

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195599	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/14/2024
NAME OF PROVIDER OR SUPPLIER  Legacy Nursing and Rehabilitation of Port Allen		STREET ADDRESS, CITY, STATE, ZIP CODE 403 15th Street Port Allen, LA 70767	

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 - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43868</p> <p>Based on observation, interviews, and record review, the facility failed to ensure each resident was treated with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (#61) of 33 residents reviewed in the initial pool for dignity. The facility failed to ensure staff treated Resident #61 with respect and dignity.</p> <p>Findings:</p> <p>Review of the Medical Record for Resident #64 revealed the resident was admitted to the facility on [DATE] with diagnosis, which included Left Sided Hemiplegia following Cerebral Vascular Accident (CVA).</p> <p>Review of the most recent MDS (Minimum Data Set) for Resident #61 with an ARD (Assessment Reference Date) of 06/25/2024 revealed Resident #61 had a BIMS (Brief Interview for Mental Status) of 14, which indicated the resident was cognitively intact. Further review revealed Resident #61 required substantial assistance for ADLs.</p> <p>Review of the most current Care Plan for Resident #61 revealed the following:</p> <p>Problem: I require staff assistance for all transfers related to Left Sided Hemiplegia following CVA.</p> <p>Goal: Resident will have needs met by staff through next review date.</p> <p>On 08/13/2024 at 10:30 a.m., an interview was conducted with Resident #61. He reported he pressed his call light last night for assistance to get back in the bed, and S13CNA came into his room and stated, Do not press the call light again.</p> <p>On 08/13/2024 at 10:35 a.m., an interview was conducted with Resident #61's roommate. He reported Resident #61 pressed the call light last night for assistance to get back in the bed, and S13CNA came into the room and stated, Do not press the call light again.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/14/2024 at 2:04 p.m., an interview was conducted with S13CNA. She stated she worked the night shift and was assigned to Resident #61. She stated this week, he pressed the light when she was passing ice and she told him she had to finish her job first before she could put him back in bed. She stated before she finished passing ice for the hall, Resident #61 pressed the call light again. She stated, I just told you, let me finish my work and don't press the call light again. She further stated Resident #61 did understand directions and was not forgetful.</p> <p>On 08/14/2024 at 2:15 p.m., an interview with the S2DON. She confirmed CNA's should wrap up what they are doing and tend to residents when the call light was pressed. She further confirmed staff should never tell residents, do not press the call light again.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44590</b></p> <p>Based on observations, interviews and record reviews, the facility failed to ensure residents call lights were within reach for 2 of 2 (#1 and #16) residents reviewed for accommodation of needs.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled, Use of Call Light, revealed, in part, the following:</p> <p>Procedure:</p> <p>10. When providing care to residents be sure to position the call light conveniently for the resident to use.</p> <p>11. Tell the resident where the call light is and show him/her how to use the call light.</p> <p>Resident #1</p> <p>Review of Resident #1's Clinical Record revealed an admitted [DATE].</p> <p>Review of Resident #1's most recent MDS, with an ARD of 06/25/2024, revealed a BIMS of 3, which indicated resident was severely cognitively impaired. Further review revealed Resident #1 was highly visually impaired and required moderate to maximum physical assist for transfers, repositioning and ADLs.</p> <p>Review of Resident #1's current Care Plan revealed, in part, the following:</p> <p>Focus: Resident has impaired Visual Function.</p> <p>Goal: I will maintain optimal quality of life within limitation imposed by visual function.</p> <p>Interventions/Tasks: Tell the resident where you are placing their items. Be consistent.