

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER Maranatha Village, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 233 East Norton Road Springfield, MO 65803	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599</p> <p>Based on observation, interviews, and record review, the facility failed to protect the dignity of all residents when the facility failed to respect one resident's (Resident #50) preference to help with nighttime care and when staff failed to protect one resident's (Resident #39) health information from public viewing. A sample of 33 residents was reviewed in a home with a census of 85.</p> <p>Review of the facility's policy titled, Dignity, dated 02/21, showed the following:</p> <ul style="list-style-type: none"> -Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem; -Residents are treated with dignity, and respect at all times; -The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's facility stay; -Staff protect confidential clinical information. The resident's clinical status or care needs are not openly posted in the resident's room unless specifically requested by the resident or family member. Discreet posting of important clinical information for safety reasons is permissible. <p>1. Review of Resident #50's Face Sheet located in the electronic medical record (EMR) under the Clinical tab, showed the following:</p> <ul style="list-style-type: none"> -Readmitted [DATE]; -Diagnoses included monoplegia (paralysis limited to a single limb) of upper limb following cerebral infarction (stroke) affecting left side and other sequelae (condition which is the consequence of a previous disease or injury) of cerebral infarction. <p>Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff) with an Assessment Reference date of 02/01/24, located in the EMR under the RAI tab, showed the resident was cognitively intact.</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>During an observation and interview on 04/16/24, at 11:00 AM, the resident said the night Certified Nurse Aide (CNA) #3 is uncouth, treats the resident in an undignified manner when changing the resident's brief at night. The resident said CNA #3 barges in and yells at the resident to roll over. The resident said he/she didn't like that the CNA rolled him/her so close to the bed. The resident feels like he/she is going to fall when that happens. The resident has asked CNA #3 not to do that and he/she does it anyway. The resident became teary in the interview and said, CNA #3 just doesn't like me.</p> <p>During an interview on 04/17/24, at 7:40 P.M., the resident's Family Member (FM) #1 confirmed the resident's comments stating, I'm surprised he/she told you about this. He/she is a very good reason and will not complain as that is not his/her belief. FM #1 said he/she can always tell when CNA #3 has taken care of the resident. The resident is very upset and says he/she hasn't slept all night and feels like he/she is going to fall off the bed. FM #1 does not like to see the resident upset. FM #1 said he/she was going to bring up the concern at the next care conference in May. He/she and the resident had brought up the concern to the nursing staff, but could not remember who as it had been going on for a while.</p> <p>During an interview on 04/18/24, at 10:39 A.M., the Administrator and the Director of Nurses (DON) said they did not have knowledge of the concern.</p> <p>During an interview on 04/18/24, at 10:50 P.M., CNA #3 said he/he worked on the night shift on the 100 hall and would answer a call light on the 200 hall if the other CNAs were busy. CNA #3 confirmed that he/she had cared for the resident many times and that the resident will say don't roll me too close to the edge and I tell him I'm right here, I won't let you fall. CNA #3 denied providing care to the resident in another way to help alleviate his/her fear of falling off the bed.</p> <p>During an interview on 04/18/24, at 6:02 P.M., the DON said the resident did not want CNA #3 to care for him/her any longer, even if he/she was restrained.</p> <p>During an interview on 04/19/24, at 10:50 A.M., the resident said CNA #3 only wanted to do it his/her way and not allow the resident to help with lifting him/herself up.</p> <p>2. Review of Resident #39's Profile located in the EMR under the Clinical tab, showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included acute and chronic respiratory failure with hypoxia (low levels of oxygen in body tissues), acute and chronic respiratory failure with hypercapnia (high levels of carbon dioxide in the blood), and acute kidney failure; -The resident was placed on Hospice care on 03/18/24. <p>Review of the resident's significant change MDS with an ARD of 03/26/24, showed the resident was severely cognitively impaired.