

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Community Springs Healthcare Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 400 East Hospital Road El Dorado Springs, MO 64744	

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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22411</p> <p>Based on interview and record review, the facility failed to support each resident's right to self-determination related to care when staff failed to care plan and provide showers per residents' preference for three residents (Resident #3, #28, and #6).</p> <p>Review of the facility's policy titled, Personal Hygiene, revised 03/2023, showed the following:</p> <ul style="list-style-type: none"> -Purpose to establish guidelines for ensuring the hygiene needs of residents are addressed and met; -Purpose to identify the roles of the nursing staff and the patients in maintaining the patients' and residents' personal hygiene; -Staff are to assist with personal hygiene tasks as patients need; -If a patient is unable to care for self, nursing staff will provide full assist with bathing, changing clothing, oral care and other needs; -Patients are expected to shower at two-day intervals or more frequently when requested or required, maintain dental hygiene, wear clean clothes, and take care of personal grooming. <p>1. Review of Resident #3's Patient Information, showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included of bipolar II disorder (a chronic mental health condition characterized by alternating episodes of hypomania (elevated mood) and major depression). <p>Review of the resident's current Care Plan showed staff to encourage/remind resident to request assistance.</p> <p>(Staff did not care plant related to the resident's preferred bathing frequency preference.)</p> <p>Review of the resident's Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), with an assessment reference date (ARD) of 10/22/24, showed the following:</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident was cognitively intact;</p> <p>-Resident required use of a walker;</p> <p>-Resident required partial to moderate assistance with shower/bath.</p> <p>Review of the resident's shower sheets, dated October 2024 through January 2025, showed the resident did not receive scheduled showers on the following dates:</p> <p>-On 10/17/24;</p> <p>-On 10/25/24;</p> <p>-On 11/01/24;</p> <p>-On 11/04/24;</p> <p>-On 11/14/24;</p> <p>-On 12/02/24;</p> <p>-On 12/23/24.</p> <p>During an interview on 01/02/25, at 3:02 P.M., the resident said staff seemed to not be able to keep up with showers. Sometimes he/she would go a week or so and not get a shower because there was no one to assist with showers. Residents are supposed to get two showers a week.</p> <p>2. Review of Resident #6's Patient Information showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included acute and chronic respiratory failure with hypoxia (a condition where there is an inadequate supply of oxygen to the body's tissues).</p> <p>Review of the resident's current Care Plan showed the following:</p> <p>-Resident required partial to substantial assistance with my activities of daily living (ADL) and transfers related to weakness;</p> <p>-Resident required substantial assistance with showers. Staff to encourage resident to actively participate.</p> <p>(Staff did not care plan related to the resident's preferred bathing frequency preference.)</p> <p>Review of the resident's quarterly MDS, with an ARD of 10/02/24, showed the following:</p> <p>-Resident was cognitively intact;</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident required substantial/maximal assistance with showers.</p> <p>Review of the resident's shower sheets, dated October 2024 through December 2024, showed the resident did no received showers on the following scheduled days:</p> <p>-On 10/05/24;</p> <p>-On 11/16/24;</p> <p>-On 12/29/24.</p> <p>During an interview on 01/02/25, at 3:02 P.M., the resident said residents should not have to wait to get showers. Resident are supposed to get showers two times a week and they are not providing residents with the showers.</p> <p>3. Review of Resident #28's Patient Information showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included urinary tract infection, morbid (severe) obesity, dementia, and anxiety.</p> <p>Review of the resident's current Care Plan showed the following:</p> <p>-Resident required partial assistance with showers;</p> <p>-Staff to encourage resident to shower self and encourage independence.</p> <p>(Staff did not care plant related to the resident's preferred bathing frequency preference.)</p> <p>Review of the resident's quarterly MDS, with an ARD of 11/21/24, showed the following:</p> <p>-The resident was cognitively intact;</p> <p>-The resident required substantial/maximal assistance for showers.</p> <p>Review of the resident's shower sheets, dated October 2024 to December 2024, showed the resident did not get scheduled showers on the following days:</p> <p>-On 10/01/24;</p> <p>-On 10/15/24;</p> <p>-On 11/26/24.