

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Highland Place Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1736 Irving Place Shreveport, LA 71101	

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 - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>39897</p> <p>45317</p> <p>Based on record reviews, observations and interviews, the facility failed to accommodate the needs of 2 (#39 and #67) of 5 (#21, #39, #51, #67, and #120) residents investigated for environment. The facility failed to ensure residents' call lights remained within reach.</p> <p>Findings:</p> <p>Review of Facility's Call Light, Answering procedure dated April 2022 revealed in part:</p> <p>Purpose</p> <p>The purpose of this procedure is to respond to the resident's requests and needs.</p> <p>Key Procedural Points .</p> <p>5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .</p> <p>Resident #39</p> <p>During an interview on 06/03/2024 at 9:45 a.m., Resident #39 reported she did not have a call light.</p> <p>Observation on 06/03/2024 at 9:45 a.m. failed to reveal Resident #39's call light within reach. Further observation revealed Resident #39's call light cord was connected to wall plug and the call light was on the ground between the wall and piece of furniture.</p> <p>Observation on 06/04/2024 at 10:30 a.m. revealed Resident #39's call light cord was connected to teh wall plug wall and the call light was on the ground between the wall and piece of furniture.</p> <p>During an interview on 06/05/2024 at 10:30 a.m. with S2 DON (Director of Nursing) present, Resident #39 reported she did not have a call light to call for assistance.</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 - Some</p>	<p>Observation on 06/05/2024 at 10:30 a.m. revealed Resident #39 in her room, sitting up in bed. Further observation revealed S2 DON located Resident #39's call light was on the ground wedged between the wall and a piece of furniture.</p> <p>During an interview on 06/05/2024 at 10:30 a.m. S2 DON confirmed Resident #39's call light was not within Resident #39's reach and should have been.</p> <p>Resident #67</p> <p>Review of Resident #67's Care Plan revealed a problem of at risk for falls related to decreased mobility, history of falls with T11-12 compression fracture: Interventions included anticipate and meet resident's needs, attempt to keep resident's call light within reach, and encourage the resident to use call light for assistance as needed.</p> <p>Observation on 06/03/24 at 9:40 a.m. revealed Resident #67's call light cord was wrapped around and wedged in the bed wheel at the foot of Resident #67's bed and was not in Resident #67's reach.</p> <p>Observation on 06/04/2024 at 12:30 p.m. revealed Resident #67's call light cord was wrapped around and wedged in the bed wheel at the foot of Resident #67's bed and was not in Resident #67's reach.</p> <p>During an interview on 06/04/2024 at 12:30 p.m. S2 DON acknowledged Resident #67's call light cord was wrapped around and wedged in the bed wheel at the foot of Resident #67's bed and was not in Resident #67's reach.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36921</p> <p>Based on record reviews and interviews the facility failed to consider the views of the resident council group and act promptly to concerns related to laundry presented in the resident council meetings. The deficient practice had the potential to affect a total of 189 residents according to Long-Term Care Facility Application for Medicare and Medicaid dated 06/03/2024.</p> <p>Findings:</p> <p>Review of the resident council meeting notes from January 2024 through May 2024 revealed the following grievances related to laundry/ missing clothes:</p> <p>01/22/2024:</p> <p>Resident #62: missing her black blanket, activities gave her another one. Review of Resident #62's MDS dated [DATE] revealed a BIMS of 6 out of 15 indicating severely impaired cognition.</p> <p>Resident #69: states his laundry is slow coming back sometimes a week. Review of Resident #69's MDS dated [DATE] revealed a BIMS of 15 out of 15 indicating cognitively intact.</p> <p>Resident #13: states he is missing a gray shirt. Review of Resident #13's MDS dated [DATE] revealed a BIMS of 15 out of 15 indicating cognitively intact.</p> <p>02/18/2024:</p> <p>Resident #19: states he is still missing black jeans with gray patch. Review of Resident #19's MDS dated [DATE] revealed a BIMS of 15 out of 15 indicating cognitively intact.</p> <p>Resident #58: missing cowboy shirt blue. Review of Resident #58's MDS dated [DATE] revealed a BIMS of 15 out of 15 indicating cognitively intact.</p> <p>05/27/2024:</p> <p>Resident #71: states her clothes are coming back from the laundry bleached. Review of Resident #71's MDS dated [DATE] revealed a BIMS of 13 out of 15 indicating cognitively intact.</p> <p>Resident #149: states she is missing a black pajama shirt and one pair of camouflage pants. Review of Resident #149's MDS dated [DATE] revealed a BIMS of 15 out of 15 indicating cognitively intact.</p> <p>Resident #113: missing three pair of sweat pants. Review of Resident #113's MDS dated [DATE] revealed a BIMS of 10 out of 15 indicating moderately impaired cognition.</p> <p>Review of facility's Grievance/Complaint log for May 2024 revealed:</p> <p>Resident #107: missing clothing. Grievance/ Complaint received on 05/23/2024-facility response on 06/06/2024 to request family to replace items and provide receipt for reimbursement</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>Resident #149: missing clothing. Grievance/ Complaint received on 05/27/2024-facility response on 05/29/2024 resident still not satisfied items have not been found, but did thank me for taking out time to look.</p> <p>During an interview on 06/03/2024 at 2:00 P.M. during meeting of resident council group Resident #3 reported receiving other residents clothes back from the laundry. Resident #3 reported sometimes it may take up to a month to get your clothes back from laundry and then sometimes you still do not get your clothes back or you may get clothes that do not belong to you.</p> <p>During an interview on 06/03/2024 at 2:00 P.M. during meeting of resident council group Resident #149 reported she had missing clothes in the past. Resident #149 described the clothes as a pajama shirt: black sleeve with a yellow face that she received for Christmas from her brother and a pair of camouflage pants. Resident #149 was unable to recall how long her clothes have been missing, but she reported she no longer sends her clothes to the facility laundry her family does her laundry.</p> <p>During an interview on 06/03/2024 at 2:00 P.M. during meeting of resident council group Resident #9 reported she has seen other residents with her clothes on that were labeled with her name. Resident #9 reported she told the staff and followed the resident along with the staff to get her clothes back from the resident wearing her clothes. Resident #9 reported her family now does her laundry.</p> <p>During an interview on 06/03/2024 at 2:30 P.M. S15 Activity Director reported the turn around time for clothes to be returned from the laundry was up to 3 days and after 5 days she would write up a grievance. S15 Activity Director reported when residents had issues she would log them into the grievance/ complaint log then turn it in to social services. S15 Activity Director reported S16 Housekeeping/ Laundry Supervisor looked out for reported missing clothes. S15 Activity Director reported if the missing clothes were not able to be found sometimes they were replaced; if staff had seen residents wearing clothes. S15 Activity Director reported she had heard of clothes from the laundry being given to wrong residents.