

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/12/2024
NAME OF PROVIDER OR SUPPLIER Blueberry Hill Rehabilitation and Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 75 Brimbal Avenue Beverly, MA 01915	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to ensure six Residents (#41, #43, #73, #87, #61 and #19) were provided a dignified existence and were able to exercise their rights as residents of the facility, out of a total of 39 sampled residents. Specifically; 1. For Resident #41, Resident #43, Resident #73, and Resident #87 the facility failed to ensure mail in ballots were obtained and submitted for the 11/5/24 Presidential election. 2. For Resident #61, the facility failed to respect the Residents right to self determination when he/she expressed interest in being intimate with his/her spouse. 3. For Resident #19, the facility failed to ensure a dignified dining experience when staff stood over the Resident while assisting with meals. Findings include: Review of the facility policy titled Voting Rights, undated, indicated: - Residents are encouraged to exercise their right to vote in local, state and national elections. The facility assists residents expressing a desire to vote. The Resident exercises his or her right to vote without interference, coercion, discrimination or reprisal from the facility or facility staff. 1a. Resident #41 was admitted to the facility in July 2020 with diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side and schizophrenia. Review of the Minimum Data Set Assessment, dated 9/25/24, indicated Resident #41 was moderately cognitively impaired evidenced by a score of nine out of a possible 15 on the Brief Interview for Mental Status Exam. On 11/03/24 at approximately 7:45 A.M., and 12:00 P.M. the surveyor observed a sealed absentee ballot addressed to Resident #41 for the presidential election on top of desk at Hale Unit Nursing station. The undelivered sealed absentee ballot was postmarked 10/4/24. (continued on next page)		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 225133	Facility ID: 225133 If continuation sheet Page 1 of 111

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/3/24 at 1:32 P.M., the Activities Director said that she had worked with the Resident and completed his/her ballot, and it was sent out. During an interview on 11/4/24 at 11:35 A.M., the Regional Activities Director said she was aware the Activities Director had been registering residents to vote, however, was unaware of how many residents still needed absentee ballots. The Regional Activities Director said the Activities Director seemed to not be aware that after registering a resident to vote, there still had to be a request for an absentee ballot and assistance with mailing the ballot back. Review of checkmyballot.org indicated Resident #41's ballot was mailed to the facility on [DATE] and not returned to the clerks office. During an interview on 11/6/24 at approximately 7:15 A.M., the Activities Director said she made a mistake by not following up and confirming resident's ballots were sent out or residents were registered locally to vote. 41456 1b. Resident #43 was admitted to the facility in January 2024 with diagnoses including muscular dystrophy. Review of Resident #43's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, which indicated he/she was cognitively intact. During an interview on 11/3/24 at 8:28 A.M., Resident #43 said he/she would like to vote and he/she has not been assisted with this. During an interview on 11/3/24 at 1:15 P.M., the Activities Director said she has gotten every resident who wanted to vote registered and has sent all the registrations and absentee ballots back in to the voting center. The Activities Director provided the surveyor with the list of residents registered to vote and Resident #43 was not on the list. During an interview on 11/4/24 at 11:35 A.M., the Regional Activities Director said she was aware the Activities Director had been registering residents to vote, however, was unaware of how many residents still needed absentee ballots. The Regional Activities Director said the Activities Director seemed to not be aware that after registering a resident to vote, there still had to be a request for an absentee ballot and assistance with mailing the ballot back. During a follow-up interview on 11/4/24 at 1:32 P.M., the Activities Director again said she had registered residents to vote but was unable to provide a full list of all residents who had successfully sent in absentee ballots. Review of checkmyballot.org failed to indicate Resident #43 was sent an absentee ballot. During an interview on 11/5/24 at approximately 7:15 A.M., the Activities Director said she made a mistake by not following up and confirming residents ballots were sent out or residents were registered locally to vote and Resident #43 had not yet voted. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/4/24 at 11:35 A.M., the Regional Activities Director said she was aware the Activities Director had been registering residents to vote, however, was unaware of how many residents still needed absentee ballots. The Regional Activities Director said the Activities Director seemed to not be aware that after registering a resident to vote, there still had to be a request for an absentee ballot and assistance with mailing the ballot back. During a follow-up interview on 11/4/24 at 1:32 P.M., the Activities Director again said she had registered residents to vote but was unable to provide a full list of all residents who had successfully sent in absentee ballots. Review of checkmyballot.org failed to indicate Resident #87 was sent an absentee ballot. During an interview on 11/5/24 at approximately 7:15 A.M., the Activities Director said she made a mistake by not following up and confirming residents ballots were sent out or residents were registered locally to vote and Resident #87 had not yet voted. 43846 2. Review of the facility policy titled Resident Rights, not dated, indicated employees shall treat all residents with kindness, respect, and dignity. e. self-determination; h. be supported by the facility in exercising his or her rights; i. exercise his or her rights without interference, coercion, discrimination or reprisal from the facility. Resident #61 was admitted to the facility in August 2023 with diagnoses that included cerebral infarction, type 2 diabetes, and anxiety. Review of Resident #61's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated the Resident had intact cognition. Further review of the MDS indicated the Residents' health care proxy had not been invoked. Review of Resident #61's nursing progress note, dated 10/24/24, indicated the following: - CNA (Certified Nurse Aide) came to this writer and asked for this writer to speak with resident. Resident had made a comment stating I want to have sex with my [spouse] I have not had sex in 3 years. Resident wanted to know if sex in the facility was a possibility. This writer stated that it was not a good idea as resident was not strong enough and it could reopen coccyx wound. During an interview on 11/6/24 at 8:43 A.M., Resident #61 said he/she would like to have private time with his/her spouse but staff told them it was not a good idea and did not want him/her to engage in that activity. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to 1a. assess decision-making capacity and 1b. obtain consent for a psychotropic medication for one Resident (#323), out of a total sample of 39 residents. Findings include: Review of the facility policy titled Advance Directives, dated 2001, indicated the following: - Upon admission the interdisciplinary team assesses the residents decision-making capacity and identifies the primary decision-maker if the resident is determined not to have a decision-making capacity. - The interdisciplinary team conducts ongoing review of the residents decision-making capacity and invokes the resident representative or health care agent if he resident is determined not to have decision-making capacity. Changes are documented in the care plan and medical record. Resident #323 was admitted in June 2024 with diagnoses including dementia and chronic kidney disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #323 could not participate in the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. Review of the MDS indicates Resident #323 required supervision to assistance with meals, supervision with touching assistance for standing, and supervision with touching assistance with walking. 1a. Review of Resident #323's hospital discharge paperwork, dated 6/25/24, indicated Resident #323 had advanced dementia and type of advance directive: Health Care Proxy. Review of the advance directive care plan for Resident #323 indicated the following: - Focus: The resident has the following advance directives on record: full code Interventions: - The resident is not capable of making informed consent regarding their health care decisions (initiated 6/26/24). Review of the psychotropic consents for Depakote (a mood stabilizer used to treat bipolar), Zyprexa (an antipsychotic used to treat mood disorders), and Trazodone (a medication used to treat anxiety and depression) indicated Resident #323 signed them him/herself on 7/1/24, after his/her care plan had indicated he/she was not capable of making decisions. Review of the Physician Determination to Invoke Health Care Proxy was signed by a facility representative on 7/2/24, one day after Resident #323 signed his/her own psychotropic consents. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/6/24 at 6:43 A.M., the Social Worker said when an admission comes through she goes through the hospital discharge summary and makes an advance directive and psychosocial care plan. The Social Worker said if there is a health care proxy in the hospital then a health care invocation is completed immediately on admission and the physician would usually sign it on the same day. The Social Worker was unable to say why the facility did not follow this protocol with Resident #323. During an interview on 11/06/24 at 7:23 A.M., the Director of Nursing (DON) said if a resident had their health care proxy invoked at the hospital the physician will often activate the proxy at the facility during the admission process. The DON said if a resident becomes confused, the facility will often ask family members to be present when the resident is signing any type of consent. The DON said she could not remember Resident #323's level of confusion but knows it worsened throughout his/her stay. The DON did not know why Resident #323's health care proxy was not activated during the admission process and could not say if the Resident's family members were present when he/she signed his/her own consents. Review of the health care proxy invocation form indicated the physician signed the form on 7/26/24, twenty four days after the facility representative signed the form. 1b. Review of the physician orders for Resident #323 indicated that an order for Mirtazapine (a medication used to treat depression and increase appetite) was initiated on 8/27/24. Review of the record failed to indicate an informed consent was signed for the medication by the health care proxy. During an interview on 11/4/24 at 1:32 P.M., the health care proxy for Resident #323 said she felt that Resident #323 was being over medicated and that no one from the facility went over medication changes with her at any time. She said she was never asked to sign any consents for medications. During an interview on 11/5/24 at 10:06 A.M., the Director of Nursing said that consents need to be obtained prior to the start of any medications and with any medication changes.		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on record reviews and interviews, the facility failed to ensure one Resident (#111) was allowed to participate in the care planning process, out of a total sample of 39 residents. Findings include: Review of the policy titled, Care Plans, Comprehensive Person-Centered, dated 2001, indicated the following: - The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. - The resident is informed of his or her right to participate in his or her treatment, and provided advanced notice of care planning conferences. - If participation of the resident and his/her representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process. - Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her care plan, including the right to: a. participate in the planning process; Resident #111 was admitted to the facility in April 2024 with diagnoses including dementia. Review of Resident #111's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident #111 had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #111 required supervision for all functional tasks. During an interview on 11/3/24 at 11:35 A.M., Resident #111 said he/she has not been told of his/her plan of care. Review of Resident #111's medical record indicated he/she had care plan conference meetings on 4/25/24 and 8/1/24 and he/she was not in attendance at either meeting. The word confused was written in under the Resident's name on the attendance form dated 8/1/24. The medical record included letters written to the Resident's guardian to inform them of the meeting, however, failed to include letters written to the Resident to inform him/her of the meetings. Review of Resident #111's psychosocial wellbeing care plan initiated on 4/24/24, indicated the following intervention: - Allow me time to answer questions and to verbalize feelings, perceptions and fears. (continued on next page)		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/5/24 at 8:31 A.M., Nurse #1 said care plan meetings include all members of the interdisciplinary team and the residents are invited to their own meetings, even if their health care proxy is invoked. During interviews on 11/6/24 at 6:34 A.M., and 7:19 A.M., the Social Worker said care plan meetings are held quarterly for all residents. The Social Worker said letters are sent to family members and legal representatives to inform them of the meetings, so they have the opportunity to attend and participate in the care planning process. The Social Worker said residents also attend the care plan meeting and if a resident was confused or unable to attend, the meeting would be rescheduled to allow for the resident to attend when able. The Social Worker said all residents have the right to attend and participate in their care plan meetings even in their health care proxy has been invoked or they have a guardian. The Social Worker said Resident #111 has a guardian and has good and bad days but would typically be able to attend and participate in his/her care plan meetings. The Social Worker was unable to say why Resident #111 was not at his/her care plan meeting on 4/25/24 and said the meeting on 8/1/24 could have been rescheduled and was not, and, therefore, Resident #111 was not at either care plan meetings this year.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to provide one Resident (#18) with the right to alternate the position of his/her bed independently, out of a total sample of 39 residents. Findings include: Resident #18 was admitted to the facility in May 2021 with diagnoses including dysphagia (difficulty swallowing), bipolar disorder and anxiety. Review of Resident #18's most recent Minimum Data Set (MDS), dated [DATE], indicated Resident #18 had a Brief Interview for Mental Status (BIMS) score of 7 out of a possible 15, which indicated he/she had severe cognitive impairment. On 11/3/24 at 8:30 A.M., Resident #18 was observed eating breakfast in his/her room while lying in bed and the Resident's bed was reclined to a 45-degree angle. The Resident did not have a bed remote allowing him/her to incline the bed if desired. The Resident was observed coughing while eating. On 11/3/24 at approximately 12:15 P.M., Resident #18 was observed eating lunch alone in his/her room while lying in bed. The Resident did not have a bed remote allowing him/her to incline the bed if desired. On 11/4/24 at 10:32 A.M., Resident #18 was observed lying in bed without a bed remote present. Resident #18 said he/she would like a bed remote so that he/she can move the position of the head of the bed him/herself. During an interview on 11/4/24 at 12:17 P.M., Nurse #2 said all residents should have a bed remote to move the position of their bed as desired. During an interview on 11/5/24 at 10:06 A.M., the Director of Nursing said she was unaware if residents should all have a bed remote/the ability to move their beds themselves.		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49880 Based on observations, interviews and record review, the facility failed to ensure timely and accurate physician notification of a significant change in a resident's status for one Resident (#24) out of a total sample of 39 residents. Specifically, for Resident #24, the facility failed to provide a covering Nurse Practitioner (NP) with complete and accurate information about a resident with coffee ground emesis and ongoing black stools, including but not limited to the Resident's significant history of bowel obstructions and Gastrointestinal (GI) bleeding, resulting in hospitalization and subsequent death. Findings Include: Review of facility policy titled Change in a Resident's Condition or Status, undated, indicated the following: -Our facility promptly notifies the resident, his or her attending physician and the resident representative of changes in the residents medical/ mental condition and or status. -The nurse will notify the resident's attending physician or physician on call when there has been a(an) significant change in the resident's physical/emotional/mental condition; need to transfer the resident to a hospital/ treatment center. -Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR (situation, background, assessment, recommendation) Communication Form. Resident #24 was admitted to the facility in December 2014 with diagnoses that include partial intestinal obstruction, muscle weakness, gastrointestinal hemorrhage, and iron deficiency anemia. Review of Resident #24's Minimum Data Set (MDS) Assessment, dated 8/19/24, indicated a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating that the Resident has moderate cognitive impairment. The MDS further indicated that the resident has medically complex conditions with a primary diagnosis of partial intestinal obstruction. On 11/4/24 at 8:36 A.M., a surveyor overheard Nurse #3 say thank you to Nurse #4 for sending Resident #24 to the hospital. During an interview on 11/4/24 at 8:42 A.M., Nurse #4 said to the surveyors that Resident #24 started vomiting on her shift, around 1:00 A.M., but at first the Resident did not want to go to the hospital. She said she called the Nurse Practitioner (NP), and she ordered labs and Zofran (a medication to treat nausea). When asked about the Resident's history, Nurse #4 said that he/she does have a history of a bowel obstruction as well as a recent fall on 11/1/24. Nurse #4 said that she did not provide a full report of Resident #24's medical history to the Nurse Practitioner that she spoke to at 1:00 A.M., and only gave report on the current situation, that the Resident was vomiting. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Blueberry Hill Rehabilitation and Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 75 Brimbal Avenue Beverly, MA 01915	
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow up interview on 11/4/24 at 9:21 A.M., Nurse #4 said Resident #24 started vomiting between 1:00 A.M., and 2:00 A.M. and then again around 6:00 A.M. Nurse #4 said she called the covering practitioner again around 6:00 A.M. and was ordered to send the Resident out to the emergency room . Nurse #4 said Resident #24 was not agreeable to go to the hospital earlier in the morning, however said at this time the Resident agreed to be sent out. Nurse #4 said that she called for transport between 6:00 and 7:00 A.M. and was told that it would be about one to two hours before transport could be there. She said that the facility can call 911 for transfers but she felt like the Resident was stable and his/her vitals were stable. During a follow up interview on 11/6/24 at 7:45 A.M., Nurse #4 said that on the night before Resident #24 was sent out it was around 1:00 A.M. that the Resident began vomiting. She said that it was coffee ground. She said that as soon as she could, she called the NP. She said that she told the NP the Resident was vomiting but could not remember if she told her that it was coffee ground. She said she did not tell the NP about the history of obstructions or GI bleeding. She said that the NP ordered labs and Zofran for nausea. Nurse #4 said she called the NP again at 6:00 A.M., and an order was given to send the Resident to the hospital. During an interview on 11/4/24 at 8:45 A.M., Nurse #3 said that she arrived at the facility around 7:20 A.M. and was told in report that the resident had coffee ground emesis (vomiting) during the night. She said she went right into Resident #24's room when she got there, and he/she said they wanted to go to the hospital. At the time of the interview the ambulance company was picking up the Resident for transport to the hospital. Nurse #3 said that the Resident looks bad right now and said he/she looks pale and grey, and that the Resident also looked like that at 7:20 A.M. when she saw him/her. During an interview and observation on 11/4/24 at 8:48 A.M., the surveyor observed Resident #24 with black vomit on him/her. Resident #24 said that he/she knew what was happening was bad and that he/she wanted to go to the hospital and did not refuse to go earlier in the morning when the vomiting started. During a phone interview on 11/6/24 at 8:33 A.M. Certified Nurses Aid (CNA) #7 said that she worked over night on 11/3/24 into 11/4/24. CNA #7 said that Resident #24 was moving his/her bowels and vomiting all night long and that both the vomit and stool was liquid and black. CNA #7 said that she provided incontinence care at least five times over night for liquid black stools and that the vomiting was continuous all night and did not stop. CNA #7 said that she told the nurse. CNA #7 said that after the first time Resident #24 vomited he/she did not want to go to the hospital but that at around 3:00 A.M., Resident #24 said that he/she wanted to go to the hospital and after getting the Resident cleaned and changed again at that time, she told the nurse (Nurse #4) that the Resident wanted to go to the hospital. CNA #7 said that when her shift ended, and she left the facility around 7:15 A.M. and Resident #24 was still at the facility. Review of a progress note written by Nurse #4 on 11/4/24 at 8:52 A.M., indicated, at 1 AM Patient started vomiting, I informed NP [#2], and she gave order to do labs. CBC with diff and BMP. Patient refused to go to the hospital at this point. He/she said I want to wait. Around 6 AM, patient started vomiting again and I notified NP [#3], and she said send patient to hospital. Vital signs were bp [blood pressure] 107/77, pulse 66, O2 [oxygen saturation] 96%, temp [temperature] 98, resp [respirations] 18. HCP (health care proxy) was called and left a message. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the nursing progress note written on 11/4/24 failed to indicate a comprehensive GI (gastrointestinal) assessment or abdominal assessment. Review of the Patient Care Report for Resident #24 from the Ambulance service dated 11/4/24 indicated that dispatched received the call from the facility for transfer to the hospital at 8:01 A.M. on 11/4/24. The Patient Care Report indicated that the chief complaint was general illness- GI bleed for 7 hours with a primary symptom of abdominal distension. The Patient care report further indicated that the ambulance was dispatched to the facility for a patient with incontractible vomiting. (sic) The BLS (basic life support) crew arrived at the patient at 8:39 A.M. and patient found lying supine in assigned bed with head elevated and several towels draped over him/her, coffee ground emesis noted on towel .Skin is pale, warm and dry. Significant distension noted on initial impression. The report further indicated, Nursing staff reported coffee ground emesis began at 1:00 A.M. that morning with 3 episodes . No vitals or assessments taken to provide EMS (emergency medical service) staff. Vital signs revealed hypotension with a blood pressure of 80/60 and weakened radial pulses. BLS crew called dispatch at 8:44 A.M. for ALS (advanced life support) secondary to hypotension and likely GI (gastrointestinal) bleed. In route to the hospital at 8:55 A.M. vital signs included a blood pressure of 70 systolically and a weak pulse of 180 beats per minute. During a follow up interview on 11/4/24 at 9:24 A.M., Nurse #3 said she did not call for the transport of Resident #24 to the hospital for evaluation but if she knew it was going to be one to two hours for the transport, she would have called 911 for a more emergent transfer. During a phone interview on 11/6/24 at 9:00 A.M., the surveyor spoke to Nurse Practitioner (NP) #1 who returned a phone call to the surveyor regarding when phone calls were placed into the call service to report the change in condition on Resident #24. NP #1 said that she was not the one who responded to the call, but the service got one call at 1:13 A.M. with a message stating the Resident was vomiting a lot. She said this is the only call that came into the service on the 11:00 P.M. to 7:00 A.M. shift. During an interview on 11/6/24 at 9:42 A.M., Nurse Practitioner (NP)#2 said she was the covering NP for the night of 11/3/24 into 11/4/24 and the only page she got from the facility for this Resident was at 1:13 A.M. and said she called the facility right away. NP #2 said the report she was given was that the Resident's vitals were stable, and the Resident had a lot of vomiting. The NP said it was never reported to her that he/she had coffee ground emesis or multiple loose dark stools. The NP said she was never given a report of the Resident's history or that the Resident had a recent unwitnessed fall. The NP said she would have sent him/her out right away if she was given an accurate report of Resident #24's status and his/her history. During an interview on 11/4/24 at 9:40 A.M., Nurse Practitioner (NP) #3 said that she was paged to call the facility around 7:56 A.M. and said that she called back right around 8:00 A.M. NP #3 said that with Resident #24's history she would have sent him out overnight but was not sure what the initial report was that was given to the covering NP. NP #3 said that if the nurse was given an estimated time of arrival of one to two hours, then 911 should have been called as this was a change in condition. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #24's discharge summary from the hospital, dated 11/4/24 at 4:39 P.M., indicated a diagnosis of bowel obstruction and a reason for admission of Abdominal pain, with bowel obstruction and 1600-2000 milliliters (ml) of fecal material suctioned from NGT (nasogastric tube, a thin flexible tube that is passed through the nose and down through the esophagus into the stomach. It can be used to either remove substances from or add them to the stomach.) The discharge summary further indicated that Resident #24 had prior admissions for bowel obstructions including in May 2023, February 2024, May 2024, June 2024 and November 2024. Further, the report indicated that Resident #24 presented to the emergency department from his extended care facility with coffee ground emesis x3 and a report of some dark bowel movements. Resident #24's main complaint was abdominal discomfort, and his/her blood pressure was in the 70's according to the prehospital personnel. The discharge summary also indicated Patient underwent central line insertion for severe hypotension with Afib (atrial fibrillation- an irregular and often very rapid heart rhythm) with RVR (rapid ventricular rate) and on dilt drip (Diltiazem - a medicated intravenous solution used in adults to treat certain heart rhythm disorders such as atrial fibrillation or dangerously rapid heartbeats) with still uncontrolled heart rate and hypotension status post several liters of IV [intravenous] fluid resuscitation, in the setting of AKI (acute kidney injury) with possible pulmonary edema as well. He/she had a nasogastric tube inserted with approximately 2 liters of feculent material suctioned out immediately. CT (cat scan) of the abdomen and pelvis shows markedly distended stomach and proximal duodenum with markedly dilated loops of bowel and air-fluid levels, markedly dilated rectosigmoid. Review of Physical exam indicates an abdominal assessment with hypoactive/ absent bowel sounds, markedly distended abdomen, tenderness to palpation. Review of Nursing progress notes indicated the following: - A progress note dated 11/5/24 at 1:27 A.M., indicating, Patient came back from hospital on a 3-11p shift, earlier this nurse took report from the ED [emergency department] nurse stating that, 'Patient had a bowel obstruction', this nurse asked the ED Nurse if patient had any surgeries to correct the obstruction, she said No, patient is coming back to the facility for comfort care admitted to Hospice. however, it is not stated in the Hospital visit, paperwork. Will F/u [follow up] with facility MD. Review of the nursing progress note dated 11/5/24 at 12:03 P.M., indicated the following: - At approximately 8:28 A.M., the resident was noted to be unresponsive. Resident did not respond to verbal or physical stimuli. There was no palpable pulse or visual chest rise/fall and no audible breath sounds. Time of death 8:29 A.M. Health care proxy notified, and body released to funeral home at 10:30 A.M. During an interview on 11/6/24 at 1:13 P.M., Physician #2 said that Resident #24 has a significant history of bowel obstructions and in the past has declined surgical interventions. Physician #2 said that there is a process issue in the facility in terms of communication with covering providers and ensuring that a full and accurate report is provided to the NP or covering providers on call. