Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265312 | A. Building<br>B. Wing | 09/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Gainesville Nursing | 77 Medical Drive<br>Gainesville, MO 65655 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906<br><br>Based on interview and record review, the facility failed to ensure all allegation of possible neglect were reported within two hours to the State Survey Agency (Department of Health and Senior Services - DHSS) when the facility Administrator received an allegation of possible neglect involving one resident (Resident #1) in a facility and failed to report it to DHSS. The facility census was 43.<br><br>Review of the facility policy titled, Abuse, Prevention, and Prohibition Policy, dated October 2022, showed the following:<br><br>-The facility Administrator will be designated as the facility Abuse Coordinator and will be responsible for overseeing the Abuse Prevention and Prohibition Program and directing any abuse investigation.<br><br>-Resident abuse must be reported immediately to the Administrator. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. While a facility investigation is under way, steps will be taken to prevent further abuse. Initiate investigation including initial notifications of all listed on the notification form, documenting on the form. This includes the State Agency and law enforcement if this is reasonable suspicion of a crime;<br><br>-Complete a report of alleged resident abuse within the required timelines;<br><br>-The facility employee or agent, who becomes aware of abuse on neglect, shall immediately report the matter to the facility Administrator or his/her designated representative in his/her absence;<br><br>-The Administrator will notify the Corporate Nurse;<br><br>-The facility Administrator shall report to the mandated state agency per reporting criteria;<br><br>-All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property will be reported immediately to the Administrator. The person made aware of the allegation of abuse or neglect of the Administrator will report the allegation of abuse and neglect to the mandated state agency and law enforcement;<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The allegation will be reported no later that two hours after the allegation is made if the events involve abuse or result in serious bodily injury;<br><br>-Neglect means failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress.<br><br>1. Review of the Resident #1's face sheet showed the following:<br><br>-admitted [DATE];<br><br>-Diagnoses included acute kidney failure (AKF), severe dementia with agitation, repeated falls, need for assistance with personal cares, and weakness.<br><br>Review of the resident's admission Minimum Data Set (MDS - a federally mandated, comprehensive assessment tool completed by facility staff), dated 07/22/24, showed the following:<br><br>-Severely cognitively impaired;<br><br>-Required set up or clean up assistance of staff with eating;<br><br>-Dependent on staff for toileting hygiene, personal hygiene, mobility, and transfers;<br><br>-Required substantial or maximum assistance of staff for showers.<br><br>Review of the resident's progress note dated 10/14/24, at 9:45 A.M., showed the facility Administrator documented the following:<br><br>-A visitor said the Administrator was letting the resident die. The resident had lost 25% of his/her body weight and the Administrator was fine with the resident lying in bed, dying. The Administrator asked the visitor how he/she knew the resident's weight. The visitor said he/she saw the resident when entering the facility to pick up other residents. The Administrator informed the visitor per the request of the resident's durable power of attorney (DPOA), the visitor should not seek out the resident while in the facility. The visitor said he/she saw the resident while he/she was in the facility conducting business. The visitor stated that on the previous day, 11/13/24, the resident had food on his/her clothes and was dirty. The visitor again told the Administrator that he/she (the Administrator) was just going to let the resident lay in bed and die. The Administrator told the visitor that their conversation was over and he/she did not appreciate what the visitor was accusing the Administrator of and that any further information needed, he/she would need to get the information from the DPOA, from Adult Protective Services (APS), or he/she could hire a lawyer and file for guardianship. After the visitor left, he/she went to the resident's room. The resident was resting in bed. The Administrator had assisted the resident back to his/her room after breakfast and he/she was doing fine. The resident had fresh ice water and snacks available on his/her overbed table. The Activity Director was present during the conversation.<br><br>Review of DHSS records showed the facility did not file a self-report regarding the allegation of possible neglect.<br><br>During an interview on 11/14/24, at 4:30 P.M., Certified Nurse Aide (CNA) D said the following:<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/she would instantly report any allegation of resident abuse or neglect to the nurse, the Director of Nursing (DON), or Administrator;<br><br>-The facility must notify DHSS within two hours of any allegation of resident abuse or resident neglect;<br><br>-If someone alleged the facility staff were letting a resident lay there and die, he/she would consider that to be an allegation of neglect and would immediately report the allegation to his/her charge nurse.