</p> <p>During an interview on 06/06/2024 at 10:30 A.M. S17 Social Services reported S16 Housekeeping/ Laundry Supervisor investigated missing clothing and if clothing was not found the facility would replace the clothing.</p> <p>During an interview on 06/06/2024 at 2:30 P.M. S16 Housekeeping/ Laundry Supervisor reported the return of the residents clothes depend on many things, as laundry was liberal and there was no laundry schedule for hall or unit. S16 Housekeeping/ Laundry Supervisor reported sometimes residents did not have their names in their clothes or residents may have moved to another room/ floor and clothes are returned to previous room/ floor and this was a back and forth issue with returning resident's clothes.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34708</p> <p>Based on record reviews and interview the facility failed to ensure the MDS (Minimum Data Set) assessment accurately reflected the resident's status for 1 (#178) of 2 (#178, #34) residents investigated for hospitalization .</p> <p>Findings:</p> <p>Review of Resident #178's record revealed a discharge date of [DATE].</p> <p>Review of Resident #178's progress note dated 03/12/2024 revealed resident #178 was discharged to another long term care facility.</p> <p>Review of Resident #178's discharge MDS assessment dated [DATE] revealed Resident #178 was discharged to a short term general hospital.</p> <p>During an interview on 06/05/2024 at S10 RN (Registered Nurse)/MDS Director reviewed Resident #178's record and acknowledged Resident #178 was discharged to another long term care facility. S10 RN/MDS Director further acknowledged Resident #178's discharge MDS assessment dated [DATE] indicated Resident #178 was discharged to the hospital and should have indicated Resident #178 was discharged to another long term care facility.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36665</p> <p>Based on record review and interviews the facility failed to ensure a plan of care was developed and implemented for 2 (#25, 98) of 2 residents reviewed for UTI (urinary tract infection). The facility failed to:</p> <ol style="list-style-type: none"> 1. Develop a plan of care for 2 (#25, 98) residents diagnosed with urinary tract infection. 2. Administer medication as ordered for resident # 98. <p>Findings:</p> <ol style="list-style-type: none"> 1. <p>Resident #25,</p> <p>Review of resident #25's electronic health record revealed an admitted [DATE] and a diagnosis of but not limited to chronic congestive heart failure, primary hypertension, type 2 diabetes and Urinary Tract Infection.</p> <p>Review of resident #25's MDS (minimum data set) revealed resident #25 had a BIMS (Brief Interview Mental Status) score of 12 indicating moderately impaired cognition.</p> <p>Review of resident #25's lab results dated 05/29/2024 revealed resident #25 had cloudy yellow urine with a blood urea nitrogen level of 22 and a creatinine level of .56, a presumed UTI pending urine culture.</p> <p>Review of resident #25's Physician's orders revealed an order for Keflex 500 mg give 1 mg (milligram) by mouth three times a day for 5 days dated 05/30/2024 for UTI (Urinary Tract Infection).</p> <p>Review of resident #25's comprehensive plan of care failed to reveal a problem or approach related to resident #25's diagnosis of UTI.</p> <p>During an interview on 06/05/2024 at 1:30 p.m. S8 LPN (licensed practical nurse)/MDS Nurse confirmed a plan of care for resident #25's diagnosis of UTI had not been developed and should have been.</p> <p>Resident #98</p> <p>Review of resident #98's electronic health record revealed an admitted [DATE] and a diagnosis of but not limited to UTI, generalized epilepsy, type 2 diabetes, cerebral infarction affecting right dominant side, essential hypertension, and Aphasia.</p> <p>Review of resident #98's MDS dated [DATE] revealed resident #98 had a BIMS score of 9 indicating moderately impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of resident #98's Physicians Orders revealed an order for Macrobid Oral Capsule 100 mg give 1 capsule by mouth two times a day for UTI for 5 days.</p> <p>Review of resident #98's comprehensive plan of care failed to reveal a problem or approaches related to resident #98's diagnosis of UTI.</p> <p>During an interview on 06/05/2024 at 1:30 p.m. S8 LPN/MDS Nurse confirmed a plan of care for resident #98's diagnosis of UTI had not been developed and should have been.</p> <p>2.</p> <p>Review of resident #98's lab work dated 05/29/2024 revealed a result of leukocytosis and a high white blood cell count of 13.5 (range 4.6 to 10.2). Further review of resident #98's lab work revealed hand written order signed by the facility's nurse practitioner to Start Doxycycline 100 mg(milligrams) by mouth twice a day for 5 days, and add Acidophilus one tab by mouth daily for 30 days.</p> <p>Review of resident #98's May 2024 and June 2024 Physicians Orders failed to reveal an order for Doxycycline 100 mg(milligrams) by mouth twice a day for 5 days, and Acidophilus one tab by mouth daily for 30 days.</p> <p>Review of resident #98's May 2024 and June 2024 MAR (medication administration record) failed to reveal any documentation indicating doxycycline 100 mg and acidophilus had been administered to resident #98.</p> <p>During an interview on 06/05/2024 at 3:30 p.m. S2 DON (Director of Nurses) confirmed the orders for doxycycline or acidophilus had not been put in resident #98's electronic health record and had not been administered to resident #98.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34708</p> <p>Based on record reviews and interviews the facility failed to ensure the resident's plan of care was revised to meet the resident's needs for 1 resident (#159) out of 4 residents (#159, #7, #121, #161) investigated for weight loss.</p> <p>Findings:</p> <p>Review of Resident #159's record revealed an admitted [DATE] with a readmitted [DATE]. Further review of Resident #159's record revealed Resident #159 was NPO (nothing by mouth) and was fed via enteral feedings through a PEG (percutaneous endoscopic gastrostomy) tube.</p> <p>Review of Resident #159's weight log revealed on 02/02/2024, the resident weighed 112.6 lbs. (pounds). Further review of Resident #159's weight log revealed the following weights:</p> <ul style="list-style-type: none"> -on 02/23/2024 Resident #159 weighed 107.0 lbs. -on 03/25/2024 Resident #159 weighed 106.1 lbs. -on 04/02/2024 Resident #159 weighed 101.3 lbs. -on 04/10/2024 Resident #159 weighed 99.4 lbs. -on 05/08/2024 Resident #159 weighed 97.6 lbs. which indicated a -13.32 % (percent) loss from 02/02/2024. <p>Review of Resident #159's record failed to reveal Resident #159's care plan was revised to include a dietician consult to follow Resident #159's nutritional needs. Further review of Resident #159's record failed to reveal Resident #159's care plan was revised to include documentation that weekly weights were implemented to further monitor Resident #159 for weight loss.