| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265539 | A. Building<br>B. Wing | 04/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Aegis Health and Rehabilitation | 1441 Charic Drive<br>Wildwood, MO 63021 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>32847<br><br>Based on observation, interview and record review, the facility failed to ensure residents allowed to self-administer medications had been assessed by the interdisciplinary team to ensure the residents were knowledgeable and safe to self-administer medications and ensure there was a physician order for medication self-administration for two residents observed with medications left at the bedside (Residents #4 and #7). The census was 41.<br><br>Review of the facility's undated Self-Administration of Medications policy, showed:<br><br>-To maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if they facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer;<br><br>-If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual abilities to carryout this responsibility during the care planning process;<br><br>-For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis or when there is a significant change in condition;<br><br>-If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted.<br><br>Review of the facility's Admission Packet, showed Resident rights. No medication will be kept in the Resident's room or possession unless in accordance with the Plan of Care.<br><br>1. Review of Resident #4's medical record, reviewed on 4/3/24, showed:<br><br>-An order dated 9/30/21, for Proventil hydrofluoroalkane (HFA) aerosol solution 90 microgram (McG)/puff (albuterol sulfate HFA, used to treat asthma) 2 inhalation inhale orally every 6 hours as needed for shortness of breath;<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 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -An order dated 8/4/23, for albuterol sulfate (used to treat lung disease and asthma) nebulization solution (2.5 milligram (mg)/3 milliliter (ml)) 0.083% 3 ml inhale orally via nebulizer every 4 hours as needed for shortness of breath;<br><br>-An order dated 8/14/23, for Trelegy Ellipta (used to treat lung disease) inhalation aerosol powder breath activated 100-2.5-25 McG/puff 1 puff inhale orally one time a day related to chronic obstructive pulmonary disease (COPD, lung disease);<br><br>-An order dated 9/7/23, for ipratropium-albuterol solution 0.5-25, 3 mg/3 ml per 1 vial, inhale orally every 6 hours related to COPD every 6 hours;<br><br>-No order to self-administer medications;<br><br>-No assessment to self-administer medications.<br><br>Observation and interview on 4/3/24 at 9:35 A.M., showed the resident in his/her room. Three inhalers in a zip lock bag sat on the resident's bed and 4 vials of nebulizer medications sat on the nebulizer machine and bedside table. Liquid noted in the nebulizer medication chamber. The Resident said he/she is waiting on staff to fix his/her nebulizer so he/she can use it. He/She has requested the new part. He/She uses the nebulizer every 6 hours but has not used it this morning because a piece is missing. At approximately 10:00 A.M., the resident said the breathing machine part is still missing. Observation showed the resident had a fluticasone propionate inhaler, Trelegy inhaler and Proventil inhaler at the bedside. At 10:28 A.M., the Director of Nursing (DON) came into the room to check on the resident and the resident reported the missing nebulizer part. The DON left the room and brought in a new nebulizer chamber and tubing and applied it to the machine.<br><br>During an observation and interview on 4/4/24 12:05 P.M., the resident said he/she has had his/her medications at bedside since he/she came to the facility. Nurses leave a couple nebulizer vials of medication, and he/she self-administers the vials with the nebulizer machine. Observation at this time showed 4 nebulizer vials of medication at the bedside. Observation and interview at 1:23 P.M., showed the resident picked up the Proventil and said he/she takes it when necessary, he/she does not know how often, probably two times a day when he/she coughs. He/She cannot read the label. He/She does not use very much of it but is needing it more and more. The Trelegy is very important, he/she takes it one time a day in the morning. The Resident held the fluticasone propionate and attempted to read the label and said he/she takes this medication in the afternoon and it's very hard to use it really as he/she attempted to open the medication. Observation showed the resident now had 5 nebulizer vials at the bedside. The Resident said he/she takes them every 6 hours/four times a day. He/She watches the clock to know when to take it. The staff wash the cup to the nebulizer out once a week. He/She does rinse his/her mouth out after the nebulizer because it tastes bad.<br><br>During an interview with the DON and Regional Nurse L on 4/4/24 at 12:28 P.M., they said there are no orders for self-administration and no assessment for self-administration of medications completed for the resident.<br><br>During an interview on 4/4/24 at 1:13 P.M., the DON said she reached out to Physician N and received an order for the resident's self-administration assessment to be completed and if the resident passes the test, Physician N gave an order for self-administration.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of Resident #7's medical record, showed:<br><br>-An order start date 4/26/22, for daily-vitamin one tablet one time a day related to vitamin deficiency, scheduled administration time 10:00 A.M.;<br><br>-An order start date 4/26/22, for oxybutynin 5 mg extended release. One tablet one time a day related to overactive bladder, scheduled administration time 10:00 A.M.;<br><br>-An order start date 3/9/24, for sertraline HLC 150 mg one tablet daily for depression;<br><br>-No assessment to self-administer medications.<br><br>Observation on 4/4/24 at 12:46 P.M., showed the resident not in his/her room, a medication cup sat on the resident's bedside table and contained one yellowish colored round pill and one blue oval pill. At 3:07 P.M., the resident sat in his/her room and said he/she took his/her pills when he/she returned to his/her room after lunch. He/She does not know what the pills were.<br><br>During an interview on 4/4/24 at 4:40 P.M., the DON said medications should not be left at the bedside. She is not sure if the resident had been assessed safe to self-administer medication. To qualify for self-administration of medications, the resident would need to know what the medications were and know that they could not be left at the bedside unattended.<br><br>During an interview on 4/9/24 at 8:34 A.M., Certified Medication Technician (CMT) C said the only oval blue pill the resident takes is his/her sertraline HLC. His/Her yellowish round pill is his/her oxybutynin.<br><br>50366 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49992<br><br>Based on interview and record review, the facility failed to ensure the resident assessment was accurately coded for one of three closed resident records reviewed for accuracy of resident assessments (Resident #35). The census was 41.<br><br>Review of Resident #35's medical record, showed:<br><br>-discharged [DATE];<br><br>-A nursing note, dated 3/18/24 at 6:57 A.M., non-emergent transport was called to arrange transportation to the hospital.<br><br>Review of the resident's discharge MDS, dated [DATE], showed:<br><br>-admitted [DATE];<br><br>-discharged [DATE];<br><br>-Discharge status: Inpatient Rehabilitation Facility (IRF, free standing facility or unit).<br><br>During an interview on 4/5/24 at 1:41 P.M., the MDS Coordinator said she was aware that the resident was sent to the hospital and she anticipated a return. She did select the incorrect coding for the resident's discharge. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** 32847<br><br>Based on observation, interview, and record review, the facility failed to ensure resident care plans were comprehensive, person-centered and were developed based on the Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) care area assessment summary (CAAS), for four of 14 sampled residents (Residents #33, #23, #188, and #187). The census was 41.<br><br>Review of the facility's Comprehensive Care Plans policy, dated 9/1/21, showed:<br><br>-It is the policy of this facility to develop and implement a comprehensive, person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment;<br><br>-The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed;<br><br>-The compressive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All CAAS triggered by the MDS will be considered in developing the plan of care;<br><br>-The comprehensive care plan will describe, at a minimum the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being;<br><br>-The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment;<br><br>-The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment.<br><br>1. Review of Resident #33's Hospital Discharge Summary, dated 2/15/24, showed:<br><br>-Diagnoses included acute on chronic respiratory failure, pneumonia, end-stage chronic obstructive pulmonary disease (COPD, lung disease) with acute exacerbation, recent facial burns, difficulty swallowing, and high blood pressure;<br><br>-History significant for end-stage COPD, on 3 liters of home oxygen, recent facial burns that occurred smoking while using oxygen requiring admission to a burn center.<br><br>Review of the resident's admission MDS, dated [DATE], showed:<br><br>-Cognitively intact;<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 - Some | -Used a wheelchair;<br><br>-Supervision or touch assistance required for eating, oral hygiene, toileting hygiene, and upper body dressing;<br><br>-Substantial/maximal assistance required for lower body dressing, putting on/taking off footwear, and personal hygiene;<br><br>-Partial/moderate assistance required to roll left and right and sit to lying;<br><br>-Substantial/maximal assistance (helper does more than half of the effort) required for lying to sitting, sit to stand, and chair/bed-to-chair transfer;<br><br>-Partial/moderate assistance required for toilet transfer and tub/shower transfer;<br><br>-Walking not attempted due to medical condition or safety concerns;<br><br>-Frequently incontinent of bowel and bladder;<br><br>-Diagnoses included heart failure, high blood pressure, pneumonia, asthma or other lung disease, respiratory failure. cataracts, glaucoma, or macular degeneration;<br><br>-On a scheduled pain medication regimen, received as needed pain medications, received non-medication interventions for pain;<br><br>-Presence of pain: Yes, occasionally. Occasionally effects sleep. Occasionally interferes with therapy activities and day to day activities;<br><br>-Pain rating: 6 (0 indicates no pain and 10 indicates the worse pain imaginable);<br><br>-Received oxygen therapy;<br><br>-CAAS: visual function, activity of daily living (ADL) functional/rehabilitation potential, urinary incontinence, psychosocial well-being, nutritional status, dehydration/fluid maintenance, pressure ulcer, and pain triggered and indicated by the facility as incorporated into the comprehensive care plan.<br><br>During an observation and interview on 4/4/24 at 1:03 P.M., the resident lay in his/her room in bed. Oxygen on at 2.5 liters per simple face mask. The resident said he/she had a dry nose and he/she used the mask because of it. When he/she eats, he/she cannot breath because he/she cannot breath from his/her nose. Observation at this time showed the resident's right nasal opening with significant scar tissue and the nasal opening very small. The resident said he/she gets very short of breath. He/She has constant left hip pain due to arthritis and gets ibuprofen. He/She has anxiety and wishes someone would just sit and listen to his/her concerns. He/She always wears oxygen per mask due to shortness of breath and COPD. He/She is incontinent and staff have to clean him/her. He/She is also blind in one eye.<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 - Some | During an interview on 4/4/24 at 2:14 P.M., Licensed Practical Nurse (LPN) B said the resident uses oxygen at 2-3 liters per mask. He/She cannot find an order, but there should be an order. The resident has difficulty breathing from his/her nose. He/She was a smoker but quit after he/she got burnt. He/She is blind in the right eye per the progress notes. The resident does have shortness of breath. The right nostril has issues, and it causes shortness of breath. That is why the resident wears an oxygen mask. When having shortness of breath, raising his/her head of bed helps. He/She does have anxiety because he/she thinks he/she is not breathing and feels his/her nostril is tight. He/She only has occasional pain. Staff to have to assist with care but he/she is not sure how much assistance he/she needs to do things, such as transfer.<br><br>During an interview on 4/4/24 at 2:31 P.M., Certified Medication Technician (CMT) C said staff assist the resident with assist of one, but the resident can do stuff on his/her own. His/Her preference is to not get out of bed.<br><br>Review of the resident's care plan, in use at the time of the survey, showed:<br><br>-Focus: Activity intolerance due to refuses participation:<br><br>-Goal: Resident will maintain optimum activity level;<br><br>-Interventions: Encourage resident to set small obtainable activity goals. Encourage times of rest and relaxation between care activities;<br><br>-Focus: Potential for impairment to skin integrity:<br><br>-Goal: Maintain or develop clean and intact skin;<br><br>-Interventions: Encourage good nutrition and hydration in order to promote healthier skin. Provide preventative skin care;<br><br>-The resident's respiratory issues, need for a simple face mask for oxygen, shortness of breath, and history of facial burns were not included in the care plan with goals and interventions;<br><br>-The resident's incontinence of bowel and bladder and need for assistance with ADL care were not included in the care plan;<br><br>-The triggered CAAS for ADL care, urinary incontinence, vision and pain were not on the care plan.<br><br>During an interview on 4/4/24 at 3:02 P.M., the MDS Coordinator said the care plan is updated by the Director of Nursing, herself, and other department heads, such as activities and social services. She would expect respiratory concerns such as those the resident has to be on the care plan. It should include goals for care and interventions to address the problems. Any CAAS triggered and identified as incorporated into the care plan should be on there.<br><br>2. Review of Resident #23's admission MDS, dated [DATE], showed:<br><br>-Cognitively intact;<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 - Some | -Indwelling urinary catheter (a sterile tube inserted into the bladder to drain urine), always incontinent of bowel;<br><br>-Diagnoses included end stage renal disease (ESRD), atrial fibrillation (a-fib, irregular heart rhythm), pneumonia, asthma, hip fracture, and urinary tract infection (UTI).<br><br>Review of the resident's electronic medical record (EMR), showed a progress note dated 3/9/24 at 3:09 P.M., resident arrived at facility via ambulance with two attendants. Resident with a recent fall at home. He/She was hospitalized with diagnosis of femur fracture. The resident can make his/her needs known. The resident has a 16 French (F, catheter size)/10 milliliter (ml, the amount of ml used to inflate the balloon inside the urinary catheter) catheter in place. The catheter draining to gravity with yellow urine. The physician notified and medications verified. The pharmacy notified of new admit.<br><br>Review of the resident's electronic Physician Order Sheet (ePOS) showed:<br><br>-An order start date 3/11/24 and end date 3/18/24, voiding trial to begin after catheter is discontinued on 3/12/24 for 24 hours. Document urine output every shift. If unable to void (urinate), notify physician for orders to reinsert indwelling catheter every shift for voiding trial after discontinue of catheter;<br><br>-An order start date 3/12/24, indwelling catheter to be discontinued on 3/12/24 and begin voiding trial. One time only for catheter removal for one day.<br><br>Review of the resident's care plan, initiated and revised on 4/3/24, showed:<br><br>-Problem: The resident has a catheter;<br><br>-Goal: The resident will show no signs/symptoms of urinary infection through the review date;<br><br>-Intervention: The resident has a catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door; Monitor/document for pain/discomfort due to catheter. Provide catheter care every shift.<br><br>Observations of the resident in his/her room on 4/3/24 at 9:00 A.M. and 4/4/24 at 11:15 A.M., showed no urinary catheter tubing or bag.<br><br>During an interview on 4/4/24 at 11:25 A.M. , the resident said he/she does not have a urinary catheter. He/She has not had one since he/she was in the hospital.<br><br>During an interview on 4/5/24 at 8:50 A.M., LPN K said the resident does not have a catheter. The resident used to when he/she first came to the facility.<br><br>During an interview on 4/5/24 at 9:10 A.M., LPN H said the resident does not have a catheter.<br><br>3. Review of Resident #188's admission MDS, dated [DATE], showed:<br><br>-Cognitively intact;<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 - Some | -Little Interest or pleasure in doing things: Yes, Frequency: 2-6 days (several days);<br><br>-Feeling down, depressed, or hopeless: Yes, Frequency: 7-11 days (half or more the days);<br><br>-Trouble falling or staying asleep, or sleeping too much: Yes, Frequency: 12-14 days (nearly every day);<br><br>-Feeling tired or having little energy: Yes, Frequency: : 7-11 days (half or more the days);<br><br>-Feeling bad about yourself: Yes, 7-11 days (half or more the days);<br><br>-Frequently incontinent of bowel and bladder;<br><br>-Diagnoses include anemia (condition in which the body does not have enough healthy red blood cells), diabetes, asthma, respiratory failure, ESRD, and heart failure;<br><br>-CAA area triggered and indicated as addressed on care plan: Psychosocial well-being and mood state.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed:<br><br>-Mild cognitive impairment;<br><br>-Mood: Should Resident Mood Interview be Conducted: Yes;<br><br>-Little Interest or pleasure in doing things: Yes, Frequency: 12-14 days (nearly every day);<br><br>-Feeling down, depressed, or hopeless: Yes, Frequency: 12-14 days (nearly every day);<br><br>-Trouble falling or staying asleep, or sleeping too much: Yes, Frequency: 12-14 days (nearly every day);<br><br>-Feeling tired or having little energy: Yes, Frequency: 12-14 days (nearly every day);<br><br>-Trouble concentrating on things: Yes, 7-11 days (half or more the days);<br><br>-Occasionally incontinent of bladder, Frequently incontinent of bowel;<br><br>-Diagnoses include heart failure, ESRD, diabetes, and respiratory failure.