<br><br>During an interview on 11/14/24, at 4:40 P.M., [NAME] E said the following:<br><br>-Facility staff members were required to immediately report any allegation of resident abuse or neglect to their supervisors;<br><br>-The facility was required to notify DHSS within two hours of any allegation of resident abuse or neglect;<br><br>-If someone accused a facility staff member of letting a resident lay in bed and die, he/she would consider that to be an allegation of neglect and would immediately report that information to his/her supervisor or charge nurse.<br><br>During interviews on 11/14/24, at 4:35 P.M., and 11/15/24, at 2:30 P.M., the Activity Director (AD) said the following:<br><br>-Examples of resident neglect would be staff leaving a resident alone or not tending to a resident's needs;<br><br>-If anyone made an allegation or resident abuse or neglect, he/she would immediately notify the Administrator;<br><br>-The facility was required to notify DHSS within two hours of any allegation of abuse or neglect;<br><br>-If someone accused the staff of allowing a resident to lay there and die, the AD would consider that to be an allegation of neglect and would immediately report to the Administrator;<br><br>-He/she overheard the conversation on 10/14/24 between the Administrator and the visitor in regards to the resident;<br><br>-The visitor accused the facility of neglecting the resident;<br><br>-The facility should have called in the allegation of neglect to within two hours to DHSS.<br><br>During an interview on 11/14/24, at 2:33 P.M., the DON said the following:<br><br>-He/She was unaware of the specifics of the situation with the resident and a visitor who had become involved in his/her care;<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She would be concerned of an allegation of the facility letting a resident lay in bed and die;<br><br>-He/She could see how an allegation of this nature would be considered an allegation of possible neglect;<br><br>-Staff should notify DHSS within two hours with any allegation or resident abuse or neglect.<br><br>During an interview on 11/14/24, at 3:13 P.M., the Administrator said the following:<br><br>-On 10/14/24, at that time he/she did not consider what the visitor said about the resident to be an allegation of abuse or neglect;<br><br>-He/She should have notified DHSS of the possible allegation;<br><br>-The facility was required to notify DHSS of any allegation of abuse or neglect within two hours;<br><br>-He/she did not notify DHSS of the allegation of neglect.<br><br>MO00243241 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906<br><br>Based on interviews and record review, the facility failed to ensure all allegations of possible neglect were investigated by the facility and the investigation submitted to the State Survey Agency (Department of Health and Senior Services - DHSS) within five days when a staff member received an allegation of possible neglect of one resident (Resident #1) and the facility failed to complaint a full investigation. The facility census was 43.<br><br>Review of the facility policy titled, Abuse, Prevention, and Prohibition Policy, dated October 2022, showed the following:<br><br>-The facility prohibits mistreatment, neglect, or abuse of residents. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychological wellbeing.<br><br>-The facility Administrator will be designated as the facility Abuse Coordinator and will be responsible for overseeing the Abuse Prevention and Prohibition Program and directing any abuse investigation.<br><br>Investigation.<br><br>-The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. While a facility investigation is under way, steps will be taken to prevent further abuse.<br><br>-Utilize Resident Abuse Investigation Forms for completing investigation;<br><br>-A licensed professional nurse will assess the resident for signs of injury and notify the resident's physician and responsible party of any injuries noted;<br><br>-Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing a questionnaire and statements if indicated that will be attached to the Abuse Investigation Format;<br><br>-Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift, all staff for the identified shift only will complete a questionnaire and complete a statement if indicated;<br><br>-Interview the resident if they are cognitively able to answer questions in private setting free from any intimidating factors;<br><br>-Complete the investigative summary and statements within five business days;<br><br>-Neglect means failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1. Review of the Resident #1's face sheet showed the following:<br><br>-admitted [DATE];<br><br>-Diagnoses included acute kidney failure (AKF), severe dementia with agitation, repeated falls, need for assistance with personal cares, and weakness.<br><br>Review of the resident's admission Minimum Data Set (MDS - a federally mandated, comprehensive assessment tool completed by facility staff), dated 07/22/24, showed the following:<br><br>-Severely cognitively impaired;<br><br>-Required set up or clean up assistance of staff with eating;<br><br>-Dependent on staff for toileting hygiene, personal hygiene, mobility, and transfers;<br><br>-Required substantial or maximum assistance of staff for showers.