</p> <p>During an interview on 06/05/2024 at 12:37 p.m. S2 DON (Director of Nursing) reported resident's weights were entered into the resident's weight log by the unit managers. S2 DON further reported residents with a weight loss of greater than 5% in 30 days, greater than 10% in 120 days, or any steady declining weight was reviewed and discussed in the monthly patient at risk meetings. S2 DON reported nurses implement weekly weights and consult the dietician on residents with weight loss. S2 DON reviewed Resident #159's weight loss and acknowledged that Resident #159 had a gradual weight loss in which the last weight on 05/08/2024 resulted in greater than 10% weight loss in the last 120 days. S2 DON further reviewed Resident #159's record and acknowledged the dietician had not been consulted and weekly weights had not been implemented to address Resident #159's weight loss.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36665</p> <p>Based on record review, observations, and interviews the facility failed to ensure a resident who was unable to complete their activities of daily living received the necessary services to maintain grooming and hygiene for 6 (#25, #57, #98, #120, #141, #174) of 10 residents (#16, #25, #33, #57, #65, #98, #120, #141, #174) reviewed for Activities of Daily Living. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. residents #25, #57, #98, and #141's fingernails were clean and trimmed. 2. resident #120's toenails were clean and trimmed. 3. resident #174 received scheduled bath/shower. <p>Findings:</p> <p>Review of the facility's Nail Care (Finger and Toe) Policy dated 11/15/2024 revealed the following:</p> <p>The purpose is to clean the nail bed, prevent infection and comfort the resident.</p> <p>Practice Guidelines</p> <p>Key points</p> <ol style="list-style-type: none"> 1. Nails can be partially cleaned during bathing. 2. Nursing Assistants do not trim the nails of diabetic residents 3. Nail care includes daily cleaning and regular trimming 4. Stop and report any evidence of ingrown toes nails, infection, pain, or nails are too hard or thick to cut with ease. <p>1.</p> <p>Resident #25</p> <p>Review of resident #25's electronic health record revealed an admitted [DATE] with a diagnosis of but not limited to congestive heart failure, diabetes mellitus, lack of coordination, essential hypertension, communication deficit and atrophy of left upper arm.</p> <p>Review of resident #25's MDS (Minimum Data Set) dated 04/12/2024 revealed a BIMS (brief interview mental status) of 12 indicating moderately impaired cognition.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of resident #25's comprehensive plan of care included in part; the resident has Diabetes Mellitus; Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails.</p> <p>Observation on 06/03/2024 at 2:25 p.m. revealed resident #25 fingernails were long and protruded past the nail beds on both hands.</p> <p>During an interview on 06/03/2024 at 2:25 p.m. resident #25 stated, I need to get my nails cut, they grow back so fast, I used to try to cut them myself. When asked by surveyor if staff cut her nails, resident #25 stated, they never ask me to cut them.</p> <p>During an interview on 06/04/2024 at 3:56 p.m. S11 LPN (licensed practical nurse) confirmed resident #25's fingernails were not trimmed and reported any CNA (certified nursing assistance) may trim nails, except for diabetics, diabetics must see the podiatrist.</p> <p>Resident #57</p> <p>Review of resident #57's electronic health record revealed an admitted [DATE] with a diagnosis of but not limited to Alzheimer's disease, contracture of muscle right hand, muscle wasting and atrophy in arms and lack of coordination.</p> <p>Review of resident #57's comprehensive plan of care included in part the problem/risks and interventions for potential for ADL(activities of daily living) self-care performance deficit. Resident #57 requires fluctuating assistance with ADL's from extensive to total and requires the assistance of one staff with personal hygiene and oral care.</p> <p>Observation on 06/03/2024 at 9:30 a.m. revealed resident #57 lying in bed with her fingers in her mouth. Further review revealed resident #57's fingernails long with black substance underneath and resident putting her fingers in her mouth.</p> <p>Observation on 06/04/2024 at 12:15 p.m. with S2 DON (Director of Nursing) revealed resident #57 lying in bed with her fingers in her mouth. Further review revealed resident #57's fingernails long with black substance underneath and resident putting her fingers in her mouth.</p> <p>During an interview on 06/04/2024 at 12:15 p.m. S2 DON confirmed resident #57's fingernails were long with a black substance underneath and should have cleaned and trimmed during resident #57's bath.</p> <p>Resident #98</p> <p>Review of resident #98's electronic health record revealed an admitted [DATE] and a diagnosis of but not limited to UTI (urinary tract infection), generalized epilepsy, type 2 diabetes, cerebral infarction affecting right dominant side, essential hypertension, and aphasia.</p> <p>Review of resident #98's MDS (minimum data set) dated 11/22/2021 revealed resident #98 had a BIMS score of 9 indicating moderately impaired cognition.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of resident #98's comprehensive plan of care revealed resident #98 had a Self Care Performance Deficit related to hemiplegia and hemiparesis following a cerebral infarction affecting right dominant side with an approach of; Bathing check nail length and clean on bath day, report any changes or necessity for trimming to the nurse.</p> <p>Observation on 06/03/2024 at 2:18 p.m. revealed resident #98 had long jagged fingernails on his right hand.</p> <p>Observation on 06/04/2024 at 2:00 p.m. revealed resident #98 had long jagged fingernails on his right hand.</p> <p>During an interview on 06/04/2024 at 3:15 p.m. S19 CNA (certified nursing assistant) reported I usually trim nails on bath days, resident #98's nails grow really fast and need frequent trimming.</p> <p>During an interview on 06/04/2024 at 3:56 p.m. S11 LPN reported any CNA may trim nails, except for diabetics and confirmed resident #98's fingernails needed trimming.</p> <p>Resident #141</p> <p>Review of resident #141's electronic health record revealed and admitted [DATE] with a diagnosis of but not limited to major depressive disorder.</p> <p>Review of resident #141's Quarterly MDS dated [DATE] revealed a BIMS of 14 indicating intact cognition.</p> <p>Review of resident #141's comprehensive care plan revealed resident #141 had an ADL self-care performance deficit related to disease process. Resident #141 requires fluctuating assistance from extensive to total assistance with ADLS.</p> <p>Observation on 06/03/2024 at 10:34 a.m. revealed resident #141 fingernails were long, uneven and jagged.</p> <p>During an interview on 06/03/2024 at 10:34 a.m. resident #141 reported she liked her nails long but her left thumb nail was cracked across the nail bed and needed to be trimmed. Resident #141 reported her left thumb nail had been cracked across the nail bed for the last 3-4 days.</p> <p>During an interview on 06/03/2024 at 12:30 p.m. S21 LPN confirmed resident #141's left thumb nail was cracked across the nail bed and should have been trimmed.</p> <p>2.