</p> <p>On 08/13/2024 at 3:56 p.m., Resident #1 was observed lying in bed with her call light located out of reach at the foot of her bed. Resident #1 attempted to locate her call light but was unable to, stating she couldn't see to find it. Resident #1 stated she was hungry and wanted a snack but couldn't find her call light so she had been waiting for someone to come ask her if she needed anything. When asked what she does if she is unable to locate her call light, Resident #1 stated I just pray someone comes to check on me eventually.</p> <p>On 08/13/2024 at 4:00 p.m., an interview was conducted with S6CNA. She confirmed she was Resident #1's regular CNA. She confirmed Resident #1 was blind. She confirmed Resident #1's call light was not within reach and Resident #1 could not see to locate it. S6CNA confirmed call lights should always be within reach and easily accessible for residents.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/14/2023 at 10:48 a.m., Resident #1 was observed lying in bed with her call light located out of reach at the foot of her bed. Resident #1 attempted to locate her call light but was unable to.</p> <p>On 08/14/2024 at 10:50 a.m., an interview was conducted with S7CNA. She confirmed she was Resident #1's regular CNA. She confirmed Resident #1 was blind. She confirmed Resident #1's call light was not within reach and Resident #1 could not see to locate it. She confirmed Resident #1's call light should always be within her reach and clipped to her sheet next to her pillow so she could find it easily and it had not been.</p> <p>Resident #16</p> <p>Review of Resident #16's Clinical Record revealed an admitted [DATE].</p> <p>Review of Resident #16's most recent quarterly MDS, dated [DATE], revealed a BIMS of 15, which indicated resident was cognitively intact. Further review revealed Resident #16 had bilateral upper and lower limb impairment for range of motion; required a wheelchair for mobility, and was totally dependent on staff for transfers, repositioning, and ADLs.</p> <p>On 08/13/2024 at 3:30 p.m., an observation was conducted of Resident #16 seated in a chair across the room from his bed. Resident #16's call light was observed lying on his bed 8 feet away from the resident. Resident #16 confirmed he was unable to get up and get his call light. Resident stated he had not been able to let anyone know he needed assistance to get in his wheelchair.</p> <p>On 08/13/2024 at 3:50 p.m., an interview was conducted with S2DON. She confirmed Resident #16's call light was not within his reach and should be. She confirmed she would expect call lights to be within reach and easily accessible to all residents at all times.</p>		

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<p>F 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43868</p> <p>Based on interviews and record reviews, the facility failed to promote and facilitate residents' self-determination through support of the residents' choice about aspects of his or her life in the facility that were significant to the resident for 1 (#61) of 33 residents in the initial pool. The facility failed to ensure Resident #61 had a choice of when to go to bed.</p> <p>Findings:</p> <p>Review of the facility's policy titled Resident Rights and Quality of Life Policy and Procedure, with no review date, revealed the following, in part;</p> <p>Policy: All residents have the right to a dignified existence, self-determination, and communication with and access to people and services inside and outside the facility.</p> <p>A resident has the right:</p> <p>22. To be treated with .individuality .</p> <p>Review of the Medical Record for Resident #64 revealed the resident was admitted to the facility on [DATE] with diagnosis, which included Left Sided Hemiplegia following Cerebral Vascular Accident (CVA).</p> <p>Review of the most recent MDS (Minimum Data Set) for Resident #61 with an ARD (Assessment Reference Date) of 06/25/2024 revealed Resident #61 had a BIMS (Brief Interview for Mental Status) of 14, which indicated the resident was cognitively intact. Further review revealed Resident #61 required substantial assistance for ADLs.</p> <p>Review of the most current Care Plan for Resident #61 revealed the following:</p> <p>Problem: I require staff assistance for all transfers related to Left Sided Hemiplegia following CVA.</p> <p>Goal: Resident will have needs met by staff through next review date.</p> <p>On 08/13/2024 at 10:30 a.m., an interview was conducted with Resident #61. He reported last night he pressed his call light for assistance to get back in the bed at about 7:00 p.m., and he had to wait 45 minutes to an hour to get into the bed. He stated staff told him she had to finish her job first.