| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175540 | A. Building<br>B. Wing | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Nottingham Health and Rehabilitation | 14200 W 134th Place<br>Olathe, KS 66062 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037<br><br>The facility identified a census of 74 residents. The sample included 19 residents with one resident reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 40's right to be treated with respect and dignity when staff provided personal care with the window blinds open to the side street of the facility. This deficient practice placed the R40 at risk for negative psychosocial outcomes and decreased dignity.<br><br>Findings included:<br><br>- R40's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of heart failure, hypertension (HTN-elevated blood pressure), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel).<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R40 required the assistance of two staff members with dressing.<br><br>The Quarterly MDS dated [DATE] documented a BIMS score of 13 which indicated intact cognition. The MDS documented that R40 required substantial to maximum assistance from staff for dressing.<br><br>R40's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/03/23 documented she was at risk of not having the ability to make her needs known and staff would reorient her as needed. Staff would anticipate her needs.<br><br>R40's Care Plan dated 03/27/24 documented she required one staff member's assistance for dressing.<br><br>On 06/17/24 at 07:34 AM, Certified Nurse Aide (CNA) N and Certified Medication Aide (CMA) T transferred R40 with the Hoyer (total body mechanical lift) from her bed into the wheelchair with her window blinds open to the street on the side of the facility. CNA N removed R40's top and assisted her with redressing. The window blinds remained open.<br><br>On 06/20/24 at 11:20 AM, CMA S stated the window blinds should always be closed when providing care for a resident to ensure their dignity.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/20/24 at 11:30 AM, Licensed Nurse (LN) I stated the window blinds should be closed when staff provide any personal care to ensure a resident's dignity.<br><br>On 06/20/24 at 12:28 PM, Administrative Nurse D stated she expected the staff to close the window blinds when providing any personal care to ensure the resident's dignity.<br><br>The facility ' s Right to Dignity policy reviewed on 01/31/24 indicated the facility will ensure the residents were provided an environment that promotes resident-centered care, respect, and dignity. The policy indicated the facility will ensure the resident ' s right to voice grievances, choices, and receive care in a manner that promotes autonomy and dignity.<br><br>The facility failed to ensure R40's right to be treated with respect, and dignity, related to staff providing personal care with the window blinds open to the side street of the facility. This deficient practice placed the R40 at risk for negative psychosocial outcomes and decreased autonomy and dignity. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>45668<br><br>The facility identified a census of 74 residents. The sample included 19 residents with one reviewed for care plan revisions. Based on observation, record review, and interviews, the facility failed to revise Resident (R) 44's care plan to reflect toileting needs after meals. This deficient practice placed R44 at risk for preventable accidents and falls related to uncommunicated care needs.<br><br>Findings Included:<br><br>- The Medical Diagnosis section within R44's Electronic Medical Records (EMR) included diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), 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), and recent femur fracture (bone break in the large leg bone).<br><br>A review of R44's Significant Change Minimum Data Set (MDS) completed 05/28/24 noted a Brief Interview for Mental Status (BIMS) score of 10 indicating mild cognitive impairment. The MDS indicated she had impairments to one side of her upper and lower extremities. The MDS indicated she required substantial to maximal assistance for personal hygiene, toileting, bathing, grooming, transfers, and dressing. The MDS indicated she was frequently incontinent of bowel and bladder. The MDS noted she had two falls since her last assessment.<br><br>R44's Fall Care Area Assessment (CAA) completed 06/04/24 indicated she was at risk for falls related to her medical diagnoses, medications, and cognitive decline. The CAA indicated staff will incorporate interventions to decrease her fall risks. The CAA indicated she was able to use her call light, wore non-skid footwear, and required assistance with her activities of daily living (ADLs).