</p> <p>Resident # 120</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Highland Place Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1736 Irving Place Shreveport, LA 71101	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of resident #120's electronic health record revealed and admitted [DATE] with a diagnosis of but not limited to; displaced fracture of lateral condyle of left tibia, sequela, displaced Maisonneuve's fracture of left leg, sequela, unspecified injury at unspecified level of cervical spinal cord, sequela, 08/31/2023: complete rotator cuff tear or rupture of right shoulder, 09/01/2023: pain in the right shoulder, 01/09/2023: Muscle weakness, unsteadiness on feet, pain in left lower leg, pain in left knee, 06/02/2023: muscle wasting and atrophy, right upper arm & left upper arm, and lack of coordination.</p> <p>Review of resident #120's Quarterly MDS dated [DATE] revealed resident #120 had a BIMS score of 15 indicating intact cognition.</p> <p>Review of resident #120's comprehensive care plan revealed resident had an ADL (activities of daily living) self-care deficit requiring fluctuating assistance with ADL's from supervision to limited assist due to decreased mobility.</p> <p>Observation on 06/03/2024 at 9:10 a.m. revealed resident #120's toe nails were thick, long and curved.</p> <p>During an interview on 06/03/2024 at 11:18 a.m. resident #120 reported his toe nails had not been trimmed and they were so long they hurt.</p> <p>Observation on 06/04/2024 at 3:20 p.m. with S7 CNA Supervisor revealed resident #120's toe nails were long and thick. S7 CNA Supervisor also confirmed resident #120 should have been seen by the podiatrist. S7 CNA Supervisor reported the last time she could recall resident #120 was seen by the podiatrist was about a year ago.</p> <p>3.</p> <p>Resident #174</p> <p>Review of resident # 174's electronic health record revealed an admitted [DATE] with a diagnosis of but not limited unspecified fracture of lower end of left tibia, closed fracture with routine healing, unspecified dislocation of left knee, and pain in left leg.</p> <p>Review of resident #174's admission MDS (Minimum Data Sets) dated 05/14/2024 revealed BIMS of 14 indicating intact cognition.</p> <p>During an interview on 06/03/2024 at 11:02 a.m. resident #174 reported she scheduled to get a bath on the night shift, but her bath is often put off resulting in not receiving a bath. Resident #174 reported she would like to get a shower. Resident #174 further reported she had to wash herself off this morning in the bathroom sink before going to bingo.</p> <p>Review of the printed resident shower schedule with S7 CNA (Certified Nurse Assistant) Supervisor revealed resident #174 was scheduled to receive a shower on Monday, Wednesday, and Friday on 11p.m. to 7a.m. shift.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of EHR (Electronic health Record) POC (Point of care) charting by CNAs (Certified Nurse Assistant) with S9 LPN (Licensed Practical Nurse) on 06/04/2024 at 4:00 p.m. failed to reveal resident # 174 had received a shower since admit.</p> <p>During an interview on 06/04/2024 at 4:00 p.m. S9 LPN confirmed resident #174 was not set up in the EHR POC system to prompt a shower or bath to be done and should have been set up when resident #174 was admitted . S9 LPN further confirmed resident #174 had not been bathed or showered as scheduled.</p> <p>36921</p> <p>39897</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>36921</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure 1 (#139) resident out of 1 reviewed for edema received treatment and care in accordance with professional standards of practice by failing to follow physician orders for applying ted hose, monitoring for edema with use of diuretics (Lasix), and revision to care plan of edema with use of diuretics (Lasix).</p> <p>Findings:</p> <p>During an interview on 06/03/2024 at 11:45 A.M. Resident #139 reported he had a medical history of blood clots and cellulitis, and reported he was not sure if his edema was from the cellulitis since he has completed treatment of antibiotics and legs are still swollen or from history of blood clots. Resident #139 went on to report he should be wearing ted hose.</p> <p>Observation on 06/03/2024 at 11:45 A.M. revealed Resident #139 had edema to bilateral lower extremities and failed to reveal Resident #139 had ted hose applied to lower extremities.</p> <p>Observation on 6/5/2024 at 2:20 P.M. revealed Resident #139 had edema to bilateral lower extremities and failed to reveal Resident #139 had ted hose applied to lower extremities.</p> <p>Review of Resident #139's medical diagnoses revealed the following diagnoses but not limited to embolism and thrombosis of unspecified deep veins of lower extremity (08/15/2023).</p> <p>Review of Quarterly MDS (Minimum Data Sets) dated 05/22/2024 revealed a BIMS (Brief Interview of Mental Status) of 12 out of 15 indicating Resident #139 was cognitively intact.</p> <p>Review of Resident #139's June 2024 physician orders revealed:</p> <p>05/25/2024: Apply [NAME] hose during day only and remove at night; one time a day for DVT (deep vein thrombosis) risk reduction.</p> <p>08/24/2023: Apixaban Oral Tablet 5 MG (milligram) (Apixaban); Give 1 tablet by mouth two times a day for DVT (deep vein thrombosis)</p> <p>09/06/2023: Lasix Oral Tablet 40 MG (Furosemide); Give 1 tablet by mouth one time a day for CHF (congestive heart failure) with edema</p> <p>Further review of Resident's #139's June 2024 EMAR (Electronic Medication Administration Record) failed to reveal Resident #139 was monitored for edema with use of diuretics.</p> <p>Review of Resident #139 Comprehensive Care Plan failed to reveal problems and approaches addressing edema.</p> <p>During an interview on 06/05/2024 at 2:20 P.M. S6 LPN (Licensed Practical Nurse) reported Resident #139 did have a physician order for ted hose and an order had been placed with medical supply company but have not arrived at the facility for Resident #139.</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 - Some</p>	<p>During an interview on 06/05/2024 at 2:20 P.M. S6 LPN reviewed Resident # 139's June 2024 physician orders and daily task to confirm monitoring of edema for diuretics was not included on the EMAR or daily task.</p> <p>During an interview on 6/6/2024 at 1:40 P.M. S2 DON (Director of Nursing) reported a special order for thigh high ted hose was placed last week for Resident #139. S2 DON was unable to present surveyor with an invoice or documentation of ordering TED hose or follow up from corporate office or medical supply company.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34708</p> <p>Based on record reviews and interviews the facility failed to ensure 1 resident (#164) out of 3 residents (#164, #6, #94) investigated with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing and prevent infection. The facility failed to obtain and implement wound care treatment orders on Resident #164 upon readmission to the facility.</p> <p>Findings:</p> <p>Review of Resident #164's record revealed Resident #164 was admitted to the facility on [DATE] with a readmission on 05/30/2024. Resident #164's diagnoses included in part anoxic brain damage, cardiac arrest-cause unspecified, acute and chronic respiratory failure with hypoxia, sepsis-unspecified organism, chronic osteomyelitis with draining sinus-left radius and ulna, osteomyelitis-unspecified, bacterial infection-unspecified, bacteremia, carrier of methicillin resistant staphylococcus aureus, and severe hypoxic ischemic encephalopathy.