</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>Observations of the resident's room on 04/16/24, at 10:47 A.M., 04/18/24, at 10:20 A.M., and on 04/18/24, at 3:00 P.M., showed a sign on the outside of the door that read 1800 fluid restriction. The sign was visible to other residents, staff, and visitors utilizing the hallway where the resident resided.</p> <p>During an interview on 04/18/24, at 9:03 A.M., in reference to the fluid restriction sign on the door, the resident said, I don't know what it means, no one's told me, I don't ask.</p> <p>During an interview on 04/18/24 at 10:25 A.M., with the unit charge nurse Licensed Practical Nurse (LPN) #5 confirmed that the sign, 1800 fluid restriction, was on the outside of the resident's door. LPN #5 said that's a HIPPA (Health Insurance Portability and Accountability Act of 1996) violation and maybe the MDS Coordinator put the sign up.</p> <p>During an interview on 04/18/24, at 10:36 A.M., the MDS Coordinator (MDSC) #1 said, It shouldn't be on the outside of the door.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824</p> <p>Based on interview and record review, the facility failed to provide the resident and/or responsible party (RP) information regarding a Bed Hold for three residents (Resident #30, #50, and #67) of a sample of three residents reviewed for hospitalizations of 33 sampled residents. The facility census was 85.</p> <p>Review of the facility's policy titled, Bed Hold Policy, undated, showed the following:</p> <ul style="list-style-type: none"> -The resident and/or responsible party will be held responsible for 75% of the daily room rate should they wish to reserve their room while in the hospital; -The nursing home has an obligation to inform the resident or the responsible person that is paying them to hold a bed is voluntary; -When a resident is transferred to a hospital, the nursing home is required both by federal statute and by federal regulation, to readmit the resident immediately upon the first availability of a bed in a semiprivate room should the resident choose not to do a bed hold. <p>Review of the facility's policy titled, Bed-Holds and Returns, revised 10/22, showed the following:</p> <ul style="list-style-type: none"> -Residents and/or representatives are informed in writing of the facility and state (if applicable) bed-hold policies; -All residents/representatives are provided written information regarding the facility and state bed-hold policies which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave); -Residents, regardless of payor source, are provided written notice about these policies at least twice including well in advance of any transfer and at the time of transfer or, if the transfer was an emergency, within 24 hours; -The written bed-hold notices provided to the resident/representatives explain in detail the duration of the state bed-hold policy, the reserve bed payment policy, the facility policy regarding bed-hold periods, and the facility per-diem rate required to hold a bed. <p>1. Review of Resident #30's Admission Record located in the electronic medical record (EMR) under the Admission tab, showed an admitted [DATE].</p> <p>Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), with an Assessment Reference Date (ARD) of 03/07/24, showed revealed the resident was severely cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's Progress Notes located in the EMR under the Progress Notes tab showed the resident was discharged to the hospital on 02/24/24 and returned on 02/28/24.</p> <p>Review of the resident's medical records, provided by the facility, did not include Bed Hold Notification documentation provided to the resident or the RP as required.</p> <p>2. Review of Resident #50's Admission Record located in the EMR under the Admission tab showed an admitted [DATE].</p> <p>Review of the resident's significant change MDS with an ARD of 02/01/24, showed the resident was cognitively intact.</p> <p>Review of the resident's Progress Notes located in the EMR under the Progress Notes tab showed the resident was discharged to the hospital on 01/17/24 and returned on 01/30/24.</p> <p>Review of the resident's medical records, provided by the facility, did not include Bed Hold Notification documentation provided to the resident or the RP as required.</p> <p>During an interview on 04/18/24, at 3:25 P.M., the resident said he/she had not received a Bed Hold Notification form/paper in January when he/she went to the hospital. When asked if bed holds were discussed or explained to him/her, he/she said no and that he/she assumed everything would just stay the same when he returned.</p> <p>3. Review of Resident #67's Admission Record located in the EMR under the Admission tab, showed an admitted [DATE].