

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/02/2024
NAME OF PROVIDER OR SUPPLIER  Merriam Gardens Healthcare & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 9700 W 62nd Street Merriam, KS 66203	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634</b></p> <p>The facility identified a census of 74 residents. The sample included 18 residents. Two residents were sampled for reasonable accommodations of needs. Based on observation, record review, and interview, the facility failed to ensure Resident (R)47 was given a lipped plate and his meat was cut up into bite-size portions. The facility further failed to ensure R50's call light was within her reach. This deficient practice left R47 and R50 vulnerable to unmet care needs.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- R47's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN-elevated blood pressure), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following a cerebral infarction (stroke - the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the right dominant side, aphasia (condition with disordered or absent language function), and anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues).</li> </ul> <p>R47's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R47 was impaired on one side of his body. The MDS documented R47 needed substantial to maximum assistance with oral hygiene, bathing, toileting, dressing, and cueing or touching assistance with eating.</p> <p>R47's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/14/24 documented R47 was at risk for impaired functional abilities related to chronic conditions with hemiplegia. R47's CAA documented he would need nursing and care staff to continue to observe activities of daily living (ADL) function and aid as indicated.</p> <p>R47's Care Plan revised on 08/04/24 documented R47 was at risk for nutritional problems, and weight loss related to hemiplegia and hemiparesis. R47's plan of care documented R47 needed a lipped plate for all meals to help him with scooping his food.</p> <p>R47's EMR under Orders revealed the following physician's order:</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Fortified Foods diet, regular texture, thin consistency [liquid], cut up meat into bite-size pieces. Divided-lipped plate, and a Magic Cup (frozen nutritional supplement) with the evening meal dated 05/02/24.</p> <p>On 10/02/24 at 09:37 AM, R47 sat up in his bed with his breakfast plate on his bedside table. R47 had a sausage patty, scrambled eggs, hot cereal, and toast. R47's sausage patty was not cut into bite-size pieces and R47 did not have a lipped plate. Observation revealed R47 used his left hand to grasp a spoon and attempted to cut his sausage patty with the spoon but was unable to do so. R47 used the spoon to try to pick up some eggs though the eggs just slid across the plate and onto the tray. R47 did not eat his eggs or sausage patty.</p> <p>On 10/02/24 at 10:23 AM Certified Nurse's Aide (CNA)RR stated the trays were plated in the kitchen, but the nursing staff passed the trays and were to read the residents meal ticket to ensure each resident received what food each resident ordered, or any special equipment needed.</p> <p>On 10/02/24 at 12:48 PM Dietary Staff BB stated the cook plated the trays for each resident. She stated each resident's ticket stated if there were any special utensils, trays, or diet orders. Dietary Staff BB stated the cook was the first check, and the nursing staff was the second check ensuring each resident was getting what was ordered. She stated the lipped plates were not very deep, but they were called lipped plates. She stated she had ordered new lipped plates that are deeper.</p> <p>On 10/02/24 at 03:11 PM Administrative Nurse D stated trays are plated in the kitchen with a meal ticket. She stated when trays come out to the nursing floor, nursing was to check each ticket, before giving the tray to the resident.</p> <p>The facility's Accommodation of Needs policy documented the facility would treat each resident with respect and dignity and would evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered.</p> <p>The facility failed to ensure R47 was given a lipped plate, and his meat was cut up into bite-size portions. This deficient practice left R47 vulnerable to unmet care needs.</p> <p>45668</p> <p>- R50's Electronic Medical Record (EMR) documented diagnosis of hypertension (HTN- elevated blood pressure), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid).</p> <p>R50's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. R50 had impairment on one side of both upper and lower extremities. R50 was dependent on staff for all functional abilities.</p> <p>R50's Quarterly MDS dated [DATE] documented a BIMS score of zero which indicated severely impaired cognition. R50 had impairment on both sides of her lower extremities. R50 was dependent on staff for all functional abilities.</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>R50's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 11/11/23 documented she had a nontraumatic intracranial hemorrhage (a type of stroke that occurs when a hematoma forms in the brain without trauma).</p> <p>R50's Care Plan revised on 08/15/24 documented R50's communication was impaired; staff were to anticipate and meet her needs by nonverbal indicators of discomfort or distress and follow up. R50's plan of care documented that staff should use the following techniques to enhance communication with her: simple words, cues, asking yes or no questions, and speaking clearly and slowly.</p> <p>On 09/30/24 at 07:02 AM R50 was sat up at 45 degrees in her bed. R50's call light was under her bed at the head of her bed, the call light was out of R50's reach.</p> <p>On 10/02/24 at 10:23 AM Certified Nurse's Aide (CNA) R stated call lights should always be in the resident's reach if the resident was in bed.</p> <p>On 10/02/24 at 10:17 AM Licensed Nurse (LN) G stated call lights should never be left behind or under the bed. She stated all nursing staff were to ensure call lights were placed where the resident could reach the light.</p> <p>On 10/02/24 at 02:24 PM Administrative Nurse D stated call lights should always be within reach or on the resident, and the call light should never be out of reach if the resident was in their room or bed.</p> <p>The facility's Accommodation of Needs policy documented the facility would treat each resident with respect and dignity and would evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered.</p> <p>The facility failed to ensure R50 had a call light to communicate her needs. This deficient practice placed the resident at risk for unmet care needs.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>45668</p> <p>The facility reported a census of 74. The sample included 18 residents. Based on observations, record reviews, and interviews, the facility failed to address and resolve recurring issues reported by the Resident Council. This deficient practice placed the residents at risk for decreased psychosocial well-being.</p> <p>Findings Included-</p> <p>- A review of the facility's Resident Council Minutes from 09/2023 through 09/2024 indicated the council had recurring concerns with the food choices, menus, temperatures, and availability. The minutes also noted concerns related to maintaining and cleaning the shower rooms.</p> <p>The 09/2023 Resident Council Minutes documented concerns that the residents were not getting their showers on time, the food was being served cold, and residents were not being offered options. The minutes also documented concerns noting the [NAME] hall's right shower room was out-of-order and needed to be fixed. The minutes lacked actions taken or outcomes for the repeat concerns.</p> <p>The 10/2023 Resident Council Minutes documented concerns indicating the facility needed a plumber for the shower room. The minutes lacked actions taken or outcomes for the repeat concerns.</p> <p>The 11/2023 Resident Council Minutes documented concerns instructing staff to ensure cleaning and sanitizing of the shower rooms after use. The minutes lacked actions taken or outcomes for the repeat concerns.</p> <p>The 12/2023 Resident Council Minutes documented concerns related to direct care staff not asking the residents what they wanted for meals and noted meals were still served cold. The minutes lacked actions taken or outcomes for the repeat concerns.</p> <p>The 01/2024 Resident Council Minutes noted continued concerns with residents not getting showers in the evening. The minutes noted that the residents were not asked what they wanted to eat and the food was often served cold. The minutes noted the resident would have to ask staff to warm their food. The minutes lacked actions taken or outcomes for the repeat concerns.</p> <p>The 02/2024 Resident Council Minutes documented concerns related to not being provided condiments and options for meals. The minutes lacked actions taken or outcomes for the repeat concerns.</p> <p>The 03/2024 Resident Council Minutes documented concerns related to the residents not being offered tickets to choose what they want for meals. The minutes lacked actions taken or outcomes for the repeat concerns.</p> <p>The 04/2024 Resident Council Minutes documented concerns that the food needed to be served hot. The minutes lacked actions taken or outcomes for the repeat concerns.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The 05/2024 Resident Council Minutes documented concerns that the menus didn't match the meals served and the residents wanted condiments served with their meals. The minutes lacked actions taken or outcomes for the repeat concerns.</p> <p>The 06/2024 Resident Council Minutes documented concerns that the residents did not get their meal of choice for May 2023. The minutes lacked actions taken or outcomes for the repeat concerns.</p> <p>The 08/2024 Resident Council Minutes documented concerns that the showers needed to be cleaned and sanitized after each use. The minutes documented concerns that the kitchen always ran out of food items and food was continually served cold. The minutes lacked actions taken or outcomes for the repeat concerns.</p> <p>The 08/2024 Resident Council Minutes documented concerns the direct care staff were not removing the soiled laundry out of the shower rooms after use. The minutes documented continued concerns the food was served cold.