</p> <p>Review of Resident #164's record revealed an incomplete skin assessment on 05/30/2024. Further review of Resident #164's record revealed a skin assessment dated [DATE] with Resident #164 assessed to have a stage IV pressure ulcer to the sacrum, a stage II pressure ulcer pressure ulcer to the right arm, and a stage II pressure ulcer to the left foot.</p> <p>Review of Resident #164's record failed to reveal wound care treatment orders were obtained and implemented on readmission to the facility on 05/30/2024. Further review of Resident #164's record revealed wound care treatment orders were not obtained and implemented until 06/03/2024.</p> <p>During an interview on 06/05/2024 at 11:00 a.m. S14 RN (Registered Nurse)/Unit Manager reviewed Resident #164's record and acknowledged wound care care treatment orders were not obtained and implemented until 06/03/2024 after Resident #164's readmission on 05/30/2024.</p> <p>During an interview on 06/05/2024 at 12:18 p.m. S2 DON (Director of Nursing) reviewed Resident #164's record and acknowledged wound care treatment orders were not obtained and implemented until 06/03/2024 after Resident #164's readmission on 05/30/2024.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>36921</p> <p>Based on record reviews and interview, the facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Resident #85 received at least quarterly Registered Dietician assessments according to policy. 2. Monthly weights were documented in EHR (electronic health record) to ensure Resident #135 maintained a desired weight. <p>There were a total of 9 (#7, #21, #34, #52, #79, #85, #135, #159, #161) residents reviewed for nutrition.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. <p>Review of facility's Role of the Dietician policy dated April 2022 revealed in part,</p> <ol style="list-style-type: none"> 1. Review all new admissions on each visit. (minimum of Monthly) 2. Review all tube feedings at least quarterly unless there is weight loss/gain, or pressure ulcer. 9. Review residents on dialysis quarterly and as needed. <p>Observation on 06/03/2024 at 9:00 a.m. revealed Resident #85 receiving Glucerna via feeding pump.</p> <p>Review of Resident #85's medical record revealed diagnoses that include in part hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, encounter for attention to gastrostomy, and Type 2 diabetes mellitus.</p> <p>Review of Resident #85's record revealed previous Registered Dietician (RD) Nutritional assessment completed 07/15/2021.</p> <p>Review of Resident #85's Registered Dietician MINI assessment completed 06/06/2024.</p> <p>Review of Resident #85's comprehensive care plan revealed resident has nutritional problem or potential nutritional problem related to dysphagia, Gastroesophageal reflux disease, hyperlipidemia, malnutrition, peg tube, and nothing by mouth.</p> <p>During an interview on 06/06/2024 at 2:55 p.m. S22 RD reported the last Health Care RD Nutritional Assessment was completed on 03/21/2023 for Resident #85 but could not provide the documentation. S22 RD further reported she did not see the Resident on 06/06/2024 for the mini assessment, she only gathered the information from Resident #85's record.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 06/06/2024 at 3:30 p.m. S12 RDCO (Regional Director of Clinical Operations) reported the Registered Dietician should see all residents on admit or readmit, all residents that receive tube feeding, any resident with weight loss, any resident with wounds, and residents on dialysis or nutritional consult.</p> <p>2.</p> <p>Review of facility's weight management Policy dated 01/01/2023 revealed in part,</p> <p>Intent: It is the policy of the facility to provide care and services related to weight management in accordance to State and Federal regulation.</p> <p>Procedure:</p> <p>2. All residents will be weighted on a monthly basis unless otherwise ordered by the physician or deemed necessary by the dietician and or the interdisciplinary team.</p> <p>3. Monthly weights will be completed by the fifth of each month.</p> <p>7. All weights will be documented in the resident's electronic medical record.</p> <p>Review of Resident # 135's medical diagnoses revealed the following medical diagnoses but not limited to unspecified sequelae of unspecified cerebrovascular disease, traumatic subdural hemorrhage with loss of consciousness status unknown, nontraumatic intracerebral hemorrhage, intraventricular, aneurysm of unspecified site, dysphagia following other cerebrovascular disease, encounter for attention to gastrostomy</p> <p>Review of Resident #135's June 2024 Physician Orders revealed:</p> <p>08/01/2023: Enteral Feed; every shift Jevity 1.5 at 55 ml (milliliters)/HR (hour) per peg per pump continuously</p> <p>08/01/2023: NPO (Nothing by mouth) diet</p> <p>Review of Resident #135's Quarterly MDS (Minimum Data Sets) Swallowing/ Nutritional Status dated 05/17/2024 revealed:</p> <p>Height: 72 inches</p> <p>Weight: 164 pounds</p> <p>Weight loss: no or unknown</p> <p>51% or more in proportion of total calories the resident received through parenteral or tube feeding. 501 cc/day or more of average fluid intake per day by IV (intravenous) or tube feeding</p> <p>Review of EHR (Electronic Health Record) revealed Resident # 135's last recorded weight was 164.4 pounds on March 1, 2024.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Weight Binder with S7 CNA (Certified Nurse Assistant) Supervisor on 06/04/2024 at 3:40 P.M. revealed Resident #135's hand written weight dated May 7, 2024 was 158.9 pounds.</p> <p>Review of Resident # 135's care plan revealed Resident has nutritional problems or potential nutritional problem related to NPO status, vitamin deficiency, SDH (subdural hematoma) with interventions monitor/record/report to physician as needed signs & symptoms of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3 pounds in 1 week, more than 5% in 1 month, more than 7.5% in 3 months, more than 10% in 6 months, weights per facility policy</p> <p>During an interview on 6/5/2024 at 2:10 P.M. S2 DON (Director of Nursing) reported weights should be obtained monthly and the weights should be recorded in the EHR by the unit manager. S2 DON reviewed Resident # 135's EHR and confirmed Resident # 135's weights were not recorded for the month of April 2024 and May 2024.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39897</p> <p>45317</p> <p>Based on record reviews, observations and interview the facility failed to provide appropriate treatment and services for 2 (#85 and #161) of 3 (#21, #85, and #161) residents reviewed for tube feeding. The facility failed to ensure the tube feeding container was appropriately labeled.</p> <p>Findings:</p> <p>Review of Facility's undated procedure with subject of Enteral Tube Feeding via Pump, revealed in part:</p> <p>Intent:</p> <p>It is the policy of the facility to provide enteral feeding as ordered by the physician via pump to ensure adequate nutrition for residents that are unable to maintain their nutrition orally.</p> <p>Procedure .