

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Colfax Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 366 Webb Smith Drive Colfax, LA 71417	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>20604</p> <p>Based on observations and interviews, the facility failed to treat each resident with respect, dignity and care in a manner that promotes maintenance of his or her quality of life by failing to ensure residents sitting at dining room tables were served together during mealtime. This deficient practice had the potential to affect any residents that use the facility's dining room during mealtime.</p> <p>Findings:</p> <p>Observations on 06/02/2024 at 12:20 p.m. revealed 2 resident sitting at a dining room table together. At 12:25 p.m., the 1st resident was served his tray of food. Staff were observed serving resident at other tables at this time. The 2nd resident was served his tray of food 19 minutes later at 12:44 p.m.</p> <p>Observations on 06/02/2024 at 12:30 p.m. revealed 2 resident sitting at a dining room table together. At 12:30 p.m., the 1st resident was served his tray of food. Staff were observed serving resident at other tables at this time. The 2nd resident was served his tray of food 9 minutes later at 12:39 p.m.</p> <p>Interview on 06/04/2024 at 11:05 a.m. S2 DON confirmed that residents sitting at the same table were not being served together, but should have been.</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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>38373</p> <p>Based on record review and interview, the facility failed to inform each resident of the charges for services for which the residents may be responsible for paying for 2 (#21 and #44) of 3 (#21, #44, & #240) sampled residents for Advanced Beneficiary Notice of Non-Coverage (ABN). Findings:</p> <p>Review of the facility's undated policy titled Medicare Advance Beneficiary and Medicare Non-Coverage Notices on 06/04/2024 at 10:00 a.m. revealed in part .</p> <p>Skilled Nursing Facility Advance Beneficiary Notice (CMS form 10055)</p> <ol style="list-style-type: none"> 1. If the director of admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the services may not be covered and of the resident's potential liability for payment of the non-covered service(s). 2. 3. The resident (or representative) is informed that they may choose to continue receiving the skilled services that may not be paid for by Medicare, and assume financial responsibility. <p>Review of the ABN notices (CMS form 10055) signed by Resident #21's representative on 03/27/2024 and Resident #44's representative on 04/08/2024 revealed the estimated cost section was not completed but left blank.</p> <p>In an interview on 06/03/2024 at 4:38 p.m., S10 Clerical confirmed she was responsible for sending the ABN notices to resident's representatives and sent them to Resident #21 and #44's representatives. S10 acknowledged the estimated cost sections were blank and did not inform the residents/representatives of the amount of charges they may incur if they continued the services.</p> <p>In an interview on 06/04/2024 at 7:50 a.m., S11 Office Manger stated she was the supervisor for S10 Clerical who was responsible for sending the ABN notices and confirmed there was no estimated costs on the ABN notices, but there should have been.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>47004</p> <p>Based on observation and interview, the facility failed to maintain a clean, comfortable, and homelike environment by failing to ensure residents received housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled Floors on 06/03/2024 at 11:14 a.m. read in part .Floors shall be maintained in a clean, safe, and sanitary manner. All floors shall be mopped/cleaned/vacuumed daily in accordance with our established procedures.</p> <p>Observation on 06/02/2024 at 9:20 a.m. of Resident #23 in Room A on Hall X revealed a large amount of food debris on the side of her bed. Room A had a large amount of brownish black substance observed throughout the room, and the floor was sticky. Resident #23 stated her room had not been cleaned since Friday 05/31/2024. Hall X was observed with a very strong urine odor throughout the hall.</p> <p>Observation on 06/02/2024 at 9:39 a.m. of Resident #6 in Room B on Hall X revealed the floor had black substances, a large amount of food debris, and the floor was sticky. Resident #6 stated housekeeping staff did not clean her room hardly ever, and she did not know the last time her floor was mopped.</p> <p>Interview on 06/02/2024 at 9:43 a.m. with S18 HK revealed she was the only housekeeper working at the facility today. S18 HK stated she worked full time for the facility, and the facility had been short staffed in housekeeping for a while. S18 HK stated it was extremely hard to complete her duties being the only housekeeper in the facility, and sometimes her duties were not completed during her shift.</p> <p>Interview on 06/02/2024 at 10:17 a.m. with S4 ADON on Hall X confirmed Hall X was in need of cleaning as the floor throughout the hall and within Resident's rooms were unclean, had large amounts of sticky brownish/black substances on floors, and there was a strong urine odor throughout hall.</p> <p>Interview on 06/02/2024 at 10:23 a.m. with S19 HK Supervisor revealed she was currently understaffed with only 3 workers within the house keeping department. S19 HK Supervisor stated the facility had recently reduced housekeeper's hours from 12 hour shifts to 8 hour shifts. S19 HK Supervisor confirmed Hall X was unsanitary and needed to be cleaned.</p> <p>31206</p> <p>Room F</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 06/02/2024 at 9:30 a.m. of Room F revealed loose, cracked and water stained ceiling tiles in the bedroom and bathroom, privacy curtains stained with large red and brown substance in multiple areas. The wall mounted air condition/heating unit was not properly fitted against the wall with a small exposed area of the outside visible. The vertical window blind was not able to open/close nor go up/down. The window pane was covered with light green film, not being able to clearly see out of the window.</p> <p>Interview on 06/02/2024 at 9:30 a.m. with Resident #5 revealed she was bed bound and would like to be able to have the blinds raised to provide some light into her room and to be able to see out of her window.