

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Country Gardens Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2045 Grand Army Highway Swansea, MA 02777	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>34145</p> <p>Based on a resident group meeting, staff interviews, and document review, the facility failed to ensure grievances and concerns from the Resident Council were documented to ensure they were acted upon timely and included the facility response and rationale for response.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Resident Council, dated 3/2/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> -The Activity Director shall be designated, if approved by the group, to serve as a liaison between the group and the facility's administration and any other staff members. -The group may appoint a resident to take notes/maintain meeting minutes, or may elect that the Activity Director/designated liaison to take notes/maintain minutes. -The facility shall act upon concerns and recommendations of the Council, make attempts to accommodate recommendations to the extent practicable, and communicate its decisions to the Council. <p>Review of the Resident Council Minutes, dated 3/21/24, indicated eight residents participated in the meeting, and brought forward the following grievance:</p> <ul style="list-style-type: none"> -One resident complained that lettuce is shredded and does not like it; prefers chopped lettuce. <p>Review of the Resident Council Minutes for April 2024 indicated the residents refused to attend or participate in resident council meeting due to the Activities Director being out on leave.</p> <p>Review of the Resident Council Minutes, dated 5/23/24, indicated eight residents participated in the meeting, and brought forward the following grievance:</p> <ul style="list-style-type: none"> -Food was uneatable (sic) on the weekend. Dietary Manager notified. <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/25/24 at 1:00 P.M., the surveyor held a Resident Group meeting with five residents in attendance. The surveyor reviewed Resident Council Minutes from 3/21/24 through 5/23/24 with the residents. The Resident Council President said the minutes do not reflect the meetings at all. He/she said every month they talk about problems with the food and missing and damaged laundry. He/she said no one has followed up or attempted to make it better. They said the Activity Director was out for a long time and Activity Assistant #3 ran the Resident Council Meetings.</p> <p>During an interview on 6/25/24 at 2:25 P.M., Activity Assistant #3 said she ran the Resident Council Meetings while the Activity Director was out on leave. She said she doesn't take minutes or notes about anything discussed during the meetings. Activity Assistant #3 and the surveyor reviewed the March and May 2024 meeting minutes and said she did not write them and doesn't know who did. She said she did not remember if any residents brought up concerns during the meetings.</p> <p>During an interview on 6/27/24 at 9:35 A.M., the Activity Director said Activity Assistant #3 has been running the Resident Council meetings in her absence. The Activity Director said, although she was not working in the facility during the times the meetings were held, she typed up March and May 2024 meeting minutes because she does not think Activity Assistant #3 knows how to document the meetings. The Activity Director said she is aware that food and laundry complaints have been ongoing and the Resident Council bring it up at every meeting she has attended. She said the complaints should be documented on a grievance form so it can be addressed and resolved.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>34145</p> <p>Based on record review and interview, the facility failed to ensure the Physician/Practitioner was notified of a change in treatment for one Resident (#44), out of a total sample of 14 residents. Specifically, the facility failed to ensure the Physician/Practitioner was notified when a prescribed anticoagulant (blood thinner) was not available from the pharmacy and administered as ordered.</p> <p>Findings include:</p> <p>Resident #44 was originally admitted to the facility in June 2022 and had diagnoses including dementia.</p> <p>Review of the medical record indicated Resident #44 was admitted to the hospital on 8/14/24 after sustaining a right hip fracture following a fall.</p> <p>The hospital discharge summary, dated 8/18/24, indicated Resident #44 underwent an open reduction internal fixation (surgery to re-align and stabilize serious fractures) on 8/15/24. The summary and discharge medications indicated the Resident was to receive enoxaparin (anticoagulant) 40 milligrams/0.4 mL injection every 24 hours starting on 8/19/24 for Deep Vein Thrombosis (DVT) prophylaxis postoperatively.</p> <p>Review of August 2024 physician's orders indicated, but was not limited to:</p> <p>-Enoxaparin Sodium Injection Solution, Prefilled syringe 40 mg/0.4 mL, inject 40 mg subcutaneously (under the skin) one time a day until 9/20/24 (8/19/24)</p> <p>Review of the August 2024 Medication Administration Record (MAR) indicated the number 9 and initials in the box corresponding to the order for enoxaparin on 8/19/24. Review of the legend on the MAR identified the code 9 was other/See Nurse Notes.</p> <p>A medication administration note, dated 8/19/24, indicated a notation of n/a next to the order for enoxaparin 40 mg/0.4 mL with no other documentation.</p> <p>Further review of the medical record failed to indicate the Physician/Nurse Practitioner was notified that enoxaparin was not administered on 8/19/24 as ordered.</p> <p>During an interview on 8/20/24 at 3:04 P.M., Nurse #3 said she documented the code 9 on the MAR and n/a in a note for not available because the Resident did not get the enoxaparin as it had not been delivered by the pharmacy yet. She said it was delivered the next day. Nurse #3 said she did not notify the Physician or Nurse Practitioner that the enoxaparin was not administered on 8/19/24 as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/20/24 at 3:25 P.M., Unit Manager #1 reviewed Resident #44's medical record and said Nurse #3 should have notified the Physician or Nurse Practitioner, but did not.</p> <p>See F760</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>48695</p> <p>Based on observations and staff interviews, the facility failed to ensure the privacy and confidentiality of resident records were maintained. Specifically, the facility failed to ensure residents' private health information was securely stored and not accessible in the facility's copy room and Staff Development Coordinator's (SDC) office, which were located on the main hallway on the first floor of the facility.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Safeguarding of Resident Identifiable Information, last revised 3/4/24, indicated but was not limited to the following:</p> <p>-Policy: It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the safety and confidentiality of the resident's identifiable information and to safeguard against destruction or unauthorized release of information and records.</p> <p>-Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> 1. The facility may not release information that is resident-identifiable to the public. 4. Medical records shall not be left in open areas where unauthorized persons could access identifiable resident information. <p>On 6/26/24 at 4:24 P.M., the surveyor observed the door to the copy room of the main hallway with the door open and unattended with two boxes labeled medical records visible from the hallway and physician notes which included medical diagnoses and resident face sheets on the fax machine. Upon further investigation, the boxes labeled medical records contained but were not limited to hospital discharge summaries and resident diagnoses.</p> <p>During an interview on 6/26/24 at 4:27 P.M., the Administrator said the doctors and nurse practitioners would fax their notes to the fax machine and the two boxes of medical records were waiting to be filed. The Administrator said the door to the copy room should be locked to protect resident information because it is accessible to anyone walking by.</p> <p>On 6/26/24 at 4:51 P.M., the surveyor observed the door to the copy room of the main hallway with the door open and unattended with two boxes labeled medical records visible from the hallway and physician notes which included medical diagnoses and resident face sheets on the fax machine. Upon further investigation, the boxes labeled medical records contained but were not limited to hospital discharge summaries and resident diagnoses.</p> <p>During an interview on 6/26/24 at 4:55 P.M., the Chief Nursing Officer (CNO) said the door to copy room should have been closed and locked because the room contains residents' personal medical information but it was not.</p> <p>34145</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/27/24 at 8:19 A.M., the surveyor observed the SDC's office door wide open with no staff inside the office. Two large piles of residents' physician's orders were on a table. The physician's orders contained private health information including but not limited to residents' name, date of birth, allergies, diagnoses, diet orders, treatment orders, and medication orders. A large box containing three, 3-ring binders were on a chair. The binders contained resident specific information on Kardex cards (card that identifies residents and their care needs), Activity of Daily Living Flow sheets (includes bowel and bladder information) and daily census listings. A purple binder was on a desk and was labeled Infection Control Line Listings for 2024. The binder contained pages of information including, but not limited to resident's names, infections, signs and symptoms of infection experienced by the residents and treatments.</p> <p>During an interview on 6/27/24 at 8:52 A.M., the surveyor alerted the Director of Nursing (DON) that the SDC's office door was wide open and resident's private health information was not secured and accessible to anyone. The DON said it should be closed at all times when no one is in the office.</p> <p>On 7/1/24 at 8:02 A.M., the surveyor observed the SDC's office door wide open with no staff inside the office. Two large piles of residents' physician's orders were on a table. The physician's orders contained private health information including but not limited to residents' name, date of birth, allergies, diagnoses, diet orders, treatment orders, and medication orders.</p> <p>On 7/1/24 at 9:13 A.M., the surveyor observed the SDC's office door wide open with no staff inside the office. Two large piles of residents' physician's orders were on a table. The physician's orders contained private health information including but not limited to residents' name, date of birth, allergies, diagnoses, diet orders, treatment orders, and medication orders.</p> <p>On 7/1/24 at 9:22 A.M., the surveyor observed the SDC's office door wide open with no staff inside the office. Two large piles of residents' physician's orders were on a table. The physician's orders contained private health information including but not limited to residents' name, date of birth, allergies, diagnoses, diet orders, treatment orders, and medication orders.</p> <p>During an interview on 7/1/24 at 10:04 A.M., the CNO said the door to the SDC office should never be left open and unattended because there are resident records in there and accessible to anyone.</p>

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>50740</p> <p>Based on record review and interviews, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately completed to reflect the status for one Resident (#10), in a total sample of 19 residents. Specifically, the facility failed to ensure MDS assessments accurately reflected the Resident's bipolar disorder diagnosis.</p> <p>Findings include:</p> <p>Review of the facility's policy titled MDS 3.0 Completion, dated 3/4/24, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan; -According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI (Resident Assessment Instrument) specified by the State; -All disciplines shall follow the guidelines in Chapter 3 of the current RAI Manual for coding each assessment. <p>Resident #10 was admitted to the facility in January 2024 with diagnoses including bipolar disorder.</p> <p>Review of the Initial Psych Evaluation, dated on 2/7/24, by Nurse Practitioner (NP) #1, indicated Resident #10's prior psychiatric history included bipolar disorder.</p> <p>Review of Resident #10's Chronic Care Management note, dated 2/2/24, by Physician #1, included a diagnosis of bipolar disorder.</p> <p>Review of Subsequent Psychopharm Note documentation, written by NP #1, dated 2/21/24, 4/17/24, 5/15/24, and 6/19/24, indicated that Resident #10's psychiatric history included bipolar disorder.</p> <p>Review of Resident #10's MDS assessments, Section I: Active Diagnoses, on the following dates failed to indicate his/her diagnosis of bipolar disorder:</p> <ul style="list-style-type: none"> -Admission assessment, dated 2/6/24, -Quarterly assessment, dated 5/8/24, -Discharge assessment, dated 5/18/24 <p>During an interview on 6/27/24 at 2:18 P.M., MDS Nurse #1 said it was her expectaion that the MDSs were completed accurately.</p> <p>(continued on next page)</p>		

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 7/1/24 at 10:04 A.M., the Chief Nursing Officer (CNO) said it was her expectation that the MDSs were completed accurately. 48695