</p> <p>During an Interview on 01/01/25, at 4:51 P.M., the resident said residents are scheduled to receive showers twice per week. However, these showers often do not occur due to insufficient staff available to provide assistance. The facility attempts to schedule additional staff specifically for shower days, but this fails as well. The resident felt showers were needed more than twice weekly.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During an interview on 01/02/25, at 4:39 P.M., CNA 9 said there were different people designated as shower aides that handle nothing but showers. CNA 9 has helped with resident showers when the shower aide called off. Sometimes residents do not get shower like they are supposed to.</p> <p>5. During an interview on 01/03/25, at 1:06 P.M., CNA 8 said there were issues with residents getting showers. Sometimes the shower aides have to be pulled off showers to help on the floor. They have make-up days where extra staff are called in the help with showers.</p> <p>6. During an interview on 01/02/25, at 5:53 P.M., with the Director of Nursing (DON) and Staff Development Coordinator (SDC), the SDC said the facility had shower aides, but if a CNA calls off they will have to pull the shower aide to assist on the floor. Management is aware of the issue of residents not getting showers. Staff try to accommodate the resident as much as possible with getting their showers. The DON said staff always try to accommodate residents with showers, by providing them in the evening or the next day.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679</p> <p>Based on interview and record review, the facility failed to ensure all allegations of possible abuse were reported to the State Survey Agency (SSA - Department of Health and Senior Services (DHSS)) within two hours when staff failed to report an allegation of possible sexual abuse by one resident (Resident #37).</p> <p>Review of the facility policy titled, Patient Abuse/Neglect, Elder Abuse, and Persons with Disability Abuse, dated 08/2024, showed the following:</p> <ul style="list-style-type: none"> -Purpose to guide staff, employees, physicians, and any mandated reporter in identifying victims of abuse and provide a reporting mechanism in accordance with all local, state and federal laws; -Purpose to provide safe and efficient care for the patients/residents; -Purpose to keep patients/residents free from abuse, mistreatment, and neglect. <p>1. Review of Resident #37's Patient Information showed the following:</p> <ul style="list-style-type: none"> -An admitted [DATE]; -Diagnoses included dementia and agitation. <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 11/07/24, showed the following:</p> <ul style="list-style-type: none"> -The resident had severe cognitive impairment; -The resident had verbal behaviors directed to others which occurred one to three times during the assessment period. <p>Review of a the resident's Behavior Monitoring, dated 12/28/24, showed the resident asked another resident to expose his/her breasts.</p> <p>Review of DHSS records showed the facility did not report the allegation of possible resident to resident abuse.</p> <p>During an interview on 01/01/25, at 6:04 P.M., Registered Medication Technician (RMT) 1 confirmed she saw the resident make the comment to another resident to expose his/her breasts. He/she immediately reported the incident to Registered Nurse (RN) 1. All potential allegations of abuse were to be reported immediately.</p> <p>During an interview on 01/01/25, at 6:38 P.M., RN 1 confirmed he/she did not inform the facility's abuse coordinator of the potential sexual abuse from between the residents.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/01/25, at 4:28 P.M., the Minimum Data Set Coordinator (MDSC) said the resident asked another resident to expose his/her breasts on 12/28/24.</p> <p>During an interview on 01/01/25, at 5:03 P.M., Director of Social Work (DSW) confirmed she was the facility's abuse coordinator. She learned of the allegation of potential sexual abuse from Resident #37 towards another resident during the facility's morning meeting on 12/30/24. She did not report the allegation to the SSA.</p> <p>During an interview on 01/02/25, at 7:46 A.M., the Director of Nursing (DON) said all allegations of abuse were to be reported immediately to the abuse coordinator.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679</p> <p>Based on record review and interview, the facility failed to ensure all allegations possible abuse had documented complete investigations when staff failed to document a full investigation of an allegation of possible abuse by one resident (Resident #37).</p> <p>Review of a facility policy titled Patient Abuse/Neglect, Elder Abuse, and Persons with Disability Abuse, dated 08/2024, showed the following:</p> <p>-Personnel will complete an electronic Incident Report for further investigation by the designee(s), nursing administration, the Administrator, and/or other disciplines within the facility or outside to ensure resident safety and quality of care.