| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175236 | A. Building<br>B. Wing | 04/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hutchinson Operator, LLC | 2301 N Severance Street<br>Hutchinson, KS 67502 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768<br><br>The facility had a census of 42 residents. The sample included 12 residents with three reviewed for pressure ulcers (PU-localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, interview, and record review the facility failed to provide interventions to prevent a pressure injury for Resident (R) 22 who had recurring blisters to the left heel and was at risk for skin breakdown. This placed the resident at risk for pressure injury and delayed healing.<br><br>Findings included:<br><br>- R22's Electronic Medical Record (EMR) documented diagnoses of protein-calorie malnutrition, adult failure to thrive, neuropathy (sharp, shocking nerve pain), chronic pancreatitis (progressive inflammatory disorder), and a Stage 2 pressure ulcer (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) of the left heel.<br><br>The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of nine indicating moderately impaired cognition. The MDS documented R22 had a range of motion impairment in both lower extremities. R22 required moderate assistance for eating and was dependent on staff for all other activities of daily living (ADL). The MDS documented R22 weighed 116 pounds, and had one Stage 2 PU, and one unstageable PU (the depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus). R22 received pressure relief devices for the chair, repositioning, and PU care and medications to an area other than the feet.<br><br>R22's Care Plan, dated 11/10/23 (revised on 02/22/24) documented the resident was at risk for skin breakdown due to a loss of muscle strength. An intervention dated 11/10/23 directed staff that a licensed nurse would complete a weekly skin assessment and notify the primary care physician if abnormalities were noted. An intervention dated 02/22/24 and revised on 04/02/24 directed staff to keep off-loading boots 24 hours a day, except during transfers to both heels.<br><br>A Progress Note dated 12/12/23 at 11:21 AM, stated the resident had a possible blister on his right inner heel. The nurse assessed the heel and noted a 3.5 centimeter (cm) by 3 cm area that had been a fluid-filled blister. The note documented the fluid had absorbed back into the foot and there was a faint outline of where it had been. All skin was intact, and the surrounding skin was blanchable (a term used to describe skin that remains white or pale for longer than normal when pressed). The note recorded the resident reported no pain in the area.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175236 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/15/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Hutchinson Operator, LLC | 2301 N Severance Street Hutchinson, KS 67502 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Skin Assessment, dated 01/01/24, documented a closed blister on the left heel.<br><br>The Progress Note, dated 01/11/24 at 08:16 PM, documented R22 continued with a healing blister on the left heel.<br><br>The Physician Order, dated 01/30/24, directed to admit R22 to palliative care.<br><br>The Physician Note, dated 02/08/24, documented there were no skin lesions or wounds and directed staff to apply Skin-prep (liquid skin barrier) wipes to R22's left heel topically two times a day for a skin condition and discontinue when resolved. The note recorded the physician ordered a multiple vitamin with minerals daily for wound healing.<br><br>The Physician Order, dated 02/23/24, directed staff to administer a multiple vitamin with minerals daily for wound healing.<br><br>The Physician Order, dated 02/26/24 ordered the wound care specialist to evaluate and treat.<br><br>The Skin Assessment, dated 03/25/24, documented a left heel PU that measured 1.5 cm by 2.5 cm by 0.3 cm.<br><br>The Physician Order, dated 04/02/24, directed to make sure staff turned and repositioned the resident in bed at least every two hours for skin care and wound prevention.<br><br>The Skin Assessment, dated 04/09/24, documented that the left heel PU measured 2.3 cm by 2 cm by 0.3 cm and had moderate drainage.<br><br>The Physician Order, dated 04/10/24 directed staff to off-load R22's bilateral heels with boot at all times except during transfers.<br><br>On 04/10/24 at 08:30 AM, observation revealed R22 lay in a low bed. He refused breakfast. At 11:44 AM, Certified Medication Aide (CMA) S and Licensed Nurse (LN) H assisted the resident in repositioning from his left side to his back. He wore foot protector boots on both feet and the air mattress was on.