<br><br>R44's Functional Abilities CAA completed 06/04/24 indicated she required assistance with her ADLs related to her medical diagnoses. The CAA noted she suffered a right hip fracture on 05/13/24. The CAA noted she had a decline and started hospice services. The CAA indicated her needs would be met.<br><br>R44's Care Plan initiated 09/08/22 indicated she was at risk for falls related to her medical diagnoses and overall weakness. The plan indicated she required two staff for assistance with her bed mobility, dressing, toileting, bathing, and transfers. The plan instructed staff to provide a two-hour toileting check and change (09/09/22). A review of R44's physical and electronic care plan lacked instructions to toilet her after meals as discussed in her interdisciplinary team note on 05/13/24.<br><br>R44's EMR revealed a Nursing Progress note dated 05/10/24. The note indicated she was found on the floor next to her bed. Staff noted R44 informed them she attempted to use the restroom and fell from her chair. The note indicated R44 denied pain or discomfort at the time of her fall and was assessed by the nurse.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R44's EMR revealed an Interdisciplinary Team (IDT) note dated 05/13/24. The note indicated a root-cause analysis was completed for R44's fall on 05/10/24. The note listed decreased safety awareness and impulsivity as causative factors to her fall. The note indicated she would be toileted after meals as she allowed as an intervention.<br><br>On 06/18/24 at 08:10 AM R44 rested in her bed. She stated she was waiting for breakfast. R44's wheelchair sat next to her bed. R44 wore non-skid socks. Staff entered the room and assisted her with toileting.<br><br>On 06/20/24 at 10:15 AM Certified Nurse's Aide (CNA) O stated all staff had access to the care plans and could review the paper plans for updated information. She stated staff were expected to review the care plans before caring for each resident. She stated that fall and toileting interventions should be reviewed to ensure safe care.<br><br>On 06/20/24 at 12:32 PM Administrative Nurse D stated the interdisciplinary team met every Monday to discuss care for residents. She stated that implemented interventions provided by the team should be included in the resident's care plans.<br><br>The facility ' s Care Plan Revisions policy reviewed on 01/31/24 indicated the facility will provide ongoing care-related assessments to ensure the care plan reflects the accurate care needs, preferences, and changes to ensure the resident's treatments meet each resident ' s care goals.<br><br>The facility failed to revise R44's care plan to reflect toileting after meals. This deficient practice placed R44 at risk for preventable accidents and falls related to uncommunicated care needs. |

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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** 45668<br><br>The facility had a census of 74 residents. The sample included 19 residents with two reviewed for accidents. Based on observation, record review, and interview the facility failed to secure electrical panels and cleaning chemicals in a safe, locked area, and out of reach of the nine cognitively impaired, independently mobile residents. This placed the affected residents at risk for preventable accidents. The facility additionally failed to implement fall interventions for Resident (R) 43 and R2.<br><br>Findings Included:<br><br>- On 06/17/24 at 07:23 AM a walkthrough of the facility's [NAME] unit revealed an unlocked laundry room. The room contained two unlocked high-voltage circuit panels labeled P1W and E1W. The room also contained laundry detergent pods (the product contained the Keep out of reach from children warning) and an unknown chemical inside a spray bottle.<br><br>On 06/17/24 at 07:32 AM a walkthrough of the facility's [NAME] unit revealed an unlocked laundry room. The room contained two unlocked high-voltage circuit panels labeled P1E and E1E. At 07:35 AM Licensed Nurse (LN) H secured the door. He stated the door should be locked and residents were not permitted to enter the room.<br><br>On 06/20/24 at 12:32 PM Administrative Nurse D stated the laundry rooms have electronic keypads but should be always locked. She stated the resident should not have access to the rooms due to the hazardous chemicals and equipment stored in the rooms.<br><br>The facility ' s Control of Hazardous Chemicals policy reviewed 01/31/24 indicated the facility will ensure areas containing hazardous material and chemicals remain inaccessible to the residents and visitors. The policy indicated staff will be educated to eliminate resident exposure to potentially hazardous materials and designated by the facility.<br><br>The facility failed to secure electrical panels and chemicals in a safe, locked area, and out of reach of the nine cognitively impaired, independently mobile residents. This placed the affected residents at risk for preventable accidents.