</p> <p>3. Label the enteral feeding bag/bottle, to include the tubing, with the following information:</p> <ul style="list-style-type: none"> a. Resident's name and room # b. Type of formula (if using bags) c. Date and time formula is being hung d. Rate of administration <p>Resident #85</p> <p>Review of resident #85's medical record revealed an admitted [DATE] and a readmitted [DATE] with diagnoses that included in part hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, encounter for attention to gastrostomy, and Type 2 diabetes mellitus.</p> <p>Review of registered Dietician assessment dated [DATE] revealed in part: Current diet: NPO (nothing by mouth); Enteral Feeding: Glucerna 1.2 at 55 ml (milliliter)/hr (hour) X 24 hrs/day.</p> <p>Observation on 06/03/2024 at 06/03/2024 at 9:00 a.m. revealed Resident #85 was receiving Glucerna via feeding pump. Further observation revealed Resident #85's tube feeding formula label failed to include the time the feeding was hung.</p> <p>Resident #161</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #161's medical record revealed an admitted [DATE] and diagnoses which included, in part, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, aphasia, dysphagia, severe protein-calorie malnutrition, body mass index 19.9 or less, and encounter for attention to gastrostomy.</p> <p>Review of Resident #161's physician orders revealed, in part an order dated 03/20/2024 for Jevity 1.5 at 50 ml (milliliters)/hr. (hour) per peg, per pump continuously.</p> <p>Observation on 06/03/2024 at 9:00 a.m. revealed Resident #161's tube feeding formula label failed to include the time the feeding was hung.</p> <p>During an interview on 06/03/2024 at 9:50 a.m. S5 LPN (Licensed Practical Nurse) confirmed Resident #85 and Resident #161's tube feeding formula labels failed to include the time the feeding was hung and should have.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36921</p> <p>Based on record reviews, observations, and interviews the facility failed to ensure residents who need respiratory care were provided care consistent with professional standards of practice for 4 (#79, #120, #136, #139) out of 5 (#79, #120, #136, #139, #164) residents reviewed for respiratory care.</p> <p>The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. The oxygen concentrator and filter were clean and the nasal cannula was dated for Resident #79. 2. The respiratory supplies (oxygen mask and tubing for Resident ##139 and nebulizer mask and tubing for Resident #120, #136, and #139 were changed weekly, labeled with date and initials upon opening and stored in plastic bag between uses. <p>Findings:</p> <p>Review of facility's Respiratory Therapy equipment policy dated April 2022 revealed in part:</p> <p>This procedure may involve potential/direct exposure to blood, body fluids, infectious disease, air containments, and hazardous chemicals.</p> <p>Purpose</p> <p>The purpose of this procedure is to provide guidelines to help prevent nosocomial infections associated with respiratory therapy equipment, including ventilators, and to prevent transmission of infections to resident and staff.</p> <p>Procedure Guidelines</p> <p>Oxygen Administration:</p> <ol style="list-style-type: none"> 3. [NAME] bottle with date and initials upon opening. 5. Change oxygen cannulas and tubing used PRN (as needed) in a plastic bag when not in use. 7. Wash filters from oxygen concentrators weekly. Rinse and squeeze dry. <p>Medication Nebulizers/Continuous Aerosol:</p> <ol style="list-style-type: none"> 7. Store circuit in plastic bag, marked with date and resident's name, between uses 9. Discard administration set-up every 7 days. Date new tubing. <p>Resident #79</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Highland Place Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1736 Irving Place Shreveport, LA 71101	

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #79's medical record revealed an admitted [DATE] with diagnoses that include but not limited to COPD (Chronic Obstructive Pulmonary Disease), multiple myeloma not having achieved remission, chronic diastolic (congestive) heart failure, chronic respiratory failure with hypoxia, anxiety disorder and dependence on renal dialysis.</p> <p>Review of Resident #79's physician orders revealed in part:</p> <p>04/23/2024: Change and date all respiratory supplies and tubing weekly. If oxygen concentrator is present, clean filter every day shift every Tuesday and as needed.</p> <p>12/31/2020: Oxygen at (4) liters per nasal cannula while in room, every shift related to shortness of breath.</p> <p>Observation on 06/03/2024 at 9:30 A.M. revealed Resident #79's oxygen concentrator and filter with a thick layer of dust covering the machine and Resident #79's oxygen tubing laying across the bedrail with no date.</p> <p>Observation on 06/04/2024 at 11:50 A.M. revealed Resident #79's oxygen was in use via nasal cannula. Further observation revealed oxygen concentrator and filter with a thick layer of dust covering the machine and filter, oxygen tubing with no date.</p> <p>During an interview on 06/04/2024 at 12:45 P.M. S2 DON (Director of Nursing) confirmed Resident #79's oxygen concentrator and filter should have been cleaned and the oxygen tubing should have been dated.</p> <p>Resident #120</p> <p>Review of Resident # 120's June 2024 physician orders revealed an order dated</p> <p>05/10/2024: Ipratropium-Albuterol Inhalation solution 0.5-2.5 (3) mg (milligrams)/ 3ml (milliliters); 1 application inhale orally every 6 hours as needed for SOB (shortness of breath)</p> <p>Observation on 06/03/2024 at 9:31 A.M. revealed Resident # 120's nebulizer and mask on the overbed table. Further observation revealed Resident # 120's nebulizer and mask was not labeled/ dated.</p> <p>During an interview on 06/03/2024 at 12:40 P.M. S21 LPN (licensed practical nurse) confirmed Resident #120's nebulizer mask was not labeled/dated with the opening date and was not stored properly when not in use.</p> <p>Resident #136</p> <p>Review of Resident # 136's medical diagnoses revealed chronic respiratory failure with hypoxia (08/31/2023) and COPD (08/31/2023).</p> <p>Review of Resident # 136's June 2024 Physician Orders revealed:</p> <p>08/26/2023: Levalbuterol Hydrochloride Inhalation Nebulization solution 1.25 mg/3ml; 1 vial inhale orally via nebulizer three times a days for COPD/shortness of breath</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #136's MDS (Minimum Data Set) dated 04/12/2024 revealed a BIMS (Brief Interview of Mental Status) of 15 out of 15 indicating cognitively intact.</p> <p>Observation on 06/03/2024 at 10:00 A.M. revealed Resident #136's nebulizer and mask were in Resident # 136's bed. Observation revealed Resident #136's nebulizer was not in use. Further observation revealed Resident # 136's nebulizer mask was dated 05/15/2024 and was not stored in a plastic bag when not in use.</p> <p>Observation on 06/03/2024 at 12:00 P.M. revealed Resident #136's nebulizer and mask was in Resident # 136's bed. Observation revealed Resident #136's nebulizer was not in use. Further observation revealed Resident # 136's nebulizer mask was dated 05/15/2024 and was not stored in a plastic bag when not in use.</p> <p>Observation on 06/03/2024 at 12:35 P.M. with S21 LPN revealed Resident #136's nebulizer and mask was in Resident #136's bed. Further observation revealed Resident # 136's nebulizer mask was dated 05/15/2024 and was not stored in a plastic bag when not in use.