</p> <p>The 09/2024 Resident Council Minutes documented that food was still being served cold. The report indicated the resident's choice meal for September was requested as pizza, but the facility served pulled pork. The minutes lacked actions taken or outcomes for the repeat concerns.</p> <p>On 10/01/24 at 01:30 PM, the Resident Counsel reported continued concerns related to the serving of cold meals. The council reported the kitchen continually runs out of food products on the menu and condiments. The council reported the [NAME] Hall shower had been out of service for over a year. They reported the lack of two shower rooms resulted in either missed showers or late showers.</p> <p>On 10/02/24 at 10:45 AM inspection of the facility's [NAME] Hall shower room revealed the right shower room was closed due to maintenance issues. An inspection of the left shower room revealed soiled towels on the floor, feces in the toilet, and a reddish rust-like substance on the lower wall inside the shower area.</p> <p>On 10/02/24 at 01:45 PM Dietary Staff BB stated she was not aware of concerns related to food continually being served cold or running out of food items. She stated the floor staff could always notify the kitchen if there were issues related to food services. Dietary staff BB stated the facility no longer uses the tickets for the residents to select their meals for the day. She stated the residents will get what's on the menu or can ask staff to request something else for their meals. She stated sometimes the kitchen will run out of certain items due to the request of doubles or preferring more of one kind of food item. She stated everyone should be served first before staff serve extras. She stated the facility was making up the missed pizza day for June. She stated staff should be offering condiments with each meal service.</p> <p>On 10/02/24 at 01:45 PM Administrative Nurse D stated staff should offer showers per the resident's preferences and selected times. She stated the [NAME] Hall shower has been out of service but the left side shower still works and staff should be using it. She stated staff were expected to ensure the resident areas remained clean. She stated soiled laundry should never be left on the floor.</p> <p>On 10/02/24 at 02:01 PM Maintenance Staff V stated the facility was looking for bids to fix the busted pipe in the shower room. He was not sure how long the showers had been out of service or when it would be fixed.</p> <p>(continued on next page)</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's Resident Council policy indicated the resident response form was to be utilized to track council concerns and facility resolution. The policy indicated the department related to any issue will be responsible for addressing the concerns. The policy indicates the facility shall act upon the concerns and recommendations of the council in a timely manner and make attempts to accommodate the presented recommendations.</p> <p>The facility failed to adequately address and resolve recurring issues reported by the Resident Council. This deficient practice placed the residents at risk for decreased psychosocial well-being and impaired quality of life.</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>41037</p> <p>The facility identified a census of 74 residents. The sample included 18 residents with three reviewed for Center for Medicare and Medicaid Services (CMS) Beneficiary Liability notices. Based on record review and interviews, the facility failed to provide form CMS-10055, Skilled Nursing Facility (SNF) Advance Beneficiary Notice of Non-coverage (ABN) for Resident (R) 3 and R132. This deficient practice placed these residents at risk for uninformed decisions.</p> <p>Findings included:</p> <p>- A review of R3 's Electronic Medical Record (EMR) documented that the Medicare Part A episode began on 07/09/24 and ended on 7/16/24. R3 remained in the facility for custodial care. The facility issued R3 form CMS-R-131 instead of the required CMS-10055.</p> <p>A review of R132 's EMR documented that the Medicare Part A episode began on 01/31/24 and ended on 03/12/24. R33 remained in the facility for custodial care. The facility issued R132 form CMS-R-131 instead of the required CMS-10055.</p> <p>On 10/01/24 at 12:25 PM, Social Services X stated the ABN form the facility had instructed her to use was different from the form CMS-R-131. She stated the regional manager had provided her with an updated CMS-10055 form two weeks ago that she was to start issuing now.</p> <p>The facility's Advance Beneficiary Notices policy dated 11/01/19 documented it was the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. For Part A items and services, the facility would use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), Form CMS-10055. The current CMS-approved version of the forms would be used at the time of issuance to the beneficiary (resident or resident representative). Contents of the form shall comply with related instructions and regulations regarding the use of the form.</p> <p>The facility failed to issue R3 and R132 the correct SNF ABN form CMS-10055. This deficient practice placed these residents at risk for uninformed decisions.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual 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>45668</p> <p>The facility identified a census of 74 residents. The sample included 18 residents. Based on observation, record review, and interviews, the facility failed to promote a safe, homelike environment. This deficient practice had the potential for decreased psychosocial well-being and impaired safety and comfort for the affected residents.</p> <p>Findings Included:</p> <p>- On 09/30/24 at 07:01 AM a walkthrough of the facility was completed with the following observation noted:</p> <p>An inspection of the 100-hallway revealed two wedge cushions, a bathroom commode, a walker, and an intravenous (IV) pole in the hall.</p> <p>An inspection of the 200 hallway revealed a shower bed and two wheelchairs stored out in the resident area.</p> <p>An inspection of the 300 hallway revealed a two-step ladder, walker, and wheelchair stored in the resident area.</p> <p>An inspection of the 400 hallway revealed a wheelchair and Broda chair (specialized wheelchair with the ability to tilt and recline) stored next to the emergency exit in the hall.</p> <p>An inspection of the [NAME] Hall - (left side) bathroom revealed soiled towels on the floor and a rust-colored substance on the floor of the lower tiles of the shower.</p> <p>On 10/01/24 at 01:30 PM, the Resident Council reported repeated concerns related to the cleanliness of the bathroom. The council reported concerns that medical equipment should not be stored in or around the resident common areas. The council stated they have complained to staff multiple times about sanitizing the bathrooms after use and picking up used towels and clothing. The council reported the west hall had only one working shower and the other one could be used to store the equipment until it gets fixed.</p> <p>On 10/01/24 and 10/02/24 the facility made numerous non-emergency overhead pages heard throughout the facility for communication to staff.</p> <p>On 10/02/24 at 10:45 AM inspection of the facility's [NAME] Hall shower room revealed the right shower room was closed due to maintenance issues. An inspection of the left shower room revealed soiled towels on the floor, feces in the toilet, and a reddish rust-like substance on the lower wall inside the shower area.</p> <p>On 10/02/24 at 10:50 AM Housekeeping Staff V stated direct care staff were responsible for cleaning the showers after giving the residents care. He stated cleaning staff usually cleaned the shower rooms daily or when needed.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/02/24 at 02:30 PM Administrative Nurse D stated the facility's 500-hallway was under construction and the equipment was moved into some of the hallways.</p> <p>The facility's Safe and Homelike Environment policy dated 10/25/19 documented in accordance with residents' rights the facility will provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. The facility will maintain comfortable sound levels in the facility Overhead paging will be limited to emergency situations and as needed for providing prompt care and treatment of the residents.</p> <p>The facility failed to promote a safe, homelike environment. This deficient practice had the potential for decreased psychosocial well-being and impaired safety and comfort for the affected residents.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41713</p> <p>The facility identified a census of 74 residents. The sample included 18 residents with two sampled residents reviewed for hospitalization . Based on observation, record review, and interviews, the facility failed to provide written notification of transfer to Resident (R) 45 or their representatives for their facility-initiated transfers. The facility also failed to notify to the long-term care ombudsman (LTCO) for R45. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunities for healthcare service for R45.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- R45's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia and hemiparesis (weakness and paralysis on one side of the body), and a pressure ulcer (localized injury to the skin and underlying tissue usually over a bony).</li> </ul> <p>R45's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero which indicated a severely impaired cognition. R45 had impairment on both sides of his upper and lower extremities. R45 required the use of a Broda chair (specialized wheelchair with the ability to tilt and recline) for mobility. R45 was dependent on staff for all functional abilities. R45 was always incontinent of bowel and bladder. R45 required enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food).</p> <p>R45's Quarterly MDS dated [DATE] documented both long and short-term memory loss and severely impaired cognitive skills for daily decision-making. R45 had impairment on both sides of his upper and lower extremities. R45 required the use of a Broda chair for mobility. R45 was dependent on staff for all functional abilities. R45 was always incontinent of bowel and bladder. R45 required enteral nutrition.</p> <p>R45's Cognition Care Area assessment dated [DATE] documented R45 had cognitive loss and memory loss.</p> <p>R45's Care Plan directed staff that R45 planned to remain in the facility. Staff was directed to provide services according to his care plan to enhance optimum functioning and well-being.