</p> <p>Review of the resident's significant change MDS with an ARD of 02/28/24, the resident was severely cognitively impaired.</p> <p>Review of the resident's Progress Notes, located in the EMR under the Progress Notes tab, showed the resident was discharged to the hospital on 02/20/24 and returned on 02/26/24.</p> <p>Review of the resident's medical records, provided by the facility, did not include Bed Hold Notification documentation provided to the resident or the RP as required.</p> <p>During an interview on 04/18/24, at 1:42 P.M., the resident's Family Member (FM) #3 said he/she was notified via telephone of the resident being sent to the hospital, but did not receive any paperwork or written notification of transfer or Bed Hold Notification</p> <p>4. During an interview on 04/18/24, at 12:20 P.M., the Director of Resident Services (DRS) said when a nurse sent out a resident to the hospital, the RP was notified by phone, and the DRS mailed out an Emergency Transfer Notice within 24 hours. He/she was not aware of the need to send out Bed Hold Notices to the resident/RP.</p> <p>5. During an interview on 04/18/24, at 12:50 P.M., the Director of Social Services (DSS) said when a resident was sent out to the hospital, the RP was notified by phone and was sent a copy of the Emergency Transfer Notice. He/she was not aware of the need to send out Bed Hold Notices to the resident/RP.</p> <p>(continued on next page)</p>		

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an interview on 04/19/24, at 7:22 P.M., the Director of Nursing (DON) said she was aware that the facility provided a copy of the Bed Hold Policy in the Admission Agreement Packet, but was not aware of the need to provide a Bed Hold Notification when a resident was discharged to the hospital.		

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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** 40824</p> <p>Based on observations, interviews, and record review, the facility failed to maintain and update comprehensive care plan to ensure their accuracy when staff failed to care plan the use of usage for four residents (Resident #9, #30, #45, and #54) and failed to care plan anticoagulant (medicines that help prevent blood clots) usage for one resident (Resident #75). The facility census was 85.</p> <p>Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, showed the following:</p> <ul style="list-style-type: none"> -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; -The comprehensive, person-centered care plan includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions; -Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making; -When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers; -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. <p>1. Review of Resident #9's Admission Record, located in the electronic medical record (EMR) under the Profile tab, showed an admitted [DATE].</p> <p>Review of the resident's Medical Diagnosis, located in the EMR under the Diagnosis tab, showed diagnoses included acute and chronic respiratory failure with hypoxia (low blood oxygen levels) and heart disease.</p> <p>Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff) located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 01/15/24, showed staff did not indicate the use of oxygen.</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 Order Details provided by the facility and dated 11/23/23, showed an order, dated 11/23/23 and discontinued on 12/04/23, showed oxygen via nasal cannula at two liters per minute (LPM) to keep oxygen saturation greater than 90%.</p> <p>Observations during the survey showed staff administered oxygen to the resident during survey.</p> <p>Observation during the initial tour on 04/16/24, between 9:50 A.M. and 10:30 A.M., showed the resident had an oxygen concentrators in his/her rooms.</p> <p>Review of the resident's Care Plan, provided by the facility and dated 04/15/24, showed staff did not care plan the use of oxygen.</p> <p>During an interview on 04/18/24, at 3:32 P.M., the Minimum Data Set Coordinator (MDSC) 1 confirmed that the resident's care plan did not include the use of oxygen, but should have.</p> <p>2. Review of Resident #30's Admission Record, located in the EMR under the Profile tab, showed an re-admitted [DATE].</p> <p>Review of the resident's Medical Diagnosis, located in the EMR under the Diagnosis tab, showed diagnoses included heart disease with heart failure.</p> <p>Review of of the resident's significant change MDS, located in the EMR under the MDS tab, with an ARD of 03/07/24, showed the MDS included the use of oxygen.</p> <p>Review of of the resident's Order Summary Report, provided by the facility and dated 04/15/24, showed an order, with a start date of 02/28/24, for oxygen at four LPM via nasal cannula to maintain oxygen saturation greater than 90%.