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>34145</p> <p>Based on record review and interview, the facility failed to ensure staff developed a baseline or comprehensive care plan within 48 hours of the resident's admission, which included the instructions needed to provide effective and person-centered care for two Residents (#20 and #74), out of a total sample of 19 residents. Specifically, the facility failed:</p> <ol style="list-style-type: none"> 1. For Resident #20, to develop a baseline care plan for the Resident's diagnosis of diabetes mellitus; and 2. For Resident #74, to develop a baseline care plan for the Resident's diagnosis of endocarditis (infection of the heart's inner lining, usually involving the heart valves), presence of a Peripherally Inserted Central Catheter (PICC: a thin, flexible tube inserted into a vein in the upper arm then guided (threaded) into a large vein above the right side of the heart called the superior vena cava), and administration of intravenous antibiotic therapy. <p>Findings include:</p> <p>Review of the facility's Baseline Care Plan policy, last revised 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> -The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. -The baseline care plan will be developed within 48 hours of a resident's admission. -Include minimum healthcare information necessary to properly care for a resident including, but not limited to: <ul style="list-style-type: none"> -Initial goals based on admission orders. -Physician orders. -Dietary orders. -The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. -Once gathered, initial goals shall be established that reflect the resident's current needs including: <ol style="list-style-type: none"> i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk. <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living.</p> <p>iii. Any special needs such as for IV therapy, dialysis, or wound care.</p> <p>1. Resident #20 was admitted to the facility in April 2024 with diagnoses including diabetes mellitus.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 4/19/24, indicated Resident #20 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15, was diabetic, required a therapeutic diet and received insulin injections.</p> <p>Review of the medical record indicated Physician's Orders for the following anti-diabetic medications:</p> <p>-Glipizide ER 2.5 milligrams (mg), give one tablet one time a day for type 2 diabetes mellitus (4/16/24)</p> <p>-Humalog Injection Solution 100 unit/milliliters (mL), inject per sliding scale for type 2 diabetes mellitus (4/16/24)</p> <p>-Metformin HCl 500 mg, give one tablet two times a day for type 2 diabetes mellitus (4/16/24)</p> <p>-Ozempic Subcutaneous Solution Pen Injector 4 mg/3 mL, inject 1 mg subcutaneously (under the skin) one time a day for type 2 diabetes mellitus (4/16/24)</p> <p>Further review of Resident #20's medical record failed to indicate a baseline or comprehensive care plan was developed within 48 hours of admission to address the Resident's diagnosis, treatment and monitoring of diabetes mellitus.</p> <p>During an interview on 6/25/24 at 11:29 A.M., Unit Manager #1 reviewed Resident #20's medical record and said a baseline or comprehensive care plan should have been developed within 48 hours for the Resident's diagnosis and treatment plan for diabetes mellitus and it was not.</p> <p>2. Resident #74 was admitted to the facility in May 2024 with diagnoses including endocarditis and had a PICC line for infusion of antibiotic medication.</p> <p>Review of the MDS assessment, dated 6/2/24, indicated Resident #74 was cognitively intact as evidenced by a BIMS score of 14 out of 15 and received intravenous antibiotic medication.</p> <p>Review of the medical record indicated that Resident #74 had a PICC line placed to the left antecubital (inner surface of the forearm) for infusion of antibiotic medication during a recent hospitalization .</p> <p>Review of Physician's Orders indicated but was not limited to:</p> <p>-Change Cap and Extensions set on PICC/ Midline catheter 24 hours after insertion or on admission, then weekly with dressing change, and as needed (prn) for PICC/ Midline Protocol (5/29/24)</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Change PICC/ Midline dressing on admission, weekly, Thursday and as needed for Dressing Change (5/29/24)</p> <p>-Measure external catheter on admission, and with dressing change (5/29/24)</p> <p>-Ampicillin Sodium Injection Solution (antibiotic) Reconstituted 2 grams (gm), use 2 gm intravenously every 4 hours related to acute and subacute endocarditis for 6 Weeks (5/29/24)</p> <p>-Ceftriaxone Sodium Injection Solution (antibiotic) Reconstituted 2 gm, use 2 gm intravenously every 12 hours related to acute and subacute endocarditis for 6 Weeks (5/29/24)</p> <p>Further review of Resident #74's medical record failed to indicate a baseline or comprehensive care plan was developed within 48 hours of admission to address the Resident's diagnosis and treatment of endocarditis utilizing a PICC line.</p> <p>During an interview on 6/27/24 at 2:21 P.M., Nurse #8 reviewed Resident #74's medical record and said there were no baseline or comprehensive care plans for the Resident's admission diagnosis of endocarditis, the use of antibiotic therapy, and a PICC line. She said a baseline care plan should have been developed for these care needs and were not.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>48695</p> <p>Based on observations, interviews, and records reviewed, for nine Residents (#55, #231, #48, #78, #74, #20, #72, #30 and #47), out of 19 sampled residents, the facility failed to develop and/or implement comprehensive care plans to reflect the individual needs of the residents. Specifically, the facility failed:</p> <ol style="list-style-type: none"> 1. For Resident #55, <ul style="list-style-type: none"> a. to implement a care plan for an indwelling Foley catheter (tube placed in the body to drain and collect urine from the bladder), and b. to develop and implement a care plan for psychotropic medications; 2. For Resident #231, to develop and implement a care plan for an anticoagulant (blood thinning) medication; 3. For Resident #48, to implement a care plan for an anticoagulant medication; 4. For Resident #78, to implement a care plan for antidepressant medication; 5. For Resident #74, to develop a comprehensive care plan for the Resident's diagnosis of endocarditis (infection of the heart's inner lining, usually involving the heart valves), presence of a Peripherally Inserted Central Catheter (PICC: a thin, flexible tube inserted into a vein in the upper arm then guided (threaded) into a large vein above the right side of the heart called the superior vena cava), and administration of intravenous antibiotic therapy; 6. For Resident #20, to develop a comprehensive care plan for the diagnosis, treatment and monitoring of diabetes mellitus; 7. For Resident #72, to develop and implement a care plan for intravenous (IV) therapy, wound assessment and care, enhanced barrier and transmission-based precautions, and implantable cardioverter defibrillator (a battery-operated device used to correct abnormal heart rhythms); 8. For Resident #30, to develop and implement a care plan for a cardiac pacemaker; and 9. For Resident #47, to develop and implement a care plan for elopement risk. <p>Findings include:</p> <p>Review of the facility's policy titled Comprehensive Care Plans, last reviewed/revised 3/4/24, indicated but was not limited to:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment.</p> <p>- Policy Explanation and Compliance Guidelines:</p> <p>1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally-competent and trauma-informed.</p> <p>3. The comprehensive care plan will describe, at a minimum, the following:</p> <p>a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>1. Resident #55 was admitted to the facility in October 2024 with diagnoses including retention of urine, anxiety, obsessive compulsive disorder, depression, and obstructive and reflux uropathy.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 3/5/24, indicated Resident #55 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of the MDS indicated the Resident had an indwelling catheter, and received antipsychotic, antianxiety, and antidepressant medications.</p> <p>a. During an observation with interview on 6/24/24 at 9:37 A.M., the surveyor observed Resident #55 sitting in a chair with his/her Foley catheter in a privacy bag. Resident #55 said he/she has had the Foley catheter for a while now and it has been changed monthly.</p> <p>Review of Resident #55's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - Intake and output every shift until Foley is discontinued (11/5/23) - Change Foley catheter as needed for leakage/blockage or dislodgement (11/6/23) - May irrigate Foley Catheter with 30 cc (cubic centimeter) or 60 cc of Normal Saline for blockage. Document amount used as needed for blockage (11/6/23) - Foley Catheter Size: 16 Fr (French) 5-10 cc (1/28/24) - Empty Foley drainage bag every shift and record output every shift (2/25/24) - Change Foley catheter monthly for care 16 Fr 5-10 cc every evening shift once monthly (3/4/24) <p>Review of Resident #55's April, May, and June 2024 Treatment Administration Record (TAR) indicated Foley catheter care was performed as ordered by the Physician.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #55's interdisciplinary care plan indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - Focus: I have a Foley catheter in place due to D/X (diagnosis) URINARY RETENTION and unsuccessful voiding trial and ongoing UTI (urinary tract infection) (Last revised 2/1/2024) -Goal: I will not present with any complications from my Foley Catheter. For example - I will not develop a urinary tract infection. (Dated 11/7/2023) -Interventions: Please empty my drainage bag each shift. Note the amount, color, consistency, and odor of my urine. (Dated 11/7/2023) <p>Further review of Resident #55's Physician Orders failed to indicate an order to monitor for color, consistency, and odor of my urine.</p> <p>During an interview on 6/26/24 at 4:40 P.M., Unit Manager #1 said Resident #55 did not have a separate order to monitor color, consistency, and odor but should have.</p> <p>During an interview on 6/28/24 at 2:18 P.M., the Director of Nursing (DON) said Resident #55 should have had his/her urine monitored for color, consistency, and odor but it was not.</p> <p>b. Review of Resident #55's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - Escitalopram (antidepressant) 20 milligrams (mg) tab by mouth one time a day (10/27/23) - Aripiprazole (antipsychotic) 2 mg tab by mouth one time a day (10/27/23) - Remeron (antidepressant) 7.5 mg by mouth one time a day (11/20/23) - Xanax (antianxiety) 0.5 mg by mouth three times a day (11/16/23) <p>Review of Resident #55's April, May, and June 2024 Medication Administration Records (MAR) indicated he/she received Escitalopram, Aripiprazole, Remeron, and Xanax as ordered.</p> <p>During an interview on 6/25/24 at 12:40 P.M., Unit Manager #1 said any resident taking an antipsychotic, antianxiety, and antidepressant medication should have a care plan. Unit Manager #1 and surveyor reviewed resident #55's care plans. Unit Manager #1 said Resident #55 did not have a care plan for his/her antipsychotic, antianxiety, and antidepressant medications but should have.</p> <p>During an interview on 6/27/24 at 12:55 P.M., the DON said residents who are receiving antidepressant, antianxiety, and antipsychotic medications should have a care plan for the medications. The DON said the care plans should be developed and implemented for Resident #55 but were not.</p> <p>2. Resident #231 was admitted to the facility in June 2024 with diagnoses including hypertension and alcohol abuse.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #231's MDS assessment, dated 6/8/24, indicated that Resident #231 had a moderate cognitive impairment as evidenced by a BIMS score of 12 out of 15. Further review of the MDS indicated that Resident #231 received anticoagulant medication.</p> <p>Review of Resident #231's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - Enoxaparin Sodium (anticoagulant) 40 mg/0.4 milliliter (ml); Inject subcutaneously (under the skin) one time a day (6/5/24) <p>Review of Resident #231's June 2024 MAR indicated he/she received Enoxaparin Sodium as ordered.</p> <p>Review of Resident #231's care plan failed to indicate that a care plan for the use of anticoagulant medication had been developed.</p> <p>During an interview on 6/26/24 at 4:49 P.M., Nurse #5 reviewed Resident #231's physician's orders, MAR, and care plans. Nurse #5 said Resident #231 received anticoagulant medication and should have had a care plan in place but did not.</p> <p>During an interview on 6/27/24 at 12:55 P.M., the DON said residents who are receiving anticoagulant medications should have a care plan for the medications. The DON said the care plan for Resident #231 should be developed and implemented but was not.</p> <p>3. Resident #48 was admitted to the facility in April 2024 with diagnoses including atrial fibrillation and muscle wasting and atrophy.</p> <p>Review of Resident #48's MDS assessment, dated 4/11/24, indicated Resident #48 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Further review of the MDS indicated Resident # 48 received anticoagulant medication.</p> <p>Review of Resident #48's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - Apixaban (anticoagulant) 5 mg give 1 tablet two times a day (4/8/24) <p>Review of Resident #48's April, May, and June 2024 MARs indicated he/she received Apixaban as ordered.</p> <p>Review of Resident #48's care plan failed to indicate that a care plan for the use of anticoagulant medication had been developed.</p> <p>During an interview on 6/26/24 at 4:49 P.M., Nurse #5 reviewed Resident #48's physician's orders, MAR, and care plans. Nurse #5 said Resident #231 received anticoagulant medication and should have had a care plan in place but did not.</p> <p>During an interview on 6/27/24 at 12:55 P.M., the DON said residents who are receiving an anticoagulant medication should have a care plan. The DON said the care plan for Resident #48 should have been developed and implemented but was not.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Resident #78 was admitted to the facility in April 2024 with diagnoses including major depressive disorder.</p> <p>Review of Resident #78's BIMS assessment, dated 4/4/24, indicated Resident #78 was cognitively intact as evidenced by a BIMS score of 15 out of 15.</p> <p>Review of Resident #78's MDS assessment, dated 4/12/24, indicated that Resident #78 received antidepressant medication.</p> <p>Review of Resident #78's current Physician's Orders indicated but were not limited to:</p> <ul style="list-style-type: none"> - Citalopram (antidepressant) 20 mg give one tab daily (5/17/24) - Sertraline (antidepressant) 25 mg give one tab daily (4/4/24) <p>Review of Resident #78's April, May, and June 2024 MARs indicated he/she received Citalopram and Sertraline as ordered.</p> <p>Review of Resident #78's care plan included but was not limited to:</p> <ul style="list-style-type: none"> -Focus: I uses [SIC] antidepressant medication Sertraline and Citalopram r/t (related to) Depression (date initiated 5/13/24) -Goal: I will be free from discomfort or adverse reactions related to antidepressant therapy through the review date (date initiated 5/13/24) -Interventions: <ul style="list-style-type: none"> -Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT (every shift) (date initiated 5/13/24) -Monitor/document/report PRN (as needed) adverse reactions to ANTIDEPRESSANT therapy (date initiated 5/13/24) <p>Further review of Resident #78's medical record indicated the facility failed to implement Resident #78's care plan to monitor potential side effects of antidepressant medications.</p> <p>During an interview on 6/27/24 at 12:55 P.M., the DON said residents who are receiving antidepressant medications should have a care plan for monitoring potential side effects of the medications. The DON said the care plan for Resident #78 should have been implemented but was not.</p> <p>During an interview on 7/1/24 at 10:04 A.M., the Chief Nursing Officer (CNO) said that if a care plan indicated to monitor side effects of antidepressant medications, then staff should have asked the physician to write an order so the intervention could be implemented.</p> <p>34145</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Resident #74 was admitted to the facility in May 2024 with diagnoses including endocarditis and had a PICC line for infusion of antibiotic medication.</p> <p>Review of the MDS assessment, dated 6/2/24, indicated Resident #74 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 14 out of 15 and received intravenous antibiotic medication.</p> <p>Review of the medical record indicated that Resident #74 had a PICC line placed to the left antecubital (inner surface of the forearm) for infusion of antibiotic medication during a recent hospitalization .</p> <p>Review of Physician's orders indicated, but was not limited to:</p> <ul style="list-style-type: none"> -Change Cap and Extensions set on PICC/ Midline catheter 24 hours after insertion or on admission, then weekly with dressing change, and as needed (prn) for <p>PICC/ Midline Protocol (5/29/24)</p> <ul style="list-style-type: none"> -Change PICC/ Midline dressing on admission, weekly, Thursday and as needed for Dressing Change (5/29/24) -Measure external catheter on admission, and with dressing change (5/29/24) -Ampicillin Sodium Injection Solution (antibiotic) Reconstituted 2 grams (gm), use 2 gm intravenously every 4 hours related to acute and subacute endocarditis for 6 Weeks (5/29/24) -Ceftriaxone Sodium Injection Solution (antibiotic) Reconstituted 2 gm, use 2 gm intravenously every 12 hours related to acute and subacute endocarditis for 6 Weeks (5/29/24) <p>Further review of Resident #74's medical record failed to indicate a comprehensive care plan was developed to address the Resident's care needs related to his/her diagnosis and treatment of endocarditis utilizing a PICC line.</p> <p>During an interview on 6/27/24 at 2:21 P.M., Nurse #8 reviewed Resident #74's medical record and said a comprehensive care plan had not been developed for the Resident's diagnosis of endocarditis, the use of antibiotic therapy, and a PICC line but should have been.</p> <p>6. Resident #20 was admitted to the facility in April 2024 with diagnoses including diabetes mellitus.</p> <p>Review of the MDS assessment, dated 4/19/24, indicated Resident #20 had moderate cognitive impairment as evidenced by a BIMS score of 9 out of 15, was diabetic, required a therapeutic diet, and received insulin injections.</p> <p>Review of the medical record indicated Physician's Orders for the following anti-diabetic medications:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Glipizide ER 2.5 milligrams (mg), give one tablet one time a day for type 2 diabetes mellitus (4/16/24)</p> <p>-Humalog Injection Solution 100 unit/milliliters (mL), inject per sliding scale for type 2 diabetes mellitus (4/16/24)</p> <p>-Metformin HCl 500 mg, give one tablet two times a day for type 2 diabetes mellitus (4/16/24)</p> <p>-Ozempic Subcutaneous Solution Pen Injector 4 mg/3 mL, inject 1 mg subcutaneously (under the skin) one time a day for type 2 diabetes mellitus (4/16/24)</p> <p>Further review of Resident #20's medical record failed to indicate a comprehensive care plan was developed to address the Resident's diagnosis, treatment, and monitoring of diabetes mellitus.</p> <p>During an interview on 6/25/24 at 11:29 A.M., Unit Manager #1 reviewed Resident #20's medical record and said comprehensive care plan should have been developed for the Resident's diagnosis and treatment plan for diabetes mellitus and it was not.</p> <p>50740</p> <p>7. Resident #72 was admitted to the facility in May 2024 with the following diagnoses: sepsis (an infection of the bloodstream) and Methicillin-Susceptible Staphylococcus aureus (MSSA) infection (a bacterial infection that can be treated by antibiotics).</p> <p>Review of the MDS assessment, dated 5/21/24, indicated Resident #72 was cognitively intact as evidenced by a BIMS score of 15 out of 15, and had diagnoses including a multi-drug resistant organism infection, septicemia, and wound infection. Further review of the MDS indicated he/she received application of dressings to his/her feet and received IV (intravenous) antibiotic therapy.</p> <p>Review of Resident #72's Order Summary Report indicated but was not limited to the following:</p> <p>-Clean area to Left Great Toe with normal saline, pat dry. Apply protective dressing every evening shift (order date 5/17/24);</p> <p>-Clean area to Right Ankle with normal saline. Pat dry. Apply dry protective dressing every evening shift (order date 5/17/24);</p> <p>-D/C (discontinue) midline after abx (antibiotic) therapy is completed on 6/26/24 (order date 6/19/24);</p> <p>-Enhance Barrier Precautions and Contact Precautions every shift (order date 5/17/24);</p> <p>-Patient has a implantable cardioverter defibrillator [sic] (order date 5/17/24).</p> <p>Review of Resident #72's May and June 2024 MAR and TAR indicated but was not limited to:</p> <p>-Resident #72 was administered IV Cefazolin (an antibiotic) 5/18/24 through 5/31/24 and 6/1/24 through 6/26/24.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident #72 received treatment, including cleansing area with normal saline and application of a dry protective dressing, to left great toe and right ankle areas every evening shift 6/1/24 through 6/19/24 and 6/21/24 through 6/25/24.</p> <p>Review of Resident #72's comprehensive care plans failed to indicate that a person-centered care plan had been developed to specify the goals or interventions for Resident #72's IV therapy, wound assessment and care, enhanced barrier and transmission-based precautions, and implantable cardioverter defibrillator.</p> <p>During an interview on 6/27/24 at 12:55 P.M., the CNO said that care plans should be individualized for each resident.</p> <p>49428</p> <p>8. Resident #30 was admitted to the facility in March 2024 with diagnoses including presence of cardiac pacemaker, sick sinus syndrome (a disease in which the heart's natural pacemaker is no longer able to generate normal heartbeats at the normal rate), atrial fibrillation, and dementia.</p> <p>Review of the MDS assessment, dated 4/3/24, indicated for Resident #30 that no BIMS assessment was conducted. Further review of the MDS indicated the presence of a cardiac pacemaker.</p> <p>Review of Resident #30's active Physician's Orders indicated but were not limited to:</p> <ul style="list-style-type: none"> - Resident has pacemaker left chest wall (LCW), every shift. Active 3/5/24. <p>Further review of Resident #30's Medical Record included but was not limited to:</p> <ul style="list-style-type: none"> - Clinical Nurses Note, dated 3/4/24: dual pacemaker LCW family contacted for further details [sic]. - Outside record, dated 1/27/23, indicating the brand of pacemaker and pacemaker testing results. <p>Review of Resident #30's active care plan did not include a cardiac pacemaker.</p> <p>During an interview on 6/27/24 at 11:10 A.M., Nurse #3 said Resident #30's cardiac pacemaker was still in use despite the Resident being admitted to hospice on 3/22/24. Nurse #3 and the surveyor reviewed Resident #30's medical record together. Nurse #3 said she had the name of the surgeon, name of the cardiologist, and where the cardiac pacemaker implant procedure was done, but she could not find the cardiac pacemaker setting information or monitoring schedule. Nurse #3 said she was unsure of the plan for Resident #30's pacemaker.</p> <p>During an interview on 7/1/24 at 9:42 A.M., the DON reviewed the Resident #30's care plan in the medical record and said there was no care plan for the Resident's cardiac pacemaker. The DON said there should be a care plan for Resident #30's cardiac pacemaker regardless of whether the pacemaker was being utilized.</p> <p>31830</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9. Resident #47 was admitted to the facility in December 2023 with diagnoses which included Alzheimer's disease.</p> <p>Review of the facility's policy titled Elopements and Wandering Residents, dated as revised 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> - the facility ensures that residents who exhibit wandering behavior and/or risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. <p>Review of the MDS assessment indicated Resident #47 was severely impaired as evidenced by a BIMS score of 2 out of 15 and was able to ambulate independently.</p> <p>Review of the Elopement Risk Screen, dated 3/5/24, indicated Resident #47:</p> <ul style="list-style-type: none"> - Scored 2 and was a moderate actual risk for elopement - a. Wandering is not easily ended or diverted and/or - b. Resident is responding negatively to being contained within boundaries set by other and/or - c. Infrequent and unsuccessful attempts to transgress boundaries set by others. <p>Further review of Resident #47's medical record failed to indicate a comprehensive care plan was developed to address the Resident's care needs related to risk for elopement.</p> <p>During an interview on 6/28/24 at 10:50 A.M., Nurse #8 said Resident #47 had the potential to be an elopement risk especially after visits from family members. Nurse #8 reviewed the Resident's medical record and said a comprehensive care plan for elopement risk had not been developed but should have.</p> <p>During an interview on 6/28/24 at 12:50 P.M., the CNO said it was the expectation that residents who are assessed as an elopement risk have a comprehensive care plan developed and in place.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49428</p> <p>Based on observation, interview, and record review, the facility failed to follow professional standards of practice for four Residents (#28, #20, #48, and #72), out of a total sample of 19 residents. Specifically, the facility failed:</p> <ol style="list-style-type: none"> 1. For Resident #28, to notify the Physician that the Resident's oxygen saturation levels trended above the range specified in the Physician's orders; 2. For Resident #20, <ol style="list-style-type: none"> a. to ensure physician's orders were in place for fingerstick blood sugars (FSBS) in order to implement the Physician's order for sliding scale insulin (medication used in the treatment and management of diabetes mellitus), to monitor for symptoms of hyper/hypoglycemia (high/low blood sugar) and treatment interventions to address the potential for hypoglycemia, and b. to ensure physician's orders for a change in treatment with psychotropic medication was accurately documented and implemented, and to inform the Physician when the Resident was not administered medication as ordered for 10 days; 3. For Resident #48, to obtain an order for care and treatment of a [NAME] drain (a piece of surgical thread that's left in an anal fistula (an abnormal tunnel under the skin that connects the anal canal in the colon to the skin of the buttocks) for several weeks to keep it open; and 4. For Resident #72, to document weekly comprehensive skin assessments. <p>Findings include:</p> <p>Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice dated as revised April 11, 2018, indicated but was not limited to:</p> <p>Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers 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.</p> <ol style="list-style-type: none"> 1. Review of the facility's policy titled Oxygen Administration, dated as reviewed/revised on 3/4/24, indicated but was not limited to: <ul style="list-style-type: none"> - Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. - Oxygen is administered under orders of a physician. <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy.</p> <p>- Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen.</p> <p>Resident #28 was admitted to the facility in November 2018 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD, a chronic inflammatory lung disease that causes obstructed airflow from the lungs), major depressive disorder, and general anxiety disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 3/27/24, indicated Resident #28 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating severe cognitive impairment. Further review of the MDS indicated Resident #28 was receiving oxygen therapy.</p> <p>Review of Resident #28's current Physician's Orders included but was not limited to:</p> <p>- Goal oxygen (O2) saturation (sat) for COPD patient is between 88-92%. It should not be any higher. Please monitor O2 sats every 4 hours for COPD. Active 5/13/2024.</p> <p>- Check O2 sat at every shift, maintain O2 between 88-92% every shift for prevention. Active 5/13/24.</p> <p>- Oxygen at 1-3 Liters (L) per minute continuous to maintain O2 sat 88-92% every shift for oxygen therapy AND as needed for shortness of breath (SOB). Active 5/14/24.</p> <p>Review of Resident #28's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for May, June, and July 2024 indicated nursing was administering oxygen to the Resident and obtaining O2 sat levels per Physician's orders.</p> <p>Further review of Resident #28's medical record indicated but was not limited to:</p> <p>- Oxygen Saturation Values (oxygen via nasal cannula, a plastic cannula in the nostrils, unless otherwise noted):</p> <p>7/1/24: 95%</p> <p>6/30/24: 95%, 96%, 95%</p> <p>6/29/24: 96%, 96% (room air), 96%</p> <p>6/28/24: 96%, 97% (room air), 97%</p> <p>6/27/24: 93%</p> <p>6/26/24: 95%, 96%, 96%, 96%</p> <p>6/25/24: 96% (room air), 89%, 90%</p> <p>(continued on next page)</p>		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/24/24: 94%, 93%, 93%, 94% (room air), 93% 6/23/24: 96%, 94%, 94% 6/22/24: 94%, 96% 6/21/24: 95%, 94%, 94% 6/20/24: 93%, 94%, 95% 6/19/24: 97%, 96%, 96% 6/18/24: 95%, 95%, 98% 6/17/24: 95% (room air), 95%, 98%, 98%, 98% 6/16/24: 95%, 94%, 95% 6/15/24: 95%, 95% 6/14/24: 95%, 94% 6/13/24: 95%, 95%, 96% (room air) 6/12/24: 95%, 96%, 95% 6/11/24: 92%, 92%, 92% 6/10/24: 96%, 95%, 94%, 96% (room air) 6/9/24: 94%, 95% 6/8/24: 95%, 96% (room air), 96% (room air) 6/7/24: 96% (room air), 96% (room air), 97% 6/6/24: 95%, 97%, 97% 6/5/24: 95%, 95% 6/4/24: 96%, 94%, 95% 6/3/24: 95%, 94% (room air), 92%, 93% 6/2/24: 93%, 92%, 92% 6/1/24: 96%, 88%, 91% (continued on next page)