</p> <p>R45's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated.</p> <p>R45's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated.</p> <p>R45's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility was unable to provide evidence that written notification of transfer was issued for R45 for the hospitalizations on 11/27/24, 04/09/24, and 09/04/24.</p> <p>The facility was unable to provide evidence that the LTCO was notified of R45's facility-initiated transfers to the hospital on 11/27/23, 04/09/2, or 09/04/24.</p> <p>On 10/02/24 at 09:34 AM R45 lay in bed, with the head of the bed elevated slightly. His enteral nutrition infused via a kangaroo pump (a portable pump used to deliver enteral nutrition). R45's left knee was propped on a pillow.</p> <p>On 10/01/24 at 11:52 AM, Administrative Staff B stated the facility had not been doing the bed hold or the written notification as they should have been. Administrative Staff B stated the written notification of transfer should be provided to the resident and the resident representative for each discharge as well as the notification sent to the LTCO.</p> <p>On 10/02/24 at 10:5 AM Social Services X stated that the written notification of transfers had not been done. Social Services X stated the facility had started a Performance Improvement Plan (PIP) on 04/01/24 to improve on submitting the discharge reports to the LTCO but had not provided the written notification of transfers as they should have.</p> <p>The facility did not provide a policy regarding notification of transfer or notification to the LTCO as requested.</p> <p>The facility failed to provide written notification of transfer to R45 or their representatives for their facility-initiated transfers. The facility failed to provide notification to the LTCO for R45. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunities for healthcare service for R45.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41713</p> <p>The facility identified a census of 74 residents. The sample included 18 residents with two sampled residents reviewed for hospitalization . Based on observation, record review, and interviews, the facility failed to provide a bed hold policy notice to Resident (R) 45 or their representatives when they transferred to the hospital. This deficient practice had the risk of impaired ability to return to the facility and to his previous room for R45.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- R45's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia and hemiparesis (weakness and paralysis on one side of the body), and a pressure ulcer (localized injury to the skin and underlying tissue usually over a bony).</li> </ul> <p>R45's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero which indicated a severely impaired cognition. R45 had impairment on both sides of his upper and lower extremities. R45 required the use of a Broda chair (specialized wheelchair with the ability to tilt and recline) for mobility. R45 was dependent on staff for all functional abilities. R45 was always incontinent of bowel and bladder. R45 required enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food).</p> <p>R45's Quarterly MDS dated [DATE] documented both long and short-term memory loss and severely impaired cognitive skills for daily decision-making. R45 had impairment on both sides of his upper and lower extremities. R45 required the use of a Broda chair for mobility. R45 was dependent on staff for all functional abilities. R45 was always incontinent of bowel and bladder. R45 required enteral nutrition.</p> <p>R45's Cognition Care Area assessment dated [DATE] documented R45 had cognitive loss and memory loss.</p> <p>R45's Care Plan directed staff that R45 planned to remain in the facility. Staff was directed to provide services according to his care plan in an effort to enhance optimum functioning and well-being.</p> <p>R45's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated.</p> <p>R45's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated.</p> <p>R45's Discharge MDS dated [DATE] documented he had an unplanned discharge to a short-term acute hospital with a return anticipated.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility was unable to provide evidence a bed hold was issued for R45 for the hospitalization s on 11/27/23 or 09/04/24.</p> <p>On 10/02/24 at 09:34 AM R45 lay in bed, with the head of the bed elevated slightly. His enteral nutrition infused via a kangaroo pump (a portable pump used to deliver enteral nutrition). R45's left knee was propped on a pillow.</p> <p>On 10/01/24 at 11:52 AM, Administrative Staff B provided R45's bed hold notice for 04/09/24. Administrative Staff B stated the facility had not been doing the bed hold or the written notification as they should have been. Administrative Staff B stated the bed hold should be provided to the resident and the resident representative for each discharge.</p> <p>The facility's Bed Hold Notice Upon Transfer policy, not dated, directed at the time of transfer for hospitalization or therapeutic leave, the facility provided the resident and/or their representative a written notice that specified the duration of the bed-hold policy and addressed information explaining the return of the resident to the next available bed.</p> <p>The facility failed to provide a bed hold notice to R45 or their representative when R45 was transferred to the hospital. This deficient practice had the risk of impaired ability to return to the facility or the same room for R45.</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41713</p> <p>The facility identified a census of 74 residents. The sample included 18 residents. Based on observation, record review, and interviews, the facility failed to fully complete the annual comprehensive Minimum Data Set (MDS) for Resident (R) 45 by not completing documentation analysis for triggered care areas. This placed this resident at risk for inaccurate reflections of the resident's status and an inaccurate care plan.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- R45's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia and hemiparesis (weakness and paralysis on one side of the body), and a pressure ulcer (localized injury to the skin and underlying tissue usually over a bony area).</li> </ul> <p>R45's Annual MDS dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero which indicated a severely impaired cognition. R45 had impairment on both sides of his upper and lower extremities. R45 required the use of a Broda chair (specialized wheelchair with the ability to tilt and recline) for mobility. R45 was dependent on staff for all functional abilities. R45 was always incontinent of bowel and bladder. R45 required enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food).</p> <p>R45's Quarterly MDS dated [DATE] documented both long and short-term memory loss and severely impaired cognitive skills for daily decision-making. R45 had impairment on both sides of his upper and lower extremities. R45 required the use of a Broda chair for mobility. R45 was dependent on staff for all functional abilities. R45 was always incontinent of bowel and bladder. R45 required enteral nutrition.</p> <p>R45's Cognition Care Area Assessment (CAA) dated 08/01/24 documented R45 had cognitive loss and memory loss.</p> <p>R45's CAA dated 08/01/24 lacked documented analysis of findings for the triggered care areas for communication, urinary incontinence, psychosocial well-being, activities, falls, feeding tube (tube for introducing high-calorie fluids into the stomach), pressure ulcer, and pain.</p> <p>R45's Care Plan last revised on 08/09/24 directed staff that R45 was dependent on staff for all functional abilities due to his medical condition. Staff was directed to provide services according to his care plan to enhance optimum functioning and well-being.</p> <p>On 10/02/24 at 09:34 AM R45 lay in bed, with the head of the bed elevated slightly. His enteral nutrition infused via a kangaroo pump (a portable pump used to deliver enteral nutrition). R45's left knee was propped on a pillow.</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/02/24 at 02:06 PM Administrative Nurse F stated either she or the unit nurses completed the MDS assessments and then the assessments would be given to the MDS coordinator when she was at the facility. Administrative Nurse F stated the MDS coordinator was responsible for completing the CAA and updating of the care plans.</p> <p>On 10/02/24 at 02:24 PM Administrative Nurse D stated the MDS coordinator was responsible for ensuring that the MDS was completed including the CAA all the information was documented and the care plan was updated.</p> <p>The undated facility Resident Assessment - RAI policy documented: Documentation of the summary information regarding the additional assessment performed on the care areas triggered by the completion of the MDS. The assessment process would include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.</p> <p>The facility failed to ensure staff fully completed the annual comprehensive MDS for R45 when staff did not complete the documentation analysis for triggered care areas. This placed R45 at risk for inaccurate reflections of the resident's status and an incomplete comprehensive plan of care.</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>45668</p> <p>The facility reported a census of 74 residents. The sample included 18 residents with two reviewed for activities of daily living (ADLs). Based on records review, interviews, and observations, the facility failed to provide the required ADL assistance for Resident (R)11 for dressing. This deficient practice placed R11 at risk for impaired independence and a loss of ADL function.</p> <p>Findings Including:</p> <ul style="list-style-type: none"> <li>- The Medical Diagnosis section within R11's Electronic Medical Records (EMR) included diagnoses of altered mental status, cognitive communication deficit, major depressive disorder (major mood disorder), and unsteadiness on his feet.</li> </ul> <p>R11s Annual Minimum Data Set (MDS) completed 08/12/24 noted a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. The MDS indicated he required supervision or touch assistance for dressing and personal hygiene. The MDS indicated he required partial to moderate assistance from staff for bathing, transfers, and toileting. The MDS indicated he required set-up assistance from staff for meals. The MDS indicated he was at risk but had no pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) or skin impairments.