<br><br>On 04/10/24 at 05:17 PM, observation revealed R22 lying in bed with a Prevalon boot (special pressure-reducing heel protectors) on the right foot and a blue foam bootie on his left foot. Administrative Nurse D performed wound care to the left heel which had a small amount of drainage and the open wound at the bottom of the heel was approximately 2 cm by 1.5 cm. She cleansed the area and applied Skin-prep to the peri-wound and calcium alginate (highly absorbent dressing) to the wound. Administrative Nurse D covered the wound with a bordered foam dressing.<br><br>On 04/15/24 at 01:20 PM, Administrative Nurse F stated R22 was at risk for skin breakdown due to muscle loss. She stated the 11/10/23 care plan identified the risk but had no interventions to prevent wounds. Administrative Nurse F stated the facility should have revised R22's care plan when the heel blisters were noted in December 2023 and then re-occurred in February 2024.<br><br>(continued on next page) |

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| | 175236 | A. Building<br>B. Wing | 04/15/2024 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's Pressure Injury Treatment Guidelines policy, dated 03/2024, directed staff to determine the cause of pressure and relieve, redistribute pressure, implement pressure redistributing devices, notify the physician and family, and initiate a skin documentation protocol and care plan.<br><br>The facility failed to provide interventions for pressure ulcer prevention such as off-loading for R22 who was at risk for prolonged pressure ulcer risks and infection. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768<br><br>The facility had a census of 42 residents. The sample included 12 residents with four reviewed for falls. Based on observation, interview, and record review the facility failed to ensure an environment free from accident hazards when the accessible hot water at the dining room sink was 131 degrees F (Fahrenheit) and further failed to provide effective interventions to prevent further falls for Resident (R) 13. This placed the residents at risk for injuries related to hot water hazards and falls.<br><br>Findings included:<br><br>- On 04/09/24 at 11:37 AM, observation revealed the facility's dining room sink had a hot water temperature of 130 degrees F.<br><br>On 04/09/24 at 11:40 AM, Maintenance Staff U obtained a water temperature of 131.6 degrees F. He stated he had just turned up the hot water thermostat that morning after finding the dishwasher temperature was not high enough at 115 degrees F. He stated both the dining room sink and the kitchen were on the same water line. At that time, he turned off the hot water valve under the sink.<br><br>The Water Temperature Testing Log, included the following:<br><br>02/14/24 dining sink 131F<br><br>03/11/24 dining sink 135F<br><br>04/01/24 dining sink 130F<br><br>On 4/10/24 at 10:45 AM, Administrative Staff A stated she educated the maintenance staff regarding the hot water temperatures in any common area that residents could access. She verified the maintenance checks on 02/14/24, 03/11/24, and 04/01/24 were all greater than 130 degrees. She stated the hot water was turned off to that sink until the situation was resolved with a separate water heater or valve to maintain appropriate temperatures.<br><br>The facility's Safety of Water Temperatures policy, dated 10/2023, stated tap water shall be kept within a temperature range to prevent scalding (to burn or affect painfully with or as if with hot liquid or steam) of residents. The policy stated water heater that serviced resident rooms and common use areas would be set to a temperature of no more than 115F. The policy stated maintenance staff would conduct periodic tap water temperatures per community protocol and any time the water temperature felt excessive to the touch (hot enough to be painful or cause reddening of the skin) staff were to report this to their supervisor.<br><br>The facility failed to ensure an environment free from accident hazards when the accessible hot water at the dining room sink was 131 degrees F placing the residents at risk for accidental skin injury.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - R13's Electronic Medical Record (EMR) documented diagnoses of heart disease, heart attack, urinary tract infection (UTI-an infection in any part of the urinary system), pseudobulbar affect (inappropriate involuntary laughing and crying due to a nervous system disorder), pain, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hallucinations (sensing things while awake that appear to be real, but the mind created), extrapyramidal and movement disorder (movement disorders as a result of taking certain medications) psychosis (any major mental disorder characterized by gross impairment in reality perception), and glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow).<br><br>The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented R13 required set-up supervision, or touching assistance with sitting up in bed, and transfers to stand or toilet. The MDS documented one non-injury fall and one minor injury fall since the prior MDS.<br><br>R13's Fall Care Plan, dated 02/07/24, stated R13 was at risk for falls due to a fall risk score of 10 or greater and psychotropic (alters mood or thought) drug use. The care plan directed staff to follow the facility fall protocol. Physical therapy would evaluate and treat as ordered or as needed. The plan directed staff to ensure the resident wore proper footwear during the day meaning no bare feet. The plan stated R13 was educated to ambulate with her walker, not while holding onto the wheelchair. Staff were to anticipate and meet her needs, offer non-skid socks, and educate R13 to wait for assistance before self-transfer and call for assistance with transfers. Staff were to offer toileting every two hours through the night; ensure her bed was not in a low position and ensure R13's call light was within reach and encourage her to use it. All the above interventions were initiated in 2022. Further falls resulted in the following care plan interventions:<br><br>Educate the resident, family, and caregivers about safety reminders and what to do if a fall occurs. Initiated: 09/06/23<br><br>Medication review requested. Initiated: 09/12/23<br><br>Ensure the resident was wearing appropriate footwear such as non-skid socks or slippers when ambulating or mobilizing in the room or with a wheelchair. Initiated: 11/11/23<br><br>Encourage the resident to limit the number of blankets in her recliner. Initiated: 11/17/23.<br><br>Ensure the resident's chair is cleaned out and items put away. Initiated: 11/17/23.<br><br>Ensure personal items are within reach when in the room. Initiated: 03/08/24<br><br>Review information on past falls and attempt to determine the cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident, family, and caregivers as to causes. Initiated: 03/08/24<br><br>The Fall Risk Assessment, dated 02/06/24 documented R13 was at high risk for falls with a score of 11.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Fall Note, dated 06/5/23: at 04:23 AM, stated the resident was reminded it was acceptable and encouraged to use the call light through night. gave verbal understanding.<br><br>The Fall Note, dated 06/16/23: at 0915 AM, stated staff assisted the resident to the recliner. The resident was sitting comfortably in her recliner, the call light within reach, resident could make needs known.<br><br>The Fall Note, dated 07/5/23: at 1100 AM, R13 stated she slipped while trying to get a shirt from her closet.<br><br>The Fall Note, dated 09/6/23 at 01:30 PM, stated staff educated R13 about safety reminders and what to do if a fall occurs. Resident verbally educated on the importance of calling for assistance during transfers, resident voiced understanding.<br><br>The Fall Note, dated 09/10/23 at 05:50 PM, stated staff was educated to toilet the resident every two hours and ensure she was always wearing non-skid socks.<br><br>The Fall Note, dated 09/12/23: at 05:30 AM, stated staff noted she did not have on grippy socks and staff put some on her before standing her up. Staff re-educated her to use the call light for assistance.<br><br>The Fall Note, dated 09/16/23, stated staff noted R13's call light behind the chair hanging and her grippy socks were worn down. R13 reported she had slipped and fell . She reported she could not find her call light to call for help. Staff exchanged all her socks for grippy socks that were not worn down and reminded her to call for help when getting up.<br><br>The Fall Note, dated 11/11/23 at 12:45 PM, stated staff noted R13 to have poor grippers on socks. Care Plan: Ensure wearing appropriate footwear.<br><br>The Fall Note, dated 11/17/23 at 04:01 PM, stated staff found R13 sitting on the floor in front of her recliner with clothing items under her more clothing items and a small pillow in the chair.<br><br>The Fall Note, dated 12/29/23 at 01:32 AM, stated staff educated R13 to call and wait for assistance.<br><br>The Fall Note, dated 02/17/24 at 03:00 AM, stated R13 told staff she was getting off the toilet and fell and slid on the floor.<br><br>The Fall Note, dated 03/8/24 at 05:30 PM, stated staff were to review information on past falls and attempt to determine the cause of falls, record possible root causes, and remove any potential causes if possible. Educate resident, family, and caregivers as to causes and the possible cause of this fall was room change or bare feet.