed R32's nails were to be cut weekly by the nurse on night shift, was signed off as being completed on 6/26/24, and was not done.</p> <p>The Face Sheet dated 6/27/24 for R32 showed medical diagnoses including type 2 diabetes mellitus, parkinson's disease, schizoaffective disorder, cellulitis of right lower limb, spastic hemiplegia, adult failure to thrive, and history of falling.</p> <p>The Minimum Data Set, dated dated [DATE] for R32 showed a BIMS (Brief Interview for Mental Status) score of 13; cognitively intact. R32 needs substantial/maximal assistance for personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident's dressings were in place for a resident (R20) with venous stasis ulcers. This applies to 1 of 6 residents reviewed for skin conditions in the sample of 38.</p> <p>Findings include:</p> <p>R20's electronic face sheet printed on 6/27/24 showed R20 has diagnoses including but not limited to venous insufficiency, Parkinson's disease with dyskinesia, non-pressure chronic ulcer of other part of left lower leg, alcoholic cirrhosis, bipolar disorder, peripheral vascular disease, and heart failure.</p> <p>R20's physician's orders dated 10/2/23 showed, (multipurpose support bandage): apply knee high to bilateral lower extremities in the morning and remove at bedtime.</p> <p>R20's facility assessment dated [DATE] showed R20 has no cognitive impairment.</p> <p>R20's care plan dated 9/25/23 showed, (R20) has actual alterations in skin integrity related to venous stasis to left lower extremity and peripheral vascular disease. (R20) is also noted to pick at her skin and remove dressings when ordered. Noncompliant with skin interventions. Refuses to allow staff to complete treatment and consistent use of compression stockings as ordered.</p> <p>R20's physician's orders dated 6/20/24 showed, medihoney/maxorb apply to left leg topically every day shift for skin condition.</p> <p>R20's physician's orders dated 10/2/23 showed, (multipurpose support bandage): apply knee high to bilateral lower extremities in the morning and remove at bedtime.</p> <p>On 6/25/24 at 12:14PM, R20 was up in her wheelchair, dressed for the day. R20 had multiple open sores to her lower left leg that had drainage coming out of them. R20 stated, They are supposed to put dressings on my legs every morning but it's not done yet. It's supposed to be done every day but there have been many times where it's not getting done.</p> <p>R20's treatment administration record for June 2024 was reviewed on 6/26/24 and showed R20's leg wound dressing and support bandage were not completed on 6/25/24. R20's treatment administration record also shows that the staff have not had to use any as needed treatment orders for R20 taking her dressings off.</p> <p>On 6/26/24 at 2:08PM, V15 (Licensed Practical Nurse) stated, (R20) has vascular wounds on her legs. She is very noncompliant with her dressings because she will take the dressings off and pick at them. She denies doing it but we have caught her doing it. It would be safe to assume that her dressing wasn't done if it's not documented since that's the only way to know for sure if it was done or not. If it's not on and she took it off we should be re-wrapping her leg and documenting that she took it off and it was re-wrapped. The same goes for her (support bandage).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Alden Debes Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 550 South Mulford Avenue Rockford, IL 61108	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/27/24 at 12:15PM, V2 (Director of Nursing) stated, If (R20) is taking her dressings off the nurse's should be documenting refusals for those and for her (support bandage). If the nurse's know that her dressings are off then they should be documenting that as well as PRN (as needed) documentation that shows the dressings were replaced. Her wounds will not heal without the correct treatment being administered.</p> <p>The facility's policy titled, Prevention and treatment of pressure injury and other skin alterations dated 03/02/21 showed, Policy: 3. Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan .</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>33761</p> <p>Based on observation, interview and record review the facility failed to provide services to prevent a resident's Range of Motion from declining.</p> <p>This applies to 1 of 1 resident (R23) reviewed for Range of Motion in a sample of 38 residents.</p> <p>Findings include:</p> <p>R23's Facesheet shows her diagnoses to include hemiparesis (muscle weakness or partial paralysis) and hemiplegia (full paralysis) affecting her left side following a cerebral infarction in January of 2022.