

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/22/2024
NAME OF PROVIDER OR SUPPLIER  Florissant Valley Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Graham Road Florissant, MO 63031	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795</b></p> <p>Based on observation, interview and record review, the facility failed to treat three residents (Resident #174, Resident #23, and Resident #55) with dignity by leaving a resident exposed to the hallway, speaking to residents in an unprofessional manner when they referred to residents as feeders in front of residents, and staff stood over residents while assisting residents with their meal. The sample was 19. The census was 83.</p> <p>Review of the facility's Residents' [NAME] of Rights, showed your rights and protections as a nursing home resident:</p> <p>-As a nursing home resident, you have certain rights and protections under federal and state law that help ensure you get the care and services you need;</p> <p>-You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose.</p> <p>1. Review of Resident #174's medical records, showed;</p> <p>-An admitted [DATE];</p> <p>-Diagnosis that included: stroke, dysphagia (difficulty swallowing), weakness, and heart disease.</p> <p>Review of the resident's baseline care plan, in use at the time of survey, showed it did not address the resident's activity of daily living (ADL) needs.</p> <p>Observation on 11/18/24 at 5:41 A.M., showed the door to the resident's room opened and the resident visible from the hallway. The resident lay in bed with no covers, a hospital gown and his/her incontinent brief exposed. Multiple staff members walked past the resident's room and no staff entered the room to provide privacy to the resident. At 7:25 A.M., Certified Medicine Technician (CMT) G entered the resident's room, walked past the resident's bed, administered medication to the resident's roommate, and then left the resident's room. The resident remained with his/her covers off, his/her brief exposed, and the door remained opened. At 7:34 A.M., the resident's door to his/her room remained opened and the resident lay in bed with his/her covers off with his/her brief exposed. Licensed Practical Nurse (LPN) R entered the resident's room and covered the resident with a sheet and blanket.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident #23's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 9/26/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident is rarely or never understood;</li> <li>-Upper and lower extremity impairment;</li> <li>-Diagnoses included heart disease, kidney disease, diabetes, stroke, and dementia;</li> <li>-The resident dependent on staff for eating assistance.</li> </ul> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: The resident has an ADL self-care performance deficit related to dementia;</li> <li>-Interventions: The resident is dependent with meals consumed and assisted in the dining room.</li> </ul> <p>During an observation and interview on 11/22/24 at 8:45 A.M., the resident sat in a Broda chair (a specialized reclining chair on wheels) in the main dining room. Certified Nursing Assistant (CNA) Q stood over to the resident with his/her hand on his/her hip and assisted the resident to eat a pureed diet. CNA Q said the resident required a lot of assistance with meals and the resident was a feeder. There were two other residents that sat near the resident and within hearing range of CNA Q.</p> <p>3. Review of Resident #55's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-Moderate cognitive impairment;</li> <li>-The resident has upper and lower body extremity impairments.</li> <li>-The resident is dependent on staff for eating.</li> </ul> <p>Review of the resident's face sheet, undated, showed diagnoses that included dystonia (a neurological movement disorder), weakness, depression, and anxiety.</p> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: The resident has an ADL performance deficit related to being legally blind and generalized weakness;</li> <li>-Interventions: Provide finger foods when having difficulty with utensils.</li> </ul> <p>During an observation and interview on 11/22/24 at 8:47 A.M., showed the resident sat in his/her wheelchair in the main dining room. The resident moaned and had his/her eyes closed. CNA Q stood over the resident and fed the resident his/her pureed breakfast. CNA Q said the resident requires a lot of assistance with meals and the resident was a feeder. Two other residents sat near the resident and within hearing range of CNA Q.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. During an interview on 11/22/24 at 8:55 A.M., CNA O said staff should sit down while assisting residents with their meals, it is a dignity issue. Staff are not to call residents feeders if they require assistance with their meals and it is disrespectful to call a resident that. If a resident is exposed and is visible from the hall. Staff should go in and see if the resident requires assistance and then cover the resident.</p> <p>5. During an interview on 11/22/24 at 9:45 A.M., LPN I said staff are not to call residents feeders, and they should not be standing over the residents while assisting them to eat. Staff should cover the resident when a resident is exposed to the hallway. These are all dignity issues.</p> <p>6. During an interview on 11/22/24 at 1:34 P.M., the Administrator said she would expect all staff to provide dignity to the residents. Residents are not to be called feeders. Staff are expected not to stand over the resident while assisting them with their meals and the staff is expected to cover the resident immediately when exposed to the hallway.</p> <p>MO00245336</p> <p>MO00245508</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290</b></p> <p>Based on observation, interview and record review, the facility failed to ensure residents were assessed to self-administer medications and to ensure staff adequately supervised residents during medication administration (Residents #26 and #128). The sample was 19. The census was 83.</p> <p>Review of the facility's Medication Administration - General Guidelines, dated December 2017, showed:</p> <ul style="list-style-type: none"> <li>-Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so;</li> <li>-Administration: <ul style="list-style-type: none"> <li>-Medications are administered in accordance with written orders of the prescriber;</li> <li>-When medications are administered by mobile cart taken to the resident's location (room, dining area, etc.) medications are administered at the time they are prepared;</li> <li>-Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications;</li> <li>-The resident is always observed after administration to ensure that the dose was completely ingested.</li> </ul> </li> </ul> <p>1. Review of Resident #26's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/2/24, showed:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Diagnoses included stroke, Alzheimer's disease, and dementia.</li> </ul> <p>Review of the resident's care plan, in use at the time of survey, showed no documentation the resident was assessed as able to self-administer his/her medications or take his/her medications without supervision.</p> <p>Review of the resident's medical record, showed no self-administration of medication assessment.</p> <p>Review of the resident's physician order summary (POS) and medication administration record (MAR) for November 2024, showed:</p> <ul style="list-style-type: none"> <li>-An order, dated 4/4/23, for thiamine hydrochloride (HCl) (used to treat vitamin deficiency) 100 milligram (mg), once daily. The 9:00 A.M. dose for 11/17/24 initialed as administered by Licensed Practical Nurse (LPN) H;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-An order, dated 4/4/23, for folic acid (vitamin) tablet 1 mg, once daily. The 9:00 A.M. dose for 11/17/24 initialed as administered by LPN H;</p> <p>-An order, dated 5/13/23, for aspirin chewable tablet 81 mg, once daily. The 9:00 A.M. dose for 11/17/24 initialed as administered by LPN H;</p> <p>-An order, dated 5/13/23, for multivitamin tablet, one tablet once daily. The 9:00 A.M. dose for 11/17/24 initialed as administered by LPN H;</p> <p>-An order, dated 12/28/23, for amlodipine besylate (used to treat high blood pressure and prevent heart disease) oral tablet 5 mg, once daily. The 9:00 A.M. dose for 11/17/24 initialed as administered by LPN H;</p> <p>-An order, dated 9/5/24, for metformin HCl (used to lower blood sugar) 500 mg, one tablet twice daily. The 9:00 A.M. dose for 11/17/24 initialed as administered by LPN H.</p> <p>Observation on 11/17/24 at 11:37 A.M., showed the resident sat upright in bed with eyes closed. A cup contained five medications on his/her bedside table.</p> <p>2. Review of Resident #128's significant change MDS, dated [DATE], showed:</p> <p>-Moderate cognitive impairment;</p> <p>-Diagnoses included stroke, anxiety, and depression.</p> <p>Review of the resident's care plan, in use at the time of survey, showed no documentation the resident assessed as able to self-administer his/her medications or take his/her medications without supervision.</p> <p>Review of the resident's self-administration of medication assessment, dated 10/15/24, showed the resident not capable of self administration of medication.</p> <p>Review of the resident's POS and MAR for November 2024, showed:</p> <p>-An order, dated 10/24/23, for aspirin chewable tablet 81 mg, once daily. The 9:00 A.M., dose documented as administered by Certified Medication Technician (CMT) BB;</p> <p>-An order, dated 10/24/23 for Celexa (antidepressant) oral tablet 20 mg, once daily. The 9:00 A.M., dose documented as administered by CMT BB;</p> <p>-An order, dated 10/24/23, for Nexium (used to treat acid reflux) oral capsule delayed release 40 mg, one capsule once daily. The 9:00 A.M., dose documented as administered by CMT BB;</p> <p>-An order, dated 10/24/23, for benzotropine mesylate (used to treat tremors) oral tablet 1 mg, twice daily. The 9:00 A.M., dose documented as administered by CMT BB;</p> <p>-An order, dated 10/24/23, for Keppra (used to treat seizures) oral tablet 750 mg, give 1500 mg twice daily. The 9:00 A.M., dose documented as administered by CMT BB;</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-An order, dated 11/2/23, for senna (stool softener) tablet 8.6 mg, one tablet twice daily. The 9:00 A.M., dose documented as administered by CMT BB.</p> <p>-An order, dated 7/27/24, for hydrochlorothiazide (used to treat high blood pressure and fluid retention) oral capsule 12.5 mg, in the morning. The 9:00 A.M., dose documented as administered by CMT BB;</p> <p>-An order, dated 8/24/24, for anastrozole (used to treat breast cancer) coral tablet 1 mg, once daily. The 9:00 A.M., dose documented as administered by CMT BB;</p> <p>-An order, dated 10/15/24, for ferrous sulfate (used to treat iron deficiency) oral tablet 325 mg, one tablet twice daily. 9:00 A.M., dose documented as administered by CMT BB;</p> <p>-An order, dated 10/16/24, for Colace (stool softener) capsule 100 mg, one capsule twice daily. The 9:00 A.M. , dose documented as administered by CMT BB.</p> <p>Observation on 11/20/24 at 8:53 A.M., showed the resident in bed with eyes closed. A cup contained seven medications on his/her bedside table.</p> <p>3. During an interview on 11/22/24 at 7:55 A.M., Certified Nurse Aide (CNA)/CMT F said the facility does not have any residents who can self-administer their own medications in pill form. When passing medications, it is sometimes acceptable for staff to drop off a resident's medications and walk away, but only if the resident is more alert. Otherwise, staff must watch residents take their medication. Resident #26 is confused and cannot take his/her medications on his/her own. Resident #128's cognition is up and down, but he/she cannot take his/her medications on his/her own. Residents #26 and #128 should be watched during medication administration.</p> <p>4. During an interview on 11/22/24 at 10:47 A.M., LPN I said there are no residents in the facility who can self-administer their medications. During medication administration, it is not acceptable for staff to drop off a resident's medication with the resident and walk away. Staff must watch residents take their medications for safety, so they don't choke. Residents #26 and #128 have confusion and must be watched taking their medications.</p> <p>5. During an interview on 11/22/24 at 12:42 P.M., Assistant Director of Nurses (ADON) A said during medication administration, staff cannot drop off a resident's medication with the resident and then walk away. Staff must ensure a resident takes their medication by watching them take it. If a resident is sleeping during medication administration, staff should try to wake the resident. If the resident does not wake up, staff should discard the medication and come back later. Residents #26 and #128 should be supervised during medication administration.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40290 42795</p> <p>Based on observation, interview and record review, the facility failed to provide reasonable accommodation of individual needs and preferences by failing to ensure call lights were in reach for six residents (Residents #12, #23, #174, #20, #175 and #6). The facility also failed to have one resident's communication device within reach (Resident #126). The sample was 19. The census was 83.</p> <p>1. Review of Resident #12's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/19/24, showed:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Always incontinent of bowel and bladder;</li> <li>-Required substantial assistance from staff for toileting and lower body dressing;</li> <li>-Required moderate assist from staff from lying to sitting at the side of the bed , sitting to standing and chair to bed transfers;</li> <li>-Diagnoses included Parkinson's disease (a chronic, progressive brain disorder that affects the nervous system and causes movement problems), dementia, stroke and seizures.</li> </ul> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: The resident is as risk of falling and risk of injury due to falls;</li> <li>-Interventions: Educate resident on use of call light;</li> <li>-Focus: The resident needs help with his/her activities of daily living (ADLs) due to the resident has Parkinson's disease, arthritis, and psychosis (a mental disorder);</li> <li>-Intervention: Encourage the resident to use the call light.</li> </ul> <p>Observation and interview on 11/18/24 at 4:35 A.M. and 6:02 A.M., showed the resident lay in bed in a low position and the resident's call light was attached to the top of the privacy curtain located near the resident's bed. At 7:34 A.M., the resident attempted to get out of the bed. The resident's call light was clipped to the top of the privacy curtain near the resident's bed. Certified Medication Technician (CMT) G went into the resident's room. The resident said he/she had to go to the bathroom. CMT G instructed the resident to lay back in the bed and CMT G cleaned the resident and changed his/her brief. CMT G left the room. The call light remained clipped on the privacy curtain near the resident's bed and out of the resident's reach.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 11/19/24 at 12:15 P.M., showed the resident stood at his/her closet in his/her room, looking through his/her clothing items. The resident's unlocked wheelchair was positioned behind him/her. The resident's call light was clipped at the top of the privacy curtain, out of the resident's reach near the resident's bed. At 4:25 P.M., the resident sat in his/her wheelchair in his/her room, attempting to stand up. Licensed Practical Nurse (LPN) Y went into the resident's room and instructed the resident to sit down. The resident sat down in his/her wheelchair. LPN Y left the resident's room. The resident's call light was clipped at the top of the privacy curtain near the resident's bed and out of the resident's reach.</p> <p>2. Review of Resident #23's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-Rarely or never understood;</li> <li>-Upper and lower extremity impairment;</li> <li>-Always incontinent of bowel and bladder;</li> <li>-Dependent on staff for toileting hygiene, eating and bathing;</li> <li>-Required substantial assistance from staff from lying to sitting to the side of the bed, sitting to a standing position, and chair to bed transfers;</li> <li>-Diagnoses included heart disease, kidney disease, diabetes, stroke and dementia.</li> </ul> <p>Review of the resident's care plan, in used at the time of survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: The resident has an ADL self-care performance deficit related to dementia;</li> <li>-Interventions: Encourage the resident to use the call light for assistance.</li> </ul> <p>Observation on 11/18/24 at 5:41 A.M., showed the resident lay in bed and the resident's call light was positioned on top of a set of drawers located near to the resident's bed. The call light was not within reach of the resident. At 7:25 A.M., CMT G entered the resident's room, administered the resident's medications and left the room. The resident's call light remained on top of the set of drawers next to the resident's bed out of the resident's reach.