<br><br>Review of the resident's progress note dated 10/14/24, at 9:45 A.M., showed the facility Administrator documented the following:<br><br>-A visitor said the Administrator was letting the resident die. The resident had lost 25% of his/her body weight and the Administrator was fine with the resident lying in bed, dying. The Administrator asked the visitor how he/she knew the resident's weight. The visitor said he/she saw the resident when entering the facility to pick up other residents. The Administrator informed the visitor per the request of the resident's durable power of attorney (DPOA), the visitor should not seek out the resident while in the facility. The visitor said he/she saw the resident while he/she was in the facility conducting business. The visitor stated that on the previous day, 11/13/24, the resident had food on his/her clothes and was dirty. The visitor again told the Administrator that he/she (the Administrator) was just going to let the resident lay in bed and die. The Administrator told the visitor that their conversation was over and he/she did not appreciate what the visitor was accusing the Administrator of and that any further information needed, he/she would need to get the information from the DPOA, from Adult Protective Services (APS), or he/she could hire a lawyer and file for guardianship. After the visitor left, he/she went to the resident's room. The resident was resting in bed. The Administrator had assisted the resident back to his/her room after breakfast and he/she was doing fine. The resident had fresh ice water and snacks available on his/her overbed table. The Activity Director was present during the conversation.<br><br>Review of facility records showed the facility did not provide documentation of a full investigation completed regarding the allegation of neglect.<br><br>Review of DHSS records showed an investigation report related to the allegations of neglect was not received.<br><br>During an interview on 11/14/24, at 4:30 P.M., Certified Nurse Aide (CNA) D said if someone alleged the facility staff were letting a resident lay there and die, he/she would consider that to be an allegation of neglect and would immediately report the allegation to his/her charge nurse.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/14/25, at 4:40 P.M., [NAME] E said if someone accused a facility staff member of letting a resident lay in bed and die, he/she would consider that to be an allegation of neglect and would immediately report that information to his/her supervisor or charge nurse.<br><br>During an interview on 11/14/24, at 4:35 P.M., the Activity Director (AD) said the following:<br><br>-Examples of resident neglect would be staff leaving a resident alone or not tending to a resident's needs;<br><br>-If anyone made an allegation or resident abuse or neglect, he/she would immediately notify the Administrator;<br><br>-If someone accused the staff of allowing a resident to lay there and die, the AD would consider that to be an allegation of neglect and would immediately report to the Administrator.<br><br>During an interview on 11/14/24, at 2:33 P.M., the Director of Nursing (DON) said the following:<br><br>-He/She was unaware of the specifics of the situation with the resident and a visitor who had become involved in his/her care;<br><br>-He/She would be concerned of an allegation of the facility letting a resident lay in bed and die;<br><br>-He/She could see how an allegation of this nature would be considered an allegation of possible neglect;<br><br>-The Administrator is in charge of investigating allegations of resident abuse or neglect.<br><br>During an interview on 11/14/24, at 3:13 P.M., the Administrator said the following:<br><br>-He/she was responsible for facility abuse/neglect investigations;<br><br>-He/she had five days to investigate allegations of resident abuse/neglect and submit the completed investigations;<br><br>-On 10/14/24, at that time he/she did not consider what the visitor said about the resident to be an allegation of abuse or neglect;<br><br>-After the visitors left, he/she went to the resident's room to check on the resident;<br><br>-He/she did not conduct a full investigation of the allegation;<br><br>-He/she did not interview other residents or staff about the allegations of resident neglect.<br><br>MO00243241 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540<br><br>Based on observation, interview, and record review, the facility failed to develop complete a person centered care plan for each resident when staff failed to care plan related to side rails use for one resident (Resident #13) and wandering/elopement risks for one resident (Resident #36) of 21 sampled residents.<br><br>Review of the facility's Care Planning - Interdisciplinary Team policy, dated January 2017 showed the following:<br><br>-Upon completion of comprehensive assessments care areas of concern will be triggered to be addressed in the plan of care for that resident.<br><br>-Each triggered care area will be reviewed by designated staff to determine if a triggered condition affects the resident's function and quality of life.<br><br>-Staff will document whether or not a care plan is needed to address the triggered area.