</p> <p>Review of Resident #5's MDS revealed a BIMS of 15 (cognitively intact).</p> <p>Observation on 06/04/2024 at 1:00 p.m. accompanied by SS9 Maintenance Supervisor confirmed the above findings.</p> <p>Room G</p> <p>Observation on 06/02/2024 at 9:00 a.m. of Room G revealed loose, cracked and brown water stains in the bathroom ceiling tile and holes in the sheet rock between the toilet and the sink. The privacy curtain between the two beds, with red and brown stains in multiple places was observed. There were curtain hooks on the curtain track with no privacy curtain for bed b. The wall molding 1x12, approximately 12 inches, behind the bed and night stand was noted with splits in the molding and visible splinters.</p> <p>Observation on 06/04/2024 at 1:16 p.m. accompanied by S9 Maintenance Supervisor confirmed the above findings.</p> <p>Room H</p> <p>Observation on 06/02/2024 at 2:30 p.m. of Room H revealed flies and gnats flying around in the room, landing on both residents in the room. The wall mounted air condition and heating unit was not secure properly to the wall. The floor had a large film of dried grayish substance with a large brown streak approximately 2 feet from the door entrance to the bathroom, floor tile to the bathroom entrance broken, sheet rock below the television peeled and ripped. The wall molding 1x12, approximately 12 inches, behind the bed and night stand had splits in the molding and visible splinters. Two over bed tables had torn and ripped plastic veneers and missing plastic edges. There were two 3 drawer night stand with split wood and jagged wood edges.</p> <p>Observation on 06/04/2024 at 1:32 p.m. accompanied by S9 Maintenance Supervisor confirmed the above findings.</p> <p>Room I</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 06/02/2024 at 11:10 a.m. of Room I room revealed tears in the sheet rock across from bed, trash and bread crumbs on floor mat on left side of bed, window blinds not able to open, and window pane with large white film covering it, with outside not visible. The privacy curtains was noted to have large dried brown stains in the center. The wall molding 1x12, approximately 12 inches, behind the bed and night stand had splits in the molding and visible splinters.</p> <p>Interview on 06/02/2024 at 11:10 a.m. with Resident #1 revealed the rooms' and hallways smell like urine and they are not cleaned every day. Resident #1 stated there are not enough housekeepers to keep the facility clean. Resident #1 stated she would like to have her blinds open and to be able to see out of the window.</p> <p>Review of Resident #1's MDS revealed a BIMS of 15 (cognitively intact).</p> <p>Observation on 06/04/2024 at 1:32 p.m. accompanied by S9 Maintenance Supervisor confirmed the above findings.</p> <p>Room J</p> <p>Observation on 06/02/2024 at 1:00 p.m. of Room J revealed flies and gnats flying around resident, and inside a box next to the bed, and the room reeked the smell of feces. There were loose, broken and water stained ceiling tiles in the bathroom. The wall paper on the wall between the bathroom door and the window was noted to be bulky and coming off.</p> <p>Interview on 06/02/2024 at 1:00 p.m. with Resident #33 revealed there was a big problem with flies and gnats. Resident #33 stated his room was not cleaned every day and sometimes the room only gets cleaned twice a week. Resident #33 stated the facility didn't have enough housekeepers to keep the rooms cleaned.</p> <p>Observation on 06/04/2024 at 2:20 p.m. accompanied by S9 Maintenance Supervisor confirmed the above findings.</p> <p>Hall Z</p> <p>Observation accompanied by S9 Maintenance Supervisor on 06/04/2024 at 1:50 p.m. of shower room on Hall Z revealed water stained and loose ceiling tiles, peeling and missing sheet rock and missing molding wall tile near the door. The whirlpool was noted to have water on the bottom surface and water on the seat, with a large soap film ring inside. There were 2 shower chairs in each shower stall with water dripping from the seat, hair and wet yellow stains under the seat ring and between the grooves.</p> <p>S9 Maintenance Supervisor confirmed the above findings at the time of the observation.</p> <p>Hall Y</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation accompanied by S9 Maintenance Supervisor on 06/04/2024 at 1:56 p.m. of shower room on Hall Y revealed water stained loose missing tiles and broken wall molding tile. The whirlpool had a pool of water in the center, dripping from the seat with water pooled in the center of the center, and the front panel with dried water stains. There were 2 shower chairs in each shower stalls which were noted to have brown and yellow substance in the seat grooves, and streaks of long brown and black strings of hair underneath the seat ring.</p> <p>Hall X</p> <p>Observation accompanied by S9 Maintenance Supervisor on 06/04/2024 at 2:15 p.m. of shower room on Hall X revealed water stained, loose and broken ceiling tiles and missing and broken wall tile molding. The whirlpool was noted to have a wet face towel, can of shaving cream, 2 razor covers, and pool of water on the seat, dried dripping streaks on the front panel, black specks of substance in the bottom surface, and a soap scum ring around the tub. The 2 shower chairs located in both shower stalls revealed: One large chair with worn back cushion and leg rest, water dripping on the seat ring, hair and yellow stains underneath the seat ring. The second shower chair was noted to have streaks of hair on the top seat ring, and wet yellow stain underneath the seat ring.</p> <p>S9 Maintenance Supervisor confirmed the above findings at the time of the observation.</p> <p>Observations accompanied by S2 DON of showers on Hall X, Y, and Z on 06/04/2024 at 2:18 p.m., 2:20 p.m. and 2:30 p.m. confirmed the 3 whirlpools, and 6 shower chairs had not been cleaned and/or disinfected after use and should have been. S2 DON identified the yellow substance as urine around the seat rings around the bottom of 3 of 6 shower chairs.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46773</p> <p>Based on interview and record review the facility failed to ensure a resident's right to be free from sexual abuse by another resident, for 1 (Resident #33) of 1 resident reviewed for abuse, in a total sample size of 38.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled Seven Step Abuse Prevention Policy, read in part .