</p> <p>On 08/14/2024 at 2:04 p.m., an interview was conducted with S13CNA. She stated she worked the night shift and was assigned to Resident #61. She stated this week, he pressed the light when she was passing ice and she told him she had to finish her job first before she could put him back in bed. She further stated Resident #61 had to wait for his snack before he went back to bed.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/14/2024 at 2:15 p.m., an interview with S2DON. She confirmed residents had the right to go to bed when they wanted.</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>43868</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure each resident was provided a safe, clean, and comfortable interior by failing to ensure necessary housekeeping and maintenance services were maintained for 2 (Room A and Room C) of 6 rooms reviewed for environment.</p> <p>Findings:</p> <p>Review of the facility's policy Titled, Safety and Supervision of Residents effective February 2020 revealed the following, in part:</p> <p>Purpose and/or Policy Statement:</p> <p>Residents are provided with a safe, clean, comfortable and homelike environment .</p> <p>Definitions and Interpretation:</p> <p>2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:</p> <p>a. Clean, sanitary and orderly environment</p> <p>Room A</p> <p>On 08/12/2024 at 10:34 a.m., an observation was made of Room A. The window unit cover was lying on the floor with the filter exposed.</p> <p>On 08/14/2024 at 9:04 a.m., and observation was made of Room A. The window unit cover was missing with the filter exposed.</p> <p>On 08/14/2024 at 9:19 a.m., an observation was made of Room A with S1ADM present. An interview was conducted with S1ADM at that time. S1ADM confirmed the window unit cover was missing with the filter exposed. S1ADM stated there should have been a cover over the window unit filter.</p> <p>Room C</p> <p>Review of the Maintenance Log revealed the following, in part:</p> <p>07/04/2024 - Fix door on Room C, side to the bathroom. The entry was noted to not be signed off by maintenance.</p> <p>On 08/12/2024 at 10:42 a.m., an interview was conducted with Resident #111. He stated the bathroom door to Room C had a 1 inch gap noted when the door was closed.</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>On 08/13/2024 at 8:00 a.m., an observation was made of Room C's bathroom door. The door was noted to hit the top of the framing, not close completely, and leave a 1 inch gap from the bottom to midway of the door. There was also a 4 inch by 4 inch piece of tile lifted up in the corner of Room C next to the closet dresser.</p> <p>On 08/13/2024 at 4:00 p.m., an observation was made of Room C with S1ADM present. An interview was conducted with S1ADM at that time. S1ADM confirmed the bathroom door did not close and had a 1 inch gap from the bottom to midway of the door. He further confirmed a 4 inch x 4 inch tile lifted up in the corner next to the closer dresser. S1ADM stated the door should close and the tile should not be lifted up.</p> <p>44965</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44590</b></p> <p>Based on interviews and record reviews, the facility failed to transmit MDS assessments in the required timeframe for 8 of 8 (#11, #12, #22, #24, #34, #45, #53, #110) residents reviewed for resident assessment.</p> <p>Findings:</p> <p>Resident #11</p> <p>Review of Resident #11's Clinical Record revealed an admitted [DATE].</p> <p>On 08/13/2024 at 9:40 a.m., review of Resident #11's most recent Annual MDS revealed the assessment was opened on 07/09/2024 with a current status of In Progress.</p> <p>Resident #12</p> <p>Review of Resident #12's Clinical Record revealed an admitted [DATE].</p> <p>On 08/13/2024 at 9:43 a.m., review of Resident #12's most recent Annual MDS revealed the assessment was opened on 07/09/2024 with a current status of In Progress.</p> <p>Resident #22</p> <p>Review of Resident #22's Clinical Record revealed an admitted [DATE].</p> <p>On 08/13/2024 at 9:46 a.m., review of Resident #22's most recent Quarterly MDS revealed the assessment was opened on 07/09/2024 with a current status of In Progress.</p> <p>Resident #24</p> <p>Review of Resident #24's Clinical Record revealed an admitted [DATE].</p> <p>On 08/13/2024 at 9:48 a.m., review of Resident #24's most recent Quarterly MDS revealed the assessment was opened on 07/02/2024 with a current status of In Progress.</p> <p>Resident #34</p> <p>Review of Resident #34's Clinical Record revealed an admitted [DATE].</p> <p>On 08/13/2024 at 9:55 a.m., review of Resident #34's most recent Annual MDS revealed the assessment was opened on 07/09/2024 with a current status of In Progress.</p> <p>Resident #45</p> <p>(continued on next page)</p>

