

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER St Joseph Continuing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2301 Sterlington Road Monroe, LA 71203	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118</p> <p>Based on record review and interview, the facility failed to retain the resident's personal possessions, including clothing, by not having a system in place to record residents' personal belongings. The facility failed to have an inventory record of the resident's personal belongings for 1 (#62) of 2 (#42 and #62) residents reviewed for personal property.</p> <p>Findings:</p> <p>Review of the medical record for resident #62 revealed an admitted [DATE] with diagnoses including encephalopathy, hypertension, epilepsy, insomnia, acute kidney failure, insomnia, atrial fibrillation, malignant neoplasm, protein calorie malnutrition, dehydration, and chronic pain.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed resident #62's Brief Interview for Mental Status (BIMS) score was 99 which indicated the resident was unable to complete the interview. Resident #62 was dependent on staff for activities of daily living.</p> <p>Review of the record revealed resident #62 did not have an inventory record of his personal belongings.</p> <p>On 10/02/2024 at 9:30 a.m., an interview with S7Assistant Director of Nursing (ADON) revealed she was unable to find an inventory sheet for resident #62 that kept a list of the personal items the resident brought or obtained during his stay at the facility.</p> <p>On 10/02/2024 at 2:30 p.m., an interview with S2Director of Nursing (DON) revealed she was unable to find an inventory sheet for resident #62's personal items. S2DON further revealed the staff should have completed an inventory sheet of the personal items that resident #62 was admitted with and acquired during his stay at the nursing facility.</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 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405</p> <p>Based on observation and interview, the facility failed to ensure the most recent state inspection results since the last annual survey were available for resident or family review.</p> <p>Findings:</p> <p>An observation upon entrance to the facility on [DATE] at 7:35 a.m. revealed the results of the last survey in the facility's survey binder was the last annual survey dated 09/13/2023. Further review of the survey binder revealed the last complaint survey results dated 08/16/2024 were not in the binder.</p> <p>An interview on 09/30/2024 at 7:40 a.m. with S2Director of Nursing (DON) confirmed the facility's survey binder did not have the most recent survey results for the complaint dated 08/16/2024.</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** 19098</p> <p>Based on record reviews and interviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet the resident's needs by not 1) having documentation of meal percentage intakes for 1 (#62) of 4 (#37, #43, #62, and #321) residents reviewed for nutrition. Also the failed practice was evidenced by not developing a care plan for 1 (#16) of 10 (#3, #16, #37, #40, #41, #58, #62, #221, #223, and #324) residents reviewed for Activities of Daily Living (ADL), and for 1 (#324) resident observed to have medications at the bedside.</p> <p>Findings:</p> <p>Review of the Self - Administration of Medications policy and procedure dated 06/14/2006 revealed:</p> <p>A patient may self-administer medications if the patient is determined safe for the patient and other patients of the facility by the facility's interdisciplinary team.</p> <p>Procedure:</p> <p>An assessment for Self-Administration of Medications must be completed on each patient requesting to self-administer medications and quarterly thereafter. An assessment for self-administration of Medications is kept with the patient's medical record under the Assessment tab.</p> <p>If it has been determined the patient is capable of self-administering his/her medications, a physician order must be obtained, a care plan formulated, and staff in-serviced.</p> <p>The nursing staff must interview the patient on every shift to verify that all self-administered doses on the patient's medication administration record. If the shift interview indicates any question as to the continued safety of self-administration, then the nurse will initiate the re-assessment process outlined above.</p> <p>All medications for self-administration must be stored in a locked storage area in the patient's room. Narcotics must be under double lock.</p> <p>Resident #323</p> <p>On 09/30/2024 at 10:39 a.m., observation of resident #323's room revealed a bottle of Fluticasone Nasal spray 100 micrograms (mcg)/150mcg in the room on the bedside table. Review of the label on the box revealed to administer 2 sprays. Resident stated she sprays 2 in each nostril every day.</p> <p>On 10/01/2024 at 7:54 a.m. and 9:07 a.m., observations of resident #323's room revealed the Fluticasone nasal spray remained at the bedside.</p> <p>Review of the current Physician orders for resident #323 revealed an order dated 09/19/2024 for Fluticasone Propionate 50 mcg/actuation nasal spray, suspension (2 sprays) both nostrils at bedtime.