</p> <p>3. Review of the resident #174's medical record, showed his/her diagnoses included stroke, dysphagia (difficulty swallowing), weakness and heart disease.</p> <p>Review of the resident's care plan, in use at the time of survey, showed it did not address the resident's ADL needs.</p> <p>Observation and interview on 11/18/24 at 5:41 A.M., showed the resident lay in bed and the resident's call light was positioned under the resident's pillow. The resident said he/she could not reach the call light and would like some water. At 7:25 A.M., CMT G entered the resident's room, administered the resident's roommate's medications and left the room. The resident's call light remained under the resident's pillow and out of reach for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Moderate cognitive impairment;</p> <p>-Always incontinent of bowel and bladder;</p> <p>-Required substantial assist from staff for toileting, personal hygiene, sitting to a standing position, and chair to bed transfers;</p> <p>-Diagnoses included Alzheimer's disease, eye disease, fractures and depression.</p> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <p>-Focus: The resident has a ADL self-care deficit related to decreased activity, weakness and functional decline;</p> <p>-Intervention: Encourage use of call light for staff assistance.</p> <p>Observation and interview on 11/18/24 at 4:47 A.M., showed the resident lay in the bed, in his/her room. When the resident was approached, he/she was tearful and appeared nervous. The resident was unable to identify where the call light was on his/her bed. The call light was attached the mattress, at the head of the bed, near the bed frame, not within reach of the resident.</p> <p>7. Review of Resident #126's medical record, showed diagnoses included aphasia (language impairment), unspecified speech disturbances, anxiety, complete traumatic amputation at knee level to left lower leg and generalized muscle weakness.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <p>-No speech - absence of spoken words;</p> <p>-Ability to express ideas and wants: Sometimes understands, responds adequately to simple, direct communication only;</p> <p>-Moderate cognitive impairment;</p> <p>-Upper and lower extremity impairment on both sides;</p> <p>-Substantial/maximal assistance required for roll left and right;</p> <p>-Dependent on assistance for sit to lying, lying to sitting on side of the bed, and chair/bed-to-chair transfer.</p> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <p>-Focus: Resident has communication, history of previous trachea and vocal cord damage causing him/her to be nonverbal. He/She communicates by head nods, picture cards, pointing to words, and communication board;</p> <p>-Goal: Resident will be able to make basic needs known on a daily basis through the review date;</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Interventions included:</p> <ul style="list-style-type: none"> <li>-Use alternative communication tools as needed;</li> <li>-Resident prefers to communicate in writing and gestures</li> <li>-Resident requires an assistive device to communicate. Ensure availability and functionality of adaptive communication equipment;</li> <li>-The resident is able to communicate by writing, using gestures.</li> </ul> <p>Observation on 11/18/24 at 5:42 A.M., showed the resident in bed. A bedside table with stacks of notebooks, paper, and a writing utensil, approximately four feet from the left side of the resident's bed, was not within reach. During an interview, the resident was nonverbal and nodded and shook his/her head in response to questions. The resident shook his/her head no, he/she cannot move from the bed on his/her own.</p> <p>Observations on 11/18/24 at 6:12 A.M., 7:05 A.M., and 10:05 A.M., showed the resident in bed. His/Her bedside table containing notebooks, paper, and writing utensil was positioned approximately four feet from the left side of the bed, not within reach.</p> <p>Observations on 11/19/24 at 10:52 A.M., 11:48 A.M., and 12:34 P.M., showed the resident in bed. His/Her bedside table containing notebooks, paper, and writing utensil was positioned approximately four feet from the left side of the bed, not within reach. During an interview at 12:34 P.M., the resident nodded to the paper and notebooks on the bedside table. He/She nodded yes, he/she can write and uses the communication devices on the table to communicate to staff.</p> <p>Observations on 11/19/24 at 1:35 P.M., 2:32 P.M., 3:30 P.M., 4:55 P.M., and 5:47 P.M., showed the resident in bed. His/Her bedside table containing notebooks, paper, and writing utensil was positioned approximately four feet from the left side of the bed, not within reach.</p> <p>Observations on 11/20/24 at 7:32 A.M., 9:58 A.M., 10:32 A.M., 11:44 A.M., and 1:10 P.M., showed the resident in bed. His/Her bedside table containing notebooks, paper, and writing utensil was positioned approximately four feet from the left side of the bed, not within reach.</p> <p>Observations on 11/21/24 at 7:52 A.M. and 9:22 A.M., showed the resident in bed. His/Her bedside table containing notebooks, paper, and writing utensil was positioned approximately four feet from the left side of the bed, not within reach. During an interview at 9:22 A.M., the resident shook his/her head no, he/she cannot reach his/her bedside table. He/She nodded his/her head yes, that he/she has trouble communicating with staff. He/She nodded his/her head yes, he/she can write and point to things, and it would be easier to communicate if he/she had the ability to write or point at a communication board.</p> <p>During an interview on 11/22/24 at 9:38 A.M., CNA J said the resident cannot transfer him/herself. He/She is nonverbal but is cognitively intact. At 11:15 A.M., CNA J said the resident communicates to staff by gesturing, nodding and shaking his/her head, and writing in his/her notebooks.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/22/24 at 12:09 P.M., CNA E said the resident requires assistance from staff to transfer him/herself out of bed. He/She cannot talk but can write. He/She points to things and can write in his/her notebooks to tell staff what he/she needs. Staff should ensure the resident's notebooks and communication devices are within reach. Staff should position the resident's bedside table next to his/her bed, within reach, before they leave the room.</p> <p>During an interview on 11/22/24 at 11:12 A.M., LPN H said the resident is alert and has difficulty expressing him/herself. He/She points at things to communicate and writes. Staff should ensure the resident's notebooks are within his/her reach.</p> <p>During an interview on 11/22/24 at 12:42 P.M., Assistant Director of Nurses (ADON) A said the resident is alert and oriented times three of four (person, place, time and situation). He/She cannot speak and communicates with gestures and by using a writing board. The resident's writing board should be within his/her reach at all times. If staff move the resident's communication items while providing care, they should ensure the items are put back within the resident's reach when they are finished.</p> <p>8. During an interview on 11/22/24 at 10:47 A.M., LPN H and CNA/CMT G said staff should ensure call lights and other needed items are within a resident's reach before staff leave the room. It is not appropriate to clip a call light on a privacy curtain, outside of the resident's reach.</p> <p>9. During an interview on 11/22/24 at 1:32 P.M., the Administrator said she expected staff to ensure call lights and other needed items are placed within a resident's reach before leaving the room. All staff are responsible for this.</p> <p>MO00245336</p> <p>Surveyor: [NAME], [NAME]</p> <p>46888</p> <p>.</p>		

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>40290</p> <p>Based on interview and record review, the facility failed to follow general accounting principles by failing to employ proper bookkeeping techniques to track the amount of cash on hand used for resident withdrawals from the resident trust account. This affected 44 residents whose funds were handled by the facility. The census was 83.</p> <p>Review of the facility's petty cash daily log sheets, showed no ongoing tracking of the total amount of cash on hand at any given time and no monthly reconciliation.</p> <p>During an interview on 11/21/24 at 1:58 P.M., the Business Office Manager (BOM) said the facility keeps cash on hand for resident requests for cash. There is no set amount of cash kept on hand and the amount of cash available varies at any given time. The facility maintains a spreadsheet to show the date of cash requests and the amount withdrawn, but there is no running total to show how much money is in the cash box at any given time. She can calculate the amount that should be in the cash box by reviewing the resident trust fund account and subtracting pending transactions. They do not reconcile the petty cash at the end of the month, as this is tracked in the facility's accounting system. During the interview, the BOM reviewed the resident trust account system and said the facility should have a total of \$338.00 on hand. She counted the money in the cash box, which totaled \$388.00, a difference of \$50.00. the BOM said she understands why it would be helpful to align to the petty cash report to show the total amount of cash on hand at any given time.</p> <p>During an interview on 11/22/24 at 1:32 P.M., the Administrator said she expects cash on hand to be reconciled routinely and appropriately tracked to ensure money is not misplaced.</p>

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40290</p> <p>Based on interview and record review, the facility failed to ensure third party liability (TPL) forms were completed within 30 days for the final accounting for residents who expired. This affected three residents who expired and had money in their accounts (Residents #133, #131, and #132). The census was 83.</p> <p>Review of the facility's Business Office - Resident Trust Fund Policy and Procedure, undated, showed:</p> <p>-Upon the discharge or passing of the resident, funds shall be disbursed as follows:</p> <p>--Medicaid residents: All personal funds must be reported to the State based on regulatory requirements involving estate recovery. These funds can only be released by the State or made payable directly to a mortuary to cover any unpaid funeral expense. A copy of an invoice reflecting the unpaid balance must be provided.</p> <p>1. Review of Resident #133's resident fund account, showed the following:</p> <p>-Expired [DATE];</p> <p>-Balance of \$943.88;</p> <p>-TPL completed [DATE].</p> <p>2. Review of Resident #131's resident fund account, showed the following:</p> <p>-Expired [DATE];</p> <p>-Balance of \$361.88;</p> <p>-TPL completed [DATE].</p> <p>3. Review of Resident #132's resident fund account, showed the following:</p> <p>-Expired [DATE];</p> <p>-Balance of \$5,204.72;</p> <p>-TPL completed [DATE].</p> <p>(continued on next page)</p>

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. During an interview on [DATE] at 12:51 P.M., the Business Office Manager (BOM) said when a Medicaid resident expires with funds left in their account, she is responsible for submitting the TPL to Medicaid within 30 days of the resident's death. She began working with the facility in [DATE] and she had to learn the facility's procedures for fund reconciliation. She is working on catching up on the TPLs.</p> <p>5. During an interview on [DATE] at 1:32 P.M., the Administrator said she expects TPLs to be submitted for expired residents within the timeframes outlined in the State regulations and for their accounts to be closed out timely. She expects the BOM to follow up with this timely.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>42795</p> <p>Based on observation, interview and record review, the facility failed to provide a safe, comfortable, homelike environment by failing to address water stains on the ceiling near the window, peeling wallpaper and flaking paint on the ceiling due to water damage in one resident room which two residents shared (Resident #23 and #174). The sample was 19. The census is 83.</p> <p>Review of Resident #23's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/26/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident is rarely or never understood;</li> <li>-Diagnoses included heart disease, kidney disease, diabetes, stroke and dementia.</li> </ul> <p>Review of Resident #174's medical records, showed;</p> <ul style="list-style-type: none"> <li>-Diagnoses included stroke, dysphagia (difficulty swallowing), weakness and heart disease.</li> </ul> <p>Observation on 11/17/24 at 9:00 A.M., of Resident #23's and #174's room, showed the room had yellow ring stains on the ceiling above the window. The wall next to the bathroom had bubbled, peeled, and flaked paint. The ceiling near the doorway had flaked and bubbled paint. Family Member Z said when he/she came in on 11/5/24, it was raining hard outside and the staff had placed a bedspread on the windowsill to catch the water. Staff had turned the heat up on high to dry the water in the wall. When he/she would touch the drywall next to the sink, it was spongy and felt wet. No one came in to fix the walls or ceilings.</p> <p>Observations of Resident #23's and #174's room on 11/18/24 at 6:47 A.M. and 11/19/24 at 11:17 A.M., showed yellow ring stains on the ceiling above the window. The wall next to the bathroom had bubbled, peeled, and flaked paint. The ceiling near the doorway had flaked and bubbled paint.</p> <p>During an interview on 11/22/23 at 9:00 A.M., Certified Nursing Assistant (CNA) Q said the room that Resident #23 and Resident #174 shared, always leaks water. Staff always have to put bath blankets on the floor and windowsill to catch the leaking water. The flaking paint on the walls and ceiling are from water coming in the room when it rains. It has been like that for at least a couple of months. Staff verbally tell the maintenance staff when there is something broken or needs repair.</p> <p>During an interview on 11/22/24 at approximately 10:00 A.M., Licensed Practical Nurse (LPN) I said when a room or equipment need maintenance attention, staff can place a request in the computer. Not all staff have access to place the request. He/She was not aware any of water leaking issues in the residents' room.</p> <p>During an interview on 11/21/24 at 8:40 A.M., the Maintenance Director said he was aware of the ceiling stains and water leaking. He was waiting for the walls and ceiling to dry out and then he was going to repair it. He thought the leaking was coming from the roof because the roof is flat and does not drain very well. He did not think the wall and ceiling in the current condition was home-like.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/22/24 at 1:34 P.M., the Administrator said she expected repairs to be made in a timely manner. Staff is expected to ensure the residents have a home-like environment.</p> <p>MO00245336</p> <p>MO00245508</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>40290</p> <p>Based on interview and record review, the facility failed to notify a representative of the State Long-Term Care (LTC) Ombudsman of resident transfers and discharges. The census was 83.</p> <p>Review of the facility's Discharge/Transfer - Involuntary policy, revised 10/7/21, showed:</p> <ul style="list-style-type: none"> <li>-Policy: Transfer and discharge includes movement of a resident to a bed outside of the facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility;</li> <li>-The policy did not provide any guidance related to notification to the Ombudsman regarding resident transfers and discharges.</li> </ul> <p>Review of the facility's Discharge Plan/Summary - Voluntary policy, revised 10/7/21, showed no guidance related to notification to the Ombudsman regarding resident transfers and discharges.</p> <p>During an interview on 11/13/24 at 12:29 P.M., the Ombudsman said he/she has not received monthly notification of transfers and discharges from the facility in about five to six months.</p> <p>During an interview on 11/21/24 at 9:20 A.M., the Social Services Director (SSD) said she began working for the facility in May 20224. She is responsible for notifying the Ombudsman of residents' transfers/discharges. She does not think she has sent the Ombudsman notification of transfer/discharge since she started but will double check. She usually sends the Ombudsman notification in the early part of the month for the month prior. During an interview at 9:55 A.M., the SSD said she checked and has not sent any notifications to the Ombudsman of transfers and discharges from the facility.</p> <p>During an interview on 11/22/24 at 1:32 P.M., the Administrator said she expected the Ombudsman to be notified of resident transfers and discharges monthly. The SSD is responsible for sending the notification to the Ombudsman.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>42795</p> <p>Based on observation, interview and record review, the facility failed to ensure services provided met professional standards by not providing transportation to two residents' medical appointments (Resident #66 and Resident #12). The sample was 19. The census was 83.