</p> <p>R11's Functional Abilities Care Area Assessment (CAA) completed 08/25/24 indicated staff will assist with care as needed. The CAA instructed staff to anticipate his care needs and promote his independence.</p> <p>R11's Care Plan initiated 05/28/24 indicated he required supervision or touch assistance with bathing, transfers, toileting, personal hygiene, dressing, and meals. The plan instructed staff to allow adequate time to express his needs and ensure he understood staff requests.</p> <p>On 09/30/24 at 07:45 AM R11 sat at his bedside with his pants around his ankle. R11's bed was next to his room's door. R11 had an incontinence brief on. R11 stood up several times to pull his pants up but was unable. R11 sat back down on his bed. At 08:09 AM R11 reported he was having difficulty with pulling his pants up. He reported staff would often come in to assist him, but they may be busy. At 08:15 R11 was able to maneuver his feet, raise his pants, and pull them up over his brief. R11 reported staff brought his meals but did not supervise or help during meals.</p> <p>On 10/02/24 at 10:31 AM Certified Nurses Aide (CNA) QQ stated some residents may require assistance for dressing in their rooms and staff should provide assistance when needed. She stated R11 was more independent and would often try to dress himself. She states staff should provide supervision to ensure his needs are met and he is safe.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/02/24 at 10:40 AM Licensed Nurse (LN) G stated all staff had access to the care plan and what level of assistance each resident required. She stated some residents required assistance from staff for ADL care. She stated staff expected to review the level of assistance listed in the care plans and provide it. She stated staff were expected to check the residents while in their rooms to see if they needed assistance or wanted something.</p> <p>On 10/02/24 at 02:30 PM Administrative Nurse D stated staff were expected to assist the residents per their care-planned needs. She stated staff should ensure the residents were safe in their rooms and the call lights were within reach.</p> <p>The facility's Activities of Daily Living (ADLs) policy revised 10/2019 indicated the facility will assess each resident's needs based upon the comprehensive assessment. The policy indicates the facility will identify the level of assistance needed for each resident and ensure staff follows the care-planned interventions. The policy noted interventions will be routinely monitored for effectiveness.</p> <p>The facility failed to provide assistance for R11 with dressing. This deficient practice placed R11 at risk for impaired independence with a loss of ADL function.</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>49634</p> <p>The facility identified a census of 74 residents. The sample included 18 residents with one resident reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to follow a physician's order for weight monitoring for fluid overload and further failed to ensure Resident (R) 73's as-needed (PRN) diuretic (a medication used to promote formation and excretion of urine) was administered per orders when needed. This deficient practice placed R73 at risk for fluid overload and related complications.</p> <p>Findings included:</p> <p>- R73's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), malnutrition (lack of proper nutrition, caused by not having enough to eat), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and blindness of both eyes.</p> <p>The Quarterly Minimum Data Set (MDS) for R73 dated 08/20/24 recorded a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R73 was dependent on staff for eating, bathing, toileting, and dressing. The MDS documented R73 was not on a diuretic during the observation period.</p> <p>R73's Urinary Incontinent and Indwelling Catheter Care Area Assessment (CAA) dated 02/26/24 documented R73 was dependent on staff for toileting transfer and toileting hygiene. R73 was frequently incontinent of urine during the observation period.</p> <p>R73's Care Plan revised on 06/10/24 documented R73 had CHF and was at risk of developing complications. Staff were to administer medication as ordered and monitor for effectiveness.</p> <p>A review of the EMR under the Orders tab revealed the following physician orders:</p> <p>Weekly weights every dayshift on Mondays dated 09/23/24.</p> <p>Furosemide (a diuretic) oral tablet every 24 hours as needed for fluid overload/CHF taken for a weight gain of greater than three pounds in one day, and five pounds in two days dated 09/20/24.</p> <p>A review of R73's EMR under the Weights and Vitals tab revealed the following recorded weights:</p> <p>On 09/23/24 weight of 142.0 pounds.</p> <p>On 09/24/24 weight of 150.0 pounds.</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>On 09/25/24 weight of 154.0 pounds.</p> <p>On 09/30/24 weight of 125.8 pounds.</p> <p>On 10/01/24 weighed 124.0 pounds.</p> <p>R73's Treatment Administration Record (TAR) documented that the PRN furosemide was not given from 09/20/24-10/01/24.</p> <p>On 09/30/24 at 07:05 AM R73 laid in bed on her right side. R73 was asleep.</p> <p>On 10/01/24 at 06:52 AM R73 lay in bed. R73 was on her right side. R73 was asleep.</p> <p>On 10/02/24 at 10:01 AM Certified Nurse's Aide (CNA) QQ stated nursing would make a list of anyone who needed to be weighed. She stated the aides obtained the weights and returned the list to the nurse.</p> <p>On 10/02/24 at 10:17 AM Licensed Nurse (LN) G stated nurses gave the CNA staff a list of residents needed weighted for the day. LN G stated the nurse should follow up to ensure the weights were done and call the physician if needed.</p> <p>On 10/02/24 at 02:24 PM Administrative Nurse D stated nursing was to ensure weights were obtained. Administrative Nurse D said nurses would then report to the physician or follow the orders as prescribed.</p> <p>The facility's Accommodation of Needs policy documented the facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered.</p> <p>The facility failed to follow a physician's order for weight monitoring for fluid overload and further failed to ensure R73's PRN diuretic was administered per orders when needed. This deficient practice placed R73 at risk for fluid overload and related complications.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49634</p> <p>The facility identified a census of 74 residents. The sample included 18 residents with one resident reviewed for positioning and mobility. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)47's palm splint was available. This deficient practice placed the resident at risk for discomfort and decreased range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension).</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- R47's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN-elevated blood pressure), hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following a cerebral infarction (stroke - the sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting the right dominant side, aphasia (condition with disordered or absent language function), and anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues).</li> </ul> <p>R47's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R47 was impaired on one side of his body. The MDS documented R47 needed substantial to maximum assistance with oral hygiene, bathing, toileting, dressing, and cueing or touching assistance with eating. The MDS documented R47 did not receive restorative care or physical therapy during the observation period.</p> <p>R47's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 01/14/24 documented R47 was at risk for impaired functional abilities related to chronic conditions with hemiplegia. R47's CAA documented he would need nursing and care staff to continue to observe activities of daily living (ADL) function and aid as indicated.</p> <p>R47's Care Plan revised 08/04/24 documented R47 was at risk for skin breakdown due to hemiplegia and hemiparesis following a cerebral infarction affecting his right dominant side. R47's plan of care documented R47 was to wear a palm protector to the right hand as tolerated throughout the day.</p> <p>R47's EMR under Task lacked direction for staff to apply the palm splint.</p> <p>R47's EMR lacked documentation or evidence of any refusals to wear the plan splint on 10/01/24.</p> <p>On 10/01/24 at 09:01 AM R47 laid in his bed on his back. R47 's fingers on his right hand were curled and his hand was closed. R47 pointed to his right hand. R47 did not have his splint in his palm.</p> <p>On 10/01/24 at 01:55 AM R47 laid in his bed on his back on his bed watching a cartoon, R47's right arm lay under the blanket, his fingers were curled, and his hand was closed. R47 pointed to his right hand, R47 did not have his splint in his palm.</p> <p>(continued on next page)</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>On 10/02/24 at 10:23 AM Certified Nurse's Aide (CNA) RR stated staff would know what devices each resident needed either by the resident's care plan or in the nursing report each morning. CNA RR said occasionally therapy hangs a list on each resident's wall.</p> <p>On 10/02/24 at 10:34 AM Licensed Nurse (LN) G stated all staff have access to care plans. She stated if the nursing staff does not check the care plan, therapies usually hang a duty list for devices in each resident's room. LN G stated it was the duty of all nurses to ensure residents have and use their devices.</p> <p>On 10/02/24 at 02:26 PM, Administrative Nurse D stated she expected each staff to read or know what the resident's care plan states. She said she expected an order to be placed on the EMR for splints and devices to so that nursing staff had a second check to ensure all devices were being placed.</p> <p>The facility's Prevention of Decline in Range of Motion policy documented residents who enter the facility without a limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion was unavoidable.</p> <p>The facility failed to ensure R47 palm splint was placed in his right palm. This deficient practice placed the resident at risk for discomfort and decreased ROM.