<br><br>Review of the resident's EMR, showed:<br><br>-A note at the top banner that said the resident's spouse is not allowed to have any information;<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 - Some | -A progress note, dated 2/29/24 at 4:50 A.M., resident returned from emergency department (ED) via Emergency Medical Services (EMS). Resident stated, he/she did not want his/her spouse to be told anything about him/her. Staff asked the resident is this really what he/she wants or is this because he/she and his/her spouse were arguing in the ED. Resident stated they go back and forth a lot, sometimes he/she does not want his/her spouse to know anything and other times it is okay to tell him/her. Staff made the resident aware that staff will not be going back and forth on yes we can talk to him/her and no we cannot talk with him/her. Staff informed the resident that the decision needs to be consistent. Resident then stated, do not tell him/her anything. Nurse made aware;<br><br>-A progress note, dated 2/29/24 at 1:29 P.M., spouse came to facility to see resident and asked this nurse how he/she was doing and did staff know about his/her behavior in the ER. This nurse stated he/she could not discuss his/her care with him/her. He/She asked if this was the resident's choice. Staff stated he/she could not discuss his/her care with him/her. He/She then handed staff his/her amazon packages and stated to tell him/her that he/she could perform sexual things on himself/herself. Staff asked him/her to leave. He/She has left and returned two times at this point. The first time a staff from human resources was in the room and the resident asked him/her to leave. The spouse found this nurse and stated he/she was going to call his/her lawyer because this marriage was over. Then continued to ask questions about his/her care which staff told him/her staff could not answer and asked him/her to leave. He/She just returned with his/her lawyers name to contact if he/she kicks the bucket. Then he/she is dead;<br><br>-A progress note, dated 3/6/24 at 10:58 A.M., Resident resided alone in a house, his/her spouse in another home. Resident home is unkept and per spouse resident is a hoarder at baseline;<br><br>-A progress note, dated 3/30/24 at 12:00 A.M., Resident demanding to be up in the recliner. Resident assisted to his/her recliner. After in recliner, he/she had all of his/her clothes off and thrown on the floor. [NAME] and trash thrown everywhere. Resident's feet were hanging down and noted some edema (swelling) starting. Resident encouraged to keep his/her feet up for one hour. Resident started yelling and waking other residents up, was put back to bed. Resident was becoming hostile but encouraged him/her to sleep;<br><br>-A progress note, dated 4/4/24 at 1:53 P.M., Resident has requested to change his/her request to allow his/her wife to receive any information about this resident. This writer edited his/her face sheet.<br><br>During an interview on 4/3/24 at 11:20 A.M., the resident said he/she did not want his/her spouse to be given information because he/she worries and has obsessive compulsive disorder (OCD). The resident said they have been married since 1996 and he/she did not talk to the resident for two months over that decision to not provide information.<br><br>During an interview on 4/4/24 at 3:36 P.M., LPN O said the resident's mood/mental status goes up and down. Sometimes he/she is very ok. Sometimes he/she is upset over his/her spouse. LPN O said the resident told him/her that his/her spouse used to beat him/her up. The resident has some memory loss and can be in left field sometimes where you do not what he/she is talking about. He/She is aware most of the time. The resident also likes to be naked even when he/she is out of his/her room.<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 - Some | During an interview on 4/5/24 at 915 A.M., LPN H said the resident does not really have specific behaviors, but he/she will get frustrated sometimes on how staff do things for him/her. He/She will want to do things a different way. Overall, he/she is cooperative. When staff tried to assist him/her out of bed, staff could tell he/she got frustrated. Staff just stopped and asked him/her how he/she wants to be helped.<br><br>Review of the resident's care plan, initiated and revised on 4/3/24, showed:<br><br>-Focus: The resident has depression;<br><br>-Goal: The resident will remain free of signs/symptoms of distress, symptoms of depression, anxiety or sad mood by/through the review date;<br><br>-Interventions: Administer medications as ordered. Arrange for psychiatric consult, follow up as indicated. Monitor/document/report PRN (as needed) any risk for harm to self. Monitor/document report PRN any signs/symptoms of depression. Monitor/record/report to physician PRN risk for harming other. Pharmacy review monthly or per protocol;<br><br>- The care plan did not address the resident's behaviors or interventions for care when the resident has behaviors, such stopping and asking the resident how he/she wanted to be helped;<br><br>-No psychosocial well-being, mood state listed on the resident's care plan, as triggered in the CAAs.<br><br>4. Review of Resident #187's admission MDS, dated [DATE], showed:<br><br>-Cognitive assessment not completed with the resident;<br><br>-Signs and Symptoms of Delirium:<br><br>-Inattention: Behavior present, fluctuates (comes and goes, changes in severity);<br><br>-Disorganized thinking: Behavior present, fluctuates (comes and goes, changes in severity);<br><br>-Should resident mood interview be conducted: Yes;<br><br>-Resident Mood Interview: Only first two answered below;<br><br>-Little interest or pleasure in doing things: No response;<br><br>-Feeling down, depressed, or hopeless: No response;<br><br>-Verbal behavioral symptoms directed towards others: Behavior of this type occurred 4 to 6 days but less than daily;<br><br>-Significantly interfere with the resident's care: Yes;<br><br>-Significantly disrupt care of living environment: Yes;<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 - Some | -Rejection of Care-Presence and Frequency: Behavior of this type occurred 4 to 6 days , but less than daily;<br><br>-Diagnoses include ESRD, UTI (last 30 days), and low sodium;<br><br>-Care areas checked as triggered and indicated as addressed in care plan: Delerium, cognitive loss/dementia, ADL functional/rehabilitation potential, urinary incontinence, psychosocial well-being, behavioral symptoms, nutritional status, dehydration/fluid maintenance, pressure ulcer;<br><br>Review of the resident's All-Inclusive Admission and Readmission Assessment, showed:<br><br>-Admission 3/21/24;<br><br>-Adjustment Concerns/Behaviors include: Current smoker, alcohol regularly-daily or most days, history of alcohol dependence, drug use-rarely;<br><br>-Mood/Behavior: Behavior concerns angry and anxiety.<br><br>Review of the resident's Psychosocial Admission Assessment, dated 3/26/24, included: Resident verbally aggressive toward staff trying to give care. Resident verbalizes just wanting to be left alone.<br><br>During an interview on 4/4/24 at 3:36 P.M., LPN O said the resident refuses care and cusses everyone out. LPN O said oh my God, yes when asked if the resident has behaviors. Sometimes talking to the resident will help to calm him/her down but not really if he/she is demanding something. When the resident wants something, he/she wants something. The resident can be high strung and anxious. LPN O said he/she was told the resident is a recovering addict and just seems angry. The resident has pain but due to history of drug abuse, the physician does not want to give anything stronger than Tylenol. As far as bothering the residents, some of them get tired of the resident's cussing. LPN O said he/she was told the resident's parents dropped him/her off and put a restraining order on the resident. The cops dropped off the papers last week. The resident is supposed to be discharged to an alcohol rehabilitation soon. The resident is very narcissistic to nurses.<br><br>During an interview on 4/5/24 at 9:00 A.M., LPN K said the resident does have behaviors. He/She just tries not to argue with the resident. Earlier this morning the resident was ranting about the quality of the food. Then staff agreed with the resident, and he/she started laughing. Better to agree with the resident if you can. The resident seems to like it when someone argues with him/her and gives him/her a reason to argue and keep going with the argument. The resident seems angry, so staff pick their battles. He/She cannot always agree with what the resident says. The resident does seem to react better to men. He/She also loves whoever takes him/her out to smoke.<br><br>During an interview on 4/5/24 at 9:15 A.M., LPN H said as far as behaviors for the resident, the answer is yes and no. It is more cussing. The resident does not usually bother other residents. Once he/she said something to him/her when he/she came out of his/her room and the resident told him/her to shut up. For the most part, if you remain calm and do not say anything he/she will calm down.<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 - Some | During an interview on 4/9/24 at 12:37 P.M., Regional Nurse M said if a resident has a history of calling out or yelling those behaviors should be care planned. However, this resident was not at the facility long enough to do a comprehensive care plan. That would play a part in behaviors not on the care plan. When we do the admission, the things we know generate the baseline care plan. The facility knew about the drugs but not about the behaviors.<br><br>Review of the resident's care plan, in use at the time of the survey, showed:<br><br>-The comprehensive care plan not developed within 7 days after completion of the comprehensive assessment;<br><br>-The care plan did not show focus for alcohol abuse or behaviors as mentioned in the baseline care plan upon admission.<br><br>5. During an interview on 4/9/24 at 12:37 P.M., Regional Nurse M said the care plans are updated quarterly with the MDS. He/She would expect the care plan to be accurate.<br><br>44950 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>44950<br><br>50366<br><br>Based on observation, interview and record review, the facility failed to follow acceptable standards of practice for quality of care for two residents (Residents #337 and #20). Resident #337's peripherally inserted central catheter (PICC, a thin, flexible tube that is inserted into a vein in the upper arm and guided (threaded) into a large vein above the right side of the heart) line dressing had not been changed in accordance with the facility policy and physician orders. Staff had not documented Resident #20's skin assessment since February 2024. The resident had a wound to the left heel. The sample was 14. The census was 41.<br><br>1. Review of the facility's PICC/MIDLINE/central venous access device (CVAD) dressing change policy, dated 9/1/21, showed: It is the policy of this facility to change PICC, midline or CVAD dressing, weekly or if soiled, in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequency of changes.<br><br>Review of Resident #337's physician orders, showed:<br><br>-Diagnoses included sepsis (a life-threatening complication of an infection);<br><br>-An order dated 3/26/24, for intravenous (IV) PICC change dressing as needed if loose, not occlusive, moisture accumulation, drainage, redness, or irritation;<br><br>-An order dated 3/26/24, IV PICC Change dressing every day shift every 7 days for PICC line dressing change.<br><br>Review of the resident's Treatment Administration Record (TAR) report, showed an order for a dressing change to the PICC line, dated 4/2/24. Licensed Practical Nurse (LPN) H documented he/she did not perform the PICC line dressing change.<br><br>Observation on 4/4/24 at 2:24 P.M. and 4/8/24 at 8:44 A.M., showed the resident's PICC line dressing to the left upper arm, dated 3/22/24.<br><br>During an interview on 4/9/24 at 8:50 A.M., the Director of Nursing (DON) said the PICC line dressing change should be followed per physician orders.<br><br>2. Review of the facility's Skin Assessment Policy, revised 9/1/22, included:<br><br>-Policy: It is our policy to perform a full body skin assessment as part of our systematic approach to pressure, injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment;<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Policy Explanation and Compliance Guidelines: A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury.<br><br>-Documentation of skin assessment:<br><br>-Include date and time of the assessment, your name, and position title;<br><br>-Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.);<br><br>-Document type of wound;<br><br>-Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain);<br><br>-Document if resident refused assessment and why;<br><br>-Document other information as indicated or appropriate.<br><br>Review of Resident #20's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/14/24, showed:<br><br>-Cognitively intact;<br><br>-Occasionally incontinent of bowel and bladder;<br><br>-Is resident at risk of developing pressure ulcers: Yes;<br><br>-Does resident have 1 or more unhealed pressure ulcer at stage 1 or higher: No<br><br>-Foot Problems: None;<br><br>-Skin and ulcer treatments: Pressure reducing device for chair and pressure reducing device for bed;<br><br>-Diagnoses included anemia (body does not have enough healthy red blood cells), diabetes, depression and respiratory failure.<br><br>Review of the resident's electronic Physician Order sheet (ePOS) showed:<br><br>-An order, start date 1/17/24, Perform skin assessment weekly. Every night shift every Monday, Wednesday;<br><br>-An order, start date 4/3/24, Ok for wound care plus to evaluate and treat;<br><br>-An order, revision date 4/4/24, Prevalon boots (boots that lift the heel to help prevent the development of heel pressure injuries) on at all times while in bed;<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -An order, revision date 4/4/24, Float bilateral heels while in bed on a pillow;<br><br>-An order, revised 4/4/24, Cleanse left heel with vashe (wound cleanser that contains pure Hypochlorous Acid). Apply Santyl (ointment used in the healing of burns and skin ulcers), calcium alginate (highly absorptive dressing) and border gauze every day for wound care;<br><br>-An order, revision date 4/6/24 and start date 4/7/24, Cleanse left heel with vashe. Apply Santyl, calcium alginate and border gauze every day for wound care.<br><br>Review of the resident's electronic medical record (EMR), showed:<br><br>-A progress note, dated 4/4/24 at 6:47 P.M., Left heel wound measurements are 2.8 by 3.1 with eschar in the middle and pink in color in surrounding areas. Area is soft around the edges and squishy;<br><br>-No unit of measurement given for wound measurement.<br><br>Review of the resident's skin assessments, showed:<br><br>-A wound assessment, dated 2/7/24, showed no new wounds;<br><br>-A weekly wound assessment, dated 4/4/24, date of onset 4/3/24;<br><br>-Wound Site: Left foot heel<br><br>-Wound Type: Pressure;<br><br>-Classification: Unstageable;<br><br>-Length (centimeters, cm): 2.8<br><br>-Width (cm): 3.1;<br><br>-Depth: 0<br><br>-Wound Bed Color: Black;<br><br>-Slough (the yellow/white material in the wound bed)/Yellow (%): 10;<br><br>-Necrosis/Black (%): 90;<br><br>-Amount of Drainage (Exudate): Moderate (25%-75% drainage);<br><br>-Type of Drainage (Exudate): Purulent (thin/thick, opaque, tan/yellow drainage);<br><br>-Odor: No;<br><br>-Wound Edges: Macerated;<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Periwound tissue: Other-fluctuance, friable;<br><br>-Pain related to wound: No;<br><br>-Wound Healing Progression: New;<br><br>-Additional comments: Treated and evaluated by Nurse Practitioner (NP) V with wound care company. Will continue with current treatments and interventions as ordered.<br><br>-A weekly skin check, dated 4/9/24, Left lower leg scab, Left heel pressure unstageable;<br><br>-No skin assessments done between 2/7/24 and 4/3/24.<br><br>-Review of the wound care progress note, dated 4/4/24, showed:<br><br>-Left Foot, Heel: Wound 1<br><br>-Wound State: Open<br><br>-Wound Cause: Pressure<br><br>-Where Wound was Caused: Facility;<br><br>-Tissue Type: Eschar (dead tissue ) 90%, Slough 10%;<br><br>-Pressure versus Non-Pressure Screening Tool: The ulcer is consistent with pressure as the primary etiology;<br><br>-Plan of Care:<br><br>-Cleanse wound with Hypochlorous Acid. Apply collagenase Santyl topically to the entire wound, edge to edge, every day. Do not substitute. Apply calcium alginate to wound base. Cover with bordered gauze. Change dressing daily and as needed for soiling, saturation, or unscheduled removal;<br><br>-Assessment Notes: Debridement with Curette and Scissors;<br><br>-Reason Procedure Required: Remove unhealthy tissue, Stimulate wound healing;<br><br>Blood loss: Yes, scant;<br><br>Nonviable Tissue Removed: Slough, Biofilm, Eschar, Exudate;<br><br>Pain: No<br><br>Debrided: 20%.<br><br>Review of the resident's care plan, initiated 4/5/24, showed:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Focus: The resident has unstageable pressure ulcer Left Foot Heel related to decreased mobility;<br><br>-Goal: The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date;<br><br>-Interventions: Administer treatments as ordered and monitor for effectiveness, Float heels while in bed, Prevalon boots on while in bed, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and exudate.<br><br>Review of the resident's TAR for March 2024, showed:<br><br>-An order, dated 1/17/24, Perform skin assessment weekly. Monday night shift. Every night shift, every Monday, Wednesday. If there are any new skin issues, identify on skin assessment.<br><br>-Marked at completed on 3/4/24, 3/6/24, 3/11/24, 3/13/24, 3/20/24, 3/25/24 and 3/27/24;<br><br>-Blank on 3/18/24.<br><br>Review of the resident's TAR for April 2024 through 4/9/24, showed:<br><br>-An order, dated 1/17/24, Perform skin assessment weekly. Monday night shift. Every night shift, every Monday, Wednesday. If there are any new skin issues, identify on skin assessment.<br><br>-Marked as completed on 4/1/24, 4/3/24 and 4/8/24.<br><br>-An order, dated 4/3/24, Ok to have consult with wound care plus evaluate and treat. One time only for wound care for 1 days.<br><br>-Marked as completed on 4/3/24.<br><br>-An order, start date 4/7/24, Clean left heel with vashe. Apply Santyl, calcium alginate, and border gauze every day for wound care. Every day shift for wound healing.<br><br>Review of the resident's assessments in the EMR, showed last skin assessment completed prior to 4/8/24 was a skin assessment on 2/7/24.<br><br>During an interview on 4/4/24 at 3:36 P.M., Licensed Practical Nurse (LPN) O said the wound care company was at the facility today and saw the resident. NP V placed an order to change daily. The resident also got an order for Prevalon boots. LPN O is not sure what to do with the wound. The outside is pink but the inner part is necrotic and soft in the middle. It is 2.8 cm by 3.1 cm with no depth. LPN O just noticed it yesterday. He/She covered it up then got an order from the physician for the wound care company to evaluate and treat. He/She went over paperwork and the packet for the wound care company with the resident. LPN O said since NP V was scheduled to come today, he/she did not put in a daily order for dressing changes. It was late in the day and he/she asked the Assistant Director of Nursing (ADON). She said just leave it for now if paperwork is faxed over to the wound care company. LPN O said normally he/she would call the doctor and get an order for treatment to be provided until wound care can assess the resident.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 4/4/14 at 4:00 P.M., showed LPN O enter the resident's room. LPN removed the resident's sock from his/her left foot. The resident had a dressing on his/her left heel. The dressing was soiled with light pink drainage. The dressing was dated 4/4/24. LPN O donned gloves and removed the dressing. The wound was circular. The outer top portion of the wound was bright red/purple. The center was a dark brown/tan color, and the bottom outer portion light pink. LPN O gathered supplies and cleaned the wound. He/She reapplied the dressing.<br><br>During an interview on 4/5/24 at 9:00 A.M., LPN K said skin assessments are to be done weekly. The nursing shift it is done on differs and so does the day of the week. To chart it, go to assessment and click on the assessment tab.<br><br>During an interview on 4/5/24 at 9:15 A.M., LPN H said assessments are done weekly. The day they are due typically, since they are done on the day of admission, is to keep the skin assessment on that day.<br><br>During an interview on 4/4/24 at 5:57 P.M., the Director of Nursing (DON) said they do not have skin assessments for the resident since 2/7/24. She expected nursing staff to fill out skin assessments weekly. She said she could go and check yes it was done on the Treatment Administration Record (TAR) but that does not mean it is done. Staff are supposed to complete an assessment in the EMR.<br><br>During an interview on 4/5/24 1:15 P.M., NP V said he/she did the initial consult with the resident yesterday. He/She debrided the wound. The wound bed was necrotic with dry skin around it. The center had eschar. NP V said he/she cannot say when this wound developed. It could have developed in a day. He/She cannot judge, these can happen from deep tissue injury. |