<br><br>On 04/10/24 at 12:23 PM, observation revealed Therapy Staff HH asked R13 if she was ready to exercise. He tied her shoes, applied a gait belt, asked about pain, and used minimum assistance to help her stand and turn to sit in her wheelchair with small steady steps. He assisted her to ambulate with her walker in the hall 20 feet.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 04/10/24 at 12:08 PM, Certified Medication Aide (CMA) S stated the resident sometimes self-transferred.<br><br>On 04/15/24 at 12:02 PM, Administrative Nurse F stated the Interdisciplinary Team (IDT) does a risk management assessment right after a resident fall. She stated they use a root cause analysis form and update the care plan when they get the report from risk management.<br><br>On 04/15/24 at 12:25 PM, Administrative Nurse D verified education to R13 as an intervention or fall prevention had not been effective for this resident as she continued experiencing falls.<br><br>The Fall Risk Assessment policy, dated 10/2023, stated the IDT would review the resident's history of falls, medications that could relate to falls, current and underlying medical conditions, functional factors, and environmental factors that may contribute to falls. The IDT would complete an evaluation of the resident's actions leading to a fall to identify the root cause. The IDT would collaborate to identify and address modifiable fall risk factors and interventions to minimize the modifiable risk factors. The IDT would revise the care plan as needed.<br><br>The facility failed to implement different, effective interventions when to prevent further falls for R13 after repeated attempts at education were unsuccessful. This placed the resident at risk for injuries related to falls. |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168<br><br>The facility had a census of 42 residents. The sample included 12 residents with three reviewed for mood and behavior. Based on observation, record review, and interview, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for Resident (R)21. This placed her at risk for impaired quality of life due to untreated and ongoing mental health concerns.<br><br>Findings included:<br><br>- R21's Electronic Health Record (EHR) revealed diagnoses of post-traumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder.<br><br>R21's Annual Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented the resident had a mood score of three which indicated a major depressive disorder was likely. The MDS further indicated the resident had disorganized thinking and inattention.<br><br>R21's Care Plan, dated 01/02/24 documented the resident had depression, and staff would monitor and record target behaviors and symptoms such as crying, wandering, disrobing, inappropriate response to verbal communication, and violence and aggression towards staff and others. The care plan directed staff to closely monitor the resident treated with antidepressants (medication used to treat depression) for clinical worsening, and for emergence of suicidal thoughts and behaviors. The care plan documented the resident had been seen by an in-house psychiatric provider and had an order for a behavioral health unit if necessary. The care plan directed staff to redirect the resident when name-calling and threatening staff when she was upset and to keep the resident free from any form of abuse from other residents and or staff.<br><br>The Psychiatric Intake Notes, dated 07/18/23, documented the resident was seen at the facility by the Advance Practice Registered Nurse (APRN) who recommended increasing the resident's Sertraline (antidepressant medication) to 100 milligrams (mg) daily to target mood and anxiety. The APRN recommended a referral to psychotherapy and a follow-up in one month.<br><br>The Social Service Notes, dated 08/11/23 at 07:38 AM, documented the social services designee (SSD) emailed the APRN regarding the resident's need for a psychotherapy appointment. The notes recorded the SSD would await an update.<br><br>R21's clinical record lacked evidence of a psychotherapy appointment, notes, or follow-up on the mental health services.<br><br>(continued on next page) |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 04/10/24 at 07:35 AM, observation revealed R21 sat in a wheelchair beside the medication cart awaiting Certified Medication Aide (CMA) R, who administered the resident's morning medications including her Sertraline.<br><br>On 04/10/24 at 03:30 PM, Administrative Staff A and Nurse Consultant GG verified the resident saw the APRN but said the facility did not follow up with a referral to get psychotherapy. They verified the resident had a diagnosis of PTSD and the facility staff lacked information related to R21's triggers.