</p> <p>Policy: It is the policy of [NAME] Nursing and Rehab to have a 7-step plan to assist in preventing abuse, neglect, misappropriate pf resident's property, and to keep residents as safe as possible.</p> <p>Identification: Sexual Abuse is non-consensual sexual contact of any type with a resident.</p> <p>Resident #33</p> <p>Review of Resident #33's clinical record revealed an admitted [DATE], with diagnoses that included: Anxiety Disorder, Osteoarthritis, Peripheral Vascular Disease, Atherosclerotic Heart Disease, and Hyperlipidemia.</p> <p>Review of Resident #33's Quarterly MDS with an ARD of 03/06/2024, revealed a BIMS score of 11, indicating moderate cognitive impairment.</p> <p>Resident #75</p> <p>Review of Resident #75's clinical record revealed an admitted [DATE], with diagnosis that included: Depression, Essential HTN, Schizoaffective Disorder, and Mild Intellect Disability.</p> <p>Review of Resident #75's Quarterly MDS with an ARD of 03/27/2024, revealed a BIMS score of 13, indicating intact cognition.</p> <p>Review of Resident #75's Care Plan with review date of 06/27/2024, revealed in part .</p> <p>Socially inappropriate/disruptive behavior as evidenced by judgment or reasoning deficit due to Schizoaffective Disorder.</p> <p>Review of a facility report dated 05/17/2024, revealed on 05/08/2024, Resident #33 awoke feeling something touching his private area, and found his roommate, Resident #75, over him trying to pull his pants down and making inappropriate, sexual comments. Resident #33 reported this incident to the Day Program staff on 05/10/2024, who immediately notified the facility on 05/10/2024.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 06/02/2024 at 10:45 a.m. with Resident #33, revealed on 05/08/2024, he awoke feeling something touching his private area. Resident #33 stated he found his roommate, Resident #75, over him trying to pull his pants down and making inappropriate, sexual comments. Resident #33 stated he told Resident #75 to get away and leave him alone, and Resident #75 left the room immediately. Resident #33 stated he notified staff at the Day Program on 05/10/2024. Resident #33 stated once the facility was notified of the incident, he was moved to a different hall, away from Resident #75. Resident #33 revealed he is not fearful in the facility, and felt the staff were doing a good job of keeping him safe.</p> <p>Interview on 06/03/2024 at 8:55 a.m. with Resident #75, revealed he had touched Resident #33 in his private area, but he was just joking with him. Resident #75 stated he did not want to have sexual relations with any of the staff or residents in the facility.</p> <p>Interview on 06/03/2024 10:22 a.m. with S1 Administrator, confirmed a resident to resident sexual abuse incident occurred between Resident #33 and Resident #75 on 05/08/2024. S1 Administrator stated Resident #75 had not exhibited inappropriate sexual behaviors since the incident occurred.</p>		

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38373</p> <p>FACILITY</p> <p>Based on record review and interview, the facility failed to ensure a quarterly assessment was completed timely for 1 (#51) of 1 resident reviewed for Resident Assessments. There were 84 residents in the facility. Findings:</p> <p>Review of Resident #51's medical record revealed an admitted [DATE] with diagnoses that included in part . Hyperlipidemia, Seizures; Schizoaffective Disorder, Dementia, and Chronic Kidney Disease.</p> <p>Review of Resident #51's MDS assessments revealed a quarterly assessment was completed on 01/24/2024 with no MDS quarterly assessments accepted since that time.</p> <p>In an interview on 06/04/2024 at 3:52 p.m., S3 Corporate Nurse stated the facility did not have an MDS nurse at this time. S3 Corporate Nurse stated she became aware Resident #51's MDS was late and transmitted one last night. S3 Corporate Nurse confirmed Resident #51's quarterly MDS was not submitted timely.</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** 31206</p> <p>Based on record review and interview, the facility failed to develop and implement a person-centered care plan for each resident by failing to:</p> <ol style="list-style-type: none"> 1. Develop and implement a care plan for Resident #59 related to depression, and 2. Record food intake for and notify Resident #26's physician and family of significant weight loss. <p>There were 38 sampled residents.</p> <p>Findings:</p> <p>Resident #59</p> <p>Review of Resident #59's EHR revealed an admitted [DATE] with diagnoses that included in part . Cerebral Infarction, Acute Respiratory Failure, Essential (primary) Hypertension, and Major Depressive Disorder.</p> <p>Review of June 2024 Physician orders revealed:</p> <ol style="list-style-type: none"> 1. Torsemide 10 mg po qd 2. Aricept 10 mg po hs 3. Buspirone 5 mg po tid <p>Review of Resident #59's quarterly MDS with an ARD of 05/08/2024 revealed the resident had a BIMS of 11, which indicated moderate cognitive impairment. Review of the MDS revealed Resident #59 received Antianxiety and Antidepressant medications with Active Diagnoses that included . CVA, Anemia, Coronary Artery Disease, ESRD, HTN, Heart Failure, Non-Alzheimer's Dementia, Depression, and Pneumonia.</p> <p>Review of Resident #59's care plan with a target date of 08/08/2024 revealed the resident was not care planned for Major Depressive Disorder and Anxiety.</p> <p>In an interview on 06/04/2024 at 2:55 p.m. with S2 DON confirmed Resident #59 was not care planned for Depression and should have been.</p> <p>38373</p> <p>Resident #26</p> <p>Review of Resident #26's medical record revealed an admitted [DATE] with diagnoses that included in part . Malignant Neoplasm of Parotid Gland, Hypothyroidism, Anemia, and Dementia.</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 #26's quarterly MDS revealed the resident had a BIMS of 11, which indicated moderate cognitive impairment. Review of the MDS revealed Resident #26 required set up or clean up assistance with eating.