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #45's Clinical Record revealed an admitted [DATE].</p> <p>On 08/13/2024 at 9:50 a.m., review of Resident #45's most recent Quarterly MDS revealed the assessment was opened on 07/02/2024 with a current status of In Progress.</p> <p>Resident #53</p> <p>Review of Resident #53's Clinical Record revealed an admitted [DATE].</p> <p>On 08/13/2024 at 9:53 a.m., review of Resident #53's most recent Annual MDS revealed the assessment was opened on 07/09/2024 with a current status of In Progress.</p> <p>Resident #110</p> <p>Review of Resident #110's Clinical Record revealed an admitted [DATE].</p> <p>On 08/13/2024 at 9:58 a.m., review of Resident #110's most recent Quarterly MDS revealed the assessment was opened on 07/02/2024 with a current status of In Progress.</p> <p>An interview was conducted on 08/13/2024 at 10:45 a.m. with S4MDSN. She confirmed she was responsible for entering MDS Assessments and they should be transmitted within 14 days of the assessment completion. She reviewed and confirmed the following:</p> <p>Resident #11 - Annual MDS Assessment was opened on 07/09/2024 and was not transmitted by the due date of 07/30/2024;</p> <p>Resident #12 - Annual MDS Assessment was opened on 07/09/2024 and was not transmitted by the due date of 07/30/2024;</p> <p>Resident #22 - Quarterly MDS Assessment was opened on 07/09/2024 and was not transmitted by the due date of 07/30/2024;</p> <p>Resident #24 - Quarterly MDS Assessment was opened on 07/02/2024 and was not transmitted by the due date of 07/16/2024;</p> <p>Resident #34 - Annual MDS Assessment was opened on 07/09/2024 and was not transmitted by the due date of 07/30/2024;</p> <p>Resident #45 - Quarterly MDS Assessment was opened on 07/02/2024 and was not transmitted by the due date of 07/16/2024;</p> <p>Resident #53 - Annual MDS Assessment was opened on 07/09/2024 and was not transmitted by the due date of 07/30/2024; and</p> <p>Resident #110 - Quarterly MDS Assessment was opened on 07/02/2024 and was not transmitted by the due date of 07/16/2024.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44590</p> <p>44965</p> <p>Based on interviews and record reviews, the facility failed to ensure resident's MDS assessments accurately reflected the resident's Pre-Admission Screening and Resident Review (PASARR) status for 2 (#22 and #108) of 8 (#13, #22, #24, #55, #61, #99, #108, and #111) residents reviewed for PASARR.</p> <p>Findings:</p> <p>Resident #22</p> <p>Review of Resident #22's Clinical Record revealed an admitted [DATE] and diagnoses, which included Schizoaffective Disorder - Bipolar Type, Psychotic Disorder with Hallucinations, and Mild Intellectual Disabilities.</p> <p>Review of Resident #22's BHSF Form 142 revealed she was approved for admission by Level II PASARR effective 06/08/2023.</p> <p>Review of Resident #22's Annual MDS with an ARD of 10/31/2023 revealed question A1500, Resident evaluated for PASARR, was answered as no.</p> <p>An interview was conducted with S4MDSN on 08/13/2024 at 1:14 p.m. S4MDSN reviewed Resident #22's yearly MDS with an ARD of 10/31/2023, and confirmed it was coded Resident #22 did not have a Level II PASARR. She confirmed Resident #22 had a Level II PASARR at the time of the assessment, and the assessment was inaccurate. S4MDSN confirmed residents' plans of care were created based on the coding on the MDS assessment.</p> <p>Resident #108</p> <p>Review of Resident #108's Clinical Record revealed an admitted [DATE] and diagnoses, which included Unspecified Psychosis, Schizoaffective Disorder, Generalized Anxiety Disorder, and Major Depressive Disorder.</p> <p>Review of Resident #108's BHSF Form 142 revealed she was approved for admission by Level II PASARR effective 12/28/2023.</p> <p>Review of Resident #108's Annual MDS with ARD of 01/16/2024 revealed question A1500, Resident evaluated for PASARR, was answered as no.