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/6/24 at 1:30 P.M. the Director of Nursing (DON) said that she didn't think it was necessary to provide a history about Resident #24's previous bowel obstructions because the Resident having coffee ground emesis was not an emergent situation. She said she would not have called the covering again at any point during the shift and wouldn't call again until the Resident was ready to go to the hospital. She said one policy regarding change in condition or transfers does not fit all, if it was something critical, she would have called again, but she said she did not take this as a critical situation. The DON said she talked to Nurse #4 who worked over night and that the Resident had only vomited 3 times. The DON said however, she had not spoken to CNA #7, who reported to the surveyor ongoing black vomiting and black stooling throughout the night.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to ensure a clean, homelike environment on one out of three resident care units. Specifically, the Hale Unit had lingering, stale urine odors in the hallway. Findings include: Review of the facility's policy titled 'Homelike Environment, dated as revised February 2021, included the following: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation 2. The facility staff and management maximized, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment; f. pleasant, neutral scents; 3. The facility staff and management minimizes, to the extent possible, the characteristic of the facility that reflect a depersonalized, institutional setting. The characteristics include: b. institutional odors: The surveyors observed the following on the Hale Unit: On 11/3/24 at 7:42 A.M., the hallway outside of rooms [ROOM NUMBER] had malodorous stale scent of urine. On 11/3/24 at 1:00 P.M., the hallway outside of resident rooms had a strong odor of stale urine. Several misters were observed above resident doorways which would randomly spray air freshener to mask the odors. On 11/4/24 8:36 A.M., the hallway outside of resident rooms had smelled of stale urine with close by areas smelling of air freshener. On 11/5/24 at 10:00 A.M., the hallway outside of the resident rooms had a strong odor of old, stale urine while other areas had an odor of air freshener. On 11/6/24 at approximately 9:00 A.M., the hallway was malodorous with a strong scent of old urine. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 11/6/24 at 10:03 A.M., in the hallway of the Hale Unit, the Regional Maintenance Director said all areas of the resident care units should be clean and in good condition. The Regional Maintenance Director said the odor in the hallway was identified last year during survey. The Regional Maintenance Director said the hallway is treated with routine carpet cleaning and a timed spray neutralizer, located on the wall, and sprays scented neutralizers intermittently. The Regional Maintenance Director said that the spray masks the odors and that the carpet should be replaced.		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review and interview, the facility failed to protect two Residents (#24 and #323), from neglect, out of a total sample of 39 residents. Specifically, 1. For Resident #24, the facility neglected to monitor, assess and notify the physician timely for the Resident who was found to be vomiting coffee ground emesis and exhibiting continuous stooling of black liquid. 2. For Resident #323, the facility neglected to a) review and intervene on abnormal laboratory tests, resulting in a delay in treatment, and subsequent hospitalization and death; b) implement treatments timely for a newly acquired pressure injury, resulting in an untreated wound for 6 days and; c) address a significant, 11%, weight loss. Findings include: Neglect, as defined at S483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The American Nurses Association (ANA), Scope of Nursing Practice, Third Edition, indicated Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations. Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised [DATE], indicated the following: - Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. - Develop and implement policies and protocols that prevent and identify abuse or mistreatment of residents; neglect of residents; and/or theft, exploitation or misappropriation of resident property. 1. Resident #24 was admitted to the facility in [DATE] with diagnoses that include partial intestinal obstruction, muscle weakness, gastrointestinal hemorrhage, and iron deficiency anemia. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #24's Minimum Data Set (MDS) Assessment, dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating that the Resident has moderate cognitive impairment. The MDS further indicated that the resident has medically complex conditions with a primary diagnosis of partial intestinal obstruction. On [DATE] at 8:36 A.M., a surveyor overheard Nurse #3 say thank you to Nurse #4 for sending out Resident #24. During an interview on [DATE] at 8:38 A.M., Nurse #4 said she is sending Resident #24 to the hospital as he/she was vomiting a lot over night that was coffee ground in color and has a history of bowel obstructions. Nurse #4 said the Resident started vomiting around 1:00 A.M. Nurse #4 said she called the on-call service Nurse Practitioner (NP) and the NP ordered labs because the Resident did not want to go to the hospital. Nurse #4 said the Resident only vomited a few times around 1:00 A.M. but then the Resident was okay and was asleep until 6:00 A.M. Nurse #4 said she then called the on-call service around 6:00 A.M. as the Resident again vomited dark coffee ground substances and wanted to go to the hospital at that time. During a follow up interview on [DATE] at 8:42 A.M., Nurse #4 said to the surveyors that Resident #24 started vomiting on her shift, around 1:00 A.M., but at first the Resident did not want to go to the hospital. She said she called the Nurse Practitioner (NP), and she ordered labs and Zofran (a medication to treat nausea). When asked about the Resident's history Nurse #4 told the surveyors that he/she does have a history of a bowel obstruction as well as a recent fall on [DATE]. Nurse #4 said that she did not provide a full report of Resident #24's medical history to the Nurse Practitioner that she spoke to at 1:00 A.M., and only gave report on the current situation; that the Resident was vomiting. During an interview on [DATE] at 8:45 A.M., Nurse #3 said that she arrived to the facility around 7:20 A.M. and was told in report that the Resident had coffee ground emesis (vomiting) during the night. She said when she got there Resident #24 said he/she wanted to go to the hospital. Nurse #3 said that the Resident looks bad right now and said he/she looks pale and grey, and that the Resident also looked like that at 7:20 A.M. when she saw him/her. During an interview and observation on [DATE] at 8:48 A.M., the surveyor observed Resident #24 with black vomit on him/her. Resident #24 said that he/she knew what was happening was bad and that he/she wanted to go to the hospital and did not refuse to go. Review of Resident #24's nursing progress note, dated [DATE] at 8:52 A.M., indicated, at 1 AM Patient started vomiting, I informed NP [#2], and she gave order to do lab. CBC with diff and BMP. Patient refused to go to the hospital at this point. He/she said I want to wait. Around 6 AM, patient started vomiting again and I notified NP [#3], and she said send patient to hospital. Vital signs were bp [blood pressure] ,d+[DATE], pulse 66, O2 [oxygen saturation] 96%, temp [temperature] 98, resp [respirations] 18. HCP [health care proxy] was called and left a message. Review of the Electronic Medical Record (EMR) for Resident #24 indicated special instructions as follows: (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Please document on every shift on GI (Gastrointestinal) status- appearance: distended, tenderness, flatus, BMs (bowel movements) and size, N/V (nausea and vomiting), GS/ bloating; anything clinically pertinent; behaviors- refusal of care; GU (genitourinary)- signs or symptoms of UTIs (urinary tract infections); always add effects of any PRN (as needed) medications administered during shift. Review of Resident #24's medical record failed to indicate that any assessments or other vitals were taken on [DATE]. During a follow up interview on [DATE] at 9:21 A.M., Nurse #4 said the vomiting started between 1:00 and 2:00 A.M. and then again around 6:00 A.M. Nurse #4 said that she called the covering practitioner again around 6:00 A.M. and was ordered to send the Resident out to the emergency room . She said at this time the Resident agreed to be sent out. Nurse #4 said that she called for transport, not 911 emergency services, between 6:00 and 7:00 A.M. and was told that it would be one to two hours before transport could be there. She said that the facility can call 911 for transfers but she felt like the Resident was stable and his/her vitals were stable. During a follow up interview on [DATE] at 9:24 A.M., Nurse #3 said she did not call for the transport of Resident #24 to the hospital for evaluation but if she knew it was going to be one to two hours for the transport, she would have called 911 for a more emergent transfer. During an interview on [DATE] at 9:40 A.M., Nurse Practitioner (NP) #3 said that she was paged to call the facility around 7:56 A.M. and said that she called back right around 8:00 A.M. NP #3 said she was told he vomited around 1:00 A.M. and then again prior to the page at 7:56 A.M. NP #3 said that with Resident #24's history she would have sent him out overnight but was not sure what the initial report was that was given to the covering NP. NP #3 said that if the nurse was given an estimated time of arrival of one to two hours, then 911 should have been called as this was a change in condition. During an interview on [DATE] at 8:33 A.M. Certified Nurses Aid (CNA) #7 said that she worked over night on [DATE] into [DATE]. CNA #7 said that Resident #24 was moving his/her bowels and vomiting all night long. She said that both the vomit and stool was liquid and black. She said that she provided incontinence care at least five times overnight for liquid black stools and that the vomiting was continuous all night and did not stop. CNA #7 said that she told the nurse. She said that after the first time Resident #24 vomited he/she did not want to go to the hospital but that at around 3:00 A.M., Resident #24 said that he/she wanted to go to the hospital, and she told the nurse (Nurse #4) that he/she wanted to go to the hospital. CNA #7 said that her shift ended, and she left the facility around 7:15 A.M., and Resident #24 was still at the facility. During an interview on [DATE] at 9:42 A.M., NP #2 said the only page she got from the facility for Resident #24 was at 1:13 A.M. and said she called the facility right away. NP #2 said the report she was given was that the Resident's vitals were stable, and the Resident had a lot of vomiting. The NP said it was never reported to her that he/she had coffee ground emesis or multiple loose dark stools. The NP said she was never given a report of the Resident's history or that the Resident had a recent unwitnessed fall. The NP said she would have sent him/her out right away if she was given an accurate report of Resident #24's status and his/her history. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:13 P.M., Physician #2 said that Resident #24 has a significant history of bowel obstructions and in the past has declined surgical interventions. Physician #2 said that there is a process issue in the facility in terms of communication with covering providers and ensuring that a full and accurate report is provided to the NP or covering providers on call. During an interview on [DATE] at 1:30 P.M. the Director of Nursing (DON) said that she didn't think it was necessary to provide a history about Resident #24's previous bowel obstructions because the Resident having coffee ground emesis was not an emergent situation. When asked if she was aware that the CNA #7 said that Resident #24 said he/she wanted to go to the hospital at 3:00 A.M., the DON said that after CNA #7 notified Nurse #4, Nurse #4 went into the room and the Resident said he/she didn't want to go. She said she would not have called the covering again at that point and wouldn't call again until the Resident was ready to go to the hospital. She said one policy regarding change in condition or transfers does not fit all, if it was something critical she would have called again, but she said she did not take this as a critical situation. The DON said she talked to Nurse #4 who worked over night and that the Resident had only vomited 3 times and denied the Resident was having coffee ground emesis. The DON said she had not spoken to CNA #7 who reported to the surveyor the Resident had ongoing black vomiting and black stooling throughout the night. Review of Resident #24's Ambulance Patient Care Report, dated [DATE], indicated dispatched at 8:01 A.M. to the facility for chief complaint of incontractable [sic] vomiting. Pt (patient) found lying supine in assigned bed with head elevated and several towels draped over him/her, coffee ground emesis noted on towel. Skin is pale, warm and dry. Significant distension noted on initial impression. Nursing staff reported coffee ground emesis began at 0100 (1:00 A.M.) that morning with 3 episodes. No vitals or assessments taken to provide EMS (emergency medical services) staff. Vitals revealed hypotension (,d+[DATE]) and weakened radial pulses. Regrouped in patient room and called dispatch at 8:44 A.M. for ALS (advanced life support) secondary to hypotension and likely GI bleed. In route to the hospital at 8:55 A.M. vital signs included a blood pressure of 70 systolically and a weak pulse of 180 beats per minute. Review of Resident #24's discharge summary from the hospital, dated [DATE] at 4:39 P.M., indicated a diagnosis of bowel obstruction and a reason for admission of Abdominal pain, with bowel obstruction and , d+[DATE] milliliters (ml) of fecal material suctioned from NGT (nasogastric tube, a thin flexible tube that is passed through the nose and down through the esophagus into the stomach. It can be used to either remove substances from or add them to the stomach.) The discharge summary further indicated that Resident #24 had prior admissions for bowel obstructions including in [DATE], February 2024, [DATE], [DATE] and [DATE]. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The discharge summary indicated that Resident #24 presented to the emergency department from his/her extended care facility with coffee ground emesis times three and a report of some dark bowel movements. Resident #24's main complaint was abdominal discomfort, and his/her blood pressure was in the 70's according to the prehospital personnel. Further the discharge summary indicated Patient underwent central line insertion for severe hypotension with Afib (atrial fibrillation- an irregular and often very rapid heart rhythm) with RVR (rapid ventricular rate) and on dilt drip (Diltiazem - a medicated intravenous solution used in adults to treat certain heart rhythm disorders such as atrial fibrillation or dangerously rapid heartbeats) with still uncontrolled heart rate and hypotension status post several liters of IV [intravenous] fluid resuscitation, in the setting of AKI (acute kidney injury) with possible pulmonary edema as well. He/she had a nasogastric tube inserted with approximately 2 liters of feculent material suctioned out immediately. CT (cat scan) of the abdomen and pelvis shows markedly distended stomach and proximal duodenum with markedly dilated loops of bowel and air-fluid levels, markedly dilated rectosigmoid. After lengthy conversation with patient and nursing at the bedside patient seems for comfort measures at end of life. He/she was requesting narcotics for abdominal discomfort . Patient was cognizant and fully intact to make this decision. Review of Physical exam indicates an abdominal assessment with hypoactive/ absent bowel sounds, markedly distended abdomen, tenderness to palpation. Review of Resident #24's medical record indicated the Resident returned to the facility on [DATE] on the 3:00 P.M. to 11:00 P.M. shift and was readmitted on care and comfort measures. Further review of the medical record indicated that Resident #24 died at the facility on [DATE] at approximately 8:28 A.M. 41019 2. For Resident #323, the facility neglected to: a) review and intervene on abnormal laboratory tests, resulting in a delay in treatment, and subsequent hospitalization and death; b) implement treatments timely for a newly acquired pressure injury, resulting in an untreated wound for 6 days and; c) address a significant, 11%, weight loss. Resident #323 was admitted to the facility in [DATE] with diagnoses including dementia and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #323 could not participate in the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. The MDS further indicated Resident #323 required supervision to assistance with meals, supervision with touching assistance for standing and walking. Review of the record indicated that effective [DATE] Resident #323 had an activated Health Care Proxy (deemed incapable of making medical decisions for self). The Health Care Proxy was Resident #323's daughter. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:32 P.M., Resident #323's daughter said she felt the facility did not listen to any of her concerns. Resident #323's daughter said her parent died and she believed it was the direct result of the facility's mistreatment and neglect. Resident #323's daughter said at the time of the Resident's death, he/she had significant wounds on his/her feet and had lost a significant amount of weight. Resident #323's daughter said she believes Resident #323 was overmedicated and said she was never made aware of medication changes and was never asked to sign consents for changes to Resident #323's medications. She said prior to passing Resident #323 could not get out of bed like he/she used to due to being overmedicated and was left in bed a lot of the day, creating wounds on the Resident's heels. Resident #323's daughter said that when the wounds were discovered on his/her heels that she was horrified. She said that the condition of Resident #323's heels were due to severe neglect by the facility. The Resident's daughter also said the Resident required assistance with chewing and swallowing and his/her meals were often left by the bed side, which likely contributed to the Resident's weight loss. The daughter said she believes that the Resident's death could have been prevented. 2 a. Review of the facility policy titled Lab and Diagnostic Test Results- Clinical Protocol, revised [DATE], indicates the following: - High or toxic serum medication levels. If a test was obtained to monitor the blood level of a medication and the level is reported as high (above therapeutic range) or toxic, the nurse will notify the physician promptly and will not give the next dose until the situation has been reviewed with the physician. - Time frames. A physician will respond within an appropriate time frame, based on the request from nursing staff and the clinical significance of the information. o A physician should respond within one hour regarding a lab test result requiring immediate notification, and by the end of the next office day to a non-emergency message regarding non-immediate lab test notification with a request for response. o If the attending or covering physician does not respond to immediate notification within an hour, the nursing staff should contact the medical director for assistance. Review of the hospital admission paperwork, prior to admission, for Resident #323, dated [DATE], indicated Resident #323 was admitted to the hospital with a Covid infection and the family's inability to care for him/her at home. Review of the lab results on the hospital admission paperwork, dated [DATE], indicated Resident #323 had the following lab results: - BUN: 31 - Creatinine: 1.87 - Glomerular Filtration Rate: 37 (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Blood urea nitrogen is a measure of nitrogen in the blood and is a measure of kidney function. The normal ranges for BUN are ,d+[DATE] milligrams per deciliter. Creatinine is a lab used to measure kidney function. The normal ranges for creatinine is 0XXX,d+[DATE].3 milligrams per deciliter. GFR is a lab used to measure the filtration rate of the kidneys. The normal range for GFR is ,d+[DATE] milliliters per minute.) Review of multiple nursing progress notes since admission indicated Resident #323 had been experiencing agitation, intrusiveness, and yelling out. On [DATE], a urine culture was obtained. Review of the medical record failed to indicate why a urine culture was obtained for Resident #323. Review of the laboratory results, dated [DATE], indicated the following: - Culture 10,,d+[DATE],000 CFU/mL (colony forming units per milliliter) mixed urogenital flora, probable contamination (mixed bacteria in the urine with possible contamination) Review of the record failed to indicate if a urine sample or lab was ever obtained after [DATE]. Review of the record failed to indicate any follow up documentation from the Nurse Practitioner or Physician or if the laboratory results were ever reported to the physician or nurse practitioner from [DATE]-[DATE]. Review of the nursing progress note, dated [DATE], indicated that the facility attempted to obtain a urine sample via a straight catheter (a device used to obtain a urine sample), but Resident #323 refused and yelled get out, get out!. Review of the medical record failed to indicate any follow up documentation from the Nurse Practitioner or Physician following the [DATE] progress note or if a urine sample was obtained after [DATE]. Review of the nursing progress note, dated [DATE], indicated Resident #323 had a Basic Metabolic Panel (BMP) lab completed and resulted in abnormal lab values. Specifically, a blood urea nitrogen (BUN) of 80, creatinine of 2.70, and a glomerular filtration rate (GFR) of 23, which are considered abnormally high. The nursing progress note indicated that the Director of Nursing was made aware, and the Nurse Practitioner was contacted. Review of the Nurse Practitioner monthly progress note, dated [DATE], indicated the following: - No acute concerns from nursing. - Labs and image results: All labs reviewed and found to be negative. - #CKD: Encourage po fluids, monitor renal, monitor retention Review the medical record failed to indicate that any further review or action of the abnormal labs from [DATE] through [DATE] a total of 27 days. Review of the labs draw on [DATE] indicated the following: (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- BUN 172 - Creatinine 5.6 - GFR 10 Review of the progress note, dated [DATE], indicated Resident #323 was transferred to the hospital with critically high labs with a diagnosis of shock, acute kidney failure, and hyperkalemia (high potassium levels). Review of the hospital discharge summary, dated [DATE], indicated the following: - He/she was found to be acidotic with PH of 7.19. He/she has hypernatremia (high sodium), hyperkalemia (high potassium), acute kidney injury, acute NSTEMI (mild heart attack), sepsis (blood infection) likely due to acute cystitis (infection of the bladder from bacteria). Resident #323 expired shortly after arrival to the hospital. During an interview on [DATE] at 8:30 A.M., the Nurse Practitioner said that she doesn't remember the resident, but if there are abnormal labs drawn that are different from the resident's baseline, then he/she should have been sent to the hospital. The Nurse Practitioner said she would have expected to be notified if the facility could not obtain a urine sample via a straight catheter. The Nurse Practitioner said that if a family member refuses any treatment then that should be documented. Review of the medical record failed to indicate the healthcare proxy was made aware or refused any treatment. During an interview on [DATE] at 8:37 A.M., Physician #1 said that if a resident has a suspected urinary tract infection (UTI) then the resident should be treated with antibiotics as a precaution. Physician #1 said if labs come back abnormal, most of the time the Nurse Practitioner will address the labs and make the decision with what to do with the Resident. Physician #1 said if he was notified of the labs, he would have sent the Resident to the hospital or hydrated him/her with intravenous fluids because the labs reflected dehydration. During an interview on [DATE] at 10:47 A.M., the Director of Nursing said she doesn't remember that far back, but that the urine was done because of the daughter's request. The Director of Nursing said the urine came back inconclusive and the facility attempted to straight cath (use a straight catheter to obtain a urine sample) but were unsuccessful and notified the Nurse Practitioner. The Director of Nursing could not remember why the additional BMP (basal metabolic panel) labs were done, but if labs are abnormal then staff should notify the Nurse Practitioner. During an interview on [DATE] at 9:47 A.M., the Physician said that most of the time the Nurse Practitioner makes the decision on what to do with abnormal labs. He said the Nurse Practitioner has been here for 7 years and is usually on top of these things. He said he was upset when they told him about Resident #323 and that this was a big concern. 2 b. Review of Resident #323's care plan for skin indicated the following: (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Focus: I have the potential for skin breakdown r/t (related to) impaired mobility (initiated [DATE]) - Interventions: o Apply barrier cream after incontinence care (initiated [DATE]) o Document skin checks weekly and PRN (as needed). Notify physician and resident/RP (representative) of new areas if observed. Follow up as indicated (initiated [DATE]). Review of the weekly skin check, dated [DATE], indicated Resident #323 had no open areas. Review of the medical record failed to indicate weekly skin checks were being completed per the Resident's care plan from [DATE] until [DATE]. The weekly skin check, dated [DATE], indicated Resident #323 had a new open area on his/her right heel and his/her left heel due to pressure. The skin check failed to indicate any measurements for the wounds. Review of the Nurse Practitioner's progress note, dated [DATE], four days after the weekly skin check was completed, indicated the following: -Skin: no lesions or rashes noted in b/l (bilateral) UE (upper extremity) or LE (lower extremity). Review of the medical record failed to indicate if the Nurse Practitioner or Physician were notified of the new open pressure wounds. Review of the physician's orders indicated that a treatment order was implemented on [DATE], 8 days after the initial wound was identified and 4 days since he/she was last seen by the Nurse Practitioner, for both heels to cleanse with normal saline, apply Xerofoam gauze, to wound perimeter cover with ABD pad, wrap with kerlix. Review of the Initial Wound Evaluation and Management Summary, dated [DATE], 15 days after the wound was initially identified, indicated Resident #323 had the following: - an unstageable wound (due to necrosis) of the left heel, approximately greater than 14 days in duration, that was 4x3.8 centimeters. - An unstageable wound (due to necrosis) of the left heel, approximately greater than 14 days in duration, that was 4x3.8 centimeters. During an interview on [DATE] at 9:37 A.M., the Wound Physician said when she met with Resident #323, he/she had bad DTI's (deep tissue injuries) and that the treatment for a DTI is to offload the wound. The wound doctor said that in her assessment note she documents duration of the wound. She said the duration is her professional opinion of how long the wounds existed prior to her evaluation. For Resident #323 she said that she believes the wounds were due to pressure, indicating the heels were not offloaded. Review of the medical record failed to indicate any intervention to offload Resident #323's heels after the wounds were first identified. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:47 A.M., the Director of Nursing said if a wound is identified then she would have expected the skin prep (a liquid applied to the skin to provide a barrier) to go in earlier, but depends on what the doctor says. 2 c. Review of Resident #323's nutrition care plan indicated the following: Focus: I have a nutritional problem or potential nutritional problem related to significant weight changes, suspected malnutrition, past medical history significant for dementia, anemia pressure ulcers, and GERD (Gastroesophageal reflux disease). Review of the weight report for Resident #323 indicated the following weights: [DATE]: 158.2 lbs (pounds) [DATE]: 135 lbs [DATE]: 120 lbs Review of the nutrition risk assessment, dated [DATE], indicated Resident #323 had an ideal body weight of 153 lbs. Review of the weights indicated Resident #323 lost 23.2 lbs in one month from [DATE] to [DATE], which is a 14.6% significant weight loss. Review of the progress note, dated [DATE], indicated the following: RD (registered dietitian) suspects pt (patient) meets criteria for protein calorie malnutrition. Malnutrition in the context of chronic illness r/t (related to) dementia AEB (as evidenced by) significant weight loss with NFPE (nutrition focused physical exam) finding indicating fat and muscle loss. Review of the weight warning note, dated [DATE], indicated the dietitian recommended a re-weight and to start weekly weights, as well as, a nutritional drink BID (twice per day) and fortified foods. Review of the medical record failed to indicate that weekly weights were implemented as recommended. Review of the weights indicated Resident #323 lost an additional 15 lbs from [DATE] to [DATE], which is an 11% significant weight loss in one month. Review of the clinical record failed to indicate that the significant weight loss was addressed, the care plan was reviewed, or any new interventions were implemented. During an interview on [DATE] at 9:00 A.M., the Dietitian said that after the initial significant weight loss, she recommended weekly weights, but said they were not being done. The dietitian said she was not notified of the weight loss that occurred on [DATE] and would have expected to be notified so that she could address the weight loss.