</p> <p>1. Review of Resident #66's medical record, showed diagnoses that include diabetes, morbid obesity, shortness of breath, obstructive sleep apnea (a condition that cause breathing to slow down or stop during sleep), heart failure and difficulty walking.</p> <p>Review of the resident's progress notes, showed:</p> <p>-On 8/28/24 at 3:10 P.M., Follow up with the pulmonary doctor and neurosurgery doctor forwarded to social worker;</p> <p>-On 10/9/24 at 2:56 P.M., The resident's pulmonary doctor's appointment rescheduled for 10/23/24 at 12:30 P.M. The resident was notified of new appointment. Will arrange transport.</p> <p>During an interview on 11/19/24 at 1:50 P.M., Medical Assistant U at the resident's neurosurgeon office said the resident's appointment was scheduled 9/30/24 and the resident was listed as no show and a new appointment has not been rescheduled.</p> <p>During an interview on 11/19/24 at 2:02 P.M., Medical Assistant V at the resident's pulmonary doctor's office said the resident's appointment was for 10/23/24 and the resident was a no show and a new appointment has not been rescheduled.</p> <p>During an interview on 11/17/24 at 9:14 A.M., the resident said he/she has been missing his/her doctor's appointments. The facility told him/her that a special transportation unit is required due to his/her body size. He/She cannot go in the regular facility van. He/She requires to see the pulmonary doctor due to having breathing problems. The neurosurgery appointment was because he/she is having difficulty walking.</p> <p>During an interview on 11/20/24 at 9:28 A.M., the Social Service Director said she was not aware that the resident did not make it to his/her appointments. The resident does require a special van with a special lift due to his/her size. The transportation company needs at least three days prior notice for the appointments.</p> <p>2. Review of Resident #12's medical record, showed diagnoses include Parkinson's disease (a neurological disorder that causes tremors), difficulty walking, falls and Alzheimer's disease.</p> <p>Review of the resident's progress notes showed on 10/16/24 at 2:37 P.M., received a call from neurology department, the resident's appointment on 11/5/24 was changed from 1:30 P.M. to 1:00 P.M.</p> <p>During an interview on 11/20/24 at 1:45 P.M., Medical Assistant W at the resident's neurology clinic said the resident had an appointment for 6/17/24, 7/2/24, and 11/5/24. All three appointments we noted as the resident being a no show. There were no current appointments for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/20/24 at 2:20 P.M., the Director of Social Services said she was not aware the resident had three appointments missed. She was not informed by nursing staff.</p> <p>During an interview on 11/21/24 at 8:45 A.M., Licensed Practical Nurse (LPN) R said nursing is to fill the transportation request and place it in the log book, and verbally inform the Social Worker. He/She was not aware the resident missed his/her neurology appointment.</p> <p>3. During a group interview on 11/19/24 at 2:24 P.M., five residents, whom the facility identified as alert and oriented, attended the group meeting. Five residents said it takes a long time for facility staff to schedule their appointments. Two residents said they had missed appointments due to the facility not providing transportation.</p> <p>4. During an interview on 11/22/24 at 8:20 A.M. Transportation Driver X said the nurses are responsible to fill out the transportation paperwork. A copy of the request stays with him/her and a copy stays in the book at the nurse's station. The nurses communicate the transportation information verbally. He/She works 6 days a week and needs 24 hour notice for appointments.</p> <p>5. During an observation and interview on 11/20/24 at 9:28 A.M., the Social Service Director said the nursing staff is to inform her verbally and fill out a transportation request when appointments need to be made or there is one already established. The Social Worker obtained the transportation logbook, and it was empty. She does not know what happened to all the requests that were in the book.</p> <p>6. During an interview on 11/22/24 at 1:34 P.M., the Administrator said she expected transportation to be arranged in a timely manner for all residents that have outside appointments.</p> <p>MO00244195</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40290</p> <p>42795</p> <p>46888</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were changed in a timely manner (Residents #23, #25 and #44), failed to ensure residents received a minimum of two showers per week and activities of daily living (ADL) care as needed (Residents #2, #36, #45, #54, #66, #276 and #126), and failed to ensure residents were repositioned in bed as needed (Residents #126 and #41 ). The sample was 19. The census was 83.</p> <p>Review of the facility's ADL bathing policy, dated 7/21/22, showed:</p> <ul style="list-style-type: none"> <li>-Policy: nursing staff will assist in bathing residents to promote cleanliness and dignity. The charge nurse will be made aware of residents who refuse bathing;</li> <li>-Procedure: assist resident into the shower. Encourage them to hold onto to safety bars. Encourage resident to bathe him/herself and assist as needed. When resident has finished bathing instruct them to stand and ensure skin is free of soap. Assist with dressing and grooming as needed.</li> </ul> <p>Review of the facility's ADL shaving policy, dated 7/21/22, showed</p> <ul style="list-style-type: none"> <li>-Policy: the facility will provide aid with shaving as directed in the care plan. ADL care will include shaving to promote cleanliness and preserve dignity.</li> </ul> <p>Review of the facility's Skin Integrity policy, reviewed 7/5/24, showed:</p> <ul style="list-style-type: none"> <li>-Purpose: To establish best practice guidelines for skin integrity monitoring and maintenance to reduce potential risk of skin breakdown where clinically appropriate;</li> <li>-Incontinence care shall be provided in a timely after each episode of incontinence.</li> </ul> <p>1. Review of Resident #23's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/26/24, showed:</p> <ul style="list-style-type: none"> <li>-Rarely or never understood;</li> <li>-Upper and lower extremity impairment;</li> <li>-Always incontinent of bowel and bladder;</li> <li>-Required maximum assistance from staff for toilet hygiene;</li> <li>-Diagnoses included heart disease, kidney disease, diabetes, stroke and dementia.</li> </ul> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Florissant Valley Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1200 Graham Road Florissant, MO 63031	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's care plan, in used at the time of survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: The resident is at risk for urinary decline related to dementia;</li> <li>-Interventions: Provide peri-care after each incontinent episode; Assist to bathroom as needed; Use absorbent products as needed.</li> </ul> <p>During observation and interview on 11/17/24 at 9:00 A.M., the resident's Family Member A was providing peri-care to the resident. The family member removed the resident's brief and the resident's brief and bed pad were saturated with urine. Family Member A said he/she must clean the resident every day when he/she first arrives to the facility in the morning because the resident is left wet all night and the resident cannot communicate his/her needs.</p> <p>2. Review of Resident #25's annual MDS, dated , 8/24/24, showed:</p> <ul style="list-style-type: none"> <li>-Moderate cognitive impairment;</li> <li>-Frequently incontinent of bowel and bladder;</li> <li>-Upper and lower extremity impairment;</li> <li>-Required maximum assist from staff with toilet hygiene;</li> <li>-Diagnoses included stroke, dementia, lung disease, eye disease and depression.</li> </ul> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: The resident has an ADL self-care performance deficit related to fatigue, blindness, and occasional confusion:</li> <li>-Interventions: The resident requires maximum assist with toilet hygiene and personal hygiene.</li> </ul> <p>During observation and interview on 11/18/24 at 6:47 A.M., the resident lay in bed and Certified Nursing Assistant (CNA) N explained to the resident that he/she was going to provide peri-care. CNA N turned the resident to his/ her right side and the resident was wearing two briefs. Both of the briefs were moderately saturated. CNA N said he/she had last changed the resident at 1:00 A.M. CNA N said the resident urinates a lot and due to be being short staffed on nights, that is why CNA N had placed two briefs on the resident.</p> <p>3. Review of Resident #44's quarterly MDS, dated , 8/25/24, showed:</p> <ul style="list-style-type: none"> <li>-Mild cognitive impairment;</li> <li>-Upper and lower extremity impairment;</li> <li>-Always incontinent of bowel and bladder;</li> <li>-Required maximum assist from staff for toilet hygiene;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Diagnoses included heart failure, diabetes, stroke, and depression.</p> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <p>-Focus: bowel and bladder incontinency noted, at risk for urinary tract infection (UTI), and skin breakdown;</p> <p>-Interventions: provide incontinence and perineal (cleansing of the genitals) care after each incontinent episode; Check resident before and after meals and as needed for incontinence episodes; Document incontinent status every shift.</p> <p>During observation and interview on 11/18/24 7:02 A.M., the resident lay in bed and CNA N explained to the resident that he/she was going to complete peri- care. CNA N turned the resident to his/ her right side and the resident was wearing two briefs. Both briefs were moderately saturated. The resident's incontinet pad had a yellow ring and was saturated. CNA N removed the two briefs and cleansed the resident buttock region. CNA N said the resident does not like to be bothered at night so that is why he/she placed the double brief on the resident. The resident said, I have never said that. The last time CNA N checked the resident for incontinence was at 1:00 A.M.</p> <p>4. During an interview on 11/18/24 at 7:02 A.M., CNA N said the residents are to be checked for incontinence every two hours.</p> <p>5. During an interview on 11/22/24 at 8:45 A.M., CNA O said there are no residents for any reason that should be doubled briefed. The residents are to be checked for incontinence every two hours so residents don't develop skin breakdown or UTIs.</p> <p>6. During an interview on 11/22/24 at 12:42 P.M., the Assistant Director of Nursing (ADON) said the residents are to be checked for incontinence every two hours to prevent any type of skin breakdown. It is never acceptable for a resident to wear two briefs.</p> <p>7. Review of Resident #2's electronic medical record (EMR), showed:</p> <p>-Diagnoses included type two diabetes mellitus, major depressive disorder and end stage renal disease;</p> <p>-Moderately impaired cognition.</p> <p>Review of the resident's care plan, in use at the time of the survey, showed:</p> <p>-Focus: resident has a ADL self-care performance deficit;</p> <p>-Goal: resident will maintain current level of function with ADLs through the review date;</p> <p>-Interventions: offer bathing/showering twice weekly and as necessary.</p> <p>During an interview on 11/17/24 at 8:20 A.M., the resident said that he/she feels there is not enough staff employed at the facility. He/She said staff never get him/her out of bed on time. He/She said it had been weeks since his/her last shower.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the shower sheets, dated September and November, 2024, did not show completed showered sheets.</p> <p>During observation and interview on 11/17/24 at 8:05 A.M., 11/18/24 at 4:58 A.M., and 11/22/24 at 8:28 A.M., the resident's hair appeared very oily with large chunks of white flakes throughout his/her hair. The resident had anti-dandruff shampoo located in his/her room. He/She said staff do not use his/her anti-dandruff shampoo and said staff use body wash to clean his/her hair. The resident said he/she has difficulty washing his/her hair due to lack of mobility in his/her arms. The resident said he/she has not had a shower and his/her hair washed for about two weeks. He/She does not like the way his/her hair looks.</p> <p>During an interview on 11/22/24 at 9:00 A.M., CNA Q said the resident needs to be supervised with his/her showers and assistance with hair washing. The resident's hair should be washed every time the resident gets a shower. CNA Q was not aware the resident had anti-dandruff shampoo in his/her room.</p> <p>10. Review of Resident #54's EMR, showed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included acquired absence of left leg above the knee and history of falling;</li> <li>-Cognitively intact.</li> </ul> <p>Review of the resident's care plan, in use at the time of the survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: the resident is limited assistance with bed mobility and transfers. Balance is poor. Resident is extensive assist with upper and lower body dressing and toileting;</li> <li>-Goal: resident will maintain current level of function with ADLs through the review date;</li> <li>-Intervention: offer bathing or showering twice weekly and as necessary.</li> </ul> <p>During an interview on 11/17/24 at 8:43 A.M., the resident said he/she does not remember the last time he/she received at shower. He/She said the facility is always short staffed and he/she felt like the staff did not have enough time to give him/her a shower. The resident was observed to have oily hair and his/her beard was unkempt. Shower sheets?</p> <p>11. Review of Resident #66's quarterly MDS, dated [DATE] showed:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Upper and lower extremity impairment;</li> <li>-Requires maximum assistance from staff for bathing;</li> <li>-Always incontinent of bowel and bladder;</li> <li>-Diagnoses included lung disease, heart failure and diabetes.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's care plan, in use at the time of survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: ADL self-performance deficit related to shortness of breath and heart failure;</li> <li>-Interventions: Offer bathing or shower weekly or as necessary; Use simple instructions to promote independence.</li> </ul> <p>Review of the shower sheets, dated September and November, 2024 did not show completed showered sheets.</p> <p>During observation and interview on 11/17/24 at 9:14 A.M. and 11/19/24 at 12:00 P.M., the resident sat in his/her wheelchair in his/ her room. The resident raised his/her pant legs and exposed his/her lower legs. The resident's skin appeared extremely dry, leather-like and very thick. The resident said he/she picks at his/her skin to try to get the dead skin off. The resident said he/she has not received a shower in three weeks. The resident thinks it is due to his/her size that staff does not assist with his/her showers. The resident said his/her dry legs have been like that since he/she was admitted .</p> <p>During an interview on 11/22/24 at 9:00 A.M., CNA Q said the resident's legs have always been extremely dry. Residents should have showers twice a week. The resident requires a bariatric (large) shower chair and total assistance of two persons transferring into the shower.</p> <p>12. Review of Resident #276's EMR, showed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included low blood pressure, high cholesterol, and recent hip fracture;</li> <li>-Resident admitted on [DATE].</li> </ul> <p>Review of resident nurse's progress notes, dated 11/4/24, showed:</p> <ul style="list-style-type: none"> <li>-Resident will need minimum to moderate assistance for toileting and showering.</li> </ul> <p>Review of the hospital discharge summary to the nurse at the facility, dated 11/4/24, showed:</p> <ul style="list-style-type: none"> <li>-Remove staples to right hip 14 days from the date of the surgery.</li> </ul> <p>Review of the Bath Schedule for South/South Beach, Day shift, the resident is scheduled for a shower on Monday and Thursday.</p> <p>During observation and interview on 11/17/24 at 8:42 A.M., the resident said he/she has incontinent episodes and he/she has not gotten a shower. He/She said there are people coming to visit and he/she would like to be clean. The resident has requested a shower.</p> <p>During observation and interview on 11/18/24 at 8:40 A.M., the resident said he/she did not get a shower yesterday. The resident's hair was tangled on the back of the resident's head. The resident wore the same shirt he/she wore the day before.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/19/24 at 12:48 P.M., the resident's power of attorney (POA) BB said the resident needs a shower. POA BB has mentioned to the staff the resident needed a shower, the staples have been out since 11/14/24 and there is no reason not to get a shower.