<br><br>1. Review of the facility policy titled Proper Use of Side Rails, reviewed 02/2021, showed the use of side rails will be addressed in the resident's care plan.<br><br>Review of Resident #13's Admission Record, located in the electronic medical record (EMR) under the Profile tab, showed the following:<br><br>-admitted [DATE];<br><br>-Diagnoses that included history of frequent repeated falls and unsteadiness on feet.<br><br>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 06/16/24, showed the resident was cognitively intact.<br><br>Review of the resident's EMR under the Misc tab, showed the following:<br><br>-Consent for Side Rail Usage, dated 05/24/24, for bilateral (both sides) half side rails to assist with bed mobility and repositioning.<br><br>Review of the resident's EMR, under the Progress Notes tab, a Progress Note,, dated 06/19/24 showed bilateral half side rails continued for mobility assist and repositioning assist while in bed.<br><br>Observation and interview on 09/09/24, at 11:13 A.M., showed the resident in bed with half side rails on both sides of the bed. The resident said the rails were on the bed at his/her request to assist in positioning and support when he/she gets out of bed.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's EMR, under the Care Plan tab, showed staff did not care plan the use of side rails.<br><br>During an interview on 09/12/24, at 11:32 P.M., the MDS Coordinator confirmed staff did not care plan the resident's use of side rails that were installed on 04/21/23. The use of side rails should have been care planned.<br><br>During an interview on 09/12/24, at 12:14 P.M., the Director of Nursing (DON) confirmed residents with side rails should have a care plan for side rails and confirmed the staff did not care plan the resident's use of side rails.<br><br>42440<br><br>2. Review of Resident #36's Admission Record, located in the Profile tab of the EMR, showed the following:<br><br>-admitted [DATE];<br><br>-Diagnoses included Alzheimer's disease.<br><br>Review of the resident's Elopement Assessment - V3, dated on 08/12/24 and located under the Assmnts tab of the EMR, showed the following:<br><br>-At risk for elopement;<br><br>-Interventions included frequent visual monitoring and provided with distracting activity.<br><br>Review of the resident's Behavior Note, dated 08/19/24 and located in the Prog Note tab of the EMR, showed the resident was exit seeking at the end door of 600 hall and required redirection.<br><br>Review of the resident's admission MDS assessment, with an ARD of 08/25/24, located in the resident's EMR under the MDS tab, showed the following:<br><br>-The resident had severely impaired cognition.<br><br>-The resident walked with supervision or touching assistance.<br><br>-The resident had daily wandering behavior and did not utilize a wander/elopement device.<br><br>-The resident had dementia and would get up and wander if not busy. Staff should give resident tasks to do, games to play, magazines to peruse, etc. Family visits also helps keep the resident busy.<br><br>-The behavior CAA stated wandering would be on the Care Plan.<br><br>Review of the resident's Care Plan, located in the resident's EMR under the Care Plan tab of the EMR, showed staff did not care plan regarding the resident's identified wandering and elopement risk.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's Behavior Note, dated 08/27/24 and located in the Prog Note tab of the EMR, showed the resident exited out the door at the end of 300 hall and required redirection.<br><br>During an interview on 09/09/24, at 2:21 P.M., the resident's representative said a couple of weeks ago, facility staff told him/her the resident ,had tried to get out the front door twice in one day.<br><br>During an interview on 09/11/24 at 10:56 A.M., Certified Nurse Aide (CNA) 3 said the resident was confused and had a recent room change so he/she gets turned around needed redirection.<br><br>During an interview on 09/11/24, at 2:01 P.M., the Infection Preventionist (IP) said the resident walked by himself and was confused. On 08/27/24, the resident walked by himself and pushed on the 300-hall door, which alarmed. Staff responded and redirected the resident as he reached the threshold.<br><br>During an interview on 09/12/24, at 11:14 A.M., the MDS Coordinator (MDSC) said the Social Services Director (SSD) completed the Behavior section of the MDS. The MDSC confirmed the resident wandered daily. The MDSC stated the wandering should be care planned.<br><br>During an interview on 09/12/24,at 3:00 P.M., the Director of Nursing (DON) said she expected wandering to be addressed on the Care Plan. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20243<br><br>Based on observation, interview, and record review, the facility failed to ensure an environment as free from accident hazards as possible for all residents when staff failed to evaluate effective of interventions, care plan new interventions, and failed to complete root cause analysis after multiple elopement attempts and combativeness for one of two residents (Resident #22) reviewed for wandering.<br><br>Review of the facility's policy titled Elopement Policy, undated, showed it was the intent of the facility to maintain and enhance a resident's dignity by promoting free access in and around the facility, while safeguarding the well-being of the resident, and to monitor behavior or residents to identify potential elopers, such as excessive wandering, especially to doors.