</p> <p>An interview was conducted on 08/14/2024 at 1:35 p.m. with S4MDSN. S4MDSN stated she and S5MDSN were both responsible for entering MDS assessments, and they should be entered accurately. S4MDSN reviewed Resident #108's Admission Assessment, dated 01/16/2024, and confirmed it was not coded for a Level II PASARR and should have been.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with S2DON on 08/13/2024 at 1:51 p.m. She confirmed Level II PASARRs should have been coded on each resident's MDS assessment.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44590</p> <p>Based on record reviews and interviews, the facility failed to coordinate assessments with the resident's Pre-Admission Screening and Resident Review (PASARR) Level II by failing to incorporate PASARR Level II determinations and recommendations into each resident's assessment and care plan for 4 (#13, #22, #24, and #108) of 8 (#13, #22, #24, #55, #61, #99, #108, #111) residents reviewed for PASARR.</p> <p>Findings:</p> <p>Review of the facility's policy, PASARR Policy and Procedure, approved 11/29/2022, revealed the following, in part:</p> <p>Policy:</p> <p>This facility shall coordinate assessments with the PASARR program under Medicaid to the maximum extent practicable to avoid duplicative testing and effort.</p> <p>Purpose:</p> <p>PASARR is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. PASARR requires that:</p> <ol style="list-style-type: none"> <li>1. All applicants to Medicaid certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability;</li> <li>2. Receive the services they need in those settings.</li> <li>3. Receive the services they need in those settings.</li> </ol> <p>Procedure:</p> <p>Coordination shall include:</p> <ol style="list-style-type: none"> <li>1. Incorporating the recommendations from the PASARR Level II determination and the PASARR Evaluation Report into the resident's assessment, care planning and transitions of care.</li> <li>2. The state is required to provide a copy of the PASARR report to the facility. This report must list the specialized services that the individual requires and that are the responsibility of the state to provide. All other needed services are the responsibility of the facility to provide.</li> </ol> <p>Resident #13</p> <p>Review of Resident #13's Clinical Record revealed an admitted [DATE] and diagnoses which included Major Depressive Disorder, Bipolar Disorder, Anxiety Disorder, Unspecified Psychosis, and Schizoaffective Disorder.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #13's BHSF Form 142 revealed he was approved for Level II Authority for a temporary period effective 06/17/2024 through 06/16/2025.</p> <p>Review of Resident #13's OBH-PASARR Level II Evaluation Summary and Determination Notice, dated 06/17/2024, revealed the following, in part:</p> <p>Recommendations for Lesser Services:</p> <p>Short term counseling to adjust to the nursing facility</p> <p>Crisis intervention plan/safety plan</p> <p>Occupational therapy evaluation</p> <p>Physical therapy evaluation</p> <p>Specialized Services Recommendations:</p> <p>Outpatient therapy - individual, family, and group</p> <p>Review of Resident #13's current Care Plan revealed no documentation of a Level II PASARR and/or recommendations.</p> <p>Review of Resident #13's Clinical Record revealed no documentation the OBH recommendations for services were implemented and/or offered.</p> <p>Resident #22</p> <p>Review of Resident #22's Clinical Record revealed an admitted [DATE] and diagnoses which included Schizoaffective Disorder - Bipolar Type, Psychotic Disorder with Hallucinations, and Mild Intellectual Disabilities.</p> <p>Review of Resident #22's BHSF Form 142 revealed she was approved for admission by Level II Authority for a temporary period effective 06/07/2024 through 06/06/2025.</p> <p>Review of Resident #22's OBH-PASARR Level II Evaluation Summary and Determination Notice dated 05/17/2024 revealed the following, in part:</p> <p>Recommendations for Lesser Services:</p> <p>Crisis intervention plan/safety plan</p> <p>Recommendations for Specialized Services:</p> <p>CPST</p> <p>PSR-Group</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #22's current Care Plan revealed no documentation of a Level II PASARR and/or recommendations.</p> <p>Review of Resident #22's Clinical Record revealed no documentation the OBH recommendations for services were implemented and/or offered.</p> <p>Resident #24</p> <p>Review of Resident #24's Clinical Record revealed an admitted [DATE] and diagnoses which included Schizoaffective Disorder, Major Depressive Disorder, Anxiety Disorder, and Unspecified Mood Disorder.