</p> <p>Review of Resident #26's weights revealed the following which represented a significant weight loss of 11.03%:</p> <p>05/27/2024-117 pounds</p> <p>04/29/2024-119 pounds</p> <p>02/07/2024-130 pounds</p> <p>01/01/2024-130.5 pounds</p> <p>12/04/2024-131.5 pounds</p> <p>Review of the nurses' notes revealed the following entry by S8 RD:</p> <p>05/09/2024: RD assessment related to weight change. Height: 62 Weight 117.5 pounds (05/06/24) -9.6% x 88 days . Nursing reports poor appetite and intakes. House Supplement 8 oz increased to TID on 4/14/24. Tolerating regular, NAS diet. Nursing will continue to encourage oral intake of meals, snack and supplements. Continue w/ diet and supplement as prescribed .Will continue to monitor weight and oral intake.</p> <p>Review of Resident #26's care plan with a target date of 06/20/2024 revealed the resident was care planned for risk for altered nutrition related to decreased appetite, weight loss, due to depression, dementia, CAD, delirium, etc. Interventions included in part .Encourage fluids as tolerated, avoid fluid overload; administer medications as ordered; Record percentage of food intake and follow diet as ordered; Monitor food intake each meal. Record and report decline in intake to MD and RD; Report weight variance to MD and RD;</p> <p>Review of Resident #26's medical record revealed the last weight loss notification was sent to Resident #26's physician and family on 09/06/2023.</p> <p>In an interview on 06/04/2024 at 10:30 a.m., S2 DON stated she could not provide documentation of Resident #26's food intake because no one had been documenting it. S2 DON confirmed staff should have been recording Resident #26's food intake at meals.</p> <p>In an interview on 06/04/2024 at 4:56 p.m., S2 DON stated the last weight loss notification letter sent to Resident #26's medical doctor and family was sent in September 2023. S2 DON confirmed they had not notified the resident's family and physician of her weight loss since September 2023 but should have.</p>

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NAME OF PROVIDER OR SUPPLIER Colfax Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 366 Webb Smith Drive Colfax, LA 71417	
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38373</p> <p>Based on record review, observation, and interview, the facility failed to ensure services were provided to meet professional standards of practice for 2 (#23 and #30) of 38 sampled residents. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Physician's orders for referring Resident #30 to a dermatologist were followed, and 2. Abnormal lab results were reported to provider and urine sample was recollected for Resident #23. <p>Findings:</p> <p>Resident #30</p> <p>Review of Resident #30's medical record revealed an admitted [DATE] with diagnoses that included in part . Hemiplegia, Cerebral infarction, Type 2 Diabetes Mellitus, and Anxiety Disorder.</p> <p>Review of Resident #30's quarterly MDS with an ARD of 04/03/2024 revealed a BIMS score of 14 which indicated intact cognition. Review of the MDS revealed Resident #30 required supervision/touching assistance with eating, partial/moderate assistance with toileting hygiene and was independent with rolling left and right and sit to lying</p> <p>In an interview on 06/02/2024 at 9:45 a.m., Resident #30 stated he had been trying to get three cysts removed from his face for about 6 months. Resident #30 stated he reported this complaint to the Nurse Practitioner and a male doctor but had never received an appointment to get them removed.</p> <p>In an observation on 06/03/2024 at 1:53 p.m., Resident #30's right temple area near the right eye revealed 2 small cysts, one which was noted to be pea sized and another larger, marble sized cyst. In an interview at this time, Resident #30 stated they were getting larger and now has one on right cheek.</p> <p>Review of a progress note by S12 NP dated 03/21/2024 revealed the following in part .</p> <p>History of Present Illness: On assessment today patient complains of 2 small cysts to right cheek area that he would like to be evaluated by dermatology. Patient reports he has had them in the past and had them removed with no difficulty. Reports they are becoming bothersome.</p> <p>Physical Exam-Skin: 2 small pea-sized nodular cysts noted to right cheek area.</p> <p>Plan: Epidermoid cyst of skin of cheek: Refer to Dermatology for eval and treat.</p> <p>In an interview on 06/03/2024 at 2:33 p.m., S13 [NAME] Clerk stated she was the person responsible for making the dermatology appointment for Resident #30. S13 [NAME] Clerk stated no one notified her of the NP ordering a dermatology referral. S13 [NAME] Clerk stated the nurse probably forgot to tell her. S13 [NAME] Clerk stated no one else would have made the dermatology appointment.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/04/2024 at 10:40 a.m., S2 DON stated she was unaware the dermatology referral wasn't made but should have been.</p> <p>47004</p> <p>Resident #23</p> <p>Record review revealed Resident #23 had an admitted [DATE] with diagnoses that included in part . Retention of Urine, Urinary Tract Infection, Anxiety, Chronic Pain, Heart Failure, Major Depressive Disorder, and Type 2 Diabetes Mellitus.</p> <p>Review of Resident #23's Quarterly MDS with ARD of 03/06/2024 revealed Resident #23 had a BIMS of 13 (Cognition Intact). Resident #23 was dependent on staff for toileting, showering/bathing, personal hygiene and dressing. Resident #23 was always incontinent of bowel and had a urinary catheter.</p> <p>Review of Resident #23's CPOC revealed Resident had potential for complications related to the presence of Foley catheter. Interventions included: Wash around catheter site every day with mild soap and water. Change Foley catheter and bag as needed. Assess, record, and report to physician signs and symptoms of UTI. Labs as ordered, report abnormal results to MD/NP.</p> <p>Review of Resident #23's 04/2024-06/2024 Physician's Orders revealed the following in part .</p> <p>16 French Foley catheter for retention of urine. Change monthly on the 1st. 03/07/2024</p> <p>Catheter Care Q Shift 03/07/2024</p> <p>U/A with C&S 04/03/2024</p> <p>U/A with C&S 05/04/2024</p> <p>Review of Resident #23's UA laboratory results dated [DATE] revealed the following in part . Abnormal results of: Blood 5+, Nitrate-Positive, Leukocyte Esterase 3+, Catalase Bacteria Screen-Positive.</p> <p>Review of Resident #23's C&S laboratory results dated [DATE] revealed the following in part . High Pathogens detected- Complex Sample-see note. Note read: Greater than 3 organisms present. Probable contamination. Recommend recollecting with sterile in/out catheter procedure. Review of the 04/08/2024 UA C&S laboratory results revealed the reports were not signed off by facility staff. Review of Resident #23's medical record revealed no documentation that the provider was notified of the abnormal lab results on 04/08/2024, and no record of treatment.