</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>Further review of the record revealed no Physician's order to allow resident #323 to keep medication in the room at the bedside, and there was no assessment to determine if resident #323 was safe to have medication in the room at the bedside to self-administer. Further review of the record revealed there was no plan of care developed for the self-administration of medications for resident #323.</p> <p>On 10/02/2024 at 11:20 a.m., an interview with S5Licensed Practical Nurse (LPN) revealed she was not aware resident #323 had the Fluticasone nasal spray in her room. S5LPN said there was a bottle of the Fluticasone Nasal spray on the medication cart and resident #323 received the medication in the evening.</p> <p>Observation of the bottle of Fluticasone Nasal spray in the resident's room revealed the label from the pharmacy was from the hospital the resident was in prior to admission. Resident #323 said the hospital gave it to her and she actually took her own dose this morning.</p> <p>Interview on 10/02/2024 at 11:20 a.m. with S5LPN revealed she was not aware of the medication in resident #323's room. She confirmed there was no order for resident #323 to have the medication at the bedside and there was no assessment for resident #323 to keep the medication at bedside and self-administer the medication.</p> <p>On 10/02/2024 at 11:45 a.m., an interview with S2Director of Nursing (DON) revealed she was not aware the resident had the medication in her room. S2DON said if a resident has medications in their room and is self-administering the medication then they are supposed to have a self-medication assessment, a plan of care to self-administer medications and store the medications in a secured box. S2DON confirmed there was no plan of care developed for resident #323 to self-administer medications.</p> <p>18118</p> <p>Resident #62</p> <p>Review of the medical record for resident #62 revealed an admitted [DATE] with diagnoses including encephalopathy, epilepsy, malignant neoplasm, protein calorie malnutrition, and dehydration.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed resident #62's Brief Interview for Mental Status (BIMS) score was 99 which indicated that the resident was unable to complete the interview. Resident #62 was dependent on staff for activities of daily living.</p> <p>Review of the current care plan revealed resident #62 required extensive assistance with eating. Further review of the care plan revealed interventions were to allow the resident adequate time to eat, monitor his food intake at each meal, and to document the meal percentage consumed.</p> <p>Review of the resident #62's Activities of Daily Living (ADL) Verification Worksheet for daily meal intake percentages revealed there was no documented evidence of the breakfast, lunch and dinner meal percentage intakes on 09/10/2024, 09/14/2024, 09/15/2024 and 09/26/2024. Further review of the worksheet revealed no documented evidence of the breakfast and lunch meal percentage intakes on 09/12/2024, 09/21/2024 and 09/27/2024.</p> <p>On 10/01/2024 at 12:45 p.m., an interview with S2DON confirmed the meal intake percentages were incomplete for the month of September 2024 for resident #62.</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>32231</p> <p>Resident #16</p> <p>Review of resident #16's medical record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, obstructive sleep apnea, acute and chronic respiratory failure with hypoxia, insomnia, altered mental status, and obesity.</p> <p>Review of the admission minimum data set assessment dated [DATE] revealed resident #16 had a BIMS score of 15. A score of 13-15 revealed resident #16 was cognitively intact with daily decision making skills.</p> <p>On 09/30/2024 at 11:30 a.m., an observation revealed resident #16's fingernails were dirty with grime observed underneath the nail beds of both hands. An interview with resident #16 revealed that the staff had not offered to clean her fingernails.</p> <p>Further observations of resident #16 on 10/01/2024 at 12:40 p.m. and 5:00 p.m., the resident continued to have dirty fingernails.</p> <p>During an interview on 10/02/2024 at 11:43 a.m., S1Administrator and S2Director of Nursing were notified of the above findings.</p> <p>On 10/02/2024 at 11:51 a.m., an observation revealed resident #16's fingernails remained dirty. S8Assistant Director of Nursing and S4Regional Director of Clinical Services were present during the observation and interview with resident #16. After the observation and interview was finished, S8Assistant Director of Nursing and S4Regional Director of Clinical Services both confirmed that resident #16's fingernails needed to be cleaned.</p> <p>On 10/02/2024 at 11:55 a.m., S9Certified Nursing Assistant was notified of the above findings. She revealed that she had given resident #16 a bath earlier that morning and that she was aware of the resident's fingernails being dirty.</p> <p>Review of the medical record revealed there was no documented evidence of a care plan being developed to address nail care for resident #16.</p> <p>On 10/02/2024 at 12:00 p.m., an interview with S4Regional Director of Clinical Services reviewed the electronic health record for resident #16. She confirmed there was no documented evidence of a care plan being developed to address the cleaning of the resident's fingernails.