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5/31/24: 95%, 95%, 95%</p> <p>5/30/24: 96% (room air), 95%, 96% (room air)</p> <p>5/29/24: 95%, 94%</p> <p>5/28/24: 91%, 92%, 94%</p> <p>5/27/24: 95%, 92%, 92%, 92%, 92%, 93%</p> <p>5/26/24: 96% (room air), 95%, 96%</p> <p>5/25/24: 96%, 96%, 95%</p> <p>5/24/24: 97% (room air), 93%</p> <p>5/23/24: 96% (continuous positive airway pressure, CPAP), 92%, 92%</p> <p>5/22/24: 96%, 95%</p> <p>5/21/24: 97%, 97%</p> <p>5/20/24: 96%, 92%, 95%, 95%, 95%, 96%</p> <p>5/19/24: 95%, 97%, 97%</p> <p>5/18/24: 96% (room air), 93%, 93%</p> <p>5/17/24: 99%, 97%</p> <p>5/16/24: 92%, 98%, 95%</p> <p>5/15/24: 96%, 96%, 96%</p> <p>5/14/24: 93%, 93%, 94%, 90%</p> <p>Further review of the Resident's medical record indicated:</p> <ul style="list-style-type: none"> - Clinical Nurse's Note, dated 6/24/24: Shows no signs or symptoms of respiratory distress as of this note. Continue with plan of care. - Progress Note, dated 6/6/24: Check O2 sat at every shift, maintain O2 between 88-92% every shift for prevention. Turned down to 1L. - Progress Note, dated 5/28/24: Check O2 sat at every shift, maintain O2 between 88-92% every shift for prevention. Turned down to 1L. <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Clinical Nurse's Note, dated 5/20/24: No acute respiratory distress noted. Patient continues on 1.5L oxygen, O2 sats between 93-95%. No sign of discomfort. Plan of care continues.</p> <p>- Progress Note, dated 5/19/24: Check O2 sat at every shift, maintain O2 between 88-92% every shift for prevention. O2 turned down to 0.5L to maintain proper pulse oximeter oxygen saturation (SPO2). Will continue to monitor.</p> <p>- Clinical Nurse's Note, dated 5/18/24: No respiratory distress notes. 93% 1L via nasal cannula.</p> <p>- Clinical Nurse's Note, dated 5/17/24: Continue on azithromycin and prednisone taper for upper respiratory infection. No respiratory distress noted. Sat 94% on 1L O2.</p> <p>- Progress Note, dated 5/14/24: Check O2 sat at every shift, maintain O2 between 88-92% every shift for prevention. Patient was on 3L, turned patient down to 1L to maintain correct oxygenation.</p> <p>During an interview on 6/27/24 at 12:57 P.M., Nurse #3 reviewed Resident #28's physician's orders for oxygen therapy (including maintaining O2 sats between 88-92%) and monitoring. Nurse #3 reviewed the Resident's medical record and said Resident #28's O2 sats were quite often higher than 92%. Nurse #3 said the Resident was currently receiving 1L of oxygen, the lowest amount ordered by the Physician, but O2 sats remain above the Physician's ordered range. Nurse #3 said the Physician should be notified if the oxygen therapy regimen is not producing the intended outcome of an O2 sat range of 88-92% so the Physician can reassess the Resident and plan of care.</p> <p>During an interview on 6/27/24 at 4:20 P.M., the Director of Nursing (DON) said Resident #28 was experiencing a COPD exacerbation in mid-May. The DON reviewed the Resident's medical record, and said her expectation would be for nursing to notice Resident #28's O2 sats were consistently above the Physician's recommended parameters. The DON said she would then expect nursing to notify the Physician or Nurse Practitioner of the trend so the Practitioner can re-assess the oxygen therapy plan.</p> <p>34145</p> <p>2. Resident #20 was admitted to the facility in April 2024 with diagnoses including diabetes mellitus.</p> <p>Review of the MDS assessment, dated 4/19/24, indicated Resident #20 had moderate cognitive impairment as evidenced by a BIMS score of 9 out of 15, was diabetic, required a therapeutic diet and received insulin injections.</p> <p>a. Review of Physician's Orders included, but was not limited to:</p> <p>- Glipizide ER 2.5 milligrams (mg) (insulin), give one tablet one time a day for type 2 diabetes mellitus (4/16/24)</p> <p>- Metformin HCl 500 mg (insulin), give one tablet two times a day for type 2 diabetes mellitus (4/16/24)</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Ozempic Subcutaneous Solution Pen Injector 4mg/3mL (injectable treatment for type 2 diabetes mellitus similar to insulin), inject 1 mg subcutaneously (under the skin) one time a day for type 2 diabetes mellitus (4/16/24) - Humalog Injection Solution 100 unit/milliliters (mL) (insulin), inject per sliding scale for type 2 diabetes mellitus (4/16/24) - blood sugar levels less than 70 or greater than 300, call Physician/Nurse Practitioner; - If 0-149= 0 units; - 150-199=2 units; - 200-249=4 units; - 250-299=6 units; - 300-999=8 units. <p>According to the Mayo Clinic (2023), hypoglycemia needs immediate treatment. Treatment involves quickly getting your blood sugar back to within the standard range either with a high-sugar food or drink or with medication.</p> <p>Signs and symptoms of hypoglycemia can include, but are not limited to:</p> <ul style="list-style-type: none"> - Looking pale - Shakiness - Sweating - Headache - Hunger or nausea - An irregular or fast heartbeat - Fatigue - Irritability or anxiety - Difficulty concentrating - Dizziness or lightheadedness - Tingling or numbness of the lips, tongue or cheek <p>Symptoms of hyperglycemia develop slowly over several days or weeks.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Recognizing early symptoms of hyperglycemia can help identify and treat it right away. Watch for:</p> <ul style="list-style-type: none"> - Frequent urination - Increased thirst - Blurred vision - Feeling weak or unusually tired <p>The physician's orders failed to indicate an order to monitor for signs and symptoms of hyper/hypoglycemia, failed to include an order for fingerstick blood sugars (FSBS-a lancet used to prick the fingertip to obtain a blood sample) to obtain the capillary blood glucose level (CBG) to implement the order for sliding scale insulin administration, and failed to include interventions for the potential of hypoglycemia.</p> <p>Review of April, May and June 2024 Medication/Treatment Administration Records (MAR/TAR) indicated Resident #20's CBG level was obtained on 184 occasions without a Physician's order to do so.</p> <p>During an interview on 6/25/24 at 11:29 A.M., Unit Manager #1 said Resident #20 has his/her CBG checked utilizing a FSBS three times a day. She said all residents with diabetes mellitus should be monitored for signs/symptoms of hyper/hypoglycemia with interventions, and have orders in place for obtaining CBGs if there is a sliding scale. She reviewed the medical record and was unable to find a Physician's order to obtain the capillary blood glucose level or to monitor for signs/symptoms of hyper/hypoglycemia. She said there were no orders for interventions if the Resident experiences signs and symptoms of hypoglycemia but should be.</p> <p>b. Review of Physician's orders included, but was not limited to:</p> <ul style="list-style-type: none"> -Klonopin (anticonvulsant used to treat anxiety) 1 mg, give 1 mg at bedtime (HS) (4/16/24) -Klonopin 1 mg, give 1mg every 12 hours as needed (prn) for anxiety for 90 Days (6/15/24) <p>Review of the facility's Psychiatric Consultant Nurse Practitioner's note, dated 6/19/24, indicated a recommendation to discontinue Klonopin 1mg prn. A handwritten signature of Resident #20's Nurse Practitioner (NP) with the letters, OK and date 6/21/24 were noted in the lower left corner of the note.</p> <p>Review of a Nursing Progress Note, dated 6/21/24, indicated Klonopin 1mg every 12 hours prn was discontinued.</p> <p>Review of Physician's orders indicated the order for Klonopin 1 mg at HS was discontinued, and not Klonopin 1 mg every 12 hours prn as authorized by Resident #20's NP.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/25/24 at 11:29 A.M., Unit Manager #1 reviewed Resident #20's medical record including the consultant Psychiatric NP's note dated 6/19/24. She confirmed the initials on the lower left corner of the note indicated the NP approved the recommendation to discontinue Klonopin 1 mg every 12 hours prn. She reviewed Resident #20's medical record and said the incorrect Klonopin order was discontinued on 6/21/24. The Resident should still be receiving Klonopin 1 mg at bedtime and not Klonopin 1 mg every 12 hours prn.</p> <p>Review of the medical record on 7/1/24 indicated Resident #20 still had an active order for Klonopin 1 mg every 12 hours as needed and not Klonopin 1 mg at bedtime. The medical record failed to indicate that either the Resident's Physician or Nurse Practitioner were notified that the wrong order for Klonopin was discontinued and the Resident had not received Klonopin as ordered for 10 days.</p> <p>48695</p> <p>3. Resident #48 was admitted to the facility in April 2024 with diagnoses including rectal abscess (collection of pus in the tissue around the anus and rectum) and muscle wasting and atrophy (wasting away of a body part).</p> <p>Review of Resident #48's MDS assessment, dated 4/11/24, indicated Resident #48 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Further review of the MDS indicated Resident #48 received anticoagulant medication.</p> <p>Review of Resident #48's Hospital Discharge Summary, dated 4/8/24, indicated but was not limited to:</p> <p>-CT scan showed large peri-rectal abscess up to 5.5 cm (centimeters) concerning for infectious source. Underwent I&D (incision and drainage) of abscess with packing placed by colorectal surgery on 2/6.</p> <p>During an interview on 6/24/24 at 11:25 A.M., Resident #48 said he/she had staples in his/her rectum that were causing him/her pain. Resident #48 said he/she was admitted with the staples and had an appointment scheduled to see the doctor tomorrow (6/25/24).</p> <p>On 6/24/24 at 1:00 P.M., the surveyor observed Unit Manager #1 perform a skin check of Resident #48's rectum. The surveyor observed that Resident #48 had four [NAME] drains in his/her rectum.</p> <p>Review of Resident #48's medical record failed to indicate orders for care and maintenance of the [NAME] drains.</p> <p>Review of the National Library of Medicine (NLM), dated 8/8/23, indicated but was not limited to:</p> <p>[NAME] drains have few complications. There is some leakage of stool with the [NAME], and instructions for cleaning should be given. There may be some bleeding from the raw tract, and this should be minor. Infections are uncommon, but if they occur, this should prompt either another exam under anesthesia or oral antibiotics if not severe, or IV (intravenous) antibiotics and exploration if severe such as a perineal necrotizing infection. Incontinence is rare with the [NAME] placement.</p> <p>(https://www.ncbi.nlm.nih.gov/books/NBK555998/)</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #48's GI (gastroenterology) consult, dated 6/25/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> - 3 Setons (skin bridging removed) - [NAME] connected anal canal remains <p>During an interview on 6/25/24 at 1:30 P.M., Unit Manager #1 said Resident #48 should have an order to monitor for placement of the [NAME] drains and to monitor signs and symptoms of infection at a minimum. Unit Manager #1 reviewed Resident #48's medical record and said Resident #48 did not have orders for care and maintenance of the [NAME] drains but should.</p> <p>During an interview on 6/25/24 at 2:27 P.M., Resident #48 said he/she had a follow today with his/her gastroenterologist and they removed all but one of the drains in his/her rectum. Resident #48 said he/she has a follow-up in six months but the drain can fall out before then.</p> <p>During an interview on 6/26/24 at 12:34 P.M., the DON said Resident #48 was admitted to the facility with the [NAME] drains from the hospital. The DON said the hospital discharge paperwork did not include how to care for the [NAME] drain. The DON said Resident #48 should have had an order for care and treatment of the [NAME] drain including to monitor placement of the [NAME] drain and for signs and symptoms of infection but did not.</p> <p>50740</p> <p>4. Review of the facility's policy titled Skin Assessment, dated 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> -A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, daily for three days, and weekly thereafter. -Documentation of skin assessment: <ul style="list-style-type: none"> a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in the wound bed, drainage, odor, pain). e. Document if resident refused assessment and why. f. Document other information as indicated or appropriate. <p>Review of the facility's policy titled Wound Treatment Management, dated 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> - The effectiveness of treatments will be monitored through ongoing assessment of the wound. <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #72 was admitted to the facility in May 2024 with the following diagnoses: sepsis (an infection of the bloodstream) and Methicillin-Susceptible Staphylococcus aureus (MSSA) infection (a bacterial infection that can be treated by antibiotics).</p> <p>Review of the MDS assessment, dated 5/21/24, indicated Resident #72 was cognitively intact as evidenced by a BIMS score of score of 15 out of 15, and had diagnoses including a multi-drug resistant organism infection, septicemia, and wound infection. Further review of the MDS indicated he/she received application of dressings to his/her feet and received IV (intravenous) antibiotic therapy.</p> <p>Review of Resident #72's Hospital Discharge Summary, dated 5/17/24, indicated that he/she had a left leg wound with purulent discharge that grew MSSA and was likely the source of the Resident's bacteremia (bacteria in the bloodstream).</p> <p>Review of Resident #72's Order Summary Report indicated but was not limited to:</p> <ul style="list-style-type: none"> - Clean area to Left Great Toe with normal saline, pat dry. Apply protective dressing every evening shift (order date 5/17/24); - Clean area to Right Ankle with normal saline. Pat dry. Apply dry protective dressing every evening shift (order date 5/17/24); - Weekly skin check with shower Thursday 7-3 (order date 5/17/24) <p>Review of Resident #72's May and June 2024 MARs and June 2024 TARs indicated but was not limited to:</p> <ul style="list-style-type: none"> - Resident #72 received treatment, including cleansing area with normal saline and application of a dry protective dressing, to left great toe and right ankle areas every evening shift 6/1/24 through 6/19/24 and 6/21/24 through 6/25/24. - Resident #72 received weekly skin check with shower 6/6/24, 6/13/24, and 6/20/24. <p>Review of Resident #72's Weekly Skin Assessment tools indicated but was not limited to:</p> <ul style="list-style-type: none"> - 6/7/24: Yes, has open areas or marks on skin. - 6/8/24: Yes, has open areas or marks on skin. - 6/13/24: right elbow: superficial healing moist area; right ankle: superficial area with moist base; other: left foot open area with sm amt drg [sic]. <p>Further review of Resident #72's Weekly Skin Assessment tools failed to indicate the size and/or a description of the open areas.</p> <p>During an interview on 6/27/24 at 10:15 A.M., Nurse #4 said that Resident #72 had a wound and that the last time she saw the wound, it was small.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/27/24 at 9:54 A.M., Unit Manager (UM) #1 said that Resident #72 was admitted with a wound on his/her toe that she had only seen once but was nearly healed when she saw it. UM #1 said that Resident #72 was not followed on wound rounds but should have weekly skin checks documenting the measurements/condition of any wounds.</p>

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NAME OF PROVIDER OR SUPPLIER Country Gardens Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2045 Grand Army Highway Swansea, MA 02777	

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>28450</p> <p>Based on record review and staff interview, the facility failed to document the recapitulation (a summary) of the Resident's stay from the facility for one Resident (#80), out of two closed records reviewed.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Transfer Discharge (including AMA), last Reviewed/Revised 3/4/24, indicated but was not limited to:</p> <p>Policy: Anticipated Transfers or Discharges - resident-initiated discharges.</p> <ul style="list-style-type: none"> - A member of the interdisciplinary team completes relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to the following: <ul style="list-style-type: none"> - i. A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results. - ii. A final summary of the residents' status. - iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter). - iv. A post discharge plan of care that is developed with the participation of the resident, and the resident's representative (s) which will assist the resident to adjust to his or her new living environment. <p>Resident #80 was admitted to the facility in May 2024 with diagnoses including metabolic encephalopathy, urinary tract infection, hypertension, diabetes mellitus, chronic kidney disease stage three, muscle weakness and displaced bimalleolar fracture (involve both the lateral and medial malleoli at the distal ends of the fibula and tibia, respectively) of left lower leg, hyperlipidemia, and anxiety disorder.</p> <p>Review of the medical record indicated the Resident was discharged Home on 5/10/24.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 5/25/24, indicated Discharge return not anticipated.</p> <p>Review of the Discharge Review Form indicated discharge home with services.</p> <p>Review of the Patient Care Referral Form indicated the sections Physician's orders and Physician's Signature were not completed.</p> <p>(continued on next page)</p>