</p> <p>Review of Resident #23's UA laboratory results dated [DATE] revealed the following in part . Abnormal results of: UA color- Cloudy, Blood-Trace, Leukocyte Esterase- Large, RBC- 10-20, WBC >50. The 05/04/2024 UA Laboratory results was signed off by facility staff on 05/05/2024 at 5:55 a.m. Review of Resident #23's medical record revealed Macrobid (antibiotic) 100mg capsule po bid x 7 days was ordered on 05/05/2024. Review of Resident #23's EMAR revealed she received the antibiotic as ordered.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/02/2024 at 9:21 a.m. with Resident #23 revealed she had frequent UTI's. Resident #23 stated she could not recall the last time she was diagnosed , but felt it was recent. Resident #23 was observed with a Foley catheter hanging in privacy bag on left side of bed frame draining clear yellow urine. Resident #23 denied having signs/symptoms of current UTI.</p> <p>Interview on 06/04/2024 at 11:56 a.m. with S2 DON revealed a review of Resident #23's UA orders and 04/08/2024 laboratory results. S2 DON stated she was unsure why Resident #23 did not receive treatment for abnormal UA results on 04/08/2024. S2 DON reviewed the 04/08/2024 UA results and confirmed the provider should had been notified. S2 DON confirmed there was no staff sign offs on the lab report, so the provider was likely not notified.</p> <p>Interview on 06/04/2024 at 12:28 p.m. with S12 NP revealed a review of Resident #23's 04/03/2024 UA order and results reported on 04/08/2024. S12 NP stated Resident #23 had chronic colonization of Klebsilea (bacteria), so she did not always treat the resident with positive UA results. S12 NP stated Resident #23 was not symptomatic, and based off the 04/08/2024 C&S report stating probable contamination with recollection recommended, she would not have treated the resident with antibiotics, but would expect staff to perform a recollection. S12 NP confirmed she was not notified of the 04/08/2024 abnormal UA results.</p> <p>Interview on 06/04/2024 at 1:00 p.m. with S2 DON confirmed staff did not notify MD/NP of positive UA results on 04/08/2024, but should have. S2 DON stated when staff receive abnormal results, they were to sign off on the lab report, notify md, and make a progress note within the Resident's medical record. S2 DON stated staff did not recollect UA on 04/08/2024 as recommended on C&S report likely because staff did not review the lab results. S2 DON confirmed staff should have notified the MD upon receiving the abnormal UA results and recollected the UA as recommended, but failed to do so.</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** 46773</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents who were unable to carry out ADLs (Activities of Daily Living) received the necessary services to maintain good grooming and personal hygiene. The facility failed to provide baths, shaving, and nail care to dependent residents for 5 (#6, #10, #12, #66, and #87) of 7 (#6, #10, #12, #33, #44, #66, and #87) residents reviewed for ADL's.</p> <p>Findings:</p> <p>Review of the facility policy on at 06/03/2024 at 10:35 a.m. titled: Activities of Daily Living (ADL), Supporting, revealed in part .Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care , including appropriate support and assistance with:</p> <p>a. Hygiene (bathing, dressing, grooming, and oral care);</p> <p>Review of the facility policy on 06/03/2024 at 10:35 a.m. titled: Fingernails/Toenails, Care of</p> <p>General Guidelines read in part .</p> <p>1. Nail care includes daily cleaning and regular trimming.</p> <p>#66</p> <p>Review of Resident #66's Quarterly MDS with an ARD of 05/08/2024 revealed a BIMS of 13 indicating severe cognitive impairment. Resident #66 required supervision and touch assistance with personal hygiene.</p> <p>Review of Resident #66's care plan with a review date of 05/26/2024 read in part</p> <p>Resident #66 has self-care deficit and required assistance with ADL's due to Intellectual Disability and Schizophrenia.</p> <p>Observation on 06/02/2024 at 12:17 p.m. revealed Resident #66's fingernails were 1/4 inch in length, jagged, and with brown substance under all nails. Resident #66 stated that he would like to have his fingernails cleaned and cut.</p> <p>Observation on 06/03/2024 at 9:40 a.m. revealed Resident #66 nails were long, jagged and had a brown substance under all nails.</p> <p>Interview on 06/03/2024 at 9:45 a.m. with S2 DON confirmed Resident #66's nails were long, jagged and dirty and should have been cleaned and clipped, but had not been.</p> <p>47004</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 #6</p> <p>Record review revealed Resident #6 was admitted to the facility on [DATE] and had diagnoses that included in part . UTI, Bacteriuria, Chronic Kidney Disease- Stage 4, Generalized Muscle Weakness, Dysphagia, Cognitive Communication Deficit, Type 2 Diabetes Mellitus, and Major Depressive Disorder.</p> <p>Review of Resident #6's Quarterly MDS with ARD of 03/13/2024 revealed Resident #6 had a BIMS of 15 (Cognition Intact). Resident #6 had lower extremity Range of Motion impairment on both sides. Resident #6 was dependent on staff for showering/bathing.</p> <p>Review of Resident #6's Comprehensive Person Centered Plan of Care revealed Resident required assistance with ADLS.</p> <p>Review of Resident #6's medical record revealed no documentation of assistance with bathing performed.</p> <p>Interview on 06/02/2024 at 9:38 a.m. with Resident #6 revealed she was to receive baths on Monday-Wednesday-Friday, and stated she was only getting bathed once a week.</p> <p>Interview on 06/03/2024 at 10:18 a.m. with S17 CNA revealed Resident #6 did not have refusals for ADL care. S17 CNA stated she does not document when a resident received a bath, as the computer system did not allow her to. S17 CNA stated Resident #6 required assistance from staff for bathing and was 2 person assist. S17 CNA stated Resident #6 was to receive a bath today.</p> <p>Resident #12</p> <p>Record Review revealed Resident #12 was admitted to the facility on [DATE] and had diagnoses that included in part .Unspecified Dementia, Schizoaffective Disorder, Primary Generalized Osteoarthritis, Unspecified Abnormalities of Gait and Mobility, and UTI.