<br><br>41037<br><br>- R43's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body), hypertension (HTN-elevated blood pressure) and atrial fibrillation (rapid, irregular heartbeat).<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 Annual Minimum Data Set (MDS) dated [DATE] documented moderately impaired cognition with poor decision-making ability under staff interview. The MDS documented R43 had functional limitation of his range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) on one side of his upper extremities. The MDS documented R43 required partial to moderate assistance from staff for transfers from the bed to the wheelchair. The MDS documented R43 had two non-injury falls since the prior MDS assessment.<br><br>R43's Falls Care Area Assessment (CAA) dated 04/16/24 documented he had multiple falls. Staff would assist R43 with his activities of daily living and place his wheelchair next to the bed.<br><br>On 06/18/24 at 01:06 PM, R43 lay on his bed asleep with his call light on his left side. The floor mat was on the floor next to his bed and his wheelchair sat at the foot of his bed and faced the wall.<br><br>On 06/20/24 at 09:15 AM R43 lay on his bed asleep with his call light on his left side. The floor mat lay on the floor next to his bed. R43's wheelchair sat across the room in front of his closet out of his reach.<br><br>On 06/20/24 at 11:20 AM, Certified Medication Aide (CMA) S stated everyone can review a resident's care plan. CMA S stated the care plan or Kardex (a nursing tool that gives a brief overview of the care needs of each resident) lists what fall interventions that are in place for each resident. CMA S stated R43's wheelchair should be placed by his bed within his reach.<br><br>On 06/20/24 at 11:30 PM, Licensed Nurse (LN) I stated everyone had access to the Kardex to review the fall interventions in place for each resident. LN I stated the nurse would care plan a new intervention after each fall and the interdisciplinary team (IDT) would review the fall and the intervention. LN I stated she would communicate the fall and all the fall interventions that were in place prior to the current fall to all the nursing staff taking care of the resident through the facility's internal communications system.<br><br>On 06/20/24 at 12:28 PM, Administrative Nurse D stated all nursing staff were to put an intervention into the care plan after a fall. Administrative Nurse D stated the care plans were kept on the houses at the nursing station and nursing was notified when new interventions were put in place by the facility's internal communications system. Administrative Nurse D stated all nursing staff should follow the plan of care put into place for each resident. Administrative Nurse D stated she expected staff to place R43's wheelchair next to his bed within his reach if that was what was care planned.<br><br>The facility ' s Accident and Incident Policy revised 01/31/24 indicated the facility will ensure a safe care environment and minimize the risks of accidents and hazards. The policy indicated the facility will implement fall prevention strategies based on individual resident assessment.<br><br>The facility failed to ensure the R43's wheelchair was placed next to his bed within his reach. This deficient practice placed R43 at risk of falls and possible injuries.<br><br>49634<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 | - R2's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following 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), malnutrition (lack of proper nutrition, caused by not having enough to eat), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), hypotension (low blood pressure), muscle weakness, adult failure to thrive (a syndrome of weight loss, decreased appetite and poor nutrition, and inactivity), and communication deficit.<br><br>The Significant Change Minimum Data Set (MDS) for R2 dated 06/11/24 recorded a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. The MDS recorded R2 had falls during the observation period.<br><br>R2's Falls Care Assessment (CAA) dated 06/11/24 documented R2's falls exhibited a significant change in health condition. The CAA documented the need for assistance with activities of daily living (ADLs). The CAA documented R2 had falls since admission and was taking medication that could increase the risk for falls. The CAA documented R2 will be assisted with ADLs, wear nonskid footwear, and work with therapy.<br><br>R2's Functional Abilities CAA dated 06/11/24 documented R2 was at an increased risk of decline due to her need for assistance with ADLs. The CAA documented nursing would continue to assist with ADLs to reduce decline.