</p> <p>1. Review of Resident #37's Patient Information showed the following:</p> <p>-An admitted [DATE];</p> <p>-Diagnoses included dementia and agitation.</p> <p>Review of a the resident's Behavior Monitoring, dated 12/28/24, showed the resident asked another resident to expose his/her breasts.</p> <p>Review of Department of Health and Senior Services (DHSS) records showed a written investigation regarding the allegation of possible abuse was not received.</p> <p>During an interview on 01/01/25, at 6:04 P.M., Registered Medication Technician (RMT) confirmed he/she observed the statement from Resident #37. He/she was not asked to provide a written statement by the abuse coordinator.</p> <p>During an interview on 01/01/25, at 6:21 P.M., the Director of Nursing (DON) said during a potential abuse investigation, witness statements should be gathered.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690</p> <p>Based on record review and interview, the facility failed to ensure the accuracy of all Minimum Data Sets (MDS - a federally mandated assessment completed by facility staff) when staff failed to accurately complete one resident's (Resident #56) MDS.</p> <p>Review of the RAI Manual, dated October 2023 showed the following:</p> <ul style="list-style-type: none"> -Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions; -The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider. <p>1. Review of Resident #56's Patient Information, showed the following:</p> <ul style="list-style-type: none"> -An admitted [DATE]; -Diagnoses included Alzheimer's disease. <p>Review of the resident's quarterly MDS, with an assessment reference date (ARD) of 12/12/24, showed the following:</p> <ul style="list-style-type: none"> -The resident had cognitive impairment; -The resident independent with all activities of daily living (ADL); -The resident received hospice care. <p>Review of the resident's medical record showed staff did not document recommendations for hospice care.</p> <p>During an interview on 01/02/25, at 7:52 A.M., with the MDS Coordinator (MDSC) and the Director of Nursing (DON), the MDSC said the resident's MDS indicated that the resident received hospice services, which was the same as palliative care. She said since hospice and palliative care are similar and Section O of the MDS should be selected. The MDSC staid the MDS should be accurate. The DON said the MDS should be accurate.</p> <p>During an interview on 01/02/25, at 8:13 A.M., the Clinical Services Nursing Administration (CSNA) said Section O in the MDS should not be triggered under hospice care if the resident is receiving palliative care only.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679</p> <p>Based on observation, interview, and record review, the facility failed to develop a person-centered comprehensive plan of care with measurable goals and plans for one resident (Resident #57) related to the resident taking antidepressant and an anti-anxiety medication.</p> <p>Review of the Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) 3.0 Resident Assessment Instrument (RAI) Manual, dated 10/2024, showed the following:</p> <ul style="list-style-type: none"> -The RAI process, which includes the federally mandated MDS, is the basis for an accurate assessment of nursing home residents; -The MDS information and the CAA (Care Area Assessment) process provide the foundation upon which the care plan is formulated; -There are 20 problem-oriented CAAs, each of which includes MDS-based trigger conditions that signal the need for additional assessment and review of the triggered care area; -Detailed information regarding each care area and the CAA process, including definitions and triggers; -After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems; -Subsequently, the IDT (Interdisciplinary Team) must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths, problems, and needs. <p>1. Review of Resident #57's Patient Information showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included dementia. <p>Review of the resident's annual MDS, with an Assessment Reference Date (ARD) of 09/02/24, showed the following:</p> <ul style="list-style-type: none"> -The resident had severe cognitive impairment; -The resident had no behavior directed to self or to others; -The resident had depression and anxiety; -The assessment indicated the resident received an antidepressant and an anti-anxiety; <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Under the CAA, the resident triggered for the use of psychotropic medications and directed the staff to develop a care plan.</p> <p>Review of a the resident's current Care Plan showed staff did not care plan the resident's use of antidepressant and anti-anxiety medications.