</p> <p>Review of Resident #12's Quarterly MDS with ARD of 02/14/2024 revealed Resident had a BIMS of 12 (Moderate Cognitive Impairment). Resident #12 required setup assistance for showering/bathing, and personal hygiene.</p> <p>Review of Resident #12's Comprehensive Person Centered Plan of Care revealed Resident required assistance with ADLS.</p> <p>Review of Resident #12's medical record revealed no documentation of assistance with bathing performed.</p> <p>Interview on 06/02/2024 at 10:43 a.m. with Resident #12 revealed she had concerns of only getting a bath once weekly.</p> <p>Interview on 06/03/2024 at 10:18 a.m. with S17 CNA revealed Resident #12 did not have refusals for ADL care, and required assistance of staff for ADL care.</p> <p>Resident # 87</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>Record review revealed Resident #87 was admitted to the facility on [DATE] and had diagnoses that included in part Unspecified Dementia, Major Depressive Disorder, Alzheimer's Disease, and Coronary Artery Disease.</p> <p>Review of Resident #87' sAdmission MDS with ARD of 03/14/2024 revealed Resident #87 had a BIMS of 10 (Moderate Cognitive Impairment). Resident #87 had lower extremity impairment on both sides. Resident #87 required Substantial/Maximal assistance with toileting, showering/ bathing, and dressing. Resident #87 was dependent on staff for personal hygiene.</p> <p>Review of Resident #87's Comprehensive Person Centered Plan of Care revealed Resident required assistance with ADLS.</p> <p>Review of Resident #87's medical record revealed no documentation of assistance with bathing performed.</p> <p>Interview on 06/02/2024 at 10:13 a.m. with Resident #87 revealed he stated he was frustrated because staff left him with a dirty diaper and he called for help, but the CNA's leave him dirty. Resident #87 stated he received a bath once a week, and had complained about not getting bathed multiple times, but could not recall who he spoke to. Observation revealed a strong BM odor within Resident #87's room.</p> <p>Interview on 06/03/2024 at 3:03 p.m. with S2 DON revealed the bathing schedule for Residents was Monday-Wednesday-Friday for women, and Tuesday-Thursday-Saturday for men, and Sundays were a makeup day. S2 DON stated Residents are also bathed as needed. S2 DON confirmed Resident #6, Resident #12, and Resident #87 had no documented baths, but should have. S2 DON confirmed staff should have documented when a Resident received baths per schedule, or PRN within the Resident's medical record, but failed to do so.</p> <p>20604</p> <p>Resident #10</p> <p>Review of Resident #10's current care plan revealed ADL self-care deficit with interventions to remove chin hairs as needed.</p> <p>Observations on 06/02/2024 at 11:17 a.m. revealed Resident #10 had facial hair that was approximately 1/16th to 1/8th inches long. Resident #10 stated that he can't shave himself anymore because of his hands and would like to be shaved.</p> <p>Observation on 06/03/2034 at 8:48 a.m. Resident #10 continues with long facial hair. Resident #10 stated he believes the facility does not have enough razors to shave him.</p> <p>Observations on 06/04/2024 at 08:50 a.m. revealed Resident #10 unshaven. Interview with Resident #10 at that time revealed he had a bath this morning but was not shaved by staff.</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>Interview on 06/04/2024 at 9:15 a.m. S2 DON stated the facility has the necessary equipment available to shave residents. S2 DON stated she is not aware of Resident #10 refusing care. S2 DON confirmed Resident #10 has long facial hair and should have been shaved when he was bathed, but had not been.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 47004</p> <p>Based on observation, interview, and record review the facility failed to provide respiratory care consistent with professional standards for 1 (#87) of 2 (#40, and #87) sampled residents for respiratory care. The facility failed to ensure Resident #87 had a physician's order to receive oxygen therapy. Findings:</p> <p>Review of the facility's undated policy titled Oxygen Administration on 06/04/2024 at 9:44 a.m. read in part . The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure.</p> <p>Review of Resident #87's medical record revealed an admitted [DATE]. Resident #87 had diagnoses that included in part Unspecified Dementia, Major Depressive Disorder, Alzheimer's Disease, and Coronary Artery Disease.</p> <p>Review of Resident #87's Admission MDS with ARD of 03/14/2024 revealed Resident #87 had a BIMS of 10 (indicating moderate cognitive impairment).</p> <p>Review of Resident #87's Comprehensive Person Centered Care Plan revealed Resident had a potential for complications related to diagnoses of Coronary Artery Disease and Hypertension with interventions of; Administer oxygen as ordered. Observe O2 saturation as ordered.</p> <p>Review of Resident #87's 06/2024 orders revealed there was no order for Oxygen Administration. Resident #87 had an order dated 03/02/2024 to monitor temperature and oxygen saturation every shift.</p> <p>Observation on 06/02/2024 at 10:00 a.m. revealed Resident #87 was wearing oxygen via NC at 2L/min. Resident #87 stated he wore oxygen frequently, but mostly while sleeping.</p> <p>Observation on 06/04/2024 at 9:10 a.m. of Resident #87 revealed his Oxygen concentrator was running and set at 2L/min. Resident #87 stated he had just taken his oxygen off to eat breakfast.</p> <p>Interview on 06/04/2024 at 10:07 a.m. with S15 LPN revealed Resident #87 required the use of oxygen. S15 LPN confirmed Resident #87 did not have an order for Oxygen therapy, but should have.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>20604</p> <p>Based on observation, interview, and record review the facility failed to meet the nutritional needs of residents in accordance with established national guidelines. The facility failed to follow the menu to ensure nutritional adequacy.</p> <p>Findings:</p> <p>Record review of the menu for the 06/02/2024 lunch meal revealed in part:</p> <p>Oven roasted turkey breast - 3 ounces</p> <p>Roasted turkey gravy - 2 ounces</p> <p>Au gratin potatoes - 1/2 cup</p> <p>Green peas - 1/2 cup</p> <p>Observations on 06/02/2024 at 12:29 p.m. of the food serving line in the kitchen, revealed S6 Dietary [NAME] preparing trays on the serving line for residents in the dining room. As the trays were prepared, they were then given to the CNAs to serve the residents. Observations revealed that roasted turkey gravy was not being served.