</p> <p>During observation and interview on 11/20/24 at 7:15 A.M., the resident said he/she had an accident in bed last night. He/She said that bed was soaked with urine from the head to the foot of the bed. The staff removed the soiled linen and wiped down the back of the resident's body. At the foot of the bed, on the floor, there was a dried outline, approximately two feet in diameter with a liquid puddle in the middle, approximately a foot in diameter.</p> <p>During an interview on 11/21/24 at 7:35 A.M., the resident said he/she still has not gotten a shower.</p> <p>During an interview on 11/22/24 at 7:47 A.M., the resident he/she still has not gotten a shower.</p> <p>Observation on 11/22/24 at 7:52 A.M., showed shower sheets from the day before were in the cubby behind the desk. There was no shower sheet for the resident.</p> <p>13. Review of Resident #126's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-No speech - absence of spoken words;</li> <li>-Moderate cognitive impairment;</li> <li>-Rejection of care behavior exhibited 4-6 days, but less than daily;</li> <li>-Upper and lower extremity impairment on both sides;</li> <li>-Substantial/maximal assistance required for roll left and right;</li> <li>-Dependent on assistance for sit to lying and lying to sitting on side of the bed;</li> <li>-Diagnoses included aphasia (language impairment), kidney disease, diabetes and anxiety.</li> </ul> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: Activities of self-care performance deficit. Resident on staff one to two for ADL needs;</li> <li>-Interventions included: Bed mobility: Requires staff assistance to turn and reposition in bed. Bathing/showering: Offer bathing/showering twice weekly and as necessary. Bathing/showering: Provide sponge bath when a full bath or shower cannot be tolerated;</li> <li>-Focus: Resident has behaviors of refusal to get out of bed and turning and repositioning when in bed. Potential risk for impaired skin integrity, sciatic pain, and constipation;</li> <li>-Interventions included: If possible, negotiate a time for ADLs so that the resident participates in the decision-making process. Return at the agreed upon time. If resists with ADLs, offer reassurance, leave and return 5-10 minutes later and re-attempt care.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's medical record, showed the resident was in the hospital from 10/5/24 to 10/16/24.</p> <p>Review of the facility's bath schedule, undated, showed the resident was scheduled for bathing on Tuesday and Thursday evenings.</p> <p>Review of the resident's shower sheets from 10/1/24 through 11/19/24, showed:</p> <ul style="list-style-type: none"> <li>-On 10/9/24, staff documented at the hospital,</li> <li>-No other shower sheets completed and no showers or bed baths documented as completed;</li> <li>-The resident missed a total of 12 showers or bed baths on days he/she was in the facility during this timeframe.</li> </ul> <p>Observations on 11/17/24 at 9:57 A.M. and 11:11 A.M., showed the resident seated upright on a low air loss (LAL) mattress with his/her back flush to the bed. A hospital band was on his/her right wrist. The resident's hair was unkempt and his/her beard was scruffy and unkempt.</p> <p>Observations on 11/18/24 at 5:42 A.M., 6:12 A.M., 7:05 A.M., and 10:05 A.M., showed the resident seated upright on a LAL mattress with his/her back flush to the bed. A hospital band was on his/her right wrist. The resident's hair was unkempt and his/her beard scruffy and unkempt.</p> <p>Observations on 11/19/24 at 10:14 A.M., 10:52 A.M., 11:48 A.M., and 12:34 P.M., showed the resident showed the resident seated upright on a LAL mattress with his/her back flush to the bed. During an interview at 12:34 P.M., the resident was nonverbal and nodded or shook his/her head in response to questions. The resident shook his/her head no, he/she is not comfortable. He/She pointed to his/her lower body and nodded his/her head yes when asked if his/her backside hurts. He/She shook his/her head no, he/she cannot turn him/herself and staff have not turned or repositioned him/her. He/She shook his/her head no, staff have not offered to get him/her out of bed and he/she nodded yes, he/she would like to get out of bed.</p> <p>Observations on 11/19/24 at 1:35 P.M., 2:32 P.M., 3:30 P.M., 4:55 P.M., and 5:47 P.M., showed the resident seated upright on a low air loss (LAL) mattress with his/her back flush to the bed. A hospital band was on his/her right wrist. The resident's hair was unkempt and his/her beard was scruffy and unkempt. During an interview at 12:24 P.M., the resident was nonverbal and nodded or shook his/her head in response to questions. He/She shook his/her head no, he/she has not gotten a shower since he/she came back from the hospital, and has not received a full bed bath. He/She nodded yes, he/she wants to have a shower and his/her beard to be trimmed.</p> <p>Observations on 11/20/24 at 9:58 A.M., 10:32 A.M., 11:44 A.M., and 1:10 P.M., showed the resident seated upright on a low air loss (LAL) mattress with his/her back flush to the bed.</p> <p>During an interview on 11/22/24 at 9:38 A.M., CNA J said the resident is total care and does not like to get out of bed. Staff should turn him/her every two hours.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/22/24 at 12:09 P.M., CNA E said the resident requires assistance with bed mobility and transfers. He/She prefers to be out of bed on Tuesdays and Thursdays. The resident is total care. He/She is ok with getting bed baths or showers.</p> <p>During an interview on 11/22/24 at 9:49 A.M., Licensed Practical Nurse (LPN) H said the resident prefers to stay in bed. He/She is total care and requires staff assistance for bed mobility and transfers. He/She has a history of wounds. Staff should turn and reposition the resident every two hours to help with wound prevention. The resident prefers bed baths. He/She might refuse care if he/she is agitated, but usually, he/she is agreeable.</p> <p>14. During an interview on 11/22/24 at 8:28 A.M., CNA E said residents are assigned showers by their room number. There is a shower list in the binder on the hall. Residents should get at least two showers a week, more if requested or needed. Once a shower is completed, the staff document and sign a shower sheet to give to the nurse. It is important for residents to get their showers to prevent sores, to be clean, and so they do not smell.</p> <p>15. During an interview on 11/22/24 at 9:48 A.M., LPN H said that staff are made aware of their showers per the assignment sheet that is filled out by the nurse. There is also a shower list in the binder at the desk. If the resident is unable to get into a shower, the staff should give the resident a bed bath. Shower sheets are completed by the staff and nurse reviews. At times, there are staffing issues and the staff have to prioritize what resident needs to be showered, usually one-two residents on the list. LPN H was not aware Resident #276 requested a shower. His/Her shower should have been done on the assigned days. Residents need showers to help the circulation and healing of the body.</p> <p>16. During an interview on 11/22/24 at 12:42 P.M., ADON A said she expected staff to provide showers to the residents. Staff is expected to follow a shower schedule and inform the nurse if a resident's shower was missed, or if the resident refuses.</p> <p>17. During an interview on 11/22/24 at 1:34 P.M., the Administrator said she expected staff to follow the facility policy on bathing. Residents should receive at a minimum, two showers a week.</p> <p>18. Review of Resident #41's EMR, showed:</p> <p>-Diagnoses included anemia, heart failure (the inability of the heart to pump oxygenated blood), high blood pressure, diabetes, high cholesterol, dementia and depression.</p> <p>Review of the resident's quarterly MDS, dated [DATE] showed:</p> <p>-Resident admitted on [DATE];</p> <p>-Resident is dependent for toileting hygiene, showering, bathing, lower body dressing, rolling from right to left in bed, to get out of the bed, and all transfers;</p> <p>-Severe cognitive impairment.</p> <p>Review of the resident's care plan, dated 8/13/24, showed:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Focus: ADL self-care performance deficit due to weakness, shortness of breath, fatigue, and loss of appetite;</p> <p>-Goal: resident will maintain current level of function with ADL's through the review date;</p> <p>-Intervention: dependent on two for transfers with mechanical lift, turning and repositioning safely in bed.</p> <p>Observations on 11/18/24 at 4:18 A.M., 5:11 A.M. and 7:55 A.M., showed the resident in bed on his/her back, head facing the doorway.</p> <p>Observations on 11/19/24 at 10:15 A.M. and at 12:51 P.M., showed the resident in bed on his/her back. At 1:05 P.M., the resident was in bed, on his/her back, with staff attempting to feed the resident. At 2:22 P.M., the resident was in bed on his/her back.</p> <p>Observation and interview on 11/19/24 at 3:07 P.M., showed CNA M and CNA J entered the resident room, proceeded to provide care to the resident. After care completed, staff left the resident lying on his/her back. CNA M said the air mattress alternates the air from different areas to relieve pressure.</p> <p>Observations on 11/20/24 at approximately 8:20 A.M., 9:21 A.M., 10:11 A.M., 10:57 A.M. and 10:57 A.M., showed the resident in bed, on his/her back.</p> <p>During an interview on 11/22/24 at 8:28 A.M., CNA E said the resident required total care. The resident has to be checked as much as possible for incontinence and to be repositioned. Repositioning means that a resident is placed on their side or their back. The reason for turning and repositioning and incontinence is to prevent wounds, and so the resident does not smell.</p> <p>19. During an interview on 11/22/24 at 10:41 A.M., LPN I said she expected staff to check the resident for incontinence and to turn and reposition the resident. A low air loss mattress is not a substitute for turning and repositioning, which helps with wound healing.</p> <p>20. During an interview on 11/22/24 at 11:06 A.M., LPN H said staff should check and turn the resident frequently. A low air loss mattress is not a substitute for turning and repositioning. The benefit of turning and repositioning is to relieve the pressure on the resident's bottom and help healing of wounds.</p> <p>21. During an interview on 11/22/24 at 12:42 A.M., ADON A said a low air loss mattress does not replace turning and repositioning the resident. She expected staff to make rounds every two hours, check for incontinence and to turn and reposition.</p> <p>22. During an interview on 11/22/24 at 1:34 P.M., the Administrator said she expected staff to check on the residents every two hours and to turn and reposition the resident. The low air loss mattress is not a substitute for turning and repositioning.</p> <p>MO00237643</p> <p>MO00244184</p> <p>(continued on next page)</p>		

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F 0677  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	MO00245021  MO00244195  49992

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42795</p> <p>Based on observation, interview and record review, the facility failed to ensure residents received care consistent with professional standards by failing to identify one resident's wound and obtain a treatment order (Resident #14) and obtain proper skin care treatment orders for one resident (Resident # 66). The sample was 19. The census was 83.</p> <p>Review of the facility's Skin Integrity policy, reviewed 7/5/24, showed:</p> <p>-Purpose: to establish best practice guidelines for skin integrity monitoring and maintenance to reduce potential risk of skin breakdown where clinically appropriate;</p> <p>-Policy: Skin evaluations shall be completed upon admission and routinely, as per the care plan, to monitor skin integrity; Skin integrity risk factors will be evaluated upon admission and routinely, as per the care plan; Appropriate interventions will be initiated based on the risk factors identified; Lotion and moisture barrier products shall be available and applied as per the care plan; Minimize, as much as possible, any friction or vigorous rubbing of the skin while providing care; Any skin abnormalities noted shall be communicated to the licensed nurse; The licensed nurse shall notify the provider as needed for appropriate skin care orders; Staff shall be educated on skin integrity best practices.</p> <p>1. Review of Resident #14's medical record, showed:</p> <p>-Diagnoses included dementia and diabetes;</p> <p>-Severe cognitive impairment.</p> <p>Review of the resident's care plan, in use at the time of the survey, showed:</p> <p>-Focus: resident has actual impairment to skin integrity;</p> <p>-Goal: resident will have minimum complications of wounds through the review date;</p> <p>-Interventions: Enhanced Barrier Precautions (EBP, use of personal protective equipment (PPE, isolation gowns and gloves) and refer to the use of gowns and gloves during high contact resident care activities that provides opportunities for transfer of multi drug resistant organism (MDRO) to hands or clothing).</p> <p>Review of the resident's Physician Order Summary (POS), showed:</p> <p>-An order, dated 11/17/24, for Zinc Oxide External Ointment 10% (an ointment to treat and prevent skin irritation). Apply to buttocks/back topically every shift for skin management;</p> <p>-No order for the wound on the resident's left flank (side of a person's body between the ribs and hip).</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 the resident's most recent skin observation tool, dated 11/17/24, showed:</p> <ul style="list-style-type: none"> <li>-No documentation of the resident's wound on his/her left flank.</li> </ul> <p>Observation on 11/20/24 at 11:53 A.M., of the resident's skin, showed:</p> <ul style="list-style-type: none"> <li>-A wound dressing was observed on the resident's left flank. The wound dressing was not dated;</li> <li>-The wound had no drainage. The skin appeared to have a small break. The wound appeared to be shearing (skin that is removed when rubbed, moved or repositioned).</li> </ul> <p>During an interview on 11/22/24 at 10:47 A.M., Licensed Practical Nurse (LPN) I said he/she expected for wound treatments/dressings to be placed in accordance with the resident's POS. He/She expected for the resident's dressings to be dated. He/She was not aware of the resident's left flank injury.</p> <p>During an interview on 11/22/24 at 12:42 P.M., Assistant Director of Nursing (ADON) A said he/she expected wound treatments/dressings to be placed in accordance with a physician order. He/She expected the resident's dressings to be dated. He/She said the resident's lower flank wound should have an order for a dressing and should be covered.</p> <p>During an interview on 11/22/24 at 1:32 P.M., the Administrator said she expected wound treatments/dressings to be placed in accordance with a physician order. She expected the resident's dressings to be dated.</p> <p>2. Review of Resident # 66's quarterly MDS, dated [DATE] showed:</p> <ul style="list-style-type: none"> <li>-An admitted [DATE];</li> <li>-Cognitively intact;</li> <li>-Upper and lower extremity impairment;</li> <li>-Requires maximum assistance from staff for bathing;</li> <li>-Requires substantial assistance from staff for lower body dressing and putting on and taking off footwear;</li> <li>-Always incontinent of bowel and bladder;</li> <li>-Diagnoses included lung disease, heart failure and diabetes.</li> </ul> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: The resident is at risk for impaired skin integrity and pressure ulcers (wounds that occur when pressure is applied for an extended period), related to dryness to both lower extremities and history of lymphedema (swelling);</li> </ul> <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>--Interventions: assess areas and initiate skin sheet, initiate treatment per order. Report progress and wound healing to the physician, with any changes or lack of response to treatment;</p> <p>-Focus: ADL self-performance deficit related to shortness of breath and heart failure;</p> <p>--Interventions: Offer bathing or shower weekly or as necessary. Use simple instructions to promote independence.</p> <p>Review of the resident's skin observation tools, showed:</p> <p>-On 10/15/24, no open areas;</p> <p>-On 10/22/24, no open areas;</p> <p>-On 10/29/24, right front lower leg, left front lower leg, right rear lower leg; feet have erosion;</p> <p>-On 11/5/24, right front lower leg, left front lower leg, right rear lower leg. Feet have erosion;</p> <p>--The skin observation tool did not address the type of skin condition of the resident's lower legs and feet.</p> <p>Review of the resident's POS, dated November 2024, showed:</p> <p>-An order, dated 3/28/24, Urea external cream 40% (cream used for dry skin), apply to feet and legs topically at bedtime.</p> <p>-An order, dated 11/17/24, apply warm towel around both lower extremities for 10 minutes, every night.</p> <p>Review of the shower sheets dated September and November, 2024 did not show the resident had showers completed by staff.