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| Aegis Health and Rehabilitation | 1441 Charic Drive<br>Wildwood, MO 63021 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>44950<br><br>Based on observation and interview, the facility failed to ensure a resident who is incontinent of bowel and bladder received appropriate treatment and services after an incontinent episode. One resident was left by a staff member in the middle of providing personal care. The resident was left saturated with urine (Resident #23). Later that morning, the same resident had an incontinent bladder and bowel episode. The resident requested personal care and a staff member told the resident to wait until after lunch service to have personal care provided. The resident waited over 30 minutes for the second time that morning while soiled. The resident had stool stuck to his/her skin as a result, as well as a reddened area to his/her buttocks. The staff did not apply cream to the area after staff provided personal care. The sample size was 14. The census was 41.<br><br>Review of Resident #23's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/13/24, showed:<br><br>-Cognitively intact;<br><br>-Indwelling urinary catheter (a sterile tube inserted into the bladder to drain urine), always incontinent of bowel;<br><br>-Diagnoses included end stage renal disease (ESRD), atrial fibrillation (a-fib, irregular heart rhythm), pneumonia, asthma, hip fracture, and urinary tract infection (UTI);<br><br>Review of the resident's electronic Physician Order Sheet (ePOS), showed:<br><br>-An order start date 3/11/24 and end date 3/18/24, voiding trial to begin after catheter is discontinued on 3/12/24 for 24 hours. Document urine output every shift. If unable to void (urinate), notify physician for orders to reinsert indwelling catheter every shift for voiding trial after discontinue of catheter;<br><br>-An order start date 3/12/24, indwelling catheter to be discontinued on 3/12/24 and begin voiding trial. One time only for catheter removal for one day.<br><br>Observation on 4/5/24 at 9:25 A.M., showed the resident lay in bed. The resident motioned for the surveyor to come in his/her room. The resident asked when the Certified Nursing Assistant (CNA) would return. He/She said the CNA started to clean him/her. The CNA said he/she had to go to bathroom really bad and would be back. The CNA never came back. That was about 30 minutes ago and he/she was still dirty.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation and interview on 4/5/24 at 9:30 A.M., showed Licensed Practical Nurse (LPN) K at the nurses station, and was informed of the resident's situation. LPN K looked at the nursing schedule and gave three CNA names. LPN K said it would have to be CNA I or CNA W. LPN K went to the resident's room and spoke to the resident. The resident repeated the information and a description of the staff member. LPN K left the resident's room and went to find CNA I and CNA W on the 100 hall. LPN K entered the resident's room on the 100 hall that had CNA I and CNA W in it. LPN K entered the room and asked if either had left the resident wet. Both CNA I and CNA W said no, they had been on the 100 hall. LPN K left the room and went to the 200 hall to find CNA J. CNA J said he/she had not been with the resident. At this time, LPN K returned to the nurses station. CNA I and CNA W walked towards the nurses station. CNA W said it was not him/her.<br><br>Observation on 4/5/23 at approximately 9:40 A.M., showed CNA I entered the resident's room. The resident told the CNA he/she was a big mess and his/her stomach hurt. CNA I left the room and returned with personal care supplies. CNA I put on gloves. CNA W entered the resident's room and put on gloves. The resident said he/she was in pain. CNA W said he/she would make sure the resident got a pain pill when they are done. CNA W unfastened the resident's brief and wiped the resident front to back. CNA W rolled the resident to his/her right side. The resident said his/her pain was a little better now. CNA W wiped the resident front to back. He/She removed his/her gloves and grabbed a plastic trash bag. CNA W donned new gloves without hand hygiene. He/She put the resident's soiled brief in the plastic bag. With the same gloves, CNA W tucked a new clean brief under the resident. The resident rolled to his/her back and CNA I and CNA W secured the resident's brief. CNA W told the resident he/she will get the nurse for a pain pill. Both CNA I and CNA W removed their gloves and washed their hands then assisted the resident to his/her wheelchair. As the resident sat down, he/she said I think I messed my pants. CNA I and CNA W asked the resident if he/she wanted to go back to his/her bed. The resident said no, I want to go smoke. CNA W assisted the resident out of his/her room.<br><br>Observation and interview on 4/5/24 at 11:45 A.M., showed the resident in his/her room. He/She sat in his/her chair. The resident's spouse sat in the room. The resident said he/she was never cleaned up after his/her smoke break. The resident said staff told him/her care would be provided after lunch but he/she did not want to wait.<br><br>During an interview on 4/5/24 at 11:47 A.M., LPN H was informed the resident requested assistance. LPN H said the resident has a UTI so the resident said he/she thought he/she went to the bathroom but the resident was not sure.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 4/5/24 at approximately 11:49 A.M., showed LPN J and CNA J entered the resident's room. The resident had his/her cervical collar (c-collar, a medical device used to support and immobilize a person's neck) off. LPN J left the room and returned with the Director of Nursing (DON) to fix the c-collar while CNA J gathered supplies. At approximately 12:00 P.M., LPN J returned with CNA J. At approximately 12:00 P.M., LPN H and CNA J entered the resident's room. LPN H and CNA J donned gloves and transferred the resident into his/her bed. LPN H unfastened the resident's brief and assisted the resident to his/her left side. The resident's buttocks were red. The resident had loose stool in the soiled brief and dry hardened stool dried to his/her buttock area. LPN H looked at the resident's buttocks and said it looks better; sorry it hurts. LPN H told CNA J that he/she does not have barrier cream. CNA J wiped the resident front to back and tucked the soiled brief under the resident. CNA J took the new brief and placed it under the resident, then rolled the resident to his/her back and wiped the resident front to back. CNA J did not remove his/her gloves or perform hand hygiene. The new brief had a brown smudge of stool. LPN H removed his/her gloves and left the room. He/She did not perform hand hygiene. LPN H returned with a clean brief. He/She donned gloves and assisted the resident to his/her left side. CNA J wiped the resident's buttock area again as LPN H placed a new brief under the resident while wearing the same gloves. The resident was turned to the right and then to his/her back and positioned. LPN H and CNA J secured the resident's brief. LPN H and CNA J fixed the resident's blankets while wearing the same gloves. CNA J grabbed the trash with one gloved hand and then adjusted the resident's bed control with the other gloved hand. CNA J set the trash bag down on the floor and went into the bathroom. He/She removed his/her gloves and washed his/her hands. LPN H removed his/her gloves, grabbed the trash and left the room.<br><br>During an interview on 4/9/24 at 12:37 P.M., Regional Nurse M said staff should complete care once they have started to provide personal care. If they cannot complete care and have an emergency, the staff person should get someone so the resident's care can be completed. Regional Nurse M said a resident should not be told to wait until after lunch to have care completed when they have had an incontinence episode. Care should be completed within a reasonable amount of time, which is approximately 5-10 minutes, depending on the situation. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>44950<br><br>Based on observation, interview and record review, the facility failed to ensure pain management is provided to residents who require such services when staff failed to inform the nurse one resident experienced symptoms of pain. The resident was admitted to the facility with a femur (bone that goes from the hip to the knee) fracture that required surgical repair and a cervical spinal cord compression. The resident also wore a cervical collar (c-collar, a medical device used to support and immobilize a person's neck) related to the spinal cord compression. The resident did not receive pain medication for over two hours after requesting pain medication (Resident #23). The sample size was 14. The census was 41.<br><br>Review of the facility's Pain Management policy, revised 9/1/21, showed:<br><br>-Policy: The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>-Policy Explanation and Compliance Guidelines: The facility will utilize a systematic approach for recognition, assessment, treatment and monitoring of pain. Recognition:<br><br>-In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility shall:<br><br>-Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated;<br><br>-Evaluate the resident for pain upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g. after a fall, change in behavior or mental status, new pain or an exacerbation of pain);<br><br>-Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences;<br><br>-Facility staff shall observe for nonverbal indicators which may indicate the presence of pain.<br><br>-Pain Assessment:<br><br>-The facility shall utilize a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain.<br><br>-Pain Management and Treatment:<br><br>-Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission;<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The interventions for pain management will be incorporated into the components of the comprehensive care plan, addressing conditions or situations that may be associated with pain or may be included as a specific pain management need or goal.<br><br>Review of Resident #23's All-Inclusive Admission and Readmission assessment, dated 3/9/24, included:<br><br>-Admission details: 3/9/24 at 12:00 P.M.;<br><br>-Reasons for Admission according to resident/Power of Attorney (POA): Femur fracture;<br><br>-Past Medical History:<br><br>-Has resident had surgery in the past 100 days: Yes<br><br>-If yes, specify type of surgery if known: Left hop, base of head, down neck and back;<br><br>-Pain Evaluation:<br><br>-Should pain assessment interview be conducted: Yes;<br><br>-Pain Presence:<br><br>-Ask, resident: Have you had pain or hurting at any time in the last 5 days?: Yes;<br><br>-Pain Frequency:<br><br>-Ask resident: How much of time have you experienced pain or hurting over the last 5 days?: Occasionally;<br><br>-Pain Effect on Function:<br><br>-Ask resident: Over the past 5 days, has pain made it hard for you to sleep at night? No;<br><br>-Ask resident: Over the past 5 days, has you limited your day-to-day activities because of pain? No;<br><br>-Pain Intensity:<br><br>-Most recent pain level: 0 3/9/24 at 2:40 P.M.;<br><br>-Indicators of Pain or Possible Pain: Nothing checked<br><br>-Non-verbal sounds;<br><br>-Vocal Complaints of pain;<br><br>-Facial expressions;<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Protective body movements or postures<br><br>-Pain Management: Nothing marked<br><br>-On a scheduled pain medication regimen;<br><br>-Received as needed (PRN) pain medications?<br><br>-Received non-medication intervention for pain?<br><br>Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/13/24, showed:<br><br>-Cognitively intact;<br><br>-Always incontinent of bowel;<br><br>-Pain Management:<br><br>-At any time in the last 5 days, has the resident:<br><br>-Been on a scheduled pain medication regime? No;<br><br>-Received as needed (PRN) pain medication? Yes;<br><br>-Received non-medication intervention for pain? No;<br><br>-Should Pain Assessment Interview be Conducted? Yes;<br><br>-Pain presence: Yes;<br><br>-Pain frequency: Occasionally;<br><br>-Pain effect on sleep: Occasionally;<br><br>-Pain Interference with Therapy Activities: Occasionally;<br><br>-Pain Interference with Day-to-Day Activities: Occasionally;<br><br>-Pain Intensity:<br><br>-Numeric Rating Scale (00-10): 06;<br><br>-Verbal Descriptor Scale: No answer;<br><br>-Should the Staff Assessment for Pain be Conducted? No<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Diagnoses included end stage renal disease (ESRD), atrial fibrillation (a-fib, irregular heart rhythm), pneumonia, asthma, hip fracture and urinary tract infection (UTI).<br><br>Review of the resident's current care plan, showed pain was not identified or addressed.<br><br>Observation on 4/5/24 at approximately 9:40 A.M., showed Certified Nurse's Aide (CNA) I entered the resident's room. The resident told the CNA his/her stomach hurt. CNA I left the room and returned with supplies. CNA I and CNA W re-entered the resident's room. The resident said he/she was in pain. CNA W said he/she would make sure the resident got a pain pill when they were done providing care. CNA W unfastened the resident's brief and wiped the resident. CNA W assisted the resident to his/her right side. The resident said his/her pain was a little better now. CNA W and CNA I finished providing incontinence care. CNA W told the resident he/she would get the nurse for a pain pill.<br><br>Observation on 4/5/24 at approximately 12:00 P.M., showed Licensed Practical Nurse (LPN) H and CNA J entered the resident's room. LPN H and CNA J donned gloves and transferred the resident into his/her bed. LPN H unfastened the resident's brief and assisted the resident to his/her left side. The resident was rolled to his/her left side. The resident's bottom was red. The resident had loose stool and dry hardened stool dried to his/her buttock area. LPN H looked at the resident's buttocks and said it looked better, he/she was sorry it hurt. CNA J and LPN finished providing personal care for the resident. The resident said he/she wanted a pain pill. The resident said he/she asked earlier but no one came. LPN H asks if the resident wants a Tylenol or his/her prescription pain pill. The resident said a pain pill, Tylenol did not do anything. LPN J left the room. The resident shook his/her head. The resident said no one came in earlier when he/she asked.<br><br>Review of the resident's electronic physician order sheet, (ePOS), showed:<br><br>-An order, dated 3/9/24, pain monitoring every shift;<br><br>-An order, dated 3/9/24, Hydrocodone-Acetaminophen (opioid pain medication used to relieve moderate to severe pain) 10-325 milligram (mg). Give 1 tablet by mouth every 4 hours as needed for pain.<br><br>Review of the resident's April 2024 Medication Administration Record (MAR), on 4/5/24 at 12:36 P.M., showed:<br><br>-Pain level documented for day and night shift as ordered;<br><br>-Pain level documented for day shift (no time specified) on 4/5/24: 0;<br><br>-Hydrocodone-Acetaminophen 10-325 mg administered on 4/5/24 at 12:24 P.M.<br><br>During an observation and interview on 4/5/24 at 1:55 P.M., the resident lay in bed. The resident said his/her pain is better.<br><br>During an interview on 4/9/24 at 12:37 P.M., Regional Nurse M said a pain assessment should be completed upon admission and then the pain level is recorded on the MAR each shift. Regional Nurse M would not consider a resident waiting over two hours for a pain pill to be reasonable unless the resident was not due for the medication. The resident should not have to wait over an hour and then ask again before the pain medication is administered. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observe each nurse aide's job performance and give regular training.<br><br>35394<br><br>Based on interview and record review, the facility failed to ensure each nurse aide had no less than twelve hours of in-service education per year based on their individual performance review and calculated by their employment date rather than the calendar year, for 4 of 4 sampled Certified Nursing Assistants (CNAs) sampled. The facility identified four CNAs employed for more than a year. The census was 41.<br><br>Review of the Facility Assessment Tool, updated 3/24/24, completed by the facility, showed:<br><br>-Total number needed or average: 5-10 Nurse aides;<br><br>-Staff training/education and competencies: Staff training/education is conducted by in-services;<br><br>-1 on 1 training education packets with post-tests;<br><br>-Clinical staff is monitored for 1 on 1 competencies for resident care, resident's rights, abuse prevention and reporting, person centered care, medication pass, transfers, perineal care, intravenous (IV) therapy, wound care, repositioning, restorative, trach care, gastrostomy (G-tube, feeding tube) care, behavioral interventions, physical assessment, documentation, dementia care, COVID-19 care, infection control, mandatory 12 hour for nurse aide training, etc.<br><br>Review of CNA R's employee file, showed date of hire 11/30/22. No In-service tracking provided based on hire date, to show 12 hours of in-service training provided.<br><br>Review of CNA F's employee file, showed date of hire 12/10/20. No In-service tracking provided based on hire date, to show 12 hours of in-service training provided.<br><br>Review of CNA S's employee file, showed date of hire 3/3/06. No In-service tracking provided based on hire date, to show 12 hours of in-service training provided.<br><br>Review of CNA T's employee file, showed date of hire 7/29/16. No In-service tracking provided based on hire date, to show 12 hours of in-service training provided.<br><br>During an interview on 4/9/24 at 10:38 A.M., the Director of Nursing (DON) said she was responsible for the in-service and training of the CNAs. Regional Nurse M said nursing and Human Resources are responsible as well. The DON said she was behind on training for March 2024 and had not started April 2024.<br><br>During an interview on 4/9/24 at 12:06 P.M., the DON said she was looking for the binder that held the training; however, she had a binder with sign in sheets for every month.<br><br>Review on 4/9/24 at 12:06 P.M., showed a binder of in-service training provided by the facility. No documented number of hours for each in-service provided, no individualized tracking record for individual CNAs.<br><br>(continued on next page) |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/9/24 at 12:33 P.M., Regional Nurse M said she would expect the CNA 12-hour training to be documented and reflect at least twelve hours of in-service training per year. She would expect nursing to have a system in place to provide evidence the facility can produce that demonstrates the in-service education. |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>35394<br><br>Based on observation, interview and record review, the facility failed to provide necessary behavioral health care services for a resident's psychosocial well-being when staff did not address a suspected eating disorder after it was reported the resident was binge eating and vomiting (Resident #13). In addition, staff comments addressing the suspected eating disorder were not only denied by the resident, but left the resident self-conscious about what he/she ate and whom he/she ate in front of. The sample was 14. The census was 41.<br><br>Review of the facility's Behavior Management policy, revised 9/1/22, showed:<br><br>-Residents who exhibit behavioral concerns may require a behavior management care plan to ensure they are receiving appropriate services and interventions to meet their needs. The interdisciplinary team, including the family member, should develop a behavioral plan for each resident with identified behaviors through the RAI process;<br><br>-A behavior management plan can include a schedule of daily life events, which addresses the individuality of the resident. The plan should reflect the resident's personal preferences and usual routine, to the extent possible. The plan should include the recreation schedule, non-pharmacological interventions, and environmental adjustments needed to help the resident meet his or her highest practicable well-being;<br><br>-Policy explanation and compliance guidelines: Upon admission of a new resident, the Unit Coordinator or designee will determine if the resident's behaviors warrant a behavior management care plan;<br><br>-Within twenty-four hours of admission, the Unit Coordinator or designee should develop an interim behavior management plan for use by staff, until the comprehensive assessment and plan of care are developed. Any behavioral interventions should also be included on the baseline care plan;<br><br>-Information regarding the resident's usual routine may be gathered from the pre-screening application tool, from the resident and family members, and/or the comprehensive assessment;<br><br>-Behaviors should be documented clearly and concisely by facility staff. Documentation should include specific behaviors, time and frequency of behaviors, observation of what may be triggering behaviors, what interventions were utilized, and the outcomes of the interventions;<br><br>-Behaviors should be identified and approaches for modification or redirection should be included in the comprehensive plan of care;<br><br>-The plan of care and behavior management plan should be reviewed at least quarterly for continued need of behavior management and appropriate interventions.<br><br>Review of Resident #13's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/29/24, showed:<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -No cognitive impairment;<br><br>-Total mood severity score: 2 out of 30 (minimal depression);<br><br>-Feeling down, depressed, or hopeless: yes;<br><br>-Little pleasure or interest in doing things: yes;<br><br>-No behaviors;<br><br>-Required supervision with eating;<br><br>-Diagnoses included anemia (low red blood cell), Crohn's disease (inflammatory bowel disease), diabetes, malnutrition and Post Traumatic Stress Disorder (PTSD, mental health condition triggered by a terrifying event, causing flashbacks, nightmares, and severe anxiety);<br><br>-Has pain occasionally with pain intensity score of 5 out of 10;<br><br>-Weight of 95 pounds;<br><br>-Has feeding tube.<br><br>Review of the physician's notes, dated 1/30/24, showed:<br><br>-Patient also has a history of having severe pancreatitis, he/she does have a gastrostomy tube (g-tube, a tube inserted into the stomach to provide nutrition, hydration and/or medications). He/She weighs approximately 95 pounds. He/She does have a lot of gastrointestinal (GI) issues. He/She supposedly has Crohn's disease and possibly ulcerative colitis (swelling or inflammation of the large intestine). He/She said the hospital diagnosed him/her with Crohn's disease one time and then he/she saw another gastroenterologist and he/she thought he/she had ulcerative colitis. He/She has protein calorie malnutrition. He/She also has a g- tube, is also taking Creon and numerous medications for his/her GI problems. He/She does have some epigastric pain that goes through to his/her back. There is no current lab work to review on this patient. He/She denies ever having bowel movements with blood and says he/she did throw up blood once or twice. There is no literature to review from patient's past diagnosis for his/her GI issues. The patient also states that every time he/she eats it goes right through him/her. He/She does eat quite a bit during the day as well as taking his/her tube feedings;<br><br>-Severe acute pancreatitis: Continue Creon, all other medications related to his/her digestive tract. Patient is taking in oral intake at this time. He/she does eat solid foods, unsure if patient needs to be kept on continuous tube feeding at this time. No nausea or vomiting noted;<br><br>-Severe protein-calorie malnutrition: Patient was supposed to get 80 ml/h of tube feeding. They do not have a pump at the facility. I went ahead and told him/her they can do 120 cc of tube feeding at night and let him/her eat the rest of the time because he/she is taking in foods orally. He/She has no nausea;<br><br>(continued on next page) |