</p> <p>During an interview on 01/03/25, at 8:39 A.M., the MDS Coordinator (MDSC) confirmed she did not develop a care plan for the resident and the use of antidepressant and anti-anxiety medications. The MDSC confirmed the resident received medications for depression and anxiety during the assessment period.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679</p> <p>Based on record review and interview, the facility failed to ensure each resident's care plan was updated and review for accuracy timely when the care plans of five residents (Resident #37, #31, #33, #10, and #26) were not updated to reflect the residents' current conditions.</p> <p>Review of a facility's policy titled, Assessments in Long Term Care. dated 12/2024, showed the following:</p> <ul style="list-style-type: none"> -The nursing care plan will be initiated according to identified needs from the admission assessment by a licensed nurse; -Licensed nursing personnel will update care plans as needs are assessed; -The dietitian, social worker, and rehabilitation personnel can assess patients, within the scope of their service and will integrate information into the medical record and assist in identifying and assigning priorities for the resident care needs via the care plan and progress notes. <p>1. Review of Resident 37's Patient Information showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included dementia. <p>Review of the resident's Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an Assessment Reference Date (ARD) of 08/15/24, showed the following:</p> <ul style="list-style-type: none"> -Staff could not determine a cognitive assessment score for the resident; -The resident had both physical and verbal behaviors directed to self and to others. <p>Review of the resident's Behavior Monitoring, dated 08/20/24, showed the resident grabbed the breast of a certified nurse aide (CNA).</p> <p>Review of the resident's Nurse Note, dated 08/21/24, showed the resident told a CNA that he/she had nice tits and attempted to grab his/her buttocks.</p> <p>Review of the resident's Nurse Note, dated 08/23/24, showed the nurse documented the resident made sexual advances to the nursing staff.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's Behavior Monitoring, dated 09/14/24, showed while being changed by a CNA, the resident pulled the CNA's smock down and looked down his/her shirt.</p> <p>Review of the resident's Social Service Note, dated 11/07/24, showed the Director of Social Services (DSS) noted the resident would yell at the staff.</p> <p>Review of the resident's Nurse Note, dated 11/25/24, showed the resident had his/her hands around the throat of a staff member (trainee) and refused to receive care by a CNA.</p> <p>Review of the resident's current Care Plan showed staff failed to care plan the resident's verbal, physical, and sexual behaviors towards staff.</p> <p>During an interview on 01/01/25, at 5:03 P.M., the Director of Social Work (DSW) said there was no care plan in place that addressed the resident's sexual behaviors.</p> <p>During an interview on 01/01/25, at 6:21 P.M., the Director of Nursing (DON) confirmed there were no care plans in place for the resident that addressed his/her sexual behavior towards the staff.</p> <p>2. Review of Resident #31's Patient Information, showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included dementia. <p>Review of a the resident's MDS, with an ARD of 11/11/24, showed the following:</p> <ul style="list-style-type: none"> -The resident had moderate cognitive impairment; -The resident had no physical or verbal behaviors directed to others. <p>Review of the resident's Behavior Monitoring, dated 11/17/24, showed the resident admitted to a CNA that he/she was looking down in his/her shirt and then said his/her wallet did not contain condoms.</p> <p>Review of the resident's Behavior Monitoring, dated 11/30/24, showed the resident touched the cheek of a CNA and told the CNA he/she loved him/her and then asked that the CNA lay with him/her.</p> <p>Review of the resident's Behavior Monitoring, dated 12/01/24. showed the resident attempted to grab a CNA and made sexual comments to the CNA while the CNA provided the resident with a shower.</p> <p>Review of a the resident's current Care Plan, showed staff did not are plan related to the resident's sexual behaviors towards staff.</p> <p>During an interview on 01/01/25, at 5:03 P.M., the DSW said there was no care plan in place that addressed the resident's sexual behaviors.</p> <p>During an interview on 01/01/25, at 6:21 P.M., the DON confirmed there were no care plans in place for the resident that addressed his/her sexual behavior towards the staff.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review Resident #33's Patient Information, showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included of post-traumatic stress disorder (PTSD - a mental health condition that's caused by an extremely stressful or terrifying event).</p> <p>Review of the resident's admission MDS, with an ARD of 08/19/24, showed the resident was cognitively intact.