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record failed to include a physician's recapitulation of stay.</p> <p>During an interview on 06/27/24 at 3:45 P.M., the Director of Nursing reviewed the electronic record and said she did not retrieve the recapitulation note.</p> <p>During an interview on 06/28/24 at 9:34 A.M., the Administrator said they do not have a medical record person. He thought the recapitulation was in the medical record office and had not yet been uploaded into the system. He would look.</p> <p>During an interview on 06/28/24 at 2:50 P.M., the Administrator said the Physician did not write a recapitulation note.</p> <p>During an interview on 6/28/24 at 2:55 P.M., the Social Worker reviewed her file and said she could not find a completed discharge summary for Resident #80.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145</p> <p>Based on observation and interview, the facility failed to ensure its staff provided a meaningful and engaging activity program for residents on one Unit (West Unit), out of two units observed. Specifically, the facility failed to ensure staff implemented facility sponsored group activities for all residents on the [NAME] Unit.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Activities, last revised 3/4/24, indicated but was not limited to the following:</p> <p>-Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community.</p> <p>-Activities will be conducted in different ways:</p> <p>a. One-to-One Programs.</p> <p>b. Person Appropriate-activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for.</p> <p>c. Program of Activities-to include a combination of large and small groups, one-to-one, and self-directed as the resident desires to attend.</p> <p>-Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs.</p> <p>Review of the facility's June 2024 Activity Calendar posted on the [NAME] Unit indicated the following activities scheduled for 6/24/24:</p> <p>9:00 A.M. Chronicles</p> <p>10:00 A.M. Music trivia</p> <p>11:15 A.M. Rosary</p> <p>11:30 A.M. Lunch</p> <p>2:00 P.M. Bingo</p> <p>On 6/24/24, the surveyor observed the following on the [NAME] Unit nursing unit in the large dining/dayroom:</p> <p>9:19 A.M.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Seven residents seated in the unit dining/dayroom area at dining tables; three residents were seated in chairs in the vicinity of the television.</p> <p>-The television on with the volume low and inaudible to the surveyor.</p> <p>-No other activities taking place in the room.</p> <p>-The residents had no materials in front of them for self-directed activity.</p> <p>-No staff were observed in the dining/dayroom area.</p> <p>9:30 A.M., the surveyor observed Daily Chronicles being distributed to residents in the dining/day room.</p> <p>10:17 A.M.</p> <p>-13 residents seated in the unit dining/dayroom.</p> <p>-The television was on to a drama show.</p> <p>-No other activities taking place in the room.</p> <p>-The residents had no materials in front of them for self-directed activities.</p> <p>At 10:19 A.M., Activity Assistant #1 opened a supply drawer and began to take items out and bring them to residents seated in the room.</p> <p>During an interview on 6/24/24 at 10:35 A.M., Activity Assistant #1 said she is a Certified Nursing Assistant (CNA) but picked up some hours as an Activity Assistant. She said she usually comes to the [NAME] Unit in the morning to get everyone set up with something to do, then helps out with activities off of the [NAME] unit.</p> <p>The following activities were scheduled for 6/25/24:</p> <p>9:00 A.M. Chronicles</p> <p>10:00 A.M. Hairdresser</p> <p>11:30 A.M. Lunch</p> <p>2:00 P.M. [NAME]</p> <p>On 6/25/24, the surveyor observed the following on the [NAME] Unit nursing unit in the large dining/dayroom:</p> <p>12:30 P.M.</p> <p>-Seven residents were seated in the unit dining/dayroom area.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The television was on with the volume low.</p> <p>-No other activities were taking place in the room.</p> <p>-The residents had no materials in front of them for self-directed activity.</p> <p>The following activities were scheduled for 6/25/24:</p> <p>9:00 A.M. Chronicles</p> <p>10:00 A.M. Trivia</p> <p>10:30 A.M. Music</p> <p>11:30 A.M. Lunch</p> <p>2:00 P.M. Mass</p> <p>On 6/26/24, the surveyor observed the following on the [NAME] Unit nursing unit in the large dining/dayroom:</p> <p>10:32 A.M. to 11:00 A.M.</p> <p>-Ten residents were seated in the dayroom/dining room: Four of which were seated at tables with a Chronicle newsletter in front of them as they slept; Six were seated in chairs near the television.</p> <p>-The television was on and set to a still picture with no audio.</p> <p>-No other activities were taking place in the room.</p> <p>-No staff were observed in the dining/dayroom area.</p> <p>During an interview on 6/27/24 at 9:35 A.M., the Activity Director said they used to have scheduled activities on the [NAME] Unit, but they don't anymore. She said staff were pulling the Activity Assistants to work as CNAs, so they stopped sending Activity Assistants to that unit.</p>		

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<p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p>34145</p> <p>Based on interviews and review of the Activity Director's (AD) personnel file, the facility failed to ensure the activity program was directed by a qualified activities professional.</p> <p>Findings include:</p> <p>During an interview on 6/25/24 at 11:13 A.M., the Activity Director (AD) said she used to be the First [NAME] at the facility and picked up hours every other week as an Activity Assistant for a while. She said she was hired as the AD for the facility in July 2023 when the former AD left. She said a few weeks after she started her position as AD, she had to take a leave of absence, and June 2024 is her first full month back to work.</p> <p>Review of the AD's personnel file on 6/25/24 failed to indicate she was qualified therapeutic recreation specialist or an activities professional who had two years of experience in a social or recreational program within the last five years, one of which was full-time in a therapeutic activities program, or was a qualified occupational therapist or occupational therapy assistant.</p> <p>During an interview with the AD and Regional Activity Director on 6/27/24 at 9:35 A.M., the Regional AD said she was aware the AD is not qualified to direct the activity program at the facility.</p> <p>During an interview on 6/27/24 at 2:15 P.M., the Human Resource Director said the former AD was terminated on 7/19/23, and they have been without a qualified AD since that time.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>34145</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review and interviews, the facility failed to promote and manage the delivery of safe nursing care in accordance with accepted Standards of Nursing Practice for one Resident (#32), out of a total sample of 19 residents. Specifically, the facility failed to ensure a Certified Nursing Assistant (CNA) did not move a resident off the floor after the Resident sustained an unwitnessed fall with a head strike, prior to having a nurse assess the Resident.</p> <p>Findings include:</p> <p>Review of the facility's Fall Reduction policy, last reviewed 6/22/22, included but was not limited to:</p> <p>In the event a resident falls, the following measures will be instituted:</p> <ul style="list-style-type: none"> -Conduct a physical assessment to determine if there are any injuries. Notify the nursing supervisor/Director of Nursing Services immediately. Administer appropriate first aid. -If the resident fall was unwitnessed or if a head injury is suspected, monitor neurological signs. <p>Resident #32 was admitted to the facility in January 2024 with diagnoses including dementia, abnormalities of gait and mobility, and unsteadiness on his/her feet.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 4/13/24, indicated Resident #32's cognitive status was not assessed, required maximum assistance for toileting, maximum assistance to get on and off the toilet and maximum assistance to walk 10 feet.</p> <p>Review of a Brief Interview for Mental Status (BIMS) assessment, conducted on 3/5/24, indicated Resident #32 had moderate cognitive impairment as evidenced by a score of 11 out of 15.</p> <p>Review of a Nursing Progress note, dated 5/10/24, indicated Nurse #3 was seated at the Nurses' station at 10:40 A.M. when Certified Nursing Assistant (CNA) #9 brought Resident #32 out to the common area in a wheelchair. The CNA told the Nurse the Resident was standing in the bathroom while she left the room to bring dirty clothes to the bin in the hallway. When she returned to the bathroom, she found the Resident lying on the floor on his/her left side. The CNA assisted the Resident off the floor and put him/her in a wheelchair and brought the Resident out to the common area. The note indicated the Resident stated he/she was standing near the toilet and fell and hit his/her head on the floor.</p> <p>Review of the Incident Report indicated Resident #32 had an unwitnessed fall in the bathroom in his/her room on 5/10/24 while the CNA left the room to put dirty clothing in a bin in the hallway. The Resident was put in a wheelchair and brought out to the common area by a CNA and then assessed by Nurse #3.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a statement from Nurse #3 indicated the Nurse was seated at the nurses' station when CNA #9 brought Resident #32 out to the common area in a wheelchair at approximately 10:40 A.M. and informed the nurse that the Resident was standing in the bathroom and the CNA had gone out of the room to put dirty clothes in a bin, and when she came back, the Resident was lying on the floor on his/her left side. The CNA assisted the Resident off the floor and put him/her in a wheelchair and brought the Resident to the common area. The Resident stated he/she struck the left side of his/her head on the floor. Family, doctor, Director of Nursing (DON) and Unit Manager were informed and neurological checks were initiated.</p> <p>Review of a statement from CNA #9 indicated when she was done washing Resident #32, she stepped out of the room to throw away dirty linens and came back and found the Resident lying on the floor.</p> <p>Review of a statement from Nurse #1 indicated she was at the medication cart when a CNA told her that the Resident was on the floor.</p> <p>Review of statements from CNAs #4 and #8 indicated they did not know about the incident.</p> <p>During an interview on 6/28/24 at 12:20 P.M., CNA #8 said Resident #32 was on her assignment the day he/she fell in the bathroom. She said she was helping the Resident in the bathroom and left the room to put dirty laundry in a bin in the hallway. When she returned to the bathroom, she found the Resident on the floor. She said she picked up the Resident and put him/her onto the toilet, then left the room and got Nurse #1. When asked if it was routine practice to pick residents up off the floor when they have had a fall, then tell the nurse, CNA #8 said it depends on the fall. She said if they slide onto the floor, she can pick them up, but if they have a bigger fall (she gave an example of another resident that fell with blood coming from his/her head), then everyone comes to help.</p> <p>During an interview on 6/28/24 at 12:25 P.M., the DON and Chief Nursing Officer (CNO) said the CNA should not have moved the Resident after finding him/her on the floor after having a fall. She said she should have notified the Nurse right away so she could assess the Resident.</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>34145</p> <p>Based on observation, interview, and policy review, the facility failed to ensure the proper care and treatment of a peripherally inserted central catheter (PICC) line device (inserted into a vein in the upper arm and is advanced until the internal tip of the catheter is in the superior vena cava to deliver medications and other treatments directly to the large central veins near your heart) was provided in accordance with professional standards of practice for one Resident (#74), out of a total sample of 19 residents. Specifically, the facility failed to ensure:</p> <ul style="list-style-type: none"> -nursing staff measured the external length of the PICC line catheter as ordered by the Physician to ensure the catheter had not migrated (moved) out of place, and -the insertion site was visible for routine assessment by the licensed nurses. <p>Findings include:</p> <p>Review of the Peripherally Inserted Central Catheter/Midline/Central Venous Access Device (CVAD) Dressing Change policy and Documentation Guidelines, last revised 3/4/24, included but was not limited to:</p> <ul style="list-style-type: none"> -It is the policy of this facility to change PICC, midline or CVAD dressing weekly or if soiled, in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequency of changes. -Inspect the catheter-skin junction and surrounding area, palpating through the intact dressing for redness, tenderness, swelling and drainage. -Documenting Infusion Therapy -Document every shift if resident has an infusion catheter in place, or whenever an infusion treatment is given. The shift note should include the following information: <ul style="list-style-type: none"> a. location and objective description of insertion site b. patency and/or functionality of the device. c. type, rate and length of infusions. d. any complications, interventions. e. resident education, questions. f. a statement from the resident how they are tolerating treatment. If the resident is non-verbal, describe any objective signs/symptoms of problems. g. date, time, signature and title. <p>(continued on next page)</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Additional Documentation for Midline Catheters and PICCs:</p> <p>-At established intervals, document the external length of the catheter and the original length of the catheter inserted.</p> <p>Review of the Administration Set/Tubing Changes policy, dated 1/1/21, indicated but was not limited to:</p> <p>-Primary or secondary intermittent infusion administration sets: change every 24 hours.</p> <p>-Assessment: Inspect intravenous catheter for any signs/symptoms of IV related complications at scheduled intervals.</p> <p>-Label administration set and tubing with date, time and initials.</p> <p>-Documentation: The following information should be recorded in the resident's medical record:</p> <ol style="list-style-type: none"> 1. The date and time of the administration set change. 2. The type of flow-control device. 3. The type of solution or medical infusing. 4. The amount of solution or medication to be infused. 5. The rate of infusion. 6. The condition of the IV site. 7. Notification of the provider of any intravenous complications. 8. Resident's response to treatment. 9. The signature and title of the person recording the data. <p>Resident #74 was admitted to the facility in May 2024 with diagnoses including endocarditis (infection of the heart's inner lining, usually involving the heart valves) and had a PICC line for infusion of antibiotic medication.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 6/2/24, indicated Resident #74 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15 and received intravenous (IV) antibiotic medication.</p> <p>Review of the medical record indicated that on 5/25/24, Resident #74 had a double lumen PICC line placed in the left basilic vein at the antecubital region (inner surface of the forearm) for infusion of antibiotic medication during a recent hospitalization . A chlorhexidine gluconate dressing (CHG-also known as Tegaderm) was applied to the PICC line site.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the National Institute of Health (2016), a chlorhexidine gluconate dressing is a transparent securement dressing that covers and protects catheter sites and secures devices to the skin. It comprises a transparent adhesive dressing to act as a barrier against external contamination and an integrated gel pad containing an antiseptic agent.</p> <p>According to the manufacturer's website (2024), transparent dressing and CHG gel pad allow continuous site visibility to easily assess for early signs of infection.</p> <p>Review of the Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> -Change Cap and Extensions set on PICC/ Midline catheter 24 hours after insertion or on admission, then weekly with dressing change, and as needed (prn) (5/29/24) -Change PICC/ Midline dressing on admission, weekly, Thursday and as needed (5/29/24) -Measure external catheter on admission, and with dressing change (5/29/24) -Ampicillin Sodium Injection Solution Reconstituted 2 gram (gm), use 2 gm intravenously every 4 hours for 6 weeks (5/29/24) -Normal Saline Flush Solution, use 10 milliliters (ml) intravenously as needed for IV antibiotics. Flush each IV catheter lumen with 10 ml normal saline after each intermittent IV administration. AND Use 10 ml intravenously every shift for IV infusion. Flush each IV catheter lumen with 10 ml normal saline before and after each intermittent IV administration (5/29/24) -ceftriaxone Sodium Injection Solution Reconstituted 2 gm, use 2 gm intravenously every 12 hours for 6 weeks (5/29/24) <p>Review of a Clinical Nurse's Note, dated 5/29/24, indicated the PICC line dressing was changed upon admission to the facility, the lumen length (external catheter length) was 11 centimeters (cm) and showed no signs or symptoms of infection.</p> <p>Review of the June 2024 Medication/Treatment Administration Record (MAR/TAR) indicated Resident #74's PICC line dressing was changed on 6/6/24, 6/12/24, 6/19/24 and 6/26/24. Review of the medical record, including Nursing Notes and the MAR/TAR, failed to indicate the external catheter length was measured with each dressing change as ordered by the physician.</p> <p>During an interview with observation on 6/24/24 at 9:00 A.M., Nurse #1 flushed Resident #74's PICC line upon conclusion of the antibiotic infusion. A dressing was in place on the Resident's left antecubital area. The PICC line insertion site was not visible as it was covered by a 2 inch X 2 inch opaque pad and a transparent covering over the pad.</p> <p>On 6/24/24 at 12:20 P.M., the surveyor observed Nurse #1 enter Resident #74's room and hook up the antibiotic medication to the Resident's PICC line. The Nurse said the Resident receives this antibiotic every four hours. The insertion site was not visible as it was covered by a 2 inch X 2 inch opaque pad and a transparent covering over the pad.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record, from 5/29/24 through 6/24/24, failed to indicate nursing staff assessed the Resident's insertion site and documented the information in a shift note for 64 shifts out of a total of 81 shifts from 5/29/24 through 6/24/24.</p> <p>During an interview on 6/25/24 at 11:29 A.M., Unit Manager (UM) #1 said the pharmacy sends a standard dressing kit weekly for the Resident's PICC line. When asked if it was routine to cover the insertion site with an opaque pad making the insertion site not visible for assessment, UM #1 said she likes to visualize the site to see if it's red or swollen and if an opaque pad is there, you can't see the site to assess it. She said the insertion site should be assessed and documented in the medical record every shift either on the MAR/TAR or in a note. She reviewed the medical record and said there was no documentation to indicate the insertion site had been assessed every shift. She said the antibiotic is hung every four hours and nursing looks at the site at this time and they should document their assessment in the medical record. UM #1 reviewed the medical record and said there were no measurements of the external catheter since the first dressing change upon admission to the facility and there was no way to tell if the line had migrated or not.</p> <p>During interviews on 6/28/24 at 10:48 A.M. and 7/1/24 at 8:05 A.M., the Staff Development Coordinator (SDC) reviewed Resident #74's medical record and said she could not find any documentation to indicate the external length of the catheter had been measured since the first dressing change upon admission to the facility. She said the nurse is supposed to measure the external length of the catheter with every dressing change, assess the insertion site and document it in the medical record. The SDC said when residents are admitted from the hospital, a lot of orders are incomplete and need to be clarified with the Physician. She said the orders for the PICC line dressing should have identified the type of dressings to be used and allowed for the insertion site to be visible for assessment.</p> <p>Refer to F726</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>48695</p> <p>Based on observation, interviews, and record review, the facility failed to maintain respiratory equipment according to professional standards of practice for one Resident (#78), out of a total sample of 19 residents. Specifically, the facility failed to obtain a physician's order for the use of a continuous positive airway pressure machine (CPAP, machine used to treat sleep apnea).</p> <p>Findings include:</p> <p>Review of the facility's policy titled Continuous Positive Airway Pressure (CPAP), undated, indicated but was not limited to:</p> <ul style="list-style-type: none"> - Policy: The operation of the CPAP machine is the responsibility of licensed staff. - Procedure: <ul style="list-style-type: none"> 1. Check physician orders. They should include the level of CPAP pressure and the oxygen liter flow if required. - Documentation: <ul style="list-style-type: none"> 1. Date and Time 2. CPAP mode 3. CPAP pressure 5. Patient's tolerance of procedure <p>Resident #78 was admitted to the facility in April 2024 with diagnoses including hypertension and hyperlipidemia (high cholesterol).</p> <p>Review of Resident #78's Brief Interview for Mental Status (BIMS) assessment, dated 4/4/24, indicated Resident #78 was cognitively intact as evidenced by a score of 15 out of 15.</p> <p>During an interview with observation on 6/24/24 at 9:10 A.M., Resident #78 said he/she brought the CPAP from home and that he/she manages the CPAP themselves. The surveyor observed a CPAP machine on Resident #78's nightstand with the CPAP mask in the top drawer, a one-gallon distilled water jug was noted next to his/her nightstand.</p> <p>Review of Resident #78's medical record failed to indicate Resident #78 had an order for their CPAP.</p> <p>During an interview on 6/25/24 at 8:50 A.M., Resident #78 said he/she would wear their CPAP sometimes. Resident #78 said the nurses would fill the water reservoir with distilled water and turn the machine on for him/her.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/26/24 at 4:34 P.M., Unit Manager #1 said any Resident with a CPAP machine should have an order for settings, cleaning schedule, when to apply the CPAP mask and when to take it off. Unit Manager #1 reviewed Resident #78's medical record and said Resident #78 should have an order for the CPAP but he/she does not.</p> <p>During an interview on 6/27/24 at 7:51 A.M., Nurse #7 said she was not sure if Resident #78 wears his/her CPAP machine, but she is aware that Resident #78 has a CPAP machine at his/her bedside. Nurse #7 said Resident #78 should have an order for his/her CPAP machine including pressure settings, cleaning schedules, and when to apply the CPAP. Nurse #7 reviewed #78's medical record and said Resident #78 did not have any orders for their CPAP machine but should have orders.</p> <p>On 7/1/24 at 8:08 A.M., the surveyor observed Resident #78 in bed with his/her CPAP on.</p> <p>During an interview on 7/1/24 at 8:12 A.M., Nurse #9 said Resident #78 should have an order for his/her CPAP but does not.</p> <p>During an interview on 7/1/24 at 10:04 A.M., the Director of Nursing (DON) and Chief Nursing Officer (CNO) said Resident #78 should have an order for his/her CPAP.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>34145</p> <p>Based on observation, record review, and interview, the facility failed to ensure licensed nursing staff possessed the appropriate competency and skills to care for one Resident (#74), who required intravenous (IV) administration of antibiotics through a Peripherally Inserted Central Catheter (PICC), out of a total sample of 19 residents. Specifically, the facility failed to ensure that nine Nursing staff (#1, #3, #5, #8, #10, #12, #13, Unit Manager #1, and the Director of Nursing) had demonstrated necessary competencies to care for residents in the facility with specialized needs, inclusive of IV/PICC line care and treatment.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Competency Evaluation, last revised 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> - Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. - Evaluating competency of staff is accomplished through the facility's training program. - Initial competency is evaluated during the orientation process. - Subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations. - Checklists are used to document training and competency evaluations. - Employee competency forms are maintained in the Staff Development Coordinator's office for current training year, then forwarded to the Human Resource Director for placing into the employee's personnel file. <p>Review of the Facility Assessment, updated 6/1/24, indicated the facility provided for medication administration via IV (peripheral or central line). Further review of the Facility Assessment indicated that the role of the Director of Staff Development is to provide on-going education to both licensed and non-licensed staff related to the provision of care to their residents. Together, with the respective Department Head, the Director of Staff Development monitors staff competency. The Facility Assessment indicated that all licensed nursing staff should complete IV medication administration competencies.</p> <p>Resident #74 was admitted to the facility in May 2024 with diagnoses including endocarditis (infection of the heart's inner lining, usually involving the heart valves) and had a PICC line for infusion of antibiotic medication.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Minimum Data Set (MDS) assessment, dated 6/2/24, indicated Resident #74 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15 and received intravenous (IV) antibiotic medication.</p> <p>Review of the medical record indicated that on 5/25/24, Resident #74 had a double lumen PICC line placed in the left basilic vein at the antecubital region (inner surface of the forearm) for infusion of antibiotic medication during a recent hospitalization . A chlorhexidine gluconate dressing (CHG-also known as Tegaderm) was applied to the PICC line site.</p> <p>Review of the Physician's Orders indicated, but was not limited to:</p> <ul style="list-style-type: none"> - Change Cap and Extensions set on PICC/ Midline catheter 24 hours after insertion or on admission, then weekly with dressing change, and as needed (prn) (5/29/24) - Change PICC/ Midline dressing on admission, weekly, Thursday and as needed (5/29/24) - Measure external catheter on admission, and with dressing change (5/29/24) - Ampicillin Sodium Injection Solution Reconstituted 2 grams (gm), use 2 gm intravenously every 4 hours for 6 weeks (5/29/24) - Normal Saline Flush Solution, use 10 milliliters (ml) intravenously as needed for IV antibiotics. Flush each IV catheter lumen with 10 ml normal saline after each intermittent IV administration. AND Use 10 ml intravenously every shift for IV infusion. Flush each IV catheter lumen with 10 ml normal saline before and after each intermittent IV administration (5/29/24) - Ceftriaxone Sodium Injection Solution Reconstituted 2 gm, use 2 gram intravenously every 12 hours for 6 weeks (5/29/24) <p>Review of a Clinical Nurse's Note, dated 5/29/24, indicated the PICC line dressing was changed upon admission to the facility, the lumen length (external catheter length) was 11 centimeters (cm) and showed no signs or symptoms of infection.</p> <p>Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) for May 2024 and June 2024 indicated that Nurses #1, #3, #5, #8, #10, #12, #13, Unit Manager #1 and the Director of Nursing had all provided care and/or administered medication through Resident #74's IV line.</p> <p>Review of the June 2024 MARs and TARs indicated Resident #74's PICC line dressing was changed on 6/6/24, 6/12/24, 6/19/24 and 6/26/24. Review of the medical record, including Nursing Notes and the MARs and TARs, failed to indicate the external catheter length was measured with each dressing change as ordered by the physician.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interviews on 6/27/24 at 11:00 A.M. and 6/28/24 at 10:48 A.M., the Staff Development Coordinator (SDC) reviewed Resident #74's medical record and said she could not find any documentation to indicate the external length of the catheter had been measured since the first dressing change upon admission to the facility. She said the nurse is supposed to measure the external length of the catheter with every dressing change and document it in the medical record. She said when she started in March 2024, she realized there was a need for staff education and competencies to be done. She provided the surveyor with a sign-in sheet for PICC line and Midline education provided to 16 nurses on 3/18/24, only four of which provided care to Resident #74. However, she was unable to provide evidence of completed competency checklists for any nursing staff. She said there was no system in place to determine if all of the Nurses who have provided IV care and services to Resident #74 had the required training and competencies.</p>