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| | 265539 | A. Building<br>B. Wing | 04/09/2024 |

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| Aegis Health and Rehabilitation | 1441 Charic Drive<br>Wildwood, MO 63021 |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Plan: Spent approximately 65 minutes plus with this patient face-to-face encounter, reviewing his/her history doing a physical exam, also reviewing 50 plus pages of paperwork from a previous facility that he/she was in. There was no hospital paperwork to review. We also looked through his/her medication list to try and get his/her medications figured out and straightened out. This patient is very complicated. He/She is also very young. There is a lot of issues with his/her medical care that do not make a lot of sense to me. There is no proof of what things are true or not true, but is obvious this patient's had some serious medical complications from issues with his/her GI tract and diabetes.<br><br>Review of resident's psychosocial assessment, dated 1/31/24, showed no presence of poor appetite or overeating.<br><br>Review of the resident's care plan, dated 1/29/24, showed:<br><br>-Focus: Residents' Rights are guaranteed by the Federal 1987 Nursing Home Reform Law. The law requires Skilled Nursing Facilities to promote and protect the rights of each resident, placing emphasis on individual preferences, dignity, and self-determination;<br><br>-Goal: The resident's autonomy and dignity will be honored in the personal choices that they make;<br><br>-Interventions: The resident has the right to accept and/or refuse any medication, treatment, recommendation, or services that are offered;<br><br>-The resident has the right to be treated with consideration, respect, and dignity. To be free from mental and physical abuse, corporal punishment, involuntary seclusion, and to be free from restraint (physical or chemical);<br><br>-The resident has the right to make independent informed choices: Personal decisions;<br><br>-The resident has the right to privacy and confidentiality;<br><br>-Focus: Resident has an Activity of Daily Living (ADL) self-care performance deficit;<br><br>-Goals: The resident will improve current level of function in all ADLs through the review date;<br><br>-Interventions: The resident is able to: feed him/herself after set up of meal with encouragement due to malnutrition;<br><br>-Focus: The resident requires bolus (a way to send formula through the feeding tube so it flows by gravity over a short period of time) tube feeding every day of 240 milliliters (ml) of Glucerna 1.5;<br><br>-Goal: The resident will remain free of side effects or complications related to tube feeding through review date;<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Interventions: The resident needs the head of bed (HOB) elevated 45 degrees during and thirty minutes after tube feed; Discuss with the resident/family/caregivers any concerns about tube feeding, advantages, disadvantages, potential complications; Resident completes the bolus him/herself with supervision by licensed nursing staff; Provide local care to g-tube site as ordered and monitor for signs and symptoms of infection;<br><br>-Focus: The resident has diarrhea related to Crohn's and pancreatitis;<br><br>-Interventions: The resident will be free from signs and symptoms of dehydration through the review date;<br><br>-Goal: Monitor/document for pain and discomfort, give analgesics as ordered. Document frequency, severity and location of pain;<br><br>-Give anti-diarrheal medications as ordered;<br><br>-Encourage fluid intake as tolerated;<br><br>-Focus: The resident uses antidepressant medication related to diagnosis of PTSD;<br><br>-Goal: The resident will show decreased signs and signs and symptoms of depression through the review date;<br><br>-Interventions: Monitor/document/report as needed (PRN) adverse reactions to antidepressant therapy: change in behavior/mood/cognition, hallucinations/delusions, social isolation, suicidal thoughts, withdrawal, decline in ADL ability, continence, no voiding, constipation, fecal impaction, diarrhea, gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth, dry eyes;<br><br>-Educate the resident, family, and caregivers about risks, benefits and the side effects and/or toxic symptoms of antidepressants;<br><br>-Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness every shift;<br><br>-Focus: The resident has unplanned/unexpected weight loss related to failure to thrive;<br><br>-Goal: No significant weight loss of 5% in 30 days or 10% in 180 days;<br><br>-Interventions: Monitor and record food intake at each meal; Monitor and evaluate any weight loss. Determine percentage lost and follow facility protocol for weight loss; Labs as ordered. Report results to physician and ensure dietitian is aware;<br><br>-Focus: The resident has abdominal pain related to pancreatitis and Crohn's disease;<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Goal: The resident will voice a level of comfort of using pain scale of 1-10 when assessed by staff; The resident will not have an interruption in normal activities due to pain through the review date;<br><br>-Interventions: Monitor/record pain characteristics every shift and PRN: Quality, Severity (1 to 10 scale), Anatomical location, onset, duration, aggravating factors, relieving factors; The resident is able to (specify) call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain; Monitor/record pain characteristics every shift and PRN;<br><br>-No documentation regarding a suspected eating disorder, binge or overeating, or vomiting and/or bulimia. No documentation regarding a history of an eating disorder, resident's denial, or potential emotional causes or distresses leading to disordered eating.<br><br>Review of the resident's progress notes, dated 2/19/24 at 12:50 P.M., showed:<br><br>-Dietary Manager reported to this nurse, resident is eating his/her regular meals and then requesting an opposite of meal to be prepared to go. It was reported the resident is binge eating then purging. This nurse made Administrator and DON aware;<br><br>-No further documentation regarding a potential eating disorder, referrals made, or physician and dietician contact. There is no documentation of Social Services follow up or documentation of what was eaten, how much, or potential triggers that lead to binge eating and/or vomiting.<br><br>During an interview on 4/3/24 at 12:03 P.M., the resident said he/she was upset due to the treatment from the Director of Nursing (DON). He/She felt the DON was mean to him/her. He/She had complaints of pain for a week and the DON would not allow him/her to go to the hospital. He/She had an infection in his/her colon, but he/she is much better now. The DON believed the resident made him/herself vomit. He/She would not intentionally make him/herself vomit. If he/she was sick, that is different. Sometimes he/she becomes sick because of other medical conditions such as the g-tube the resident had. The resident said he/she used to weigh 200 pounds and would like to get back to a healthy weight. In front of staff and other residents, the DON said the resident made him/herself vomit. The resident became tearful. He/She said now other residents made comments that he/she made him/herself vomit.<br><br>During an interview on 4/5/24 at 4:29 P.M., the DON said she did not remember who reported the resident's binge eating/vomiting. The resident had a prior history of it. It was known at the time of his/her admission and it was why he/she had a g-tube. The resident was binging, purging and was not eating. They had several conversations about it, but the resident denied binge eating. He/She denied it all. The DON did not remember if his/her prior facility had any documentation of anorexia or bulimia. It was a verbal report. It is all based on previous staff members. There are six staff members who were involved in his/her care at prior facilities. The DON received this information from several staff members who knew the resident from his/her prior facility. They were familiar with him/her. Since he/she was admitted to the facility, he/she had also been admitted to the hospital.<br><br>Review of the resident's progress notes, dated 2/20/24 at 2:20 P.M., showed:<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Physician has requested this resident be sent out to the emergency room for evaluation of abdominal pain at g-tube site. Attempted pharmalogical intervention, which has been unsuccessful. Nursing notified to transfer resident out to the emergency room ;<br><br>-No further documentation regarding a potential eating disorder, referrals made, or physician and dietician contact. There is no documentation of Social Services follow up or documentation of what was eaten, how much, or potential triggers that lead to binge eating and/or vomiting.<br><br>Review of the hospital records, dated 2/20/24, showed:<br><br>-Date of Admission: 2/20/24;<br><br>-Date of Discharge: 2/22/24;<br><br>-Reason for admission: Abdominal pain. Patient in emergency department with Emergency Medical Services (EMS) for diffuse lower mid abdominal pain x 3 days, unable to flush g-tube x 3 days, no feedings x 3 days, reports chronic diarrhea;<br><br>-History of Crohn's disease, irritable bowel syndrome (IBS), chronic pancreatitis (inflammation of the pancreas), insulin dependent diabetes mellitus (IDDM), diabetic gastroparesis (prevents proper stomach emptying), failure to thrive, status post gastrostomy-jejunostomy tube (G-J tube, tube placed into the stomach and small intestine), multiple organ dysfunction (MOD), generalized anxiety disorder (GAD), tobacco abuse, who presents with G-J-tube malfunction. He/She noted G-tube was clogged about 2 days ago, unable to flush. He/She had nausea and vomiting that night as well, although no vomiting yesterday. He/She is able to tolerate food by mouth yesterday, and last bowel movement was this morning. Patient has diarrhea at baseline. Also, he/she notes abdominal pain at G-tube site. Denies any hematemesis (vomiting of blood). Patient presented from facility, where they attempted to unclog his/her G-tube, but were unsuccessful. Interventional radiology (IR) was able to successfully unclog G-tube in the emergency room . Patient continues to describe pain even after G-tube is flushing well. Computed tomography (CT, imaging test) abdomen demonstrated that G-J tube is coiled in the stomach. IR then replaced G-J-tube on 2/21/24. Patient was tolerating tube feeds through G-J-tube well. Patient was discharged to the facility with no changes to medications. Patient to follow-up with his/her primary care physician within five days of discharge.<br><br>During an interview on 4/5/24 at 4:29 P.M., the DON said prior to the 4/1/24 hospital visit for abdominal pain and nausea, the resident's g-tube was twisted and coiled. It will do that when you make yourself vomit and purge. When he/she came back to the facility, everything was fine.<br><br>Review of the resident's progress notes, showed:<br><br>-On 3/28/24 at 12:17 P.M., Resident complaints of persistent abdominal pain and frequent bathroom visits. Doctor called and ordered a kidney, ureter and bladder (KUB) abdominal x-ray and Bentyl 10 milligrams (mg), four times a day ordered. Resident received pain pill at 1:00 P.M.;<br><br>-On 3/28/24 at 3:20 P.M. x-ray tech arrived to do abdominal x-ray on resident, resident tolerated well and stated, I want to see how dinner goes and then decide what I want to do from there;<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -On 3/29/24 at 1:35 P.M., resident states that he/she is in pain in his/her abdominal and wants to call 911 him/herself. This A.M., he/she stated that he/she felt fine. He/She had a couple of bowel movements that were normal soft stool. His/Her abdominal was not distended or hard. He/She was given a PRN medication for pain per physician's orders. His/Her blood work came back and was reported to physician's office. No new orders also his/her KUB done yesterday came back and results were negative. No new orders at this time;<br><br>-On 3/30/24 at 12:53 P.M., Resident called an ambulance for him/herself to go hospital for evaluation for persistent abdominal pain. Paperwork, meds, and x-ray results printed and sent along with resident to the emergency room . Doctor made aware of resident calling 911 and that resident is heading to hospital for evaluation. Ambulance arrived at 12:50 to take resident;<br><br>-On 3/30/24 at 4:09 P.M., Resident admitted to hospital for inflammation of the abdominal and lower intestine. Doctor made aware and resident is his/her own responsible party;<br><br>-No further documentation regarding a potential eating disorder, referrals made, or physician and dietician contact. There is no documentation of Social Services follow up or documentation of what was eaten, how much, or potential triggers that lead to binge eating and/or vomiting.<br><br>During an interview on 4/5/24 at 4:29 P.M., the DON said he/she ate all that food (referring to a day when he/she ate McDonalds) prior to the 3/30/24 hospital visit. The resident had an another occurrence with binging, and he/she called 911 him/herself. He/She had complaints of abdominal pain. A few days prior to that, the resident ate breakfast, lunch, and ordered door dash from McDonalds. Someone said it was $40 worth of McDonalds, then he/she had dinner. Someone reported he/she ordered double potions for dinner. The resident asks for double portions, but denies the purging. The resident said, no I did not do it. He/She complained about abdominal pain. They notified the physician, x-ray was ordered, they administered doxycamine for cramping, and KUB was negative. On Saturday morning, the resident called 911. He/She stayed overnight in the hospital and returned.<br><br>Review of the resident's hospital records, showed:<br><br>-Date of admission: 3/30/24;<br><br>-Date of discharge: 4/1/24;<br><br>-Admitting diagnoses: diarrhea and abdominal discomfort;<br><br>-Discharge diagnoses: diarrhea with evidence colitis (inflammatory reaction in the colon) on imaging;<br><br>-Hospital course: History of multiple hospital admissions, significant history of abdominal pain, malnutrition, g-tube feeding dependence via J tube, Crohn's disease, depression, IDDM. Nursing home patient presented on 3/30/24 with complaints of abdominal discomfort. Computer tomography (CT, procedure that produces pictures of cross-sections of the body) imaging in emergency department showed evidence hemi colitis, proctitis (inflammation of the lining of the rectum). Gastroenterologists (GI) consulted. Placed on intravenous (IV) ceftriaxone (antibiotic), IV Flagyl (antibiotic) and admitted to medicine service for further monitoring;<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Provider assessment/plan: Regular diet combined with tube feeding to supplement via G-J tube;<br><br>-Current diet and/or nutritional supplementation ordered: Diet tube feeding;<br><br>-Daily weights;<br><br>-Impact of malnutrition on patient condition and outcomes: IDDM;<br><br>-Continue home medications;<br><br>-No need to restrict diet given degree of underweight/malnutrition;<br><br>-Will adjust insulin as needed based on by mouth intake/blood sugars.<br><br>During an interview on 4/3/24 at 12:03 P.M., the resident said the DON made comments about what he/she ate and how much. He/She orders out once in a while. For example, he/she purchased a meal from McDonalds that included chicken nuggets, a cheeseburger, fries and a drink. He/She ate half the nuggets and gave the rest to another resident. The DON said, that is why you are sick because you are eating all that food. The resident had become self-conscious about eating in front of people and what he/she was eating.<br><br>During an interview on 4/5/24 at 4:29 P.M., the DON said she returned from vacation February 2024, and vomit was found in the resident's bathroom. The resident said the vomit was from his/her roommate. The DON never witnessed the resident vomiting and was not aware of anyone else witnessing the resident vomiting. The DON said the vomit in the bathroom was from the resident, but he/she blamed it on the roommate. The roommate said it wasn't her/him. There had not been any comments made from residents about the resident vomiting except for the roommate. After the bathroom incident, there was no more vomiting that was reported. It was only reported to the DON, she did not see it. The DON could not recall interventions put in place after discovering the resident's suspected binge eating and vomiting. They did talk about it in meetings. The physician was notified. The DON did not recall if the dietician was notified. They should be aware of it. The DON later said the dietician was aware, but she was not sure if there were any interventions. The DON did not recall if Social Services was aware. The resident has a psychiatrist. The DON said the resident seemed to be a little depressed. Everything is in the progress notes. If there is was resident with a suspected eating disorder, the DON expected the resident to be offered the help, services, and referrals that are needed. The DON confirmed people who have a eating disorder history often deny it. There is no medical diagnoses in the resident's chart. There is no physician who gave him/her the diagnosis. It is based on his/her history, what was provided, and staff who took care of him/her. The resident often has complaints of pain to his/her abdomen. There were no reports of throat pain or acid reflux. Those were not brought to the DON's attention. There is no evidence of Crohn's disease. The DON said the conversation she had with the resident about binge eating and vomiting were not documented because the conversations were in passing, such as in the dining room or in the hall. The DON said the conversations included telling the resident, you cannot stuff yourself, do not do that, watch yourself, and you have to be careful. If the DON is in the dining room and heard the resident ask for more food, the DON would say be careful, do not eat too much. The resident's response is, I am being careful. I am not doing that. The DON had these conversations during or before the meal.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/9/23 at 8:38 A.M., the Social Services Designee said he/she was familiar with the resident. He/She had known him/her for four or five years. The resident was at the first facility he/she ever worked it. They used to talk back and forth. The resident vents and expresses how he/she is feeling. He/She seemed like a depressed soul. The Social Services Designee encouraged the resident to go out and make friends and talk if he/she needed anything. The resident is reclusive. He/She never had a conversation with the resident regarding a suspected eating disorder. The resident went to the hospital and his/her diet was changed to a gastric soft diet, so they talked about refraining from greasy foods. The DON had a conversation with the resident and he/she becomes upset when the conversation comes up. The resident does not have a diagnosis, but there was word that an aide walked in the resident's room and there was vomit on the floor. No one knew where it came from.<br><br>During an interview on 4/9/24 at 12:32 P.M., Regional Nurse M said if a resident had a suspected eating disorder, she expected staff to follow up with the physician and other services if warranted if it was a current problem for resident. They should contact the dietician and Social Services. If staff observed a resident who was suspected of binge eating, it should be documented and staff should notify the physician and Social Services can follow if need be. It is not appropriate to say don't stuff yourself or don't eat too much. She said it is common for many people to deny having an eating disorder. If a resident denied having an eating disorder, staff should consult with the physician, Social Services, and outside services if needed. She expected staff to document the resident's meals if there is suspected binge eating. She expected care plans to be updated quarterly and as needed.<br><br>44950 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>32847<br><br>49992<br><br>Based on interview and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in a sufficient detail to enable accurate reconciliation. The facility failed to ensure accuracy and monitoring for controlled substances for 2 of 2 narcotic count books reviewed. The census was 41.<br><br>Review of the facility's Controlled Substance Administration & Accountability policy, dated 9/1/21, showed:<br><br>-It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion, or accidental exposure;<br><br>-Policy Explanation and Compliance Guidelines: Inventory Verification: For areas without automated dispensing systems, two licensed nurse or per state regulation account for all controlled substances and access keys at the end of each shift.<br><br>Review of the facility's Narcotics Book #1 and Narcotics Book #2, reviewed on 4/5/24 at 6:22 A.M., showed:<br><br>-The sheet contains eight columns: Shift, Date, Starting Count, Cards In, Cards Out, Ending Count, Off Going Nurse, On Coming Nurse;<br><br>-The sheet prompted for a day/night and night/day count for each shift change.<br><br>1. Review of the Narcotics Book #1, on 4/5/24 at 6:22 A.M., showed a controlled substance shift change count sheet, starting date 2/26/24 and ending date 3/10/24:<br><br>-No day/night count completed for four of 28 opportunities;<br><br>-No night/day count completed for three of 28 opportunities;<br><br>-Only one nurse signature for the count for eight of 28 opportunities.<br><br>2. Review of the binder labeled Narcotics Book #2, on 4/4/24 at 6:22 A.M., showed a controlled substance shift change count sheet, starting 3/17/24 and ending date 4/3/24:<br><br>-No day/night count completed for eight of 26 opportunities;<br><br>-No night/day count completed for eight of 26 opportunities;<br><br>-Only one nurse signature for the count for 16 of 26 opportunities.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The off going nurse pre-signed the narcotic count sheet for off going with no date listed.<br><br>3. During an interview on 4/5/24 at 7:01 A.M., the Assistant Director of Nursing (ADON) said she worked the night shift. The narcotic count process is confusing. There are times she must count narcotics by herself. Last night when she came on duty, the day shift nurse left before they counted narcotics, so she had to count by herself. The process is, the oncoming and off going count together. The off going marks the book, the oncoming nurse physically counts. First count the number of cards in the cart total, then we count the number of pills in each card.<br><br>4. During an interview on 4/9/24 at 8:02 A.M., Licensed Practical Nurse (LPN) B said that nurses are expected to count narcotics at the beginning and end of their shifts. Nurses should not pre-sign the narcotic book before the end of their shift.<br><br>5. During an interview on 4/9/24 at 8:50 A.M., the Director of Nursing (DON) said she would expect the nurses to follow the policy and procedures for counting narcotics, not pre-sign before the oncoming shift, there is always someone to count with. |