</p> <p>During an interview on 12/31/24, at 10:29 A.M., the resident confirmed his/her diagnosis of PTSD and said he/she had triggers from former abuse and the triggers included yelling, slamming doors, and the tone of a person's voice.</p> <p>Review the resident's current Care Plan showed staff did not care plan regarding the resident's PTSD diagnosis or associated triggers.</p> <p>During an interview on 01/03/25, at 9:41 A.M., the DON said she was not aware the resident's PTSD triggers were not incorporated into her care plan. She would have expected staff to place this information in the resident's care plan to make it individualized.</p> <p>4. Review of Resident #10's Admission Record showed the following:</p> <p>-An admitted [DATE];</p> <p>-Diagnoses included acute and chronic respiratory failure and secondary malignant neoplasm (cancer) of left lung.</p> <p>Review of the resident's Physician Order, dated 12/04/24, showed an order for oxygen at 5 liters (L). Staff may titrate up to 10 L via nasal cannula continuous and may switch over to mask, if needed.</p> <p>Review of the resident's Care Plan, dated 12/15/24, showed the resident was at risk for ineffective breathing pattern. Staff did not care plan the resident's oxygen usage.</p> <p>5. Review of Resident #26's Admission Record showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included heart failure and cerebral vascular accident (stroke).</p> <p>Review of the resident's Physician Order, dated 05/19/20, showed an order for oxygen at 2 L via nasal cannula intermittent. Staff may titrate to keep blood oxygen levels greater than 90%.</p> <p>Review of the resident's Care Plan, dated 10/25/24, showed a history of congestive heart failure and shortness of air. Staff did not care plan the resident's oxygen usage.</p> <p>During an Interview on 01/01/25, at 4:09 P.M., the MDS Coordinator (MDSC) said the resident's oxygen usage was not care planned.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>39857</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690</p> <p>Based on record review and interviews, the facility failed to ensure services were provided per standards of practice for all residents when staff failed to document timely follow-up regarding a possible bruise and failed document regarding resident's wishes to have an area removed for one resident (Resident #5).</p> <p>1. Review of Resident #5's Patient Information, showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included urinary tract infection. <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), with an assessment reference date (ARD) of 11/20/24, showed the following:</p> <ul style="list-style-type: none"> -The resident had cognitively impairment; -The resident required moderate assistance with dressing and toileting and setup with eating and oral hygiene; -The resident had no other skin problems present and did have a pressure reducing device for his/her bed. <p>Review of the resident's Nurse Note, dated 11/22/24, showed upon resident return to facility from outing the family reported several concerns. The resident had a bruise on the back of his/her head that looked fresh with no yellow or green colors to it. This was noticed by hairdresser at hair appointment.</p> <p>Review of the resident's Nurse Note, dated 01/02/25, showed the resident had a soft knot on top of the posterior head of his/her head that was not discolored and non-tender. The resident said he/she had it forever and was asking to have it removed.</p> <p>Review of resident's current Care Plan showed staff did not document relating to the resident's soft knot on the resident's head.</p> <p>During an interview on 01/01/25, at 4:48 P.M., the MDS Coordinator (MDSC) said she reviewed all nurse notes prior to the daily stand-up meeting. She remembered seeing the note and mentioning it during their morning stand-up meeting. She said the resident's skin should have been checked after this was discussed in the meeting.</p> <p>During on interview on 01/02/24, at 8:32 A.M., the Infection Preventionist 1 (IP1) said the note written on 11/22/24 was incorrect. It was not a bruise, but a raised soft area. He/She assessed it the day after the note was written, but he/she did not document his/her assessment. He/she said when he/she assessed it the resident told him/her he/she had it a long time and wanted it removed.</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 01/03/25, at 8: 37 A.M., the Director of Social Services (DSS) said it was discussed in their daily stand-up meeting. The next day she remembered IP 1 saying he/she would assess the resident's head.</p> <p>During an interview 01/03/25, at 8:55 A.M., Certified Nurse Aide (CNA) 7 said she would report a bruise to the charge nurse if she saw one.</p> <p>During an interview 01/03/25, at 11:35 A.M., IP 2 said normally he/she would be notified by the CNA if they saw a bruise and he/she would assess it, inform the Director of Nursing (DON) and notify the resident's physician.</p>		