</p> <p>Review of Resident #24's BHSF Form 142 revealed he was approved for admission by Level II Authority for a temporary period effective 06/10/2024 through 06/09/2025.</p> <p>Review of Resident #24's OBH-PASARR Level II Evaluation Summary and Determination Notice dated 06/10/2024 revealed the following, in part:</p> <p>Recommendations for lesser services:</p> <p>Crisis intervention plan/safety plan</p> <p>Occupational Therapy Evaluation</p> <p>Physical Therapy Evaluation</p> <p>Recommended specialized services (MH services):</p> <p>Outpatient Therapy (Individual)</p> <p>Outpatient Therapy (Family)</p> <p>Review of Resident #24's current Care Plan revealed no documentation of a Level II PASARR and/or recommendations.</p> <p>Review of Resident #24's Clinical Record revealed no documentation the OBH recommendations for services were implemented and/or offered.</p> <p>Resident #108</p> <p>Review of Resident #108's Clinical Record revealed an admitted [DATE] and diagnoses which included Unspecified Psychosis, Schizoaffective Disorder, Generalized Anxiety Disorder, and Major Depressive Disorder.</p> <p>Review of Resident #108's BHSF Form 142, dated 12/28/2023, revealed she was originally approved for admission by Level II Authority for a temporary period effective 12/28/2023 through 04/05/2024.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #108's original OBH-PASARR Level II Evaluation Summary and Determination Notice, dated 12/28/2023, revealed the following, in part:</p> <p>Recommendations for Lesser Services:</p> <p>Crisis intervention plan/safety plan</p> <p>Specialized Services Recommendations:</p> <p>PSR - Individual</p> <p>Outpatient therapy - individual</p> <p>Review of Resident #108's BHSF Form 142, dated 03/27/2024, revealed her approval for Level II Authority was renewed for a temporary period effective 04/06/2024 through 04/05/2025.</p> <p>Review of Resident #108's renewed OBH-PASARR Level II Evaluation Summary and Determination Notice, dated 03/27/2024, revealed the following, in part:</p> <p>Specialized Services Recommendations:</p> <p>Outpatient therapy - individual and group</p> <p>Review of Resident #108's current Care Plan revealed no documentation of a Level II PASARR and/or recommendations.</p> <p>Review of Resident #108's Clinical Record revealed no documentation the OBH recommendations for services were implemented and/or offered from either Level II PASRR.</p> <p>An interview was conducted with S3SW on 08/13/2024 at 1:02 p.m. S3SW stated she was responsible to review and implement PASARR Level II recommendations. She stated she did not usually review the recommended lesser services or the recommended specialized services.</p> <p>S3SW reviewed Resident #13's PASARR Level II determination dated 06/17/2024. She confirmed a crisis intervention/safety plan was not developed for Resident #13. She confirmed OT and PT evaluations had not been conducted in a timely manner for Resident #13. She confirmed there was no documentation in Resident #13's Clinical Record of him being offered short term counseling or outpatient services.</p> <p>She reviewed Resident #22's Level II PASARR effective 06/07/2024 through 06/06/2025 and confirmed the recommended lesser services included a crisis intervention plan. She stated a crisis intervention plan had not been developed for Resident #22. She reviewed Resident #22's Specialized Services recommendations and confirmed CPST and PSR-group were checked. She stated CPST and/or PSR-group was not offered and/or implemented for Resident #22. She stated she was unsure what CPST was.</p> <p>(continued on next page)</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>She reviewed Resident #24's PASARR Level II determination dated 06/10/2024 and confirmed the recommendations for lesser services included a crisis intervention/safety plan, an Occupational Therapy evaluation, and a Physical Therapy evaluation. She confirmed a crisis intervention/safety plan was not developed for Resident #24. She further confirmed an OT evaluation and/or PT evaluation had not been conducted on Resident #24. She confirmed there was no documentation in Resident #24's Clinical Record he had been offered outpatient services.