</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** 18118</p> <p>Based on observations, record reviews, and interviews the facility failed to ensure a resident who is unable to carry out activities of daily living (ADL) received the necessary services to maintain good personal hygiene for 7 (#3, #16, #41, #45,#58, #62 and #221) of 11 (#3, #16, #37, #40, #41, #45, #58, #62, 221, #223, and #324) residents reviewed for Activities of Daily Living (ADL) care. The facility failed to ensure 1) residents' fingernails were kept clean and/or trimmed for #16, #41, #58 and #62, and 2) residents #3, #45 and #221 received baths as scheduled.</p> <p>Findings:</p> <p>Resident #62</p> <p>Review of the medical record for resident #62 revealed an admitted [DATE] with diagnoses including encephalopathy, hypertension, epilepsy, atrial fibrillation, malignant neoplasm, protein calorie malnutrition, dehydration and chronic pain.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed resident #62's Brief Interview for Mental Status (BIMS) score was 99 which indicated that the resident was unable to complete the interview. Resident #62 was dependent on staff for activities of daily living.</p> <p>On 09/30/2024 at 2:10 p.m., and 10/01/2024 at 9:52 a.m., observations of resident #62 revealed his fingernails were long and needed to be trimmed.</p> <p>On 10/01/2024 at 9:10 a.m., an interview with the S2Director of Nursing (DON) revealed the resident was dependent of staff for ADLs.</p> <p>On 10/01/2024 at 1:35 p.m. S2DON observed resident #62's fingernails, and S2DON confirmed resident #62's fingernails were long and needed to be trimmed.</p> <p>19121</p> <p>Resident #45</p> <p>Review of resident #45's record revealed an admitted [DATE] with diagnosis of hypertension, heart disease, atrial fibrillation, urine retention, peripheral vascular disease, bilateral amputation of legs, sepsis, and neuropathic bladder.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed a BIMS of 14 which indicates the resident is cognitively aware and able to make daily decisions. Further review of the MDS revealed the resident is dependent on staff for toileting, hygiene, shower/bathing, upper and lower body dressing, personal hygiene, and transfers.</p> <p>Interview on 09/30/2024 at 10:10 a.m. with resident #45 stated he does not get his baths three times a week and sometimes he goes a week without getting a bath.</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 the bath schedule effective 06/25/2024 revealed resident #45 should receive a bath on the evening shift on Tuesday, Thursday and Saturday.</p> <p>Review of the ADL verification worksheets dated 08/01/2024 through 09/30/2024 revealed no documented evidence that resident #45 received baths as scheduled for 13 days in August 2024 and 11 days in September 2024.</p> <p>Interview on 10/02/2024 at 7:20 a.m. with S12Certified Nursing Assistant (CNA) that works with resident #45 stated he was to receive baths on the evening shift on Tuesday, Thursday and Saturdays and she stated the resident does not refuse bathing.</p> <p>Interview on 10/02/2024 at 3:00 p.m. with S2DON confirmed that resident #45's documentation did not reflect him receiving baths on Tuesday, Thursdays and Saturdays in August and September 2024.</p> <p>32231</p> <p>Resident #16</p> <p>Review of the resident #16's medical record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, obstructive sleep apnea, acute and chronic respiratory failure with hypoxia, insomnia, altered mental status, and obesity.</p> <p>Review of the admission minimum data set assessment dated [DATE] revealed resident #16 had a brief interview for mental score of 15. A score of 13-15 revealed resident #16 was cognitively intact with daily decision making skills.</p> <p>On 09/30/2024 at 11:30 a.m., an observation revealed resident #16 in her room, sitting up in her wheelchair, and visiting with her family member. Further observation revealed resident #16's fingernails were dirty with grime observed underneath the nail beds of both hands. An interview with resident #16 revealed that the staff had not offered to clean her fingernails.</p> <p>Further observations of resident #16 on 10/01/2024 at 12:40 p.m. and 5:00 p.m., the resident continued to have dirty fingernails.</p> <p>During an interview on 10/02/2024 at 11:43 a.m., S1Administrator and S2Director of Nursing were notified of the above findings.</p> <p>On 10/02/2024 at 11:51 a.m., an observation revealed resident #16 in her room, sitting up in her wheelchair positioned close to her bedside table where the resident's meal tray had been placed. Further observation revealed the resident's fingernails remained dirty. S8Assistant Director of Nursing and S4Regional Director of Clinical Services were present during the observation and interview with resident #16. After the observation and interview was finished, S8Assistant Director of Nursing and S4Regional Director of Clinical Services both confirmed that resident #16's fingernails needed to be cleaned.</p> <p>On 10/02/2024 at 11:55 a.m., S9Certified Nursing Assistant was notified of the above findings. She revealed that she had given resident #16 a bath earlier that morning and that she was aware of the resident's fingernails being dirty.