</p> <p>R23's Careplan shows she requires Activities of Daily Living (ADL) assistance secondary to her cerebral infarction. The intervention dated 1/24/22 shows the facility is to provide ROM to affected extremities as ordered.</p> <p>R23's 5/9/24 MDS (Minimum Data Set) shows she is cognitively intact with a BIMS (Brief Interview for Mental Status) of 15.</p> <p>On 06/26/24 at 11:23 AM, R23 was in bed, with her left arm bent and her elbow close to her body. R23's hand was close to her neck. Her left hand had a rolled up washcloth in it.</p> <p>On 06/26/24 at 11:23 AM, R23 said, the facility is not providing Range of Motion (ROM) therapy, and she has lost mobility in her left arm. R23 said, her left arm wasn't like that before her stroke.</p> <p>On 06/27/24 at 12:21 PM, V18 (Restorative Nurse) said, R23 was on a restorative ROM program for her left arm, but it was stopped in February of 2024. V18 was not sure why that was removed from R23's restorative program.</p> <p>On 06/27/24 at 12:21 PM, V2 DON (Director of Nursing) said, she thought that dressing the resident counted for ROM therapy.</p> <p>R23's 1/9/22 Initial Nursing Assessment upon admission shows her left arm is flaccid but not rigid.</p> <p>R23's 2/11/24 Restorative Nursing Assessment shows section 5. Restorative Program Quarterly Progress Notes, have questions that are not answered, such as, what is the goal,? Objective, measurable documentation indicating progress, maintenance or regression towards the goal? Has the resident's self performance improved in the last 90 days? If there was a decline, explain the contributing factors, and based on these answers are there changes that need to be made to the restorative plan of care? The same section was left blank for the 5/8/24 and the 6/26/24 Restorative Nursing Assessment.</p> <p>R23's Task Sheet does not show ROM under the category of Restorative.</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>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** 36186</p> <p>Based on observation, interview and record review the facility failed to safely transfer a resident using a mechanical lift. This applies to one of one residents (R71) reviewed for safety in the sample of 38.</p> <p>Findings include:</p> <p>The facility face sheet for R71 shows she was admitted to the facility with diagnoses to include morbid obesity, osteoarthritis, and congestive heart failure. The facility assessment dated [DATE] shows R71 to be cognitively intact and is dependent on staff for transfers. The care plan dated 6/5/24 shows R71 requires the use of a mechanical lift for transfers. The interventions include to provide two staff assistance for transfers.</p> <p>On 6/26/24 at 10:45 AM, R71 was sitting in her room and a bruise was observed to her right eye. R71 said she was being transferred from her bed into her recliner by one CNA (Certified Nursing Assistant). R71 said as she was being lowered into the recliner, the CNA was at the end of the lift controlling the lift. R71 said it happened quickly when the arm of the lift hit her in the eye. R71 said it was the arm of the lift that holds the straps in place. R71 said she yelled out loudly because it hurt. R71 said the nurse came to see her right away and applied ice. R71 said the facility staff just told her the CNA was being fired for doing the transfer by herself and to never let just one staff person transfer her.</p> <p>On 6/26/24 at 3:30 PM, V3 RN (Registered Nurse) said she was at the nursing station when V6 CNA came to her and said that R71 was hit by the arm of the lift when she was being transferred to her recliner. V3 said V6 told her the arm bar that holds the sling hit R71 in the eye as she was releasing the sling from the bar. V3 said she went to R71 and noticed swelling to R71's eye. V3 said she only saw V6 in the room and wasn't sure if any other CNA had been in the room to help. V3 said she was working with three CNA's that shift and they were V6-V8 all CNA's. V3 said all mechanical lift transfers are to be done with two staff.</p> <p>Calls were made to the three CNA's working that shift and no contact could be made.</p> <p>On 6/27/24 at 10:47 AM, V2 Director of Nursing said she was notified of the incident after it happened. V2 said she talked to V7 and V8 CNA's and they stated they were not in the room when it happened. V2 said she reached out to V6 and has been unable to talk to her. V2 said all staff are expected to always use two staff for transfers using the mechanical lift for the residents safety.