</p> <p>Interview on 06/02/2024 at 12:30 p.m. with S6 Dietary Cook, confirmed that she had not served roasted turkey gravy to any of the trays that she had prepared, and there was no gravy on the serving line.</p> <p>Interview on 06/02/2024 at 12:30 p.m. with S5 Dietary Manager, confirmed that the menu called for 2 ounces of roasted turkey gravy, and there was no turkey gravy served, and there was no gravy on the serving line.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>46773</p> <p>Based on interview and record review the facility failed to ensure pureed foods were prepared according to the approved recipe by methods which conserved nutritional value for 8 residents that are served pureed diets by the facility's kitchen.</p> <p>Findings:</p> <p>Review of the facility's policy on 06/04/2024 at 9:51 a.m. titled Standardized Recipes read in part .</p> <p>Policy Statement: Standardized recipes shall be developed and used in the preparation of food.</p> <p>Policy Interpretation:</p> <ol style="list-style-type: none"> 1. Only tested , standardized recipes will be used to prepare foods. 2. Standardized recipes will be adjusted to the number of portions required for a meal. 3. The food service manager will maintain the recipe file and make it available to food service staff. <p>Interview on 06/02/2024 at 11:45 a.m. S6 Dietary [NAME] revealed she had already pureed lunch. S6 Dietary [NAME] stated she did not measure the amount of turkey she added to the dish to be pureed. S6 Dietary [NAME] stated she did not use the recipe to prepare the pureed meal.</p> <p>Interview on 06/02/2024 at 12:35 p.m. S5 Dietary Manager confirmed the recipe for the pureed meals were not followed because she could not locate them, but should have been.</p> <p>Interview on 06/03/2024 at 12:30 p.m. with S8 RD revealed the recipe for all meals should be followed to ensure residents are receiving adequate caloric intake.</p>

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NAME OF PROVIDER OR SUPPLIER Colfax Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 366 Webb Smith Drive Colfax, LA 71417	
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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>38373</p> <p>Based observation, record review, and interview the facility failed to ensure residents received meals at regular times, comparable to normal meal times in the community and in accordance with residents' needs and preferences. This deficient practice had the potential to affect all residents who are served meals in the dining room.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled Frequency of Meals on 06/03/2024 at 11:00 a.m. revealed in part .</p> <p>The facility will serve at least three meals or their equivalent daily at scheduled times.</p> <p>Meals will be served 4 to 6 hours apart to help assure residents receive nutritional requirements. The following meal times have been established by our facility for residents:</p> <p>Breakfast starts at 6:30 a.m.</p> <p>Lunch starts at 11:30 a.m.</p> <p>Dinner starts at 4:30 p.m.</p> <p>Observation of the lunch meal on 06/02/2024 revealed staff began serving residents in the dining room at 12:20 p.m.</p> <p>Observation of the breakfast meal on 06/03/2024 revealed staff began serving residents in the dining room at 8:00 a.m.</p> <p>Observation of the lunch meal on 06/03/2024 revealed staff began serving residents in the dining room at 12:11 p.m.</p> <p>Observation of the breakfast meal on 06/04/2024 at 8:00 a.m. revealed only a few residents in the dining room had been served trays and the others were still waiting on their trays to be served.</p> <p>In an interview on 06/02/2024 at 12:49 p.m., Resident #78 (BIMS of 14) stated most times she gets dinner at 6:00 p.m. but they are supposed to be served at 4:00 p.m. Resident #78 stated most times she received lunch around 2:00 PM.</p> <p>During an interview on 06/02/2024 at 1:30 p.m., Resident #78 stated she received lunch at 1:20 p.m.</p> <p>In an interview on 06/02/2024 at 12:51 p.m., S14 CNA stated lunch should be served at 11:30 a.m. with the dining room served first and then the carts are brought down the halls. S14 CNA stated her hall is served last and most residents don't get their meal until at least 1:30 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 06/02/2024 at 8:40 a.m., S6 Dietary [NAME] stated there was only 2 employees working today in the kitchen. S6 Dietary [NAME] stated she was doing everything she could but they are short-handed. S6 Dietary [NAME] stated that they have been short for a few weeks, and that was why breakfast was late.</p> <p>During the Resident Council meeting on 06/02/2024 at 2:00 p.m., the residents voiced concerns of not receiving meals on time. Residents stated they are served anywhere from 1 to 2 hours late.</p> <p>In an interview on 06/04/2024 at 4:00 p.m., S5 Dietary Manager stated she did not have a staffing schedule for June 2024. When asked about the staffing for Sunday, June 2, 2024, she indicated that she does not know if 2 staff members were adequate to get the meals out on time. S5 Dietary Manager indicated that she was recently hired and they have a lot of things that she needs to work on.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>20604</p> <p>Based on observation, interview and record review, the facility failed to ensure that food was properly stored, prepared, distributed and served in accordance with professional standards for food service safety. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Freezer and refrigerator temperatures were monitored; 2. Sanitation levels were checked in the 3 compartment sink; 3. Refrigerated food contents were labeled, dated, and stored in a sanitary manner; and 4. Kitchen equipment was clean and sanitary. <p>Findings:</p> <p>Observation on 06/02/2024 at 8:45 a.m., revealed the refrigerator and freezer temperature logs had not been checked with temperatures documented, from 05/31/2024 through 06/02/2024.</p> <p>Observation on 06/02/2024 at 8:50 a.m., revealed the walk-in freezer had a bag of approximately 20 breadsticks, and a bag of approximately 50 breadsticks that were opened and not dated. An interview with S6 Dietary [NAME] at that time, verified the bags of breadsticks were open and not dated.