</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>Resident #221</p> <p>Review of the medical record revealed resident #221 was admitted to the facility on [DATE] and was discharged home on 07/30/2024. Resident #221's diagnoses included in part, cerebral infarction, essential (primary) hypertension, systolic and diastolic congestive heart failure, pain, dizziness, chronic obstructive pulmonary disease, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, facial weakness following cerebral infarction, encounter for surgical aftercare following surgery on the circulatory system, chronic pulmonary embolism, and chronic pulmonary embolism.</p> <p>Review of the discharge minimum data set assessment dated [DATE] revealed the resident required partial to moderate assistant with showering and bathing.</p> <p>Review of the medical record revealed resident #221 had a baseline care plan that revealed she required bathing support.</p> <p>Review of the Activities of Daily Living Verification Worksheet revealed there was no documented evidence of resident #221 having received a bath a total of twenty-two times from the dates of 07/08/2024 - 07/30/2024.</p> <p>On 10/02/2024 at 3:20 p.m., S1Administrator and S2Director of Nursing were notified of the findings noted above. S2Director of Nursing confirmed there was no documented evidence of resident #221 having received a bath for the 22 days. She further confirmed that there was no documented reason as to why the resident had not received a bath on those dates.</p> <p>41829</p> <p>Resident #58</p> <p>Record review revealed resident #58 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia, dysphagia, essential hypertension, insomnia, anemia, constipation, chronic pain syndrome, and major depressive disorder.</p> <p>Review of quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 7 which indicated severe cognitive impairment. Further review revealed resident #58 required substantial/maximal assistance with eating, oral hygiene, toileting hygiene, shower/bathing, dressing upper and lower body, and personal hygiene.</p> <p>Review of active care plans revealed resident #58 had a self-care deficit and required extensive assistance with bathing, hygiene, dressing, grooming. An intervention listed was to clean and manicure fingernails as needed.</p> <p>Observations of resident #58, on 09/30/2024 at 10:00 a.m. and on 10/01/2024 at 8:35 a.m., revealed his fingernails on both hands were very long with a dark brown grimy substance under the fingernails on both hands.</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>On 10/01/2024 at 12:05 p.m., an observation of resident #58 with S2Director of Nursing revealed resident #58's fingernails on both hands were very long with a dark brown grimy substance under the fingernails on both hands. S2DON confirmed resident #58's fingernails needed to be cleaned and trimmed.</p> <p>43405</p> <p>Resident #3</p> <p>Review of resident #3's record revealed an admitted [DATE] with diagnoses including anxiety disorder, chronic kidney disease, other schizoaffective disorders, pain unspecified, unspecified dementia with behavioral disturbance, unstageable pressure ulcer of right heel, dysphagia, and long term use of opiate analgesics.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 indicating cognitively intact. Further review of the MDS revealed resident #3 dependent on staff for toileting hygiene, shower/bathing, upper and lower body dressing, personal hygiene, bed mobility, and transfers.</p> <p>Review of the Bath Schedule effective 06/25/2024 revealed resident #3 should be getting a bath on Monday, Wednesday, and Fridays on the evening shift.</p> <p>Review of the Activities of Daily Living Verification Worksheet for 08/01/2024-09/30/2024 revealed no documented evidence that resident #3 received baths as scheduled for 5 days in August 2024 and 8 days in September 2024.</p> <p>An interview on 10/02/2024 at 2:15 p.m. with S2DON confirmed that resident #3 did not have documentation of baths for 5 days in August 2024 and 8 days in September 2024.</p> <p>Resident #41</p> <p>Review of resident #41's record revealed an admitted [DATE] with diagnoses including cerebral infarction, transient ischemic attack, unspecified convulsions, age related physical debility, chronic obstructive pulmonary disease, lobar pneumonia, and peripheral vascular disease.</p> <p>Review of resident #41's quarterly MDS dated [DATE] revealed a BIMS of 11 indicating moderate cognitive impairment. Further review of the MDS revealed resident #41 was dependent on staff for toileting, bathing, dressing, transfers, and personal hygiene.</p> <p>Observations of resident #41 on 09/30/2024 at 9:05 a.m. and 10/01/2024 at 4:25 p.m. revealed resident's fingernails on bilateral hands were long.</p> <p>An interview on 09/30/2024 at 9:05 a.m. with resident #41 revealed he's unable to trim his own fingernails.</p> <p>An interview on 10/01/2024 at 4:25 p.m. with resident #41 revealed he does not like his fingernails to be this long.</p> <p>Review of resident #41's careplan dated 11/22/2023 revealed ADL functions for resident included nail care.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405</p> <p>Based on record review and interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 (#3) of 3 (#3, #62, and #222) residents reviewed for quality of life. The facility failed to transport resident #3 to her appointment in a timely manner to ensure she was seen by the physician.