</p> <p>S3SW reviewed Resident #108's PASARR Level II determinations, dated 12/28/2023 and 03/27/2024. She confirmed a crisis intervention/safety plan was not developed for Resident #108. She confirmed there was no documentation in Resident #108's Clinical Record of her being offered PSR or outpatient services.</p> <p>She confirmed there was not currently a process in place to ensure lesser and specialized recommendations on PASARR Levels IIs were implemented and/or offered.</p> <p>An interview was conducted with S4MDSN and S5MDSN on 08/13/2024 at 1:14 p.m. S4MDSN stated she and S5MDSN were both responsible for care planning Level II PASARRs. S4MDSN and S5MDSN both confirmed prior to today, they had not been incorporating Level II PASARRs into the residents' care plan. S4MDSN reviewed Resident #13, #22, #24 and #108's care plans and confirmed their care plan did not incorporate their Level II PASARR and their recommended services. S4MDSN confirmed Level II PASARRs and recommendations should have been incorporated in the residents' care plans. S4MDSN stated S3SW was responsible to implement PASARR Level II recommendations.</p> <p>An interview was conducted with S2DON on 08/13/2024 at 1:51 p.m. She stated she expected Level II PASARR recommendations for lesser services and specialized services to be implemented and/or offered. She stated she expected a residents' care plan to reflect their PASARR status and to include Level II PASARR recommended services offered and/or implemented.</p> <p>44965</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43868</p> <p>Based on observations, interviews, and record review, the facility failed to ensure a resident who was unable to carry out ADLs received the necessary services to maintain good grooming and personal hygiene for 1 (#61) of 2 (#61 and #99) residents reviewed for ADL's. The facility failed to trim and clean fingernails for Resident #61.</p> <p>Findings:</p> <p>Review of the facility's policy, Nail Care Policy and Procedure, with no review date, revealed the following, in part:</p> <p>Policy: To promote cleanliness</p> <p>Procedure:</p> <ol style="list-style-type: none"> <li>1. Care of fingernails and toenails is part of the bath</li> <li>2. Be certain nails are clean</li> <li>4. Nails are to be clipped and filed smoothly</li> </ol> <p>Review of the Medical Record for Resident #64 revealed the resident was admitted to the facility on [DATE] with a diagnosis, which included Left Sided Hemiplegia following Cerebral Vascular Accident.</p> <p>Review of the most recent MDS (Minimum Data Set) for Resident #61 with an ARD (Assessment Reference Date) of 06/25/2024 revealed Resident #61 had a BIMS (Brief Interview for Mental Status) of 14, which indicated the resident was cognitively intact. Further review revealed Resident #61 required substantial assistance for ADLs.</p> <p>Review of the current Physician Orders for Resident #61 revealed no orders for nail care.</p> <p>Review of the current TAR (Treatment Assessment Record) for Resident #61 revealed no entry for nail care.</p> <p>On 08/12/2024 at 10:48 a.m., an observation was conducted of Resident #61. His fingernails were long, jagged with a black substance underneath 4 fingernails and approximately 0.5 cm past the tip of all 10 fingers.</p> <p>On 08/13/2024 at 10:29 a.m., an observation and interview was conducted of Resident #61. His fingernails were long, jagged with a black substance underneath 4 fingernails and approximately 0.5 cm past the tip of all 10 fingers. Resident #61 stated he would like his fingernails trimmed and cleaned, and they were not done when he went to the shower room yesterday.</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 - Few</p>	<p>On 08/13/2024 at 12:01 p.m., an interview was conducted with S10CNA. She stated Resident #61 did get a shower on 08/12/2024, but she did not clean his fingernails. She further stated the wound care nurse was responsible for nail care for the residents.</p> <p>On 08/13/2024 at 1:34 p.m., an interview was conducted with S9RN. She stated the wound care nurse was responsible for nail care, all residents should have an order for monthly nail care, and it should be on the TAR. She reviewed Resident #61's current Physician Orders and TAR and confirmed Resident #61 did not have any nail care orders. An observation was made at this time of Resident #61 with S9RN. S9RN confirmed Resident #61's nails had a black substance underneath 4 fingernails.