<br><br>1. Review of Resident #22's Admission Record, undated, found under the Profile tab of the electronic medical record (EMR), showed the following:<br><br>-admitted [DATE];<br><br>-Diagnoses included dementia.<br><br>Review of the resident's annual Minimum Data Set (MDS - federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 06/28/24, showed the following:<br><br>-The resident had severe cognitive impairment;<br><br>-The resident experienced delusions, did not exhibit wandering, and used a wheelchair for mobility.<br><br>Review of the resident's Care Plan showed the following:<br><br>-Elopement risk and wanderer;<br><br>-Interventions, initiated on 06/15/23, included to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books;<br><br>-Identify a pattern of wandering;<br><br>-An elopement wandering risk due to dementia and was independently ambulatory and able to propel wheelchair.<br><br>Review of the resident's Progress Notes, found in the EMR under the Progress Notes tab, showed the following:<br><br>-On 06/02/24, the resident exited out the hall side door two times alone. Interventions were that staff redirected and assisted resident back into the facility and offered the resident a snack and drink.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265312 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/12/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Gainesville Nursing | | STREET ADDRESS, CITY, STATE, ZIP CODE 77 Medical Drive Gainesville, MO 65655 | |

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

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -On 07/29/24, the resident exited out 200 hall side door. The aide immediately went out to bring the resident back in. Interventions were therapeutic communication, and redirection, both were ineffective.<br><br>-On 07/30/24, the resident was repeatedly exiting the facility out 200 hall side door unsupervised. Staff assisted the resident back into the facility.<br><br>-On 08/03/24, the resident exited out 200 hall side door several times. The Certified Nursing Aide (CNA) immediately went out to bring the resident back in. The resident was hitting at staff and yelling to leave him/her alone. Staff attempts to redirect were unsuccessful.<br><br>-On 08/07/24, the resident continued to exit seek out of the 200-hall side door. The resident was monitored while he/she was outside in the fenced in area.<br><br>-On 08/21/24, the resident was exiting 200 side door during a non-smoking time.<br><br>-On 08/25/24, the resident exited out the front door while another resident was coming back into the building with family. The nurse was immediately alerted and got the resident. Resident saw nurse coming and began wheeling his/her wheelchair faster while ignoring the nurse. The nurse brought the resident back into the facility.<br><br>-On 08/27/24, the resident was exiting out 200 side door alone. Staff followed the resident out and attempted to redirect and the resident became agitated and tried to evade them. The resident hit a CNA four times. Buspirone (used to treat anxiety) was increased on 08/07/24 and has not seemed to help with behaviors.<br><br>-On 08/27/24, the resident exited out 200 hall side door, again. Resident agitated and combative. Staff redirected resident back into facility.<br><br>-On 08/29/24, the resident attempted to exit 200 hall side door unsuccessfully once this evening, but the staff caught and redirected.<br><br>-On 09/10/24, the resident was found several times trying to enter the nursing staff's break room and has now figured out how to unlock the break room door with the nearby key. The resident went around the dining room during supper touching and moving around several other resident's plates and food. The resident found throwing away several plastic cups in the dining room that are used for hot beverages. The resident was redirected several times and therapeutic communication was tried unsuccessfully. The physician was notified and the resident was transferred to a behavioral unit for evaluation and treatment.<br><br>Review of the resident's Elopement Assessment, dated 09/10/24, showed the resident was at risk for elopement, did not have a history of elopement, did have a desire to leave the facility, exit seeking with a purpose, and wandering activity.<br><br>Observation on 09/10/24, at 11:20 A.M., showed hall 200 had two exit doors, one at the end of the hall and one exit door on the right side of the hall exiting to a patio, flower/vegetable garden, and smoking area. The area was fenced from the end of hall 200 exit door to the corner of hall 300. The area had closed gates that were unlocked.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's medical record showed staff did not update the care plan with new interventions after the multiple elopement attempts and did not complete a root cause analysis to determine the cause of elopements and steps to be take to deter the elopement behaviors.<br><br>During an interview on 09/10/24, at 11:20 A.M., the Director of Nursing (DON) said the gates were not locked for emergency purposes. The DON confirmed the resident had not had an elopement assessment completed since June of 2024 until 09/10/24.