</p> <p>During observations and interviews on 11/17/24 at 9:14 A.M., and 11/19/24 at 12:00 P.M., showed the resident sat in his/her wheelchair in his/ her room. The resident raised his/her pant legs and exposed his/her lower legs. The resident's skin appeared extremely dry, with multiple layers of dark and very thick flaky skin. The resident said he/she picks at his/her skin to try to get the dead skin off. He/She has not had a shower in three weeks. The resident said his/her legs have been like that since he/she has been at the facility. He/She also has some swelling to his/her legs at times. The cream that staff is using now is not working to treat his/her legs. The resident said his/her feet and legs look awful. When he/she went to the hospital on 8/27/24, the hospital doctor said the treatment was not doing anything because the cream is applied to dead skin and recommended the facility try to remove the dead skin off his/ her legs by gently scrubbing his/her legs. His/Her treatment orders or cream to his/her legs have been the same since he/she has been at the facility. The staff is aware of the condition of his/her legs and assist him/her with getting dressed and applying socks and shoes every day.</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>Observation and interview on 11/19/24 at 4:00 P.M., LPN R said the floor nurses are responsible for weekly skin assessments and treatments. The skin assessments are to have anything that is abnormal included. The resident has had the same treatment to his/her legs and feet for a long time. LPN I removed the resident's socks and shoes. The resident's feet were extremely dry with white flaky skin. LPN R said the resident's legs and feet look the same and have not improved since he/she has been at the facility.</p> <p>During an interview on 11/22/24 at 9:00 A.M., Certified Nursing Assistant (CNA) Q said the resident has always had dry skin to his/her legs and feet and will apply lotion that is in the resident's room when the resident requests it. The resident does require assistance with dressing and putting on socks and shoes.</p> <p>During an interview on 11/22/24 at 9:45 A.M., LPN I said the resident has always had the same treatment order in place. The resident's legs have extremely dry thick non-viable skin to his/her legs. The resident needs a whirlpool treatment, but the facility does not offer that treatment. When a treatment has failed to help the resident's skin condition, the physician should be notified to get a different treatment order. He/She has no idea what foot erosion is, that was noted on the resident's skin observation tool.</p> <p>During an interview on 11/22/24 at 12:42 P.M., ADON A said she expected the weekly skin assessments to be accurate and include all skin issues. He/She did not know what was meant by foot erosion, that was documented on the resident's skin observation tool. He/She expected staff to obtain a different order from the physician for the resident's skin condition when the current treatment is not working.</p> <p>46888</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>40290</p> <p>Based on observation, interview and record review, the facility failed to ensure residents received respiratory care consistent with professional standards of practice when staff failed to follow physician orders for oxygen use for two residents (Residents #46 and #14) and failed to consult the physician regarding oxygen administration at a higher rate than what was ordered for one resident (Resident #46). The sample was 19. The census was 83.</p> <p>Review of the facility's Oxygen Administration and Storage policy, issued 1/1/24, showed:</p> <p>-Purpose: To ensure staff follow safety guidelines and regulation for storage and use of oxygen;</p> <p>-General guidelines included:</p> <p>-Pulse Oximetry (a device used to determine oxygen saturation, the percentage of oxygen in the blood):</p> <p>-Residents who have oxygen orders should have oxygen saturation levels measured by oximetry. The physician should be notified of any concerns identified with oxygen titration (the increasing or decreasing of oxygen needed to maintain therapeutic oxygen levels in the blood) needs so the physician may determine a need to change the order to best meet the resident's oxygen needs;</p> <p>-Procedure included:</p> <p>-Verify physician's order for the procedure;</p> <p>-Turn on oxygen and set flow rate to prescribed amount. In the absence of an order, start the flow rate at 2-3 liters (L) per minute and titrate to maintain acceptable oxygen saturation levels;</p> <p>-Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through.</p> <p>1. Review of Resident #46's medical record, showed:</p> <p>-Diagnoses included acute respiratory failure with hypoxia (low levels of oxygen in the blood) and shortness of breath;</p> <p>-A physician order, dated 1/7/24, for oxygen at 2L as needed (PRN) for shortness of breath.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/13/24, showed:</p> <p>-Cognitively intact;</p> <p>-Upper and lower extremity impairment on both sides;</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>-Oxygen therapy not indicated.</p> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <p>-Focus: Resident has altered respiratory status/difficulty breathing related to dyspnea (shortness of breath) on exertion such as self-propelling in wheelchair and transferring. Resident lays in bed with head of bed elevated due to dyspnea when lying flat. Frequently exerted and utilizes supplemental oxygen and able to self-apply;</p> <p>-Interventions included:</p> <p>-Monitor for signs and symptoms of respiratory distress and report to physician PRN;</p> <p>-Monitor/document/report abnormal breathing patterns to physician;</p> <p>-Provide oxygen as ordered.</p> <p>Observation on 11/18/24 at 5:29 A.M., showed the resident seated upright in bed. An oxygen concentrator was under the window to the right of the resident's bed, off. During an interview, the resident said he/she wants to use his/her oxygen. He/She uses it as needed, not continuously. The resident pressed his/her call light and Licensed Practical Nurse (LPN) Y entered the room. LPN Y exited the room one minute later. At 5:33 A.M., the resident was in bed with a nasal cannula (device used to deliver oxygen with two small tubes that fit into the nostrils) on. The oxygen concentrator was on at 5L. During an interview, the resident said the nurse turned on the oxygen and he/she is breathing better now.</p> <p>Observation on 11/18/24 at 8:43 A.M., showed the resident on his/her back in bed with his/her eyes closed, snoring loudly with the nasal cannula on. The oxygen concentrator was on at 5L.</p> <p>Review of the resident's medical record, showed:</p> <p>-No documentation of the resident's oxygen saturation levels on the morning of 11/18/24;</p> <p>-No documentation of notification to the physician related to use of oxygen at 5L.</p> <p>Observation on 11/20/24 at 7:27 A.M., showed the resident on his/her back in bed with eyes closed, snoring loudly with nasal cannula on. The oxygen concentrator on at 5L. The resident opened his/her eyes and during an interview, said staff put the oxygen on him/her last night.</p> <p>Observation on 11/20/24 at 8:32 A.M., showed the resident seated upright in bed with the nasal cannula on and oxygen concentrator on at 5L. The Director of Nurses (DON) entered the resident's room and spoke to the resident about how he/she was doing. The DON opened the shades above the oxygen concentrator and did not adjust the concentrator or talk to the resident about his/her breathing and oxygen use.</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>Observations on 11/20/24 at 10:31 A.M., 11:27 A.M., and 1:03 P.M., showed the resident seated upright in bed with the nasal cannula on and oxygen concentrator on at 5L. During an interview at 1:03 P.M., the resident said he/she knows the oxygen is on at the highest level and he/she asked one of the nurses about it and they said it is ok, so he/she guesses it is ok. He/She is not sure what the oxygen setting should be, but he/she is able to breathe without difficulty at this time.</p> <p>During an interview on 11/22/24 at 9:49 A.M., LPN H said the resident uses his/her oxygen every day. He/She has periods when he/she can be without it but has been using it more frequently lately. During the interview, LPN H reviewed the resident's medical record and confirmed the resident's physician order is for oxygen at 2L, not at 5L. He/She said it is not appropriate to administer the resident's oxygen at 5L because it goes against the physician order and there is risk to over oxygenate.</p> <p>2. Review of Resident #14's medical record showed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included dementia and diabetes;</li> <li>-Severe cognitive impairment.</li> </ul> <p>Review of the resident's care plan, in use at the time of the survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: resident has a history of supplemental oxygen usage;</li> <li>-Goal: resident will have no side effects of poor oxygen absorption through the review date;</li> <li>-Interventions: Change residents position every two hours to facilitate lung secretion movement and drainage. Give medications as ordered by physician. Monitor/document side effects and effectiveness. Monitor for symptoms of respiratory distress and report to physician. Oxygen settings: oxygen per facility protocol/as ordered.</li> </ul> <p>Review of the resident's electronic Physician's Order Summary (ePOS) showed:</p> <ul style="list-style-type: none"> <li>-An order, dated 7/31/23, for oxygen at 2L per nasal cannula PRN for comfort supplemental oxygen;</li> <li>-An order, dated 8/6/24, to add humidifier (device to keep moisture in the oxygen) to oxygen tank.</li> </ul> <p>Observation on 11/17/24 at 9:35 A.M., showed the resident asleep in his/her bed. The resident's nasal cannula was in his/her nose. The resident's concentrator on and set to 3 liters of oxygen. No humidifier was attached to the concentrator.</p> <p>Observation on 11/20/24 at 11:15 A.M. and 11/21/24 at 7:00 A.M., showed the resident asleep in his/her bed with the nasal cannula on. The resident's oxygen concentrator was on and set to 2L. No humidifier was attached to the concentrator.</p> <p>During an interview on 11/22/24 at 9:49 A.M., LPN H said the resident should have a humidifier on his/her oxygen concentrator. His/Her oxygen concentrator should be set at 2L.</p> <p>3. During an interview on 11/22/24 at 9:49 A.M., LPN H said he/she expected physician orders for oxygen to be followed. Nurses are responsible for ensuring oxygen is on at the appropriate setting.</p> <p>(continued on next page)</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. During an interview on 11/22/24 at 12:42 P.M., Assistant Director of Nurses (ADON) A said physician orders for oxygen should be followed. The nurse is responsible for ensuring oxygen is on at the appropriate setting. It is not appropriate to set a resident's oxygen at 5L when orders are for oxygen at 2L. If the nurse feels it is necessary to administer a resident's oxygen at a higher level than what is in the physician order, the nurse should notify the physician.</p> <p>5. During an interview on 11/22/24 at 1:32 P.M., the Administrator said she expected physician orders for oxygen to be followed, including the use of a humidifier on an oxygen concentrator. She expected oxygen concentrators to be on at the correct setting, per physician order. If the nurse turns on a resident's oxygen to a higher level than what is ordered for whatever reason, the nurse should notify the physician and obtain new orders, if necessary.</p> <p>46888</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49992</p> <p>Based on interview and record review, the facility failed to ensure residents who received dialysis (the clinical purification of blood as a substitute for the normal function of the kidney) had documented assessments and monitoring related to dialysis. The facility identified seven residents who received dialysis, and two residents were sampled (Resident #275 and #70). The sample was 19. The census was 83.</p> <p>On 11/21/24 at 10:56 A.M., an email was sent to the Assistant Director of Nursing for a policy regarding care for a resident receiving dialysis service. As of the exit date, on 11/22/24, no policy was provided.</p> <p>1. Review of Resident #70's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/6/24, showed:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Cognitively intact;</li> <li>-The resident is receiving hemodialysis while at the facility;</li> <li>-Diagnoses included high blood pressure, high cholesterol, end stage kidney disease with dialysis, and asthma.</li> </ul> <p>Review of the care plan, in use at the time of survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: resident receives hemodialysis 3 times a week for end stage kidney disease-potential for infection, bleeding, and pain related to internal jugular (a vein in the neck, IJ) catheter;</li> <li>-Goal: The resident will have no signs or symptoms of complications from dialysis through the review date;</li> <li>-Interventions: Check and change dressing daily at access site. Do not draw blood or take blood pressure in the right arm.</li> </ul> <p>Review of resident's physician's orders, showed:</p> <ul style="list-style-type: none"> <li>-An order dated 11/17/24 to perform a skin check over all bony prominence post hemodialysis every shift every Monday, Wednesday, and Friday;</li> <li>-An order dated 11/17/24 to check AV site for thrill and bruit (light vibration of blood flow and a whooshing sound) and signs and symptoms of infection to the right IJ every shift for AV fistula site thrill/bruit check.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MARTAR, dated 11/1/24 through 11/18/24, showed no documentation to show staff checked every shift for monitoring dialysis access or report the absence or weak thrill or bruit to the dialysis provider and primary medical doctor.</p> <p>Observation and interview on 11/17/24 at 8:05 A.M., showed the resident has a tunneled catheter, covered with gauze and tape to the left chest/neck area. The resident said that he/she goes to dialysis three times a week.</p> <p>During an interview on 11/22/24 at 9:48 A.M., Licensed Practical Nurse (LPN) H said vitals and weights are obtained prior to the resident going to dialysis, documented on a communication sheet and the communication sheet is taken to the dialysis center. Nurses should reassess the resident when they return, assess the dialysis access for bleeding.</p> <p>During an interview on 11/22/24 at 12:42 P.M., the Assistant Director of Nursing (ADON) A said when a resident is admitted to the facility, the nurse should obtain orders for care of the access site, pre/post dialysis communication, the type of access, days of the week resident would go to dialysis, and the location of the dialysis center. The care plan should reflect to appropriate type of access for that resident and orders should be written on the day of admission.</p> <p>During an interview on 11/22/24 at 1:34 A.M., Administrator said she would expect the nursing staff to follow the policy for care with residents who receive dialysis.</p> <p>2. Review of Resident #275's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/7/24, showed:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Cognitively intact;</li> <li>-Does not reflect the resident is receiving hemodialysis while in the facility;</li> <li>-Diagnoses included anemia (low iron in the blood), irregular heartbeat, high blood pressure, kidney failure, diabetes, and asthma.</li> </ul> <p>Review of the care plan, in use at the time of survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: resident receives hemodialysis 3 times a week for end stage kidney disease-potential for infection, bleeding, and pain related to internal jugular catheter (tubing inserted into a vein in the neck);</li> <li>-Goal: The resident will be able to resume normal daily activities of daily living by the review date;</li> <li>-Interventions: No blood pressure in the left arm due to dialysis access site;</li> <li>-There is no documentation in the care plan for an AV fistula.</li> </ul> <p>Review of resident's physician's orders, showed:</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-An order dated 11/17/24 to check left upper AV site thrill/bruit every shift, signs and symptoms of infection every shift;</p> <p>-An order dated 11/17/24 to perform a skin check over all bony prominence post hemodialysis every shift every Tuesday, Thursday, and Saturday.</p> <p>Observation and interview on 11/17/24 at 8:40 A.M., showed the resident has an AV site in the right forearm covered with a dressing. The resident said that she goes to dialysis three times a week.</p> <p>During an interview on 11/22/24 at 9:48 A.M., Licensed Practical Nurse (LPN) H said vitals and weights are obtained prior to the resident going to dialysis, documented on a communication sheet and the communication sheet is taken to the dialysis center. Nurses should reassess the resident when they return, assess the dialysis access for bleeding.