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>50740</p> <p>Based on observation, interviews, and record review, the facility failed to ensure staff had the skills necessary to meet the behavioral needs of one Resident (#10), out of a sample of 19 residents. Specifically, the facility failed to ensure staff had training in areas such as mental health needs and care of cognitively impaired residents.</p> <p>Findings include:</p> <p>Review of the Facility Assessment, updated 6/1/24, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - To achieve strong clinical out-comes, we continue to strive to develop skill set/competency of associates. We recognize the resident population we serve is affected by multiple co-morbidities requiring a well-rounded clinical team. - Category: Psychiatric/Mood Disorders; Common Diagnoses or Conditions: Impaired cognition, depression, anxiety disorder, Schizophrenia, Bipolar Disorder, Dementia - Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities. <p>Resident #10 was admitted to the facility in January 2024 with diagnoses including dementia, anxiety disorder, major depressive disorder, and bipolar disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 5/8/24, indicated Resident #10 had moderate cognitive impairment as evidenced by a score of 8 out of 15 on the Brief Interview for Mental Status (BIMS).</p> <p>Review of Resident #10's care plans indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - Focus: I am taking an antipsychotic, antidepressant medication r/t (related to) agitation, mood, and behaviors. My behaviors include: calling out for attention repeatedly. Anxiousness where his/her room is. [sic] <p>Goal: My doctors will monitor my medications and attempt to reduce the use of psychotropic (medications that affect behavior, mood, thoughts, or perception) through the review date.</p> <p>Interventions: Assure that the RN, Social Worker, MD, and family are aware of my behaviors; I will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date; Reassure and redirect me when I am behavioral.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Focus: I have behaviors like constant request for attention, crying at times and repetitive questions and sentences. I frequently ask for the same things (water, heating up coffee) multiple times even when staff has assisted me. 5/18/24 I attempted to use my cane as a weapon, unable to be redirected. I am intrusive at times, wander into other peoples space, come in the hallway disrobed and yell and swear at staff.</p> <p>- Goal: I will have fewer behaviors through next review date.</p> <p>- Interventions: s/p (status post) fall 4/18/2024. Resident slowly placed his/herself on the floor; PT screen; Staff to encourage resident to discuss his/her needs and will assist with needs in a timely manner; Staff will assist me when I ask for things in a timely manner; transfer out to Outside Hospital for geri (geriatric) psych 5/18/24; Follow by psych as needed.</p> <p>Review of a Clinical Nurse's Note, written by Nurse #12 and dated 5/18/2024, indicated Resident #10 was verbally abusive to staff and physically abusive several times, using his/her cane as a weapon. Further review of the Clinical Nurse's Note indicated that the Resident was warned multiple times to stop with the aggression and cane use as a weapon or he/she would be sent to the hospital. The Resident stated he/she wanted to go and 911 was called to transport the Resident to the hospital for further evaluation.</p> <p>On 6/24/24 at 9:15 A.M., the surveyor observed Resident #10 standing in his/her room, crying and unable to answer questions. Certified Nursing Assistant (CNA) #1 entered the room to assist the Resident and stated he/she was always like this and assisted the resident back to bed.</p> <p>Review of employee education documents provided failed to indicate that CNA #1 had in-servicing and/or training on caring for residents with mental and psychosocial disorders.</p> <p>Review of employee education documents provided failed to indicate that Nurse #12 had in-servicing and/or training on caring for residents with mental and psychosocial disorders.</p> <p>During an interview on 7/1/24 at 10:00 A.M., the Staff Development Coordinator (SDC) said all education files and records had been provided to the survey team. The SDC said all education was completed on paper and the facility did not utilize any electronic training programs.</p> <p>During an interview on 7/1/24 at 12:12 P.M., the Chief Nursing Officer (CNO) said the mandatory training on written standards, policies, and procedures for behavioral health should be completed upon hire and then annually.</p> <p>Refer to F949</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>48695</p> <p>Based on record review, policy review, and interview, the facility failed to monitor adverse consequences (side effects) of anticoagulant medications (used to prevent the blood from clotting, a blood thinner) and anti-hypoglycemic medications (used to lower blood sugar) prescribed for three Residents (#231, #48, and #10), out of a total sample of 19 residents. Specifically, the facility failed:</p> <ol style="list-style-type: none"> 1. For Residents #231 and #48, to monitor for side effects of anticoagulant medication; and 2. For Resident #10, to monitor for side effects of hypoglycemic medications. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's policy titled High Risk, dated 3/4/24, indicated but was not limited to the following: <ul style="list-style-type: none"> - Policy: This facility recognizes that some medications, including anticoagulants, are associated with greater risks of adverse consequences than other medications. This policy addresses the facility's collaborative, systemic approach to managing anticoagulant therapy for efficacy and safety. <p>Policy Explanation and Compliance Guidelines:</p> <ul style="list-style-type: none"> - The resident's plan of care shall alert staff to monitor for adverse consequences. Risks associated with anticoagulants include: <ol style="list-style-type: none"> a. Bleeding and hemorrhage (bleeding gums, nosebleed, unusual bruising, blood in urine and stool) b. Fall in hematocrit or blood pressure c. Thromboembolism (a dangerous condition that occurs when a blood clot breaks free) <p>A. Resident #231 was admitted to the facility in June 2024 with diagnoses including hypertension and alcohol abuse.</p> <p>Review of Resident #231's Minimum Data Set (MDS) assessment, dated 6/8/24, indicated Resident #231 had a moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. Further review of the MDS indicated that Resident #231 received anticoagulant medication.</p> <p>Review of Resident #231's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - Enoxaparin Sodium (anticoagulant) 40 milligrams (mg)/0.4 milliliter (ml) Inject subcutaneously (under the skin) one time a day (6/5/24) <p>Review of Resident #231's June 2024 Medication Administration Record (MAR) indicated he/she received Enoxaparin Sodium as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident #231's medical record failed to indicate Resident #231 was monitored for adverse consequences of anticoagulant medication.</p> <p>During an interview with a record review on 6/26/24 at 4:49 P.M., Nurse #5 and the surveyor reviewed Resident #231's MAR. Nurse #5 said Resident #231 received anticoagulant medication as ordered and should have had an order to monitor adverse consequences but did not.</p> <p>B. Resident #48 was admitted to the facility in April 2024 with diagnoses including atrial fibrillation.</p> <p>Review of Resident #48's MDS assessment, dated 4/11/24, indicated Resident #48 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Further review of the MDS indicated Resident #48 received anticoagulant medication.</p> <p>Review of Resident #48's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - Apixaban (anticoagulant) 5 mg give 1 tablet two times a day (4/8/24) <p>Review of Resident #48's April, May, and June 2024 MARs indicated he/she received Apixaban as ordered.</p> <p>Further review of Resident #48's medical record failed to indicate Resident #48 was monitored for adverse consequences of anticoagulant medication.</p> <p>During an interview on 6/26/24 at 4:49 P.M., Nurse #5 reviewed Resident #48's care plans and MAR. Nurse #5 said Resident #48 received anticoagulant medication as ordered and should have had an order to monitor adverse consequences but did not.</p> <p>During an interview on 6/27/24 at 12:55 P.M., the Director of Nursing (DON) said all residents who received anticoagulant medications should have an order to monitor for adverse consequences.</p> <p>During an interview on 6/28/24 at 12:50 P.M., the Chief Nursing Officer (CNO) said the expectation was for all residents who were administered anticoagulants be monitored for potential symptoms or side effects.</p> <p>50740</p> <p>2. Review of the facility's policy titled Hypoglycemia Management, dated 3/4/24, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -The facility will identify residents that are at risk for hypoglycemia (low blood sugar) and observe them for signs and symptoms of low blood glucose. -Residents that have a diagnosis of diabetes or on medications that could lower the blood sugar should have orders for glucose monitoring and treatment of hypoglycemia, unless otherwise ordered by the practitioner. <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #10 was admitted to the facility in January 2024 with diagnoses including diabetes mellitus.</p> <p>Review of the MDS assessment, dated 5/8/24, indicated Resident #10 had moderate cognitive impairment as evidenced by a BIMS score of 8 out of 15.</p> <p>Review of Resident #10's care plans indicated but was not limited to the following:</p> <p>Focus: I have nutritional [sic] problem or potential nutritional problem r/t (related to) therapeutic diet, obesity</p> <p>Interventions: Administer medications as ordered. Monitor/Document for side effects and effectiveness.</p> <p>Review of Resident #10's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - Farxiga (prescription pill to help lower blood sugar) Oral Tablet 10 mg. Give 10 mg by mouth one time a day, dated 6/17/24 - Glipizide (prescription pill to help lower blood sugar) Oral Tablet 10 mg. Give 10 mg by mouth two times a day, dated 6/10/24 - Humalog (fast acting insulin, used to lower blood sugar) injection solution 100 unit/milliliter (ml) (Insulin Lispro) Inject 12 units subcutaneously before meals, dated 1/31/24 - Humalog injection solution 100 unit/ml (Insulin Lispro) Inject as per sliding scale: if 150-199 = 2 units; 200-249 = 4 units; 250-299 = 6 units; 300-349 = 8 units Notify MD is [sic] BS (blood sugar) is above 350 or less than 70 subcutaneously before meals, dated 1/31/24 - Insulin Glargine (long-acting insulin, used to lower blood sugar) Solution 100 unit/ml Inject 14 unit subcutaneously at bedtime, dated 6/12/24 - CBG (capillary blood glucose) 4x day before meals and at bedtime, dated 1/31/24 <p>Review of Resident #10's May and June 2024 MARs indicated he/she was administered insulin and hypoglycemic medications as ordered.</p> <p>Further review of the May and June 2024 MARs and Treatment Administration Records (TARs) indicated the monitoring of adverse consequences to insulin and hypoglycemic medications was not being documented.</p> <p>During an interview on 6/28/24 at 12:50 P.M., the CNO said the expectation was for all residents who were administered medications to alter their blood sugar should be monitored for potential adverse reactions and/or side effects.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>48695</p> <p>Based on record review and interview, the facility failed to ensure each Resident's drug regimen was free from unnecessary psychotropic medications for five Residents (#55, #78, #30, #32, and #10), out of a total sample of 19 residents. Specifically, the facility failed to ensure psychotropic medications were monitored for adverse consequences (side effects) of their use.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Use of Psychotropic Medication, dated 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> - Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). <p>Policy Explanation and Compliance Guidelines:</p> <ul style="list-style-type: none"> - The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. <p>1. Resident #55 was admitted to the facility in October 2024 with diagnoses including anxiety, obsessive compulsive disorder, and depression.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 3/5/24, indicated Resident #55 had received antipsychotic, antianxiety, and antidepressant medications.</p> <p>Review of Resident #55's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - Escitalopram (antidepressant) 20 milligrams (mg) tab by mouth one time a day (10/27/23) - Aripiprazole (antipsychotic) 2 mg tab by mouth one time a day (10/27/23) - Remeron (antidepressant) 7.5 mg by mouth one time a day (11/20/23) - Xanax (antianxiety) 0.5 mg by mouth three times a day (11/16/23) <p>Review of Resident #55's April, May, and June 2024 Medication Administration Records (MAR) indicated he/she received Escitalopram, Aripiprazole, Remeron, and Xanax as ordered.</p> <p>Further review of Resident #55's medical record failed to indicate Resident #55 was monitored for potential adverse consequences of antipsychotic, antianxiety, and antidepressant medications.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/25/24 at 12:40 P.M., Unit Manager #1 said any resident taking an antipsychotic, antianxiety, and antidepressant medication should be monitored for side effects of the medications. Unit Manager #1 reviewed Resident #55's physician orders and said Resident #55 did not have an order to monitor for potential adverse consequences of his/her antipsychotic, antianxiety, and antidepressant medications but should have one.</p> <p>During an interview on 6/27/24 at 12:55 P.M., the Director of Nursing (DON) said residents who are receiving antidepressant, antianxiety, and antipsychotic medications should have order to monitor for potential adverse consequences.</p> <p>2. Resident #78 was admitted to the facility in April 2024 with diagnoses including major depressive disorder.</p> <p>Review of Resident #78's MDS assessment, dated 4/12/24, indicated that Resident #78 received antidepressant medication.</p> <p>Review of Resident #78's current Physician's Orders indicated but were not limited to:</p> <ul style="list-style-type: none"> - Citalopram (antidepressant) 20 mg give one tab daily (5/17/24) - Sertraline (antidepressant) 25 mg give one tab daily (4/4/24) <p>Review of Resident #78's April, May, and June 2024 MARs indicated he/she received Citalopram and Sertraline as ordered.</p> <p>Review of Resident #78's care plan failed to indicate but was not limited to:</p> <ul style="list-style-type: none"> - Focus: I uses [SIC] antidepressant medication Sertraline and Citalopram r/t (related to) Depression (date initiated 5/13/24) - Goal: I will be free from discomfort or adverse reactions related to antidepressant therapy through the review date (dated initiated 5/13/24) - Interventions: - Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT (every shift) (date initiated 5/13/24) - Monitor/document/report PRN (as needed) adverse reactions to ANTIDEPRESSANT therapy (date initiated 5/13/24) <p>Further review of Resident #78's medical record failed to indicate Resident #78 was monitored for potential adverse consequences of antidepressant medications.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/27/24 at 7:51 A.M., Nurse #7 said residents who take antidepressant medications should be monitored for potential adverse consequences. Nurse #7 reviewed Resident #78's medical record and said Resident #78 was administered antidepressant medications per physician's orders. Nurse #7 said the Resident did not have an order to monitor for potential adverse consequences of antidepressant medications but should have one.</p> <p>During an interview on 6/27/24 at 12:55 P.M., the DON said residents who are receiving antidepressant should have order to monitor for potential adverse consequences.</p> <p>49428</p> <p>3. Resident #30 was admitted to the facility in March 2024 with diagnoses which included anxiety disorder and dementia.</p> <p>Review of the MDS assessment, dated 4/3/24, indicated that Resident #30 received antipsychotic, antianxiety, and antidepressant medications.</p> <p>Review of Resident #30's active Physician's Orders indicated but were not limited to:</p> <ul style="list-style-type: none"> - Trazodone (antidepressant) tablet, 50 mg. Give 25mg by mouth two times a day for agitation related to unspecified dementia, moderate with other behavioral disturbance. Give one half tab (25mg) by mouth twice daily. Active 3/8/24. Revised 5/23/24. - Trazodone tablet, 50mg. Give 25mg by mouth every 8 hours as needed for agitation for 90 days. Active 4/5/24. - Seroquel (antipsychotic) tablet, 50mg. Give 50mg by mouth two times a day for dementia. Active 3/4/24. - Xanax (antianxiety) tablet 0.25mg. Give 0.25mg by mouth every 24 hours as needed for anxiety/agitation for 90 AND give 0.25mg by mouth one time a day for anxiety/agitation. Active 4/5/24. <p>Review of Resident #30's MAR for May and June 2024 indicated the Resident received Trazodone, Seroquel, and Xanax medications per physician's orders.</p> <p>Review of Resident #30's active care plan indicated but was not limited to:</p> <ul style="list-style-type: none"> - I use antidepressant medication and antianxiety medications related to depression and anxiety. - I will be free from discomfort or adverse reactions related to antidepressant/antianxiety therapy through the review date. - Administer antidepressant/antianxiety medications as ordered by physician. Monitor/document side effects and effectiveness every shift. <p>Further review of Resident #30's medical record failed to indicate physician's order for or documentation of side effects and effectiveness every shift for Trazodone, Seroquel, or Xanax medications.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/27/24 at 4:46 P.M., the DON and Chief Nursing Officer (CNO) reviewed Resident #30's medical record. The DON said the Resident should have physician's orders to monitor side effects of Trazodone, Seroquel, and Xanax.</p> <p>During an interview on 7/1/24 at 10:31 A.M., Nurse Practitioner #2 said an order should exist to monitor side effects of Trazodone, Seroquel, and Xanax for Resident #30.</p> <p>50740</p> <p>4. Resident #10 was admitted to the facility in January 2024 with diagnoses including dementia, anxiety disorder, major depressive disorder, and bipolar disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 5/8/24, indicated Resident #10 had moderate cognitive impairment as evidenced by a score of 8 out of 15 on the Brief Interview for Mental Status (BIMS).</p> <p>Review of Resident #10's care plans indicated but was not limited to:</p> <ul style="list-style-type: none"> - Focus: I am taking an antipsychotic, antidepressant medication r/t (related to) agitation, mood, and behaviors. My behaviors include: calling out for attention repeatedly. Anxiousness where her room is. [sic] - Goal: My doctors will monitor my medications and attempt to reduce the use of psychotropic (medications that affect behavior, mood, thoughts, or perception) through the review date. - Interventions: I will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. <p>Review of the Physician's Orders indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - Ativan (anti-anxiety) Oral Tablet 0.5 mg (Lorazepam) Give 1 mg by mouth every 24 hours as needed for agitation at HS (bedtime), dated 6/5/24 - Ativan Oral Tablet 0.5 mg (Lorazepam) Give 0.5 mg by mouth two times a day, dated 6/5/24 - Latuda (antipsychotic) Oral Tablet 80 mg (Lurasidone HCl) Give 80 mg by mouth one time a day, dated 6/17/24 - Trazodone HCl Oral Tablet Give 25 mg by mouth two times a day, dated 6/5/24 - Trazodone HCl Oral Tablet 100 mg Give 2 tablet [sic] by mouth one time a day, dated 6/10/24 <p>Further review of the as needed Ativan order failed to indicate a stop date or re-evaluation date as required.</p> <p>Review of the June 2024 MAR indicated that Resident #10 was administered the as needed dose of Ativan on 6/6/24 and 6/20/24.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident #10's May and June 2024 MARs and Treatment Administration Records (TARs) indicated the monitoring of adverse consequences to psychotropic medications were not being documented.</p> <p>During an interview on 6/27/24 at 12:55 P.M., the DON said all residents who are receiving antidepressant, antianxiety and antipsychotic medications should have orders to monitor for potential adverse consequences.</p> <p>34145</p> <p>5. Resident #32 was admitted to the facility in January 2024 with diagnoses including dementia, abnormalities of gait and mobility, and unsteadiness on his/her feet.</p> <p>Review of the MDS assessment, dated 4/13/24, indicated Resident #32's received psychotropic medication daily.</p> <p>Review of Resident #32's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - Ativan 0.5mg one time a day (4/25/24) - Depakote Sprinkles (anticonvulsant used for behaviors) 125mg, give 2 capsules one time a day (5/1/24) - Seroquel 25mg, give 12.5mg two times a day (6/18/24) - Trazodone 50mg, give 25mg every 12 hours as needed for anxiety (6/7/24) - Trazodone 50mg at bedtime (4/25/24) <p>Review of Resident #32's April 2024 through June 2024 MAR indicated the Resident received Ativan, Depakote, Seroquel and Trazodone as ordered by the Physician.</p> <p>Further review of the entire medical record failed to indicate Resident #32 was monitored for potential adverse consequences of antianxiety, antipsychotic and antidepressant medications.</p> <p>During an interview on 6/25/24 at 11:29 A.M., Unit Manager #1 said residents on psychotropic medications should be monitored for side effects. She reviewed Resident #32's medical record and said they were not monitoring him/her for adverse consequences of psychotropic medication use.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>34145</p> <p>Based on record review and interviews, the facility failed to ensure one Resident (#44) out of a total sample of 14 residents, was free from significant medication error when an anticoagulant (blood thinner) medication was not administered according to physician's orders</p> <p>Findings include:</p> <p>Review of the facility policy, Unavailable Medications, last revised 2/2024, indicated, but was not limited to:</p> <ul style="list-style-type: none"> -The facility maintains a contract with a pharmacy provider to supply the facility with routine, as needed (prn), and emergency medication. -An urgent (STAT) supply of commonly used medications is maintained in-house for timely initiation of medications. -Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: -Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold. -If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication error, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reactions to omission of the medication. <p>Resident #44 was originally admitted to the facility in June 2022 and had diagnoses including dementia.</p> <p>Review of the medical record indicated Resident #44 was admitted to the hospital on 8/14/24 after sustaining a right hip fracture following a fall.</p> <p>The hospital discharge summary, dated 8/18/24, indicated Resident #44 underwent an open reduction internal fixation (surgery to re-align and stabilize serious fractures) on 8/15/24. The discharge medication list indicated the Resident was to receive enoxaparin (anticoagulant) 40 milligrams(mg)/0.4 milliliters (mL) injection every 24 hours starting on 8/19/24 for Deep Vein Thrombosis (DVT) prophylaxis.</p> <p>According to the National Institute of Health (2023), the interruption of anticoagulant therapy can increase the risk of thrombotic events during and after surgery.</p> <p>Review of August 2024 physician's orders indicated, but was not limited to:</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Enoxaparin Sodium Injection Solution, Prefilled syringe 40 mg/0.4 mL, inject 40 mg subcutaneously (under the skin) one time a day until 9/20/24 (8/19/24)</p> <p>Review of the August 2024 Medication Administration Record (MAR) indicated the number 9 and initials in the box corresponding to the order for enoxaparin on 8/19/24. Review of the legend on the MAR identified the code 9 was other/See Nurse Notes.</p> <p>A medication administration note, dated 8/19/24, indicated a notation of n/a next to the order for enoxaparin 40 mg/0.4 mL with no other documentation.</p> <p>Further review of the medical record failed to indicate the Physician/Nurse Practitioner was notified that enoxaparin was not administered on 8/19/24 as ordered.</p> <p>During an interview on 8/20/24 at 3:04 P.M., Nurse #3 said she documented the code 9 on the MAR and n/a in a note for not available because the Resident did not get the enoxaparin as it had not been delivered by the pharmacy yet. She said it was delivered the next day. Nurse #3 said she did not notify the Physician or Nurse Practitioner that the enoxaparin was not available and not administered on 8/19/24 as ordered. Nurse #3 and the surveyor inspected the emergency kits (e-kits) in the medication room. An e-kit labeled #31 was noted to have an inventory list of contents that included enoxaparin 100 milligrams/milliliters. Nurse #3 said she could have used it for Resident #44, but didn't even think of accessing the e-kit for the medication.</p> <p>During an interview on 8/20/24 at 3:25 P.M., Unit Manager #1 reviewed Resident #44's medical record and said Nurse #3 should have notified the Physician or Nurse Practitioner and accessed the e-kit to obtain and administer enoxaparin, but did not.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>50740</p> <p>Based on observations, interview, and policy review, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles prior to administration and in 1 of 4 medication carts and 1 of 2 medication rooms. Specifically, the facility failed to ensure:</p> <ul style="list-style-type: none"> - For Resident #74, Intravenous (IV) medication was stored in the medication cart and not left at the bedside; - Schedule II-V controlled substance medications were maintained in a separately locked, permanently affixed compartment; - Loose pills were properly discarded; and - A multi-dose vial of Tuberculin (used to perform a skin test to diagnose Tuberculosis) which had been opened/accessed was dated and discarded within 30 days. <p>Findings include:</p> <p>Review of the facility's policy titled Medication Storage, dated 3/4/24, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - It is the policy of the facility to ensure all medications housed on the premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations; - Schedule II drugs and back-up stock of Schedule III, IV, and V medications are stored under double-lock and key; - The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. <p>On 6/25/24 at 11:32 A.M., the surveyor observed an Intravenous (IV) bag containing Ampicillin (antibiotic) 2 grams/100 milliliters (ml) along with a 10 ml saline flush, unattended on the overbed table in Resident #74's room.</p> <p>During an interview on 6/25/24 at 11:42 A.M., Nurse #1 stated she left the IV medication in Resident #74's room because he/she was not in the room and she had gone to look for him/her. Nurse #1 stated that she should not have left the medication there and it was not her usual practice.</p> <p>During an interview on 7/1/24 at 10:04 A.M., the Chief Nursing Officer (CNO) and Director of Nursing (DON) said that IV antibiotics should not have been left in the Resident's room unattended and should have been stored either in the medication room or medication cart.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During review of the East Unit A-Side medication cart, on 6/27/24 at 12:30 P.M., with Nurse #7, the surveyor observed:</p> <ul style="list-style-type: none"> - Multiple loose pills in the top drawer of the medication cart where over-the-counter medications were stored - Four unlabeled inhaler devices not stored in boxes; - Numerous schedule II-V controlled substances were not maintained within a separately locked, permanently affixed compartment. <p>During an interview on 6/27/24 at 12:30 P.M., Nurse #7 said that that loose pills should have been discarded and not left in the drawer of the medication cart. Nurse #7 said that inhaler devices should be labeled and stored in boxes marked with the residents' names and prescription information. Nurse #7 said that the lock on the separately locked compartment in the medication cart, where schedule II-V controlled substances were usually stored, had been broken for a few weeks and that the pharmacy had been contacted for repair. Nurse #7 did not know when the pharmacy had been contacted or when the lock was scheduled to be repaired. Nurse #7 said that the Director of Nursing (DON) was aware that the lock was broken.</p> <p>During an interview on 6/27/24 at 12:30 P.M., the DON said she was aware the lock was broken and that the pharmacy had been contacted. The DON said that schedule II-V controlled substances should be stored under double-lock and key.</p> <p>During an interview on 6/27/24 at 12:30 P.M., the CNO said that she was not aware that the drawer lock was broken and that controlled substances should be stored in a double-locked permanently affixed compartment.</p> <p>During review of the East Unit medication room, on 6/27/24 at 12:38 P.M., with Nurse #7, the surveyor observed a multi-dose vial of Tuberculin, which had been opened/accessed, was not labeled with the opened date and expiration date stored in the medication room refrigerator.</p> <p>Review of the manufacturer's guide for Tuberculin indicated that once opened/accessed, multiple dose vials should be discarded after 30 days.</p> <p>During an interview on 6/27/24 at 12:38 P.M., Nurse #7 said that the Tuberculin vial should have been labeled with the opened date and expiration date.</p> <p>48695</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49428</p> <p>Based on observation, policy review, and interview, the facility failed to follow their policy and professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to properly label and date food products and maintain safe and clean equipment in two of two nourishment kitchenettes.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Food: Safe Handling for Foods from Visitors, revised ,d+[DATE], indicated but was not limited to:</p> <ul style="list-style-type: none"> - Residents will be assisted in properly storing and safely consuming food brought into the facility for residents by visitors. - Refrigerator/freezers for storage of foods brought in by visitors will be properly maintained and cleaned weekly. <p>Review of the facility's policy, untitled and undated, indicated but was not limited to:</p> <ul style="list-style-type: none"> - The foodservice department will check for expired products within the inventory. Discard all expired products. If products such as milk will expire before the next visit, discard to prevent negative outcomes. - Place a chart on the refrigerator outlining the expiration period for each item on your floor stock list. Use zip lock bags for condiments and use one label that identifies the date placed in inventory. This will help identify multiple items that expire 3 months or greater. - All open items that are patient items must have a proper label with open and expiration date. Outside items are not exempt from this requirement. In addition to a proper label and date, the patient's name, date of birth, and room number must be placed on the item. Discard items without these requirements. <p>Review of the facility's policy titled Food Storage and Retention Guide, undated, indicated but was not limited to:</p> <ul style="list-style-type: none"> - Specialty Items- shakes, supplements, thickened beverages: Dry storage and refrigeration at less than or equal to 41 degrees Fahrenheit per manufacturer guidelines. <p>Review of the facility's policy titled Nourishment Room Cleaning, undated, indicated but was not limited to:</p> <ul style="list-style-type: none"> - Housekeeping is to clean all horizontal and vertical surfaces. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> - Housekeeping is to dust mop and damp mop all floors. - Dining cleans the inside of the refrigerator. - Dining cleans the inside of drawers where snacks are stored. <p>Review of the facility's cleaning schedule for the East and [NAME] units, undated, indicated but was not limited to:</p> <p>6:,d+[DATE]:45 Morning Rounds</p> <p>6:,d+[DATE]:30 Clean on unit common areas (see check sheet)</p> <p>7:,d+[DATE]:00 Clean off unit common areas (see check sheet)</p> <p>2:,d+[DATE]:30 Final Rounds</p> <p>Review of the facility's cleaning schedule check sheet for the East and [NAME] units indicated diet kitchen was on the cleaning schedule check sheet.</p> <p>Review of the facility's nourishment kitchenette par level and monitoring checklist, undated, indicated but was not limited to:</p> <ul style="list-style-type: none"> - Refrigerator cleaned inside and free from any spills. - Everything is labeled and dated clearly. - Microwave is clean inside and out and free from spills and food residue. - Cabinets and drawers are clean and neat and food is rotated. <p>Immediately throw away any food items not labeled including staff meals.</p> <p>On [DATE] at 8:30 A.M., the surveyor observed the following on the [NAME] Unit kitchenette:</p> <ul style="list-style-type: none"> -Sink faucet and handheld spray nozzle with brown buildup that was easily scraped with fingernail; -Cabinets disorganized with items scattered within; -Drawers disorganized with condiment packages scattered throughout, not bagged and labeled; -Cabinets and hardware with chipping and peeling paint; -Freezer with ice buildup; -One facility container labeled Thick-It with a use by date of [DATE]; <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Nine packets of thickened coffee and tea (beverages used as a safety precaution for residents with swallowing difficulties) with use by dates ranging from [DATE] to [DATE];</p> <p>-One bottle of nutritional supplement in the refrigerator, opened with no label, undated.</p> <p>On [DATE] at 9:00 A.M. and on [DATE] at 8:46 A.M., the surveyor observed the following on the East Unit kitchenette:</p> <ul style="list-style-type: none"> - microwave interior surface soiled on all sides; - Sink faucet and handheld spray nozzle with brown buildup that was easily scraped with fingernail; - Cabinets disorganized with items scattered and spilled sugar on shelving; - Drawers disorganized with condiment packages scattered throughout, not bagged and labeled; peeling contact paper, and small and large areas of a sticky, dark brown substance; - Cabinets and hardware with chipping and peeling paint; - Refrigerator wire shelving with drips of red liquid hanging from the wires; red drips on the lid of a Resident's yogurt; - One container of a resident's prune juice, opened, undated. Manufacturer's label read consume within , d+[DATE] days; - Ice cream with no label, undated; - Two packages of cake mix in the freezer with no label, undated. <p>During an interview with observation on [DATE] at 12:30 P.M., the Food Service Director (FSD) said the kitchen staff stocks the Unit kitchenettes, monitors item dating and labeling, monitors for expiration dates, and cleans the refrigerator and freezer. The FSD also said kitchen staff are responsible for cleaning drawers. The FSD and the surveyor observed the East Unit kitchenette together. The FSD said the refrigerator, freezer, drawers, and cabinets needed cleaning. The FSD said the sink faucets and the hand nozzles should be cleaned of buildup. The FSD said resident food items stored in the Unit kitchenettes should be labeled and dated and any food or drink that is expired or past the written use by date is discarded. The FSD said she was unaware of the prune juice's consumption range of seven to ten days after opening, and she was unaware of the expired thickened beverage packets in the [NAME] Unit kitchenette. The FSD said these items should have been discarded.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>34145</p> <p>Based on observation, record review, and interview, the facility failed to maintain accurate medical records in accordance with professional standards and practices for five Residents (#74, #20, #6, #231, and #48), out of a total sample of 19 residents. Specifically, the facility failed:</p> <ol style="list-style-type: none"> 1. For Resident #74, to accurately document the recommendations from the consultant infectious disease Physician regarding the plan of care for a peripherally inserted central catheter (PICC); 2. For Resident #20, to ensure his/her electronic medical record contained scanned documents pertaining only to Resident #20; and 3. For Residents #6, #231, and #48, to document weekly comprehensive skin assessment per physician orders. <p>Findings include:</p> <p>Review of the facility's Confidentiality of Personal and Medical Records policy and Safeguarding of Resident Identifiable Information, both dated 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> - This facility honors the resident's right to secure and confidential personal and medical records. This includes the right to confidentiality of all information contained in a resident's records, regardless of the form of storage or location of the record. - Personal and medical records include all types of records the facility might keep on a resident, whether they are medical, social, funds accounts, automated, or other. - Keep confidential is defined as safeguarding the content of information including written documentation, video, audio or other computer stored information from unauthorized disclosure without the consent of the individual and/or the individual's surrogate or representative. - It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the safety and confidentiality of the resident's identifiable information and to safeguard against destruction or unauthorized release of information and records. <p>1. Resident #74 was admitted to the facility in May 2024 with diagnoses including endocarditis (infection of the heart's inner lining, usually involving the heart valves) and had a Peripherally Inserted Central Catheter (PICC) for infusion of antibiotic medication.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 6/2/24, indicated Resident #74 had received intravenous (IV) antibiotic medication.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of an outpatient infectious disease progress note, dated 6/25/24, indicated Resident #74 was seen on 6/25/24 for a follow-up appointment. The note indicated the Resident was getting Ceftriaxone (antibiotic) 2 grams (gm) every 12 hours and Ampicillin (antibiotic) 2 gm every 4 hours to treat endocarditis. Treatment recommendation included, but was not limited to:</p> <ul style="list-style-type: none"> - Continue IV Ampicillin 2 gm every 4 hours and IV Ceftriaxone 2 gm over 12 hours. - Anticipate 6 week course of IV antibiotic therapy (end date 7/4/24), to be followed by indefinite oral antibiotic suppression with oral Amoxicillin 500 mg three times a day. <p>Review of a nursing progress note, dated 6/25/24, indicated Resident #74's PICC line was to be pulled on 7/15, and would start amoxicillin 500 mg three times a day indefinitely.</p> <p>Further review of the medical record indicated a Physician's order, entered on 6/25/24, for an RN (Registered Nurse) to remove PICC line on 7/15/24.</p> <p>During an interview on 6/28/24 at 2:00 P.M., the Staff Development Coordinator (SDC) reviewed Resident #74's medical record and said she would call the infectious disease physician to clarify the recommendations.</p> <p>During an interview on 7/1/24 at 8:05 A.M., the SDC said she spoke with the infectious disease physician's office, and they said Resident #74's antibiotic treatment will end on 7/4/24 and will begin oral antibiotics as indicated in their note. She said the information documented in the medical record was inaccurate.</p> <p>2. Resident #20 was admitted to the facility in April 2024.</p> <p>Review of the electronic medical record miscellaneous tab indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - Psychiatric Consultant Progress Notes, dated 4/17/24 for two residents who were not Resident #20; and - Psychiatric Consultant Progress Notes, dated 4/24/24 for seven residents who were not Resident #20. <p>During an interview on 7/1/24 at 12:30 P.M., the Director of Nurses (DON) reviewed Resident #20's electronic medical record and said the documents should have been uploaded into each residents' medical record and not Resident #20's medical record.</p> <p>48695</p> <p>3. Review of the facility's policy titled Skin Assessment, dated 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> -A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, daily for three days, and weekly thereafter. <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Documentation of skin assessment:</p> <p>a. Include date and time of the assessment, your name, and position title.</p> <p>b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.).</p> <p>c. Document type of wound.</p> <p>d. Describe wound (measurements, color, type of tissue in the wound bed, drainage, odor, pain).</p> <p>e. Document if resident refused assessment and why.</p> <p>f. Document other information as indicated or appropriate.</p> <p>A. Resident #6 was admitted to the facility in April 2024 with diagnoses which included diabetes mellitus, pressure ulcer of the sacral region, and pressure ulcer of the right hip.</p> <p>Review of Resident #6's current Physician's Orders indicated but was not limited to:</p> <p>-Weekly skin check with shower Fridays 3-11 every evening shift every Friday *Complete Weekly Skin Check UDA (user-defined assessment)* (4/10/24)</p> <p>Review of Resident #6's April, May, and June 2024 Treatment Administration Records (TAR) indicated a nurse had signed off weekly skin checks as being completed on 4/12/24, 4/19/24, 4/26/24, 5/3/24, 5/10/24, 5/17/24, 5/24/24, 5/31/24, 6/7/24, 6/14/24, 6/21/24, and 6/28/24.</p> <p>Further review of Resident #6's medical record failed to indicate a weekly skin check assessment form had been filled out on the following days:</p> <p>- 4/12/24</p> <p>- 5/10/24</p> <p>- 5/17/24</p> <p>- 6/28/24</p> <p>B. Resident #231 was admitted to the facility in June 2024, with diagnoses including hypertension and alcohol abuse.</p> <p>Review of Resident #231's current Physician's Orders indicated but was not limited to:</p> <p>- Weekly skin check with shower Monday PM every evening shift every Monday *Complete Weekly Skin Check UDA* (dated 6/5/24)</p> <p>Review of Resident #231's June TAR indicated a nurse had signed off weekly skin checks as being completed on 6/10/24, 6/17/24, and 6/24/24.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident #231's medical record failed to indicate a weekly skin check assessment form had been filled out on the following days:</p> <ul style="list-style-type: none"> - 6/10/24 - 6/17/24 - 6/24/24 <p>C. Resident #48 was admitted to the facility in April 2024 with diagnoses including rectal abscess and muscle wasting and atrophy.</p> <p>Review of Resident #48's current Physician's Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> - Weekly skin check with shower Fridays 3-11 every evening shift every Friday *Complete Weekly Skin Check UDA* (dated 4/8/24) <p>Review of Resident #48's April and May 2024 TAR indicated a nurse had signed off weekly skin checks as being completed on 4/12/24, 4/19/24, 4/26/24, 5/3/24, and 5/10/24.</p> <p>Further review of Resident #48's medical record failed to indicate a weekly skin check assessment form had been filled out on the following days:</p> <ul style="list-style-type: none"> - 4/12/24 - 4/19/24 - 4/26/24 - 5/3/24 - 5/10/24 <p>During an interview on 7/1/24 at 10:04 A.M. the DON said skin checks are completed on shower days and should be signed off on the TAR and a UDA completed. The DON said Residents #6, #231, and #48 all had skin checks signed off on the TAR but all three residents were missing UDAs and should not have been.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>46562</p> <p>Based on interview, policy review, and document review, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) Committee which included the required members at their meetings. Specifically, the facility Infection Preventionist failed to attend the last two quarterly QAPI meetings.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Quality Assurance and Performance Improvement (QAPI), dated as revised 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> - The QAPI program includes the establishment of a Quality Assessment and Assurance (QAA) Committee and a written QAPI Plan. - The QAA Committee shall be interdisciplinary and shall consist at a minimum of the Director of Nursing Services, the Medical Director or his/her designee, at least three other members of the facility's staff, at least one of which must be the Administrator, Owner, a Board Member or other Individual in a leadership role; and the Infection Preventionist. <p>Review of the QAPI Attendance Sheets, dated 1/19/24, 2/26/24, 3/15/24, and 4/26/24, failed to indicate the Infection Preventionist was in attendance and the designated signature space was blank. Further review of the QAPI Attendance Sheets indicated the Quarterly Meetings were held on 1/19/24 and 4/26/24.</p> <p>During an Interview on 7/1/24 at 12:10 P.M., the Chief Nursing Officer (CNO) reviewed the QAPI Attendance Sheets, dated 1/19/24, 2/26/24, 3/15/24, and 4/26/24 and said the facility IP had not signed in. The CNO said the expectation was for the facility IP to be present at the QAPI Meetings.</p> <p>48695</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50740</p> <p>Based on document review and interview, the facility failed to maintain an infection prevention and control program to help prevent the development and potential transmission of communicable diseases and infections for five Residents (#72, #74, #17, #6, and #55) of 19 sampled residents. Specifically, the facility failed to:</p> <ol style="list-style-type: none"> 1. For Resident #72, ensure staff wore personal protective equipment (PPE) as required for Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms in nursing homes) and Contact Precautions (infection control precautions used for patients who may be infected with certain infectious agents for which additional precautions are needed to prevent infection transmission); 2. For Resident #74, ensure staff wore PPE as required for EBP while providing care to a resident with a Peripherally Inserted Central Catheter (PICC); 3. For Resident #17, ensure staff wore PPE while in contact with the Resident's blood; 4. For Resident #6, ensure staff wore the appropriate PPE as required for EBP while providing direct care; 5. For Resident #55, ensure staff wore the appropriate PPE as required for EBP while providing direct care; and 6. Clean and sanitize tables before meals and perform hand hygiene for residents before meals on one of two units. <p>Findings include:</p> <p>Review of the facility's policy titled Enhanced Barrier Precautions, dated 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> - Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. - Definitions: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs targeted gown and gloves use during high contact resident care activities. - Policy Explanation and Compliance Guidelines: <ol style="list-style-type: none"> 2. Initiation of Enhanced Barrier Precautions: <ol style="list-style-type: none"> b. An order for enhanced barrier precautions will be obtained for residents with any of the following: <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO.</p> <p>4. High-contact resident care activities include:</p> <ul style="list-style-type: none"> a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters h. Wound care: any skin opening requiring a dressing <p>10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.</p> <p>Review of the facility's policy titled Transmission Based Precautions, dated 3/8/20, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - In addition to Standard Precautions Contact Precautions will be implemented for residents with known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. - Wear a clean non-sterile gown for all interaction that may involve contact with the resident or potentially contaminated items in the resident's environment. <p>Review of the Centers for Disease Control and Prevention (CDC) article titled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 6/28/24, indicated that changing linen is considered a high contact resident care activity and gown and gloves should be worn by personnel if they are changing the linen of residents on Enhanced Barrier Precautions.</p> <p>1. Resident #72 was admitted to the facility in May 2024 with the following diagnoses: sepsis (an infection of the bloodstream) and Methicillin-Susceptible Staphylococcus aureus (MSSA) infection (a bacterial infection that can be treated by antibiotics).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Minimum Data Set (MDS) assessment, dated 5/21/24, indicated Resident #72 had diagnoses including a multi-drug resistant organism infection, septicemia, and wound infection. Further review of the MDS indicated he/she received application of dressings to his/her feet and received IV (intravenous) antibiotic therapy.</p> <p>Review of Resident #72's Order Summary Report indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - Enhance Barrier Precautions and Contact Precautions every shift (order date 5/17/24) <p>On 6/24/24 at 9:26 A.M., the surveyor observed Certified Nursing Assistant (CNA) #1 in Resident #72's room handling the Resident's bed linen without a gown on. Signs posted outside the Resident's room indicated that staff were to follow EBP and Contact Precautions. A cart containing personal protective equipment was observed inside the doorway of the Resident's room.</p> <p>Review of the CDC Contact Precautions sign, undated, indicated but was not limited to:</p> <ul style="list-style-type: none"> - Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. <p>Review of the CDC EBP sign, undated, indicated but was not limited to:</p> <ul style="list-style-type: none"> - Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities. <p>Dressing</p> <p>Bathing/Showering</p> <p>Transferring</p> <p>Changing Linens</p> <p>Providing Hygiene</p> <p>Changing briefs or assisting with toileting</p> <p>Device care or use: central line, urinary catheter, feeding tube, tracheostomy</p> <p>Wound Care: any skin opening requiring a dressing</p> <p>During an interview on 6/24/24 at 9:26 A.M., CNA #1 said that Resident #72 was not on Contact Precautions.</p> <p>During an interview on 6/26/24 at 8:49 A.M., CNA #5 said that Resident #72 was on EBP due to the presence of a urinary catheter and that staff are to wear a gown and gloves when performing high-contact care activities.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/26/24 at 8:45 A.M., the Staff Development Coordinator (SDC)/Infection Preventionist (IP) said Resident #72 was on EBP but was not on Contact Precautions and that staff should be wearing a gown and gloves when changing his/her linen.</p> <p>34145</p> <p>2. Resident #74 was admitted to the facility in May 2024 with diagnoses including endocarditis (infection of the heart's inner lining, usually involving the heart valves) and had a Peripherally Inserted Central Catheter (PICC) line for infusion of antibiotic medication.</p> <p>Review of the most recent MDS assessment indicated Resident #74 received intravenous (IV) antibiotic medication.</p> <p>Review of the medical record indicated that on 5/25/24, Resident #74 had a double lumen PICC line placed in the left basilic vein at the antecubital region (inner surface of the forearm) for infusion of antibiotic medication during a recent hospitalization .</p> <p>Review of the Physician's Orders indicated, but was not limited to:</p> <p>-Enhanced Barrier Precautions every shift (5/29/24)</p> <p>On 6/24/24 at 8:59 A.M., the surveyor observed a sign posted outside the Resident's room that indicated staff were to follow EBP for high contact resident care activities including device care. A three-tiered precaution cart filled with PPE was noted outside the Resident's door.</p> <p>On 6/24/24 at 9:00 A.M., the surveyor observed Nurse #1 enter Resident #74's room, put on a pair of gloves, approach the intravenous pump at the Resident's bedside and disconnect the PICC line tubing. The Nurse failed to perform hand hygiene before applying the gloves and did not wear a gown as required.</p> <p>On 6/24/24 at 10:30 A.M., the surveyor observed Nurse #1 assist Resident #74 out of his/her wheelchair. Nurse #1 was not wearing any PPE while assisting the Resident.</p> <p>On 6/24/24 at 12:20 P.M., the surveyor observed Nurse #1 enter Resident #74's room, put on a pair of gloves and disconnect Resident #74's PICC line tubing. The Nurse failed to perform hand hygiene before applying the gloves and did not wear a gown as required.</p> <p>During an observation with interview on 6/24/24 at 4:44 P.M., the surveyor observed Nurse #1 perform hand hygiene, put on gloves, and enter Resident #74's room and administer medication through the PICC line. The Nurse failed to put on a gown. Nurse #1 said she didn't know she had to wear a gown when hanging IV (intravenous) medication.</p> <p>3. Review of Standard Precautions for All Patient Care by the CDC, dated 4/3/24, indicated Standard Precautions are used for all patient care. They're based on a risk assessment and make use of common sense practices and personal protective equipment use that protect healthcare providers from infection and prevent the spread of infection from patient to patient. Use personal protective equipment (PPE) whenever there is an expectation of possible exposure to an infectious material.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #17 was admitted to the facility in November 2019 with diagnoses including chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems).</p> <p>Review of the MDS assessment, dated 6/21/24, indicated Resident #17 had severe cognitive impairment as evidenced by a BIMS score of 4 out of 15, was dependent on staff for all activities of daily living and utilized oxygen therapy.</p> <p>On 6/24/24 at 8:00 A.M., the surveyor observed Resident #17 seated in a recliner chair in the unit dayroom being fed by a CNA. A red substance, consistent with blood, was observed smeared from the Resident's left nostril to his/her left upper lip.</p> <p>On 6/24/24 at 8:22 A.M., Nurse #2 approached Resident #17 with ungloved hands, and used the Resident's clothing protector around his/her neck to wipe away the blood that was underneath his/her left nostril. The nurse left the clothing protector with blood on it in place around the Resident's neck and the CNA continued to feed him/her.</p> <p>On 6/24/24 at 8:30 A.M., Nurse #2, with ungloved hands, removed the clothing protector with blood on it from around the Resident's neck and told the surveyor that she was going to get an ice pack for the Resident.</p> <p>48695</p> <p>4. Resident #6 was admitted to the facility in April 2024 with diagnoses of diabetes mellitus, pressure ulcer of the sacral region, and pressure ulcer of the right hip.</p> <p>Review of Resident #6's MDS assessment, dated 5/13/24, indicated Resident #6 had three stage 4 (full thickness skin and tissue loss) pressure ulcers.</p> <p>Review of Resident #6's current Physician Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> -Enhanced Barrier Precautions. Please use enhanced barrier precautions (gloves, gown) during all close contact resident care. Every shift for infection control (Dated 5/13/24) <p>Resident #6 had an EBP sign, undated, from the CDC outside his/her room, which indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - STOP ENHANCED BARRIER PRECAUTIONS - EVERYONE MUST: <ul style="list-style-type: none"> - Clean their hands, including before entering and when leaving the room. - PROVIDERS AND STAFF MUST ALSO: <ul style="list-style-type: none"> - Wear gloves and a gown for the following High-Contact Resident Care Activities. - Dressing <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Bathing/Showering - Transferring - Changing Linens - Providing Hygiene - Changing briefs or assisting with toileting - Device care or use: central line, urinary catheter, feeding tube, tracheostomy - Wound Care: any skin opening requiring a dressing <p>On 6/24/24 at 1:17 P.M., the surveyor observed a nurse and a CNA assist Resident #6 with perineal care (washing of private parts). The surveyor observed the nurse and the CNA wearing only gloves. The nurse and the CNA failed to don (put on) a gown.</p> <p>During an interview on 7/1/24 at 10:35 A.M., Unit Manager #1 said Resident #6 is on EBP for multiple wounds. Unit Manager #1 said anyone providing perineal care to Resident #6 should have been wearing a gown and had gloves on.</p> <p>During an interview on 7/1/24 at 10:04 A.M., the DON said the expectation is for staff to wear the appropriate PPE when providing direct high contact care to residents on EBP.</p> <p>5. Resident #55 was admitted to the facility in October 2024 with diagnoses including retention of urine and obstructive and reflux uropathy.</p> <p>Review of the MDS assessment, dated 3/5/24, indicated Resident #55 had an indwelling Foley catheter care.</p> <p>Review of Resident #55's current Physician Orders indicated but was not limited to:</p> <ul style="list-style-type: none"> -Enhanced Barrier Precautions. Please use enhanced barrier precautions (gloves, gown) during all close contact resident care. Every shift for infection control (Dated 5/13/24) <p>Resident #55 had an EBP sign, undated, from the CDC outside his/her room, which indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - STOP ENHANCED BARRIER PRECAUTIONS - EVERYONE MUST: <ul style="list-style-type: none"> - Clean their hands, including before entering and when leaving the room. - PROVIDERS AND STAFF MUST ALSO: <ul style="list-style-type: none"> - Wear gloves and a gown for the following High-Contact Resident Care Activities. <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Dressing - Bathing/Showering - Transferring - Changing Linens - Providing Hygiene - Changing briefs or assisting with toileting - Device care or use: central line, urinary catheter, feeding tube, tracheostomy - Wound Care: any skin opening requiring a dressing <p>On 6/25/24 at 7:41 A.M., the surveyor observed CNA #6 transfer Resident #55 out of his/her bed and assist his/her to their chair. CNA #6 was wearing gloves. CNA #6 failed to don a gown on.</p> <p>During an interview on 6/25/24 at 12:27 P.M., CNA #6 said he did not put on a gown when transferring Resident #55 because he had not seen the sign for EBP outside of Resident #55's room. CNA #6 said had he seen the sign then he would have put on a gown when transferring Resident #55 as he was supposed to.</p> <p>On 6/26/24 the surveyor made the following observations:</p> <ul style="list-style-type: none"> - At 8:45 A.M., CNA #1 entered Resident #55's room and assisted Resident #55 to the bathroom. CNA #1 did not perform hand hygiene or don a gown and gloves. - At 8:48 A.M., CNA #1 exited Resident #55's room without performing hand hygiene and walked over to the linen cart in the hall, CNA #1 returned to assist Resident #55 in the bathroom without performing hand hygiene and CNA #1 did not don a gown and gloves. - At 8:49 A.M., CNA #1 exited Resident #55's room without performing hand hygiene, went over to a linen cart in the hallway then CNA #1 entered another Resident's room, then exited the room without performing hand hygiene. - At 8:51 A.M., CNA #1 returned to Resident #55's room. CNA #1 failed to perform hand hygiene. CNA #1 donned gloves but failed to don a gown. CNA #1 assisted Resident #55 from the bathroom to his/her chair. CNA #1 doffed off the gloves. CNA #1 failed to perform hand hygiene and exited Resident #55's room. <p>During an interview on 6/26/24 at 8:57 A.M., CNA #1 said Resident #55 is on EBP because he/she has a Foley catheter. CNA #1 said when providing care in the bathroom you have to wash your hands and put on a gown and gloves. CNA #1 said she should have put on a gown and gloves as well as perform hand hygiene.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/27/24 at 7:53 A.M., the surveyor observed CNA #1 making Resident #55's bed. CNA #1 failed to have a gown and gloves on. CNA #1 exited Resident #55's room and failed to perform hand hygiene.</p> <p>During an interview on 6/27/24 at 7:56 A.M., CNA #1 said she was not aware that she had to wear a gown and gloves while making Resident #55's bed because he/she was out at the hospital.</p> <p>During an interview on 6/27/24 at 8:40 A.M., the Administrator said CNA #1 should have worn a gown and gloves while making Resident #55's bed.</p> <p>During an interview on 7/1/24 at 10:04 A.M., the DON said the expectation was to wear the appropriate PPE and perform hand hygiene when providing direct high contact care and changing linens to residents on EBP.</p> <p>49428</p> <p>6. On 6/25/24 at 11:37 A.M., the surveyor observed 17 residents in the [NAME] unit dining/activity area. The surveyor observed some of the residents handling blocks and playing cards. The surveyor observed staff clear the activities off the tables but did not clean the tabletops or perform hand hygiene for the residents prior to serving lunch.</p> <p>On 6/25/24 at 11:49 A.M., the surveyor observed one resident eating peas with their bare hands and another resident eating a roll with their bare hands.</p> <p>During an interview on 6/27/24 at 9:31 A.M., Resident #29 said they would like to have their hands cleaned and sanitized before meals.</p> <p>On 6/27/24 at 11:36 A.M., the surveyor observed in the [NAME] unit, residents sitting at tables with many residents doing activities such as building blocks, shuffling cards, and handling sensory items. The surveyor observed the lunch truck arrive at which time staff cleared activities off tables. The surveyor observed that staff did not clean any tabletops after the activities and prior to serving meals. The surveyor observed staff also did not perform hand hygiene for the residents prior to the lunch meal. The surveyor observed two residents eating sandwiches with their bare hands.</p> <p>During an interview on 6/27/24 at 3:30 P.M., CNA #4 said for the [NAME] unit there was no protocol in place to clean or sanitize tables before serving meals, nor for performing hand hygiene on resident's hands before meals. CNA #4 said staff cleaned tables and residents' hands prior to meals if they were noticeably dirty.</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>46562</p> <p>Based on record review and interviews, the facility failed to implement and maintain an effective training program for all new and existing staff. Specifically, for eight direct care staff (Nurse #1, Nurse #9, Nurse #8, Certified Nursing Assistant (CNA) #1, CNA #7, CNA #4, CNA #11, and CNA #10), out of eight direct care staff education records reviewed, the facility failed to provide all of the required training necessary to meet the needs of each resident.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Training Requirements, dated as revised 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> -Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. -Training content includes, at a minimum: <ul style="list-style-type: none"> a. Effective communication for direct care staff b. Resident rights and facility responsibilities for caring for residents c. Elements and goals of the facility's Quality Assurance and Performance Improvement (QAPI) program d. Written standards, policies, and procedures for the facility's infection prevention and control program e. Written standards, policies, and procedures for the facility's compliance and ethics program f. Behavioral health g. Dementia management and care of the cognitively impaired h. Abuse, neglect, and exploitation prevention i. Safety and emergency procedures -The Staff Development Coordinator (SDC) maintains a training schedule and documentation system for completed training by all staff, contracted staff, and volunteers. <p>Review of the staff education records indicated the following direct care staff had no documented evidence to indicate the completion of the facility's training requirements:</p> <ul style="list-style-type: none"> -Nurse #1 and Nurse #9, had no education/training records <p>(continued on next page)</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Nurse #8 and CNA #1, failed to complete compliance and ethics and behavioral health training,</p> <p>-CNA #7 failed to complete resident rights, QAPI, compliance and ethics, behavioral health, and infection prevention and control training</p> <p>-CNA #4 and CNA #11 failed to complete effective communication, resident rights, compliance and ethics, and behavioral health training</p> <p>-CNA # 10 failed to complete effective communication, resident rights, QAPI, compliance and ethics, infection control and prevention and behavioral health training.</p> <p>During an interview on 7/1/24 at 10:00 A.M., the SDC said all education files and records had been provided to the survey team. The SDC said all education was completed on paper and the facility did not utilize any electronic training programs.</p> <p>During an interview on 7/1/24 at 10:57 A.M., the SDC said she had only been in the role for three months and has been trying to catch up on the mandatory trainings. The surveyor and the SDC reviewed the employee records and the SDC said there was no evidence of the mandatory trainings. The SDC said she would check in her office and review the records again and provide the findings to the survey team, if able.</p> <p>During an interview on 7/1/24 at 12:12 P.M., the Chief Nursing Officer (CNO) said the mandatory and required trainings should be completed upon hire and then annually per the facility policy.</p> <p>As of the end of survey, on 7/1/24, the survey team did not receive any additional education/training.</p>