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45668</p> <p>The facility identified a census of 74 residents. The sample included 18 with three reviewed for accidents. Based on observation, record review, and interview the facility failed to secure potentially hazardous cleaning chemicals in a safe, locked area, and out of reach of ten cognitively impaired independently mobile residents. The facility additionally failed to ensure implemented care-planned fall interventions were in place for Resident (R)9 and R73. This placed the affected residents at risk for preventable accidents and injuries.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> <li>- On 09/30/24 at 07:10 AM an inspection of the 300 hallway revealed a bottle of purple Sani-wipes left unsecured on a table in the television area. The bottle contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed.</li> </ul> <p>An inspection of the 500 Hallway revealed an unlocked shower room. An inspection of the room revealed an unlocked cabinet that contained a bottle of Virex II disinfecting solution. The bottle contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed.</p> <p>On 10/02/24 at 10:02 AM, Certified Nurse's Aide (CNA) QQ stated cleaning products should be kept locked up when not being used or supervised.</p> <p>On 10/02/24 at 10:31 AM, Licensed Nurse (LN) G stated cleaning wipes and bottles were to be locked up in the utility closet and away from the residents.</p> <p>On 10/02/24 at 02:30 PM Administrative Nurse D stated staff were expected to lock up the cleaning chemicals when not in use.</p> <p>The facility's Accidents and Supervision policy revised 11/2017 indicated the facility will ensure an environment free from potentially hazardous materials, chemicals, and equipment.</p> <p>The facility failed to ensure a safe environment free from hazardous chemicals for ten cognitively impaired independently mobile residents. This deficient practice placed the residents at risk for preventable accidents and injuries.</p> <ul style="list-style-type: none"> <li>- The Medical Diagnosis section within R9's Electronic Medical Records (EMR) included diagnoses of Huntington's disease (a rare abnormal hereditary condition characterized by progressive mental deterioration, a disabling central nervous system movement disorder), dysphagia (difficulty swallowing), muscle weakness, quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), restlessness, and agitation.</li> </ul> <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 - Some</p>	<p>R9's Quarterly Minimum Data Set (MDS) completed on 09/06/24 noted a Brief Interview for Mental Status (BIMS) score of zero indicating severe cognitive impairment. The MDS indicated both upper and lower extremity impairments. The MDS indicated he required total staff assistance for bathing, dressing, bed mobility, transfers, personal hygiene, and toileting.</p> <p>R9's Falls Care Area Assessment (CAA) completed on 12/01/23 indicated he was at risk related to his medical diagnoses. The CAA indicated his interdisciplinary team will continue to assess his fall risks and provide interventions to minimize the risks.</p> <p>R9's Care Plan initiated 01/06/20 indicated he was at risk for an activities of daily living (ADLs) decline and falls related to his medical diagnoses. The plan indicated he required total staff assistance with bathing, transfers, dressing, bed mobility, personal hygiene, and toileting. The plan indicated he was at risk for falls and injuries related to his Huntington's disease. The plan instructed staff to anticipate his needs and provide prompt responses to his requests. The plan instructed staff to ensure his bed remained in a low position when occupied and provide a landing mat for injury prevention.</p> <p>On 09/30/24 at 08:16 AM R9 slept in his bed. His bed was in a low position. His bed contained a low air-loss mattress and mattress bolsters. The room lacked a landing pad next to R9's bed.</p> <p>On 10/02/24 at 07:06 AM R9 slept in his bed. R9's bed was in a high position with no landing mat next to his bed. At 08:30 AM his bed remained in the high position with no landing mat in place.</p> <p>On 10/02/24 at 10:01 AM Certified Nurses Aid (CNA) G stated fall interventions could be viewed on the resident's care plan. She stated staff should review the plans to ensure the fall interventions were in place for each resident. She stated R9 should have a fall mat due to his high fall risk.</p> <p>On 10/02/24 at 10:17 AM Licensed Nurse (LN) G stated R9 should have a fall mat and his bed was to be in a low position.</p> <p>On 10/02/24 at 02:24 PM Administrative Nurse D stated staff were expected to ensure all intervention put in place for the residents was used. She stated staff were expected to read the care plans.</p> <p>The facility's Accidents and Supervision policy revised 11/2017 indicated the facility will ensure all residents are assessed for potential fall risk and provided individualized interventions. The policy noted the facility staff will monitor that interventions were implemented correctly and consistently.</p> <p>The facility failed to promote a safe care environment related to implementing his care-planned fall mat and ensuring his bed remained in a low position. This deficient practice placed the resident at risk for falls and related injuries.</p> <p>49634</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 - Some</p>	<p>- R73's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), malnutrition (lack of proper nutrition, caused by not having enough to eat), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and blindness of both eyes.</p> <p>The Quarterly Minimum Data Set (MDS) for R73 dated 08/20/24 recorded a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R73 had one fall since admission. The MDS documented R73 was dependent on staff for eating, bathing, toileting, and dressing.</p> <p>R73's Falls Care Area assessment dated [DATE] documented R73 was at risk for falls related to general weakness, impaired mobility, and use of psychotropic (alters mood or thought) medications. R73 needed nursing to continue to assess fall risks and provide interventions to minimize risks.</p> <p>R73's Care Plan dated 04/13/24 documented R73 was at risk for fall-related injury due to dementia and blindness of both eyes. R73's plan of care dated 06/10/24 documented that staff was to make sure R73's call light was within her reach. R73 had a fall on 07/10/24, with the intervention of a wedge to be placed on R73's side to ensure the resident does not slide out of bed. R73 had a fall on 07/23/24; the intervention was bolsters for her bed. R73 had a fall on 08/31/24, the intervention was a fall mat at the bedside. On 09/22/24 R73 had a fall, and the intervention for her fall was her bedroom was rearranged and the fall mat reapplied.</p> <p>On 09/30/24 at 07:05 AM R73 laid in bed on her right side. R73's wedge was at the bottom of her bed.</p> <p>On 10/01/24 at 06:52 AM R73 lay in bed. R73 was on her right side. R73's pancake call light lay at the bottom of the bed, on the air conditioner, out of her reach. R73's wedge was in her Broda chair (specialized wheelchair with the ability to tilt and recline), with her boots.</p> <p>On 10/02/24 at 10:01 AM Certified Nurse's Aide (CNA) QQ stated fall interventions could be viewed on the resident's care plan. She stated staff should review the plans to ensure the fall interventions were in place for each resident. She stated R73's call light was to be placed within her reach and the wedge should have been in place.</p> <p>On 10/02/24 at 10:17 AM Licensed Nurse (LN) G stated if the intervention was to ensure R73's call light was within reach and a wedge to her side, all the nurses were responsible for ensuring those things were in place.</p> <p>On 10/02/24 at 02:24 PM Administrative Nurse D stated staff were expected to ensure all interventions put in place for the residents were implemented appropriately. She stated staff were expected to read the care plans.</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 - Some</p>	<p>The facility's Accidents and Supervision policy revised 11/2017 indicated the facility will ensure all residents are assessed for potential fall risk and provided individualized interventions. The policy noted the facility staff will monitor that interventions were implemented correctly and consistently.</p> <p>The facility failed to ensure R73's call light was within her reach and further failed to ensure R73's wedge was placed appropriately to ensure she would not roll out of bed. This deficient practice placed R73 at risk for further falls.</p>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>41037</p> <p>The facility identified a census of 74 residents. The sample included 18 residents and five Certified Nurse Aides (CNA) were reviewed for yearly performance evaluations and the associated in-service training. Based on record review and interview, the facility failed to ensure three of the five CNA staff reviewed had yearly performance evaluations completed. This placed the residents at risk for inadequate care.</p> <p>Findings included:</p> <p>- A review of the facility's staffing list revealed the following:</p> <p>CNA N, hired on 09/01/22, had no yearly performance evaluation upon request.</p> <p>CNA P, hired 09/07/22, had no yearly performance evaluation upon request.</p> <p>CNA Q, hired on 11/15/22, had no yearly performance evaluation upon request.</p> <p>On 10/01/24 at 01:28 PM Administrative Staff C stated she did not have the performance reviews for the three CNAs.</p> <p>On 10/02/24 at 02:24 PM, Administrative Nurse D stated she was responsible for completing the nursing staff's yearly performance reviews.</p> <p>The facility 's Evaluation Process policy dated 12/01/19 documented it was the policy of our facility to review the work performance of employees with a formal written evaluation annually.</p> <p>The facility failed to ensure three of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>49634</p> <p>The facility identified a census of 74 residents, two medication rooms, and five medication carts. Based on observation, record review, and interviews, the facility failed to ensure controlled substances were accounted for and reconciled between shifts. This placed the residents at risk for misappropriation and/or diversion of controlled substances.</p> <p>Findings included:</p> <p>- On 10/01/24 at 07:24 AM a review of the July, August, and September 2024 Narcotic Shift Count Sheet on the 500 and the 600 halls revealed a missing signature either for the on-coming nurse or the off-going nurse for the morning shift on 07/29, 09/01, 09/06, 09/11, 09/12, 09/14, 09/15, 09/16, 09/18, 09/22, and 09/25.