</p> <p>Findings:</p> <p>A telephone interview on 10/01/2024 at 11:53 a.m. with resident #3's son revealed that resident was taken to an appointment out of town today by the facility, and the appointment had to be rescheduled for 10/25/2024 due to resident #3 arrived late for her appointment.</p> <p>Review of the transportation appointments for 10/01/2024 revealed resident #3 had an appointment with a psychiatrist out of town at 9:00 a.m.</p> <p>Review of the current care plan revealed resident #3 currently takes psychotropic medications as evidenced by depression, anxiety, and insomnia and to obtain a psychiatric consult as needed.</p> <p>An interview on 10/01/2024 at 12:15 p.m. with S2Director of Nursing (DON) revealed resident #3 had an appointment today out of town with her psychiatrist. S2DON reported resident #3's son had notified her that resident #3 was unable to see the psychiatrist today due to the facility's transportation did not have the resident at her appointment in time. S2DON reported the transportation driver left the facility with resident #3 at 7:36 a.m. on 10/01/2024 for an out of town appointment at 9:30 a.m. S2DON reported due to traffic, parking, and the preadmission process, resident #3 was late for her appointment and was unable to see the psychiatrist today and the appointment had to be rescheduled.</p> <p>A confirmation interview with S2DON on 10/01/2024 at 3:30 p.m. revealed resident #3 should not have been late for her appointment today.</p> <p>An interview on 10/01/2024 at 4:38 p.m. with S11Transportation Driver revealed resident #3 had an out of town appointment with her psychiatrist today at 9:00 a.m. S11Transportation Driver reported when she came to work at 6:45 a.m. that resident #3 was not dressed and ready for her appointment. S11Transportation Driver reported she left the facility on [DATE] at 7:36 a.m. and when she checked resident #3 in for her appointment, she was told by the receptionist that the appointment would have to be rescheduled.</p>		

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NAME OF PROVIDER OR SUPPLIER St Joseph Continuing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2301 Sterlington Road Monroe, LA 71203	

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118</p> <p>Based on record review and interview, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible by not completing an Accident/Incident report when a resident was found sitting on the floor for 1 (#62) of 3 (#51, #62, and #222) residents reviewed for falls.</p> <p>Findings:</p> <p>Review of the facility's Accident/Incidents Policy dated May 2016 revealed:</p> <p>1 An Accident/Incident Report must be completed immediately upon facility staff becoming aware of the occurrence of an accident/incident (to include medication errors) involving a Patient and, if necessary, the Patient's Care Plan must be updated.</p> <p>Review of the facility's Fall Management Guidelines policy dated November 2022 revealed:</p> <p>1. Definition</p> <p>Unintentional change in position coming to rest on the ground, floor or onto the next lower surface. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.</p> <p>Review of the medical record for resident #62 revealed an admitted [DATE] with diagnoses including encephalopathy, hypertension, epilepsy, atrial fibrillation, malignant neoplasm, dehydration and chronic pain.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed resident #62's Brief Interview for Mental Status (BIMS) score was 99 which indicated that the resident was unable to complete the interview.</p> <p>Review of the careplan with an effective date of 06/14/2024 revealed resident #62 was at risk for falls related to weakness.</p> <p>Review of the nurses' notes dated 06/27/2024 at 11:47 a.m. revealed resident #62 was sitting on the floor in his bedroom urinating. The nurse assisted the resident with getting dressed and cleaned his room.</p> <p>Review of the record revealed an Accident/Incident Report was not completed on 06/27/2024 when resident #62 was sitting on the floor.</p> <p>On 10/01/2024 at 12:45 p.m., an interview with S2Director of Nursing (DON) confirmed on 06/27/2024 at 11:47 a.m., when resident #62 was found sitting on the floor, the nurse should have completed an Accident/Incident report.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118</p> <p>Based on record reviews, observations, and interviews, the facility failed to ensure residents were assessed for the risk of entrapment from bed rails and/or reviewed the risks and benefits of bed rails with the resident or resident's representative and/or obtain an informed consent prior to installation of bed rails for 5 (#9, #16, #31, #40, and #62) of 6 (#9, #16, #31, #40, #51, and #62) residents reviewed for accident hazards.</p> <p>Findings:</p> <p>Review of the facility's policy for Bed Safety and Bed Rails dated August 2022 revealed in part:</p> <p>Policy Statement</p> <p>Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met.</p> <p>7. The resident assessment also determines potential risks to the resident associated with the use of bed rails, including the following:</p> <p>a. Accident hazards:</p> <p>(1) The resident could attempt to climb over, around, between, or through the rails. Or over the foot board; and/or</p> <p>(2) A resident or part of his/her body could be caught between rails, the openings of the rails, or between the bed rails and mattress.