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| | 265539 | A. Building<br>B. Wing | 04/09/2024 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>32847<br><br>Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 38 opportunities observed, 11 errors occurred resulting in a 28.94% error rate (Residents #27, #6 and #28). The census was 41.<br><br>Review of the facility's Medical Provider Orders policy, dated 9/1/21, showed:<br><br>-This facility shall use uniform guidelines for the ordering and following of medical provider orders;<br><br>-Medications and/or treatments should be administered only upon the signed order of a person lawfully authorized to prescribe;<br><br>-Staff should follow all valid medical provider orders timely unless there is an emergency which would temporarily delay the implementation of the order.<br><br>Review of the facility's Medication Administration policy, dated 9/1/21, showed:<br><br>-Medications are administered by licensed nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection;<br><br>-Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs out of the physician's prescribed parameters;<br><br>-Verify the resident's name, medication name, form, dose, route, and time;<br><br>-Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician;<br><br>-Administer medication as ordered in accordance with manufacturer specifications;<br><br>-Provide appropriate amount of food and fluid;<br><br>-Medication requiring vital signs prior to administration: Anti-hypertensives (used to treat high blood pressure).<br><br>1. Review of Resident #27's medical record, showed:<br><br>-Diagnoses included diabetes, peripheral vascular disease (reduced circulation of blood), and iron deficiency anemia (insufficient iron in the blood);<br><br>-An order, dated 9/18/23, for blood sugar checks before meals and at bedtime. Notify medical doctor (MD) if lower than 60 or over 400;<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -An order, dated 1/28/24, for Insulin Glargine (long acting insulin) subcutaneous (under the skin) solution Pen-injector 100 units/milliliter (ml). Inject 28 unit subcutaneously in the morning;<br><br>-An order for Lispro (short acting insulin) subcutaneous solution Pen-injector 100 unit/ml. Inject 5 unit subcutaneously before meals;<br><br>-An order for Insulin Lispro subcutaneous solution Pen-injector 100 unit/ml. Inject as per sliding scale: if 0-200 = 0 No sliding scale indicated for blood sugar less than 200; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; BS 401 or above call MD. Subcutaneously before meals.<br><br>-No nursing documentation in the progress notes on 4/5/24, 4/6/24, and 4/7/24 that the resident had refused the ordered dose of insulin;<br><br>-The Assistant Director of Nursing (ADON) documented in the Medication Administration Record (MAR) that the resident refused the Lispro sliding scale insulin.<br><br>During a medication administration observation on 4/5/24 at 6:46 A.M., the resident obtained his/her blood sugar level using an implanted electronic device and reported to the ADON that his/her blood sugar was 327. The ADON told the resident that she was going to administer the insulin as ordered and the resident refused. The resident told the ADON to give only 18 units of the Glargine and the ordered 5 units of Lispro. The ADON administered the insulin per the resident request to the left lower quadrant of his/her abdomen.<br><br>During an interview on 4/5/24 at approximately 6:50 A.M., the ADON said that she did administer the resident's requested amount of insulin and would make the Director of Nursing (DON) aware.<br><br>During an interview on 4/9/24 at 8:02 A.M., Licensed Practical Nurse (LPN) B said that insulin should be administered as ordered by the physician, not as requested by the resident. If the ordered amount is refused the physician should be notified. The nurse should document in the medical record the refusal and physician notification.<br><br>During an interview on 4/9/24 at 8:50 A.M., the DON said that nurses should follow the policy and procedure for insulin administration. The nurses should not allow the residents to dictate the amount of insulin to be administered, the nurse should notify the physician, and the nurse should document in the resident's progress notes the resident's refusal and physician notification.<br><br>2. Review of Resident #6's medical record, showed:<br><br>-An order start date 2/28/24, for aspirin enteric coated delayed release, 81 milligram (mg) one time a day for prevention of cardiac event, scheduled administration time 10:00 A.M.;<br><br>-An order start date 2/28/24, for fluticasone propionate suspension (an inhaled steroid) 50 micrograms (mcg), two sprays in each nostril one time a day for sinus, scheduled administration time 10:00 A.M.;<br><br>-An order start date 2/28/24, for GlycoLax powder (stool softener). Give 17 grams by mouth one time a day for constipation;<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -An order start date 2/28/24, for cyanocobalamin (vitamin B12) 1000 mcg. One tablet by mouth one time a day for supplement;<br><br>-An order start date 2/28/24, for clonazepam (used to treat anxiety or seizure disorders), 0.5 mg. Give one tablet by mouth two times a day, scheduled administration times of 10:00 A.M. and 6:00 P.M.;<br><br>-An order start date 2/28/24, for sennosides-docusate sodium (stool softener) 8.6-50 mg. Give one tablet by mouth tow times a day for constipation;<br><br>-An order start date 3/18/24, for Lidocaine patch (pain medication) 4%. Apply to right shoulder topically one time a day for pain and remove per schedule. Scheduled removal time, 9:59 A.M. Scheduled application time 10:00 A.M.;<br><br>-No order for vitamin D3.<br><br>Observation on 4/5/24 at 8:55 A.M., showed CMT A administered medications to the resident. CMT A said the facility does not have open medication pass. Medications are to be administered up to one hour before or one hour after the scheduled administration time. The resident's clonazepam was not available for administration, so the resident would not receive it and he/she would need to call the pharmacy. CMT A administered aspirin 81 mg chew and said the resident is ordered aspirin enteric coated but the facility only had the chewable tablets. CMT A administered vitamin D3 400 iu orally and applied a lidocaine patch 4% to the resident's lower back. Vitamin B12, fluticasone propionate, GlycoLax powder, and sennosides-docusate sodium not administered.<br><br>During an interview on 4/5/24 at 12:01 P.M., CMT A said he/she had not gone back to administer the resident any other medications after the observed medication pass and the only medication administered prior to the observation was the resident's 6:00 A.M. scheduled medication. He/She usually removes the prior lidocaine patch prior to administering the new patch. He/She removed the prior lidocaine patch from the resident's shoulder just prior to the medication administration observation.<br><br>During an interview on 4/9/24 at 8:50 A.M., the DON said if a resident is ordered a certain form of a medication, such as enteric coated or chewable, the correct form should be administered. If a topical patch is ordered, it should be applied in the correct location. There should be an order for any medication administered. Staff should follow the order for lidocaine patches as far as how long they can stay on. She did not know what recommendations are per acceptable standards of practice but would expect the physician order to follow acceptable standards of practice.<br><br>Review of the National Library of Medicine- Medline Plus website, last revised 6/15/21, showed:<br><br>-Prescription lidocaine transdermal is applied only once a day as needed for pain. Never wear them for more than 12 hours per day (12 hours on and 12 hours off);<br><br>-If you wear too many lidocaine transdermal patches or topical systems or wear them for too long, too much lidocaine may be absorbed into your blood. In that case, you may experience symptoms of an overdose;<br><br>-In case of overdose, call the poison control helpline;<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Symptoms of overdose may include: lightheadedness, nervousness, inappropriate happiness, confusion, dizziness, drowsiness, ringing in the ears, blurred or double vision vomiting, feeling hot, cold, or numb, twitching or shaking that you cannot control<br><br>Seizures, , loss of consciousness, and slow heartbeat.<br><br>3. Review of Resident #28's medical record, showed:<br><br>-Diagnoses included, chronic obstructive pulmonary disease (COPD, lung disease), high blood pressure, depression, and pain;<br><br>-An order dated 8/31/23, for Losartan Potassium (treats high blood pressure) 100 mg, one time a day, staff to document blood pressure;<br><br>-An order dated 3/18/24, for polyethylene glycol powder (stool softener), house stock, 17 grams daily.<br><br>During a medication administration observation on 4/5/24 at 9:19 A.M., CMT A:<br><br>-Administered Losartan Potassium 100 mg to the resident prior to obtaining the residents blood pressure;<br><br>-Poured the polyethylene glycol powder in to a clear 30 ml medication cup at eye level. Then poured water into a clear 5-ounce (oz) cup, poured the powder into the water and stirred, then administered to the resident. While preparing the medication CMT A said I know this goes into 8 oz of water, but they only supply us with the small cups;<br><br>-After administration of all the medication, CMT A went back into the room to obtain the blood pressure, which resulted in 147/93 (indicates high blood pressure).<br><br>During an interview on 4/5/24 at 10:12 A.M., with LPN K, he/she was able to produce a bottle of the polyethylene glycol powder but was not able to find the directions regarding the amount of liquid that must be used to reconstitute the powder.<br><br>During an interview on 4/9/24 at 8:50 A.M., the DON said the nurses should follow the policy and procedures for medication administration. When preparing the polyethylene glycol powder the staff should follow the directions, using the correct size measuring device and the correct amount of fluid. For those residents who receive medications for high blood pressure, that indicate a blood pressure to be taken, she would expect the staff to obtain the blood pressure prior to administering the medication.<br><br>During a phone interview on 4/8/24 at 11:31 A.M., Pharmacist U, a pharmacist with the pharmacy that supplies the facility's medications, said polyethylene glycol powder is a house stock medication and is typically mixed with 8 oz of water or juice.<br><br>4. During an interview on 4/9/24 at 8:50 A.M., the DON said medications should be administered as ordered. This includes the correct medication, dose, route and time, per facility policy.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 49992 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>32847<br><br>Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors when one resident was administered the wrong dose of insulin and one resident had an for a medication patch to be applied for longer than recommended per acceptable standards of practice (Residents #27 and #6). The census was 41.<br><br>Review of the facility's Medical Provider Orders policy, dated 9/1/21, showed:<br><br>-This facility shall use uniform guidelines for the ordering and following of medical provider orders;<br><br>-Medications and/or treatments should be administered only upon the signed order of a person lawfully authorized to prescribe;<br><br>-Staff should follow all valid medical provider orders timely unless there is an emergency which would temporarily delay the implementation of the order.<br><br>Review of the facility's Medication Administration policy, dated 9/1/21, showed:<br><br>-Medications are administered by licensed nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection;<br><br>-Verify the resident's name, medication name, form, dose, route, and time;<br><br>-Administer medication as ordered in accordance with manufacturer specifications.<br><br>1. Review of Resident #27's medical record, showed:<br><br>-Diagnoses included diabetes, peripheral vascular disease (reduced circulation of blood), and iron deficiency anemia (insufficient iron in the blood);<br><br>-An order, dated 9/18/23, for blood sugar checks before meals and at bedtime. Notify medical doctor (MD) if lower than 60 or over 400;<br><br>-An order, dated 1/28/24, for Insulin Glargine (long acting insulin) subcutaneous (under the skin) solution Pen-injector 100 units/milliliter (ml). Inject 28 unit subcutaneously in the morning;<br><br>-An order for Lispro (short acting insulin) subcutaneous solution Pen-injector 100 unit/ml. Inject 5 unit subcutaneously before meals;<br><br>-An order for Insulin Lispro subcutaneous solution Pen-injector 100 unit/ml. Inject as per sliding scale: if 0-200 = 0 No sliding scale indicated for blood sugar less than 200; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; BS 401 or above call MD. Subcutaneously before meals.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -No nursing documentation in the progress notes on 4/5/24, 4/6/24, and 4/7/24, that the resident had refused the ordered dose of insulin;<br><br>-The Assistant Director of Nursing (ADON) documented in the Medication Administration Record (MAR) that the resident refused the Lispro sliding scale insulin.<br><br>During a medication administration observation on 4/5/24 at 6:46 A.M., the resident obtained his/her blood sugar level using an implanted electronic device and reported to the ADON that his blood sugar was 327. The ADON told the resident that she was going to administer the insulin as ordered and the resident refused. The resident told the ADON to give only 18 units of the Glargine and the ordered 5 units of Lispro. The ADON administered the insulin per the resident request to the left lower quadrant of his/her abdomen.<br><br>During an interview on 4/5/24 at approximately 6:50 A.M., the ADON said that she did administer the resident's requested amount of insulin and would make the Director of Nursing (DON) aware.<br><br>During an interview on 4/9/24 at 8:02 A.M., Licensed Practical Nurse (LPN) B said that insulin should be administered as ordered by the physician, not as requested by the resident. If the ordered amount is refused, the physician should be notified. The nurse should document in the medical record the refusal and physician notification.<br><br>During an interview on 4/9/24 at 8:50 A.M., the DON said that nurses should follow the policy and procedure for insulin administration. The nurses should not allow the residents to dictate the amount of insulin to be administered, the nurse should notify the physician, and the nurse should document in the resident's progress notes the resident's refusal and physician notification.<br><br>2. Review of Resident #6's medical record, showed:<br><br>-Diagnoses included pain, unspecified;<br><br>-An order start date 3/18/24, for Lidocaine patch (pain medication) 45. Apply to right shoulder topically one time a day for pain and remove per schedule. Scheduled removal time, 9:59 A.M. Scheduled application time 10:00 A.M.<br><br>Review of the National Library of Medicine- Medline Plus website, last revised 6/15/21, showed:<br><br>-Prescription lidocaine transdermal is applied only once a day as needed for pain. Never wear them for more than 12 hours per day (12 hours on and 12 hours off);<br><br>-If you wear too many lidocaine transdermal patches or topical systems or wear them for too long, too much lidocaine may be absorbed into your blood. In that case, you may experience symptoms of an overdose;<br><br>-In case of overdose, call the poison control helpline;<br><br>-Symptoms of overdose may include: lightheadedness, nervousness, inappropriate happiness, confusion, dizziness, drowsiness, ringing in the ears, blurred or double vision vomiting, feeling hot, cold, or numb, twitching or shaking that you cannot control<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Seizures, , loss of consciousness, and slow heartbeat.<br><br>Observation on 4/5/24 at 8:55 A.M., showed CMT A administered medications to the resident and applied a lidocaine patch 4% to the resident's lower back.<br><br>During an interview on 4/5/24 at 12:01 P.M., CMT A said he/she usually removes the prior lidocaine patch prior to administering the new patch. He/She removed the prior lidocaine patch from the resident's shoulder just prior to the medication administration observation.<br><br>During an interview on 4/9/24 at 8:50 A.M., the DON said staff should follow the order for lidocaine patches as far as how long they can stay on. She did not know what recommendations are per acceptable standards of practice but would expect the physician order to follow acceptable standards of practice.<br><br>MO00233990<br><br>49992 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>32847<br><br>Based on observation, interview and record review, the facility failed to ensure medications are stored in accordance with currently accepted professional principles when the medication room refrigerator temperature was out of range and staff were not checking the temperature per policy, medications were not labeled with resident names, medication carts were left unlocked and not supervised, and schedule II medications were not stored behind two locks for one of one medication room and three of three medication carts reviewed. The facility had one medication room and four medication carts. The census was 41.<br><br>Review of the facility's Medication Storage policy, dated 9/1/21, showed:<br><br>-It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security;<br><br>-All drugs and biologicals will be stored in locked compartments;<br><br>-Only authorized personnel will have access to the keys to locked compartments;<br><br>-During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart;<br><br>-Schedule II drugs are stored under double-lock and key;<br><br>-All medications requiring refrigeration are stored in refrigerators. Temperatures are maintained within 36-46 degrees Fahrenheit (F). Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee;<br><br>-The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed.<br><br>1. Observation on 4/5/24 at 6:17 A.M., of the medication room refrigerator, showed the thermometer inside the refrigerator measured 50 degrees F. The medication refrigerator contained insulin and a variety of medications in vials. The Assistant Director of Nursing (ADON) said she is not sure who checks or logs the medication room refrigerator temperatures.<br><br>Review of the medication room refrigerator temperature log book, located at the nurse's station, dated 4/2024 and reviewed on 4/5/24 at 6:20 A.M., showed:<br><br>-Monitor temperatures closely;<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Record temps twice each workday;<br><br>-Take action if temp is out of range-too warm (above 46 degrees F) or too cold (below 35 degrees F);<br><br>-The temperature taken once on the 1st, 2nd, and 3rd and documented as 40 degrees F.<br><br>Observation on 4/8/24 at 8:34 A.M., of the medication room refrigerator, showed the thermometer inside the refrigerator measured 48 degrees F.<br><br>2. Observation of the nurse medication cart on 4/5/24 at 6:07 A.M., with the ADON, showed:<br><br>-A vial of Lantus, opened with no resident name labeled on the vial;<br><br>-The ADON said this insulin is shared and not for one resident;<br><br>-A tube of diclofenac sodium 1% (used to treat arthritis pain topically);<br><br>-The ADON said she knows which resident the ointment belongs to but is not sure where the bag went. The name is on the bag that is missing.<br><br>3. Observation on 4/5/24 at 6:22 A.M., showed the Certified Medication Technician (CMT) medication cart #1 sat at the nurse's station. No staff were present at the nurse's station or in view of the medication cart. The medication cart sat unlocked and contained prescription liquid medications, stock over the counter medications, individual resident prescribed oral medications and a narcotic locked box under one lock. During this time the ADON, CMT D, Certified Nursing Assistant (CNA) F, CMT A, came and went from nurse's station and cart #1 remained unlocked through 6:44 A.M.<br><br>During an observation and interview on 4/5/24 at 9:01 A.M., CMT A pulled medications from the medication cart for a resident. At 9:06 A.M., CMT A left cart unlocked and went to the medication storage room. At 9:08 A.M., CMT A returned to the medication cart. At 9:15 A.M., CMT A entered a resident's room. The medication cart remained outside the room, unlocked. At 9:18 A.M., one resident walked past the unlocked medication cart.<br><br>Observation on 4/5/24 at 11:58 A.M., showed no nurses at the nurse's station. Medication cart #1 and medication cart #2, both sat unlocked and contained prescription liquid medications, stock over the counter medications, individual resident prescribed oral medications and a narcotic locked box under one lock. At 12:01 P.M., CMT A returned to nurse's station, medication cart #1 and medication cart #2 remained unlocked in front of nurse's station. At 12:03 P.M., a resident self-propelled in a wheelchair to the vending machines and passed the unlocked cart #2. At 12:06 P.M., medication cart #2 remained unlocked with three residents passing by. No staff were present at the nurse's station. At 12:08 P.M., Regional Nurse M locked the medication cart #2.<br><br>Observation on 4/8/24 at 8:45 A.M., showed a nurse medication cart locked with the top draw open with insulin pens visible in the top drawer. No staff were present.<br><br>(continued on next page) |