</p> <p>On 6/27/24 at 9:45 AM, V5 CNA said she was trained to use the mechanical lift with two staff assistance. One CNA is to guide the residents and keep them safe and the second CNA runs the mechanical lift. V5 said it's not ever safe to do a mechanical lift alone.</p> <p>The schedule for 6/23/24 shows three CNA's on the 400 wing were V6-V8 CNA's and V3 RN.</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>The nursing progress note for R71 dated 6/23/24 shows the resident was being transferred back to her chair after being changed in bed. While the mechanical lift was being lowered to her chair, the resident leaned forward and hit her eye on the arm of the lift resulting in a bruised eye.</p> <p>The facility policy dated 1/14/21 for total mechanical lift shows two caregivers are required to operate the mechanical lift.</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>33761</p> <p>Based on observation, interview and record review the facility failed to ensure there were physicians orders for a suprapubic catheter and it's care. This applies to 1 of 1 resident (R5) reviewed for catheters in a sample of 38 residents.</p> <p>Findings include:</p> <p>R5's 3/29/24 Nurse Practitioner notes shows his diagnoses to include a neurogenic bladder, anxiety, agitation, and paranoia.</p> <p>On 6/26/24 at 8:53 AM, R5 was sitting in the wheelchair with his urine bag on his lap.</p> <p>On 6/27/24 at 11:45 AM, V2 DON (Director of Nursing) said, R5 came back from the hospital in March of 2023 and his catheter orders were never re-wrote. V2 said they re-wrote them today. V2 said there should be an order from the Physician or Nurse Practitioner for those things, and the order for care should be on the TAR (Treatment Administration Record) to remind staff it should be done, and to document that it was done.</p> <p>R5's POS (Physician Order Sheet) shows no orders for the suprapubic catheter or the care of it prior to 6/26/24.</p> <p>R5's Care Plan shows he requires the use of an Indwelling Supra pubic Catheter related to Neuromuscular bladder secondary to Paraplegia. The Care Plan Interventions include: Catheter care per orders, and change Foley according to facility protocol.</p> <p>The 2/2011 Suprapubic Catheter Care Policy and Procedure does not clarify when to change the suprapubic catheter other than when it becomes dislodged and pulls out. The policy shows it is to be replaced by a Physician or a Nurse Practitioner.</p> <p>The April and May 2024, MAR's (Medication Administration Record) TAR's do not include treatments for the suprapubic catheter. The June TAR does include suprapubic catheter starting on 6/26/24.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident with significant weight loss was assisted and encouraged with meals. The facility failed to ensure a residents supplement intake was accurately documented for 1 of 1 residents (R93) reviewed for significant weight loss in the sample of 38.</p> <p>Findings include:</p> <p>The Weight Log for R32 showed: 12/1/23 - 118.4 pounds; 1/4/24 - 123.6 pounds; 2/2/24 - 12:39 pounds; 3/8/24 - 117.5 pounds; 4/4/24 - 110.7 pounds; 5/4/24 - 111 pounds; and 6/5/24 - 108.6 pounds. R32 had a 7.5% significant weight loss from March 2024 to June 2024.</p> <p>On 6/26/24 at 8:09 AM, R93 was sitting on the side of her bed with her breakfast tray on the over the bed table in front of her. R93 had an egg, sausage, and cheese sandwich, fortified hot cereal in a bowl with a lid on it, milk, coffee and juice.</p> <p>On 6/26/24 at 12:42 PM, R93 was laying on her back in bed with her lunch sitting on the tray table next to her. R93 stated she ate the meat and cheesecake from her lunch tray. The lid on her tray was lifted and showed R93 did not eat the broccoli or fortified potatoes. The fortified pudding was in a small container that was full with the lid intact. R93's bread was still in the wax paper bag and butter packs were not opened. R93's meal ticket on her tray showed a regular texture, general diet. Thin Fluids. Standing orders for: > 1/2 cup fortified potatoes and > 4 oz fortified pudding. R93's room mate, R32 was not in her room being assisted by staff with dining. At 12:48 PM, V9 CNA (Certified Nursing Assistant) picked up R93's meal tray from her room. R93's fortified pudding, fortified potatoes, broccoli, bread, and butter had not been touched and/or eaten.</p> <p>On 6/26/24 the task documentation for R93 and her fortified potatoes showed it was documented at 1:38 PM that the resident ate 75 - 100% of her fortified potatoes; R93 did not eat any of them.