</p> <p>During an interview on 11/22/24 at 12:42 P.M., the Assistant Director of Nursing (ADON) A said when a resident is admitted to the facility, the nurse should obtain orders for care of the access site, pre/post dialysis communication, the type of access, days of the week resident would go to dialysis, and the location of the dialysis center. The care plan should reflect to appropriate type of access for that resident and orders should be written on the day of admission.</p> <p>During an interview on 11/22/24 at 1:34 A.M., Administrator said she would expect the nursing staff to follow the policy for care with residents who receive dialysis.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40290</p> <p>Based on observation, interview, and record review, the facility failed to ensure a sufficient amount of nursing staff was available to meet the needs of residents, resulting in a resident left in bed (Resident #20), meals not delivered timely and served cold (Residents #54 and #40), residents not changed timely (Resident #25), and residents not receiving showers in accordance with their needs and preferences (Residents #20, #54, and #2). The sample was 19. The census was 83.</p> <p>1. Review of the facility's Facility Assessment, revised 7/20/24, showed:</p> <ul style="list-style-type: none"> <li>-Assistance with activities of daily living (ADL) monthly average included:</li> <li>-Bed mobility sit to lying, mobility sit to stand, bathing, transfers, and toileting: 34 with supervision/partial/moderate assistance, and 30 dependent/maximum assistance;</li> <li>-Eating: 51 with set up assistance, 16 with supervision/partial/moderate assistance, and 7 dependent/maximum assistance;</li> <li>-Staff Type/Plan:</li> <li>-10 to 15 licensed nurses providing direct care (Registered Nurse (RN), Licensed Practical Nurse (LPN));</li> <li>-20 to 30 Certified Nurse Aides (CNAs);</li> <li>-No documentation of specific nurse staffing needs for each shift to ensure a sufficient number of staff based on the resident population.</li> </ul> <p>2. During a group interview on 11/19/24 at 2:04 P.M., five out of five residents, whom the facility identified as alert and oriented, said there is not enough staff working across all shifts. There are problems with staff not getting residents out of bed and with residents not receiving their showers. These issues are due to lack of staff. One resident said when he/she asks for help from staff, sometimes the staff will say they can't help because there is not enough staff working and they are too busy. All five residents said the food is always cold and it takes a very long time for room trays to be passed out.</p> <p>3. Review of employee time punches for day shift (7:00 A.M. to 3:30 P.M.) on 11/18/24, showed:</p> <ul style="list-style-type: none"> <li>-Three LPNs clocked in during day shift;</li> <li>-Two Certified Medication Technicians (CMTs) clocked in during day shift;</li> <li>-Four CNAs clocked in during day shift.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of Resident #20's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/14/24, showed:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Upper and lower extremity impairment on both sides;</li> <li>-Dependent on assistance for sit to stand and chair/bed-to-chair transfers;</li> <li>-Diagnoses included heart disease, high blood pressure, muscle weakness, and depression.</li> </ul> <p>Review of the resident's care plan, in use at the time of the survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: the resident has an ADL self-care performance deficit;</li> <li>-Goal: resident will maintain current level of function in ADLs through the review date;</li> <li>-Interventions: the resident requires supervision with limited assistance of one staff with showering, encourage the resident to use bell to call for assistance.</li> </ul> <p>Observation on 11/17/24 at 8:31 A.M., showed the resident with white matter on his/her mouth and oily hair. During an interview, the resident said he/she only receives one shower a week. He/She should be at least receiving two showers a week.</p> <p>Observation on 11/18/24 at 10:10 A.M., showed the resident's call light attached to the resident's privacy curtain out of reach of the resident. The resident was awake in his/her bed. During an interview, the resident said he/she wants to get out of bed but is not sure how to get ahold of the staff because his/her call light is out of reach. At 10:47 A.M., the resident remained in bed with his/her call light attached to his/her privacy curtain. The resident said he/she still wants to get out of bed. He/She is usually out of bed by this time. It appears the facility is short on staff this morning.</p> <p>5. Review of Resident #54's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Set up assistance required for eating;</li> <li>-Diagnoses included heart disease, heart failure, and kidney failure.</li> </ul> <p>Review of the resident's medical record, showed diagnoses included acquired absence of left leg above the knee and history of falling.</p> <p>Review of the resident's care plan, in use at the time of the survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: the resident is limited assistance with bed mobility and transfers. Balance is poor. Resident is extensive assist with upper and lower body dressing and toileting;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Goal: resident will maintain current level of function with ADLs through the review date;</p> <p>-Intervention: offer bathing or showering twice weekly and as necessary.</p> <p>Observation on 11/17/24 at 8:43 A.M., showed the resident with oily hair and an unkempt facial hair. During an interview, the resident said he/she does not remember the last time he/she received a shower. The facility is always short staffed and he/she feels like the staff does not have enough time to give him/her a shower.</p> <p>Observation on 11/18/24 at 7:59 A.M., showed staff brought a room tray cart out of the kitchen to the North Heritage hall. At 8:43 A.M., CNA/CMT G passed breakfast trays to the rooms on the North Heritage hall. He/She was the only employee passing out the room trays on the North heritage hall. At 9:01 A.M., the last food tray served to a resident. Food temperatures were obtained from a test tray on the North Heritage room tray cart and showed sausage measured at 87.7 degrees Fahrenheit (F), waffles at 93.2 degrees F, and oatmeal at 119.8 degrees F.</p> <p>During an interview on 11/18/24 at 9:13 A.M., the resident said his/her breakfast is terrible. The food is cold and the waffles are soggy.</p> <p>6. Review of Resident #40's quarterly MDS, dated [DATE], showed:</p> <p>-Moderate cognitive impairment;</p> <p>-Supervision or touching assistance required for eating;</p> <p>-Diagnoses included heart disease, kidney failure, diabetes, and depression.</p> <p>Observation on 11/18/24 at 8:05 A.M., showed a warming cart filled with breakfast trays unplugged by the nurse's station on the South and South Beach hall. At 8:15 A.M., CNA M began passing trays from the warming cart. During an interview, CNA M said he/she is the only aide on the South and South Beach halls. He/She is passing trays by him/herself because the facility is short on staff right now. At 8:59 A.M., CNA M delivered the last tray from the warming cart on the South hall.</p> <p>During an interview on 11/18/24 at 8:56 A.M., Resident #40 said his/her breakfast is cold.</p> <p>7. Review of Resident #25's annual MDS, dated , 8/24/24, showed:</p> <p>-Moderate cognitive impairment;</p> <p>-Frequently incontinent of bowel and bladder;</p> <p>-Upper and lower extremity impairment;</p> <p>-Required maximum assist from staff with toilet hygiene;</p> <p>-Diagnoses included stroke, dementia, eye disease, and depression.</p> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Focus: The resident has an ADL self-care performance deficit related to fatigue, blindness, and occasional confusion;</p> <p>-Interventions: The resident requires maximum assist with toilet hygiene and personal hygiene.</p> <p>Observation on 11/18/24 at 6:47 A.M., showed the resident lay in bed and CNA N explained to the resident that he/she was going to provide personal care. CNA N turned the resident to his/her right side and the resident wore two briefs, one on top of the other. Both briefs were moderately saturated. During an interview, CNA N said the resident urinates a lot so he/she placed two briefs on residents who are incontinent and urinate frequently due to being short staffed on nights. It is difficult to change everyone every two hours when there is not enough staff.</p> <p>8. Review of Resident #2's significant change MDS, dated [DATE], showed:</p> <p>-Moderate cognitive impairment;</p> <p>-Upper and lower extremity impairment on both sides;</p> <p>-Substantial/maximal assist required for bathing;</p> <p>-Dependent on assistance for chair/bed-to-chair transfers;</p> <p>-Diagnoses included seizure disorder, arthritis, and depression.</p> <p>Review of the resident's care plan, in use at the time of the survey, showed:</p> <p>-Focus: Resident has an ADL self-care performance deficit;</p> <p>-Goal: Resident will maintain current level of function with ADLs through the review date;</p> <p>-Interventions: Offer bathing/showering twice weekly and as necessary.</p> <p>During an interview on 11/17/24 at 8:20 A.M., the resident said he/she feels there is not enough staff employed at the facility. Staff never get him/her out of bed on time. It had been weeks since his/her last shower.</p> <p>9. During an interview on 11/22/24 at 7:55 A.M., CNA/CMT F said the facility is short-handed at times. When the facility is short on staff, showers cannot get done and meals run late.</p> <p>10. During an interview on 11/22/24 at 10:54 A.M., CNA/CMT G said the facility is short staffed. The facility has many residents who have heavy care requirements. The facility has a lot of residents who are Hoyer (mechanical lift) transfers, which require two staff. Meal trays are passed by nursing staff, not dietary, and meal trays are late because nursing staff is short. On 11/18/24, the facility did not have enough staff working. Meals were late that day and he/she was the only aide on his/her hall, so he/she could not get everyone out of bed. When staffing is short, showers do not get done.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11. During an interview on 11/18/24 at 8:00 A.M., LPN R said it is difficult to obtain blood sugars, help pass trays on time, answer lights, assist residents out of bed, give medication to residents with gastrostomy tubes (g-tubes, a tube that has been surgically inserted into the abdomen and is used for liquid nutrition and medications), and administer narcotics in a timely manner when there is not enough staff. There currently is not a wound or treatment nurse, the floor nurses are also expected to complete wound treatments. There should be three nurses on day shift all the time.</p> <p>12. During an interview on 11/22/24 at 9:49 A.M., LPN H said on day shift, there should be seven aides and four nurses. On evening shift, there should be six aides and four nurses. When the facility is short on staff, nurses will cover the floor as CMTs and CMTs will cover the floor as CNAs. Showers have not been getting done as often as they should due to being short on staff. Staff try to get as many showers done as they can, then pass along the remaining showers to the oncoming shift. Meal trays are going out late due to staffing shortages, and he/she hears complaints from residents about cold food.</p> <p>13. During an interview on 11/21/24 at 9:57 A.M., the Staffing Coordinator (SC) said based on the census of over 80, the facility requires seven CNAs on day shift, six CNAs on evening shift, and five CNAs on night shift. The workload is reasonable with this amount of staff. If a CNA calls off, the CMT or SC may drop down to help on the floor. If a nurse calls off, one of the Assistant Director of Nurses (ADONs) will work the floor. When staff call off on the evening or night shift, the ADON or SC will be called to fill in. The SC cannot always help cover on night shift because he/she may have just worked a double on day and evening shift.</p> <p>14. During an interview on 11/22/24 at 1:32 P.M., the Administrator said when staff call off, the SC will call in other staff. The SC or nurse managers will work on the floor, if needed. If the facility has to, they will offer bonuses for staff to pick up shifts. Ideally, the facility will have six CNAs and three nurses working on day shift, five CNAs and two nurses on evening shift, and four CNAs and two nurses on night shift.</p> <p>MO00229509</p> <p>MO00244184</p> <p>MO00244195</p> <p>MO00245201</p> <p>42795</p> <p>46888</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49992</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were stored in accordance with currently accepted professional principles when expired medications were in the nurse medication carts and in the medication supply rooms. The facility had two medication rooms and four medication carts. The census was 83.</p> <p>Review of the facility's Medication Storage policy, dated 11/18, showed:</p> <p>-Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications;</p> <p>-Procedures: Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from the inventory, disposed of according to procedures for medication disposal. Certain medications or package types such as multiple dose injectable vials, ophthalmics (eye medication), nitroglycerin tablets, blood glucose testing solution and strips, once opened require an expiration date shorter than the manufacturer's expiration date to ensure the medication purity and potencies. The nurse will check the expiration date of each medication before administering it. All expired medications will be removed from the active supply and destroyed in the facility, regardless of the amount remaining.</p> <p>Review of the Assure Platinum Blood Glucose Meter (device used to test blood sugar levels) manufacturer's recommendation, showed:</p> <p>-Test strips have a 21-month shelf-life expiration and are good for up to three months after opening. It is recommended that users denote the date opened on the test strip bottle in the space provided.</p> <p>Review of the [NAME] Point-of-care CoaguChek International Normalized Ratio (INR, blood test to detect how well blood clots) manufacturer's recommendation, showed:</p> <p>-The test strips can be used up until the expiration date printed on the box and test strip container. Discard the test strips if they are past the expiration date on the container.</p> <p>Review of the [NAME] Freestyle Libre (device for testing blood sugar levels), showed:</p> <p>-Do not use if the Sensor kit is past the expiration date.</p> <p>Observation on 11/20/24 at 8:41 A.M., of the South medication room, showed:</p> <p>-FreeStyle Libre, expired on 9/23/23.</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 - Few</p>	<p>Observation on 11/20/24 at 1:57 P.M., of the North nurse medication cart, showed:</p> <ul style="list-style-type: none"> <li>-Assure Platinum Strip container, expires 2/26/26, was not dated when opened;</li> <li>-Assure Platinum Strip container, expires 3/20/26, was not dated when opened.</li> </ul> <p>Observation on 11/20/24 at 2:15 P.M., of the South nurse medication cart, showed:</p> <ul style="list-style-type: none"> <li>-Assure Platinum Strip container, expires 2/2/26, was not dated when opened;</li> <li>-CoaguChek bottle of strip, expired 10/31/24.</li> </ul> <p>During an interview on 11/20/24 at 1:57 P.M., Licensed Practical Nurse (LPN) CC said glucose strip containers should be dated when opened.</p> <p>During interviews on 11/20/24 at 8:41 A.M. and 2:15 P.M., Assistant Director of Nursing (ADON) B said the expired device should have been removed and discarded. The glucose strips containers should be dated when opened.</p> <p>During an interview on 11/22/24 at 1:34 P.M., the Administrator said she expected staff to label glucose strip containers when opened. Expired medications or equipment should be removed from the medication cart and medication rooms.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40290</p> <p>46888</p> <p>Based on observation, interview, and record review, the facility failed to ensure room trays were delivered to residents at a safe and palatable temperature affecting six residents (Residents #54, #40, #70, #275, #276 and #274). The sample was 19. The census was 83.</p> <p>Review of the facility's food safety and food handling policy, revised 8/16/23, showed:</p> <p>-Policy: food handling practices shall be consistent with Food and Drug Administration (FDA) food code guidelines and comply with federal and state regulations governing food safety and prevention of foodborne illness;</p> <p>-Procedure: food handling practices shall be completed in a manner to protect food safety and avoid cross-contamination. Minimum internal temperatures for meat should be 145 degrees Fahrenheit (F).</p> <p>1. Review of Resident #54's medical record, showed:</p> <p>-Diagnoses included acquired absence of left leg above the knee and history of falling;</p> <p>-Cognitively intact.