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|---|---|---|---|
| | 265539 | A. Building<br>B. Wing | 04/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aegis Health and Rehabilitation | 1441 Charic Drive<br>Wildwood, MO 63021 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. During an interview 4/9/24 at 8:50 A.M., the Director of Nursing (DON) said it is not acceptable for insulin to be used on more than one resident. If insulin is pulled from stock, it should be labeled with the resident's name. Prescribed creams and ointments should be labeled with the resident's name. She is not sure who is responsible to check the medication room refrigerator temperatures, but it should be per policy. If the temperature is out of range, staff should adjust the temperature and follow up to see if it is an issue that requires maintenance. Medication carts should be locked when not in use and schedule II narcotic medications should be behind a double lock.<br><br>50366 |

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| F 0776<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394<br><br>Based on observation, interview and record review, the facility failed to obtain a timely Magnetic Resonance Imagine (MRI, diagnostic test that can create detailed images inside the body) and notify the physician when the MRI was delayed for one resident (Resident #18), who showed a lesion on his/her right humerus (upper arm). The facility also failed to obtain an appointment for a swallow test timely after concerns of him/her coughing during meals (Resident #19). The sample was 14. The census was 41.<br><br>1. Review of Resident #18's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/15/23, showed:<br><br>-Severe cognitive impairment;<br><br>-Diagnoses included heart failure, pneumonia, aphasia (language disorder), stroke, quadriplegia (paralysis of all four limbs) and seizure disorder;<br><br>-Dependent with toileting hygiene;<br><br>-Range of motion impairment to both sides of the upper and lower extremities;<br><br>-Indwelling catheter.<br><br>Review of the resident's care plan, in use during survey, showed:<br><br>-Focus: Resident does not communicate;<br><br>-Goal: Resident will have needs met on a daily basis through the review date;<br><br>-Interventions: Anticipate and meet needs;<br><br>- Discuss with resident/family concerns or feelings regarding communication difficulty;<br><br>- Monitor/document for physical/ nonverbal indicators of discomfort or distress, and follow-up as needed;<br><br>- Monitor/document/report as needed (PRN) any changes in: Ability to communicate, potential contributing factors for communication problems, potential for improvement.<br><br>Review of the resident's progress notes, dated 1/25/24, showed this nurse was called to this resident's room by staff related to this resident being on the floor in his/her room. This nurse assessed this resident, vitals signs. No bleeding noted. Call placed to ambulance with an estimated time of arrival of 45 minutes. Ambulance drivers, two Emergency Medical Technicians (EMTs) arrived and transported resident to the hospital. Physician and second emergency contact notified. Resident's mother came to see him/her before being transported. Awaiting update from hospital.<br><br>(continued on next page) |

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| F 0776<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's hospital discharge record, dated 1/25/24, showed:<br><br>-Reason for visit: Fall;<br><br>-Discharge diagnoses: Mild closed head injury and right arm pain;<br><br>-Completed radiology imaging studies: Right Humerus;<br><br>-Impression: Mixed lytic and sclerotic (characterized by the presence of both components, that is areas of bone destruction and areas of increased bone formation within one metastatic tumor deposit or one primary tumor that features both kinds of bone metastase) lesion of the distal humerus.<br><br>Review of the resident's progress notes, dated 1/29/24, showed:<br><br>-Received call from resident's sister, informing me that she received a call from hospital emergency room department physician requesting her to make a follow up appt for MRI of the right humerus due to results of findings for lytic and sclerotic lesion of the distal humerus. I have left a message for Physician X to obtain an order for a MRI to be done. I will update the family of the time and date of appt once scheduled;<br><br>-Called hospital to schedule MRI for patient. Left a voicemail.<br><br>Review of the physician's notes, dated 1/29/24, showed:<br><br>-Diagnosis: Humerus lesion;<br><br>-On 1/29/24, Physician X documented: 1/29/24 x-ray of right humerus. There was no acute abnormality, and it showed mixed lytic and sclerotic lesion of distal humerus. Nurse said that he/she thinks nurse practitioner (NP) Y already saw the results. Family got a call saying that patient needs an MRI to make sure it was not cancer. Nurse is wondering if this is okay;<br><br>-NP Y: Okay to do MRI;<br><br>-There are some issues about a right bone lesion in the distal humerus. I do not have access to the x-ray report. There is some issue about the family wanted an MRI. Patient is severely contracted. I did not see any deformities noted in his/her upper or lower extremities. He/She did not appear to be in any acute distress.<br><br>During an interview on 4/4/24 at 8:52 A.M., the resident's sister said he/she had to go to the emergency room after the resident fell out of the bed. The doctor noticed nodules on his/her arm. The doctor said it could be cancerous so it was important to have the MRI done.<br><br>Review of the resident's Physician's Orders Sheet (POS), showed:<br><br>-An order, dated 1/29/24, MRI of the right humerus to related to cancer due to x-ray that showed lytic and sclerotic lesion;<br><br>(continued on next page) |

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| F 0776<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -An order, dated 2/15/24, for MRI R humerus, other specified of bone upper arm with and without contrast.<br><br>Review of the physician's notes, dated 2/2/24, showed:<br><br>-Diagnosis: Right humerus lesion;<br><br>-Plan: Humerus lesion right: I did not actually see the x-ray report there were no major deformities noted on the patient when I did my physical exam. This is only what I read in the chart.<br><br>Review of the resident's progress notes, showed:<br><br>-On 2/14/24: I called the hospital to schedule MRI of right humerus, appointment is for 3/15/24 at 9:00 A.M. We need to get an order that says MRI right humerus, other specified of bone upper arm with and without contrast and have it faxed to scheduling;<br><br>-On 2/23/24: Resident's father has been notified via phone that Physician X will no longer be this resident's physician, effective 2/24/24. Medical care will be assumed by Physician N. Power of Attorney (POA) verbalized understanding and is agreeable with having Physician N provide medical management of this resident.<br><br>Review of the physician's notes, dated 3/7/24, showed I did not see the MRI report from the right humerus that was to be done at the hospital.<br><br>Review of the resident's progress notes, showed:<br><br>-On 3/14/24: Hospital called today and said the patient needs a pre-certification before they can do his/her MRI. I have a call out to his/her physician to help us get this. As of now the MRI has been put on hold until we can get the form;<br><br>-No further documentation regarding the resident's appointment.<br><br>Review of the physician's notes, dated 3/15/24, showed:<br><br>-Imaging: No new x-ray. See patient's chart located at the facility for most recent images;<br><br>-Plan: Patient is scheduled for his/her MRI of right humerus today at hospital.<br><br>During an interview on 4/4/24 at 7:51 A.M., the hospital scheduler said the resident was scheduled for an MRI on 3/15/24, but he/she needed a pre-certification. The Medical Records Supervisor was not aware it needed to be done. The facility needed to contact insurance and they should be able to re-schedule it. Hospital scheduler did not have additional information regarding the reason for the MRI or what lead to Physician N ordering it.<br><br>(continued on next page) |