</p> <p>On 10/01/24 at 07:34 PM a review of the July, August, and September 2024 Narcotic Hand Off Count Sheet on the 500 and 600 halls revealed a missing signature either for the on-coming nurse signature or the off-going nurse for the evening shift on 07/29, 08/05, 08/07, 09/06, 09/08, 09/11, 09/12, 09/14, 09/15, 09/16, 09/18, and 09/22.</p> <p>On 10/01/24 at 10:34 AM Licensed Nurse (LN) G stated each nurse or Certified Medication Aide (CMA) was to count on the on-coming and off-going nurse daily. She stated nursing staff were not supposed to leave the facility until the narcotic count was correct.</p> <p>On 10/02/24 at 02:26 PM Administrative Nurse D said she expected anyone on the medication carts to count with the oncoming nurse each shift.</p> <p>The facility's Controlled Substance Administration and Accountability policy dated 01/01/2020 documented that the facility was to promote safe, high-quality patient care compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility would have safeguards in place to prevent loss, diversion, or accidental exposure.</p> <p>The facility failed to ensure an accurate reconciliation of controlled medications was completed. This placed residents at risk of medication misappropriation and diversion.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41713</p> <p>The facility identified a census of 74 residents. The sample included 18 residents with five sample residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported when Resident (R) 67's blood pressure medication was given outside of the physician-ordered parameter. This placed R67 at risk for unnecessary medication administration and adverse side effects.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- R67's Electronic Medical Record (EMR) documented diagnoses of respiratory failure (inadequate gas exchange by the respiratory system), and hepatic failure (a condition that can occur when the liver is damaged and can no longer function properly).</li> </ul> <p>R67's Annual Minimum Data Set (MDS) dated [DATE] documented that R67 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R67 was independent with her functional abilities. R67 used a wheelchair for mobility.</p> <p>R67's Quarterly MDS dated [DATE] documented R67 had a BIMS score of 15 which indicated intact cognition. R67 required set up to partial assistance with her functional abilities. R67 used a wheelchair for mobility. R67 received insulin (a hormone that lowers the level of glucose in the blood) injections during the observation period.</p> <p>R67's Functional Ability Care Area Assessment (CAA) dated 04/28/24 documented she had impaired functional abilities due to general weakness, impaired balance, and mobility.</p> <p>R67's Care Plan last revised 07/31/24 directed staff to administer medications as directed. Staff was to monitor and document for side effects and effectiveness.</p> <p>R67's Orders tab of the EMR documented a physician's order dated 05/01/24 for midodrine (a medication used to increase blood pressure), give one five milligrams (mg) tablet by mouth three times a day for low blood pressure (BP). If the systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) is over 130 millimeters (mm) of Mercury (Hg), hold the medication. This order was discontinued on 07/03/24.</p> <p>R67's Orders tab of the EMR documented a physician's order dated 07/04/24 for midodrine to give one five mg tablet by mouth three times a day for low blood pressure. If the SBP was over 130 mm/Hg hold the medication.</p> <p>A review of R67's Medication Administration Record (MAR) for June 2024 revealed her midodrine was administered outside of the physician-ordered parameter on six of 90 opportunities.</p> <p>A review of R67's Medication Administration Record (MAR) for July 2024 revealed her midodrine was administered outside of the physician-ordered parameter on four of 93 opportunities.</p> <p>(continued on next page)</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>A review of R67's Medication Administration Record (MAR) for August 2024 revealed her midodrine was administered outside of the physician-ordered parameter on 12 of 93 opportunities.</p> <p>A review of R67's Medication Administration Record (MAR) for September 2024 revealed her midodrine was administered outside of the physician-ordered parameter on two of 90 opportunities.</p> <p>A review of the CP's Note to Attending Physician/Prescriber recommendations from July 2023 to present for R67 revealed no evidence that the CP made a recommendation to ensure staff administered midodrine within the physician's ordered parameter.</p> <p>On 10/02/24 at 02:24 PM Administrative Nurse D stated the pharmacist made recommendations monthly and were reviewed and forwarded to the physician for responses. Administrative Nurse D stated she would expect the CP to make a recommendation when medication had been given and when it should have been held. Administrative Nurse D stated it was also the responsibility of the nurse administering the medication to make sure the physician's recommended parameter was followed.</p> <p>The facility did not provide a policy for pharmacy recommendations as requested.</p> <p>The facility failed to ensure the CP identified and reported when R67's midodrine was given outside of the physician-ordered parameter. This placed R67 at risk for unnecessary medication administration and adverse side effects.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713</b></p> <p>The facility identified a census of 74 residents. The sample included 18 residents with five sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 67's blood pressure medication was given within the physician-ordered parameter. This placed R67 at risk for unnecessary medication administration and adverse side effects.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- R67's Electronic Medical Record (EMR) documented diagnoses of respiratory failure (inadequate gas exchange by the respiratory system), and hepatic failure (a condition that can occur when the liver is damaged and can no longer function properly).</li> </ul> <p>R67's Annual Minimum Data Set (MDS) dated [DATE] documented that R67 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R67 was independent with her functional abilities. R67 used a wheelchair for mobility.</p> <p>R67's Quarterly MDS dated [DATE] documented R67 had a BIMS score of 15 which indicated intact cognition. R67 required set up to partial assistance with her functional abilities. R67 used a wheelchair for mobility. R67 received insulin (a hormone that lowers the level of glucose in the blood) injections during the observation period.</p> <p>R67's Functional Ability Care Area Assessment (CAA) dated 04/28/24 documented she had impaired functional abilities due to general weakness, impaired balance, and mobility.</p> <p>R67's Care Plan last revised 07/31/24 directed staff to administer medications as directed. Staff was to monitor and document for side effects and effectiveness.</p> <p>R67's Orders tab of the EMR documented a physician's order dated 05/01/24 for midodrine (a medication used to increase blood pressure), give one five milligrams (mg) tablet by mouth three times a day for low blood pressure (BP). If the systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) is over 130 millimeters (mm) of Mercury (Hg), hold the medication. This order was discontinued on 07/03/24.</p> <p>R67's Orders tab of the EMR documented a physician's order dated 07/04/24 for midodrine to give one five mg tablet by mouth three times a day for low blood pressure. If the SBP was over 130 mm/Hg hold the medication.</p> <p>A review of R67's Medication Administration Record (MAR) for June 2024 revealed her midodrine was administered outside of the physician-ordered parameter on six of 90 opportunities.</p> <p>A review of R67's MAR for July 2024 revealed her midodrine was administered outside of the physician-ordered parameter on four of 93 opportunities.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of R67's MAR for August 2024 revealed her midodrine was administered outside of the physician-ordered parameter on 12 of 93 opportunities.</p> <p>A review of R67's MAR for September 2024 revealed her midodrine was administered outside of the physician-ordered parameter on two of 90 opportunities.</p> <p>On 10/01/24 at 10:38 AM R67 self-propelled herself in her wheelchair to the dining room to play bingo.</p> <p>On 10/02/24 at 01:25 PM Licensed Nurse (LN) G stated that R67 did have parameters for her midodrine and should not be given when her SBP was over 130 mm/Hg. LN G stated that the blood pressure was documented before medication was given but did not recall that the module would flag a notification when the reading was outside the written parameter.</p> <p>On 10/02/24 at 02:24 PM Administrative Nurse D stated she would expect staff to hold a medication when a blood pressure was outside of the parameters. Administrative Nurse D stated it was the responsibility of the nurse administering the medication to make sure the physician's recommended parameter was followed.</p> <p>The undated facility policy Medication Administration documented that medications were to be administered by licensed nurses, or other staff who were legally authorized to do so in this state, as ordered by the physician and in accordance with the professional standard of practice, in a manner to prevent contamination or infection. Obtain and record vital signs. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.</p> <p>The facility failed to ensure R67's midodrine was given within the physician-ordered parameters. This placed R67 at risk for unnecessary medication administration and adverse side effects.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>41713</p> <p>The facility identified a census of 74 residents. The facility identified one main kitchen and one dining room. Based on observation, record review, and interview the facility failed to ensure dietary staff provided posted menu items to residents when the kitchen ran out of bacon and sausage for the breakfast meal on 09/30/24. This placed residents at risk of nutritional needs and preferences not being met.</p> <p>Findings included:</p> <p>- Observation of the breakfast meal on 09/30/24 at 08:30 AM in the dining revealed Resident (R) 6, R25, R75, R24, and R182 complained the menu for breakfast said they should get either bacon or sausage. R24 further stated that the kitchen would frequently run out of food on the weekend, the menu items were not available and all they would get would be a grilled cheese sandwich and some chips. R24 stated the kitchen today did not offer any alternative for not having the bacon or sausage and did not have extra eggs available if wanted. The resident's plates when served had toast, scrambled eggs, and jelly on them.</p> <p>The Week At A Glance - Week1 Menu for Monday Day 2 (09/30/24) documented for Breakfast: Assorted juice, choice of hot or cold cereal, egg of choice, two strips of bacon or sausage, toast, margarine and syrup, and milk or beverage.</p> <p>On 10/02/24 at 10:58 AM Consultant HH reported she was unaware that the facility had run out of protein products. Consultant HH stated she had received no concerns from the staff or residents she had spoken to about shortages of food.</p> <p>On 10/02/24 at 01:48 PM, Dietary BB stated that she was aware that some residents did not receive bacon or sausage on 09/30/24.</p> <p>Dietary BB stated that the kitchen had run out of those items and was not able to serve all residents the bacon or sausage.</p> <p>The facility failed to ensure dietary staff provided posted menu items to residents when the kitchen ran out of bacon and sausage for the breakfast meal on 09/30/24. This placed residents at risk of nutritional needs and preferences not being met.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  175123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/02/2024