</p> <p>On 6/27/24 at 7:53 AM, V9 CNA (Certified Nursing Assistant) delivered R93's breakfast tray to her room and sat on the tray table in front of her. No assistance in opening/or setting the tray up was offered. V9 then brought in R93's room mate's (R32) Tray. The curtain between the residents was closed; V9 fed R32 her meal. At 8:00 AM the curtain was still closed between the residents while R93 ate alone and R32 was being fed. The lid was on R93's fortified hot cereal. At 8:06 AM, V9 left R93/R32's room with R32's tray. V9 did not check to see if R93 was eating or provide any verbal cuing.</p> <p>The Nutrition assessment dated [DATE] for R93 showed, General/Regular texture-thin liquids. Magic cup twice a day at lunch and dinner, fortified cereal at breakfast, fortified potatoes at lunch, and fortified pudding at dinner. Recent weight history (in pounds): 4/4/24-111; 3/8/24-117.5; 2/2/24-116.4; 1/4/24-123.6; 9/1/23-121; and 5/4/23-130.7. Significant weight loss was marked for the past 1 month, 3 months and 6 months. Set up to be provided as needed. Nutrition goals to maintain hydration, accept supplements, weight stability, comfort care, and oral intake >50%. Continue to monitor oral intake and weights; offer snacks.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The MDS (Minimum Data Set) dated 5/2/24 for R93 showed the resident needs supervision or touching assistance for eating.</p> <p>The Care Plan dated 5/2/24 for R93 showed, R93 receives a General/Regular texture diet and chooses to eat meals in her room. Gradual wt loss is noted x 6 months. R93 receives supplement for additional calorie and protein intake to enhance oral intake. Weight stability is desired. R93 will intake adequate nutrition to meet needs through next review. R93 will tolerate diet as ordered. Meal monitoring and recording as indicated. Monitor for compliance with prescribed diet, inform doctor of non compliance. Provide supplements as order. Set up tray and provide assist at meals as needed. Weigh R93 per facility protocol.</p> <p>The Physician Orders for R93 showed orders on the following dates: 6/12/24 fortified potatoes for nutritional supplement given with lunch and dinner; 2/8/24 fortified pudding for nutritional supplement give with dinner; and 3/8/23 fortified cereal one time a day for nutritional supplement - give with breakfast.</p> <p>The Face Sheet dated 6/27/24 for R93 showed diagnoses including dementia, hypertension, parkinson's disease, essential tremor, and hyperlipidemia.</p> <p>On 6/27/24 at 9:13 AM, V2 DON (Director of Nursing) stated, For a resident that has a significant weight loss the staff should offer something alternative at meals, talk to the nurse, talk to management, get the dietician involved, and offer supplements. If the resident is not eating supplements then we can change them up. Documentation should be accurate. Staff can document under tasks in the computer how much of the supplement was eaten and how much of the meal was eaten. If a resident that has significant weight loss eats in their room, staff should set up tray, open everything and assist them with eating. Staff should encourage them to eat.</p> <p>On 6/27/24 at 12:17 PM, V12 RD (Registered Dietician) stated she has seen R93 in the last 6 months. V12 stated if she saw R93 it was probably because she needs a supplement added and she does have supplements. V12 stated when a resident lacks interest in meals and starts to lose weight they will offer alternatives, fortified food, and liquid supplements for the extra calories. V12 stated the resident has the right to refuse/ask for something else. V12 stated for a resident like R93 she would expect staff to provide set up and supervision. V12 stated verbal cueing would be appropriate for R93. V12 stated she looks at the task documentation for food and supplement intake to see what staff say R93 is consuming and if staff help set her up or assist her etc. V12 stated she uses the information from the task documentation in her evaluation of the resident.</p> <p>The facility's Nutrition Care Significant Weight Loss policy (1/2018) showed, Resident with a significant weight loss will be assessed by the Licensed Dietician. Purpose: To reduce the risk of resident malnutrition. Procedure: Residents with with significant weight loss will be discussed with member(s) of the interdisciplinary team (IDT). A significant weight loss is 5% one month, 7 1/2 % in 3 months, and 10% in 6 months. The Licensed Dietician (LD) will evaluate the cause of the weight loss and recommend nutrition interventions to prevent further weight loss or enhance weight gain. Interventions may include supplements such as snacks, favorite foods, referral to other member of health care team for evaluation, diet liberalization, etc. The LD will document findings and recommendations in the medical record. Recommendations will be discussed with the resident, member(s) of the IDT, and forwarded to the physician via nursing services.