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| F 0776<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/4/24 at 8:03 A.M., the Medical Records Supervisor said the resident's father called and said the hospital said the resident needed an MRI. It was set up, but the day before, the hospital said they needed pre-certification. The MRI has been put on hold. The Medical Records Supervisor called the physician to see how to do it. It was prior to the physician retiring. She has not called the physician who replaced Physician X. She has not seen any documentation of why the resident needed an MRI and she did not know who called the dad. At this time, they are waiting for the doctor to tell us where to get it. They said it goes through the insurance, but the doctor was supposed to request it. She spoke to the resident's sister and she said she would try to help figure it out too. The hospital said they were going to put the MRI on hold so they would not have to start over.<br><br>During an interview on 4/4/24 at 8:24 A.M., the Director of Nursing (DON) said the resident was at the hospital and the MRI was on the discharge paperwork. The Medical Records Supervisor tried to make an appointment, but they told her they needed pre-authorization from the physician. It changed from Physician X to Physician N, but they were having issues at the physician's office to get the pre-authorization from insurance to complete it. They do not see the residents in the office. She did not know if anyone was in the office. Physician N comes in once a week. NP Y comes in on Thursdays and Fridays. Physician N saw all the new admissions and skilled residents. Whomever is in Physicians N's office has to submit it. Physician N should not have to do it, but the primary care office can. The Medical Records Supervisor communicates with the office. The DON had not communicated with the physician's office regarding the appointment. She did not recall if she spoke to Physician N. The facility received a call from the sister, but she was not sure if it was on the discharge paperwork. It was reported to the physician. The DON did not recall if the medical record was requested from the hospital. Physician X wrote the order since it was on 1/29/24. Physician N did not start until the beginning of March. The DON had only seen NP Y one time. Physician N talks to staff. The DON expected there to be documentation in the medical record and information regarding the appointment. The Medical Records Supervisor was responsible for following up. At 9:30 A.M., the DON said she spoke to Physician N about the resident's MRI. Physician N said he would follow up on the pre-certification.<br><br>2. Review of Resident #19's quarterly MDS, dated [DATE], showed:<br><br>-Cognitively intact;<br><br>-Has physical behaviors;<br><br>-Diagnoses included coronary artery disease, high blood pressure, renal failure, diabetes, high cholesterol, anxiety, depression and respiratory failure;<br><br>-Coughs or choking during meals or when swallowing medications;<br><br>-Has therapeutic diet.<br><br>Review of the resident's POS, dated April 2024, showed:<br><br>-An order, dated 11/27/23, for regular diet, diabetic, sodium precautions diet. Regular/thin consistency;<br><br>(continued on next page) |

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| F 0776<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -An order, dated 2/26/24, for speech evaluation. Resident coughing a lot when drinking thin liquids;<br><br>-An order, dated 3/22/24, for Modified Barium Swallow due to choking with meals. To determine least restrictive.<br><br>Review of the resident's care plan, in use during survey, showed:<br><br>-Focus: Resident has nutritional problem or potential nutritional problem related to diabetic diet restriction;<br><br>-Goal: Resident will comply with recommended diet for weight reduction daily through review date;<br><br>-Interventions: Administer medications as ordered. Monitor/Document for side effects and effectiveness; Provide and serve diet as ordered; Provide, serve diet as ordered. Monitor intake and record every meal; Weigh monthly and as needed.<br><br>Review of the resident's progress notes, dated January 2024 through 4/4/24, showed no documentation of the resident coughing, difficulty swallowing food and/or beverages, or loud coughing concerns.<br><br>Observation and interview on 4/5/24, showed:<br><br>-At 8:35 A.M., the resident said he/she was served cold cereal, but he/she continued to spill it on him/herself. The resident said he/she does have trouble eating and swallowing. He/she coughs during meals. Resident was observed coughing. Resident had cereal and milk spilled on his/her shirt;<br><br>-At 12:19 P.M., the resident sat in the dining room. He/She was served a meal that included cabbage, potatoes and a chicken patty;<br><br>-At 12:55 P.M., the resident ate in the dining room. Regional Nurse M said the resident was served a chicken patty, but he/she did not want it and asked for grilled cheese and pineapple. The resident ate the grilled cheese sandwich.<br><br>During an interview on 4/9/24 at 8:33 A.M., the MDS Coordinator said he/she was aware of barium swallow test, but it had not been done yet. They were trying to find a company that could do it here. They talked about it in morning meeting.<br><br>(continued on next page) |

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| F 0776<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/9/24 at 9:01 A.M., the DON said she was aware of the swallow test. When the resident eats, he/she coughs. It is a very loud cough. She said it is when he/she drinks. His/Her insurance will not cover the test, but he/she eats everything fine. He/She is on a regular diet. The resident eats without a problem and drinks without a problem. He/She only has the cough when he/she eats his/her food. The resident does not cough when eating Cheetos. The DON was not sure if the resident ate too fast or if it is a behavior. They are monitoring him/her. The resident sneezes the same way, meaning it is loud. The DON described it as a a forced cough. There have been no episodes of choking. No one sits with the resident when he/she eats, but her office is right near his/her room. The DON can hear the cough. It is not every time he/she eats. They cannot pinpoint what is making him/her cough. It was something the DON brought up because of his/her cough. It's a dry cough, not a continuous cough. Sometimes she cannot tell the difference between the resident's coughs and sneezes. The DON did not recall if the physician has seen the resident about the cough. The Medical Records Supervisor is responsible for making appointments, but did not know if an appointment had been made. The DON did not recall if any interventions were put in place until the resident had the swallow test. The DON did not recall if the dietician had been made aware of the need for the swallow test. She expected the physician and the dietician to be notified. The DON said she never observed a swallowing problem. The resident coughs, but it is not when he/she is eating.<br><br>During an interview on 4/9/24 at 11:39 A.M., Regional Nurse M said Medical Records is responsible for scheduling the appointments as they receive it. He/She had correspondence regarding the appointments, but unsure why it was not documented in the medical record, but it should be documented. They do not have a policy regarding outside appointments.<br><br>Review of Medical records Supervisor's email, received 4/9/24 at 12:00 P.M., showed:<br><br>-An outgoing email from Medical records Supervisor, dated 3/5/24 at 12:26 P.M., we need to schedule the resident for Modified Barium Swallow (MBS) at the Veterans Administration (VA). I am going to attach what was given to me. If you need anything further, let me know;<br><br>-An incoming email from VA, dated 3/5/24 at 1:46 P.M., this seems to be forms from an outside facility. Does this need to be done at the VA? Also, I need an order sent to me from the nursing home physician requesting the MBS with the reason why the patient needs the MBS. You can email me the order or fax;<br><br>-An outgoing email from Medical records Supervisor, dated 3/22/24 at 1:53 P.M., here is the order. Attached was a phone order, dated 3/22/24, for Modified Barium Swallow due to choking with meals. To determine least restrictive diet;<br><br>-No further documentation of an appointment made for MBS test. |

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| F 0800<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847<br><br>35394<br><br>Based on observation, interview and record review, the facility failed to provide each resident with a variety of food, in an appropriate quantity, to meet the needs for 2 of 14 sampled residents (Residents #9 and #19). The facility also failed to have enough food to provide for residents who asked for seconds and failed to provide an alternate upon request. The facility also failed to ensure residents had access to a menu prior to meal service. The census was 41.<br><br>Review of the facility's Nursing Home Residents' Rights, provided upon admission to the residents showed:<br><br>-Right to a dignified existence:<br><br>-Be treated with consideration, respect, and dignity, recognizing each resident's individuality;<br><br>-Quality of life is maintained or improved;<br><br>-Exercise rights without interference, coercion, discrimination, or reprisal;<br><br>-Right to self-determination:<br><br>-Choice of activities, schedules, health care, and providers;<br><br>-Reasonable accommodation of needs.<br><br>Review of the facility's Menu Alternates policy, revised 5/31/21, showed:<br><br>-Policy: Nutritionally comparable menu items shall be available to accommodate resident food preferences;<br><br>-Procedure: Alternate menu items are planned during the menu planning process for protein source, grains, fruits, and vegetables;<br><br>-Alternate menu items may be included on the cycle menu and/or included with the always available menu;<br><br>-A By request or Always available menu will be written and available in all resident service areas;<br><br>-Various dining areas may have slightly different versions of the By request menu designed to meet resident needs.<br><br>1. Review of Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/6/24, showed:<br><br>(continued on next page) |

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|---|---|
| F 0800<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Moderately impaired cognition;<br><br>-Diagnoses included dementia and depression;<br><br>-Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency: Supervision or touching assistance-helper provides verbal cues and touching/steadying assistance as resident completes activity.<br><br>Review of the posted lunch menu for 4/5/24, showed Polish sausage, sauerkraut, diced potato and crushed pineapple.<br><br>Observation of the lunch meal service in the main dining room, on 4/5/24 at 12:30 P.M., showed the resident sat at a table near the door to the kitchen and had chicken noodle soup, and mechanically chopped Polish sausage, sauerkraut and potatoes. Staff talked to the resident and then went to the kitchen door and said the resident wanted a grilled cheese sandwich. The staff person in the kitchen said very loudly and in an angry tone it's too late. He/She just made him/her soup and he/she got it already. The staff person standing at the door said the resident is not happy with the soup. The staff in the kitchen said that is too bad. He/She already made him/her something. The staff person in the kitchen spoke very loudly and could easily be heard by the surveyor who sat approximately 20 feet further away from the kitchen than the resident. The staff person at the door entered the kitchen and whispered, then looked in the direction of the state surveyor, and said I am sorry to the staff person in the kitchen. The staff person at the doorway then returned to the resident and said the kitchen staff is making the sandwich for him/her.<br><br>During the group interview on 4/5/24 at 1:05 P.M., one resident said he/she did not know everyone else was served sauerkraut. He/She ate in their room, but he/she was served diced potatoes, peas and carrots with the Polish sausage.<br><br>During an interview on 4/9/24 at 8:50 A.M., the Director of Nursing (DON) said residents should be treated with dignity and respect. If a resident requests an alternate, it is not appropriate for staff to complain about it loud enough for residents to hear.<br><br>2. Review of Resident #19's quarterly MDS, dated [DATE], showed:<br><br>-Cognitively intact;<br><br>-Has physical behaviors;<br><br>-Diagnoses included coronary artery disease, high blood pressure, renal failure, diabetes, anxiety, depression, and respiratory failure;<br><br>-Coughing or choking during meals or when swallowing medications;<br><br>-Has therapeutic diet.<br><br>Review of the resident's physician's order sheets (POS), dated April 2024, showed:<br><br>(continued on next page) |

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| | 265539 | A. Building<br>B. Wing | 04/09/2024 |

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| Aegis Health and Rehabilitation | 1441 Charic Drive<br>Wildwood, MO 63021 |

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| F 0800<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -An order, dated 11/27/23, for regular diet, diabetic, sodium precautions diet. Regular/thin consistency.<br><br>Observation and interview on 4/5/24, showed:<br><br>-At 8:17 A.M., the resident was served breakfast in his/her room. The resident said he/she was served quiche, but he/she did not like it. The resident pressed his/her call light. The resident told staff he/she did not like the quiche. Staff told the resident that quiche was really good. The resident said he/she did not like quiche. Staff said he/she would be able to get the resident some toast. A second staff person entered the resident's room. The two staff spoke quietly before exiting the room. The second staff was overheard saying he/she would see if the resident could receive fried eggs;<br><br>-At 8:35 A.M., the resident said he/she was served cold cereal, but he/she continued to spill it on him/herself. The resident said he/she has trouble eating and swallowing. The resident said he/she coughs during meals. The resident was observed coughing and had cereal and milk spilled on his/her shirt. The resident said he/she was supposed to receive fried eggs instead.<br><br>During an interview on 4/9/24 at 11:47 A.M., the Administrator said toast is not an appropriate alternate to the spinach quiche.<br><br>3. During the group interview on 4/5/24 at 1:05 P.M., all 11 residents said the meals have been very carb heavy. They are served noodles all the time. All 11 residents said they ate fettuccine last night. It was good, but it was carb heavy. All 11 residents said they had other pasta dishes this week. When they are served tacos, the tortillas are small and they only receive one. The portions have become child size. They can eat more than a 5th grader. They are probably trying to make due, but it is hard eating only one soft taco. The residents complained about the turkey salad that was served this week. All it had were little pieces of turkey and a slice of tomato. Nine out of 11 residents shared they still felt hungry after their meals. They run out of yogurt because everyone likes it. The residents have to ask for it. A resident said he/she was supposed to have yogurt, fruit and vegetables. It is on their meal ticket, but they do not receive it. Since dinner meals are small, they are hungry by 8:00 P.M., so they would like a snack. The snacks are kept behind the nurse's station. They cannot get the snacks until 9:00 P.M. or 10:00 P.M. Staff or other residents will take the snacks and there is nothing left. The residents said they would like to be served soup. If they are sick, they will still receive what was on the menu. The flu was going around in the facility and it would be nice to receive chicken noodle soup. Sometimes a heavy meal does not look good if they are sick and soup is something sick people eat. They residents said ordering meals can get expensive, so they would like to have meals they can have, such as salads and soup. If it were available regularly, they would not fuss.<br><br>Review of the facility's weekly menu, showed:<br><br>-On 4/2/24, dinner showed turkey salad platter, lettuce, and tomato. One each was written next to each item;<br><br>-On 4/3/24, lunch showed eight ounces of beef mostaccioli;<br><br>-On 4/4/24, lunch showed eight ounces of beef mac casserole. Dinner showed chicken fettuccine alfredo.<br><br>(continued on next page) |

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| F 0800<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation of the kitchen on 4/05/24 at 3:50 P.M., showed:<br><br>-A large box of eggs that held a quantity of 15 dozen, approximately 3/4 full;<br><br>-One large box with several yogurt containers inside;<br><br>-12 cans of cream of mushroom soup. Each can was 50 ounce (oz);<br><br>-Eight cans of tomato soup. Each can was 50 oz;<br><br>-Seven cans of chicken noodle soup. Each can was 50 oz;<br><br>-One can of chicken and dumpling. The can was 48 oz;<br><br>-24 cans of tomato soup. Each can was 7.25 oz.<br><br>4. Review of the Resident Council minutes, dated 2/20/24, showed:<br><br>-Issue: Kitchen;<br><br>-Action Taken: Wants menus. Most places have menus;<br><br>-Person responsible: Dietary Manager.<br><br>During the group interview on 4/5/24 at 1:05 P.M., the residents said they used to get their menu for the day with breakfast. If they did not want fish or whatever that was on the menu, they could cross out what they did not want. They do not receive menus and when it was discussed in Resident Council, they received feedback that it would contaminate the kitchen. The residents do not have a way of informing dietary staff they do not want what is on the menu prior to being served. If they are served a meal and want something else, they get a hot dog or grilled cheese.<br><br>During an interview on 4/5/24 at 8:31 A.M., the Dietary Manager said this is not a short order diner. They have to stick to the menu. They do not have the budget, and the menu is all budget based. If they are making scrambled eggs for one resident, then all of them would want them. The Dietary Manager said he prepared eggs for a couple of residents today and he would usually make it for them, but if one resident wanted something, the rest of the residents will want it.<br><br>(continued on next page) |

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| F 0800<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 5. During an interview on 4/9/24 at 11:47 A.M., the Administrator said the alternate meals include grilled cheese and hot dogs. If it is breakfast, the alternates are oatmeal, cereal and fried eggs. The alternate items were decided prior to the Administrator starting in early 2024, but the residents enjoy them as alternates. The residents can receive alternate meals upon request, before and during meal times. If the resident was already served the meal on the menu, but did not like it, the resident should still receive an alternate. They cannot make a completely different menu. They plan to implement resident's choice. The Resident Council will vote on a meal choice. The residents should receive seconds if requested. He was unsure if there was enough food for the residents to receive seconds. The Dietary Manager has to order food, but the Administrator was not sure the number that is ordered. There is also dietician input, budgeting, and making sure there's enough food at all times. There had not been issues with running out of food. He had no idea what budget based menu meant, but it may refer to operating the needs of the residents for meals. The residents have access to the menu. The residents wanted to choose three options for their alternate meal on the menu. They wanted it to be like a restaurant where they can order. The Administrator was aware the residents order food, but he was not aware if they did not like the food or if there was not enough. He was unsure if soup could be prepared for the residents.<br><br>MO00233990 |