<br><br>During an interview on 09/10/24, at 2:57 P.M., Registered Nurse (RN) 1 said that the staff keep an eye on the resident. RN 1 said that when the staff hear the alarm, they can check the monitor and know which door to go to.<br><br>During an interview on 09/10/24, at 3:06 P.M., RN 2 said all staff monitor the resident and that when the alarm sounds, they check the appropriate door.<br><br>During an interview on 09/11/24, at 10:13 A.M., the DON said a root cause analysis for the resident's exit seeking and successfully getting out hall 200 side door had not been done. When asked if the concern regarding the resident's increased wandering had been discussed in Quality Assurance, the DON stated no.<br><br>During an interview on 09/12/24,.at 2:30 P.M., with the DON and the Administrator, the DON said his/her expectations for successful supervision in the future would mean that the resident's behaviors would have to be under control. The DON said that her hope was that the cause of the resident's exacerbation of exit seeking, wandering, aggression and combativeness could be determined and treated. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>39540<br><br>Based on observation and interview, the facility failed to ensure food prepared by the facility was palatable when residents complained the food was served cold at times, the food lacked flavor/seasoning, and the meat was tough at times.<br><br>1. Observations and interview on 09/11/24, at 1:07 P.M., showed the following:<br><br>-The Dietary Manager (DM) confirmed testing the food on the last (test) tray on the cart. Prior to leaving the kitchen the temperature of the cheesy rice casserole was 120 degrees Fahrenheit (F); pork chop was 125 degrees F; and the broccoli was 115 degrees F.<br><br>-When the tray was presented after the last tray was delivered, the casserole was 110 degrees F, the pork chop was 95 degrees F, and the broccoli was 90 degrees F.<br><br>-The DM said the food was cool and should have been warmer to be palatable for the residents.<br><br>Interviews during the Resident Council Meeting on 09/11/24, at 9:15 A.M., showed the residents said the food was cold for the residents who eat in their rooms. The pancakes that morning were cold. The prior night (09/10/24) the menu said burrito with beans/rice, but what was served was tortilla chips with meat on top and unmelted cheese on the meat. The orange Jell-O was not set and watery.<br><br>During an interview on 09/09/24, at 3:42 P.M., Resident #35 said the food was not good and was overcooked. The staff overcook the meat. The breakfast was good, just cold. The oatmeal was served without butter or brown sugar.<br><br>During an interview on 09/09/24, at 12:02 P.M., Resident #39 said the food did not always taste good. He/she had no teeth so sometimes he/she just threw the food away when he/she could not chew it.<br><br>During an interview on 09/11/24, at 2:05 P.M., Resident #38 said the pork chop for lunch that day was tough and dry.<br><br>During an interview on 09/11/24, at 2:05 P.M., Resident #20 said the food lacked seasoning. The pork chops were tough and hard to cut and chew.<br><br>During an interview on 09/10/24, at 9:37 A.M., Resident #40 said the food had no taste. The pork chops were tough and not easy to chew.<br><br>During an interview on 09/12/24, at 10:10 A.M., Resident #4 said the pork chop for yesterday's lunch was hard and not easy to chew. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540<br><br>Based on observation, interview, and record review, the facility failed to ensure all food was prepared in a form designed to meet the needs of each resident when the facility failed to cut up meat as ordered for one resident (Resident #17).<br><br>Review of the facility policy titled Menus and Food Preparation-Nutrition Services, revised January 2018, showed the purpose of the policy was to ensure resident nutritional needs are met in conjunction with resident preferences.<br><br>1. Review of Resident #17'sAdmission Record, located in the electronic medical record (EMR) under the Profile tab, showed the following:<br><br>-admitted [DATE];<br><br>-Readmitted [DATE];<br><br>-Diagnoses included gastroesophageal reflux disease.<br><br>Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 07/23/24, showed the resident was cognitively intact.<br><br>Review of the resident's Orders tab in the EMR showed a physician's order, dated 07/18/24, for regular texture, regular consistency diet with no gravy and meats to be cut small.<br><br>Review of the resident's Tray Card, printed daily by the kitchen, showed staff did not update the care to show instruction to cut up meat or to not serve gravy.<br><br>During an observation on 09/11/24, at 12:00 P.M., of lunch tray line (preparing the trays of food for the residents) the menu included pork chops. The resident's tray was served with a whole pork chop (not cut up).<br><br>During an interview on 09/11/24, at 2:00 P.M., the resident said I could not cut the meat, so I did not eat it.<br><br>During an interview on 09/11/24, at 11:10 A.M., the Director of Nursing (DON) said when a change to a diet is made by the physician, a copy of the change is given to the Dietary Manager (DM) for implementation.<br><br>During an interview on 09/12/24, at 2:15 P.M., the DON said the paperwork for the change in diet for the resident was not communicated to the DM. |