NAME OF PROVIDER OR SUPPLIER  Merriam Gardens Healthcare & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 9700 W 62nd Street Merriam, KS 66203	
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>45668</p> <p>The facility identified a census of 74 residents. The sample included 18 residents with two reviewed for nutritive diets. Based on observation, record review, and interviews, the facility failed to ensure meals were served at a palatable, safe, and appetizing temperature for Residents (R)8, R11, R24, and R27. This deficient practice placed the residents at risk for risks related to impaired nutrition and weight loss.</p> <p>Findings Included:</p> <p>- On 09/30/24 at 07:14 AM R24 sat in the dining room. R24 stated he was waiting for breakfast. He stated the food was often served cold. He stated even the food coming out of the kitchen to the dining room was often served cold.</p> <p>On 09/30/24 at 08:25 AM, R27 sat in his room preparing for breakfast. R27 reported his breakfast was often cold by the time it reached him. A temperature check of his eggs revealed them to be at 90 degrees Fahrenheit. His oatmeal was at 107 degrees Fahrenheit.</p> <p>On 09/30/24 at 08:34 AM, R11 sat in his room at the side of his bed. He reported that the facility's food was often cold and lacked alternative options.</p> <p>On 09/30/24 at 09:00 AM, R32 stated meals served in the rooms were often cold.</p> <p>On 10/01/24 at 08:10 AM, R24 was served his breakfast in the dining room. R24 reported his eggs and oatmeal were not warm. A temperature check of his eggs revealed them to be at 97 degrees Fahrenheit. His oatmeal was 101 degrees Fahrenheit upon testing. His sausage patty tested at 98 degrees Fahrenheit.</p> <p>On 10/01/24 at 12:30 PM, R11 sat at his bedside in his room. He reported he just got his meal. He stated that the chicken sandwich was cold and not good. He stated he wanted pizza but was not offered it. A temperature check of his chicken patty revealed it was 108 degrees Fahrenheit.</p> <p>On 10/01/24 at 01:30 PM, the facility's Resident Council reported continued concerns related to cold food being served in the dining and resident's rooms.</p> <p>On 10/02/24 at 08:05 AM, R24 was served his breakfast in the dining room. A temperature check of his meal was completed. His biscuits and sausage gravy tested at 104 degrees Fahrenheit, and his oatmeal was 109 degrees Fahrenheit after stirring.</p> <p>On 10/02/24 at 08:33 AM, R8 sat in the hallway outside her room. R8 reported her food was cold and needed sugar. A temperature check of her meal revealed her oatmeal was 101 degrees Fahrenheit. Her biscuits and sausage gravy tested at 98 degrees Fahrenheit.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/02/24 at 10:22 AM, Certified Nurse's Aide (CNA) QQ stated staff signed out the carts from the kitchen and delivered them directly to the residents. She stated she was not sure how long the meals sit on the cart before staff get them. She stated she sometimes had to warm up the meals for residents.</p> <p>On 10/02/24 at 10:40 AM Licensed Nurse (LN) G stated the food carts were often delivered to the unit within 15 minutes of being served. She stated the meals should never be served cold, but the residents would often complain about the food temperatures. She stated staff could heat the meals up if needed.</p> <p>On 10/02/24 at 11:21 AM Dietary Staff BB stated the meals were prepped and placed on the serving racks for staff to deliver and pass out. She stated it shouldn't take more than a couple of minutes for staff to sign out and deliver the meals to the residents. She stated staff should not be allowing the meals to sit more than 15 minutes before serving them to maintain their temperatures. She stated the nursing staff should communicate to the kitchen if meals were cold or needed reheating. She stated direct care staff were required to sign out the meal carts and deliver the meals to the residents eating in the room. She stated meals in the dining room were served directly from the kitchen.</p> <p>The facility's Dining Experience policy (undated) indicated residents will receive food that is nourishing, attractive, and palatable. The policy indicated resident meals will maintain the appropriate texture, consistency, and safe serving temperatures.</p> <p>The facility failed to ensure meals were served at a palatable, safe, and appetizing temperature. This deficient practice placed the residents at risk for risks related to impaired nutrition and weight loss.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41037</p> <p>The facility identified a census of 74 residents. The facility had one main kitchen. Based on observation and interview, the facility failed to ensure staff stored food items in accordance with the professional standards for food service safety. This placed residents at risk of foodborne illness and cross-contamination (the transfer of harmful substances to food).</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The initial tour of the kitchen on 09/30/24 at 07:13 AM revealed a large open bag of oats stored on the floor of the dry storage area. The refrigerator contained open and undated condiments. Another refrigerator contained an undated and uncovered silver pan with two heads of lettuce in an unsealed bag on top of wilted lettuce. The side-by-side freezer contained an undated and uncovered silver pan of a dessert.</li> </ul> <p>On 10/02/24 at 01:48 PM, Dietary Staff BB stated all items should be labeled, dated, and stored off the floor. Dietary Staff BB stated all food in the freezers and refrigerator must be covered, sealed, labeled, and dated.</p> <p>The Facility ' s undated Food Storage (Dry, Refrigerated and Frozen) policy documented that food would be stored on shelves in a clean, dry area free from contaminants. Food would be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. All food items would be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded.</p> <p>The facility failed to ensure dietary staff stored food items in accordance with the professional standards for food service safety. These deficient practices placed residents at risk for contamination and food-borne illness.</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49634</p> <p>The facility identified a census of 74 residents. The sample included 18 residents with two residents reviewed for (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R)3. This placed the resident at risk for inappropriate end-of-life care.</p> <p>Finding Included:</p> <ul style="list-style-type: none"> <li>- R3's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of muscle weakness, unsteadiness on her feet, dysphagia (swallowing difficulty), cognitive-communication deficit, dementia (a progressive mental disorder characterized by failing memory and confusion), Cerebral arteriosclerosis (a disease that occurs when the arteries in the brain become hard, thick, and narrow due to the buildup of plaque), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).</li> </ul> <p>The Significant Change Minimum Data Set (MDS) dated [DATE] documented R3 had a Brief Interview for Mental Status (BIMS) score of seven, which indicated moderately impaired cognition. The MDS documented R3 was dependent on staff for toileting, bathing, and dressing. The MDS documented that R3 received hospice services during the observation period.</p> <p>R3's Communication Care Area Assessment (CAA) dated 07/31/24 documented R3 was on hospice for cerebral atherosclerosis, this disease process tends to affect her ability to communicate effectively.</p> <p>R3's Care Plan dated 08/02/24 documented R3 was started on hospice on 07/17/24. The plan of care documented nursing staff would assess for pain restlessness, agitation, constipation, and other symptoms of discomfort. The plan of care documented nursing staff would medicate as ordered and evaluate for effectiveness. R3's plan of care documented that hospice would provide bereavement to R3's family, and staff was to notify the hospice provider of any changes or clinical complications. R3's plan of care documented hospice provider had not provided any equipment. R3's plan of care documented nursing would provide medications per hospice and physician orders R3's plan of care did not include what services hospice would provide, such as medication, supplies, or hospice worker visits.</p> <p>A review of the hospice-provided communication binder revealed R3 was admitted to hospice services on 07/17/24.</p> <p>On 09/30/24 at 08:05 AM R3 lay on her bed sleeping.</p> <p>On 10/01/24 at 09:14 R3 sat in her wheelchair, awaiting her breakfast meal.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/02/24 at 10:23 AM Certified Nursing Aide (CNA) RR stated he was unsure what hospice provided for residents, but if he needed to find out he could ask the charge nurse or look at her plan of care. CNA RR stated all nursing staff have access to the resident's care plan.