<br><br>R2's Care Plan dated 06/20/24 documented R2 was at risk for falls due to falls related to weakness, a history of falls, and medications that increase the risk for falls. The plan of care dated 03/26/24 documented that staff would toilet R2 before she was laid down after meals. The plan of care dated 05/03/24 documented that staff would offer and assist with toileting after her meals. The plan of care dated 05/31/24 documented that staff would place R2's wheelchair by her when she was not in the wheelchair. The plan of care dated 06/02/24 documented that staff would leave R2's door open and increase monitoring as allowed. The plan of care dated 06/04/24 documented R2 would use a perimeter mattress.<br><br>On 06/17/24 at 02:35 PM R2 laid flat in her bed on her back awake. Her bed was in the lowest position, her call light was at her side, and her wheelchair was placed at the foot of her bed. R2's wheelchair was not by her side.<br><br>On 06/20/24 at 09:42 AM R2 was reclined in her recliner with her feet elevated. R2's call light was on her lap, and her wheelchair was placed across her room by the door. R2's wheelchair was not placed beside her.<br><br>On 06/20/24 at 10:17 AM Certified Nursing Aide (CNA) M stated all CNAs can read the care plans anytime. CNA M stated all updated care plans were kept at the nursing station. CNA M stated she did know R2 was to be toileted after meals and have her call light within reach. CNA M said R2's wheelchair should be kept away from her, to ensure she doesn't try to get into the wheelchair.<br><br>On 06/20/24 at AM Licensed Nurse (LN) G stated all nursing staff should follow the care plan. LN G stated all staff can read the care plan anytime. LN G stated staff are notified by nursing when a care plan is updated.<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 06/20/24 at 11:46 AM Administrative Nurse D stated all nursing staff were to put an intervention into the care plan after a fall. She stated the care plans were kept on the houses at the nursing station and nursing was notified when new interventions were put in place by the facility's internal communications system. She stated all nursing staff should follow the plan of care put into place for each resident.<br><br>The facility ' s Accident and Incident Policy revised 01/31/24 indicated the facility will ensure a safe care environment and minimize the risks of accidents and hazards. The policy indicated the facility will implement fall prevention strategies based on individual resident assessment.<br><br>The facility failed to ensure that R2's fall interventions were followed. This deficient practice placed R2 at risk for falls and fall-related injuries. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634<br><br>The facility identified a census of 74 residents. The sample included 19 residents with one resident reviewed for hemodialysis (a procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to consistently communicate Resident (R) 7's medical condition with a pre-dialysis assessment prior to hemodialysis. This deficient practice placed R7 at risk of potential adverse outcomes and physical complications related to dialysis.<br><br>Findings included:<br><br>- R7's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), muscle weakness, difficulty in walking, renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), dependence on dialysis (procedure where impurities or wastes were removed from the blood), epilepsy (brain disorder characterized by repeated seizures), cognitive communication deficit, and protein calorie malnutrition ( a nutritional status in which reduced availability of nutrients leads to changes in the body composition and function).<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented, a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented R7 had renal failure and required hemodialysis during the observation period.<br><br>The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 05/10/24 documented R7 needed assistance with activities of daily living (ADLs), was at risk for further decline, and was care planned to improve. The assessment documented R7 would be assisted with ADLs and work with therapy as ordered.<br><br>R7's Care Plan dated 06/13/24 documented R7 requires hemodialysis related to end-stage renal failure, was at risk for fluid and electrolyte imbalance, variable weights, and increased risk of infection. The plan of care documented that nursing staff would communicate R7's condition with dialysis per written communication form with each visit and as necessary. The plan of care documented that nursing would consult with the dietician as needed, monitor the port site daily, and staff would offer breakfast and/or snack prior to leaving facility R7's plan of care documented nursing staff was to report signs and symptoms of infection to physician, and R7 was to receive dialysis three times a week.