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observation, record review, and interview, the facility failed to investigate an allegation of potential neglect for one Resident (#25) out of a total sample of 39 residents. Findings include: Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 2021, indicated the following: - Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Resident #25 was admitted in June 2023 with diagnoses including bipolar disorder and major depressive disorder. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #25 scored a 12 out of a possible 15 on the Brief Interview of Mental Status (BIMS), indicating moderate cognitive impairment. Review of the MDS indicated that Resident #25 scored a 10 out of a possible 27 points on the Patient Health Questionnaire (PH-Q9), indicating moderate depression. During an observation and interview on 11/3/24 at 7:48 A.M., Resident #25 said when he/she needs his/her diaper to be changed, staff won't come in for 3-4 hours and they take their time. The Director of Nursing was notified immediately after Resident #25 vocalized his/her concerns to the surveyor. Review of the incident reports on 11/6/24 for Resident #25 failed to indicate that any investigation had been initiated for Resident #25's allegations. During an interview on 11/6/24 at 7:18 A.M., the Director of Nursing said she did not investigate potential abuse and she filed a grievance instead based on Resident #25's care plan. The Director of Nursing said that Resident #25 has a history of not wanting to be changed and stating you can't make me be changed. The Director of Nursing said Resident #25 will cry and say no one has changed him/her for 8 hours. When asked how she distinguishes whether the Resident is exhibiting a behavior or a true allegation, the Director of Nursing said that if someone is not changed within 3-4 hours then she will figure out if it's abuse within the 2 hours by doing an investigation and if she feels it's abuse then she would report it. The Director of Nursing provided education completed with the staff on the day the potential abuse was reported to her, however failed to provide the grievance that was completed.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on record review and interviews, the facility failed to develop and implement personalized care plans for four Residents (#91, #106, #117, and #323), out of a total sample of 39 residents. Specifically: 1. For Resident #91, the facility failed to develop a care plan for suicide ideation, 2. For Resident #106, the facility failed to develop a skin at risk care plan, 3. For Resident #117, the facility failed to implement a care plan for a pacemaker. 4. For Resident #323, the facility failed to implement a plan of care for skin checks. Findings include: Review of the policy titled Care Plans, Comprehensive Person-Centered, dated 2001, indicated the following: - The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. - The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. - The comprehensive person-centered care plan: a. Includes measurable, objectives and timeframes; b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care; c. Includes the resident's stated goals upon admission and desired outcomes; d. Builds on the resident's strengths; (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Reflects currently recognized standards of practice for problem areas and conditions. - Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident problem areas and their causes, and relevant clinical decision making. - When possible, interventions address the underlining source(s) of the problem area(s), not just symptoms or triggers. 1. Resident #91 was admitted to the facility in May 2023 with diagnoses including bipolar disorder, major depression, anxiety, and suicidal ideations. Review of Resident #91's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she had a Brief Interview for Mental Status score of 12 out of a possible 15, which indicated the Resident had moderate cognitive impairment. The MDS also indicated Resident #91 required supervision for functional daily tasks. Review of Resident #91's diagnosis list includes suicidal ideation as an admitting diagnosis to the facility. Review of the Psychiatric Nurse Practitioner note, dated 10/22/24, indicated the following: - Problem: 60 yo (year old) (Male/Female) with dementia, OCD (obsessive compulsive disorder), anxiety, depression, bipolar d/o (disorder) and prior suicidal ideation is seen for a follow up. - History of SI/SA/SIB (Suicidal Ideation/Suicide Attempt/Self-Injurious Behavior): Yes Review of Resident #91's care plans failed to indicate a care plan for suicidal ideation had been developed. During an interview on 11/4/24 and 8:10 A.M., Nurse #1 and Nurse #2 said both the nurses and social worker are responsible for creating care plans upon admission and throughout a resident's stay and the care plans should address all major care areas. Nurse #1 and Nurse #2 said a suicide ideation care plan should be developed for anyone with a history of suicide ideation and if known at the time of admission, that type of care plan should be developed upon admit to the facility. Nurse #1 and Nurse #2 said they were both unaware of Resident #91's history and diagnosis of suicidal ideation. During an interview on 11/4/24 at 8:32 A.M., the Social Worker (SW) said when a new resident is admitted to the facility, she reads the discharge summary from the hospital and will develop any pertinent care plans based on the resident's diagnoses and history. The SW said this would include any psychosocial care plans. The SW said if a new resident is admitted with a history of suicidal ideation, she would expect a suicide ideation care plan to be developed upon admission. The SW said she was unaware of Resident #91's history and diagnosis of suicidal ideation. During an interview on 11/4/24 at 8:44 A.M., the Director of Nursing (DON) said she would expect any resident with a history of suicidal ideation to have a care plan developed for that diagnosis. 49880 (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #106 was admitted to the facility in May 2024 with diagnoses that include protein calorie malnutrition, non-pressure chronic ulcer of the skin and lack of coordination. Review of Resident #106's most recent Minimum Data Set (MDS) Assessment, dated 8/30/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the Resident is cognitively intact. The MDS further indicates that the Resident is at risk for the development of pressure areas. Review of Resident #106's initial Norton Assessment (an assessment to determine risk for pressure ulcer development), completed 5/23/24, indicated a score of 6, which indicates high risk for skin breakdown. Review of Resident #106's Norton Assessment, completed 8/13/24, indicated a score of 14, which indicates moderate risk for skin breakdown. Review of Resident #106's active care plan failed to indicate a risk for skin breakdown care plan. During an interview on 11/6/24 at 9:32 A.M., the Director of Nursing said that if the Norton Assessment indicates risk for skin breakdown, then there should be a plan of care around risk for skin breakdown. 43846 3. Review of the facility policy titled Pacemaker, dated December 2015, indicated: - Monitoring: the pacemaker battery will be monitored remotely through the telephone or an internet connection. The resident's cardiologist will provide instructions on how and when to do this. Resident #117 was admitted to the facility in September 2024 with diagnoses that included cardiac pacemaker, cardiac defibrillator, depression and dementia. Review of Resident #117's most recent Minimum Data Set Assessment (MDS), dated [DATE] , scored a nine out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairments. Review of Resident #117's Psychiatric Nurse Practitioner (NP) note, dated 9/30/24, indicated cardiac defibrillator placement and pacemaker. Review of Resident #117's pacemaker care plan, dated 10/8/24, indicated pacemaker checks as ordered. Review of Resident #117's physician orders failed to indicate pacemaker checks. During an interview on 11/6/24 at 10:00 A.M., Nurse #3 said the Resident admitted without a monitoring device for their pacemaker. Nurse #3 said she admitted Resident #61 and was not aware of when or how the Resident's pacemaker should be checked. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/6/24 at 10:26 A.M., Director of Nurse said pacemaker checks should have orders. 41019 4. Resident #323 was admitted in June 2024 with diagnoses including dementia and chronic kidney disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #323 could not participate in the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. Review of the MDS indicates Resident #323 required supervision to assistance with meals, supervision with touching assistance for standing, and supervision with touching assistance with walking. Review of Resident #323's care plan for skin indicated the following: Intervention: Document skin checks weekly and PRN (as needed). Notify the physician and resident/RP (representative) of new areas if observed. Follow-up as indicated. (initiated 7/5/24). Review of the weekly skin check reports failed to indicate that skin checks were being completed between 7/5/24 and 7/25/24, which was when a new wound was identified. During an interview on 11/4/24 at 4:00 P.M., Nurse #11 said that all residents have weekly skin checks. During an interview on 11/6/24 at 10:22 A.M., the Director of Nurses (DON) said skin checks should be completed weekly as ordered and said she knows it is an issue in the building.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to meet professional standards of practice for 12 Residents (#40, #47, #41, #92, #108, #4, #55, #12, #19, #106, #2 and #75) out of a total of 39 sampled residents. Specifically: 1. For Resident #40, the facility failed to a.) obtain a physicians order for the treatment of a skin tear and b.) failed to complete weekly skin checks as ordered. 2. For Resident #47, the facility failed to complete weekly skin checks as ordered. 3. For Resident #41, the facility failed to complete weekly skin checks as ordered. 4. For Resident #92, the facility failed to complete weekly skin checks as ordered. 5. For Resident #108, the facility failed to complete weekly skin checks as ordered. 6. For Resident #4, the facility failed to to complete weekly skin checks as ordered. 7. For Resident #55, the facility failed to a.) to complete weekly skin checks as ordered and b.) obtain weights as ordered. 8. For Resident #12, the facility failed to obtain weights as ordered. 9. For Resident #19, the facility failed to complete weekly skin checks as ordered. 10. For Resident #106, the facility failed to complete weekly skin checks as ordered. 11. For Resident #2 the facility failed to a.) implement the physician's order for an identified skin impairment, and b.) failed to provide skin checks. 12. For Resident #75 the facility failed to a.) implement the physician's order to hold insulin for a blood sugar below 100 and to notify the Medical Doctor/Nurse Practitioner his/her blood sugar was less than 100 and b.) failed to ensure weekly skin checks were implemented in accordance with the physician's order. Findings include: Review of [NAME], Manual of Nursing Practice 11th edition, dated 2018, indicated the following: - The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Review of the American Nursing Associations Scope and Standards of Nursing Practice, 2010, pg 32, indicated the following: Standard 1. Assessment: The Registered Nurse (RN) collects comprehensive data pertinent to the consumer's health and/or the situation. Competencies: Collects comprehensive data including but not limited to physical functional, psychosocial, emotional, cognitive, age related, environmental, spiritual/transpersonal and economic assessments in a systemic and ongoing process while honoring the uniqueness of the person. Review of the Facility's Assessment of Skin Condition and Integrity policy, dated March 2021, indicated: Purpose: The purpose of this policy is to provide information regarding the routine assessment of skin integrity. Skin Assessment: Conduct a comprehensive head to toe skin assessment upon admission, weekly, prior to discharge, and as needed. Inspect the skin daily when performing or assisting with personal care or ADL's. Review of the facility policy titled Weight Assessment and Intervention, not dated, indicated Residents are weighed upon admission and at intervals established by the interdisciplinary team. 1. Resident #40 was admitted to the facility in December 2020 with diagnoses including dementia and schizophrenia. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated he/she is severely cognitively impaired evidenced by a score of 3 out of a possible 15 on the Brief Interview for Mental Status exam. a). Review of the Skin Tears - Abrasions and Minor Breaks policy, dated September 2013, indicated: The purpose of this procedure is to guide the prevention and treatment of abrasions, skin tears and minor breaks in the skin. Preparation: 1. Obtain a physicians order as needed. Document physician notification in medical record. On 11/3/24 at 8:05 A.M., the surveyor observed Resident #40 eating breakfast with a visible bandage on his/her lower right arm. Review of physician's orders on 11/3/24 at 10:00 A.M., indicated there were no active orders for Resident #40's right arm. Review of the Interim Skin Check dated 11/1/24 indicated Resident #40 had a sustained a skin tear on his/her right lower forearm. On 11/3/24 at 11:58 A.M., the surveyor observed Resident #40 eating lunch in dining room with his/her right forearm covered in a bandage. The Resident said he/she had banged his/her arm and the nurse covered it. The bandage had no date indicating when it was applied. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/3/24 at 12:02 P.M., Nurse #6, who worked yesterday, said that Resident #40 had an old scab that opened up and the hospice nurse applied the treatment dressing yesterday. Nurse #6 said the dressing should have been dated. Review of the physician's orders on 11/3/24 at 1:00 P.M., indicated the following treatment order was initiated on 11/3/24 at 12:15 P.M.: Right lower arm skin tear: cleanse with normal saline/wound cleanser, apply xeroform, cover with protective dressing. During an interview on 11/5/24 at 9:05 A.M., the Director of Nursing (DON) said that Resident #40 sustained the skin tear on 11/1/24 during a behavioral issue while he/she was thrashing around. She said Resident #40 should have had physician orders for wound treatment in place. b). Review of the physician's orders indicated: Weekly Skin Check, initiated 4/8/24. Review of Resident #40's Weekly Skin Check and Interim Skin Evaluations Assessments indicated: September 2024: A skin check was completed on 9/6/24. There were no other skin checks completed. October 2024: A skin check was completed on 10/25/24. There were no other skin checks completed. During an interview on 11/6/24 at 8:26 A.M., the Regional Nurse said orders for weekly skin checks should be completed as ordered. 2. Resident #47 was admitted to the facility in February 2024 with diagnoses including chronic obstructive pulmonary disease, Parkinson's disease and bipolar disorder. Review of Resident #47's Minimum Data Set Assessment (MDS) dated [DATE] indicated he/she is severely cognitively impaired as evidenced by a score of 9 out of a possible 15 on the Brief Interview for Mental Status exam (BIMS). Additional review of the MDS dated [DATE], 5/16/24, and 7/9/24 all indicated Resident #47 scored a 9 out of a possible 15 on the BIMS. Review of Resident #47's physician's orders indicated: Skin Check Weekly, initiated 2/16/24. Review of Resident #47's Weekly Skin Check and Interim Skin Checks Assessments indicated: September 2024: Skin checks were completed on 9/1/24 and 9/21/24. No other skin checks were completed. October 2024: A skin check was completed on 10/10/24. No other skin checks were completed. November 2024: A skin check were completed on 11/1/24. No other skin checks were completed. During an interview on 11/6/24 at 8:26 A.M., the Regional Nurse said that weekly skin checks should be completed as ordered. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #41 was admitted to the facility in July 2020 with diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side and schizophrenia. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #41 was moderately cognitively impaired evidenced by a score of 9 out of a possible 15 on the Brief Interview for Mental Status Exam. Review of Resident #41's current physician's orders indicated: Skin Check Weekly. Review of Resident #41's Weekly Skin Checks and Interim Skin Check Assessments indicated: August 2024: A skin check was completed on 8/12/24. No other skin checks were completed. September 2024: A skin check was completed on 9/2/24. No other skin checks were completed. October 2024: No skin checks completed. November 2024: No skin check completed. During an interview on 11/6/24 at 8:26 A.M., the Regional Nurse said that weekly skin checks should be completed as ordered. 4. Resident #92 was admitted to the facility in October 2022 with diagnoses including schizophrenia and repeated falls. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #92 is severely cognitively impaired and requires assistance with transfers and bathing. Review of the physicians orders indicated: Skin check weekly, initiated 4/8/24. Review of Resident #92's Weekly Skin Checks and Interim Skin Assessment Evaluations indicated no skin checks had been completed for October 2024 and November 2024. During an interview on 11/6/24 at 8:26 A.M., the Regional Nurse said that weekly skin checks should be completed as ordered. 43846 5. Resident #108 was admitted to the facility in October 2024 with diagnoses that included protein-calorie malnutrition, adult failure to thrive, and mood disorder. Review of Resident #108's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated he/she scored a 15 out of a 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. Further review of the MDS indicated the Resident has an unhealed pressure ulcer and is at risk for developing pressure ulcers. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #108's physician's order, dated 10/16/24, indicated Weekly Skin Check on: Day: Shift: every evening shift every Wednesday. Review of Resident #108's evaluation tab indicated the only skin check completed was on 10/9/24. Review of Resident #108's October 2024 Medication Administration Record (MAR) indicated 10/16/24, 10/23/24, 10/30/24 was signed off by nursing staff as completed as ordered. Review of Resident #108's skin breakdown care plan, dated 10/20/2024, indicated Document skin checks weekly and PRN. Notify the physician and resident/RP (representative) of new areas if observed. Follow-up as indicated. During an interview on 11/6/24 at 10:00 A.M., Nurse #3 said skin checks should be completed weekly as ordered and they would be completed in the evaluation section of the medical record. During an interview on 11/6/24 at 10:22 A.M., the Director of Nurses (DON) said skin checks should be completed weekly as ordered and said she knows it is an issue in the building. 6. Resident #4 was admitted to the facility in September 2023 with diagnoses that included Post Traumatic Stress Disorder (PTSD) hemiplegia and hemiparesis, bipolar disorder, anxiety and depression. Review of Resident #4's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated he/she scored a 14 out of a possible 15 on the Brief Interview for mental status indicating intact cognition. Further review of the MDS indicated the Resident does not reject care. Further review of the MDS indicated that the Resident is at risk for developing pressure ulcers. Review of Resident #4's physician order, dated 4/24/24, indicated Skin Checks weekly on Monday 7-3 (7:00 A.M. to 3:00 P.M.). Review of Resident #4's evaluation tab, indicated the last skin check completed was 9/22/24 and prior to that was 8/3/24. Review of Resident #4's nursing progress notes from 8/1/24 through 11/4/24 failed to indicate that the Resident refused skin checks. Review of Resident #4's skin breakdown care plan, dated 10/5/2023, indicated Document skin checks weekly and PRN. Notify the physician and resident/RP of new areas if observed. Follow-up as indicated. Review of Resident #4's October and November 2024 Treatment Administration Record (TAR), indicated on 10/7/24, 10/14/24, 10/21/24, 10/28/24, 11/4/24 that skin checks were completed as ordered. During an interview on 11/6/24 at 10:00 A.M., Nurse #3 said skin checks should be completed weekly as ordered and they would be completed in the evaluation section of the medical record. During an interview on 11/6/24 at 10:22 A.M., the Director of Nurses (DON) said skin checks should be completed weekly as ordered and said she knows it is an issue in the building. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Resident #55 was admitted to the facility in October 2024 with diagnoses that included type 2 diabetes, cellulitis of right and left lower limb, protein-calorie malnutrition, anxiety and major depressive disorder. Review of Resident #55's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated he/she scored a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairments. Further review of the MDS indicated the Resident is at risk for developing pressure ulcers and has three unhealed pressure ulcers. a. Review of Resident #55's physician order, dated 10/7/24, indicated Weekly Skin Check on: every evening shift every Monday. Review of Resident #55's evaluation tab, indicated the only skin check that was completed by facility nursing staff was on 10/7/24. Review of Resident #55's October and November 2024 Medication Administration Record (MAR), indicated on 10/14/24, 10/21/24, 10/28/24, and 11/4/24 were signed off by nursing as completed as ordered. Review of Resident #55's nursing progress notes from 10/14/24 through 11/4/24 failed to indicate the Resident refused the skin checks or weights. During an interview on 11/6/24 at 10:00 A.M., Nurse #3 said skin checks should be completed weekly as ordered and they would be completed in the evaluation section of the medical record. During an interview on 11/6/24 at 10:22 A.M., the Director of Nurses (DON) said skin checks should be completed weekly as ordered and said she knows it is an issue in the building. b. Review of Resident #55's physician order, dated 10/15/24, indicated Weights Weekly one time a day every Wednesday. Review of Resident #55's nutrition care plan, dated 10/16/24, indicated Obtain weights at ordered intervals. Review of Resident #55's nutritional risk assessment, dated 10/21/24, indicated Re-weight pending d/t weight discrepancies. Weekly wt's x 4 weeks (weights times four weeks) from admission. Review of Resident #55's Nurse Practitioner (NP) progress note, dated 10/23/24, indicated Protein-calorie malnutrition: Monitor weights. Review of Resident #55's weight tab indicated the only weight taken was on 10/9/24. During an interview on 11/6/24 at 10:00 A.M., Nurse #3 said weights should be completed as ordered. During an interview on 11/6/24 at 10:23 A.M., the Director of Nurses (DON) said weights should be obtained as ordered and documented in the medical record. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/6/24 at 10:50 A.M., the Dietitian said weights should be obtained as ordered and said she is aware that Resident #55 is not being weighed as ordered. 8. Resident #12 was admitted to the facility in August 2023 with diagnoses that included cirrhosis of the liver, anxiety, portal vein thrombosis, and pancytopenia. Review of Resident #12's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident is cognitively intact. Review of Resident #12's nutrition note, dated 10/15/24, indicated Resident d/w (discussed with) IDT (interdisciplinary team) at At Risk Meeting d/t (due to) significant weight changes. Chart reviewed. Weights changed to 2x/w (two times a week). RD (Registered Dietitian) believes weight on 9/24 is inaccurate. Review of Resident #12's nursing progress note, dated 10/15/24, indicated Resident daily weights changed to 2x/week per NP (Nurse Practitioner) scheduled Mondays and Thursdays. Review of Resident #12's October and November 2024 Medication Administration Record (MAR), indicated 10/21/24, 10/24/24, 10/28/24, and 10/31/24 that weights were not obtained as ordered. During an interview on 11/6/24 at 10:00 A.M., Nurse #3 said weights should be completed as ordered. During an interview on 11/6/24 at 10:23 A.M., the Director of Nurses (DON) said weights should be obtained as ordered and documented in the medical record. During an interview on 11/6/24 at 10:50 A.M., the Dietitian said weights should be obtained as ordered and said she is aware that Resident #12 is not being weighed as ordered. 49880 9. Resident #19 was admitted to the facility September 2024 with diagnoses that include acute respiratory failure with hypoxia and aspiration. Review of Resident #19's most recent Minimum Data Set (MDS) Assessment, dated as 10/24/24, indicated a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderate cognitive impairment. The MDS further indicates that the Resident is at risk for pressure ulcer development and failed to indicate any behaviors for refusal of care. Review of Resident #19's physician's orders indicated the following: -Weekly skin checks every Monday day shift, dated 10/7/24. Review of Resident #19's active potential for skin breakdown care plan, dated 11/1/24, indicated to document skin checks weekly and PRN (as needed). (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's medical record failed to indicate that a weekly skin check had been completed since admission to the facility. Further review of the medical record failed to indicate that a Norton Assessment (an assessment to determine the risk for pressure ulcer development) had been completed since admission to the facility. During an interview on 11/5/24 at 12:26 P.M., Nurse #2 said that a physician's order for skin checks means that the nurse should do a head-to-toe assessment and document it in the evaluations portion of the electronic medical record under weekly skin checks. During an interview on 11/6/24 at 9:31 A.M., the Director of Nurses said that if there is an order for weekly skin checks then the nurses should be documenting their assessments in the evaluations tab in the electronic medical record to indicate it was completed. 10. Resident #106 was admitted to the facility in May 2024 with diagnoses that include protein calorie malnutrition, non-pressure chronic ulcer of the skin and lack of coordination. Review of Resident #106's most recent Minimum Data Set (MDS) Assessment, dated 8/30/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident is cognitively intact. The MDS further indicates that the Resident is at risk for the development of pressure areas. Review of Resident #106's most recent Norton Assessment (an assessment to determine risk for pressure ulcer development) completed 8/13/24 indicated a score of 14, which indicates moderate risk for skin breakdown. Review of Resident #106's physician's orders indicated the following: -Weekly skin check on Tuesday 7-3, dated 10/21/24. Review of weekly skin checks indicated that since admission, skin checks have been completed only on the following dates: 5/23/24, 7/14/24, 8/4/24, 8/11/24 and 9/7/24. During an interview on 11/5/24 at 12:26 P.M., Nurse #2 said that a physician's order for skin checks means that the nurse should do a head-to-toe assessment and document it in the evaluations portion of the electronic medical record under weekly skin checks. During an interview on 11/6/24 at 9:31 A.M., the Director of Nurses said that if there is an order for weekly skin checks then the nurses should be documenting their assessments in the evaluations tab in the electronic medical record to indicate it was completed. 36431 11. Resident #2 was admitted to the facility in May 2024 and has diagnoses that include chronic obstructive pulmonary disease, weakness, ventricular fibrillation, peripheral vascular disease, and unspecified dementia. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set assessment, dated 8/21/24, indicated Resident #2 scored a 6 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having severe cognitive impairment and required partial to moderate assistance from staff for toileting, and bathing. Review of Resident #2's care plans indicated the following: A Care plan focus: I have potential for impaired skin integrity r/t (related to) . (was blank), dated 5/22/24. Interventions included, -Administer treatments as ordered and monitor effectiveness, Monitor for new or worsening s/sx (signs and symptoms) of complications and infection: necrosis, erythema, warmth, edema, exudate, foul odor, maceration, pain/tenderness fever, chills, etc. Report to physician if noted and follow-up as indicated, date initiated 5/22/24. a. During an observation and interview on 11/3/24 at 8:00 A.M., Resident #2's right forearm had multiple scabbed areas the size of pencil erasers and smaller reddened areas. Resident #2 scratched the areas then said it was not itchy. Resident #2 said his/her feet looked worse and proceeded to take off his/her left sock revealing a scaly, red, discolored left lower extremity from the calf down. When asked what was being done about his/her skin, he/she pointed to a bottle of body wash. On 11/04/24 at 8:25 A.M., Resident #2 was observed in his/her room. Resident #2's right forearm was observed with multiple round dark red areas consistent with scabbing and smaller scattered redness on his/her skin. His/her left arm had a smaller amount of reddened areas on his/her forearm. At this time Resident #2's lower extremities were not observed. On 11/4/24 at 11:00 A.M., Resident #2 was observed sitting on the side of his/her bed in the dark with the television on. Resident #2 used his/her left hand to scratch his/her right forearm that had scattered pencil eraser size and smaller reddened areas on his/her forearm. On 11/5/24 at 7:26 A.M., Resident #2 was observed sitting on the side of his/her bed. Resident #2's right forearm had red scabbed areas and a few smaller areas on his/her left arm. Resident #2 pointed to a bottle of body wash and said they use that for his/her skin. Review of Resident #2's medical record indicated the following: -A health status progress note dated 10/29/24 entered by nursing, Note text: Resident noted with rash, bilateral arms, feet, groin, new order to wash areas with soap and water, dry and apply antifungal cream twice daily. -A weekly skin check dated 10/30/24, are there any skin impairments noted? yes, type of skin impairment rash site 1d. groin, 2d. other specify feet, and 3d. other both hands. The weekly skin check did not indicate any areas on Resident #2's forearms or lower extremities. Review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) dated 10/29/24-10/31/24, failed to indicate that the treatment order to wash areas with soap and water, dry and apply antifungal cream twice daily for Resident #2 was implemented. Review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) dated 11/1/24-11/5/24 failed to indicate that the treatment order to wash areas with soap and water, dry and apply antifungal cream twice daily for Resident #2 was implemented. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/6/24 at 7:08 A.M., Nurse #10 said if a Resident is identified with a skin area the DON is notified the NP/MD (nurse practitioner/Medical doctor) is notified and a treatment order is put in place. Nurse #10 said she got in report that Resident #2 has a rash on his/her hands and legs. Nurse #10 reviewed Resident #2's, physician's orders and said there was no order entered for the antifungal treatment and that the treatment order should be there. b. Review of Resident #2's active orders indicated an order dated 10/23/24 skin checks weekly on Wednesdays 3-11. Review of Resident #2's care plans indicated a care plan dated 5/22/24 that indicated I have potential for impaired skin integrity r/t (related to) . was left blank. The care plan failed to indicate the intervention to for weekly skin checks. Review of Resident #2's medical record indicated the following: -PCC skin and Wound-Norton Plus Assessments dated 5/27/24 with a score of 15, and 8/18/24 with a score of 14 indicating Resident #2 is at moderate risk for developing pressure injuries. Further review of Resident #2's medical record indicated the following: -A MAR dated 8/1/2024-8/31/24 failed to indicate an order for weekly skin checks. There was no order data found for a TAR dated 8/2024. -A MAR dated 9/1/2024-9/30/24 failed to indicate an order for weekly skin checks. There was no site administration data for the 9/2024 TAR. -A TAR dated 10/1/24 -1031/2024 indicated an order with a start date 10/23/24, skin checks weekly on Wednesday 3-11 one time a day. Review of the completed weekly skin check V.2019-V4-NE for Resident #2 indicated the following: -A weekly skin check was completed on 5/22/24. No further weekly skin checks were completed for over 6 weeks, until a weekly skin check was completed on 7/1/24. -A weekly skin check was completed 7/1/24. No further weekly skin checks were completed for over 8 weeks, until a weekly skin check was completed on 9/1/24. -A weekly skin check was completed 9/1/24. No further weekly skin checks were completed for over 6 weeks, until a skin check was completed on 10/23/24. During an interview on 11/6/24 at 8:08 A.M., the Director of Nursing said all residents are expected to have weekly skin checks completed with no exception, and documented on the weekly skin evaluation document in the medical record. 12. For Resident #75 the facility failed to implement the physician's order to hold insulin for a blood sugar below 100 and to notify the Medical Doctor/Nurse Practitioner that his/her blood sugar was less than 100, and b.) failed to complete weekly skin checks. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #75 was admitted to the facility in September 2020 and has diagnoses that include Diabetes Mellitus, and type 2 Diabetes Mellitus with diabetic chronic kidney disease. Review of the Minimum Data Set assessment, dated 9/6/24, indicated Resident #75 scored a 12 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having moderately intact cognition and is dependent on staff for care. a.) Review of the facility's policy titled Diabetes-Clinical Protocol, not dated included but was not limited to the following: Treatment/Management 1. Based on preceding assessment, including causes and complications, the Physician will order appropriate interventions, which may include: d. Insulin. Monitoring and Follow-Up 4. The Physician will order desired parameters for monitoring and reporting information related to blood sugar management. a. The staff will incorporate such parameters into the Medication Administration Record (MAR) and care plan. During an observation and interview on 11/3/24 at 8:47 A.M., Resident #75 was observed eating his/her breakfast. He/she said the nursing staff checks his/her blood sugars and that he/she is diabetic. Review of Resident #75's medical record indicated the following: -A care plan dated 9/16/202, I have Diabetes Mellitus, with the intervention Diabetes medication as ordered by the doctor. -A Physician's order NovoLog (a rapid acting insulin) mix 70/30 FlexPen Subcutaneous Suspension Pen-Injector (70-30) 100 unit/ML (insulin Aspart Protamine and Aspart (Human) Inject 15 unit subcutaneously two times a day related to Diabetes Mellitus Due To Underlying Condition With Diabetic Mononeuropathy, Hold if Blood Sugar is less than 100 before meals, notify the MD (medical doctor) if Blood Sugar is less than 100 and monitor, dated 9/5/24. Review of Resident #75's October 2024 MAR indicated the following recorded blood sugars documented at 4:30 P.M. -October 2, 2024, Blood Sugar 94. -October 4, 2024, Blood Sugar 74. -October 6, 2024, Blood Sugar 93. -October 8, 2024, Blood Sugar 83. Further, review of the MAR indicated the Novolog Mix 70/30 FlexPen was signed off as administered on October 2, 2024, October 4, 2024, October 6, 2024, and October 8, 2024, when Resident #75's blood sugar was below 100, resulting in 4 doses of unnecessary Novolog. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress notes in Resident #75's medical record, dated October 2024 failed to indicate any nursing entries that Resident #75's physician or nurse practitioner were notified of the recorded blood sugars below 100, nor were there notes indicating the monitoring of Resident #75, when his/her blood sugar was below 100. During an interview on 11/4/24 at 11:19 A.M., Nurse #7 reviewed the MAR and said on the days when Resident #75's Blood Sugars were documented below 100 the Novolog insulin should not have been administered. During an interview on 11/6/24 at 1:32 P.M., the Director of Nursing said if the orders said to call the doctor when the blood sugar is below 100, then the call should have been made, documented in the medical record, and the Resident should be monitored. b.) Review of Resident #75's physician's orders indicated an order dated 4/8/2024, Skin Check Weekly Mondays, 3-11 one time a day every MON (Monday), Document Findings on PCC evaluations tab: Review of Resident #75's weekly skin checks and interim skin evaluations indicated the following: May 2024, the week of 5/20/24, failed to have a weekly skin check. June 2024, the week of 6/24/24, failed to have a weekly skin check. July 2024, the week of 7/8/24, failed to have a weekly skin check. August 2024, the week of 8/19, failed to have a weekly skin check. September 2024 a weekly skin check was completed on 9/2/24. There were no other weekly skin checks completed. October 2024, one interim skin evaluation dated 10/17/24. There were no other weekly skin checks completed. During an interview on 11/4/24 at 4:00 P.M., Nurse #11 said that all residents have weekly skin checks. Nurse #11 said Resident #75 is at risk for developing impaired skin due to having diabetes and not wanting to get out of bed. Nurse #11 reviewed the medical record and said the last recorded weekly skin check was dated 9/2/24.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to provide supervision during meals for two Residents (#92 and #18) out of a total of 39 sampled residents. Findings include: 1. Resident #92 was admitted to the facility in October 2022 with diagnoses including schizophrenia and repeated falls. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #92 is severely cognitively impaired and requires assistance with transfers and bathing. On 11/3/24 at 8:00 A.M., the surveyor observed Resident #92 eating his/her meal in the dining room. Review of Resident #92's activities of daily living care plan included the following intervention: Eating: I require Supervision with all meals r/t (related to) significant risk of aspiration and I require cues for pacing my oral consumption as I sometimes eat too rapidly and I aspirate/choke on food. Encourage to get out of bed to consume meals in unit dining room, initiated 8/22/2024 On 11/5/24 at 8:07 A.M., the surveyor observed Resident #92 in bed with his/her breakfast meal on the overbed table in front of him/her and a staff person in the room by the window. Resident #92 removed the cover on his/her meal and began eating as the staff person exited the room and closed the door behind her. The surveyor then opened the door and observed Resident #92 eating his/her meal with the door closed and unsupervised. On 11/5/24 at 8:13 A.M. the surveyor observed Resident #92 get out of bed and attempt to carry his/her tray out of the room. The Surveyor alerted Certified Nursing Assistant (CNA) #6 that Resident #92 was attempting to ambulate and carry the tray. CNA #6 said that Resident #92 can eat alone in his/her room and requires set up assistance only. During an interview on 11/5/24 at 9:49 A.M., the Regional Nurse said that Resident #92 should not have been left alone in his/her room while eating breakfast. 41456 2. Resident #18 was admitted to the facility in May 2021 with diagnoses including dysphagia (difficulty swallowing). Review of Resident #18's most recent Minimum Data Set (MDS), dated [DATE], indicated Resident #18 had a Brief Interview for Mental Status (BIMS) score of 7 out of a possible 15, which indicated he/she had severe cognitive impairment. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing note, dated 9/25/24, indicated the following: During supper CNA (Certified Nursing Assistant) called out resident in choking nurse went in found sitting in bed 25(sic) (his/her) mouth full with food, (he/she) started to cough spit all the food out, I raised the HOB (head of bed) to 90 (degree angle) asked (him/her) to get OOB (out of bed) sit in w/c (wheelchair) to eat (he/she) refused, (he/she) said I'm done eating remained in the bed. Review of the speech therapy note, dated 9/30/24, indicated the following: DOR (Director of Therapy) was made aware this date that patient sustained a another reported choking episode on 9/28/24 at approx (approximately) 15:46 PM where NSG (nursing) reported that they provided 1:1 supervision during (his/her) meal this date and noted increased coughing and choking during meals with current food texture not ice cream or liquids. NSG reported that they downgraded the patient for safety to puree texture/ thin consistency Until patient is able to be seen by speech for safety. Patient was seen by SLP (Speech Language Pathologist) this date and patient appears to be tolerating puree texture/thin consistency well with no overt sxs (symptoms) of aspiration. Kitchen was made aware and communication was received. SLP recommendations include: 1.) continue current diet recommendations (puree diet with thin liquids, pills crushed in puree) 2.) upright for PO (by mouth) intake (at EOB (edge of bed), ideally OOB) 3.) reduce rate of intake (go slow!) 4.) reduce bolus size (small bites and sips) 5.) alternate sips of liquid and bites of solids 6.)1:1 supervision (to ensure adherence to above recommendations) Patient to be placed on SLP caseload for further caregiver/patient education and assessment of LRD (least restrictive device) with reduced risk of aspiration. NSG educated this date and call light left within reach. On 11/03/24 at 8:30 A.M., Resident #18 was observed eating breakfast alone in his/her room while lying in bed, while the door to his/her room was closed. The Resident's bed was reclined to a 45-degree angle and the Resident did not have a bed remote allowing him/her to incline the bed if desired. The Resident was observed coughing while eating. On 11/3/24 at approximately 12:15 P.M., Resident #18 was observed eating lunch alone in his/her room while lying in bed. The Resident's privacy curtain was pulled forward and the Resident was not able to be observed from the hallway. On 11/04/24 at 7:59 A.M., Resident #18 was brought his/her breakfast tray by the Certified Nursing Assistant (CNA) who then left and did not stay to supervise the Resident while he/she ate his/her meal. Review of Resident #18's Activity of Daily Living care plan indicated the following intervention: - EATING: I require supervision with all meals (small bites, alternate solids & liquids, NO STRAWS ALLOWED). I require to be upright at 90 degrees for all meals and 10 minutes after meals. Encourage to get OOB for all meals and upright into wheelchair. Please document any refusals, initiated 10/19/24. Review of Resident #18's Kardex (a form indicating all care needs of a resident) indicated the following: -Eating: I require supervision with all meals (small bites, alternate solids and liquids. NO STRAWS ALLOWED). I require to be at 90 degrees for all meals and 30 minutes after meals. Encourage OOB (out of bed) for all meals and upright into wheelchair. Please document any refusal. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing notes from 11/3/24 to 11/4/24 failed to indicate the resident refused to follow the care plan interventions for safe self-feeding. Review of the Speech Therapy evaluation, dated 9/30/24, indicated the following: - Overall Abilities: Min/ Close Supervision - Self-feeding: CTG (contact guard assist) Review of the report titled, Documentation Survey Report for the months of September, October and November 2024 indicated Resident #18 was not always provided supervision during mealtimes since the safe eating intervention was initiated. During an interview on 11/5/24 at 8:31 A.M., Nurse #1 said Resident #18 requires supervision for all meals and has been working with speech therapy. Nurse #1 said Resident #18 refuses to follow recommendations/interventions at times, however, all refusals would be documented. During an interview on 11/5/24 at 10:06 A.M., the Director of Nursing said Resident #18 is an aspiration risk and it would be optimal for him/her to have supervision during all meals. During an interview on 11/7/24 at 9:02 A.M., the Speech Therapist said Resident #18 is an aspiration risk. The Speech Therapist said Resident #18 needs supervision at all meals without exception and staff are not always compliant with this and she needs to constantly remind them of the Resident's risks and interventions.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observations, record reviews and interviews, the facility failed to provide a person-centered activity program for four Residents (#25, #103, #87, and #28) out of a total sample of 39 residents. Finding include: 1. Resident #25 was admitted in June 2023 with diagnoses including bipolar disorder and major depressive disorder. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #25 scored a 12 out of a possible 15 on the Brief Interview of Mental Status (BIMS), indicating moderate cognitive impairment. Review of the MDS indicated that Resident #25 scored a 10 out of a possible 27 points on the Patient Health Questionnaire (PH-Q9), indicating moderate depression. During observations throughout survey, Resident #25 did not get out of bed and was in his/her room in bed. Resident #25 did not have any entertainment materials provided, outside of the television, which was on one time during observation. Review of Resident #25's care plan indicated the following: Focus: I am independent in filling my leisure time as I prefer to spend time alone in my room . (initiated 4/6/23) Goal: I am no longer able to participate in meaningful group activities d/t progress dementia. I am unable to follow directions and am not aware of my surroundings during programs. Visits with Resident #25 are soft hand massages and some conversation (updated 10/31/24) Interventions: - Check on me often to ensure I am content with items provided to me for my self directed independent leisure (initiated 11/2/22) - Encourage me to utilize community areas within the facility to promote socialization (initiated 11/2/22) - Encourage my family to bring in familiar items for home to engage me in leisure activity (initiated 11/2/22) - I can be verbally inappropriate at times. Please offer gentle redirection during these times. (initiated 11/2/22) - I have a personal cell phone that I enjoy independently (initiated 11/2/22) (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Provide me with independent leisure materials. I like to be supplied with magazines, history articles, coloring pages and friendly conversation (initiated 11/2/22) - Provide me with the monthly activity calendar and continue to invite me to activities (initiated 11/2/22) - Remind me I may come an leave an activity at any time I please and I do not have to stay for the duration of the program (initiated 11/2/22) - Some of my preferred activities are talking with peers, outside socials, parties, food events, music programs and relaxing in the comfort of my own room watching TV or movies. (initiated 11/2/22) During an interview on 11/7/24 at 8:43 A.M., the Activities Director said that Resident #25 likes room visits, but sometimes refuses those. The Activities Director said that if there is refusal of room visits, then that should be documented in the record. The Activities Director said Resident #25 only likes to talk and does not like crosswords or magazines like his/her care plan says. The Activities Director said Resident #25's care plan should have been updated after 2022. Review of the activity log sheets for November 2024 indicated Resident #25 did not receive room visits for November. Review of the activity log sheets for October 2024 indicated Resident #25 did not receive any room visits for October and was unavailable on October 27th and 28th. Review of the activity log sheets for September 2024 indicated Resident #25 did not receive any room visits for September. 41456 2. Resident #103 was admitted in January 2024 with diagnoses including dysphagia. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #103 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. During an interview on 11/03/24 at 8:04 A.M., Resident #103 said he/she loves listening to music and would love a radio in his/her room. Resident #103 said he/she chooses not get out of bed, so does not join group activities, and a radio would be a blessing and a radio would be so nice to help pass the time. Throughout the survey, Resident #103 was never seen out of bed and was observed lying in bed, without the light to his/her room on, without television on and without a radio. There were no independent activities materials observed in his/her room. Review of Resident #103's activity care plan indicated the following interventions: -Provide resident with independent leisure materials. Resident wants to be supplied with reading materials and an occasional visit to talk about my past rolls and family. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #103's last quarterly activity assessment dated [DATE], indicated the following: -I am independent/dependent in fulfill my activity pursuits. I enjoy being out in the neighborhood with my peers. I will join programs of special events, entertainment. I will choose which programs to join -I enjoy being with staff and peers. Review of Resident #103's medical record failed to indicate an updated activity assessment with Resident #103's choice to stay in bed. Review of Resident #103's Kardex (a form indicating the level of care each resident requires) failed to indicate any activity information. Review of the Documentation Survey Report, a report that shows participation in activities, indicated the following: - Out of 30 days in September 2024, Resident #103 had only 4 room visits and one-on-one activities. -Out of 31 days in October 2024, Resident #103 had only 4 room visits and 6 one-on-one activities. During an interview on 11/7/24 at 8:29 A.M., the Activities Director said the activities calendar is made to the Residents' preferences. The Activities Director said the activity staff should be going room to room each morning to pass out materials and to inform the residents what the activities are for the day. She said there are both group activities on the floor and room visits offered daily. The Activities Director said the staff should be documenting all participation of activities and one-to-one room visits. The Activities Director said residents often refuse activities, and this should also be documented. The Activities Director said Resident #103 only enjoys room visits and enjoys watching television. The Activities Director was unaware Resident #103 liked to listen to music and would like a radio in his/her room. She said she was unaware Resident #103 did not have his/her television on throughout survey and was unaware he/she had so few room visits. 3. Resident #87 was admitted to the facility in April 2023 with diagnoses including heart failure. Review of Resident #87's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, which indicated he/she was cognitively intact. During an interview on 11/3/24 at 8:10 A.M., Resident #87 said there were not a lot of activities, except for Bingo, at the facility and that he/she is extremely bored in the facility. Resident #87 had no independent activity materials in his/her room for independent leisure. Throughout survey, Resident #87 was not observed in any group activities and was not observed to have any one-on-one activity visits. Review of Resident #87's activity care plan indicated the following interventions: -Modify my daily schedule, treatment plan PRN (as needed) to accommodate activity participation. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility. Review of Resident #87's last quarterly activity assessment dated [DATE], indicated the following: -I am independent/dependent in my activity pursuits. Staff will invite me to programs of my choosing. My pursuits are bingo, entertainment and special events, going outside. -I enjoy being out in the neighborhood and chatting with staff and my peers. I enjoy hanging out with the men in my neighborhood. Review of Resident #87's Kardex (a form indicating the level of care each resident requires) indicated: -Ensure appropriate visual aids are available to support my participation in activities. I wear glasses for distance and reading. -Modify my daily schedule, treatment plan PRN (as needed) to accommodate activity participation. Review of the Documentation Survey Report, a report that shows participation in activities, indicated the following: - Out of 30 days in September 2024, Resident #87 had only 3 one-on-one activity visits, participated in Bingo 7 times, and participated in other activities only 12 times. -Out of 31 days in October 2024, Resident #87 had only 8 one-on-one activity visits, participated in Bingo 7 times, and participated in other activities only 11 times. During an interview on 11/7/24 at 8:29 A.M., the Activities Director said the activities calendar is made to the Residents' preferences. The Activities Director said the activity staff should be going room to room each morning to pass out materials and to inform the residents what the activities are for the day. She said there are both group activities on the floor and room visits offered daily. The Activities Director said the staff should be documenting all participation of activities and one-to-one room visits. The Activities Director said residents often refuse activities, and this should also be documented. The Activities Director said Resident #87 likes to play Bingo, likes room visits and likes to sit in the hallway to converse with other residents. She was unable to list any other activities that the Resident prefers to participate in and was unaware Resident #87 often felt bored and had not been observed in any activities during the survey period. 4. Resident #28 was admitted to the facility in September 2020 with diagnoses including chronic obstructive pulmonary disease and paranoid schizophrenia. Review of Resident #28's most recent Minimum Data Set (MDS) dated [DATE] indicated he/she had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 which indicated he/she was cognitively intact. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/3/24 at 8:37 A.M., Resident #28 said there were not a lot of activities, except for Bingo, at the facility and that he/she is often bored. Resident #28 had minimal materials in his/her room for independent leisure. Throughout survey, Resident #28 was not observed in any group activities and was not observed to have any one-on-one activity visits. Review of Resident #28's activity care plan indicated the following interventions: -I enjoy live entertainment, invite me and remind me of these type of events. -I enjoy playing pool, art and painting, music and outside socials. -Remind me of the importance of remaining social and provide opportunities for me to socialize with others that have similar interests. -Check with me often to assess needs for independent materials and satisfaction with provided supplies. Review of Resident #28's cognition care plan indicated the following intervention: -Provide a program of activities that accommodate my abilities. I benefit from encouragement to attend activities and require getting assist getting to activities on/off unit. Review of Resident #28's quarterly activity assessment dated [DATE], indicated the following: -I enjoy watching TV, not very social but will occasionally chat with the men and staff in the neighborhood. Entertainment, gatherings, and special events are my choices of my choice. Review of Resident #28's Kardex (a form indicating the level of care each resident requires) indicated: -Psychosocial well-being: Provide a program of activities that accommodate my abilities. I benefit from encouragement to attend activities and require getting assist getting to activities on/off unit. Review of the Documentation Survey Report, a report that shows participation in activities, indicated the following: - Out of 30 days in September 2024, Resident #28 had only 3 one-on-one activity visits, participated in Bingo 8 times, and participated in other activities only 7 times. -Out of 31 days in October 2024, Resident #28 had only 6 one-on-one activity visits, participated in Bingo 8 times, and participated in other activities only on 11 days. -There were no refusals to participate documented. (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/7/24 at 8:29 A.M., the Activities Director said the activities calendar is made to the Residents' preferences. The Activities Director said the activity staff should be going room to room each morning to pass out materials and to inform the residents what the activities are for the day. She said there are both group activities on the floor and room visits offered daily. The Activities Director said the staff should be documenting all participation of activities and one-to-one room visits. The Activities Director said residents often refuse activities, and this should also be documented. The Activities Director said Resident #28 likes to sit in the hallway and converse with other residents and could not list any other activities that the Resident prefers to participate in. The Activities Director was unaware Resident #28 often felt bored and had not been observed in any activities during the survey period.		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observation, record review, and interview, the facility failed to ensure treatment and care in accordance with professional standards for 4 Residents (#323, #24, #70, and #2) out of a total sample of 39 residents. Specifically; 1. For Resident #323, the facility failed to follow up on abnormal labs that were drawn for a Resident with a known history of Chronic Kidney Disease, resulting in a subsequent panel of critically high labs, which required emergency hospitalization and resulted in death. 2. For Resident #24, the facility failed to ensure that a significant change in condition was monitored, assessed and reported timely to the physician for one resident who exhibited coffee ground emesis and continuous stooling of black liquid feces. 3. For Resident #70, the facility failed to obtain a physician's order for a wound dressing that was in place. 4. For Resident #2, the facility failed to implement orders for a known rash and failed to monitor his/her skin for further condition change, resulting in unidentified red, scaly, open wound on his/her left lower leg, requiring treatment for cellulitis and wound dressing two times a day. Findings include: 1. Review of the facility policy titled Lab and Diagnostic Test Results- Clinical Protocol, revised November 2018, indicates the following: - A physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. - The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. - When test results are reported to the facility, a nurse will first review the results. - If staff who receive or review lab and diagnostic test results cannot follow the remainder of the procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow or coordinate the procedure. - A nurse will identify the urgency of communicating with the attending physician based on physician request, the seriousness of any abnormality, and the individual's current condition. - Nursing will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results: * Whether the physician has requested to be notified soon as a result is received. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* Whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors) * Whether the resident/patient's clinical status is unclear or he/she has signs and symptoms of acute illness or condition change and is not stable or improving, or there are no previous results for comparison. - High or toxic serum medication levels. If a test was obtained to monitor the blood level of a medication and the level is reported as high (above therapeutic range) or toxic, the nurse will notify the physician promptly and will not give the next dose until the situation has been reviewed with the physician. - Time frames. A physician will respond within an appropriate time frame, based on the request from nursing staff and the clinical significance of the information. * A physician should respond within one hour regarding a lab test result requiring immediate notification, and by the end of the next office day to a non-emergency message regarding non-immediate lab test notification with a request for response. * If the attending or covering physician does not respond to immediate notification within an hour, the nursing staff should contact the medical director for assistance. Resident #323 was admitted in June 2024 with diagnoses including dementia and chronic kidney disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #323 could not participate in the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. The MDS also indicated Resident #323 required supervision to assistance with meals, supervision with touching assistance for standing, and supervision with touching assistance with walking. Review of Resident #323's advanced directive care plan indicated Resident #323 was not capable of making his/her informed consent regarding his/her health care decisions. Review of the hospital admission paperwork for Resident #323, dated 6/7/24, indicated Resident #323 was admitted to the hospital with a Covid infection and family inability to care for him/her at home. Review of the lab results on the hospital admission paperwork, dated 6/7/24, indicated Resident #323 had the following lab results: -BUN: 31 -Creatinine: 1.87 -Glomerular Filtration Rate: 37 (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	(Blood urea nitrogen is a measure of nitrogen in the blood and is a measure of kidney function. The normal ranges for BUN are 6-24 milligrams per deciliter. Creatinine is a lab used to measure kidney function. The normal ranges for creatinine is 0.7-1.3 milligrams per deciliter. GFR is a lab used to measure the filtration rate of the kidneys. The normal range for GFR is 90-120 milliliters per minute.) Review of the progress notes, since admission, indicated Resident #323 had been experiencing agitation, intrusiveness, and yelling out. On 8/14/24, a urine culture was obtained. Review of the medical record failed to indicate why a urine culture was obtained for Resident #323. Review of the lab results, dated 8/14/24, indicated the following: - Culture 10,000-50,000 CFU/mL (colony forming units per milliliter) mixed urogenital flora, probable contamination (mixed bacteria in the urine with possible contamination) Review of the progress note, dated 8/16/24, indicated the facility attempted to obtain a urine sample via a straight catheter (a device used to obtain a urine sample), but Resident #323 refused and yelled get out, get out!. Review of the record failed to indicate if a urine sample or lab was ever obtained after 8/14/24 or any follow up documentation from the Nurse Practitioner or Physician. Review of the progress note, dated 8/24/24, indicated Resident #323 had a Basic Metabolic Panel (BMP) lab completed and resulted in abnormal lab values, specifically, a blood urea nitrogen (BUN) of 80, creatinine of 2.70, and a glomerular filtration rate (GFR) of 23. The note indicated that the Director of Nursing was made aware, and the Nurse Practitioner was contacted. Review of the Nurse Practitioner monthly progress note, dated 8/25/24, the day after the abnormal labs were obtained, indicated the following: - No acute concerns from nursing. - Labs and image results: All labs reviewed and found to be negative. - #CKD (chronic kidney disease): Encourage po fluids, monitor renal, monitor retention Review the record failed to indicate that any further review or action of the abnormal labs took place. Review of the progress note, dated 9/20/24, indicated Resident #323 was transferred to the hospital with critically high labs with a diagnosis of shock, acute kidney failure, and hyperkalemia (high potassium levels). Review of the hospital summary, dated 9/19/24, indicated the following: (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- He/she was found to be acidotic with PH of 7.19. He/she has hypernatremia (high sodium), hyperkalemia (high potassium), acute kidney injury, acute NSTEMI (mild heart attack), sepsis (blood infection) likely due to acute cystitis (infection of the bladder from bacteria). During an interview on 11/5/24 at 8:30 A.M., the Nurse Practitioner said she doesn't remember the Resident, but if there are abnormal labs drawn that are different from the resident's baseline, then he/she should have been sent to the hospital. The Nurse Practitioner said she would have expected to be notified if the facility could not obtain a urine sample via a straight catheter. The Nurse Practitioner could not recall if she had been notified. The Nurse Practitioner said that if a family member refuses any treatment, then that should be documented. Review of the record failed to indicate the healthcare proxy was made aware or refused any treatment. During an interview on 11/5/24 at 8:37 A.M., Physician #1 said that if a resident has a suspected urinary tract infection (UTI) then the resident should be treated with antibiotics as a precaution. Physician #1 said if labs come back abnormal, most of the time the Nurse Practitioner will address the labs and make the decision with what to do with the Resident. Physician #1 said if he was notified of the labs, he would have sent the Resident to the hospital or hydrated with intravenous fluids because his/her labs reflected dehydration. During an interview on 11/5/24 at 10:47 A.M., the Director of Nursing said she doesn't remember that far back, but that the facility obtained Resident #323's urine for testing because of the daughter's request. The Director of Nursing said the urine came back inconclusive and the facility attempted to straight cath (use a straight catheter to obtain a urine sample) but were unsuccessful and notified the Nurse Practitioner. The Director of Nursing could not remember why additional BMP (basal metabolic panel) labs were done, but if labs are abnormal then staff should notify the Nurse Practitioner. During an interview on 11/4/24 at 1:32 P.M., Resident #323's health care proxy said the family did not feel heard by the facility and feel that Resident #323's death could have been prevented. The health care proxy said that his/her death certificate said the cause of death was sepsis, but also felt the facility was overmedicating Resident #323. The healthcare proxy said she notified the facility to be careful with medication because of the Resident's Chronic Kidney Disease. The healthcare proxy said she felt the Resident was severely neglected. 49880 2. Review of facility policy titled Change in a Resident's Condition or Status, undated, indicated the following: - Our facility promptly notifies the resident, his or her attending physician and the resident representative of changes in the resident's medical/ mental condition and or status (e.g. changes in level of care, billing/ payments, resident rights etc.) - 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the SBAR (situation, background, assessment, recommendation) Communication Form. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/ mental condition or status. Resident #24 was admitted to the facility in December 2014 with diagnoses that include partial intestinal obstruction, muscle weakness, gastrointestinal hemorrhage, and iron deficiency anemia. Review of Resident #24's Minimum Data Set (MDS) assessment, dated 8/19/24, indicated a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating that the Resident has moderate cognitive impairment. The MDS further indicated that the resident has medically complex conditions with a primary diagnosis of partial intestinal obstruction. On 11/4/24 at 8:36 A.M., a surveyor overheard Nurse #3 say thank you to Nurse #4 for sending out Resident #24. During an interview on 11/4/24 at 8:45 A.M., Nurse #3 said that she arrived at the facility around 7:20 A.M. and was told in report that the Resident had coffee ground emesis (vomiting) during the night. She said she went right into the Resident when she got there, and he/she said they wanted to go to the hospital. At this time the ambulance company was picking up the Resident for transport to the hospital. Nurse #3 said that the Resident looks bad right now and said he/she looks pale and grey, and that the Resident also looked like that at 7:20 A.M., when she saw him/her. During an interview and observation on 11/4/24 at 8:48 A.M., a surveyor observed Resident #24 with black vomit on him/her. Resident #24 said that he/she knew what was happening was bad and that he/she wanted to go to the hospital and did not refuse to go. Review of a progress note written 11/4/24 at 8:52 A.M., indicated, at 1 AM Patient started vomiting, I informed NP [#2], and she gave order to do lab. CBC with diff and BMP. Patient refused to go to the hospital at this point. He/she said I want to wait. Around 6 AM, patient started vomiting again and I notified NP [#3], and she said send patient to hospital. Vital signs were bp [blood pressure] 107/77, pulse 66, O2 [oxygen saturation] 96%, temp [temperature] 98, resp [respirations] 18. HCP (health care proxy) was called and left a message. Review of the Patient Care Report for Resident #24 from the Ambulance service dated 11/4/24 indicated that dispatched received the call from the facility for transfer to the hospital at 8:01 A.M. on 11/4/24. The Patient Care Report indicated that the chief complaint was general illness- GI bleed for 7 hours with a primary symptom of abdominal distension. The Patient care report further indicated that the ambulance was dispatched to the facility for a patient with incontractible vomiting. (sic) The BLS (basic life support) crew arrived at the patient at 8:39 A.M. and patient found lying supine in assigned bed with head elevated and several towels draped over him/her, coffee ground emesis noted on towel .Skin is pale, warm and dry. Significant distension noted on initial impression. The report further indicated, Nursing staff reported coffee ground emesis began at 1:00 A.M. that morning with 3 episodes . No vitals or assessments taken to provide EMS (emergency medical service) staff. Vital signs revealed hypotension with a blood pressure of 80/60 and weakened radial pulses. BLS crew called dispatch at 8:44 A.M. for ALS (advanced life support) secondary to hypotension and likely GI (gastrointestinal) bleed. In route to the hospital at 8:55 A.M. vital signs included a blood pressure of 70 systolically and a weak pulse of 180 beats per minute. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #24's active risk for constipation care plan, dated 12/8/2014 indicated the following interventions: - Monitor/ document/ report to MD (Medical Doctor) PRN (as needed) s/sx (signs and symptoms) of complications related to constipation: Change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, bradycardia (slow, low pulse) abdominal distension, vomiting, small loose stools, fecal smearing, bowel sounds, diaphoresis, abdomen: tenderness, guarding, rigidity, fecal compaction. - I have constipation related to decreased mobility, Hx (history) of bowel obstruction, dated 2/26/24. Further review of the nursing progress note written on 11/4/24 failed to indicate a comprehensive GI (gastrointestinal) assessment or abdominal assessment. Review of the Electronic Medical Record (EMR) for Resident #24 indicated special instructions as follows: -Please document on every shift on GI (Gastrointestinal) status- appearance: distended, tenderness, flatus, BMs (bowel movements) and size, N/V (nausea and vomiting), GS/ bloating; anything clinically pertinent; behaviors- refusal of care; GU (genitourinary)- signs or symptoms of UTIs (urinary tract infections); always add effects of any PRN (as needed) medications administered during shift. Review of the medical record failed to indicate documentation regarding the resident's GI status over the last month. Review of Resident #24's progress notes indicated a note dated 11/3/24 at 4:56 P.M. which indicated that the Resident was awake and alert, able to make needs know. During an interview on 11/5/24 at 12:08 P.M., CNA #9 said that on 11/3/24 she worked the 3:00 P.M. to 11:00 P.M. shift and took care of Resident #24. She said that he/she was their usual self, ate dinner, and had no issues. She said he/she had no vomiting on her shift. During an interview on 11/4/24 at 8:42 A.M., Nurse #4 said to the surveyors that Resident #24 started vomiting on her shift, around 1:00 A.M., but at first the Resident did not want to go to the hospital. She said she called the Nurse Practitioner (NP), and she ordered labs and Zofran (a medication to treat nausea). When asked about the Resident's history, Nurse #4 said that he/she does have a history of a bowel obstruction as well as a recent fall on 11/1/24. Nurse #4 said that she did not provide a full report of Resident #24's medical history to the Nurse Practitioner that she spoke to at 1:00 A.M., and only gave report on the current situation, that the Resident was vomiting. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a follow up interview on 11/4/24 at 9:21 A.M., Nurse #4 said Resident #24 started vomiting between 1:00 A.M., and 2:00 A.M. and then again around 6:00 A.M. Nurse #4 said she called the covering practitioner again around 6:00 A.M. and was ordered to send the Resident out to the emergency room . Nurse #4 said Resident #24 was not agreeable to go to the hospital earlier in the morning, however said at this time the Resident agreed to be sent out. Nurse #4 said that she called for transport between 6:00 and 7:00 A.M. and was told that it would be about one to two hours before transport could be there. She said that the facility can call 911 for transfers but she felt like the Resident was stable and his/her vitals were stable. During a follow up interview on 11/4/24 at 9:24 A.M., Nurse #3 said she did not call for the transport of Resident #24 to the hospital for evaluation but if she knew it was going to be one to two hours for the transport, she would have called 911 for a more emergent transfer. During a phone interview on 11/6/24 at 9:00 A.M. the surveyor spoke to Nurse Practitioner (NP) #1 who returned a phone call regarding when phone calls were placed into the call service to report the change in condition on Resident #24. NP #1 said that she was not the one that responded to the call, but the service got one call at 1:13 A.M. with a message stating the Resident was vomiting a lot. She said this is the only call that came into the service on the 11:00 P.M. to 7:00 A.M. shift. During an interview on 11/6/24 at 9:42 A.M., Nurse Practitioner (NP)#2 said she was the covering NP for the night of 11/3/24 into 11/4/24 and the only page she got from the facility for this Resident was at 1:13 A.M. and said she called the facility right away. NP #2 said the report she was given was that the Resident's vitals were stable, and the Resident had a lot of vomiting. The NP said it was never reported to her that he/she had coffee ground emesis or multiple loose dark stools. The NP said she was never given a report of the Resident's history or that the Resident had a recent unwitnessed fall. The NP said she would have sent him/her out right away if she was given an accurate report of Resident #24's status and his/her history. During an interview on 11/4/24 at 9:40 A.M., Nurse Practitioner (NP) #3 said that she was paged to call the facility around 7:56 A.M. and said that she called back right around 8:00 A.M. NP #3 said that with Resident #24's history she would have sent him out overnight but was not sure what the initial report was that was given to the covering NP. NP #3 said that if the nurse was given an estimated time of arrival of one to two hours, then 911 should have been called as this was a change in condition. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a follow up interview on 11/6/24 at 7:45 A.M., Nurse #4 said that on the night before Resident #24 was sent out it was around 1:00 A.M. that the Resident began vomiting. She said that it was coffee ground. She said that as soon as she could, she called the NP. She said that she told the NP the Resident was vomiting but could not remember if she told her that it was coffee ground. She said she did not tell the NP about the history of obstructions or GI bleeding. Nurse #4 said she only discussed the current situation. She said that the NP ordered labs and Zofran for nausea. Nurse #4 said that she gave the Resident a dose of Zofran and that he/she slept until vomiting began again around 6:00 A.M. Nurse #4 said she called the NP again at this time and an order was given to send the Resident to the hospital. Nurse #4 said the Resident agreed to go to the hospital. Nurse #4 said that she called the ambulance company and was told it would be a one to two hour wait for the transport. Nurse #4 said the Resident's vital signs were stable, so she was ok with the one to two hours wait. Nurse #4 said nurses can use their judgement and call 911 for an emergent transfer but she did not think it was necessary and said the Resident was stable. Nurse #4 said that coffee ground emesis is a change in condition and could indicate GI bleeding. During a phone interview on 11/6/24 at 8:33 A.M. Certified Nurses Aid (CNA) #7 said that she worked over night on 11/3/24 into 11/4/24. CNA #7 said that Resident #24 was moving his/her bowels and vomiting all night long and that both the vomit and stool was liquid and black. CNA #7 said that she provided incontinence care at least five times over night for liquid black stools and that the vomiting was continuous all night and did not stop. CNA #7 said she told the nurse. CNA #7 said that after the first time Resident #24 vomited he/she did not want to go to the hospital but that at around 3:00 A.M., Resident #24 said that he/she wanted to go to the hospital and after getting the Resident cleaned and changed again at that time, she told the nurse (Nurse #4) that the Resident wanted to go to the hospital. CNA #7 said that when her shift ended, and she left the facility around 7:15 A.M. and Resident #24 was still at the facility. During an interview on 11/6/24 at 1:13 P.M., Physician #2 said that Resident #24 has a significant history of bowel obstructions and in the past has declined surgical interventions. Physician #2 said that there is a process issue in the facility in terms of communication with covering providers and ensuring that a full and accurate report is provided to the NP or covering providers on call. During an interview on 11/6/24 at 1:30 P.M. the Director of Nursing (DON) said that she didn't think it was necessary to provide a history about Resident #24's previous bowel obstructions because the Resident having coffee ground emesis was not an emergent situation. She said she would not have called the covering again at any point during the shift and wouldn't call again until the Resident was ready to go to the hospital. She said one policy regarding change in condition or transfers does not fit all, if it was something critical, she would have called again, but she said she did not take this as a critical situation. She said she talked to Nurse #4 who worked over night and that the Resident had only vomited 3 times. She said however, she had not spoken to CNA #7, who reported to the surveyor ongoing black vomiting and black stooling throughout the night. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #24's discharge summary from the hospital, dated 11/4/24 at 4:39 P.M., indicated a diagnosis of bowel obstruction and a reason for admission of Abdominal pain, with bowel obstruction and 1600-2000 milliliters (ml) of fecal material suctioned from NGT (nasogastric tube, a thin flexible tube that is passed through the nose and down through the esophagus into the stomach. It can be used to either remove substances from or add them to the stomach.) The discharge summary further indicated that Resident #24 had prior admissions for bowel obstructions including in May 2023, February 2024, May 2024, June 2024 and November 2024. Further, the report indicated that Resident #24 presented to the emergency department from his extended care facility with coffee ground emesis x3 and a report of some dark bowel movements. Resident #24's main complaint was abdominal discomfort, and his/her blood pressure was in the 70's according to the prehospital personnel. The discharge summary also indicated Patient underwent central line insertion for severe hypotension with Afib (atrial fibrillation- an irregular and often very rapid heart rhythm) with RVR (rapid ventricular rate) and on dilt drip (Diltiazem - a medicated intravenous solution used in adults to treat certain heart rhythm disorders such as atrial fibrillation or dangerously rapid heartbeats) with still uncontrolled heart rate and hypotension status post several liters of IV [intravenous] fluid resuscitation, in the setting of AKI (acute kidney injury) with possible pulmonary edema as well. He/she had a nasogastric tube inserted with approximately 2 liters of feculent material suctioned out immediately. CT (cat scan) of the abdomen and pelvis shows markedly distended stomach and proximal duodenum with markedly dilated loops of bowel and air-fluid levels, markedly dilated rectosigmoid. After lengthy conversation with patient and nursing at the bedside patient seems for comfort measures at end of life. He/she was requesting narcotics for abdominal discomfort . Patient was cognizant and fully intact to make this decision. Review of Physical exam indicates an abdominal assessment with hypoactive/ absent bowel sounds, markedly distended abdomen, tenderness to palpation. Review of Nursing progress notes indicated the following: - A progress note dated 11/5/24 at 1:27 A.M., indicating, Patient came back from hospital on a 3-11p shift, earlier this nurse took report from the ED [emergency department] nurse stating that, ' Patient had a bowel obstruction', this nurse asked the ED Nurse if patient had any surgeries to correct the obstruction, she said No, patient is coming back to the facility for comfort care admitted to Hospice. however, it is not stated in the Hospital visit, paperwork. Will F/u [follow up] with facility MD. Review of the medical record failed to indicate a comprehensive assessment was completed on Resident #24 when he/she arrived back at the facility with a diagnosis of bowel obstruction. Review of the nursing progress note dated 11/5/24 at 12:03 P.M., indicated the following: - At approximately 8:28 A.M., the resident was noted to be unresponsive. Resident did not respond to verbal or physical stimuli. There was no palpable pulse or visual chest rise/fall and no audible breath sounds. Time of death 8:29 A.M. Health care proxy notified, and body released to funeral home at 10:30 A.M. 3. Review of the facility policy titled Wound Care, dated as revised October 2010 indicated the following: -The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-1. Verify that there is a physician's order for this procedure. #70 was admitted to the facility in August 2021 with diagnoses that include type 2 diabetes mellitus with diabetic neuropathy and acquired absence of other left toe(s) Review of Resident #70's most recent Minimum Data Set (MDS) Assessment, dated 8/21/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that Resident #70 is cognitively intact. The MDS further indicated intact skin. During the survey the surveyor made the following observations: -On 11/3/24 at 7:39 A.M. and 11:45 A.M., Resident #70 was observed in bed, an undated dressing was observed over the left foot with staining on the dressing. At 11:45 A.M., the Resident said that she had asked for the dressing to be placed about a week ago to cover an open skin area and it has not been changed since. -On 11/4/24 at 7:58 A.M. and 11:09 A.M., Resident #70 was observed in bed with the same undated and stained dressing covering his/her left foot. -On 11/5/24 at 7:10 A.M. and 12:12 P.M. Resident #70 was observed in bed with the same undated and stained dressing covering his/her left foot. Review of Resident #70's physician's orders failed to indicate an order for a dressing change to the left foot. Review of Resident #70's most recent weekly skin check which was completed 10/4/24 indicated no skin issues noted. Review of Resident #70's progress notes failed to indicate when the dressing was applied to the left foot and why. Review of Resident #70's physician's orders indicated the following orders: -Skin Checks weekly on Monday 3-11 one time a day every Mon, 8/9/2021. -Skin Checks weekly on Tuesday 3-11 every evening shift every Tue, 4/30/2024. During an interview on 11/4/24 at 11:19 A.M., Nurse #3 said that there should be a physician's order to put a dressing on a resident. During a follow up interview and observation on 11/5/24 at 12:46 P.M., the surveyor and Nurse #3 observed Resident #70's foot and dressing. Nurse #3 said she did not know there was a dressing on Resident #70's foot. Nurse #3 said there was no order for this dressing in the medical record. Nurse #3 removed the dressing and Resident #70 said the dry scabbed area was much bigger than it was when the dressing was placed. Nurse #3 said there should have been a physician's order to apply the dressing initially and monitor the area but there was not. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/6/24 at 9:31 A.M., the Director of Nurses said that there should be a physician's order to apply and monitor a dressing on a resident. 36431 4. For Resident #2, the facility failed to implement orders for a known rash and failed to monitor his/her skin for further condition change, resulting in unidentified red, scaly, open wound on his/her left lower leg, requiring treatment for cellulitis and wound dressing two times a day. Resident #2 was admitted to the facility in May 2024 and has diagnoses that include chronic obstructive pulmonary disease, weakness, ventricular fibrillation, peripheral vascular disease and unspecified dementia. Review of the Minimum Data Set (MDS) assessment, dated 8/21/24, indicated Resident #2 scored a 6 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having severe cognitive impairment. The MDS further indicated that the Resident requires partial to moderate assistance from staff for toileting, and bathing. During an observation and interview on 11/3/24 at 8:00 A.M., Resident #2's right forearm had multiple scabbed areas the size of pencil erasers and smaller reddened areas. Resident #2 said his/her feet looked worse and proceeded to take off his/her left sock revealing a scaly, red, discolored left lower extremity from the calf down. Review of Resident #2's care plans indicated the following: A care plan focus: I have potential for impaired skin integrity r/t (related to) . was blank, dated 5/22/24. Interventions included, Administer treatments as ordered and monitor effectiveness, Monitor for new or worsening s/sx (signs and symptoms) of complications and infection: necrosis, erythema, warmth, edema, exudate, foul odor, maceration, pain/tenderness fever, chills, etc. Report to physician if noted and follow-up as indicated, date initiated 5/22/24. Review of Resident #2's physician's order failed to indicate any treatment or monitoring of the Resident's lower extremity for possible worsening conditions. Review of Resident #2's medical record indicated the following: -A health status progress note dated 10/29/24 entered by nursing, Note text: Resident noted with rash, bilateral arms, feet, groin, new order to wash areas with soap and water, dry and apply antifungal cream twice daily. -A weekly skin check dated 10/30/24, are there any skin impairments noted? yes, type of skin impairment rash site 1d. groin, 2d. other specify feet, and 3d. other both hands. The weekly skin check did not indicate any areas on Resident #2's lower left leg. -The skin check dated 11/6/24 was incomplete and not signed off on the Treatment Administration Record. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) dated 10/29/24 through 10/31/24 failed to indicate that the treatment order to wash areas with soap and water, dry and apply antifungal cream twice daily for Resident #2 were implemented. Review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) dated 11/1/24 through 11/5/24 failed to indicate that the treatment order to wash areas with soap and water, dry and apply antifung[TRUNCATED]		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to ensure staff identified and implemented interventions related to pressure ulcers for three Residents (#48, #110, and #323), out of a total of 39 sampled Residents. Specifically, 1. For Resident #48, the facility failed to identify a deep tissue injury (DTI) upon admission and implement interventions. Additionally, the facility failed to initiate treatments recommended by the Wound Physician timely. 2. For Resident #110, the facility failed to implement a treatment for a pressure wound timely. 3. For Resident #323, the facility failed to implement treatment for a wound timely. Findings include: Review of the Prevention of Pressure Injuries, dated 2001, indicated: Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Risk Assessment: Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. Use a standardized pressure injury screening tools to determine and document risk factors. Supplement the use of a risk assessment tool with assessment of additional risk factors. Prevention: Use a barrier product to protect skin from moisture. Mobility/repositioning: Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary team. Monitoring: Evaluate, report and document potential changes in skin. Review the interventions and strategies for effectiveness on an ongoing basis. Review the interventions and strategies for effectiveness on an ongoing basis. 