</p> <p>Observation during the initial tour on 04/16/24, between 9:50 A.M. and 10:30 A.M., showed the resident had an oxygen concentrators in his/her rooms.</p> <p>Review of the resident's Care Plan, provided by the facility and dated 04/15/24, showed staff did not care plan the resident's oxygen use.</p> <p>During an interview on 04/18/24, at 3:32 P.M., the MDSC 1 confirmed that the resident's care plan did not include the use of oxygen, but should have.</p> <p>3. Review of Resident #45's Admission Record, located in the EMR under the Profile tab, showed a re-admitted [DATE].</p> <p>Review of the resident's Medical Diagnosis, located in the EMR under the Diagnosis tab, showed diagnoses included chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and heart disease with heart failure.</p> <p>Review of the resident's quarterly MDS, located in the EMR under the MDS tab, with an ARD of 04/05/24, showed staff included the use of oxygen.</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 Order Summary Report, provided by the facility and dated 04/15/24, showed an order, dated 03/13/24, for the use of oxygen at one LPM via nasal cannula to maintain oxygen saturation level between 89% to 92%.</p> <p>Observation during the initial tour on 04/16/24, between 9:50 A.M. and 10:30 A.M., showed the resident had an oxygen concentrators in his/her rooms.</p> <p>Review of the resident's Care Plan, provided by the facility and dated 04/15/24, showed staff did not care plan the use of oxygen.</p> <p>During an interview on 04/18/24, at 3:32 P.M., the MDSC 1 confirmed that the resident's care plan did not include the use of oxygen, but should have.</p> <p>4. Review of Resident #54's Admission Record, located in the EMR under the Profile tab, showed an admitted [DATE].</p> <p>Review of the resident's Medical Diagnosis, located in the EMR under the Diagnosis tab, showed diagnoses included pulmonary embolism (a sudden blockage in your pulmonary arteries, the blood vessels that send blood to your lungs) and COPD.</p> <p>Review of the resident's Order Summary Report, provided by the facility and dated 04/15/24, showed an order, dated 06/22/23, for oxygen at one to two LPM via nasal cannula continuously.</p> <p>Review of the resident's quarterly MDS, located in the EMR under the MDS tab, with an ARD of 03/29/24, showed use of oxygen.</p> <p>Observation during the initial tour on 04/16/24, between 9:50 A.M. and 10:30 A.M., showed the resident had an oxygen concentrators in his/her rooms.</p> <p>Review of the resident's undated Care Plan, located in the EMR under the Care Plan tab, showed staff did not care plan the use of oxygen.</p> <p>During an interview on 04/18/24, at 3:32 P.M., the MDSC 1 confirmed that the resident's care plan did not include the use of oxygen, but should have.</p> <p>5. Review of Resident #75's Admission Record, from the EMR Profile tab, showed an admitted [DATE].</p> <p>Review of the resident's admission MDS, with an ARD of 02/07/24, showed the resident was cognitively intact.</p> <p>Review of the resident's EMR Orders tab showed the resident had an active order for warfarin (an anticoagulant medication) three milligrams (mg) daily except on Wednesdays. On Wednesdays, the resident was prescribed two mg for the presence of the prosthetic heart valve.</p> <p>During an interview on 04/17/24, at 10:37 A.M., the resident said he/she had an artificial heart valve and took warfarin.</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 undated Care Plan, provided by the facility, showed diagnoses that included the presence of prosthetic heart valve. Staff did not care plan regarding the resident taking an anticoagulant.</p> <p>During an interview on 04/18/24, at 5:03 P.M., MDSC1 reviewed the care plan and said the anticoagulant was not care planned. The anticoagulant medication should have been care planned.</p> <p>During an interview on 04/19/24, at 6:22 P.M., the Director of Nursing (DON) said if a resident was on a blood thinner, the expectation is that staff care plan it.</p> <p>11599</p> <p>28154</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25490</p> <p>Based on observations, interviews, and record reviews, the facility failed provide respiratory care per standards of practice when staff did not have physician orders for oxygen usage for two residents (Residents #37 and #9). A sample of residents was reviewed in a facility with a census of 85.