<br><br>The EMR under the Orders tab dated 05/09/24 revealed the following nursing order: nursing to assess the dialysis port to ensure proper dressing was in place every shift.<br><br>The EMR under the Orders tab dated 05/29/24 revealed the following physician order: nursing to complete hemodialysis assessment every Monday, Wednesday, and Friday under the assessment tab every afternoon.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of R7's clinical record including the facility communication forms lacked evidence of pre-hemodialysis assessment for the dialysis dates of 04/24/24, 04/26/24, 05/08/24, 05/12/24, 05/20/24, 06/03/24, 06/07/24, 06/10/24, and 06/14/24.<br><br>On 06/20/24 at 09:37 AM Licensed Nurse (LN) stated the night shift fills out the pre-assessment with vitals, medications given, and possibly R7's condition then the assessment would go into a folder and was sent with R7 to the dialysis center. LN stated when R7 returns to the facility, the afternoon nurse documents any orders and a post-assessment for R7.<br><br>On 06/20/24 at 12:27 PM Administrative Nurse D stated the process for dialysis was the nurse on duty fills out a communication sheet with any information that is pertinent to the resident. The communication sheet was then put in a folder to be sent with the resident to the dialysis center. Administrative Nurse D said the communication sheet was then sent back to the facility for nursing to review. The afternoon nurse does the post-assessment and documents that assessment in the EMR.<br><br>The facility ' s Hemo-Dialysis policy 01/31/24 indicated the facility will ensure accurate and consistent communication between dialysis services to maintain medical management, comprehensive care planning, and coordination of care. The facility will ensure coordinated services will include weight monitoring, assessment, lab services, and changes in condition.<br><br>The facility failed to consistently communicate R7's medical condition with a pre-dialysis assessment prior to hemodialysis. This deficient practice placed R7 at risk of potential adverse outcomes and physical complications related to dialysis. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037<br><br>The facility identified a census of 74 residents. The sample included 19 residents with nine residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure that Resident (R) 60 had a documented risk assessment for the use of side rails, consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed the R60 at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails.<br><br>Findings included:<br><br>- R60's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of generalized muscle weakness, need for assistance with personal care, difficulty with walking, and hypertension (HTN-elevated blood pressure).<br><br>The Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R60 required partial to moderate assistance moving from lying to a sitting position on the side of the bed.<br><br>R60's Functional Abilities Care Area Assessment (CAA) dated 04/24/24 documented he required assistance with his activities of daily living.<br><br>R60's Care Plan dated 06/09/24 documented he required setup and supervision with dressing and toileting needs. The plan of care lacked evidence of documentation related to a safety assessment and the use of bed rails.<br><br>A review of R60's EMR lacked evidence of a safety assessment for side rails prior to the installation of bed canes. The facility was unable to provide a risk assessment and consent for the use of the side rails (bed canes) for R60.<br><br>The facility provided a Side rail Assessment printed from the EMR system but with handwritten resident information and a date of 04/13/24 that documented R60 needed assistance with transfers The assessment documented R60 demonstrated poor bed mobility and/or difficulty moving to a sitting position. R60 had difficulty with balance and poor trunk control. The assessment was located anywhere in the resident's clinical record.<br><br>The facility provided a TELS form (a web-based software for maintenance) dated 06/18/24 that documented beds-electric: bed rail. This was marked done on time by Maintenance Director U. The TELS form lacked documentation of which rooms the side rails had been checked.<br><br>A review of R60's EMR under the Progress Notes tab revealed the following nurse note:<br><br>(continued on next page) |

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|---|---|---|---|