</p> <p>During an interview on 06/03/2024 at 12:35 P.M. S21 LPN confirmed Resident # 136's nebulizer, mask and tubing was not stored properly when not in use. S21 LPN reported Resident #136's mask and tubing should have been labeled when it was opened and stored in a plastic bag when not in use.</p> <p>Resident #139</p> <p>Review of Resident #139's medical diagnoses revealed 08/15/2023 revealed in part; acute embolism and thrombosis of unspecified deep veins of lower extremity, bilateral, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, heart failure (11/09/2023), personal history of pulmonary embolism (08/15/2023)</p> <p>Review of Resident #139's June 2024 physician orders revealed:</p> <p>04/23/2024: oxygen at 2 liters per nasal cannula continuously; every shift</p> <p>04/23/2024: change and date all respiratory supplies and tubing weekly.</p> <p>09/26/2023: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg/3ml (Ipratropium-Albuterol); 1 dose inhale orally every 4 hours as needed for COPD</p> <p>Review of Quarterly MDS dated [DATE] revealed a BIMS of 12 out 15 indicating moderately impaired cognition</p> <p>Review of Resident #139's Care Plan revealed resident had COPD related to smoking, at risk for complications with interventions to give aerosol or bronchodilators, and give oxygen therapy as ordered by the physician.</p> <p>Observation on 06/03/2024 at 9:30 A.M. revealed Resident # 139's oxygen tubing and humidifier bottle was not labeled and dated. Observation revealed Resident # 139's nebulizer mask was not in use. Further observation revealed Resident # 139's nebulizer mask was not dated, labeled or stored properly when not in use.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 06/03/2024 at 11:45 A.M. revealed Resident # 139's oxygen tubing and humidifier bottle was not labeled and dated. Observation revealed Resident # 139's nebulizer mask was not in use. Further observation revealed Resident # 139's nebulizer mask was not dated, labeled or stored properly when not in use.</p> <p>Observation on 06/03/2024 at 12:40 P.M. with S21 LPN revealed Resident #139's oxygen humidifier bottle was not dated and oxygen mask was attached to the oxygen concentrator and placed over the oxygen humidifier bottle. Observation with S21 LPN revealed Resident #139's nebulizer on bedside table with mask not dated or stored in a plastic bag when not in use.</p> <p>During an interview on 06/03/2024 at 12:40 P.M. S21 LPN confirmed Resident #139's oxygen humidifier bottle was not dated and should have been. S21 LPN confirmed Resident #139's oxygen and nebulizer mask should be stored in a plastic bag when not in use.</p> <p>During an interview on 06/4/2024 at 12:10 P.M. S23 Respiratory Therapist reported respiratory supplies (humidifier bottles, tubing, mask) should be changed on the Sunday night shift. S23 Respiratory Therapist reported respiratory supplies and tubing should be signed, dated and initialed on the date it is changed.</p> <p>39897</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>45317</p> <p>Based on record reviews and interview the facility failed to ensure there was a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs. The facility failed to provide the minimum required staffing hours for 3 of 27 weekend days during FY (Fiscal Year) Quarter 1 2024.</p> <p>Findings:</p> <p>Review of the facility's PBJ (Payroll Based Journal) Staffing Data Report for FY Quarter 1 2024 (October 1 - December 31) revealed excessively low weekend staffing was triggered.</p> <p>Review of the facility's Staffing Pattern forms for weekends from FY Quarter 1 2024 revealed the facility:</p> <p>Provided 275.75 hours on 10/01/2023 and were required to provide 254.85 hours.</p> <p>Provided 375.38 hours on 10/21/2023 and were required to provide 378.35 hours.</p> <p>Provided 366.9 hours on 12/16/2023 and were required to provide 376 hours.</p> <p>During an interview on 06/06/2024 at 5:35 p.m. S13 Interim Administrator/Regional MDS (Minimum Data Set) confirmed the facility did not provide the minimum required hours on 10/01/2023, 10/21/2023, 12/16/2023 and should have.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>34708</p> <p>Based on record review and interview, the facility failed to adequately monitor for 2 (# 27, #106) residents reviewed for unnecessary medications out of a total 6 (#27, #67, #72, #78, #106, #175) residents reviewed. The facility failed to adequately monitor residents #27 and #106 for edema while on a diuretic, and resident #27 for bleeding and bruising while on an anticoagulant.</p> <p>Findings:</p> <p>Resident #27</p> <p>Review of Resident #27's current Physician orders revealed in part:</p> <p>6/4/2024 Monitor for abnormal bleeding or bruising every shift if + (positive) notify medical doctor or Nurse Practitioner.</p> <p>12/1/2023 Lasix Oral Tablet 20 MG (milligram) (Furosemide) Give one tablet by mouth one time a day related to Peripheral Vascular Disease, Check for Edema.</p> <p>10/27/2023 Eliquis Oral Tablet 2.5 MG (Apixaban) Give one tablet by mouth two times a day related to Peripheral Vascular Disease</p> <p>Review of Resident #27's medical record failed to reveal monitoring for edema, bleeding and bruising.</p> <p>During an interview on 06/06/2024 at 4:45 p.m. S9 LPN (Licensed Practical Nurse) reviewed Resident #27's medical record and acknowledged monitoring for bleeding and edema were not being done and should have been.</p> <p>Resident #106</p> <p>Review of Resident #106's current Physician orders revealed in part:</p> <p>-5/12/23 Lasix Oral Tablet 20 mg (Furosemide) Give 1 tablet by mouth one time a day for edema with HTN (hypertension).</p> <p>Review of Resident #106's medical record failed to reveal monitoring for edema.</p> <p>During an interview on 06/06/2024 at 9:50 a.m. S11 LPN (Licensed Practical Nurse) reviewed Resident #106's record and reported Resident #106 was on the diuretic Lasix. S11 LPN further reviewed Resident #106's record and acknowledged there was not documentation of monitoring for edema with administration of a diuretic for Resident #106 and should have been.</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 - Some</p>	<p>During an interview on 06/06/2024 at 12:10 p.m. S2 DON (Director of Nursing) reviewed Resident #106's record and reported Resident #106 was on the diuretic Lasix. S2 DON further reviewed Resident #106's record and acknowledged there was not documentation of monitoring for edema with administration of a diuretic for Resident #106 and should have been.</p> <p>39897</p>