<br><br>The facility's, Behavioral Health Services policy, dated June 2024, documented residents of the community would receive necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and care plan. The facility would assess residents with mental or psychosocial adjustment difficulty or who have a history of trauma and or PTSD for necessary care and services, appropriate person-centered care plans, and individualized treatment to meet their needs. The facility would review physician orders for the use of medications for behavioral issues and consultations with behavioral health services.<br><br>The facility failed to provide mental health services for R21 after the APRN determined she needed a psychotherapy appointment. This deficient practice placed R21 at risk for impaired quality of life due to untreated and ongoing mental health concerns. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>27168<br><br>The facility had a census of 42 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to discard Resident (R)1, R32, and R144s' insulin (a hormone that lowers the level of glucose in the blood) flex pens when outdated and failed to discard expired stock medications. This deficient practice placed the affected residents at risk for ineffective medications.<br><br>Findings included:<br><br>- On 04/09/24 at 09:10 AM, observation of the facility's South Hall treatment cart revealed the following:<br><br>R1's Lantus (long-acting insulin) flex pen was labeled with an open date of 03/09/24 (expired on 04/05/24, 28 days).<br><br>R32 basaglar (Lantus) flex pen was opened on 03/09/24 (expired on 04/05/24, 28 days).<br><br>R144's insulin glargine (Lantus) flex pen was opened on 02/02/24 (expired on 3/01/24, 28 days).<br><br>On 04/09/24 at 09:15 AM, Licensed Nurse (LN) I verified the nurses were supposed to date the flex pens when opened and discard the outdated insulin.<br><br>On 04/11/24 at 09:30 AM, Administrative Nurse D verified the nurses should label and date the flex pens with the resident's name and discard outdated pens.<br><br>Medlineplus.gov directs open, unrefrigerated Lantus (basiglar and glargine) can be used within 28 days; after that time, they must be discarded.<br><br>The facility's Labeling of Medication Containers policy, dated 09/2024, documented all medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. Labels for individual drug containers shall include e all necessary information.<br><br>The facility's Storage of Medication policy, dated 09/2024, documented the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.<br><br>The facility failed to discard the residents' outdated insulin flex pens, placing the residents at risk for ineffective medication.<br><br>26768<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - On 04/09/24 at 08:32 AM, observation revealed Certified Medication Aide (CMA) T at the north hall medication cart. Inspection of the medication cart revealed the following:<br><br>One bottle of acetaminophen, 325 milligrams (mg) tablets with an expiration date of March 2024.<br><br>One bottle of B1 vitamins, 100 mg, with an expiration date of March 2024.<br><br>One bottle of Vitamin B complex tablets with an expiration date of 01/2024.<br><br>On 04/09/24 at 08:32 AM, CMA T verified the medications were expired.<br><br>The facility's Storage of Medications policy, dated 09/2023, stated the facility shall not use outdated drugs or biologicals, and all such drugs would be returned to the pharmacy or destroyed.<br><br>The facility failed to ensure outdated or expired medications were removed from the medication cart, placing residents at risk of receiving ineffective medications. |

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|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Hutchinson Operator, LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 2301 N Severance Street Hutchinson, KS 67502 | |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>27168<br><br>The facility had a census of 42 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide the services of a full-time certified dietary manager for the 42 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition.<br><br>Findings included:<br><br>- On 04/09/24 at 08:30 AM, observation revealed dietary staff in the kitchen prepared the breakfast meal.<br><br>On 04/09/24 at 08:40 AM, Dietary Staff BB verified she was not a certified dietary manager. Dietary Staff BB stated the facility had three residents with mechanical soft diets and one with a pureed diet who is in the hospital.<br><br>On 04/11/24 at 02:00 PM, Administrative Staff A verified Dietary Staff BB was not certified.