</p> <p>8. Before using bed rails for any reason, the staff shall inform the resident or resident's representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent.</p> <p>a. The assessed medical needs that will be addressed with the use of bed rails;</p> <p>b. The resident's risks from the use of bed rails and how these will be mitigated;</p> <p>c. The alternatives that were attempted but failed to meet the resident's needs; and</p> <p>d. The alternatives that were considered but not attempted and the reasons.</p> <p>Resident #62</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the medical record for resident #62 revealed an admitted [DATE] with diagnoses including encephalopathy, epilepsy, atrial fibrillation, malignant neoplasm, protein calorie malnutrition, dehydration and chronic pain.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed resident #62's Brief Interview for Mental Status (BIMS) score was 99 which indicated that the resident was unable to complete the interview. Resident #62 was dependent on staff for activities of daily living (ADLs).</p> <p>Review of the Assist Rail/Enabler Device informed consent dated 06/14/2024 revealed the consent was not signed by the resident or the resident's representative.</p> <p>On 09/30/2024 at 7:50 a.m., 10/01/2024 at 7:45 a.m., and on 10/02/2024 at 7:30 a.m., resident #62 was observed lying in the bed with quarter bed rails raised and locked on both sides of the bed.</p> <p>On 10/01/2024 at 12:45 p.m., an interview with S2Director of Nursing (DON) revealed the Assist Rail/Enabler Device informed consent for resident #62 was not signed by the resident or the resident's representative.</p> <p>Resident #31</p> <p>Review of the medical record for resident #31 revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, emphysema, cachexia, malformations of cerebral vessels, and anxiety.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed resident #31's BIMS score was 10 which indicated the resident had moderate cognitive impairment and required assistance with ADLs.</p> <p>Observations of resident #31 on 09/30/2024 at 10:27 a.m., 10/01/2024 at 9:00 a.m. and 3:20 p.m., and on 10/02/2024 at 9:15 a.m. revealed he was lying in the bed with quarter bed rails raised and locked on both sides of the bed.</p> <p>Review of the Assist Rail/Enabler Device informed consent dated 11/22/2023 revealed the consent was not signed by the resident or the resident's representative.</p> <p>On 10/01/2024 at 12:45 p.m., an interview with S2DON confirmed the Assist Rail/Enabler Device informed consent for resident #31 was not signed by the resident or the resident's representative.</p> <p>32231</p> <p>Resident #16</p> <p>Review of the resident #16's medical record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, obstructive sleep apnea, acute and chronic respiratory failure with hypoxia, insomnia, altered mental status, and obesity.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the admission minimum data set assessment dated [DATE] revealed resident #16 had a Brief Interview for Mental Status (BIMS) score of 15. A score of 13-15 revealed resident #16 was cognitively intact with daily decision making skills.</p> <p>On 09/30/2024 at 11:30 a.m., an observation revealed resident #16 in her room, sitting up in her wheelchair, and visiting with her family member. Further observation revealed resident #16 had one quarter bedrails, one to each side of her bed. Both bed rails were up and in a locked position. Further observations revealed that on 10/01/2024 at 12:40 p.m., 10/01/2024 at 5:00 p.m., and 10/02/2024 at 11:51 a.m., the bed rails remained up and in a locked position.</p> <p>Review of the Assist Rail/Enabler device informed consent document dated 09/20/2024 revealed the name of the device as an Assist Rail x1. Further review revealed there was no documented evidence of the consent form being signed by resident #16 and /or the resident's representative.</p> <p>On 10/01/2024 at approximately 3:15 p.m., S2DON was notified of the above findings. S2DON reviewed resident #16's medical record and confirmed the resident should have been assessed for having two bed rails and the consent was not signed by resident #16 and /or the resident's representative prior to the bed rails being place on the bed.</p> <p>Resident #40</p> <p>Review of resident #40's medical record revealed she was admitted to the facility on [DATE] with diagnoses including in part, acute combined systolic (congestive) and diastolic (congestive) heart failure, chronic obstructive pulmonary disease, morbid (severe) obesity, functional quadriplegia, weakness, fall from bed, and pain in joints of left hand.</p> <p>Review of the annual minimum data set assessment dated [DATE] revealed resident #40 had a BIMS score of 15. A score of 13-15 revealed resident #40 was cognitively intact with daily decision making skills.</p> <p>On 09/30/24 12:13 p.m., an observation of resident #40 revealed the resident lying in bed. Further observation revealed one-half bed rails intact to each side of the resident's bed. Both bed rails were up and in a locked position. Further observation revealed that on 10/01/2024 at 12:25 p.m., resident #40 was lying in her bed with both of the bed rails up and in a locked position.