</p> <p>Review of the facility's policy titled, Oxygen Administration, dated October 2010, showed the following:</p> <ul style="list-style-type: none"> -The purpose of this procedure is to provide guidelines for safe oxygen administration; -Verify there is a physician's order for this procedure; -Review the physician's order or facility protocol for oxygen administration. <p>1. Review of Resident 37's Admission Record located in the Profile tab of the EMR, showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included of pleural effusion (the buildup of excess fluid between the layers of the pleura outside the lungs), unspecified fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate), heart disease and hypertension (high blood pressure). <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessed tool completed by facility staff) located in the MDS tab of the EMR with an ARD of 03/13/24, showed the resident was cognitively intact.</p> <p>Review of the resident's doctor's orders located in the EMR under the Orders tab, showed no order for oxygen usage.</p> <p>Review of the resident's nurse's progress note, dated 04/16/24 and located in the EMR under the Progress Notes tab, showed resident observed asleep wearing oxygen via nasal cannula at two LPM (liters per minute).</p> <p>Review of the resident's nurse's progress note, dated 04/11/24 and located in the EMR under the Progress Notes tab, showed resident observed asleep wearing oxygen via nasal cannula at two LPM.</p> <p>Review of the resident's nurse's progress note, dated 03/31/24 and located in the EMR under the Progress Notes tab, showed the resident was put on two liters oxygen and his/her pulse ox (blood oxygen level) went up to 94% on two liters.</p> <p>2. Review of Resident #9's Admission Record located in the EMR under the Profile tab, showed a readmitted [DATE].</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>Review of the resident's Medical Diagnosis located in the EMR under the Diagnosis tab, showed diagnoses included acute and chronic respiratory failure with hypoxia and heart disease.</p> <p>Review of the resident's Care Plan, provided by the facility and dated 04/15/24, did not include the use of oxygen.</p> <p>Review of the resident's significant change MDS located in the EMR under the MDS tab, with an ARD of 01/15/24, showed it did not include the use of oxygen.</p> <p>During an observation and interview on 04/16/24, at 7:45 A.M., Registered Nurse (RN) 1 confirmed that the resident was receiving oxygen at two LPM via nasal cannula while lying in bed.</p> <p>During an observation on 04/17/24, at 9:30 A.M., the resident was sitting up in a chair in her bedroom, receiving two LPM oxygen via nasal cannula.</p> <p>Review of the resident's Order Details, provided by the facility and dated 11/23/23, showed oxygen via nasal cannula at two liters per minute to keep oxygen saturation greater than 90. The order was started on 11/23/23 and discontinued 12/04/23.</p> <p>Review of the resident's hospital History and Physicals, dated 12/28/23, located in the EMR under the Miscellaneous tab, showed supplemental oxygen to maintain sats (oxygen saturation level) of 88% to 92%. Resident currently on home dose oxygen at two liters per nasal cannula.</p> <p>Review of the resident's document titled, Visit-Routine, dated 03/07/24, located in the EMR under the Miscellaneous tab, showed the resident was on room air. No other physician progress notes were available for review after 03/07/24.</p> <p>During an interview on 04/18/24, at 3:32 P.M., the Minimum Data Set Coordinator (MDSC) 1 confirmed that the resident was on intermittent oxygen without an order. All oxygen administration should have a physician's order.</p> <p>During an interview on 04/19/24, at 9:09 A.M., Hospice Registered Nurse (RN) 2 said the resident required oxygen at two LPM off and on since the resident had been on hospice services (01/08/24).</p> <p>During an interview on 04/19/24, at 7:22 P.M., the Director of Nursing (DON) confirmed the resident had been receiving oxygen without a physician's order. The DON said that she was not aware that multiple residents were receiving oxygen without a current physician's order. All residents requiring oxygen should have had a physician's order prior to oxygen administration.</p> <p>During an interview on 04/22/24, at 9:39 A.M., Hospice RN2 clarified that the resident did not have orders on file for oxygen administration with hospice, but there should have been. The resident had required oxygen as needed. Recently the resident had been requiring oxygen more often than in the past.</p> <p>During an interview on 04/22/24, at 9:00 A.M., the resident's Family Member (FM) 2 confirmed that the resident received oxygen as needed and recently had been requiring oxygen more often than in the past.</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>3. During an interview on 04/18/24, at 1:31 P.M., the Administrator said the nursing staff followed policies and federal guidelines when providing any medical services. No services should have been provided without a doctor's order.