</p> <p>On 08/13/2024 at 1:20 p.m., an interview was conducted with S2DON. She stated the wound care nurse was responsible for all nail care and it should be on the TAR. She further stated the CNAs cleaned under the fingernails during the morning care. She confirmed all residents should have monthly nail care orders, and if the resident wanted his nails trimmed and cleaned, they should be.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44965</p> <p>Based on observations, interviews, and record review, the facility failed to ensure a resident's environment remained as free of accident hazards as possible by failing to ensure a padded wall was properly secured for 1 (#26) of 3 (#26, #40, #109) residents reviewed for accidents.</p> <p>Findings:</p> <p>Review of Resident #26's Clinical Record revealed an admitted [DATE] and diagnoses, which included Unspecified Dementia, Dysphagia Following Cerebrovascular Disease, Aphasia Following Cerebrovascular Disease, Alzheimer's Disease, Functional Quadriplegia, Contracture of Muscle - Multiple Sites, Impulsiveness, Tremor, Unspecified Convulsions, Anoxic Brain Damage, and Epilepsy.</p> <p>Review of Resident #26's Quarterly MDS with an ARD of 04/16/2024 revealed he had a BIMS of 03, which indicated severe cognitive impairment.</p> <p>Review of Resident #26's current Care Plan revealed the following, in part:</p> <p>Problem: High Risk for falls and injury related to history of Cerebrovascular Accident, Transient. Ischemic Attack, Anoxic Brain Injury, and Epilepsy diagnoses.</p> <p>Interventions: Padding added to wall by resident bed for safety measures.</p> <p>An observation was made of Resident #26 on 08/12/2024 at 11:30 a.m. He was lying in bed. His bed was pushed against the wall with the wall padded. The padding was secured to the wall with screws. Some of the screws were extending out from the padding and wall with the screw heads exposed.</p> <p>An observation was made of Resident #26 on 08/12/2024 at 3:48 p.m. He was lying in bed. The wall next to his bed was padded with screws securing it to the wall. Four of the screws were partially hanging out of the padding and wall with the screw heads exposed.</p> <p>An observation was made of Resident #26 on 08/12/2024 at 3:50 p.m. with S8LPN present. An interview was conducted with S8LPN at that time. Resident #26 was positioned with his head on the edge of the bed opposite the wall and knees toward the padded wall and extended screws. S8LPN confirmed Resident #26's padded wall was secured to the wall with screws and some of them were extending away from the padding. S8LPN confirmed this was a safety hazard for Resident #26. She stated Resident #26 had a lot of voluntary and involuntary movements. S8LPN stated the screws should not have been extending from the padding and it posed a risk for injury to Resident #26.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation was made of S11CNA performing incontinence care on Resident #26 on 08/12/2024 at 3:56 p.m. During incontinence care, Resident #26 was moving his knees back and forth from left to right, his left knee making contact with the padding and screws extending from the padding. Resident #26 was also swinging his arms making contact with the padding. An interview was conducted with S11CNA at that time. She confirmed there were screws extending out from the padding next to Resident #26's bed and Resident #26 was making contact with them during incontinence care.</p> <p>An observation was made of Resident #26's room with S12MS present on 08/12/2024 at 4:06 p.m. An interview was conducted with S12MS during the observation. S12MS confirmed Resident #26 had a padded wall with his bed pushed up against the padded wall. S12MS confirmed there were a total of seven screws securing the padding to the wall with four of them extending away from the wall and padding. S12MS confirmed two of the screws extended from the padding approximately 1 and 1/2 inches. S12MS confirmed two of the screws extended from the padding approximately 1/2 inch. He confirmed the screws extending from the padding posed a risk for injury to Resident #26.</p> <p>An observation was made of Resident #26 with S2DON present on 08/12/2024 at 4:11 p.m. An interview was conducted with S2DON during the observation. S2DON stated the padding was for Resident #26's safety because he moved around so much and flailed his extremities. S2DON confirmed there were screws extending out from Resident #26's padding for his wall and should not have been. S2DON confirmed the extended screws could have injured Resident #26.</p>		