</p> <p>Observation on 11/18/24 at 9:13 A.M., showed the resident seated upright on the side of the bed. A plate of food on his/her bedside table contained waffles and a bowl of oatmeal. During an interview the resident said his/her breakfast was terrible. He/She said the food is cold and the waffles are soggy.</p> <p>2. Review of Resident #40's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/2/24, showed:</p> <p>-Supervision or touching assistance required for eating;</p> <p>-Diagnoses included heart disease, heart failure, high blood pressure, diabetes and depression.</p> <p>Observation on 11/18/24 at 8:56 A.M., showed the resident was seated upright in bed. A plate of food on his/her bedside table contained mechanical-soft sausage, waffles and a bowl of oatmeal. During an interview, the resident said his/her food is cold.</p> <p>3. Review of Resident #70's admission MDS, dated [DATE], showed:</p> <p>-Cognitively intact;</p> <p>-Diagnoses included high blood pressure, high cholesterol, kidney failure and asthma.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/17/24 at 8:40 A.M., the resident said he/she eats meals in his/her room. He/She said the food is not good and the temperature is usually too cold.</p> <p>4. Review of Resident #275's admission MDS, dated [DATE], showed:</p> <p>-Cognitively intact;</p> <p>-Diagnoses included anemia (low iron in the blood), irregular heartbeat, high blood pressure, kidney failure, diabetes and asthma.</p> <p>During an interview on 11/17/24 at 8:05 A.M., the resident said he/she eats meals in his/her room. The food has no taste, there is no variety, and the food is cold.</p> <p>5. Review of Resident #276's admission MDS, dated [DATE], showed:</p> <p>-Cognitively intact;</p> <p>-Diagnoses included high blood pressure, high cholesterol and a recent hip fracture.</p> <p>During an interview on 11/17/24 at 8:42 A.M., the resident said he/she eats meals in his/her room. He/She said the food is usually cold and is sometimes late.</p> <p>6. Review of Resident #274's admission MDS, dated [DATE], showed:</p> <p>-Cognitively intact;</p> <p>-Diagnoses included anemia, anxiety and abdominal infection.</p> <p>During an interview on 11/17/24 at 8:56 A.M., the resident said food is not always delivered at the same time and it is cold. He/She tries to eat in the dining room when possible.</p> <p>During an observation and interview on 11/17/24 at 8:18 A.M., showed the resident sat at a table in the dining room. Staff delivered a plate with waffles and sausage to the resident, which appeared to be uncooked. The resident said the waffles were cold, but he/she was hungry and was just going smother them with butter.</p> <p>7. During a group interview on 11/19/24 at 2:04 P.M., five residents, whom the facility identified as alert and oriented, attended the group meeting and said the food is always cold and that it takes a very long time for room trays to be passed out.</p> <p>8. Observation on 11/18/24, showed:</p> <p>-At 7:59 A.M., a warming cart come out of the kitchen and brought to the North heritage hallway and staff began to pass trays;</p> <p>-At 8:54 A.M., the warming cart sat on the North heritage hallway in the hallway with both doors open. The cart was not plugged in. Various trays on the cart had not been passed out to the residents.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-At 8:56 A.M., the warming cart remained in the hallway with both doors open, not plugged in. No staff were near the cart;</p> <p>-At 9:01 A.M., staff passed the last resident tray on the North heritage hallway, a test trays food temperatures tested with a calibrated digital thermometer:</p> <p>-Sausage measured at 87.7 degrees Fahrenheit (F);</p> <p>-Waffles measured at 93.2 degrees F;</p> <p>-Oatmeal measured at 119.8 degrees F.</p> <p>9. Observation on 11/20/24 at 8:24 A.M., showed a warming cart filled with breakfast trays unplugged by the nurse's station on the South/South beach hall. Certified Nursing Assistant (CNA) E moved the cart down the hallway, did not plug it in, and removed a tray from the warmer, leaving the door to the cart open. At 8:26 A.M., CNA E closed the door to the warming cart. CNA E moved the warming cart down the hall as he/she passed trays to resident rooms, opening and shutting the door of the warming cart as he/she went, leaving the warming cart unplugged. At 8:42 A.M., Dietary Aide P brought a tray containing two plates to the hall and told CNA E they were the last two plates to pass on the hall. Dietary Aide P set the tray of two plates on the bottom shelf of the beverage cart next to the warming cart. At 8:48 A.M., CNA E finished passing all trays on the hall, except one. Using a calibrated thermometer, the temperature of the food on the plate was obtained and showed the biscuit at 86.8 degrees F, scrambled eggs at 102 degrees F, and oatmeal at 116 degrees F.</p> <p>10. Observation on 11/22/24 on 12:38 P.M., of lunch trays on the North hallway, showed:</p> <p>-Chili dog measured at 106.0 degrees F;</p> <p>-French fries measured at 95 degrees F.</p> <p>11. During an interview on 11/22/24 at 9:49 A.M., LPN H said meal trays have been delivered late due to staffing. He/She does hear complaints about cold food from residents.</p> <p>12. During an interview on 11/22/24 at 12:37 P.M., Dietary Aide K said he/she brings the warming cart out to the hall and plugs it in. The nursing staff are responsible for passing the trays. He/She said the warming cart should be plugged in and the door should remain closed to keep the food warm. Hot food should be served hot and cold food should be served cold. He/She would want his/her food served this way.</p> <p>13. During an interview on 11/22/24 at 1:28 P.M., the Dietary Manager said dietary staff bring room tray carts out to the hallways and plug them in. The doors should be kept closed while passing trays. The nursing staff are responsible for passing hall trays. Food should be served in the appropriate temperature range. Hot food should be served hot and cold food should be served cold.</p> <p>14. During an interview on 11/22/24 at 1:32 P.M., the Administrator said she expected food to be delivered to residents at a safe and palatable temperature. Warming carts brought out to the hallways should stay plugged in and the doors should stay closed after trays are removed. This would help with food temperatures on the hallways.</p> <p>(continued on next page)</p>		

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F 0804  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	MO00237643  49992

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40290</p> <p>Based on interview and record review, the facility failed to ensure resident records were complete and accurately documented when staff failed to document the circumstances surrounding a discharge from the facility for one resident (Resident #72) and when an employee documented completion of neurological assessments for one resident (Resident #35) during shifts the employee did not work. The sample was 19. The census was 83.</p> <p>1. Review of Resident #72's medical record, showed:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included seizures, diabetes, heart failure, atrial fibrillation (irregular heartbeat), dementia, schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves) and bipolar disorder (mood disorder with intense mood swings).</p> <p>-discharged [DATE];</p> <p>-A progress note, dated 8/28/24 in which staff documented the interdisciplinary team (IDT) met to review the resident's skilled therapy stay. The resident participates in therapy and desires to return to prior level of functioning;</p> <p>-No documentation of the resident signing out for a leave of absence prior to the discharge date or signing out of the facility against medical advice. No documentation regarding the circumstances of the resident's discharge.</p> <p>During an interview on 11/21/24 at 12:25 P.M., the Social Services Director (SSD) said the resident left the facility with his/her family member on a Friday and never came back. On Monday or Tuesday of the following week, another facility employee got a hold of the resident's family member, who said the resident was not coming back. When staff found out the resident was not coming back to the facility, they should have charted it in the resident's medical record.</p> <p>During an interview on 11/21/24 at 12:30 P.M., Licensed Practical Nurse (LPN) C said he/she was not in the facility when it occurred, but the resident signed out for an outing with family and never came back. Outings over weekends were typical for the resident and he/she usually came back, but this time he/she did not. When residents leave for outings, staff should document the resident's leave of absence in their medical record.</p> <p>2. Review of Resident #35's medical record, showed:</p> <p>-Diagnoses included history of falling;</p> <p>-A progress note, dated 11/2/24 at 6:06 A.M., the resident witnessed by aide slipping out of bed to the mattress that was next to his/her bed. Resident assessed, no physical injuries noted. Neurologically no defects noted.</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 - Few</p>	<p>Review of the resident's neurological evaluation flow sheet, dated 11/2/24, showed the neurological assessments (neuro-checks) documented as completed during the 3:00 to 11:00 P.M. shift on 11/4/24, and during the 11:00 P.M. to 7:00 A.M shift on 11/4/24 to 11/5/24, were signed with the same initials as LPN D.</p> <p>During an interview on 11/22/24 at 10:21 A.M., Assistant Director of Nurses (ADON) confirmed the initials on the neurological evaluation flow sheet were for LPN D.</p> <p>Review of LPN D's time punches, showed the employee did not work during the 3:00 to 11:00 P.M. shift on 11/4/24, or during the 11:00 P.M. to 7:00 A.M shift on 11/4/24 to 11/5/24.</p> <p>During an interview on 11/22/24 at 10:47 A.M., LPN I said neuro-checks should be documented as completed by the nurse who performed them. It would not be appropriate for staff to document having completed something when they did not complete it.</p> <p>3. During an interview on 11/22/24 at 12:42 P.M., ADON A said she expected staff to document accurately. If staff did not complete a task themselves, they should not chart it as completed. She expected all resident records to be complete and accurate.</p> <p>4. During an interview on 11/22/24 at 1:32 P.M., the Administrator said when staff found out Resident #27 was not returning to the facility after a leave of absence, it should have been documented in the resident's clinical record. Staff should not document neuro-checks or other tasks as completed unless they complete them. The facility does not have a policy related to complete and accurate medical record documentation. She expected resident records to be complete and accurate.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40290 42795</p> <p>Based on observation, interview and record review, the facility failed to follow acceptable infection control standards by not implementing Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS) for residents with gastrostomy tubes (g-tube, a tube that is surgically inserted into the abdomen and is used for liquid nutrition and medications), wounds requiring treatments, peripherally inserted central catheter (PICC, a thin tube inserted into the vein that is utilized for medications and fluids) (Residents #126, #3, #14, #41 and #27). The facility failed to ensure staff used appropriate infection control practices for two residents when providing perineal care (peri care, cleansing of the genitals) (Residents #25 and #175). In addition, the facility failed to provide tuberculosis (TB) screening tests for five of five residents reviewed for TB testing (Residents #3, #66, #23, #45 and #12). The facility also failed to complete TB screening tests on two employees prior to employment at the facility (Employees S and T). The sample was 19. The census was 83.</p> <p>Review of the facility's Enhanced Barrier Precautions (EBP), reviewed 5/15/24, showed:</p> <p>-Policy: The facility may expand the use of personal protective equipment (PPE, isolation gowns and gloves) and refer to the use of gowns and gloves during high contact resident care activities that provides opportunities for transfer of MDRO to hands or clothing. The use of gowns and gloves for high contact care activities is indicated, when contact precautions do not otherwise apply, for facility residents with wounds and/or indwelling medical devices regardless of MDRO colonization (organisms are present but not causing any symptoms) as well as for residents with MDRO infection or colonization.</p> <p>-Procedure: Examples of high contact resident care activities requiring gown and glove use for EBP include: dressing, bathing or showering, transferring providing hygiene, changing lines, changing briefs or toileting, central line care (a flexible tube that is inserted into the vein), urinary catheter (a tube that is inserted into the bladder to drain urine), enteral tube (a surgical inserted tube in the abdomens that is used for liquid nutrition and medications), tracheostomy (a tube inserted into the windpipe that assists with breathing), wound care that requires a dressing;</p> <p>-Steps: Post signage on the door or wall outside the resident's room indicating the use of EBP; EBP signage should include information on high contact resident care activities that require the use of gown and gloves; PPE should be available inside of the resident's room.</p> <p>Review of the facility's Hand Hygiene policy, reviewed 4/28/22, showed:</p> <p>-Policy: The facility will provide guidelines to employees on proper handwashing and hand hygiene techniques that will aid in the prevention of the transmission of infections;</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>-Procedure: Hand hygiene should be performed, before and after providing care, contact with blood, body fluids, or contaminated surfaces.</p> <p>Review of the facility's policy for Incontinent Care, reviewed 7/21/22, showed:</p> <p>-Policy: The facility will provide incontinent care as directed in the plan of care;</p> <p>-Procedure:</p> <ul style="list-style-type: none"> <li>-Gather supplies;</li> <li>-Identify resident and explain the procedure;</li> <li>-Provide privacy;</li> <li>-Place equipment in clean surface within reach;</li> <li>-Assist with positioning the resident;</li> <li>-Remove soiled brief and under pad by rolling the brief and under pad;</li> <li>-Cleanse perineal area (the area between the rectum and genitals) with perineal cleanser;</li> <li>-Remove soiled gloves, perform hand hygiene and apply clean gloves;</li> <li>-Apply clean brief and clothing;</li> <li>-Discard contaminated items;</li> <li>-Remove gloves and perform hand hygiene;</li> <li>-Reposition resident in a safe and comfortable position.</li> </ul> <p>Review of the Department of Health and Senior Services (DHSS) TB Screening for Long Term Care Residents flow chart, dated 3/11/14, showed:</p> <ul style="list-style-type: none"> <li>-No documentation of prior 2 step TB test:</li> <li>-Administer first step one week after admission;</li> <li>-Read results with 48-72 hours;</li> <li>-For negative results, administer second step within one to three weeks;</li> <li>-Read results within 48-72 hours;</li> <li>-For negative results, annual evaluation to rule out signs and symptoms of TB;</li> </ul> <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>-No further skin testing is required unless the resident is exposed or develops symptoms.</p> <p>-Documentation of 2 step TB test in the past with negative results;</p> <p>-For negative results, annual evaluation to rule out signs and symptoms of TB;</p> <p>-No further skin testing is required unless the the resident is exposed or develops symptoms.</p> <p>Review of the DHSS guidance for TB screening for long-term care employees, showed:</p> <p>-Employee accepts position (the hire date);</p> <p>-If no documentation of prior two-step tuberculin skin test (TST), administer TST first step prior to employment. Can coincide reading the results with the employee start date by administering TST two to three days prior to the employee start date);</p> <p>-Read results for first step TST within 48 to 72 hours of administration.</p> <p>(language impairment);</p> <p>1. Review of Resident #126's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/4/24, showed:</p> <p>-Diagnoses included diabetes, hyperosmolality (high concentration of salt, glucose, or other substance in the blood) and hypernatremia (high sodium in the blood), kidney disease, malnutrition, and aphasia (language impairment);</p> <p>-Use of feeding tube.</p> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <p>-Focus: Resident requires tube feeding related to dysphagia (swallowing disorder) and swallowing problem;</p> <p>-Interventions included EBP related to g-tube.</p> <p>Review of the resident's electronic Physician Order Summary (ePOS), showed:</p> <p>-An order, dated 11/17/24, for enteral feed order every shift for tube feeding, continuous enteral feeding, Formula: Jevity 1.5 (calorically-dense liquid formula); Rate: 80 milliliters (ml), start at 7:00 P.M. and run until 1:00 P.M., flush with 200 ml of water every four hours, monitor every shift;</p> <p>-An order, dated 11/17/24, for EBP related to g-tube while g-tube is in place.