</p> <p>4. During an interview on 04/19/24, at 5:55 P.M., the Infection Preventionist, (IP) said several residents received oxygen without a doctor's order. No resident should have received oxygen or any treatments without a physician's order.</p> <p>40824</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28154</p> <p>Based on observation, interview, and record review, the facility failed to accommodate one resident's (Resident #88) known dietary preferences. A sample of 33 residents were reviewed in a home with a census of 85.</p> <p>Review of the facility's policy titled, Resident Food Preferences, revised July 2017, showed the following:</p> <ul style="list-style-type: none"> -Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team; -Upon the resident's admission (or within twenty-four (24) hours after his/her admission) the dietitian or nursing staff will identify a resident's food preferences; -The food services department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. <p>1. Review of Resident #88's Admission Record from the electronic medical record (EMR) Profile tab showed an admitted [DATE].</p> <p>Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff) with an Assessment Reference Date (ARD) of 04/02/24, showed the following:</p> <ul style="list-style-type: none"> -Diagnoses included debility, coronary artery disease, heart failure, and diabetes; -Resident was cognitively intact. <p>Review of the resident's EMR Progress Notes tab showed a dietary note dated 03/25/24, at 10:01 P.M., that showed the following:</p> <ul style="list-style-type: none"> -Resident receives a regular/regular/thin diet with no adaptive equipment and sugar free house shakes at all meals; -No reported allergies and no trouble with chewing or swallowing have been noted; -Care plan has been initiated with preferences will be learned and put on tray card ticket; -No admit weight] or height at this time; -Registered Dietitian (RD) is available for any nutritional concerns; -Dietary to remain available for any preference or nutritional changes. <p>(continued on next page)</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's Admitting Nutritional Assessment, completed on 04/03/24 by an RD, did not show any food preferences.</p> <p>During an observation on 04/17/24, at 3:00 P.M., the resident's midday meal tray contained breaded fish filet with approximately three fork mark bites removed from the filet, all but one floret of the broccoli was consumed, three hush puppies, an untouched house supplement shake, an untouched coffee cup, and an untouched cup of juice, and an untouched dessert cup of fruit cobbler. Review of the resident's tray card for the meal showed at the bottom of the page (in all capital letters) NO BREADS OR DESSERTS.</p> <p>During an observation and interview on 04/16/24, at 3:38 P.M., the resident said he/she had been there for about three weeks. The food is delicious, except I'm a diabetic. They serve high carb diet. I've talked to the kitchen about many things, and you can request something else, sometimes you get it. The resident's midday meal tray remained on the over bed table and a large serving of the dessert strawberry lasagna was untouched.</p> <p>During an interview on 04/18/24, at 1:40 P.M., the resident said he/she requested meat loaf, a side salad, and tomato juice on the side and he/she didn't get it. The resident's midday meal tray was observed to have meat loaf, mashed potatoes, green beans, an untouched nutrition shake, and cheesecake dessert. The resident said the nutrition shake was too sweet.</p> <p>During an interview on 04/18/24, at 2:05 P.M., the Dietary Manager (DM) provided the menus. The DM said he/she spoke with resident last week and the resident said things were fine, but the resident is very picky about what he/she eats. When asked if the nutrition shake was diabetic, the DM confirmed it was not. The DM said the resident's card states no bread or desserts. The DM showed the order sheet on the clip board that was used to record resident diet choices for the midday meal. The order sheet showed the resident's request for meat loaf, side salad, and tomato juice.</p> <p>During an interview on 04/18/24, at 4:37 P.M., the DM said the dietary aide that completed the lunch trays the past few days got in a hurry and admitted to the DM that he/she didn't read the card. The DM continued.</p> <p>During an interview on 04/19/24, at 6:30 P.M., the Director of Nursing (DON) said the expectation regarding food preferences was for staff to offer what is on the menu and if there is an alternate, the resident has the right to choose it. If a choice is made, the DON would expect that the resident to get it.