</p> <p>Review of the medical record revealed there was no documented evidence of resident #40 being assessed for having two, one-half bed rails and no signed consent by resident #40/ representative prior to the bed rails being placed on the bed.</p> <p>On 10/03/2024 at approximately 3:20 p.m., S2DON was notified of the observations of resident #40 having one-half bed rails intact, one to each side of her bed and no documented evidence of resident #40 of a signed consent for the use of the bed rails. After a review of resident #40's medical record with S2Director of Nursing, she confirmed there was no documented evidence of an assessment being completed or a signed consent being obtained prior to the use of one-half bed rails for resident #40.</p> <p>41829</p> <p>Resident #9</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review revealed resident # 9 was admitted to the facility 09/07/2012 with diagnoses that included gastrostomy status, unspecified intellectual disabilities, unspecified dementia, encephalopathy, angina pectoris unspecified, chronic pain syndrome, hyperlipidemia, gastro-esophageal reflux disease without esophagitis, constipation, unspecified glaucoma, and mild protein-calorie malnutrition.</p> <p>Review of quarterly MDS assessment dated [DATE] revealed a BIMS score of 13 which indicated resident #9 was cognitively intact. Resident #9 was dependent on staff for assistance with all Activities of Daily Living.</p> <p>On 09/30/2024 at 10:26 a.m., an observation of resident #9 revealed she was lying bed. The quarter bed rails on each side of the bed were in the upright position.</p> <p>On 10/01/2024 at 11:52 a.m., an observation of resident #9 revealed she was lying in bed. The quarter bed rails on each side of the bed were in the upright position.</p> <p>On 10/02/2024 at 9:10 a.m., an observation of resident #9 revealed she was lying in bed with the quarter bed rails on each side of the bed in the upright position.</p> <p>Review of active care plans revealed resident #9 required one person assistance with turning and repositioning in bed. An intervention listed included resident #9 used quarter assist rails x2 to assist with bed mobility and transfers.</p> <p>Further review of resident #9's medical record revealed there was no documented evidence of resident #9 being assessed for the use of bed rails or a consent for bed rails to be used.</p> <p>During an interview on 10/01/2024 at 3:08 p.m., with S2DON revealed there was no documentation that resident #9 was assessed for the use of bed rails. S2DON further revealed there was no documentation of a consent for bed rails to be used. S2DON confirmed resident #9 should have been assessed for bed rail use and a consent should have been obtained prior to the use of bedrails.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41829</p> <p>Based on record review and interviews the facility failed to ensure each resident's medication regimen was free from unnecessary medications by failing to obtain a hemoglobin A1C and lipid panel for 1 (#49) of 5 (#3, #37, #43, #49, #51) residents reviewed for unnecessary medications.</p> <p>Findings:</p> <p>Record review revealed resident #49 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus with diabetic polyneuropathy, insomnia, anemia, essential hypertension, anxiety disorder, bipolar disorder, depression, arthritis, pain unspecified, unspecified dementia without behavioral disturbance, psychotic disturbance, and mood disturbance.</p> <p>Review of the Consultant Pharmacist Communication to Nursing letter dated 08/29/2024 revealed the following recommendation: I did not find any labs ordered routinely. Please verify we are monitoring labs (lithium, hemoglobin A1C, Complete Blood Count (CBC), Complete Metabolic Profile (CMP) and Lipid levels), if not please follow up with the prescriber to obtain orders. Further review of the letter revealed a verbal order per the Nurse Practitioner obtained by S2Director of Nursing (DON) dated 09/13/2024 at 12:30 p.m. for a hemoglobin A1C, CBC, and CMP every 3 months and lipid panel and lithium level every 6 months.</p> <p>Further record review revealed documentation resident #49 had the following lab completed on 09/19/2024: CBC with differential, CMP and lithium level. There was no documented evidence of a hemoglobin A1C or lipid profile being completed.</p> <p>On 10/02/2024 at 1:45 p.m. an interview with S2DON revealed she received a verbal order from the Nurse Practitioner on 09/13/2024 at 12:30 p.m. for resident #49 to have a hemoglobin A1C, CBC, and CMP every 3 months, and a lipid panel and lithium level every 6 months. S2DON revealed the hemoglobin A1C and lipid panel were not collected. S2DON confirmed the hemoglobin A1C and lipid panel should have been completed as ordered.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19121</p> <p>Based on observation, policy review and interviews the facility failed to implement policies and procedures for enhanced barrier precautions (EBP) for 4 (#7, #45, #321, #322,) of 4 (#7, #45, #321, #322) residents reviewed for enhanced barrier precautions.</p> <p>Findings:</p> <p>Review of the facility's Enhanced Barrier Precations (EBP) policy dated March 2024 revealed in part:</p> <p>EBP is an infection control intervention to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities.</p> <p>Infections or colonization with a Centers for Disease Control and Prevention (CDC) targeted MDRO when Contact Precautions do not apply otherwise; or</p> <p>Chronic wounds (pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and venous stasis ulcers) and/or indwelling medical devices (devices fully embedded in the body, ie central lines, hemodialysis catheters, urinary catheters, feeding tubes and trach tubes) even if the resident is not known to be infected or colonized with a CDC- targeted MDRO.</p> <p>EBP will be used for any resident who meet the above criteria.</p> <p>Procedures:</p> <p>1. EBP is primarily intended to apply to care that occurs within a residents room where high contact resident care activities are performed (where there is extended contact with the resident and their environment).</p> <p>2. EBP will be used when performing the following high contact resident care activities:</p> <p>Dressing, Bathing/showering, hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tube, tracheostomy, wound care (chronic): pressure ulcer, diabetic foot ulcer, unhealed surgical wounds, and venous stasis ulcers.</p> <p>3. If splashes and sprays are anticipated during the high contact activity, face protections should be used in addition to the gown and gloves.</p> <p>4. Outside resident room EBP should be followed when performing transfers or assisting during bathing in a shared/common shower room.</p> <p>10. Residents who are on EBP will have signage placed outside their room to alert staff of those residents who require the use of EBP prior to providing high contact care activities.</p> <p>Resident #45</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>Review of the medical record for sampled resident #45 revealed an admitted [DATE] with diagnoses of hypertension, heart disease, atrial fibrillation, urine retention, peripheral vascular disease, bilateral amputation of the legs, sepsis, and neuropathic bladder.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #45 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively aware and able to make daily decisions.</p> <p>Observation on 09/30/2024 at 10:10 a.m. of resident #45's door revealed no signs posted to ensure staff were aware the resident was on Enhanced Barrier Precautions procedures when providing care.</p> <p>Interview on 09/30/2024 at 10:15 a.m. with resident #45 revealed staff only wear gloves and do not wear gowns when they empty the foley catheter bag.</p> <p>Interview on 10/02/2024 at 7:20 a.m. with S12 Certified Nursing Assistant (CNA) reported resident #45 was not on EBP.</p> <p>Interview on 10/02/2024 at 3:00 pm. with S2 Director of Nursing (DON) confirmed resident #45 should be on enhanced barrier precautions due the resident having a foley catheter. S2 DON further confirmed there should have been signage indicating EBP posted on resident #45's door.</p> <p>19098</p> <p>Resident #321</p> <p>On 09/30/2024 during initial tour of the facility observation of resident #321's room revealed no indication resident #321 was on EBP.</p> <p>Review of the record for resident #321 revealed an admitted [DATE] with diagnoses of End Stage Renal Disease and had a hemodialysis line to the right groin area.</p> <p>Resident 322</p> <p>On 09/30/2024 during initial tour observation of resident #322's room revealed no indication the resident had been placed on EBP. Review of the record revealed an admitted [DATE]. Further observation revealed resident #322 had tube feeding infusing.</p> <p>On 10/01/2024 at 11:15 a.m. observation of resident #321, and #322's door revealed there was no EBP signs posted.</p> <p>On 10/01/2024 at 11:20 a.m., an interview with S6 MDS nurse revealed she had been given a list of residents to place EBP signage on the doors. S6 MDS nurse confirmed there were no signs for EBP on resident #321 and #322's door.</p> <p>On 10/01/2024 at 11:45 a.m., an interview with S2 DON revealed she was not aware the residents' rooms did not have EBP signs placed on the door when the residents were admitted .</p> <p>32231</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>Resident #7</p> <p>On 09/30/2024 at 3:41 p.m., an observation revealed signs on the outside of resident #7's room door regarding enhanced barrier precautions and personal protective equipment use. Observation of one of the posted signs revealed that providers and staff must wear gloves and a gown for the following high-contact resident care activities which included device care or use for urinary catheters. During the observation, S13Certified Nursing Assistant was present and donning a pair of disposable gloves. She entered resident #7s room, walked to the bedside, and checked resident #7's brief. S13CNA then noted that resident #7's Foley catheter needed to be emptied. After she collected the urine, she disposed of the urine in the resident's bathroom, and left the room. S13CNA did not wear a gown when emptying the Foley catheter bag. After she exited the room, S13CNA revealed that she was told she only had to wear a pair of gloves and not a gown when caring for resident #7.</p> <p>On 10/03/2024 at 7:36 a.m., S1Administrator and S2Director of Nursing were notified of the above findings. S2Director of Nursing confirmed it was the nursing facility's policy for staff to the wear gloves and a gown when emptying a Foley catheter.</p>		