| | 175540 | A. Building<br>B. Wing | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Nottingham Health and Rehabilitation | 14200 W 134th Place<br>Olathe, KS 66062 |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 04/29/24 at 09:15 AM Nurse Progress Note documented R60 had complained of pain in his right elbow. R60 had stated one to two days prior he had hit his right elbow on the small side rail of his bed when he was trying to reach his phone. The note documented R60's right elbow was swollen and painful to touch or to rotate his right elbow.<br><br>On 06/21/24, the facility provided a Side Rail Assessment printed from the EMR system but with handwritten resident information and a date of 04/13/24 that documented R60 needed assistance with transfers The assessment documented R60 demonstrated poor bed mobility and/or difficulty moving to a sitting position. R60 had difficulty with balance and poor trunk control. The assessment was signed by Licensed Nurse (LN) I. The assessment was not located anywhere in the resident's clinical record during the survey.<br><br>On 06/17/24 at 09:53 AM R60 lay on his bed. The head of R60's bed was slightly elevated, and the bed canes were noted on both sides of his bed. R60's phone sat on the bedside table with the bed cane between him and the phone. R60 stated he had caught and injured his right arm in the bed cane as he attempted to answer his phone. R60 stated his elbow had become swollen and painful for a long period of time and still caused him discomfort at times.<br><br>On 04/20/24 at 11:30 AM, LN I stated she had never completed a side rail assessment on any of the residents. LNI stated in order to get side rails installed on a resident's bed, staff filled out a work order. LN I stated she would let the director of nursing of the work order and the director of nursing would make the final decision for the side rails.<br><br>On 04/20/24 at 12:28 PM, Administrative Nurse D stated a side rail assessment was completed upon admission and then annually. Administrative Nurse D stated the admitting nurse would complete the assessment. Administrative Nurse D stated the interdisciplinary team (IDT) would review the side rail assessment and make the final decision for the safety of the side rails. Administrative Nurse D stated the maintenance staff completed weekly safety assessments on all the side rails installed in the facility.<br><br>The facility ' s Bed [NAME] policy approved 01/31/24 indicated the facility will ensure each resident ' s assisted bed devices were assessed for need and inspected for safety and appropriate use to prevent accidents or restraint. The policy indicated bed devices would never be used for restraint or staff convenience.<br><br>The facility failed to ensure that R60 had a documented side rail risk assessment, a consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed the resident at risk for uninformed decisions and impaired safety related to the risks associated with the use of side rails. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634<br><br>The facility identified a census of 74 residents. The facility had four kitchens. Based on observation, record review, and interviews, the facility failed to ensure that food items were properly stored in a safe and sanitary manner after the original sealed package had been opened. The facility failed to ensure all foods were labeled and dated after opening. This placed the affected residents who ate food from the facility at risk for food-borne illness.<br><br>Findings included:<br><br>- During the initial tour on 06/17/24 at 07:06 AM, observation revealed the following:<br><br>The Uptown Bistro storage area revealed an ice machine with the lid up and a clear plastic bowl sitting on top of the ice.<br><br>A small steam table pan in the freezer revealed ground meat in a plastic bag without a label or date.<br><br>A bag of mixed vegetables and a bag of frozen cookie dough opened to air, and undated in the freezer.<br><br>In the [NAME]/[NAME] house pantry, a bag of flour sat on the shelf that was opened and not dated. Bags of lime gelatin, packets of au gratin cheese mix, bags of pasta, and boxes of cream of wheat, were on the shelf without dates.<br><br>In the [NAME]/[NAME] hallway refrigerator, bags of sliced turkey and ham were undated.<br><br>In the small refrigerator in [NAME]'s kitchen, a box of egg whites was open to air with no label or date, and small bags of tomatoes, cabbage, and onions were in the vegetable container without labels and dates.<br><br>On 06/18/24 at 011:30 AM Dietary staff BB stated foods should be labeled and dated as soon as they are opened.<br><br>The facility ' s Dietary Food Storage policy reviewed 03/13/24 indicated food will be stored in a manner that maintains nutritional freshness and value. The policy indicates all opened food will be dated and stored in a manner that prevents spoilage or contamination. The policy indicated dietary equipment will be properly cleaned and maintained in a sanitary manner to prevent food-borne illness or contamination.<br><br>The facility failed to store food in a safe, sanitary manner. This deficient practice placed the affected residents at risk for contamination and food-borne illness. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>45668<br><br>The facility identified a census of 74 residents. The facility identified 14 residents on enhanced barrier precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to follow sanitary infection control standards related to enhanced barrier precautions, hand hygiene, and disinfection of shared mechanical lifts. These deficient practices placed the residents at risk for infectious diseases.<br><br>Findings Included-<br><br>- On 06/17/24 at 07:19 AM Certified Nurse Aide (CNA) T pushed the Hoyer lift (total body mechanical lift) out of Resident (R)12's room to the hallway and walked back into the room without sanitizing the lift.<br><br>On 06/17/24 at 09:07 AM, soiled linens sat on the floor of R24's room.<br><br>On 06/18/24 at 08:38 CNA M exited R1's room with the Hoyer lift while wearing an enhanced barrier precaution gown. CNA M removed the gown and discarded it in the Utility room. The mechanical lift was not sanitized after use. CNA M retrieved a glass of orange juice and took it to a resident at the dining room table. CNA M did not complete hand hygiene after handling the Hoyer lift and removing her gown, and before or after she served drinks to residents.<br><br>On 06/20/24 at 10:14 AM, CNA M stated gloves and gowns should be removed before exiting the room. She stated the lift was to be sanitized using sanitary bleach wipes before and after use.<br><br>On 06/20/24 at 11:03 AM Licensed Nurse (LN) I stated hand hygiene should be completed in between changing out personal protective equipment (PPE) or when visibly soiled. She stated the Hoyer lift should be cleaned and wiped down with sanitizing wipes before and after being used. She stated soiled linen should be placed in a biohazard bag and taken to the soiled utility room.<br><br>On 06/20/24 at 12:32 PM Administrative Nurse D stated staff were expected to complete hand hygiene in between resident cares and when visibly soiled. She stated that shared equipment should be clean and sanitized in between uses. She stated staff were expected to complete hand hygiene before serving drinks and meals to the residents.<br><br>The facility's Infection Control policy revised on 01/31/24 indicated staff will be educated on and follow safe infection prevention practices to reduce the risks of transmission of infectious organisms. The policy indicated staff will complete hand hygiene when in direct contact with soiled surfaces or potential contaminants. The policy indicated staff will ensure the proper storage, cleaning, and sanitization of medical equipment.<br><br>The facility failed to follow sanitary infection control standards related to enhanced barrier precautions, hand hygiene, and disinfection of mechanical lifts. These deficient practices placed the residents at risk for infectious diseases. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037<br><br>The facility identified a census of 74 residents. The sample included 19 residents with five residents reviewed for immunization status. Based on record review and interviews, the facility failed to offer and/or obtain the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial infections) pneumococcal (type of bacterial infection) vaccination, and influenza (highly contagious viral infection that attacks the lungs, nose, and throat and can be deadly in high-risk groups) vaccination consents or informed declinations for Resident (R) 17. This placed R17 at increased risk for influenza, pneumonia, and related complications.<br><br>Findings included:<br><br>- R17 was admitted [DATE].<br><br>A review of R17's clinical record lacked documentation that the PCV20 vaccine or the influenza vaccine for the last flu season was offered and given or declined.<br><br>Upon request for R17's declination or administration of the PCV20 vaccine or the influenza vaccine, the facility provided a declination dated 10/06/22.<br><br>On 06/20/24 at 11:21 AM, Administrative Nurse E, the infection preventionist stated the facility would review vaccine consent during care plans. Administrative Nurse E stated the facility did not require the resident or resident representative to sign yearly for declinations.<br><br>The facility's Immunization Policy dated 01/31/24 documented the facility recognized the major impact and mortality of vaccine-preventable diseases on residents of nursing homes; and the effectiveness of vaccines in reducing healthcare costs and preventing illness, hospitalization , and death.<br><br>The facility failed to obtain PCV20 or influenza vaccine consents or declinations for R17, who was eligible to receive the vaccinations. This placed R17 at increased risk for acquiring, transmitting, or experiencing complications from pneumococcal disease or influenza. |