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>11599</p> <p>Based on observation, interview, and record review, the facility failed to protect food from possible contamination at all times in accordance with professional standards of practice when staff failed to wear hairnets in the kitchen, failed to store the ice scoop outside of the ice container, and failed to complete proper handwashing during meal service/prep. The facility census was 85.</p> <p>1. Observations on 04/16/24, from 9:15 A.M. to 10:20 A.M., showed the following:</p> <p>-In the serving kitchen, Certified Nurse Aide (CNA) 1 was inside the kitchen, scooping ice into a cooler without wearing a hairnet. At the time of the observation, food preparation was in process. The Dietary Manager (DM) told CNA 1 that he/she needed to have a hairnet on anytime he/she entered the kitchen. CNA 1 replied I know I do.</p> <p>Observation on 04/19/24, at 10:00 A.M., showed the following:</p> <p>-The Maintenance Director (MD) entered the kitchen without a hairnet, walked past the staff slicing meat for the residents' lunch, and proceeded to the sink. Maintenance Worker (MW) 5 directed the MD to put on a hairnet. The MD left the kitchen and returned with a beard cover placed on top of his/her head. The DM and MW 5 directed the MD to put on a hairnet. The MD repeatedly walked past the staff slicing meat without putting on a hairnet.</p> <p>During an interview on 04/19/24, at 2:40 P.M., the DM said the staff have all been in-serviced on wearing hairnets at any time when they entered the kitchen.</p> <p>28154</p> <p>2. Observation on 04/16/24, at 12:20 P.M., showed Certified Nurse Aide (CNA) 4 was filled a cup with ice from a cooler sitting on the island counter. The CNA opened the cooler took out the scoop, and when done, stored the scoop in the ice, then closed the lid. (potentially contaminating the ice). At 12:27 PM, Certified Medication Technician (CMT) 1 went to the cooler and repeated the process, again storing the scoop in the ice. At 12:28 P.M., the DM arrived at the kitchen as CMT 1 was storing the scoop, removed the scoop from the ice, washed the scoop at the kitchen sink and found a plate to place the scoop on, placing the plate next to the cooler.</p> <p>During an interview on 04/19/24, at 2:40 P.M., DM said staff knows better than to put the scoop back in the bucket. He/she has told them to do that.</p> <p>3. Observations on 04/17/24, from 11:40 A.M. to 12:52 P.M., during the meal service in the rehabilitation dining room showed the following:</p> <p>-Dietary Aide (DA) 3 placed a can of soup inside each of three serving bowls. The cans of soup were stored in a drawer, with other food items and kitchen equipment;</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-DA 3 opened the can of soup, pour it into the bowl, heated the soup, and without washing his/her hands carried the soup with his/her hand gripping the rim of the bowl (potentially contaminating the eating surface), hand over the soup, and delivered it to a resident;</p> <p>-DA 3 placed stainless steel containers of food on the steam table. During the placement, a divider fell into the steaming water. Without washing his/her hands, DA 3 retrieved the divider which fell into the noodles. The noodles were served to the residents.</p> <p>During an interview on 04/19/24, at 2:40 P.M., the Dietary Manager (DM) said staff know what to do and have been trained.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>11599</p> <p>Based on observation, interview, and record review, the facility failed to maintain their infection prevention program to reduce the likelihood of a legionella (the bacterium which causes legionnaires' disease (a severe form of pneumonia) which can grow in areas with stagnant water) in the water when the facility failed to follow their water management program by not completing the preventative steps outlined and when the facility failed to ensure staff were educated regarding the water management program. The facility census was 85.</p> <p>1. Review of the facility's policy titled, Water Management Program, undated, showed the following:</p> <ul style="list-style-type: none"> -Specific measures used to control the introduction and/or spread of Legionella; -The control limits or parameters that are acceptable and that are monitored; -A diagram of where control measures are applied; -A system to monitor control limits and the effectiveness of control measures; -a plan for when control limits are not met and/or control measures are not effective; -Documentation of the program. <p>Review of an undated document, provided by the facility, titled Lodge Paperwork, showed the following:</p> <ul style="list-style-type: none"> -The back flow inspection should be done annually; -Eye wash inspections should be done weekly; -Wastewater should be done quarterly; -Water