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members.</p> <p>46562</p> <p>Based on interviews and staff education records reviewed for five direct care staff employees (Nurse #1, Nurse #9, Certified Nursing Assistants (CNA) #4, CNA #11, and CNA #10) of eight employees reviewed, the facility failed to ensure that training on effective communications was included as mandatory training for direct care staff.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Training Requirements, dated as revised 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> -Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. -Training content includes, at a minimum: <ul style="list-style-type: none"> a. Effective communication for direct care staff -The Staff Development Coordinator (SDC) maintains a training schedule and documentation system for completed training by all staff, contracted staff, and volunteers. <p>The facility was unable to provide the surveyor with an education folder/packet for Nurses #1 and #9.</p> <p>Review of the staff education records for CNAs #4, #11, and #10 failed to include mandatory training on effective communications.</p> <p>During an interview on 7/1/24 at 10:00 A.M., the SDC said all education files and records had been provided to the survey team. The SDC said all education was completed on paper and the facility did not utilize any electronic training programs.</p> <p>During an interview on 7/1/24 at 10:57 A.M., the SDC said she had only been in the role for three months and has been trying to catch up on the mandatory trainings. The surveyor and the SDC reviewed the employee records and the SDC said there was no evidence of effective communication training. The SDC said she would check in her office and review the records again and provide the findings to the survey team, if able.</p> <p>During an interview on 7/1/24 at 12:12 P.M., the Chief Nursing Officer (CNO) said the mandatory training for effective communication should be completed upon hire and then annually.</p> <p>As of the end of survey, on 7/1/24, the survey team did not receive any additional education/training.</p>		