1. Resident #48 was admitted to the facility in May 2024 with diagnoses including cerebral infarction, dysphagia, and contractures of the lower extremity. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated he/she is severely cognitively impaired evidence by a score of six out of a possible 15 on the Brief Interview for Mental Status exam. On 11/4/24 at 7:27 A.M., the surveyor observed Resident #48 resting on an air mattress (a specialty mattress utilized to reduce pressure on the body). Due to his/her cognition, Resident #48 was unable to engage in the interview process. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/4/24 at 7:21 A.M., Certified Nursing Aide #1 said that Resident #48 has wounds and requires two staff to reposition him/her in bed. Review of Resident #48's Hospital discharge paperwork dated 5/10/24 indicated that Resident #48 developed DTPI (deep tissue pressure injury) on the right heel during his/her hospitalization . The paperwork indicated: Wound bed site assessment: (pink;purple) Structure exposed: None Peri-Wound assessment: Fragile; intact. Cover dressings: Bordered foam. Dressing complexity: Routine. Dressing status: Clean, dry, intact. The discharge forms did not provide instructions related to monitoring or care for Resident #48's DTI. Review of the Nurse Progress note 5/10/24: Skin clean dry and intact. Right heel large black discoloration covering most of the heel. covered with protective dressing. There were no measurements or further description of the DTI or evidence that the physician was notified. Review of the MDS dated [DATE] indicated Resident #48 had no areas of skin breakdown and was not at risk for the development of pressure injuries. Review of Resident #48's physicians orders for May 2024 failed to indicate any treatments or interventions related to his/her DTI. Review of the Nursing Admission Evaluation dated 5/10/24 failed to include an assessment of Resident #48's skin or an assessment of Resident #48's risk of skin breakdown. Review of Resident #48's skin care plan effective 5/10/24 through 7/30/24 indicated: Focus: I have skin breakdown and/or potential for skin breakdown, Initiated: 5/10/2024 Interventions: Document skin checks weekly and PRN (as needed). Notify the physician and resident/RP of new areas if observed. Follow-up as indicated. I need moisturizer applied to my skin as needed. Do not massage over bony prominences. I need reminding/assistance to turn/reposition at least every two hours, more often as needed or requested. The care plan failed to identify and include interventions related to Resident #48's DTI on his/her heel. Review of Resident #48's skin checks indicated no skin check was completed on 5/12/24. The skin check completed 5/21/24 indicated that Resident had no open areas and failed to indicate Resident #48's right heel DTI. Review of the nurse progress note dated 5/27/2024 (17 days after Resident #48's DTI was first documented upon admission): Pressure injury observed to right heel, measures approximately 3"x 3". DON (Director of Nursing) and on call NP (Nurse Practitioner) notified. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Wound Physician's note dated 5/28/24 indicated: Unstageable (due to necrosis) of the right heel full thickness. Etiology: Pressure. Wound Size: 10 CM X 8 CM X Not measurable due to presence of non-viable tissue and necrosis (dead tissue). Exudate (drainage): light serous. Thick adherent devitalized necrotic tissue: 100%. Dressing treatment plan: Betadine apply once daily for 30 days: ABD pad apply once daily for 30 days, gauze roll apply once daily for 30 days. Debridement Procedure (a surgical procedure utilized to remove dead tissue from wounds): The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise 16 CM of devitalized tissue and necrotic subcutaneous level tissues. The wound bed was decreased from 100 percent to 80 percent. Review of the physician's orders, and May 2024 and June 2024 Treatment Administration Records (TAR) indicated that no treatments were implemented for Resident #48's heel until 6/8/24. Review of the Nurse Practitioners note dated 5/29/24 indicated: He/she is contracted and is putting pressure on his/her right lateral ankle and heel in the position that he/she prefers to be in, upright and facing the doorway to her room (right side). I have reviewed [the wound physician's] detailed note from yesterday's consult and agree with plan of care. Review of the Wound Physician's note dated 6/4/24 indicated: Unstageable (due to necrosis) of the right heel full thickness. Etiology: Pressure. Wound Size: 10 X 8 X Not measurable due to presence of non-viable tissue and necrosis. Exudate: light serous. Thick adherent devitalized necrotic tissue: 100%. Dressing treatment plan: Betadine apply once daily for 23 days. ABD pad apply once daily for 23 days, gauze roll apply once daily for 23 days. Debridement Procedure: The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise 8 CM of devitalized tissue and necrotic subcutaneous level tissues. The wound bed was decreased from 100 percent to 90 percent. Review of the physicians orders and June 2024 TAR indicated that the treatment was not implemented for Resident #48's heel until 6/8/24. During an interview on 11/4/24 at 8:53 A.M., Nurse #7 said that every time a resident is admitted, a full skin check is done. Nurse #7 said that if a resident is admitted with wounds, the physician is notified and treatment is implemented and the Wound Physician becomes involved in resident care. Nurse #7 said that Resident #48 has wounds and due to his/her contractures, treatments can be difficult to apply. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/4/24 at 10:49 A.M., the Director of Nursing (DON) said that staff perform a full skin check on residents upon admission and if there are wounds identified upon admission staff would alert the physician and implement a treatment and involve the Wound Physician. The DON said that the Wound Physician rounds the facility weekly and her treatment recommendations are implemented within the week. The DON said she was not aware of any delay in treatment or that Resident #48 was identified as having a DTI upon admission. During an interview on 11/4/24 at 3:50 P.M., the Wound Physician said that she rounds the facility once a week with a nurse who then inputs treatment recommendations. The Wound Physician said that treatments for residents with deep tissue injuries include offloading and the use of skin prep. The Wound Physician said she could not comment on Resident #48's wounds upon admission as she was not assigned to the facility at that time. During an interview on 11/5/24 at 12:32 P.M., the Regional Nurse and DON said that they were not aware that Resident #48 had a DTI upon admission and there was no monitoring or interventions initiated. The Regional Nurse and DON said the nurse who performed the initial assessment and documented the DTI on 5/10/24 was an agency nurse and she should have communicated the DTI to the team. The Regional Nurse and DON said that there should not have been a delay in the documented initiation of the betadine treatment for Resident #48's heel until 6/8/24. 36431 2. For Resident #110 the facility failed to implement a treatment for a pressure ulcer identified on 10/18/24. Resident #110 was admitted to the facility in April 2024 with diagnoses including unspecified dementia, muscle wasting and atrophy, and moderate-protein calorie malnutrition, Review of the Minimum Data Set assessment, dated 10/23/24, indicated a staff assessment for mental status was completed and indicated Resident #110 as having severely impaired cognition. Further the MDS indicated Resident #110 is dependent on staff for toileting and bathing, is at risk for developing pressure ulcers and had one stage 2 pressure ulcer not present on admission or reentry. The MDS indicated a stage 2 pressure ulcer as partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough, may also present as an intact or open/ruptured serum-filled blister. Review of the MDS assessments indicated Resident #110 was in the hospital from 10/11/24 through 10/17/24. Review of the hospital discharge summary dated 10/17/24 indicated Resident #110 had a pressure injury present on original admission, on the coccyx with the initial staging: stage 2. Further, the discharge summary indicated on 10/16/24 the pressure injury on the coccyx was U (unstageable), had the wound length of 1.5 cm (centimeters), wound width of 1 cm and wound depth of 0.1 cm, wound bed site with slough (dead skin or tissue that separates from healthy skin or tissue), margins distinct, treatments soap and water and Triad cream (A sterile coating that can be applied to a wound to facilitate healing and debridement). (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #110 admission orders failed to indicate a treatment for the stage 2 coccyx pressure ulcer upon readmission to the facility. Review of Resident #110's medical record indicated the following: -A skin check dated 10/18/24 indicated, are there any new skin impairments? which was documented as yes, type was documented as pressure injury site was documented as coccyx and description was documented as stage 2, no further description or assessment of the pressure injury was included. Review of Resident #110's medical record failed to indicate a physician's order for the treatment of the stage 2 pressure ulcer on the Resident's coccyx was implemented. Review of the progress notes dated 10/18/24 failed to indicate that the Physician or Nurse Practitioner were notified of Resident #110's pressure injury and that a treatment order was obtained. During an interview on 11/6/24 at 5:01 A.M., Nurse #10 said Resident #110 was sent to the hospital recently and returned with a wound on his/her coccyx. Nurse #10 said she did the skin assessment for Resident #110 on 10/18/24 as part of the readmission assessment. Nurse #10 said the Resident had an open area on the coccyx and documented it as a stage 2 pressure injury. Nurse #10 said the hospital discharge summary included a picture of the Resident's pressure area on his/her coccyx. Nurse #10 said she did not notify the NP/MD (nurse practitioner/Medical doctor) or obtain an order for a treatment for the coccyx and said that Unit Manager #1 was aware, and Nurse #3 also reviewed the hospital discharge summary on 10/17/24 when the Resident returned from the hospital. Nurse #10 said when a pressure area is identified they do not wait to get an order for a treatment. Review of the nurse progress note dated 10/22/24 at 20:49 (8:49 P.M.) indicated, I was notified by the CNA (certified nursing assistant) caring for this resident that there was a new skin issue found. I went to assess the resident. Red raw area noted on his/her buttox (sic), and open area found on his/her coccyx to be a stage 2 pressure injury 1.1 cm by 0.9 cm. NP (nurse practitioner) notified, DON notified, HCP (health care proxy) notified. Treatment to apply Triad dressing/paste twice daily and as needed. Review of the Treatment Administration Record indicated the following orders: -Stage 2 Gluteal Cleft: Cleanse with normal saline, apply Triad dressing/paste twice daily, and as needed. Every day and evening shift Start date 10/22/24 D/C (discharge) date 10/31/24. This order does not indicate a treatment for the coccyx which was documented as present on the 10/18/24 skin check, and the 10/22/24 nurse's progress note. -Stage 3 (Indicated by the MDS as full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) pressure wound coccyx: cleanse with normal saline, apply mesalt sheet (an impregnated gauze used for wounds with moderate to heavy drainage,) cover with border gauze island dressing. Change daily and as needed. Start date 10/31/24. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the document titled 'Specialty Physician Wound Evaluation and Management Summary' dated 10/29/24 (eleven days after the 10/18/24 skin evaluation which indicated a coccyx pressure injury) indicated chief complaint, Patient has wounds on his/her coccyx. Focused wound exam (site 5) Stage 3 Pressure Wound Coccyx Full Thickness, Etiology: Pressure Duration greater than 5 days, wound size Length 1 x width 0.5 x depth 0.2. During an interview on 11/6/24 at 7:34 A.M., the Director of Nursing (DON) said when nurses do a skin evaluation and identify any new skin areas, they are to document the location, describe what they are seeing, give an estimate of the size, notify the doctor or nurse practitioner and obtain a treatment. The DON said staff should not be staging the wounds. The DON said nursing staff are to notify her of any wounds identified and complete a risk reporter (incident report). The DON said a resident with a new wound would be evaluated by the wound doctor on her next weekly visit. The DON said she was not aware that Resident #110 was readmitted from the hospital with a stage 2 coccyx pressure ulcer that was documented in the hospital discharge summary and documented on the skin evaluation dated 10/18/24. The DON said an order should have been put in place when it was identified by the nurse. Further, the DON said an area was identified on 10/22/24 by a CNA (certified nursing assistant) and a treatment was implemented for the gluteal cleft and documented as a stage 2 pressure area. The DON said the wound physician saw Resident #110 and documented the wound as a stage 3 coccyx wound. 41019 3. Resident #323 was admitted in June 2024 with diagnoses including dementia and chronic kidney disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #323 could not participate in the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. The MDS also indicated Resident #323 required supervision to assistance with meals, supervision with touching assistance for standing, and supervision with touching assistance with walking. Review of Resident #323's care plan for skin indicated the following: - Focus: I have the potential for skin breakdown r/t (related to) impaired mobility (initiated 7/5/24) -Interventions: * Apply barrier cream after incontinence care (initiated 7/5/24) * Document skin checks weekly and PRN (as needed). Notify physician and resident/RP (representative) of new areas if observed. Follow up as indicated (initiated 7/5/24). Review of the weekly skin check, dated 6/25/24, indicated Resident #323 had no open areas. Review of the record failed to indicate weekly skin checks were being done until 7/25/24. The weekly skin check, dated 7/25/24, indicated Resident #323 had a new open area on his/her right heel and his/her left heel due to pressure. The skin check failed to indicate any measurements for the wounds. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Nurse Practitioner note, dated 7/29/24, indicated the following: -Skin: no lesions or rashes noted in b/l (bilateral) UE (upper extremity) or LE (lower extremity). Review of the record failed to indicate if the Nurse Practitioner or physician was made aware of the new open wounds. Review of the physicians orders indicated an order for right heel area skin prep every shift, monitor for changes, which was initiated on 7/31/24, six days after the wound was identified. Review of the physician's orders indicated that a treatment order went in place on 8/2/24, 8 days after the initial wound was identified, for both heels to cleanse with normal saline, apply Xerofoam gauze, to wound perimeter cover with ABD pad, wrap with kerlix. Review of the Initial Wound Evaluation and Management Summary, dated 8/6/24, 15 days after the wound was initially identified, indicated Resident #323 had the following: - an unstageable wound (due to necrosis) of the left heel, approximately greater than 14 days in duration, that was 4x3.8 centimeters. - An unstageable wound (due to necrosis) of the left heel, approximately greater than 14 days in duration, that was 4x3.8 centimeters. During an interview on 11/5/24 at 9:37 A.M., the Wound Physician said when she met with Resident #323, he/she had bad DTI's (deep tissue injuries) and that the treatment for a DTI is to offload the wound. The wound doctor said that the duration of the wound she documents is how long she expected the wound to be there prior to her evaluation and believes his/her wounds were due to pressure. Review of the clinical record failed to indicate any intervention to offload Resident #323's heels after the wounds were identified. During an interview on 11/4/24 at 10:49 A.M., the Director of Nursing (DON) said that staff perform a full skin check on residents upon admission and if there are wound identified upon admission staff would alert the physician and implement a treatment and involve the Wound Physician. The DON said that the Wound Physician rounds the facility weekly and her treatment recommendations are implemented within the week. During an interview on 11/5/24 at 10:47 A.M., the Director of Nursing said if a wound is identified then she would have expected the skin prep to go in earlier for Resident #323, but depends on what the doctor says.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to ensure an orthotic device was worn as ordered for one Resident (#37) out of a total sample of 39 residents. Findings include: Resident #37 was admitted in October 2014 with diagnoses including stroke with left sided hemiplegia (paralysis on one side of the body). Review of Resident #37's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), which indicated he/she is cognitively intact. Section GG of the MDS also indicated Resident #37 had an impairment in range of motion of one upper extremity. On 11/03/24 at 8:46 A.M. and 11:35 A.M., Resident #37 was observed lying in bed with his/her left hand in a closed, fist position. The Resident was not wearing a splint and there was no splint observed in his/her room. Using the Resident's dry erase board to communicate, Resident #18 said he/she used to wear a splint on his/her left wrist but has not in a while. On 11/04/24 at 10:29 A.M., Resident #37 was observed lying in bed with his/her left hand in a closed, fist position. The Resident was not wearing a splint and there was no splint observed in his/her room. On 11/04/24 at 2:23 P.M., Resident #37 was observed lying in bed with his/her left hand in a closed, fist position. The Resident was not wearing a splint and there was no splint observed in his/her room. On 11/04/24 at 4:41 P.M., Resident #37 was observed lying in bed with his/her left hand in a closed, fist position. The Resident was not wearing a splint and there was no splint observed in his/her room. Review of the physician orders indicated the following order: - Orthotic Device: Please assist patient with donning (his/her) Left ulnar gutter left hand/forearm splint during AM (morning care) and removing during PM (nighttime care) with caregiver assist approx 6-8 hours or as tolerated. Please document any refusal to don splint, initiated 9/19/24. Review of Resident #37's Kardex (a form indicating the care needs of a resident) indicated the following: - Please assist me with the use of supportive devices Left Ulnar Gutter Left hand/forearm splint as recommended (6-8 hrs as tolerated during AM/PM shift). I oftentimes refuse; please document all refusals to donning left resting hand splint. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #37's nursing notes for 11/3/24 and 11/4/24 failed to indicate Resident #37 refused the wearing of his/her left-hand splint. During an interview on 11/5/24 at 8:31 A.M., Nurse #1 said all residents who have an orthotic will have it listed in the electronic medical record for the nurses to see and would also be listed on the Kardex for the nursing assistants to see. Nurse #1 said Resident #37 has a left-hand splint, however she does not know the wearing schedule. During an interview on 11/5/24 at 10:06 A.M., the Director of Nursing said if a resident needs a splint, there would either be an order for the splint, or it would be placed on the Kardex so that all staff are aware of the splint wearing schedule. The Director of Nursing said all orders should be followed as written and was unaware Resident #37 had not been wearing his/her splint.		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49880 Based on observations, record review and interviews the facility failed to maintain acceptable nutrition status for three Residents (#114, #323, and #74) out of a total sample of 39 residents. Specifically, 1. For Resident #114 the facility failed to; a. failed to identify and address significant weight loss and b. failed to provide fortified foods in accordance with physician's orders following a significant weight loss. 2. For Resident #323, the facility failed to identify and address a significant weight loss. 3. For Resident #74, the facility failed to identify and address a significant weight loss timely. Findings Include: Review of facility policy titled Weight Assessment and Intervention, undated, indicated the following: -Resident weights are monitored for undesirable or unintended weight loss or gain. -1. Weights are recorded in each unit's weight record chart and in the individual's medical record. -3. Any weight change of 5% or more since the last weight assessment, nursing will notify the dietitian. -5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight = (usual weight- actual weight)/(usual weight) x 100]: a. 1 month- 5% weight loss is significant; greater than 5% is severe. b. 3 months 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months 10% weight loss is significant; greater than 10% is severe. Review of facility policy titled Nutrition (Impaired)/ unplanned weight loss- Clinical Protocol, dated as revised September 2017 indicated the following: -The Nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time. -The staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake. -Treatment/ Management: The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis, and wishes. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	1. Resident #114 was admitted to the facility in June 2024 with diagnoses including syncope and collapse, obesity, and atrial fibrillation. Review of Resident #114's most recent Minimum Data Set (MDS) Assessment, dated 8/7/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident was cognitively intact. The MDS failed to indicate behaviors, including behaviors of refusal. a. Review of Resident #114's weights indicated the following: 6/21/24: 238.1 lbs. (pounds). 7/8/24: 224.6 lbs. 7/17/24: 222.0 lbs. 8/30/24: 221.6 lbs. 9/10/24: 204.5 lbs. 10/4/24: 198.4 lbs. 10/28/24: 189.4 lbs. 11/3/24: 191.2 lbs. - On 6/21/24, the Resident weighed 238.1 lbs. On 11/3/24, the Resident weighed 191.2 lbs., which is a -19.70 % loss in 4 months and 13 days. - On 8/30/24, the Resident weighed 221.6 lbs. On 9/10/24, the Resident weighed 204.5 lbs., which is a -7.72 % loss in 11 days. Review of the Nutrition Assessment, dated 9/11/24, indicated completion on 10/7/24, 27 days after a 7.72% weight loss from 8/30/24 to 9/10/24. The assessment indicated Rt (Resident) being reviewed for quarterly nutrition assessment and this quarter weights have ranged from 204.5# (pounds) to 222#, with significant weight changes. At this time recommendations were made for fortified foods and weekly weight as ordered. Review of physician's orders, dated 10/7/24, indicated the following: - CCHO (consistent or controlled carbohydrate) diet, regular texture, thin consistency- fortified foods related to hyperglycemia, dated 10/7/24. - Weekly weights one time a day every Tuesday, dated 10/7/24. - Glucerna every day and evening shift 237 ml (milliliters) via PO (by mouth), dated 10/28/24. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the October 2024 Medication Administration Record indicated that Resident #114 refused to be weighed on 10/8 and 10/15. On 10/22 there is no indication that a weight was obtained or that the Resident refused. Review of progress notes failed to indicate ongoing attempts to weigh the Resident after refusal or education provided to the Resident regarding weights. During an interview on 11/6/24 at 9:33 A.M., the Director of Nurses (DON) said there is no one person who enters the weights into the electronic health record and evaluates them, but generally the weights are evaluated by the Dietitian. She said she would not reweigh a resident unless the Dietitian asks for a reweight of the resident. (contrary to the facility policy) During an interview on 11/6/23 at 10:06 A.M., Nurse Practitioner #3 said that she was not notified of weight loss until 10/28/24 and said the weight loss is concerning because Resident #114 has had a lot of recent illness. During an interview on 10/6/24 at 10:12 A.M., the Dietitian said that the facility does not meet regularly for risk meetings to discuss things like weight loss, but they are trying to do it more regularly, and that she reviews resident weights outside of risk meeting as well. She said she works at a regional level, and it varies how often she is in the facility to review weights. She said that she would have expected staff to report the weight change between 8/30/24 and 9/10/24 to her and a physician, and she would have expected a reweight to be done as well to confirm the weight loss. She said both nursing and the Dietitian enter weights into the electronic health record, but they should be reviewed and compared to previous weights when entered. b. Review of physician's orders indicated the following orders: - CCHO (consistent or controlled carbohydrate) diet, regular texture, thin consistency- fortified foods related to hyperglycemia, dated 10/7/24. - Weekly weights one time a day every Tuesday, dated 10/7/24 During the survey, the surveyor made the following observations: - On 11/4/24 at 8:17 A.M., the surveyor observed Resident #114's breakfast tray. The meal ticket on the tray did not indicate that the Resident was to receive fortified foods and there were not fortified foods present on the tray. The tray contained juice, milk, eggs, and toast. - On 11/4/24 at 12:10 P.M., the surveyor observed staff bring the lunch meal tray into Resident #114. Resident #114 received milk and juice to drink along with pork, gravy, macaroni and cheese and spinach, which was the indicated meal on the menu. There were no fortified foods provided and Resident #114's meal ticket did not indicate for the Resident to receive fortified foods. - On 11/5/24 at 8:19 A.M., the surveyor observed staff bring the breakfast tray into Resident #114. Resident #114 received one piece of french toast and one piece of ham along with milk, juice, and coffee to drink. There were no fortified foods provided and the meal ticket on the tray did not indicate for the Resident to receive fortified foods. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the Nutrition assessment dated [DATE] indicated completion on 10/7/24 indicated the following: - This quarter weights have ranged from 204.5# (pounds) to 222#, with significant weight changed. - Recommend fortified foods. During an interview on 11/5/24 at 12:19 P.M., the Staff Development coordinator, who was present on the unit, said that fortified foods are foods that are supplemented by the kitchen. She said for breakfast it could mean fortified cereal which may have extra cream and sugar in the cereal to add more calories to it. She said the dietitian would arrange for those foods to come from the kitchen but was not sure if it would be reflected on the meal ticket that comes on the trays. During an interview on 11/5/24 at 12:19 P.M., Nurse #3 said that she doesn't know what fortified foods means. She said that any special diet order or recommendation should be on the meal ticket such as likes/ dislikes and allergies. During an interview on 11/6/24 at 9:33 A.M., the Director of Nurses (DON) said that fortified foods include super cereal and super potatoes that may have cream and butter added to them for added calories. The DON said that an order for fortified foods should be on the meal ticket. During an interview on 11/6/24 at 10:06 A.M., Nurse Practitioner #3 said she would expect that interventions put into place because of weight loss would be implemented and that she did not know the Resident was not receiving fortified foods with meals. During an interview on 11/6/24 at 10:12 A.M., the Dietitian said that orders for fortified foods should be on the meal ticket and is generally communicated to the kitchen on dietary communication forms. She said that fortified foods would include super cereal at breakfast and potatoes or pudding at lunch or dinner depending on the resident's preferences. She said Resident #114 should have been receiving fortified foods with all meals. 41019 2. Resident #323 was admitted in June 2024 with diagnoses including dementia and chronic kidney disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #323 could not participate in the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. Further, the MDS indicates Resident #323 required supervision to assistance with meals, supervision with touching assistance for standing, and supervision with touching assistance with walking. Review of Resident #323's nutrition care plan indicated the following: Focus: I have a nutritional problem or potential nutritional problem related to significant weight changes, suspected malnutrition, past medical history significant for dementia, anemia, pressure ulcers, and GERD (Gastroesophageal reflux disease). Review of the weight report for Resident #323 indicated the following weights: (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	7/5/24: 158.2 lbs (pounds) 8/5/24: 135 lbs 9/7/24: 120 lbs Review of the nutrition risk assessment, dated 7/10/24, indicated Resident #323 had an ideal body weight of 153 lbs. Review of the weights indicated Resident #323 lost 23.2 lbs in one month from July 2024 to August 2024, which is a 14.6% significant weight loss. Review of the progress note, dated 8/6/24, indicated the following: RD suspects pt meets criteria for protein calorie malnutrition. Malnutrition in the context of chronic illness r/t dementia AEB (as evidenced by) significant weight loss with NFPE (nutrition focused physical exam) finding indicating fat and muscle loss. Review of the weight warning note, dated 8/6/24, indicated the dietitian recommended a re-weight and weekly weights, as well as, a nutritional drink BID (twice per day) and fortified foods. Review of the physician orders indicated an order for weekly weights, started on 8/6/24. Review of the weight record failed to indicate weekly weights were done. Review of the weights indicated Resident #323 lost an additional 15 lbs from August 2024 to September 2024, which is an 11% significant weight loss in one month. Review of the clinical record failed to indicate that the significant weight loss was addressed, the care plan was reviewed, or any interventions were implemented. During an interview on 11/5/24 at 9:00 A.M., the Dietitian said that after the initial significant weight loss, she recommended weekly weights, but said they were not being done. The Dietitian said she was not notified of the weight loss that occurred on 9/7/24 and would have expected to be notified. 