temperatures should be checked weekly; -Water temperatures at mixing valves should be checked weekly. <p>Review of facility documentation binder for Water Management Program, provided by the Maintenance Director (MD), showed the following:</p> <ul style="list-style-type: none"> -An eye wash inspection log which indicated weekly inspections should be conducted. The last recorded inspection was on 12/26/23; -The Lodge main water temperature checks should be conducted weekly. The last recorded temperatures were logged on 03/18/24. <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 - Many</p>	<p>During an interview on 04/19/24, at 4:28 P.M., the MD said the facility did not have a water management program due to them being on city water and that Legionella could not grow in the pipes. The MD was unable to report any control measures that were in place to ensure the facility was free from Legionella.</p> <p>During an interview on 04/19/24, at 5:30 P.M., the Director of Nursing (DON) said the facility used city water and that she was aware that water should not sit still for more than two to three days. She said if there were unoccupied resident rooms, then the water should be flushed in the sinks and commodes every two to three days.</p> <p>During an interview on 04/19/24, at 7:07 P.M., the Infection Preventionist (IP) said she was previously told by the Administrator that the MD would be handling the water maintenance program and that she did not need to be involved.</p> <p>During an interview on 04/19/24, at 7:22 P.M., the DON said the city last tested the water on 07/05/23 to check chemical levels. The DON confirmed that weekly water temperatures had not been monitored and recorded since 12/28/23 and that she did not have any additional information to ensure control measures had been monitored. The last meeting that was held to review the Water Management Program was 06/22/21.</p> <p>28154</p> <p>40824</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>28154</p> <p>Based on record review and interviews, the facility failed to provide the pneumococcal vaccine as ordered for two residents (Resident #43 and #75) of the seven residents reviewed for immunization out of 33 sampled residents. The facility census was 85.</p> <p>Review of the facility's policy titled, Pneumonia Vaccine, revised March 2022, showed the policy did not address the procedure of who should administer the vaccine when ordered and arrived at the facility.</p> <p>1. Review of Resident #43's Medication Administration Record (MAR), dated November 2023, from the electronic medical record (EMR) under the Orders tab, showed the following:</p> <p>-The PCV 20 (pneumonia vaccine) was ordered and scheduled to be administered either on 11/21/23 or 11/22/23;</p> <p>-On 11/21/23, at 10:29 A.M., the nurse on duty charted a code 9 which, according to the legend, was Other / See Nurse Note.</p> <p>Review of of the resident's EMR Progress Notes, dated 11/2024, showed a following:</p> <p>-A note, dated 11/08/23, where the Infection Preventionist (IP) documented regarding consent for the vaccine;</p> <p>-Staff did not enter a note dated 11/21/23, or regarding not administering the vaccine.</p> <p>Observation of the Lodge 2 medication room on 04/19/24, at 4:20 P.M., with Registered Nurse (RN) 2, showed a box with the Prevnar 20 (pneumonia vaccine) for the resident present. The prescription filled date was 11/08/23. The RN confirmed the fill date and said the IP was supposed to give the vaccines. The IP must not know they are here.</p> <p>2. Review of Resident #75's MAR, dated March 2024 from the EMR under the Orders tab, showed the following:</p> <p>-The PCV 20 was to be administered on either 03/11/24 or 03/12/24;</p> <p>-On 03/12/24, at 2:32 A.M., the nurse on duty documented a code 7 which according to the legend noted the resident was sleeping.</p> <p>Review of the resident's EMR Progress note by the IP on 02/02/24 at 10:01 AM showed the resident consented for the pneumonia vaccine. Staff did not document administration of the vaccine on or since 02/02/24.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of the Lodge 2 medication room on 04/19/24, at 4:20 P.M., with RN 2 showed a box of Prevnar 20 (PCV (pneumococcal conjugate vaccine) 20) vaccine for the resident, with prescription filled date of 03/01/24. RN 2 confirmed the fill date and said the IP was supposed to give the vaccines. The IP must not know they are here.</p> <p>3. During an interview on 04/19/24, at 6:10 P.M., the IP said the expectation was the residents should have received the vaccine as ordered.</p> <p>4. During an interview on 04/19/24, at 6:40 P.M., the Director of Nursing (DON) said an expectation was that the nurse on duty, when the vaccine came, should have administered it.</p>		