</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>Observation on 11/17/24 at 9:57 A.M., showed an EBP sign posted outside the doorway to the resident's room. The resident lay on his/her back in bed with a tube feeding connected to his/her abdomen. Licensed Practical Nurse (LPN) H wore gloves while handling the tube near the resident's abdomen. LPN H did not wear a gown while he/she provided care to the resident's tube feeding.</p> <p>During an interview on 11/22/24 at 12:42 P.M., Assistant Director of Nurses (ADON) A said the resident has a tube feeding and he/she is on EBP. ADON A expected staff to wear gowns and gloves while providing care to the resident.</p> <p>2. Review of Resident #3's quarterly MDS, dated , 10/4/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident has a feeding tube;</li> <li>-Diagnosis included aphasia (inability to speak), quadriplegia (paralysis of all four extremities) and malnutrition (poor nutritional status).</li> </ul> <p>Review of the resident's physician order sheets (POS), showed:</p> <ul style="list-style-type: none"> <li>-A order, dated 6/22/23, infuse Osmolyte 1.5 ( type of high caloric liquid nutrition) at 60 mls via feeding tube;</li> <li>-An order, dated 6/10/24, EBP.</li> </ul> <p>Observation on 11/17/24 at 9:40 A.M., showed the resident had an EBP sign outside of the door and PPE in drawers in the resident's room. The resident lay in his/her bed. LPN I wore gloved hands and prepared the resident's tube feeding and flush on the resident's bedside table. LPN I removed the resident's bed covers and lifted the resident's gown to expose the resident's g-tube. LPN I flushed the residents g-tube with approximately 30 mls of water and then connected the resident's tube feeding to the resident's g-tube. LPN I's string ties from his/her sweatshirt touched the resident. LPN I then turned the tube feeding pump on. LPN I did not wear an isolation gown while accessing the resident's g-tube.</p> <p>During an interview on 11/22/24 at approximately 10:00 A.M., LPN I said staff should follow the EBP by wearing an isolation gown and gloves while providing care to the resident, because the resident has a g-tube.</p> <p>3. Review of Resident #14's medical record, showed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included dementia and type 2 diabetes mellitus;</li> <li>-Severe cognitive impairment.</li> </ul> <p>Review of the resident's care plan, in use at the time of the survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: The resident has actual impairment to skin integrity;</li> <li>-Goal: resident will have minimum complications of wounds through the review date;</li> </ul> <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>-Interventions: Enhanced Barrier Precautions (EBP).</p> <p>Review of the resident's POS, showed:</p> <p>-An order, dated 6/10/24, for EBP during care;</p> <p>-An order, dated 11/17/24, for Medihoney Wound &amp; Burn Dressing External Paste (wound dressings). Apply to coccyx topically every evening shift for wound care. Cleanse with normal saline/wound cleanser, apply Medihoney to wound bed and cover with border gauze daily;</p> <p>-An order, dated 11/17/24, for Medihoney Wound &amp; Burn Dressing External Paste. Apply to left shin topically every evening shift for wound care. Cleanse with normal saline/wound cleanser, apply Medihoney to wound bed and cover with border gauze daily;</p> <p>-An order, dated 11/17/24, for Medihoney Wound &amp; Burn Dressing External Paste. Apply to right medial knee topically every 24 hours as needed for skin. Cleanse area with normal saline/wound cleanser, apply Medihoney and cover with dry dressing;</p> <p>-An order, dated 11/17/24, for Medihoney Wound &amp; Burn Dressing External Paste. Apply to right medial knee topically every evening shift for skin;</p> <p>-An order, dated 11/17/24, for Medihoney Wound/Burn Dressing External Paste. Apply to left outer ankle topically every evening shift for wound cleanse with wound cleanser, apply Medihoney and cover with dry dressing;</p> <p>-An order, dated 11/17/24, for Vaseline Petrolatum Gauze External Pad (Wound Dressings) Apply to left breast topically every evening shift for wound care. Cleanse with normal saline/wound cleanser, apply Vaseline gauze daily to wound and cover with Silicone Border Gauze;</p> <p>-An order, dated 11/17/24, for Zinc Oxide External Ointment 10%. Apply to buttocks/back topically every shift for skin management.</p> <p>Observation on 11/20/24, showed:</p> <p>-At 11:46 A.M., Hospice Aide L stood next to the right side of the resident's bed. He/She only wore gloves. CNA M walked into the resident's room and put on a pair of gloves and walked to the left side of the resident's bed. CNA M rolled the resident to position the resident, placing his/her hands on the resident's shoulder and hip;</p> <p>-At 11:50 A.M., CNA M rolled the resident to his/her right side. His/Her hands touched the resident as he/she positioned the resident. His/Her uniform touched the resident as he/she leaned up against the resident;</p> <p>- At 11:52 A.M., CNA M rolled the resident to his/her right side while Hospice Aide L continued to perform peri-care on the resident.</p> <p>4. Review of Resident #41's EMR, showed:</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>-A quarterly MDS, dated [DATE], showed his/her diagnoses included anemia, heart failure (the inability of the heart to pump oxygenated blood), high blood pressure, diabetes, high cholesterol, dementia and depression;</p> <p>-An order, dated 9/16/24, for EBP;</p> <p>-An order, dated 11/17/24, for treatment order to the resident's coccyx to cleanse the wound bed normal saline/wound cleanser and pat dry. Apply collagen powder to wound bed, cover with calcium alginate with silver and secure with island gauze every evening shift;</p> <p>-A care plan, revised 9/5/24, EBP related to wounds.</p> <p>Observation on 11/20/24 at 11:06 A.M., showed an EBP sign on the resident's room door. CNA M and CNA J entered the resident's room and proceeded to provide care to the resident. Neither CNA wore a gown.</p> <p>5. Review of Resident #27's EMR, showed:</p> <p>-An entry MDS, dated [DATE], his/her diagnoses included infection of the intestine, atrial fibrillation (abnormal heart rhythm), and low iron;</p> <p>-An order, dated 11/13/24, 1. Empty drains every shift 2. Ceftriaxone (antibiotic) sodium intravenous solution reconstituted 2 grams (GM) every morning for 19 days 3. Micafungin (a medication to eliminate fungus in the blood) sodium intravenous solution 100-0.9 milligram/100 milliliters at bedtime for 20 days;</p> <p>-An order, dated 11/14/24, to change the PICC dressing on day shift every seven days for infection control;</p> <p>-An order, dated 11/17/24, to flush the PICC line with sodium chloride (normal saline) prior to administration of antibiotic therapy and every shift;</p> <p>-An order, dated 11/17/24, for EBP related to drains and PICC line.</p> <p>Observation and interview on 11/17/24 at 8:56 A.M., showed the resident in his/her room, with antibiotic flowing through a PICC line to the resident's right upper arm. He/She said the PICC line was inserted at the hospital for antibiotics because he/she had an infection in his/her stomach. There was sign on door to use EBP.</p> <p>Observation and interview on 11/18/24 at approximately 9:30 A.M., showed resident in his/her room. The resident said he/she had two drains in his/her stomach. He/She pulled the covers down and lifted his/her shirt, showing two drains inserted into his/her stomach. There was no sign on the door to use EBP.</p> <p>Observation on 11/19/24 at 10:00 A.M., showed an EBP sign and supplies on the outside of the resident's door.</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 11/22/24 at 8:28 A.M., CNA E said EBP is to protect the resident and also the staff. If staff perform any care with a resident who has EBP, staff should wear a gown and gloves. Supplies should be hanging on the resident's door with a sign for EBPs.</p> <p>During an interview on 11/22/24 at 9:48 A.M., LPN H said EBP is for those residents who are quarantined for 7-10 days.</p> <p>During an interview on 11/22/24 at 10:41 A.M., LPN I said if there is a sign on the door, staff should follow the instructions. Residents who have EBP are the ones who receive tube feeding and have wounds.</p> <p>During an interview on 11/22/24 12:42 A.M., ADON A said the signs on the doors mean staff have to wear gown and gloves when providing care. Those residents who have wounds, intravenous (IV) ports, drains and a g-tube are placed on EBP.</p> <p>During an interview on 11/22/24 at 1:34 P.M., the Administrator said staff should follow EBP.</p> <p>6. Review of Resident #25's annual MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>-Moderate cognitive impairment;</li> <li>-Frequently incontinent of bowel and bladder;</li> <li>-Upper and lower extremity impairment;</li> <li>-Required maximum assist from staff with toilet hygiene;</li> <li>-Diagnoses include stroke, dementia, lung disease, eye disease and depression.</li> </ul> <p>Review of the resident's care plan, in use at the time of survey, showed:</p> <ul style="list-style-type: none"> <li>-Focus: The resident has an activities of daily living (ADL) self-care performance deficit related to fatigue, blindness and occasional confusion:</li> <li>-Interventions: The resident requires maximum assist with toilet hygiene and personal hygiene.</li> </ul> <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 observation and interview on 11/18/24 at 6:47 A.M., CNA N explained to the resident he/she was going to complete peri-care. CNA N applied gloves, lowered the resident's brief between the resident's legs and cleansed the resident's genitals. CNA N then turned the resident to his/her right side and the resident was wearing two briefs. Both briefs were moderately saturated. CNA N removed the two briefs and cleansed the resident's buttock area. CNA N removed his/her gloves and washed his/her hands. CNA N then touched the trash can with his/her bare hands and moved it to the other side of the resident's bed. CNA N did not perform hand hygiene after touching the trash can. CNA N then applied new gloves. A clean brief was applied to the resident by repositioning the resident side to side. With the same gloves on, CNA N opened the resident's closet and touched multiple clothing items. CNA N then took a shirt out of the resident's closet. CNA N removed the resident's shirt that he/she had on and applied and buttoned the resident's new shirt and with the same gloved hands. CNA N removed the gloves and did not wash his/her hands or perform hand hygiene. CNA N said he/she said he/she might have forgot some steps with hand hygiene and changing gloves.</p> <p>6. Review of Resident #175's medical record, showed his/her diagnoses included stroke, dysphagia (difficulty swallowing), weakness and heart disease.</p> <p>Review of the resident's care plan, in use at the time of survey, did not address the resident's incontinence.</p> <p>Observation and interview on 11/19/24 at 11:17 A.M., showed the resident lay in bed. He/She told CNA O that his/her bottom hurt and he/she be cleaned. CNA O left the room to gather supplies and LPN I entered the room. CNA O applied clean gloves, removed the resident's brief and provided peri-care. LPN I assisted CNA O with turning the resident to his/her right side. The resident's buttock and rectal area were cleaned by CNA O. CNA O removed his/her gloves and did not perform hand hygiene. CNA O then applied new gloves, applied a clean brief, and repositioned the resident to his/her back. CNA O removed his/her gloves and left the room. CNA O did not perform hand hygiene when he/she removed his/her gloves prior to leaving the room.</p> <p>During an interview on 11/22/24 at 8:45 A.M., CNA O said staff should change their gloves and perform hand hygiene before placing a new pair of gloves on. It is not acceptable to touch the resident's clothing and help them get dressed with dirty gloves.</p> <p>During an interview on 11/22/24 at approximately 10:00 A.M., LPN I said staff should perform hand hygiene after removing gloves and when new gloves are applied. When in doubt, change gloves and perform hand hygiene.</p> <p>During an interview on 11/22/24 at 12:42 P.M., ADON A said she expected staff to use best infection control practices and wash their hands or use hand sanitizer after the soiled gloves are removed and new gloves are applied.</p> <p>7. Review of the Resident #3's medical record, showed:</p> <p>-On 7/3/23, the resident received a TB test with no results documented;</p> <p>-No further TB testing or screening was documented.</p> <p>8. Review of Resident #66's medical record, showed:</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>-An admitted [DATE];</p> <p>-No TB testing or screening was documented.</p> <p>9. Review of Resident #23's medical record, showed:</p> <p>-An admitted [DATE];</p> <p>-On 12/16/21, the resident received a TB test with no results documented;</p> <p>-No further TB testing or screening was documented.</p> <p>10. Review of Resident #45's medical record, showed:</p> <p>-An admitted d of 11/13/23;</p> <p>-No TB testing or screening was documented.</p> <p>11 Review of Resident #12's medical record, showed:</p> <p>-An admitted [DATE];</p> <p>-On 12/16/21, the resident received a TB test with no results documented.</p> <p>During an interview on 11/22/24 at 12:42 P.M the ADON said the Infection Preventionist (IP) or the Director of Nursing (DON) are expected to complete the TB testing for the residents. TB testing and screening is expected to be completed when the resident is admitted and yearly.</p> <p>During an interview on 11/22/24 at 1:32 P.M. the Administrator said she expected the facility to follow the state guidelines due to the facility not having a policy for TB testing related to residents. The DON is responsible to track the TB tests and administer them.</p> <p>12. Review of Employee S's employee file, showed:</p> <p>-Hire date 7/15/24;</p> <p>-TB first step administered on 10/23/24 and read on 10/26/24;</p> <p>-TB second step administered on 11/13/24 and read on 11/16/24.</p> <p>13. Review of Employee T's employee file and time punches, showed:</p> <p>-Hire date 8/19/24:</p> <p>-TB first step administered 8/19/24;</p> <p>-TB first step read 8/24/24;</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>-Employee worked on 8/19/24 and 8/21/24.</p> <p>During an interview on 11/21/24 at 2:17 P.M., the Human Resources (HR) Specialist said when a new employee is hired, the DON oversees the employee's TB test. The TB first step must be read within three days of it being administered and must be read before the employee starts working in the building.</p> <p>During an interview on 11/22/24 at 12:42 P.M., ADON A said all new hires must undergo two-step TB testing. The Charge Nurse, ADON, or DON can administer the TB first step and the results must be read within three days. Reading the test results in five days after the test is administered is too late. The TB first step must be read before the employee starts working in the facility. ADON A is not sure why the TB first steps were administered and read late for Employees S and T.</p> <p>During an interview on 11/22/24 at 1:32 P.M., the Administrator said the HR Specialist and DON are responsible for ensuring new hires undergo a two-step TB test. After administering the TB first step, the results must be read within 24 to 72 hours. The TB first step has be read before the employee can start working in the facility. The facility does not have a policy related to employee TB testing and they follow state guidelines. She expected the facility to follow state guidelines for staff TB testing.</p> <p>MO00245508</p> <p>46888</p> <p>49992</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>42795</p> <p>Based on interview and record review, the facility failed to designate one or more individuals with specialized training in infection prevention and control as the infection preventionist (IP) for the facility's infection control program. The census was 83.</p> <p>Review of the facility's Surveillance of Healthcare Associated Infections policy, reviewed 10/7/21, showed:</p> <ul style="list-style-type: none"> <li>-Policy: Surveillance for Healthcare Associated Infections (HAI) will be completed to calculate baseline rates, detect outbreaks, track progress, and to determine trends to help prevent the development or spread of infection;</li> <li>-Responsibility: Director of Nursing (DON), infection control designee, and licensed nurses.</li> </ul> <p>During an interview with on 11/20/24 at 2:00 P.M., the DON said she did not have the IP certificate completed. She had worked on it all night. The previous IP left about one month ago.</p> <p>During an interview on 11/22/24 at 1:34 P.M., the Administrator said she thought the DON completed the IP certification. The last IP left in September, 2024. She expected the facility to have a designated person to complete the training and receive certification.</p>