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<p>F 0942</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents.</p> <p>46562</p> <p>Based on interviews and staff education records reviewed for five direct care staff employees (Nurse #1, Nurse #9, Certified Nursing Assistant (CNA) #4, CNA #11, and CNA #10) of eight employees reviewed, the facility failed to ensure that training on resident rights was included as mandatory training for direct care staff.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Training Requirements, dated as revised 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> -Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. -Training content includes, at a minimum: <ul style="list-style-type: none"> b. Resident rights and facility responsibilities for caring for residents -The Staff Development Coordinator (SDC) maintains a training schedule and documentation system for completed training by all staff, contracted staff, and volunteers. <p>The facility was unable to provide the surveyor with an education folder/packet for Nurses #1 and #9.</p> <p>Review of the staff education records for CNAs #4, #11, and #10 failed to include mandatory training on resident rights.</p> <p>During an interview on 7/1/24 at 10:00 A.M., the SDC said all education files and records had been provided to the survey team. The SDC said all education was completed on paper and the facility did not utilize any electronic training programs.</p> <p>During an interview on 7/1/24 at 10:57 A.M., the SDC said she had only been in the role for three months and has been trying to catch up on the mandatory trainings. The surveyor and the SDC reviewed the employee records and the SDC said there was no evidence of the training on resident rights. The SDC said she would check in her office and review the records again and provide the findings to the survey team, if able.</p> <p>During an interview on 7/1/24 at 12:12 P.M., the Chief Nursing Officer (CNO) said the mandatory training for resident rights should be completed upon hire and then annually.</p> <p>As of the end of survey, on 7/1/24, the survey team did not receive any additional education/training.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Country Gardens Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2045 Grand Army Highway Swansea, MA 02777	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>46562</p> <p>Based on interviews and staff education records reviewed for two direct care staff employees (Nurse #1 and Nurse #9) of eight employees reviewed, the facility failed to ensure that training on abuse, neglect, and exploitation prevention was included as mandatory training for direct care staff.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Training Requirements, dated as revised 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> -Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. -Training content includes, at a minimum: <ul style="list-style-type: none"> h. Abuse, neglect, and exploitation prevention -The Staff Development Coordinator (SDC) maintains a training schedule and documentation system for completed training by all staff, contracted staff, and volunteers. <p>The facility was unable to provide the surveyor with an education folder/packet for Nurses #1 and #9.</p> <p>During an interview on 7/1/24 at 10:00 A.M., the SDC said all education files and records had been provided to the survey team. The SDC said all education was completed on paper and the facility did not utilize any electronic training programs.</p> <p>During an interview on 7/1/24 at 10:57 A.M., the SDC said she had only been in the role for three months and has been trying to catch up on the mandatory trainings. The surveyor and the SDC reviewed the employee records and the SDC said there was no evidence of the training on abuse, neglect, and exploitation prevention. The SDC said she would check in her office and review the records again and provide the findings to the survey team, if able.</p> <p>During an interview on 7/1/24 at 12:12 P.M., the Chief Nursing Officer (CNO) said the mandatory training for abuse, neglect, and exploitation prevention should be completed upon hire and then annually.</p> <p>As of the end of survey, on 7/1/24, the survey team did not receive any additional education/training.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>46562</p> <p>Based on interviews and staff education records reviewed for five direct care staff employees (Nurse #1, Nurse #9, Certified Nursing Assistant (CNA) #4, CNA #11, and CNA #10) of eight employees reviewed, the facility failed to ensure that training on elements and goals of the facility's Quality Assurance and Performance Improvement (QAPI) program was included as mandatory training for direct care staff.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Training Requirements, dated as revised 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> -Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. -Training content includes, at a minimum: <ul style="list-style-type: none"> c. Elements and goals of the facility's QAPI program -The Staff Development Coordinator (SDC) maintains a training schedule and documentation system for completed training by all staff, contracted staff, and volunteers. <p>The facility was unable to provide the surveyor with an education folder/packet for Nurses #1 and #9.</p> <p>Review of the staff education records for CNAs #4, #11, and #10 failed to include mandatory training on elements and goals of the facility's QAPI program.</p> <p>During an interview on 7/1/24 at 10:00 A.M., the SDC said all education files and records had been provided to the survey team. The SDC said all education was completed on paper and the facility did not utilize any electronic training programs.</p> <p>During an interview on 7/1/24 at 10:57 A.M., the SDC said she had only been in the role for three months and has been trying to catch up on the mandatory trainings. The surveyor and the SDC reviewed the employee records and the SDC said there was no evidence of the training on elements and goals of the facility's QAPI program. The SDC said she would check in her office and review the records again and provide the findings to the survey team, if able.</p> <p>During an interview on 7/1/24 at 12:12 P.M., the Chief Nursing Officer (CNO) said the mandatory training for elements and goals of the facility's QAPI program should be completed upon hire and then annually.</p> <p>As of the end of survey, on 7/1/24, the survey team did not receive any additional education/training.</p>