</p> <p>Observation on 06/02/2024 at 8:59 a.m. revealed the 3-compartment sink had water in all of the compartments. There was a wire screen and several cooking utensils on the sanitizer side sink shelf. Interview with S6 Dietary [NAME] at the time of the observation, revealed she did not check the sanitizer in the 3-compartment sink. She stated that she was too busy, and did not have enough time to check the sanitizer level.</p> <p>Observation on 06/02/2024 at 9:05 a.m. revealed the kitchen's microwave had multiple food particle splatters on the inside of the microwave. Interview with S6 Dietary [NAME] at that time, revealed the microwave should be cleaned after each use.</p> <p>Observation on 06/02/2024 at 9:10 a.m. revealed a dark brown/black substance noted on the upper portion of the inner surface of the ice machine. The inner surface was dripping on the ice below. The ice bin scoop was noted to be stored in a scoop holder, with a dark brown/black substance noted at the bottom of the scoop holder that the scoop was sitting in. Interview with S6 Dietary [NAME] confirmed the observation at that time.</p>

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>38373</p> <p>Based on record review and interview, the facility failed to include the Medical Director or his designee in the Quality Assessment and Assurance (QAA) committee quarterly meeting, as required. The facility's total census was 84.</p> <p>Findings:</p> <p>Review of the quarterly QAA meeting's sign in sheet dated 03/29/2024 revealed the Medical Director was not in attendance.</p> <p>In an interview on 06/04/2024 at 5:25 p.m., S3 Corporate Nurse confirmed the Medical Director did not sign the attendance sheet for the 03/29/2024 quarterly QAA meeting. S3 Corporate Nurse stated when the Medical Director doesn't attend a meeting, he reviews the information later.</p>

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<p>F 0924</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Put firmly secured handrails on each side of hallways.</p> <p>31206</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 Y) of 3 (Hall X, Hall Y, and Hall Z) hallways observed in the building. This had to potential to affect 24 residents residing on Hall Y.</p> <p>Findings:</p> <p>Observation on 06/04/2024 at 2:05 p.m. of the Hall Y accompanied by S9 Maintenance Supervisor revealed loose hand rails between rooms L and M.</p> <p>An interview on 06/04/2024 at 2:05 p.m., S9 Maintenance Supervisor confirmed the hand rails on Hall Y between rooms L and M were not secured to provide safety and should have been.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>47004</p> <p>Based on observation, record review, and interview, the facility failed to maintain an effective pest control program by failing to ensure the facility was free from insects. The deficient practice had the potential to affect 84 residents who resided in the facility.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled Pest Control on 06/03/2024 at 10:35 a.m. read in part . Our facility shall maintain an effective pest control program. This facility maintains an on-going pest control program to ensure that the building is free of insects and rodents.</p> <p>Observation on 06/02/2024 at 9:20 a.m. of Resident #23 in Room A on Hall X revealed there were multiple flies observed in the room. Resident #23 stated her room always had flies.</p> <p>Observation on 06/02/2024 at 9:39 a.m. of Resident #6 in Room B on Hall X revealed there were multiple flies flying around room. Resident #6 stated flies were in her room year round, and the facility could not get rid of them, likely because her room stayed dirty.</p> <p>Observation on 06/02/2024 at 9:41 a.m. of Room C, revealed the resident within room had 8 flies on his bed covering while he slept.</p> <p>Observation on 06/02/2024 at 10:13 a.m. of Resident#87 in Room D on Hall X revealed there were 7 flies lying on the covering of his bed. A red fly swatter was observed on his wheelchair. Resident #87 stated the flies were horrible, and the facility had not done anything to get rid of them.</p> <p>Interview on 06/02/2024 at 10:17 a.m. with S4 ADON on Hall X confirmed Hall X had a large amount of flies throughout the hall and within resident rooms, and should not.</p> <p>Observation on 06/02/2024 at 10:34 a.m. with Resident #78 in Room E on Hall X revealed multiple flies within room.</p> <p>Observation on 06/02/2024 at 12:25 p.m. of the dining area revealed multiple flies throughout dining room. Residents were observed swatting flies away while eating meal. Interview with Resident #43 at time of observation revealed she stated flies were always in the dining room and that made it hard to enjoy her meal. Resident #43 stated the facility needed to spray to get rid of the flies.</p> <p>Interview on 06/03/2024 at 10:49 a.m. with S1 Administrator revealed the facility had a pest control service contract. Review of the contract provided by S1 Administrator at time of interview revealed the company came out for monthly services, and as needed. S1 Administrator provided Pests Sighted log and stated this was the facility's pest control log. S1 Administrator stated employees document if pest are seen and the exterminator is called out. S1 Administrator stated when pest control came out for service, he initialed on the log. Review of the Pests Sighted log revealed the exterminator did not come out for flies reported on 10/07/2023 or 11/16/2023. Review of Pests Sighted log revealed no entries for month of June 2024. S1 Administrator confirmed the above findings and stated the facility had a problem with flies within facility.</p> <p>(continued on next page)</p>		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Telephone interview on 06/04/2024 at 4:32 p.m. with the facility's contracted pest control worker revealed he performed monthly services that included the treatment of flies. The contract worker stated he put fly bait out by the dumpster and outdoor areas, and sprayed insecticide on the outside of doors. The contract worker stated he had recommended the use of air curtains near door entries and fly lights, but the facility had not yet implemented those recommendations, and stated he was unaware the facility had a current issue with flies.		