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>34708</p> <p>Based on record review and interview the facility failed to ensure the Quality Assessment and Assurance (QAA) Committee met at least quarterly. The failed practice had the potential to affect the 189 residents residing in the facility as documented by the facility's Long-Term Care Facility Application for Medicare and Medicaid form [CMS (Centers for Medicare and Medicaid Services)-671] dated 06/03/2024.</p> <p>Findings:</p> <p>Review of the QAA meeting information provided by the facility failed to reveal evidence of quarterly QAA meetings since the last annual survey on 06/08/2023.</p> <p>During an interview on 06/06/2024 at 5:30 p.m. S1 Administrator and S12 Regional Director of Clinical Operations acknowledged they could not provide documentation of quarterly QAA meetings since the last annual survey on 06/08/2023.</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>36921</p> <p>Based on observations, interviews, and record review the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure staff practices were consistent with current infection control principles and practices to prevent cross contamination by failing to ensure staff used appropriate PPE (Personal Protective Equipment) during resident care for 1 resident (#112) who was on contact isolation. 2. Ensure an infection prevention and control program was maintained by failing to provide written evidence of implemented infection control policies and procedures for surveillance of tracking and trending of infections in the facility. <p>This deficient practice had the potential to effect the total census was 189 according to the Long-Term Care Facility Application for Medicare and Medicaid Form dated 06/03/2024.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. <p>Review of the facility's contact isolation policy dated April 2022 revealed in part:</p> <p>In addition to standard precautions, contact precautions must be implemented for resident's known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environment surfaces or patient-care items in the resident's environment</p> <ol style="list-style-type: none"> A. Place the resident in a private room B. Gloves and hand hygiene <ol style="list-style-type: none"> 1. Wear gloves when entering the room 2. Remove gloves before exiting the room and wash hands C. Gown. <ol style="list-style-type: none"> 1. In addition to wearing a gown as outlined under standard precautions, wear a gown when entering the room if you anticipate that your clothing will have substantial contact with the patient environmental surfaces, or items in the patient room ,or if the resident is incontinent, has diarrhea an ileostomy, a colostomy or wound drainage not contained by a dressing. 2. Remove the gown before leaving the resident' environment. <p>Review of Resident #112's medical record revealed in part:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>05/21/2024 Nurse's Note: CNA (Certified Nursing Assistant) reported stool is loose and has a bad odor. Assessed and observed yellowish brown, loose stool with foul odor. MD (Medical Doctor)/nurse communication sent to NP (Nurse Practitioner) communication book. Resident #112 placed on contact isolation until further notice.</p> <p>05/27/2024 at 10:29 p.m. Nurse's Note: Resident was placed on contact isolation for possible C-Diff 05/22/2024. Remains on contact isolation for positive C-diff collected 05/24/2024.</p> <p>Observation on 06/03/24 at 9:00 a.m. revealed resident #112 sitting up in geri chair watching television with doorway open. Further observation failed to reveal contact isolation information was posted and clearly visible to staff for resident #112.</p> <p>Observation on 06/03/2024 at 12:45 p.m. revealed S20 CNA feeding resident #112, without the use of appropriate PPE, gloves were the only PPE in use.</p> <p>During an interview on 06/04/2024 at 12:05 p.m. S20 CNA confirmed resident #112 was on contact isolation and confirmed not wearing appropriate PPE for contact isolation when providing resident #112's care and treatment.</p> <p>During an interview on 06/04/2024 at 12:45 p.m. S2 DON (Director of Nursing) confirmed resident #112 remained on contact isolation precautions for C-diff which required a gown, gloves, and shoe covers during resident care and a sign on the resident's door. S2 DON acknowledged S20 CNA did not follow the facility's policy for contact isolation by not wearing a gown when feeding resident #112's on 06/03/2024.</p> <p>2.</p> <p>Review of facility policy of Infection Control Monitoring revealed the following in part:</p> <p>Policy: It is the policy of the Center to investigate the cause of infections (nosocomial and community and hospital acquired) and the manner of spread.</p> <p>Record Keeping:</p> <p>Records will be maintained and infectious trends or any identified problems or potential problems will be reported to the Administrator, Director of Nurses and the Quality Assurance Committee. Follow up action will be taken as necessary.</p> <p>Procedure:</p> <p>Action</p> <p>1. The Charge Nurse must report all infections to the Infection Preventionist using the Infection Control Report Form/ the Infection Control Log.</p> <p>4. The Infection Preventionist will complete the Infection Surveillance Form for each unit or add to the Infection Control Log. The original is maintained by the Infection Preventionist.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. The Infection Preventionist will record data for the Monthly Infection Control Report including if infection was nosocomial or community' hospital acquired and summarized on the Infection Tracking Chart/ Log.</p> <p>6. The Infection Preventionist will also use an Infection Control Trending Map of the Center to identify and trends/ specific organism.</p> <p>7. The Infection Preventionist will write a brief summary each month to include the findings, trends, recommendations and plan of corrections.</p> <p>8. The Infection Preventionist will make a monthly report of infections to the Director of Nursing Services and Administrator.</p> <p>Review of facility's Infection Control binder failed to reveal monthly infection control tracking and trending had been completed for December 2023, February 2024, March 2024, April 2024, and May 2024.</p> <p>During an interview on 06/06/2024 at 1:40 p.m. S2 DON/Infection Preventionist reviewed the facility's monthly infection control tracking and trending and confirmed monthly infection tracking and trending had not been completed for December 2023, February 2024, March 2024, April 2024, and May 2024 and should have been completed monthly.</p> <p>39897</p>		

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<p>F 0924</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Put firmly secured handrails on each side of hallways.</p> <p>36665</p> <p>Based on observations and interviews the facility failed to ensure hallway hand rails were securely affixed to the walls. The facility failed to ensure hand rails were secure on 1 (Hall W) of 4 hallways in the building. This had to potential to affect 31 residents residing on Hall W.</p> <p>Findings:</p> <p>Review of the facility's Physical Environment Policy and Procedure dated 01/01/2023 revealed:</p> <p>It is the policy of the facility to provide care and services related to physical environment in accordance to State and Federal Regulation: The policy will include the Corridors have firmly secured handrails.</p> <p>Observation on 06/04/2024 at 12:50 p.m. revealed on Hall W near the exit door, the hand rail did not have an end cap on it leaving a sharp edge exposed with a crack in the hand rail.</p> <p>During an interview on 06/04/2024 at 2:00 p.m. S4 CNA reported the hand rail on Hall W near the exit door had been broken for a couple of months.</p> <p>Observation on 06/04/2024 at 2:03 p.m. with S3 Maintenance Supervisor revealed on Hall W near the exit door, the hand rail did not have an end cap on it leaving a sharp edge exposed with a crack in the hand rail.</p> <p>During an interview on 06/04/2024 at 2:05 p.m. S3 Maintenance Supervisor confirmed the hand rail near the exit door on Hall W should have been repaired.</p>