3. Resident #74 was admitted in April 2024 with diagnoses including unspecified protein-calorie malnutrition, dysphagia, and dementia. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #74 could not participate in the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. Review of Resident #74's nutrition care plan indicated the following: Focus: I have a nutritional problem or potential nutritional problem related to significant weight changes, past medical history significant for COPD (chronic obstructive pulmonary disorder), dysphagia, and malnutrition. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the weight and vitals summary for Resident #74 indicated the following: 6/2/24: 155.7 lbs (pounds) 7/1/24: 155.8 lbs 7/2/24: 149 lbs 7/5/24: 149 lbs 8/7/24: 141.6 lbs 9/3/24: 141.8 lbs Review of the weights indicate Resident #74 lost 14.1 pounds between June 2024 and August 2024, which is a 9% significant weight loss in 2 months. Review of the clinical record failed to indicate that the care plan was reviewed or interventions were put in place until 9/10/24, which is one month after the significant weight loss was identified, when the Dietitian recommends Ensure (a nutrition supplement) every day. During an interview on 11/5/24 at 9:00 A.M., the Dietitian said she put a note in on 9/10/24 acknowledging the weight loss, but ideally she would review the weights each week and see them shortly after a weight loss is identified. The Dietitian said there has been an issue with nurses notifying her of weight losses, but it has improved.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49880 Based on observations, interviews, and record review, the facility failed to provide respiratory care services in accordance with professional standards of practice for one Resident (#19) out of a total sample of 39 residents. Specifically, for Resident #19, the facility failed to ensure his/her oxygen concentrator air filter was in place. Findings Include: Resident #19 was admitted to the facility September 2024 with diagnoses that include acute respiratory failure with hypoxia and aspiration. Review of Resident #19's most recent Minimum Data Set (MDS) Assessment, dated as 10/24/24, indicated a Brief Interview for Mental Status (BIMS) score of 9 out of 15, indicating moderate cognitive impairment. The MDS further indicated the use of oxygen. The surveyor made the following observations: -On 11/3/24 at 7:38 A.M. and 11:44 A.M., the surveyor observed the resident receiving oxygen via nasal cannula. Observation of the oxygen concentrator revealed no filter in the concentrator. -On 11/4/24 at 7:57 A.M., the surveyor observed the resident receiving oxygen via nasal cannula. Observation of the oxygen concentrator revealed no filter in the concentrator. -On 11/5/24 at 7:10 A.M., the surveyor observed the resident receiving oxygen via nasal cannula. Observation of the oxygen concentrator revealed no filter in the concentrator. Review of Resident #19's physician's orders indicated the following: Change Oxygen Tubing, Bag, Humidifier, and clean filter weekly and as needed for soiling or damage, dated 9/30/24. Review of Resident #19's active oxygen use care plan, dated 11/1/24, indicated the use of supplemental oxygen related to COPD (Chronic Obstructive Pulmonary Disease). During an interview and observation on 11/5/24 at 12:28 P.M., Nurse #3 said that oxygen concentrators should have foam filters on the back, and it should be checked and cleaned at least weekly. She said without a filter on the concentrator the resident could breathe in dust and other things that are not getting filtered. Nurse #3 and the surveyor observed Resident #19's oxygen concentrator and she said there was not a filter on it but there should be. During an interview on 11/6/24 at 9:37 A.M., the Director of Nurses said some concentrators have external and some have internal filters and if it has an external filter, it should be checked and cleaned weekly.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 49880 Based on interview and record review the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice for one Resident (#39) out of a total sample of 39 residents. Specifically, for Resident #39 the facility failed to administer scheduled pain medications timely in accordance with physician's orders. Findings Include: Review of facility policy titled Pain Assessment and Management, dated as revised October 2022, indicated the following: - The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. - Pain management is defined as the process for alleviating the resident's pain based on his or her clinical condition and established treatment goals. Resident #39 was admitted to the facility in January 2024 with diagnoses that include arthropathies (surgical procedures to replace some or all of a joint) of right shoulder and contusions (bruises) of the left shoulder and right hip. Review of Resident #39's most recent Minimum Data Set (MDS) Assessment, dated 10/23/24, indicated a BIMS score of 15 out of 15 indicating that the resident was cognitively intact. The MDS further indicated that the Resident received scheduled pain medications and received no non- medication pain medication interventions for pain. During an interview on 11/3/24 at 8:29 A.M., Resident #39 said that his/her pain medications are often administered late, causing his/her pain to increase. Resident #39 said the pain gets worse and harder to control when his/her medications are administered late by the staff. During an interview on 11/5/24 at 8:00 A.M., Nurse #3 said that there is a one-hour window on each side of the prescribed time to administer a medication, for example, if a medication is ordered at 8:00 A.M., you can administer the medication between 7:00 A.M. and 9:00 A.M. Review of Resident #39's physician's orders indicated the following: - Acetaminophen extra strength 500 milligrams (mg), give 1000 mg by mouth three times daily at 8:00 A.M., 2:00 P.M., and 8 P.M., dated 1/26/24. - Gabapentin 800 mg by mouth two times a day for nerve pain at 8:00 A.M., and 8:00 P.M., dated 1/23/24. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #39's most recent Pain Evaluation, dated 9/26/24, indicated the Resident reports frequency of pain as daily to his/her lower back and bilateral knees, right knee. and right shoulder. Review of Resident #39's Medication Admin (administration) Audit Report for November 2024 indicated the following: - 11/1/24 8:00 A.M. acetaminophen administered at 9:25 A.M., 25 minutes after the scheduled time. - 11/1/24 8:00 A.M. gabapentin administered at 9:28 A.M., 28 minutes after the scheduled time. - 11/2/24 8:00 A.M. acetaminophen administered at 10:29 A.M., one hour and 29 minutes after the scheduled time. - 11/2/24 8:00 A.M. gabapentin administered at 10:33 A.M., one hour and 33 minutes after the scheduled time. - 11/3/24 8:00 A.M. acetaminophen administered at 10:04 A.M., one hour and 4 minutes after the scheduled time. - 11/3/24 8:00 A.M. gabapentin administered at 11:22 A.M., two hours and 22 minutes after the scheduled time. - 11/4/24 8:00 A.M. acetaminophen administered at 10:31 A.M., one hour and 31 minutes after the scheduled time. - 11/4/24 8:00 A.M. gabapentin administered at 10:35 A.M., one hour and 35 minutes after the scheduled time. - 11/4/24 8:00 P.M. gabapentin administered at 9:55 P.M., 55 minutes after the scheduled time. - 11/4/24: 8:00 P.M. acetaminophen administered at 9:55 P.M., 55 minutes after the scheduled time. - 11/5/24: 8:00 A.M. acetaminophen administered at 10:38 A.M., one hour and 38 minutes after the scheduled time. - 11/5/24: 8:00 A.M. gabapentin administered at 10:40 A.M., one hour and 40 minutes after the scheduled time. Review of Resident #39's active pain management care plans, dated 1/23/24, indicated: - I am on pain medication therapy r/t (related to) pain in lower back and bi-lateral knees, > right knee and right shoulder. (sic) Interventions include to administer medication as ordered and monitor for effectiveness and adverse effects. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- I have pain r/t arthritis, morbid obesity, hx (history) of spinal fusions, hip deformity, prior rotator cuff injury, and non- ambulatory (Primarily uses power chair). Interventions include to administer analgesia as per orders. Observe for effectiveness and s/sx (signs and symptoms) of side effects. During an interview on 11/6/24 at 9:38 A.M., the Director of Nursing said there is a one-hour window before and after the scheduled time that a medication is expected to be given.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review and interview, the facility failed to ensure a person-centered plan of care was developed for Trauma-Informed Care for one Resident (#4), who was admitted with the diagnosis of Post-Traumatic Stress Disorder (PTSD), out of a total sample of 39 residents. Findings include: Review of the facility policy titled Trauma Informed Care and Culturally Competent Care, dated August 2022, indicated to guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Nursing staff are trained on trauma screening and assessment tools. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. Resident #4 was admitted to the facility in September 2023 with diagnoses that included Post Traumatic Stress Disorder (PTSD), hemiplegia and hemiparesis, bipolar disorder, anxiety and depression. Review of Resident #4's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 14 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. Further review of the MDS indicated the Resident has a diagnosis of PTSD. Review of Resident #4's medical record failed to indicate that a comprehensive resident centered care plan was developed, or an assessment was completed for PTSD. During an interview on 11/4/24 at 11:07 A.M., Psychiatric Nurse Practitioner (NP) said she would expect the facility to develop a plan of care for a Resident with PTSD. The NP said Resident #4 has a diagnosis of PTSD. During an interview on 11/6/24 at 10:00 A.M., Nurse #3 said a comprehensive care plan should be in place for a resident who has a diagnosis of PTSD. Nurse #3 said she is not sure about a PTSD assessment as she is the evening supervisor most days and hasn't seen one. During an interview on 11/6/24 at 10:21 A.M., the Director of Nurses said social services should be completing a PTSD assessment and then complete a comprehensive care plan with triggers. During an interview on 11/7/24 at 8:39 A.M., the Social Worker said she is unaware of a PTSD assessment that is completed for a Resident who has a diagnosis of PTSD and said a comprehensive care plan should be in place with triggers so staff are aware on how to care for the Resident.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36431 Based on observation, record review and interviews, the facility failed to ensure sufficient staffing to assure that residents attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. Specifically, the facility failed to have sufficient staffing on the weekends as indicated on the payroll-based journal report submitted to The Centers of Medicare and Medicaid (CMS) for Fiscal Year Quarter 3 2024 (April 1 - June 30) Findings include: Review of the PBJ Staffing Data Report CASPER Report 1705D Fiscal Year Quarter 3 2024 (April 1 - June 30), indicated the following: - This Staffing Data Report identifies areas of concern that will be triggered (e.g., requires follow-up during the survey). - Excessively Low Weekend Staffing Triggered = Submitted Weekend Staffing data is excessively low. Review of the facility's 'Facility Assessment Tool' dated as reviewed 7/24/24, indicated the following: The following grid represents a typical staffing pattern based upon the average daily census of the facility. The facility adjusts staffing based upon multiple factors, including but not limited to, shifts in resident census, acuity, outbreaks, and admission and discharge volume. Nursing-Direct Care 7-3: Supervisor 1, RN (Registered Nurse) 2, LPN (Licensed Practical Nurse) 4, CNA (Certified Nursing Assistants) 16 3-11: 1 Supervisor 1, RN 2, LPN 4, CNA 16 11-7 RN 1, LPN 2, CNA 6. Review of the document titled Nursing HPPD (hours per patient day) by position for April 2024 indicated the following: Saturday 4/6/24, total residents 122, HPPD total 2.6 Sunday 4/7/24, total residents 122, HPPD total 2.5 Saturday 4/13/24, total residents 122, HPPD total 2.8 Sunday 4/14/24, total residents 121, HPPD total 2.8 Saturday 4/20/24, total residents 117, HPPD total 2.8 Sunday 4/21/24, total residents 117, HPPD total 2.7 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Saturday 4/27/24, total residents 119, HPPD total 2.9 Sunday 4/28/24, total residents 120, HPPD total 2.7 Review of the document titled Nursing HPPD (hours per patient day) by position for May 2024 indicated the following: Saturday 5/4/24, total residents 121, HPPD total 2.8 Sunday 5/5/24, total residents 120, HPPD total 3.0 Saturday 5/11/24, total residents 119, HPPD total 2.8 Sunday 5/12/24, total residents 118, HPPD total 2.6 Saturday 5/18/24, total residents 119, HPPD total 2.5 Sunday 5/19/24, total residents 120, HPPD total 3.3 Saturday 5/25/24, total residents 118, HPPD total 2.9 Sunday 5/26/24, total residents 118, HPPD total 2.7 Review of the document titled Nursing HPPD (hours per patient day) by position for June 2024 indicated the following: Saturday 6/1/24, total residents 123, HPPD total 2.7 Sunday 6/2/24, total residents 123, HPPD total 2.8 Saturday 6/8/24, total residents 122, HPPD total 2.8 Sunday 6/9/24, total residents 121, HPPD total 2.5 Saturday 6/15/24, total residents 120, HPPD total 2.8 Sunday 6/16/24, total residents 119, HPPD total 2.7 Saturday 6/22/24, total residents 119, HPPD total 2.9 Sunday 6/23/24, total residents 119, HPPD total 2.7 Saturday 6/29/24, total residents 118, HPPD total 2.7 During an interview on 11/05/24 at 2:49 P.M., the Administrator said the payroll base journal data for the third quarter was affected by difficulty in staffing and required use of agency staff who were not always reliable. He said the HPPD for the third quarter was budgeted, not including administration, for 3.15. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The data for the months of April 2024, May 2024, and June 2024 submitted to CMS indicated all 13 weekends were below the HPPD of 3.15.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 36431 Based on observation, record review and interviews, the facility failed to ensure that the nursing staff demonstrated appropriate competencies, and skill sets necessary for the care and treatment of residents. Specifically, the facility failed to ensure that 3 licensed nurses (#5, #6, and #9), two who were on the schedule during the survey, and one recently on the schedule on 11/2/24, out of a total of six nursing employee records reviewed, had nursing competency evaluations. Findings include: During the survey process the survey team through observation, record review and interview identified concerns impacting resident care specifically, pressure ulcer care, change in condition, insulin administration, infection control, and implementing the medical plan of care. Review of the Facility assessment dated as reviewed 1/29/24 indicated the following: -Services that may be required by our resident population, included but was not limited to: -Activities of Daily Living -Bowel and Bladder Programming -Chronic Illness Support -Dementia and Memory Care -Hypodermoclysis (subcutaneous injection of fluids) -Incontinence Care -Infection Prevention and Control -Injections -Mechanically Altered Diets -Medication Management -Respiratory Therapy Services -Respiratory Treatments -Skin Integrity Management -Wound Care (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff Education and Competency Education is a key component to ensuring that our residents receive quality care. Education is provided to staff in various formats. We use Relias (C) as an online training resource. In addition, we provide both individual and group training sessions. Education begins at orientation which includes job specific training. Competency evaluations are conducted as they may apply to the new employee. Department specific training and competencies are completed with staff throughout their employment to ensure that they can safely and competently provide the levels and types of care required by our resident population. Review of three out of six licensed nursing staff employee files indicated the following: Nurse #5, with a date of hire 2/12/24, had dementia training on Relias, and a hand hygiene competency dated 12/1/22, there were no further competencies in the employee file. Nurse #6, with a date of hire 6/26/24, failed to have any competency evaluations. Nurse #9, with a hire date of 6/25/24, had incomplete competency evaluations, not filled in, signed by the learner and not the evaluator. During an interview on 11/05/24 at 2:11 P.M., the Staff Development Coordinator (SDC) said her role is to onboard new nursing staff and provide them with an orientation that would include nursing competencies. The SDC said Nurse #6 and Nurse #5 were working for a staffing agency and then converted to facility staff and did not go through the same process of orientation and that is why they did not have nurse competencies in their employee files. The SDC said for Nurse #9 she sat down with him but did not complete the competencies in full. The SDC said competencies are expected to be completed to determine the Nurse's skills and level of competency. During an interview on 11/5/24 at 2:37 P.M., the Administrator said all newly hired nurses, including those who are transferred from agency, must go through orientation and are to have competency evaluations.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on record review and interviews, the facility failed to ensure recommendations from behavioral health services were relayed to the physician and implemented for two Residents (#91, #4) out of a total sample of 39 residents. Findings include: Review of the facility policy titled, Behavioral Assessment, Intervention and Monitoring, dated 2001, indicated the following: -The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. 1. Resident #91 was admitted to the facility in May 2023 with diagnoses including bipolar disorder, major depression, anxiety, and suicidal ideations. Review of Resident #91's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she had a Brief Interview for Mental Status score of 12 out of a possible 15, which indicated the Resident had moderate cognitive impairment. The MDS also indicated Resident #91 required supervision for functional daily tasks. During an interview on 11/4/24 at 8:05 A.M., Resident #91 said he/she often feels sad and anxious. Review of the Psychiatric Nurse Practitioner note dated 10/22/24 indicated the following: -Target Symptoms: Anxiety Depression -HPI (History of Present Illness): Problem: 60 yo (year old) (male/female) with dementia, OCD (obsessive compulsive disorder), anxiety, depression, bipolar d/o and prior suicidal ideation is seen for a follow up. Used to be more anxious, restless, frustrated, inability to keep still. Zoloft (an antidepressant) decreased due to increases being ineffective and ? related to increased serotonin levels, specially when combined with TCA (tricyclic antidepressants) such as Clomipramine (one of (his/her) current meds) which can increase risk of serotonin syndrome. Lamictal (a medication to control mood swings) was initiated and increased for bipolar depression which has been quite helpful. Anxiety and depressive symptoms have improved, but not optimal. -PLAN / RECOMMENDATIONS: -Recommend discontinuing Sertraline (Zoloft) 50 mg daily. -Recommend increasing Lamictal from 50 mg to 100 mg. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Blueberry Hill Rehabilitation and Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 75 Brimbal Avenue Beverly, MA 01915	
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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #91's Medication Administration Record for the months of October and November 2024 failed to indicate these recommendations were implemented. Review of Resident #91's medical record failed to indicate any nursing notes or physician notes that indicated they were aware of the recommendations made by the Psychiatric Nurse Practitioner. During an interview on 11/4/24 at 8:10 A.M., Nurse #1 and Nurse #2 said the Psychiatric Nurse Practitioner visits the facility weekly and often treats Resident #91 due to his/her anxiety and depression. Nurse #1 and Nurse #2 said the Psychiatric Nurse Practitioner often makes medication recommendations and these recommendations are first sent to the Director of Nursing and then are reported to the nursing staff. Both Nurse #1 and Nurse #2 said they are consistent workers on Resident #91's unit and were never made aware of the Psychiatric Nurse Practitioner's recommendations for the Resident and, since not aware, neither had reached out to the physician to make him aware of the recommendations. During an interview on 11/4/24 at 8:32 A.M., the Social Worker (SW) said the facility had a Psychiatric Nurse Practitioner that visits the facility weekly. The SW said she is not always made aware of medication recommendations; however, the interdisciplinary team should make sure all recommendations are reviewed and implemented as appropriate. During an interview on 11/4/24 at 8:44 A.M., the Director of Nursing (DON) said the facility has a Psychiatric Nurse Practitioner that visits the facility weekly. The DON said the Psychiatric Nurse Practitioner will email her a summary of recommendations made when she completes her weekly visits. The DON said she reads the recommendations and the expectation if that any recommendation would be reported to the physician and implemented if appropriate within a week. The DON said she does not think the recommendation for Resident #91 was reported to the physician to be implemented. During an interview on 11/4/24 at 10:15 A.M., the Psychiatric Nurse Practitioner said she would like any recommendations she makes to be reviewed and implemented as soon as possible. The Psychiatric Nurse Practitioner said she was unaware the recommendation made for Resident #91 had not been implemented. The Psychiatric Nurse Practitioner said she believes these new medications would be beneficial to Resident #91. 43846 2. Resident #4 was admitted to the facility in September 2023 with diagnoses that included Post Traumatic Stress Disorder (PTSD), hemiplegia and hemiparesis, bipolar disorder, anxiety and depression. Review of Resident #4's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 14 out of a possible 15 on the Brief Interview for mental status indicating intact cognition. Further review of the MDS indicated the Resident has a diagnosis of PTSD. Review of Resident #4's Behavioral Health Psychiatric Nurse Practitioner note, dated 10/1/24, indicated The Resident reports has been having trouble sleeping; feeling anxious around bedtime and also waking up in the middle of the night and difficulty going back to sleep. Recommend new order for Abilify 15 mg every morning. At bedtime might be impairing his sleep. (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #4's physician order, dated 7/24/24, indicated Abilify Oral Tablet 5 mg (milligrams) by mouth daily in the morning and give Abilify 10 mg by mouth daily at bedtime. Review of Resident #4's October and November 2024 through 11/5/24 Medication Administration Record (MAR), indicated the Resident received Abilify Oral Tablet 5 mg (milligrams) by mouth daily in the morning and give Abilify 10 mg by mouth daily at bedtime was given twice a day as ordered. Review of Resident #4's Behavioral Health Psychiatric Nurse Practitioner note, dated 10/15/24, indicated Continues with depressed mood, low energy, anxiety during the nights and trouble sleeping as a result. Discussion: Discuss w/nursing. During an interview on 11/4/24 at 10:25 A.M., the Psychiatric Nurse Practitioner (NP) said she expects the medication should be given in the morning as per her note. The NP said she went over the orders with nursing staff and answered any questions they had about the recommendations. During an interview on 11/5/24 at 8:04 A.M., Resident #4 said he/she is still having trouble sleeping. During an interview on 11/6/24 at 10:00 A.M., Nurse #3 said the Psychiatric Nurse Practitioner's recommendations should be transcribed correctly and relayed to the provider at the facility. During an interview on 11/4/24 at 8:32 A.M., the Social Worker (SW) said the facility had a Psychiatric Nurse Practitioner that visits the facility weekly. The SW said she is not always made aware of medication recommendations; however, the interdisciplinary team should make sure all recommendations are reviewed and implemented as appropriate. During an interview on 11/4/24 at 8:44 A.M., the Director of Nursing (DON) said the facility has a Psychiatric Nurse Practitioner that visits the facility weekly. The DON said the Psychiatric Nurse Practitioner will email her a summary of recommendations made when she completes her weekly visits. The DON said she reads the recommendations and the expectation if that any recommendation would be reported to the physician and implemented if appropriate within a week. During an interview on 11/6/24 at 10:13 A.M., the Director of Nurses (DON) reviewed Resident #4's behavioral NP health notes, and said nursing should have transcribed the Abilify order as recommended. The DON said she did know the Resident was having issues sleeping.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review and interview, the facility failed to ensure recommendations from the Monthly Medication Reviews (MMRs) conducted by the consultant pharmacist were addressed by the facility in a timely manner for two Residents (#55 and #117), out of a total sample of 39 Residents. Findings include: 1. Resident #55 was admitted to the facility in October 2024 with diagnoses that included type 2 diabetes, cellulitis of right and left lower limb, protein-calorie malnutrition, anxiety and major depressive disorder. Review of Resident #55's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairments. Review of Resident #55's consultant pharmacist recommendations, dated 10/21/24, indicated This resident has two different orders PRN (as needed) Pain: Tylenol Oral Tablet 325 mg (milligrams) (acetaminophen) give 3 tablet by mouth every 6 hours as needed for pain. Oxycodone HCL oral tablet 5 mg give 1 tablet by mouth every 6 hours as needed for pain. Please distinguish between indications for use. Further review of the consultant pharmacist recommendations indicated the in house Nurse Practitioner (NP) did not respond to the recommendation until 11/4/24 and was in agreement with the recommendation. During an interview on 11/5/24 at 10:00 A.M., Nurse #3 said the Director of Nursing (DON) takes care of the pharmacy recommendations and they should be completed timely. During an interview on 11/5/24 at 10:05 A.M., the Director of Nursing (DON) said the Nurse Practitioner rounds at the facility weekly and should be addressing the consultant pharmacist recommendations each time she is at the facility. The DON said the recommendation should have been addressed before 11/4/24. 2. Resident #117 was admitted to the facility in September 2024 with diagnoses that included cardiac pacemaker, cardiac defibrillator, depression and dementia. Review of Resident #117's most recent Minimum Data Set (MDS), dated [DATE] , indicated he/she scored a 9 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairments. Review of Resident #117's consultant pharmacist recommendations, dated 10/3/24, indicated the Resident has a PRN (as needed) order for Trazodone and Clonazepam. PRN psychotropic medications should be ordered for a duration of 14 days, reassessed, and reordered for specific duration (include duration in order directions/end date), scheduled routinely, or discontinued. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #117's consultant pharmacist recommendations indicated the in house Nurse Practitioner did not respond to the recommendation until 11/4/24 and was in agreement with the recommendation. During an interview on 11/5/24 at 10:00 A.M., Nurse #3 said the Director of Nursing (DON) takes care of the pharmacy recommendations and they should be completed timely. During an interview on 11/5/24 at 10:05 A.M., the Director of Nursing (DON) said the Nurse Practitioner rounds at the facility weekly and should be addressing the consultant pharmacist recommendations each time she is at the facility. The DON said the Resident has been back from the hospital for about three weeks and the recommendation should have been addressed before 11/4/24. 