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NAME OF PROVIDER OR SUPPLIER Country Gardens Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2045 Grand Army Highway Swansea, MA 02777	

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<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.</p> <p>46562</p> <p>Based on interviews and staff education records reviewed for four direct care staff employees (Nurse #1, Nurse #9, Certified Nursing Assistant (CNA) #7, and CNA #10) of eight employees reviewed, the facility failed to ensure that training on written standards, policies and procedures for the facility's infection prevention and control program was included as mandatory training for direct care staff.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Training Requirements, dated as revised 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> -Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. -Training content includes, at a minimum: <ul style="list-style-type: none"> d. Written standards, policies and procedures for the facility's infection prevention and control program -The Staff Development Coordinator (SDC) maintains a training schedule and documentation system for completed training by all staff, contracted staff, and volunteers <p>The facility was unable to provide the surveyor with an education folder/packet for Nurses #1 and #9.</p> <p>Review of the staff education records for CNAs #7 and #10 failed to include mandatory training on written standards, policies and procedures for the facility's infection prevention and control program.</p> <p>During an interview on 7/1/24 at 10:00 A.M., the SDC said all education files and records had been provided to the survey team. The SDC said all education was completed on paper and the facility did not utilize any electronic training programs.</p> <p>During an interview on 7/1/24 at 10:57 A.M., the SDC said she had only been in the role for three months and has been trying to catch up on the mandatory trainings. The surveyor and the SDC reviewed the employee records and the SDC said there was no evidence of the training on written standards, policies and procedures for the facility's infection prevention and control program. The SDC said she would check in her office and review the records again and provide the findings to the survey team, if able.</p> <p>During an interview on 7/1/24 at 12:12 P.M., the Chief Nursing Officer (CNO) said the mandatory training on written standards, policies and procedures for the facility's infection prevention and control program should be completed upon hire and then annually.</p> <p>(continued on next page)</p>

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<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>As of the end of survey, on 7/1/24, the survey team did not receive any additional education/training.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
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<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide training in compliance and ethics.</p> <p>46562</p> <p>Based on interviews and staff education records reviewed for eight direct care staff employees (Nurse #8, Nurse #1, Nurse #9, Certified Nursing Assistant (CNA) #1, CNA #7, CNA #4, CNA # 11, and CNA #10) of eight employees reviewed, the facility failed to ensure that training on written standards, policies, and procedures for the facility's compliance and ethics program was included as mandatory training for direct care staff.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Training Requirements, dated as revised 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> -Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. -Training content includes, at a minimum: <ul style="list-style-type: none"> e. Written standards, policies, and procedures for the facility's compliance and ethics program -The Staff Development Coordinator (SDC) maintains a training schedule and documentation system for completed training by all staff, contracted staff, and volunteers <p>During survey the facility was unable to provide an education folder/packet for Nurses #1 and #9.</p> <p>Review of the staff education records for Nurse #8, CNA #1, CNA #7, CNA #4, CNA # 11, and CNA #10 failed to include mandatory training on written standards, policies, and procedures for the facility's compliance and ethics program.</p> <p>During an interview on 7/1/24 at 10:00 A.M., the SDC said all education files and records had been provided to the survey team. The SDC said all education was completed on paper and the facility did not utilize any electronic training programs.</p> <p>During an interview on 7/1/24 at 10:57 A.M., the SDC said she had only been in the role for three months and has been trying to catch up on the mandatory trainings. The surveyor and the SDC reviewed the employee records and the SDC said there was no evidence of the training on written standards, policies, and procedures for the facility's compliance and ethics program. The SDC said she would check in her office and review the records again and provide the findings to the survey team, if able.</p> <p>During an interview on 7/1/24 at 12:12 P.M., the Chief Nursing Officer (CNO) said the mandatory training on written standards, policies, and procedures for the facility's compliance and ethics program should be completed upon hire and then annually.</p> <p>As of the end of survey, on 7/1/24, the survey team did not receive any additional education/training.</p>		

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>46562</p> <p>Based on interviews and staff education records reviewed for eight direct care staff employees (Nurse #8, Nurse #1, Nurse #9, Certified Nursing Assistant (CNA) #1, CNA #7, CNA #4, CNA # 11, and CNA #10) of eight employees reviewed, the facility failed to ensure that training on behavioral health was included as mandatory training for direct care staff.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Training Requirements, dated as revised 3/4/24, indicated but was not limited to:</p> <ul style="list-style-type: none"> -Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. -Training content includes, at a minimum: <ul style="list-style-type: none"> f. Behavioral health -The Staff Development Coordinator (SDC) maintains a training schedule and documentation system for completed training by all staff, contracted staff, and volunteers. <p>The facility was unable to provide the surveyor with an education folder/packet for Nurses #1 and #9.</p> <p>Review of the staff education records for Nurse #8, CNA #1, CNA #7, CNA #4, CNA # 11, and CNA #10 failed to include mandatory training on behavioral health.</p> <p>During an interview on 7/1/24 at 10:00 A.M., the SDC said all education files and records had been provided to the survey team. The SDC said all education was completed on paper and the facility did not utilize any electronic training programs.</p> <p>During an interview on 7/1/24 at 10:57 A.M., the SDC said she had only been in the role for three months and has been trying to catch up on the mandatory trainings. The surveyor and the SDC reviewed the employee records and the SDC said there was no evidence of the training on behavioral health. The SDC said she would check in her office and review the records again and provide the findings to the survey team, if able.</p> <p>During an interview on 7/1/24 at 12:12 P.M., the Chief Nursing Officer (CNO) said the mandatory training on written standards, policies, and procedures for behavioral health should be completed upon hire and then annually.</p> <p>As of the end of survey, on 7/1/24, the survey team did not receive any additional education/training.</p>		