<br><br>The facility's Food Service Staffing dated 10/2024, documented the community will employ sufficient staff with the appropriate competencies and skills to carry out the function of the food and nutrition services. The qualified Dietician would help oversee clinical nutrition and dietary services in the facility. The policy documented that if the Dietician is not full time the community would employ another qualified nutritional professional, to serve as the Dietary Manager. The person a minimum must meet one of the following qualifications:<br><br>A) A certified Dietary Manager,<br><br>b) A certified food service manager,<br><br>c) Have similar certification in food service management and safety from a national certifying body,<br><br>d) Has an associate or higher degree in food services management or hospitality, if the course study includes food service or restaurant management from an accredited institution or higher degree,<br><br>e) Has two or more years of experience in the position of dietary manager in a nursing facility setting and has completed a course of study in food safety management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illnesses, sanitization procedures, and food purchasing/receiving; and<br><br>f) meets the state-established standards if applicable.<br><br>The Dietary Manager would receive frequently scheduled consultations from a qualified dietician.<br><br>(continued on next page) |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The facility failed to employ a full-time certified dietary manager to evaluate residents' nutritional concerns and oversee the ordering, preparing, and storage of food for the 42 residents in the facility. This placed the residents at risk for inadequate nutrition. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>27168<br><br>The facility had a census of 42 residents. Based on observation, record review, and interview the facility failed to store food in a safe and sanitary manner and failed to adequately sanitize dishes for the 42 residents that resided in the facility and received meals from the kitchen. This placed the residents at risk for foodborne illness.<br><br>Findings Included:<br><br>- On 04/09/24 at 08:30 AM, observation during the initial kitchen tour revealed the upright refrigerator-freezer contained the following items in the bottom freezer drawer:<br><br>One bag of approximately 50 pepperoni circles with an open date of 09/15/23 and an expiration date of 03/15/24.<br><br>One bag of eight Salisbury steak patties with an open date of 03/18/24 and an expiration date of 03/25/24.<br><br>On 04/09/24 at 09:00 AM, observation revealed Dietary Staff (DS) DD operated the dishwasher and the wash temperature was at 105 degrees Fahrenheit (F) and the rinse temperature was at 110 degrees F. DS DD ran five loads and the temperature remained at 105 - 110 degrees F.<br><br>The Dishwasher Temperature Logs, dated April 2024, documented morning, noon, and evening temperatures were 100-110 degrees F. The documented chemical sanitization checks recorded 200 parts per million (the amount of chlorine left over after a process where there is more chlorine than contaminate present.)<br><br>On 04/09/24 at 08:45 AM, DS BB verified the refrigerator contained outdated food that needed to be discarded.<br><br>On 04/09/24 at 09:15 AM, DS BB verified the April 2024 Dishwasher Temperature Log recorded the temperatures were 105-110 degrees F.<br><br>On 04/09/24 at 12:45 PM, Maintenance Staff U verified the kitchen had a separate water heater and it was set at 120 degrees. He turned it up to 140 degrees after Dietary Staff BB informed him of the low dishwasher temperatures.<br><br>The facility's Food Safety Requirements, policy, dated October 2024, documented that food shall be received and stored in a manner that complies with safe food handling practices. The community would procure food from approved sources or those considered satisfactory by federal, state, and local authorities. The policy documented that all foods stored in the refrigerator or freezer would be covered, labeled, and dated. Expiration dates on unopened foods would be observed and use by dates indicated once the food is opened.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The facility's Dishwashing Machine Use, policy, dated October 2023, documented that food service staff required to operate the dishwashing machine would be trained in all steps of the dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitization. Staff would record the wash temperature and the rinse parts per million or temperature as applicable) on the appropriate log. Dishwashing machines that use chemicals to sanitize, must maintain a wash temperature of 120 degrees.<br><br>The facility failed to store food in a safe and sanitary manner and failed to sanitize dishes adequately for the 42 residents who resided in the facility and received meals from the facility kitchen, placing the residents at risk for foodborne illness. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168<br><br>The facility had a census of 42 residents. The sample included 12 residents with one reviewed for hospice (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)141. This placed R141 at risk for inappropriate end-of-life care.