41456		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 36431 Based on observation, record review and interview, the facility failed to ensure one Resident's (#75) medication regime was free from unnecessary medications, out of a total sample of 39 residents. Specifically, the facility failed to adhere to the physician's ordered parameters and administered insulin when Resident #75's blood sugar was below 100. Findings include: Review of the facility's policy titled Diabetes-Clinical Protocol, not dated, included but was not limited to the following: Treatment/Management 1. Based on preceding assessment, including causes and complications, the Physician will order appropriate interventions, which may include: d Insulin. Monitoring and Follow-Up 4. The Physician will order desired parameters for monitoring and reporting information related to blood sugar management. a. The staff will incorporate such parameters into the Medication Administration Record (MAR) and care plan. Resident #75 was admitted to the facility in September 2020 with diagnoses including type 2 diabetes mellitus with diabetic chronic kidney disease. Review of the Minimum Data Set assessment, dated 9/6/24, indicated Resident #75 scored a 12 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having moderately intact cognition and was dependent on staff for care. During an observation and interview on 11/3/24 at 8:47 A.M., Resident #75 was observed eating his/her breakfast. He/she said the nursing staff checked his/her blood sugar and that he/she is diabetic. Review of Resident #75's medical record indicated the following: - A care plan, dated 9/16/202, I have Diabetes Mellitus with the intervention, Diabetes medication as ordered by the doctor. - A Physician's order for NovoLog (a rapid acting insulin) mix 70/30 FlexPen Subcutaneous Suspension Pen-Injector (70-30) 100 unit/ML (milliliters) (insulin Aspart Protamine and Aspart (Human) Inject 15 unit subcutaneously two times a day related to Diabetes Mellitus Due To Underlying Condition With Diabetic Mononeuropathy Hold if Blood Sugar is less than 100 before meals, notify the MD (medical doctor) if Blood Sugar is less than 100 and monitor, dated 9/5/24. Review of Resident #75's October 2024 Medication Administration Record (MAR) indicated the following recorded blood sugars at 4:30 P.M. - 10/2/24: Blood Sugar 94. - 10/4/24: Blood Sugar 74. (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 10/6/24: Blood Sugar 93. - 10/8/24: Blood Sugar 83. Further review of the MAR indicated the Novolog Mix 70/30 FlexPen was documented as administered on 10/2/24, 10/4/24, 10/6/24, and 10/8/24, when Resident #75's blood sugar was below 100 resulting in four doses of unnecessary Novolog. During an interview on 11/4/24 at 11:19 A.M., Nurse #7 reviewed the MAR and said on the days with the Blood Sugar documented below 100 the Novolog insulin should not have been administered. During an interview on 11/4/24 at 4:50 P.M., the Regional Nurse said an incident report was filled out today when she became aware by Nurse #5 that Resident #75 was administered insulin outside of the physician's orders. The Regional Nurse said the order should have been followed and the insulin should not have been administered when the Resident's blood sugar was below 100.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observations and interviews, the facility failed to ensure all medications used in the facility were stored in accordance with accepted professional principles of practice on two out of three units. Specifically, 1. The facility failed to ensure nursing staff secured medications while not present at his/her medication cart, 2. The facility failed to ensure nursing staff secured the treatment cart during wound rounds, 3. The facility failed to secure antifungal cream which was left in Resident #2's room. Findings include: Review of the facility policy titled Medication Labeling and Storage, dated February 2023, indicated the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. 1. On 11/5/24 from 7:45 A.M. to 8:22 A.M., the surveyor observed an insulin pen and a Incruse Ellipta inhaler on top of the med cart on the [NAME] Unit. No nurse was present at the cart during this period. During this time multiple staff members and a resident were observed to walk by the non-secure medications. During an interview on 11/6/24 at 10:00 A.M., Nurse #3 said medications should never be left out on top of a nurse's cart unless the nurse is at the medication cart. During an interview on 11/6/24 at 10:30 A.M., the Director of Nurses said if a nurse is not present at their medication cart then medications should not be left out. 2. On 11/5/24 at 7:37 A.M., 7:39 A.M., 7:44 A.M., 7:50 A.M., 7:52 A.M., 7:54 A.M., and 8:01 A.M., the facility wound round treatment cart was left unlocked and unsupervised in the hallway without the wound nurse present. Multiple staff members and residents were observed to walk by the unlocked treatment cart. The surveyor was able to access the treatment cart that had treatment supplies, scissors and prescription ointments and creams. During an interview on 11/5/24 at 7:45 A.M., Nurse #3 observed the wound round treatment cart unlocked in the hallway without nursing staff present at the cart and said it should not be left unlocked in the hallway. Nurse #3 said she told the Wound Nurse to lock their cart but they did not. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	36431 3. Resident #2 was admitted to the facility in May 2024 and has diagnoses that include chronic obstructive pulmonary disease, weakness ventricular fibrillation, peripheral vascular disease and unspecified dementia. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #2 scored a 6 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having severe cognitive impairment and required partial to moderate assistance from staff for toileting, and bathing. Review of the Admission/Readmission Evaluation Packet dated 5/22/24 indicated that Resident #2 did not wish to administer all or some of their medications independently. During an observation and interview on 11/3/24 at 8:00 A.M., Resident #2's right forearm had multiple scabbed areas the size of pencil erasers and red rash areas. Resident #2 scratched the areas then said the areas were not itchy. Resident #2 said his/her feet looked worse and proceeded to take off his/her left sock revealing a scaly, red, discolored left lower extremity from the calf down. When asked what was being done about his/her skin, he/she pointed to a bottle of body wash. On 11/4/24 at 8:25 A.M., and 11:00 A.M., Resident #2 was in his/her room. A bottle of remedy antifungal cream was on his/her bureau. On 11/5/24 at 7:26 A.M., Resident #2 was in his/her room, sitting on the side of his/her bed. A bottle of remedy antifungal cream was on his/her bureau. Review of the physician's active orders failed to indicate an order for antifungal cream. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 10/2024 failed to indicate an order for the antifungal treatment. Review of the MAR and TAR dated 11/2024 failed to indicate an order for the antifungal treatment. During an interview on 11/6/24 at 7:11 A.M., Nurse #10 said Resident #2 is not assessed to administer his/her own medications. Nurse #10 said any skin treatments including antifungal cream are to be stored in the treatment cart and not left in a resident's room, not secured.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observation, record review and interview, the facility failed to provide dental services for four Residents (#28, #103, #18 and #111), out of a total sample of 39 residents. Specifically, 1. For Resident #111, the facility failed to follow-up with a recommendation from the dentist to have teeth extracted. 2. For Resident #18, the facility failed to make a dental appointment to ensure his/her dentures fit appropriately, 3. For Resident #28, the facility failed to have the Resident seen by the contracted dentist for over two years after the consulting dentist made the recommendation for new dentures, and 4. For Resident #103, the facility failed to have the Resident seen by the dentist since admit to the facility, Findings include: Review of the facility policy titled, Dental Services, undated, indicated the following: - Routine and emergency dental services are available to meet the resident's of oral health services in accordance with the resident's assessment and plan of care. - Social services or designee will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible. - If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay. 1. Resident #111 was admitted to the facility in April 2024 with diagnoses including dementia. Review of Resident #111's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident #111 had a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also required supervision for all functional tasks. During an interview on 11/3/24 at 11:35 A.M., Resident #111 said he/she had experienced dental pain a few months ago and was seen by the dentist. Resident #111 said he/she was unaware if there was any follow-up that needed to occur after that dental appointment. Review of Resident #111's medical record indicated he/she was seen by the dentist on 9/21/24 with the following assessment and recommendations: (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Clinical exam reveals #18 (tooth) is a root tip and #19 is fractured with very sharp pieces on the lingual. Clinical exam reveals several broken teeth and #29 is also sharp on top. No swelling or exudate noted. #19 negative to palpation and percussion. Patient is stable. No clinical sign of infection. The pain the patient is experiencing is due to the traumatic ulcer caused by the #19. Patient has several broken teeth and root tips (see tooth grid). Showed patient's ulcer and broken teeth to (his/her) nurse (name). Recommend extract the non-restorable teeth #5, 13, 18, 19, 28, 29. To alleviate patient's pain and heal ulcer, recommend smooth #19 and 29. Recommend upper and lower RPD (right partial denture) to improve patient's chewing ability and quality of life. Recommend FMX (x-rays) for insurance approval of partial denture. FMX with also determine what restorations (he/she) will need to have performed at an office based dentist. Patient appears to understand. Recommend consult with MD (physician)/NP (nurse practitioner) regarding holding Elquis prior to extraction appt (appointment).; Obtain Signature for Consent for Dentures Form.; Obtain Signature for Consent for Extractions Form. Review of the nursing note, dated 9/21/24, indicated the following: Resident given PRN (as needed) APAP (pain medication) @ 1630 for c/o (complain of) toothache. Good effect stated 1830. (He/she) was seen by the dentist this shift. She noted an ulcer on the left side of his tongue, and recommended salt water rinses. She stated that (he/she) will be needing 5-6 teeth removed. While here she filed down some sharp pointy areas on 2 teeth. Temp 97.2. Further review of Resident #111's medical record failed to indicate consent forms were signed for tooth extraction or any other follow-up to schedule the extractions of teeth. During an interview on 11/5/24 at 8:31 A.M., Nurse #1 said all recommendations from the dentist are forwarded to the Director of Nursing who then relays the recommendations to the nursing staff. Nurse #1 said she regularly works with Resident #111 and was unaware he/she needed teeth extractions. During an interview on 11/5/24 at 10:06 A.M., the Director of Nursing said the after-care visit summary from the dentist that includes all recommendations is sent via email to the Unit Secretary and then is uploaded to the electronic medical record. The Director of Nursing said the Unit Secretary is responsible for ensuring all follow-up appointments are made. During an interview on 11/6/24 at approximately 5:00 A.M., the Unit Secretary said she is responsible for making all follow-up dental appointments. The Unit Secretary said she emailed the Resident's Guardian for consent for extraction on October 25, 2024, a month after the dental recommendation, however has not yet set up the appointment. 2. Resident #18 was admitted to the facility in May 2021 with diagnoses including dysphagia (difficulty swallowing), bipolar disorder and anxiety. Review of Resident #18's most recent Minimum Data Set (MDS), dated [DATE], indicated Resident #18 had a Brief Interview for Mental Status (BIMS) score of 7 out of a possible 15, which indicated he/she had severe cognitive impairment. Resident #18 was observed eating breakfast and lunch on 11/3/24 and 11/4/24 without wearing his/her dentures. (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/7/24 at 8:22 A.M., Resident #18 was observed eating breakfast without his/her dentures. Resident #18 said his/her dentures did not fit well and haven't been wearing them for some time. Certified Nursing Assistant #4 was present during this observation and said the Resident refused to wear his/her dentures because they were ill-fitting, and she did not report this to the nurse. Review of Resident #18's denture care plan indicated the following intervention: -(contract dental company) dental as needed, initiated 10/24/23. Review of Resident #18's Kardex (a form indicating all care needs of a resident) indicated the following: -(contract dental company) dental as needed Review of the Speech Therapy evaluation dated 9/30/24, indicated the following: - Dentition = Dentures, (very ill-fitting dentures. Top dentures continually are falling out, does not have bottom dentures in as they do not fit). During an interview on 11/7/24 at 9:02 A.M., the Speech Therapist said she completed a swallowing evaluation on 9/30/24 and, at this time, observed Resident #18's dentures were not fitting properly, and she informed the nurse of this. During an interview on 11/7/24 at 8:25 A.M., the Director of Nursing said she had not heard anything about Resident #18's dentures not fitting well and said the Resident had not been seen by the dentist for this issue. 36431 3. Resident #28 was admitted to the facility in September 2020 with diagnoses that include hyperlipidemia, chronic obstructive pulmonary disease, Parkinson's disease, and unspecified protein-calorie malnutrition. Review of the Minimum Data Set assessment, dated 8/1/24, indicated Resident #28 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having intact cognition and requires partial/moderate assistance from staff for oral hygiene. During an interview on 11/3/24 at 8:37 A.M., Resident #28 said his/her top denture is broken and has been for about three to four weeks. During an observation and interview on 11/4/24 at 2:20 P.M., Resident #28 took a top denture off the windowsill that was wrapped in a tissue. Resident #28 said he/she did not wear the denture because it was broken. Observation of the upper denture revealed a piece at the top of the denture was broken off. Resident #28 said he did not have bottom dentures, that he/she did not get the top denture while living here and he/she has not been seen by a dentist that he/she could recall. Review of Resident #28's medical record indicated the following: (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A physician's order, dated 9/4/24, dental consult as needed. - A dental group document with an exam date of 2/28/22, treatment notes. Pt (patient) states bottom denture missing, top denture does not fit. Pt requested new dentures. Recommended treatment, denture full upper; denture full lower. No further dental group documents were in the medical record. During an interview on 11/4/24 at 2:55 P.M., Nurse #2 and the surveyor went to the Resident's room. Nurse #2 looked at the top denture and said it was broken and said the Resident never wore the denture. Resident #28 said he/she wants to wear dentures and said he/she wanted upper and lower dentures During an interview on 11/6/24 at 4:25 A.M., the Unit Clerk said she checked, and did not have any further documents from the contracted dentist, only the one dated 2/28/22. Review of the Minimum Data Set records indicated Resident #28 has been in the facility without any hospitalization s or interruptions in his/her stay in the facility since admission. During an interview on 11/7/24 at 9:09 A.M., the Director of Nursing said she did not know why Resident #28 was never seen by the consulting dentist after the visit dated 2/28/22. 41019 4. Resident #103 was admitted in January 2024 with diagnoses including dysphagia. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #103 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. During an observation and interview on 11/4/24 at 8:02 A.M., Resident #103 was in his/her bed and was edentulous. Resident #103 said he/she lost his/her dentures after a hospital admission and does have difficulty chewing and swallowing without them, but that he/she has adjusted. Resident #103 said he/she only consumes liquids to prevent him/herself from choking. Review of the Health Drive Request for Service form, dated 5/1/24, indicated Resident #103 agreed to sign up for dental services through the facility contracted dental service. Review of the clinical record failed to indicate Resident #103 had received any dental services since his/her admitted . During an interview on 11/7/24 at 10:28 A.M., the Director of Nursing said that she could not find anything from the contracted dental agency for Resident #103, but was going to look into it. The Director of Nursing said she is not aware how often resident's should be seen annually for dental visits.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observation and test trays, the facility failed to provide food at a safe and palatable temperature for 2 out of 3 test trays. Findings include: According to the current U.S. Department of Agriculture (USDA) website: * Hot food should be held at 140 F (Fahrenheit) or warmer. * Cold food should be held at 40 F or colder. On 11/4/24 at 7:44 A.M., on the [NAME] Unit, a test tray resulted in the following temperatures: - Ham- 93 degrees Fahrenheit - French Toast- 94 degrees Fahrenheit - Milk- 50 degrees Fahrenheit The food on the test tray on the [NAME] unit tasted cold and bland. On 11/5/24 at 8:22 A.M., on the Hale Unit, a test tray resulted in the following temperatures: - French toast- 119.7 degrees Fahrenheit - Ham- 119 degrees Fahrenheit - Milk- 50 degrees Fahrenheit The food on the test tray on the Hale unit tasted luke warm and bland.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to provide the appropriate diet texture for one Resident (#323) out of a total sample of 39 residents. Specifically, Resident #323 was given a soft cookie while being prescribed a puree diet. Findings include: Resident #323 was admitted in June 2024 with diagnoses including dementia and chronic kidney disease. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #323 could not participate in the Brief Interview for Mental Status (BIMS) due to severe cognitive impairment. Review of the MDS indicates Resident #323 required supervision to assistance with meals, supervision with touching assistance for standing, and supervision with touching assistance with walking. Review of the Speech Therapy Treatment Encounter note, dated 9/5/24, indicated the following: - Patient seen for dysphagia follow up session in the context of dinner meal. At time of encounter, patient was found with mech (mechanical) soft cookie and incomplete bolus in mouth. Patient was unable to swallow bolus and eventually expectorated bolus. Review of the physician orders for Resident #323 indicated Resident #323 was on a pureed diet with thin liquids. During an interview on 11/6/24 at 9:00 A.M., the Speech Therapist said she found Resident #323 with a soft cookie in his/her mouth and the Resident was on puree at the time. The Speech Therapist said the Resident should not have had the cookie as he/she was unable to swallow it. The Speech Therapist was not sure who gave the Resident the cookie.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to ensure nursing staff documented accurately in the medical record for two Residents (#37 and #65) out of a total sample of 39 Residents. Specifically, 1. For Resident #37, the facility failed to ensure nursing staff accurately documented an orthotic device was worn as ordered. 2. For Resident #65, the facility failed to ensure nursing staff accurately documented which arm a blood pressure was taken. Findings include: 1. Resident #37 was admitted in October 2014 with diagnoses including stroke with left sided hemiplegia. Review of Resident #37's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), which indicated he/she was cognitively intact. Section GG of the MDS also indicated Resident #37 had an impairment in range of motion of one upper extremity. On 11/3/24 at 8:46 A.M. and 11:35 A.M., Resident #37 was observed lying in bed with his/her left hand in a closed, fist position. The Resident was not wearing a splint and there was no splint observed in his/her room. Using the Resident's dry erase board to communicate, Resident #18 said he/she used to wear a splint on his/her left wrist but has not in a while. On 11/4/24 at 10:29 A.M., Resident #37 was observed lying in bed with his/her left hand in a closed, fist position. The Resident was not wearing a splint and there was no splint observed in his/her room. On 11/4/24 at 2:23 P.M., Resident #37 was observed lying in bed with his/her left hand in a closed, fist position. The Resident was not wearing a splint and there was no splint observed in his/her room. On 11/4/24 at 4:41 P.M., Resident #37 was observed lying in bed with his/her left hand in a closed, fist position. The Resident was not wearing a splint and there was no splint observed in his/her room. Review of the Treatment Administration Report indicated the nurses had checked off the physician order as complete, that the Resident had worn his/her splint. Review of the physician orders indicated the following order: (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Orthotic Device: Please assist patient with donning his Left ulnar gutter left hand/forearm splint during AM (morning care) and removing during PM (nighttime care) with caregiver assist approx 6-8 hours or as tolerated. Please document any refusal to don splint, initiated 9/19/24. During an interview on 11/5/24 at 10:06 A.M., the Director of Nursing said she was unaware Resident #37 had not been wearing his/her splint and said orders should not be checked off as complete if not done. 43846 2. Review of the facility policy titled End-Stage Disease, dated September 2010, indicated residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. The resident's comprehensive care plan will reflect the resident's needs to ESRD/dialysis. Resident #65 admitted to the facility in November 2019 with diagnoses that included end stage renal disease, hyperlipidemia, and insomnia. Review of Resident #65's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident was cognitively intact. The MDS further indicated the Resident was receiving dialysis services. Review of Resident #65's physician order, dated 12/18/19, indicated NO Blood Draws, IV's, BPs (blood pressures) on left arm (shunt/dialysis access arm). Review of Resident #65's blood pressures indicated: - 11/1/24 126 / 65 mmHg Lying I (left)/arm - 10/30/24 124 / 70 mmHg Lying I/arm - 10/28/24 128 / 55 mmHg Lying I/arm - 10/25/24 103 / 62 mmHg Lying I/arm - 10/23/24 124 / 65 mmHg Lying I/arm - 10/18/24 98 / 72 mmHg Lying I/arm - 10/16/24 124 / 668 mmHg Sitting I/arm - 10/14/24 126 / 65 mmHg Lying I/arm - 10/9/24 142 / 72 mmHg Lying I/arm - 10/7/24 128 / 67 mmHg Lying I/arm - 10/4/24 134 / 60 mmHg Lying I/arm (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 10/2/24 150 / 67 mmHg Lying l/arm Review of Resident #65's dialysis care plan, dated 5/9/23, indicated Do not draw blood or take B/P in left arm with graft. During an interview on 11/6/24 at 10:00 A.M., Nurse #3 said the Resident's blood pressure should not be taken in the left arm and said it should be documented as being taken in the right arm. During an interview on 11/6/24 at 10:28 A.M., the Director of Nurses said the nurses should be not documenting that they are taking Resident #65's blood pressure in the left arm. During an interview on 11/7/24 at 7:55 A.M., Nurse #5 said the nurses should not be documenting they are taking the Resident's blood pressure left arm because that arm is where the fistula is. Nurse #5 said it is a mistake in documentation by the nursing staff. Nurse #5 said he had taken Resident #65's blood pressure multiple times on the right arm as he is the Resident's nurse regularly and he must have documented the wrong arm.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41456 Based on observation, review of the Quality Assurance Performance Improvement (QAPI) plan, and interview, the facility failed to ensure that the Quality Assurance Committee developed and implemented an appropriate corrective action plan with effective monitoring with measurable outcomes for a pressure ulcer QAPI project. Findings Include: During the survey period, multiple residents were identified as having facility acquired pressure ulcers with delayed treatment. During an interview on 11/7/24 at 10:41 A.M., the Administrator and Director of Nursing said they had recently developed a QAPI project for skin as it was identified as an area of concern for the building. The Administrator and Director of Nursing said the project's goal was to lessen the frequency of facility acquired pressure ulcers and the facility used reports to measure the progress of the project. When asked specifics about the reports used, the Director of Nursing said the regional support team uses the KPI (Key Performance Indicator) reports and tells the facility what changes to make based on that. Neither the Director of Nursing or Administrator could list specific tools or strategies used at the facility level that monitor and measure the progress or success of the project. The Director of Nursing also said it was hard to implement strategies for skin management due to staff turn over and that the skin QAPI project was definitely not successful and we failed at that project and will have to do it again.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, interview, record review, and policy review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, 1. The facility failed to ensure staff performed hand hygiene, used sterile equipment and followed enhanced barrier precautions during a dressing change. 2. For Resident #75, the facility failed to ensure nursing staff implemented enhanced barrier precautions. 3. The facility failed to ensure staff wore appropriate personal protective equipment (PPE) for residents on enhanced barrier precautions (EBPs). Findings include: Review of the facility policy titled Enhanced Barrier Precautions (EBP), dated March 2024, indicated EBP are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of the gown and gloves for EBPs include: g. device care or use (feeding tube) and h. wound care (any skin opening requiring a dressing). 1. On 11/3/24 at 12:36 P.M., the surveyor observed Nurse #6 prepare and perform a dressing change on a Resident's right forearm skin tear. The sign on the exterior of the door indicated the Resident was on Enhanced Barrier Precautions (EBP). Nurse #6 was observed walking down the hallway with the dressing supplies and obtained a pair of gloves from the top of a precaution cart. Nurse #6 did not obtain a gown. Nurse #6 entered the Resident's room and arranged the dressing supplies on top of the Resident's bureau. Nurse #6 donned the gloves without performing hand hygiene and adjusted his/her sweatshirt and the light switch. Nurse #6 then removed the existing undated dressing on Resident #40's arm by cutting the gauze wrapping with scissors then placed the scissors on the bureau. Nurse #6 applied pressure with gauze to the Residents arm when the skin tear began to bleed. Nurse #6 then threw away the soiled bandage and bloody gauze and returned to the dressing supplies, (wearing the same gloves) where she used the contaminated scissors to cut the xerofoam dressing and apply it to Resident #40's arm. Nurse #6 then wrapped Resident #40's arm with gauze then removed the gloves and threw them away. Without performing hand hygiene, Nurse #6 then took a marker to date the dressing directly on Resident #40's arm. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/5/24 at 12:05 A.M., Nurse #6 said staff are supposed to wear a gown for residents who are on enhanced barrier precautions. Nurse #6 said she should have worn a gown during the dressing change. During an interview on 11/5/24 at 12:39 P.M., the Director of Nursing (DON) and Regional Nurse said Nurse #6 should have performed hand hygiene before donning and after removing gloves, not used contaminated scissors and should not have dated the dressing while it was on Resident #40's arm. During an interview on 11/16/24 at 10:22 A.M., the Staff Development Coordinator said that enhanced barrier precautions should be followed for dressing changes. 36431 2. Resident #75 was admitted to the facility in September 2020 and has diagnoses that include Diabetes Mellitus, and type 2 Diabetes Mellitus with diabetic chronic kidney disease. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #75 scored a 12 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having moderately intact cognition and is dependent on staff for care. Review of Resident #75's physician's orders indicated the following: - Order for diabetic wound of the left distal foot. Cleanse with normal saline, apply xeroform, cover with gauze and tape island boarder dressing, one time a day, dated 10/31/24. On 11/4/24 at 9:21 A.M., observation failed to reveal that Resident #75's room had an enhanced barrier precautions sign or personal protection equipment (PPE) near or in the vicinity of the Resident's room. On 11/4/24 11:21 A.M., Nurse #8 exited Resident #75's room. Nurse #8 said the Resident's diabetic wound is an open wound, and she just completed the dressing. Nurse #8 said she did not wear any PPE, except gloves, when she did the treatment. Nurse #8 said enhanced precautions are required for residents with catheters and open wounds. 43846 3. On 11/5/24 at 7:33 A.M. and 7:40 A.M., the surveyor observed the Wound Physician and Nurse #5 enter a resident's room with a posted Enhanced Barrier Precaution (EBP) sign and provided wound care with out PPE on. During an interview on 11/5/24 at 7:44 A.M., the Wound Physician and Nurse #5 said they did wound rounds on each of the Resident's but did not apply Personal Protective Equipment (PPE) as they thought it was only for bigger wounds. During an interview on 11/7/24 at 8:00 A.M., the Regional Nurse said PPE should be applied during all wound care.		