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186</p> <p>Based on observation, interview and record review the facility failed to remove contaminated gloves after providing incontinence care and failed to place soiled linen in a plastic bag. This failure applies to two of seven residents (R32 and R74) reviewed for infection control in the sample of 35.</p> <p>Findings include:</p> <p>1. The facility face sheet for R74 shows he was admitted to the facility with diagnoses to include hemiplegia after a stroke and congestive heart failure. The facility assessment dated [DATE] shows him to have severe cognitive impairment and is dependent on staff for all activities of daily living.</p> <p>On 6/25/24 at 11:07 AM, V4 Certified Nursing Assistant (CNA) and V5 CNA were observed providing incontinence care to R74. As V4 was providing care and removing soiled linens from R74, she was throwing the linen onto a chair in the room. When V4 was finished providing incontinence care, she did not remove her gloves, and assisted R74 with putting on a clean gown and turning him side to side to place the mechanical lift sling under R74. V4 then removed her gloves and washed her hands. V4 said she didn't throw the wet linens onto the floor because she knew that was wrong, and decided to throw in the chair since she did not have a plastic bag to put them in. V4 said dirty linen should be thrown in a garbage bag.</p> <p>On 6/27/24 at 9:45 AM, V5 CNA said dirty linen should not be placed on a chair but should be placed in a plastic bag and taken from the room. V5 said this is to prevent cross contamination.</p> <p>On 6/27/24 at 10:47 AM, V2 Director of Nursing said dirty linen should never be placed in a chair in the room, it should be placed in a garbage bag. V2 said the staff should change their gloves when they are soiled before moving onto the next task. V2 said this is for infection control practices.</p> <p>The facility policy with a revision date of 6/18 for soiled linen processing shows linen shall be transported to the laundry using closed impermeable bags. The facility policy with a revision date of 6/4/20 for hand washing shows appropriate hand hygiene is essential in preventing the spread of infectious organisms in healthcare setting. Hand hygiene must be performed after touching blood, body fluids, secretions, excretions and contaminated items. Examples include before and after providing personal care and after removing gloves.</p> <p>20042</p> <p>2. The Face Sheet dated 6/27/24 for R32 showed medical diagnoses including type 2 diabetes mellitus, parkinson's disease, schizoaffective disorder, cellulitis of right lower limb, spastic hemiplegia, adult failure to thrive, and history of falling.</p> <p>The Minimum Data Set, dated dated [DATE] for R32 showed a BIMS (Brief Interview for Mental Status) score of 13; cognitively intact. R32 needs substantial/maximal assistance for personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/26/24 at 7:51 AM, R32 was in bed laying on her left side while V9 was putting a clean incontinence brief on the resident. On the floor next to R32's bed was the hospital type night gown, top sheet, and wash cloths. After V9 was done providing care for the resident she picked the items up from the floor, put them in a clear plastic bag, removed her gloves, tied the bag shut and left the room with the bag.</p> <p>On 6/27/24 at 8:27 AM, V13 RN (Registered Nurse/Infection Preventionist) stated linen should not go on the floor. V13 stated they don't want the germs getting on the floor and tracked through the facility. V13 stated they don't want cross contamination.</p> <p>The facility's Soiled Linen Processing policy (6/2018) showed , soiled linen will be handled safely and processed in a manner to provide clean linen in adequate numbers to meet the needs of the facility. All soiled linen will be transported either by hand, cart, or chute in closed impermeable bags to the soiled linen room in the facility. The policy does not show where soiled linen should be placed when providing care. On 6/27/24, by the end of the survey this was the only policy received from the facility specifically for the concern identified of soiled linen on the floor.</p>		