<br><br>Findings included:<br><br>- R141's Electronic Health Record (EHR) revealed diagnoses of malignant (the tendency of a medical condition, especially tumors, to become progressively worse, most familiar as a characteristic of cancer) neoplasm of the lung or bronchi (the passage that connects your windpipe to your lungs), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and shortness of breath.<br><br>R141's Admission Minimum Data Set (MDS), dated [DATE], recorded that R141 was admitted to the facility on [DATE].<br><br>R141's Nursing Baseline Care Plan, dated 04/09/24, recorded R141 required pain medication and staff administered per physician order. The care plan documented staff to monitor vitals and the resident required enhanced barrier precautions. The care plan lacked any information regarding the resident's hospice services and lacked evidence of coordination of care between the hospice and the facility. The facility lacked a communication book or external document.<br><br>On 04/08/24 at 04:11 PM, a Nurse's Note documented the resident was admitted to the facility at 03:50 PM. The note recorded the resident had primary diagnoses of COPD and respiratory failure and a secondary diagnosis of lung cancer. The resident was admitted with the resident's hospice provider of choice. The length of stay was determined to be less than thirty days and R141 required oxygen continuously.<br><br>On 04/09/24 at 04:00 PM, observation revealed R141 sat in a recliner in his room watching TV, with a stocking cap on his head.<br><br>On 04/11/24 at 10:45 AM, Consultant GG and Administrative Nurse D verified the facility lacked any information from hospice such as admitting notes, assessments, and a hospice care plan. They verified the facility should have the information at the facility in the electronic health records and said would like to see a separate binder that had the hospice information kept at the nurse's station.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/11/24 at 12:38 PM, Social Service X instructed the hospice provider to bring a binder to the facility. Social Service X said the nurse stated she would put one together and bring it to the facility however she was new and unsure what all that would entail. Social Service X passed the information to Administrative Nurse D and said she requested the correct paperwork hospice should provide to the facility for the resident's care and coordinated services.<br><br>The Hospice Program policy, dated April 2024, documented the community would identify in writing the services that the hospice would be providing an address in the resident's person-centered care plan; the facility would obtain the physician certification or e-certification for hospice services. The policy directed the facility would ensure the hospice medical director and the attending physician or other practitioners collaborate and communicate to coordinate hospice care.<br><br>The facility failed to coordinate care between the facility and the hospice provider for R141, who received hospice services. This deficient practice placed him at risk for inappropriate end-of-life care. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>26768<br><br>The facility had a census of 42 residents. The sample included 12 residents with five reviewed for immunizations. Based on observation, interview, and record review the facility failed to provide Residents (R) 11, R13, R19, R25, and R143 with the most recent Center for Disease Control and Prevention (CDC) vaccination information statement (VIS) before administering vaccinations. This placed the residents at risk for uninformed decisions related to vaccinations.<br><br>Findings included:<br><br>- Five residents ' records reviewed for immunizations revealed the facility ' s vaccination consent forms lacked the most recent Center for Disease Control and Prevention (CDC) vaccination information. The facility used a consent form with information from the 08/15/19 influenza, the 10/30/19 PCV13, and the 10/30/19 PPSV23 CDC guidelines. The five residents were not provided the most recent CDC VIS at the time of their vaccinations.<br><br>On 04/11/24 at 11:22 AM, Administrative Nurse E verified the residents had not been provided the most recent VIS before vaccinations.<br><br>The facility ' s Vaccination of Residents policy, dated 09/2023, stated before receiving vaccinations, a resident or their representative, would be provided information and education regarding the benefits and potential side effects of the vaccinations.<br><br>The facility failed to provide R11, R13, R19, R25, and R143 with the most recent CDC VIS before administering vaccinations, placing the residents at risk for uninformed decision making. |