</p> <p>On 10/02/24 at 02:02 PM, Licensed Nurse (LN) F stated what the hospice provided should be collaborated on the care plan, but she did not believe medication or when the hospice staff was coming to the facility needed care planned. LN F stated the medication and when staff were to come to the facility was in the resident's hospice binder.</p> <p>On 10/02/24 at 02:26 PM, Administrated Nurse D stated she had been with the facility a short time and did not know what this facility's care planned for each resident. She stated anything hospice provided, and when the nurse and aide were to provide services, should be part of the resident's care plan.</p> <p>The facility's Coordination of Hospice Services policy documents that when a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff to promote the resident's highest practicable, mental, and psychosocial well-being.</p> <p>The facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for R3. This placed the resident at risk for inappropriate end-of-life care.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45668</p> <p>The facility identified a census of 74 residents. The facility identified 10 residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP. The facility additionally failed to follow sanitary infection control practices related to oxygen equipment, laundry services, and wearing personal protective equipment (PPE). These deficient practices placed the residents at risk for infectious diseases.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> <li>- An initial walkthrough of the facility was completed on 09/30/24 at 07:10 AM to identify signage and PPE for residents on EBP.</li> <li>An inspection of Resident(R)36's room revealed PPE posted outside her room but lacked EBP signage for her percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach) care.</li> <li>An inspection of the R40's room revealed PPE but no EBP signage posted for her Foley catheter (a tube inserted into the bladder to drain urine into a collection bag) care.</li> <li>An inspection of R45's room revealed PPE but no EBP signage posted for his PEG-tube care.</li> <li>An inspection of R66's room revealed no EBP signage or PPE for her hemodialysis care.</li> <li>An inspection of R182's room revealed he had personal protective equipment due to wound care but lacked EBP signage in or around his room to identify his needed precautions.</li> <li>On 09/30/24 at 07:10 AM R182's oxygen tubing and nasal cannula rested on top of his bed. No sanitary bag was present.</li> <li>On 09/30/24 at 07:15 AM a plastic bag of soiled clothing rested directly on the ground in front of the 300 Hall environmental service door.</li> <li>On 09/30/24 at 07:30 AM R64's nasal cannula and oxygen tubing rested in the seat of her wheelchair. No sanitary storage bag was present.</li> <li>On 09/30/24 at 07:34 AM R24 propelled himself into the dining room from his room in his wheelchair. R24's Foley catheter collection bag was inside a privacy bag. His collection bag leaked urine from his room to the dining room table.</li> <li>On 09/30/24 at 07:55 AM R3's nasal cannula tubing was laid on the floor the tubing was draped over the left-hand bed rail, and the tubing was not contained in a container.</li> </ul> <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 - Some</p>	<p>On 09/30/24 at 12:10 PM R3's nasal cannula was laid on the floor in her room behind her wheelchair, R3's cannula was not contained in a sanitary container.</p> <p>On 10/01/24 at 01:06 PM Licensed Nurse (LN) H provided wound care for R182. LN H did not wear the required protective gown during the wound care.</p> <p>On 10/01/24 at 02:00 PM Housekeeping Staff U reported the facility did not monitor the laundry temperatures and had no record to provide. She stated the facility used temperature-controlled clothes washing machines in the laundry room. The facility was unable to provide logs or evidence showing the hot water temperature was monitored to appropriately sanitize during the wash cycle.</p> <p>On 10/02/24 at 10:45 AM inspection of the facility's [NAME] Hall shower room revealed the right shower room was closed due to maintenance issues. An inspection of the left shower room revealed soiled towels on the floor, feces in the toilet, and a reddish rust-like substance on the lower wall inside the shower area.</p> <p>On 10/02/24 at 10:45 AM Certified Nurse's Aide (CNA) QQ stated staff should never place laundry directly on the floor. She stated oxygen tubing and equipment should be stored in a clean plastic bag. She stated the EBP signage was posted on the doors of each room or in a visible place.</p> <p>On 10/02/23 at 10:55 AM Licensed Nurse (LN) G stated EBP signage should be in a place visible to staff and visitors. She stated staff were required to follow EBP practices when dealing with wounds, dialysis ports, catheters, and surgical wounds. She stated laundry should always be taken directly to the soiled linen room and never left on the floor.</p> <p>On 10/02/23 at 02:34 PM Administrative Nurse D stated staff were expected to follow the EBP signage for the listed residents. She stated staff were expected to ensure the oxygen equipment was stored in a sanitary plastic bag when not in use. She stated soiled linens or bags should never be left on the floor. Administrative Nurse D stated signage should be in a highly visible place in or outside the resident's room.</p> <p>The facility's Enhanced Barrier Precautions 04/20244 indicated the facility will ensure all residents assessed and identified as at risk for multidrug-resistant organisms were placed on EBP. The policy noted staff will be provided training and guidance on the proper PPE. The policy indicated the facility would provide the required PPE but lacked information related to signage.</p> <p>The facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP. The facility additionally failed to follow sanitary infection control practices related to oxygen equipment, laundry services, and wearing PPE. These deficient practices placed the residents at risk for infectious diseases.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>41037</p> <p>The facility identified a census of 74 residents. The sample included 18 residents with five reviewed for immunization status. Based on record reviews, and interviews, the facility failed to administer the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial infections) pneumococcal (type of bacterial infection) vaccination for Resident (R) 10. This placed the residents at increased risk for complications related to pneumonia.</p> <p>Findings included:</p> <p>- A review of R10 ' s clinical record revealed a Pneumovax was administered on 05/07/15.</p> <p>Upon request for R10 ' s declination or administration of the PCV20 vaccine, the facility provided a signed consent dated 04/30/24. R10 ' s EMR lacked documentation she had received the PCV20.</p> <p>On 10/01/24 at 03:22 PM, Administrative Nurse D, the facility Infection Preventionist, stated she was unable to find documentation R10 had received the PCV20 in April 2024. Administrative Nurse D stated the Infection Preventionist should track the resident vaccination status.</p> <p>The facility ' s Pneumococcal Vaccine policy last reviewed on 01/31/22 documented it was their policy to offer the residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with current Centers for Disease Control (CDC) guidelines and recommendations.</p> <p>The facility failed to provide R10 with the PCV20 vaccination as consented. This placed R10 at increased risk for acquiring, transmitting, or experiencing complications from the pneumococcal disease.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>45668</p> <p>The facility identified a census of 74 residents. The sample included 18 residents. Based on record review, interviews, and observations, the facility failed to ensure necessary equipment remained in safe and functional status. This deficient practice placed the residents at risk for impaired quality of life.</p> <p>Findings Included:</p> <ul style="list-style-type: none"> <li>- A review of the facility's Resident Council Minutes for September 2023 revealed the council reported concerns that the right-side shower room of the [NAME] Hall needed to be fixed. An attached grievance form indicated a plumber assessed the drain and found a broken pipe three feet down in the drain.</li> </ul> <p>A review of the Resident Council Minutes for October 2023 again mentioned the need for a plumber related to the shower rooms.</p> <p>The Resident Council Minutes from November 2023 through September 2024 did not mention the out-of-order shower room.</p> <p>On 09/30/24 at 07:05 AM a walkthrough of the facility was completed. An inspection of the [NAME] Hallway revealed an out-of-order sign on the right shower room.</p> <p>On 10/01/24 at 01:30 PM, the facility's Resident Council reported the [NAME] Shower room had been closed for over a year. The council stated the lack of two shower rooms had caused residents to miss bathing opportunities or be wheeled across the building to the other shower rooms.</p> <p>On 10/01/24 at 02:52 PM an inspection of the East Hallway medication room revealed the sink was taped up and out of order. Licensed Nurse (LN) G stated the sink had been taped off and out of order for over a year.</p> <p>On 10/02/24 at 02:01 PM Maintenance Staff V stated the facility was looking for bids to fix the busted pipe in the shower room. He stated he was not aware of the out-of-order sink in the medication room. He was not sure how long the shower had been out of service or when it would be fixed.</p> <p>On 10/02/24 at 02:12 PM Administrative Nurse D stated she was not sure when the west shower would be fixed. She stated she had no complaints or concerns reported to her from the residents. She stated the medication room sink may have been shut off due to the maintenance of the 500 hallway.</p> <p>On 10/02/24 at 03:00 PM Administrative Staff A stated the facility was currently working on remodeling the shower rooms and the 500 unit, which was currently closed.</p> <p>The facility's Preventative Maintenance Program policy revised 10/2019 indicated the facility will ensure a safe, comfortable, functional, and sanitary environment.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility failed to ensure necessary equipment remained in safe and functional status. This deficient practice placed the residents at risk for impaired quality of life.</p>