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| F 0806<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 that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394<br><br>Based on observation, interview and record review, the facility failed to provide appealing options of similar nutritive value to residents who choose not to eat food that was initially served or who requested a different meal choice, when alternate meals were not provided. This had the potential to affect all residents who could not eat or did not want what was being served (Residents #187, #8 and #29). The sample was 14. The census was 41.<br><br>Review of the facility's Menu Alternates policy, revised 5/31/21, showed:<br><br>-Policy: Nutritionally comparable menu items shall be available to accommodate resident food preferences;<br><br>-Procedure: Alternate menu items are planned during the menu planning process for protein source, grains, fruits, and vegetables;<br><br>-Alternate menu items may be included on the cycle menu and/or included with the always available menu;<br><br>-A By request or Always available menu will be written and available in all resident service areas;<br><br>-Various dining areas may have slightly different versions of the By request menu designed to meet resident needs.<br><br>1. Review of Resident #187's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/25/24, showed:<br><br>-No cognitive impairment;<br><br>-Diagnosis of urinary tract infection;<br><br>-Has therapeutic diet.<br><br>During an interview on 4/5/24 at 8:16 A.M., the resident voiced complaints of the food served at breakfast. He/She said it was not good for a dog. The resident propelled in his/her wheelchair from the 300 unit to the nurses station. He/She continued to yell this food is not good enough for a dog. The resident propelled to the dining room and sat at a table. The resident was asked if he/she wanted something else to eat. Licensed Practical Nurse (LPN) H went over to the resident's table with a menu. He/She read over what was served for breakfast on 4/5/24, which included spinach quiche. The resident complained about the food again and propelled out of the dining room.<br><br>During an interview on 4/5/24 at 8:27 A.M., LPN H said the resident wanted scrambled eggs, but they have to stick to the menu. Today it was spinach quiche, toast, butter, jelly and milk. They usually have eggs to serve. LPN H said some people like quiche and some do not.<br><br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/5/24 at 8:31 A.M., the Dietary Manager said this is not a short order diner. They have to stick to the menu. They do not have the budget, and the menu is all budget based. If they are making scrambled eggs for one resident, then all of them would want them.<br><br>2. Review of Resident #8's admission MDS, dated [DATE], showed:<br><br>-Adequate hearing and vision;<br><br>-Speech Clarity: Clear speech, distinct intelligible words;<br><br>-Makes Self Understood: Understood;<br><br>-Ability to Understand Others: Understands, clear comprehension;<br><br>-Diagnosis: Diabetes and high cholesterol.<br><br>During an interview on 4/3/24 at 8:55 A.M., the resident said the food is not good, sometimes cold, no taste, and he/she cannot get alternates sometimes.<br><br>3. Review of Resident #29's quarterly MDS, dated [DATE], showed:<br><br>-Adequate hearing and vision;<br><br>-Speech Clarity: Clear speech, distinct intelligible words;<br><br>-Makes Self Understood: Understood;<br><br>-Ability to Understand Others: Understands, clear comprehension;<br><br>-Diagnosis: High blood pressure and malnutrition.<br><br>During an interview on 4/3/24 at 8:44 A.M., the resident said the menu is repeating, no changes.<br><br>4. During an interview on 4/5/24 at 1:05 P.M., the Resident Council said sometimes they receive seconds and sometimes they cannot. If there is a popular meal, they will offer an alternate if seconds are requested, but dietary will tell the residents they ran out. The meals have been very carb heavy. They are served noodles all the time. The alternates are grilled cheese or hot dogs. The grilled cheese is also carb heavy. Sometimes they will receive a bag of chips with their hot dog. The hot dog is served on a piece of white bread, not hot dog buns. The grilled cheese is good, but it gets old after a while. Salad is not an option as an alternate. Five out of 11 residents present did not eat quiche. They were not offered an alternate for the quiche. Two residents ate cold cereal, one resident ate hot cereal, and the other two residents did not eat breakfast. A member of Resident Council said he/she asked dietary for a grilled cheese and was told no. He/She said it was because he/she was served an entree already. He/She spoke to the Dietary Manager and he said it was not right. He/She did not eat anything during that meal. It made him/her feel angry because he/she was hungry and his/her blood sugar was low. Nine out of 11 residents did not like the chicken salad.<br><br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/9/24 at 11:47 A.M., the Administrator said the alternate meals include grilled cheese and hot dogs. If it is breakfast, the alternates are oatmeal, cereal, and fried eggs. The alternate items were decided prior to the Administrator starting early 2024, but the residents enjoy them as alternates. The residents can receive alternate meals upon request, before and during meal times. If the resident was already served the meal on the menu, but did not like it, the resident should still receive an alternate. They cannot make a completely different menu. If a resident did not like the food that was served, the Administrator expected staff to clarify there is not something they do not want on the menu and offer an alternate. They plan to implement resident's choice. The Resident Council will vote on a meal choice. The residents should receive seconds if requested. He was unsure if there was enough food for the residents to receive seconds. The Dietary Manager has to order food, but the Administrator was not sure of the number that is ordered. There is also dietician input, budgeting, and making sure there's enough food at all times. There had not been issues with running out of food. He had no idea what budget based menu meant, but it may refer to operating the needs of the residents for meals. The residents have access to the menu. The residents wanted to choose three options for their alternate meal on the menu. They wanted it to be like a restaurant where they can order. The Administrator was aware the residents order food, but he was not aware if they did not like the food or if there was not enough.<br><br>44950<br><br>49992 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>46970<br><br>Based on observation, interview, and record review, the facility dietary staff failed to follow proper hand hygiene while preparing food for the steam table when staff did not remove his/her gloves after he/she touched/rubbed/adjusted his/her clothing, touched their face mask, and the inside of the kitchen door frame using both gloved hands, and wiped off counter tops with a stained wet dish rag. Additionally, the facility dietary staff failed to maintain cold fruit at a temperature of 41 degrees Fahrenheit (F) or less on two separate days of observation, to prevent foodborne illness, prior to it being served to the residents in the facility. The sample size was 14. The census was 41.<br><br>Review of the facility's Hand Hygiene Policy, dated 9/1/21, showed:<br><br>-Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility;<br><br>-Hand hygiene: is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR);<br><br>-Policy Explanation and Compliance Guidelines: Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.<br><br>Review of the Centers for Medicare and Medicaid Services State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long-Term Care Facilities Food Procurement, Store/Prepare/Serve-Sanitary, revised 11/2017, showed:<br><br>-Definitions:<br><br>--Critical Control Point: a specific point, procedure, or step in food preparation and serving process at which control can be executed to reduce, eliminate, or prevent the possibility of a food safety hazard;<br><br>--Cross-contamination: the transfer of harmful substances or disease-causing microorganisms to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils;<br><br>--Water percentage of the food. Foods that have a high level of water (e. g., fruits and vegetables) encourage bacterial growth;<br><br>-Time and temperature control of the food:<br><br>--The longer food remains in the danger zone, the greater the risks for growth of harmful pathogens. Bacteria multiply rapidly in a moist environment in the danger zone;<br><br>--Danger Zone: temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness;<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | --Refrigerated Storage: Potentially Hazardous Foods (PHF)/Time/Temperature Control for Safety (TCS) foods must be maintained at or below 41 degrees F, unless otherwise specified by law. Refrigeration prevents food from becoming a hazard by significantly slowing the growth of most microorganisms. Inadequate temperature control during refrigeration can promote bacterial growth.<br><br>1. Observation on 4/4/24 at 11:45 A.M., showed Dietary Cook Q put his/her gloves on, adjusted the bill on his/her cap, slid his/her hands down the side of his/her pants, walked to the doorway leading to the dining room, and leaned onto the door frame with gloved hands. He/She came back into the kitchen near the stove and opened a bottle of water, with the same gloved hands. He/She was cued by the Registered Dietician to wash his/her hands and change gloves. During the same observation, Dietary Cook Q changed his/her gloves, touched the trash can lid under the sink nearest the steam table, touched his/her face mask, and then picked up an empty water pitcher, placed two fingers inside of the water pitcher, and then placed it upside down on a metal storage rack located against the wall. With the same gloved hands, he/she picked up a white wet wash rag and cleaned off the metal table countertop, after which, he/she grabbed a cutting board, large knife, and began chopping up cauliflower with the same gloved hands. He/She scrapped the cauliflower into a metal container and placed the container onto the steam table using the same gloved hands.<br><br>During an interview on 4/9/24 at 8:50 A.M., the Director of Nursing said staff should follow the hand hygiene policy.<br><br>2. Observation on 4/3/24 at 11:57 A.M., showed mandarin oranges for the lunch meal on the countertop covered with a food tray. They had been left out of the refrigerator. Approximately seven cups of mandarin oranges were served to residents. After the mandarin oranges went out to the residents, the Dietary Manager took the temperature of the mandarin oranges. The temperature measured 66.9 degrees F;<br><br>During an interview on 4/3/24 at 11:57 A.M., the Dietary Manager told a kitchen helper to put the mandarin oranges back into the refrigerator to chill. He said he told staff a million times to keep the fruit and other cold items cold. Observation that time, showed the dietary aide put the mandarin oranges back into the refrigerator.<br><br>3. Observation on 4/4/24 at 11:55 A.M., showed the Registered Dietitian measured the temperature of the lunch time tropical fruit. The temperature measured 51 degrees F.<br><br>During an interview on 4/4/24 at 11:55 A.M., the Registered Dietitian said the fruit had been in the refrigerator all morning, but staff should probably put it in at nighttime to be sure it was chilled. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394<br><br>44950<br><br>50366<br><br>Based on observation, interview and record review, the facility failed to follow acceptable standards of practice for infection prevention and control when staff hung medication through a single lumen (internal channel) peripherally inserted central catheter (PICC, intravenous (IV) access site) without cleaning the cap of the lumen, for one resident (Resident #337). Staff failed to ensure proper placement of indwelling urinary catheter (tube inserted into the bladder to drain urine) drainage bags when the bags lay directly on the floor and a catheter bag was not positioned to prevent reflux of urine. The facility identified four residents as having indwelling urinary catheters. Of those four, three were included in the sample and issues were identified with two (Residents #337 and #18). Staff failed to change gloves and sanitize their hands in accordance with the facility's policy and acceptable standards of practice. for one of three observations of personal care (Resident #23). In addition, staff failed to follow the facility's policy and acceptable standards of practice for infection control during wound dressing changes for three of three observations of wound care completed on two residents (Residents #3 and #20). The sample was 14. The census was 41.<br><br>Review of the facility's Hand Hygiene policy, dated 9/1/21, showed:<br><br>-All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors This applies to all staff working in all locations within the facility;<br><br>-Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR);<br><br>-Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice;<br><br>-Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table;<br><br>-Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom;<br><br>-Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves;<br><br>-Bar soap is approved for a resident's personal use only. Keep bar soap clean and dry in protective containers (i.e. plastic case or bag);<br><br>(continued on next page) |

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|---|---|---|---|
| | 265539 | A. Building<br>B. Wing | 04/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Aegis Health and Rehabilitation | 1441 Charic Drive<br>Wildwood, MO 63021 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Liquid soap reservoirs must be discarded when empty. If refillable, dispensers must be emptied and cleaned, rinsed and dried according to manufacturer instructions;<br><br>-Use lotions and creams to prevent and decrease skin dryness. Use only hand lotions approved by the facility because they won't interfere with ABHRs.<br><br>Review of the facility's Hand Hygiene Table, showed:<br><br>-Soap and water indicated when: Hands are visibly dirty, hands are visibly soiled with blood or other body fluids;<br><br>-Either soap and water or ABHR indicated: Between resident contacts. After handling contaminated objects. Before performing invasive procedures. Before applying and after removing personal protective equipment (PPE), including gloves. Before and after handling clean or soiled dressings, linens, etc. Before performing resident care procedures. After handling items potentially contaminated with blood, body fluids, secretions, or excretions. When, during resident care, moving form a contaminated body site to a clean body site. After assistance with personal body functions (e.g., elimination, hair grooming, smoking).<br><br>Review of the facility's Indwelling catheter use and removal policy: Compliance guidelines, dated 9/2021, showed:<br><br>-Keeping the urinary catheter anchored to prevent excessive tension on the urinary catheter, which can lead to urethral tears or dislodgement of the urinary catheter and;<br><br>-Securement of the urinary catheter to facilitate flow of urine, prevention no kinks in the tubing and positioning below the level of the bladder.<br><br>Review of the facility's Wound Treatment Management Policy, dated 9/1/21, showed to promote wound healing of various types of wounds it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.<br><br>1. Review of Resident #337's Physician Order Sheet (POS), showed:<br><br>-An order dated 3/25/24, for Vancomycin hydrochloride (antibiotic) IV solution 1000 milligrams (mg)/10 milliliters (ml), use 1 gram (1000 mg) every 12 hours for sepsis (presence of bacteria and infectious organisms in the blood stream) treatment;<br><br>-An order dated 3/26/24, for every 8 hours perform urinary catheter care. Notify nurse if no urine or minimal urine output;<br><br>-An order dated 3/26/24, indwelling urinary catheter, check urinary catheter anchor placement to prevent excessive tension on the urinary catheter. Keep tubing free of kinks and positioned below level of bladder every shift and as needed;<br><br>-An order dated 3/26/24 IV PICC 1 lumen, location left upper arm;<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Diagnoses included sepsis, urinary tract infection (UTI), diabetes, paraplegia, chronic buttock wound, and bipolar disorder (a mental health condition that affects your moods, which can swing from 1 extreme to another).<br><br>Review of the resident's care plan, in use at the time of the survey, showed:<br><br>-Focus: The resident has a urinary catheter;<br><br>-Goal: The resident will show no signs or symptoms of urinary infection<br><br>-Interventions: Position urinary catheter bag and tubing below the level of the bladder. Provide urinary catheter care every shift;<br><br>-Focus: The resident is on antibiotic therapy;<br><br>-Goal: The resident will be free of any discomfort or adverse side effects of antibiotic therapy;<br><br>-Interventions; Administer antibiotic medications as ordered by physician.<br><br>Observation on 4/3/24 at 11:08 A.M., showed the resident's urinary drainage bag on the floor, full of urine. The urine backed up into the tubing, as far as observation allowed due to the bed covers.<br><br>Observation on 4/5/24 at 8:37 A.M., showed Licensed Practical Nurse (LPN) K entered the resident's room. The resident's urinary drainage bag rested directly on the floor and was full to the maximum. The urine filled the drainage tubing. LPN K walked to the resident's left side of the bed and stepped on the edge of the bag, then looked down and kicked the urinary drainage bag with his/her foot out of his/her path. LPN K prepared the PICC line for IV antibiotics without cleaning lumen with alcohol prior to flushing the PICC line with 10 ml of normal saline. LPN K then hung the resident's antibiotic.<br><br>During an interview on 4/9/24 at 8:50 A.M., the Director of Nursing (DON) said urine drainage bags should not lay on the floor. They should be hung below the level of the bladder with no kinks in the tubing. Also, urine drainage bags should never be full of urine backing up into the tubing. They should be emptied a minimum of every 8 hours and as needed when full. The PICC line lumen should be cleaned with alcohol prior to flushing the IV and attaching the IV antibiotic.<br><br>2. Review of Resident #18's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/15/23, showed:<br><br>-Severe cognitive impairment;<br><br>-Diagnoses included heart failure, pneumonia, aphasia (language disorder), stroke, quadriplegia and seizure disorder;<br><br>-Dependent with toileting hygiene;<br><br>-Range of motion impairment to both sides of the upper and lower extremities;<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Indwelling catheter.<br><br>Review of the resident's care plan, in use during survey, showed:<br><br>-Focus: Resident has indwelling catheter;<br><br>-Goal: Resident will be/remain free from catheter-related trauma through review date;<br><br>-Interventions: Change catheter as ordered by physician and as needed (PRN) for obstruction, soiled tubing and damage;<br><br>-Change Foley tubing securement device weekly and PRN if loose or soiled. Apply and remove per package instructions;<br><br>-Check tubing for kinks each shift;<br><br>-Cleanse catheter with soap and water, rinse, pat dry every shift and PRN if soiling occurs;<br><br>-Monitor and document catheter output each shift. Document milliliters (ml) on Medication Administration Record (MAR);<br><br>-Monitor/document for pain/discomfort due to catheter.<br><br>Review of the resident's POS, dated April 2024, showed:<br><br>-An order, dated 12/18/23, for indwelling catheter 16 French (Fr) 10 ml balloon. Indwelling catheter indication: (obstructive uropathy, neurogenic bladder, Stage 3 or 4 pressure injury on peri-area, medical need for accurate output). No indication documented.<br><br>-An order, dated 12/18/23, for catheter output. Monitor for changes and/or signs and symptoms of infection (decreased output, dark urine, foul odor, red tinged, lower abdominal discomfort/swelling) record amount every shift;<br><br>-An order, dated 12/18/23, to change catheter and/or drainage bag when clinically indicated such as infection, obstruction, or when closed system is compromised as needed for catheter;<br><br>-An order, dated 12/18/23, for indwelling catheter care and check catheter anchor placement to prevent excessive tension on the catheter. Keep tubing free of kinks and positioned below level of bladder every shift and as needed.<br><br>Observation on 4/3/24, 4/4/24 and 4/5/24, showed:<br><br>-On 4/03/24 at 9:45 A.M., the resident lay in bed, and his/her catheter hung on the right side of bed. The drainage bag was on the floor. The catheter tube was looped/kinked with approximately three feet of dark yellow urine in the tube that failed to drain into the bag. There was approximately 300 cubic centimeters (cc) of urine in the drainage bag;<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -On 4/3/24 at 11:56 A.M., the resident lay in bed, and his/her catheter hung on the right side of bed. The drainage bag was on the floor. The catheter tube was looped/kinked with approximately three feet of dark yellow urine in the tube that failed to drain into the bag. There was approximately 1000 cc of urine in the drainage bag;<br><br>-On 4/4/24 at 5:38 A.M., the resident lay in bed, and his/her catheter hung on the right side of the bed. The drainage bag was on the floor. The catheter tube was looped with dried urine that was reddish in color inside the tube. There was approximately 250 cc of similar color urine in the bag;<br><br>-On 4/4/24 at 8:01 A.M., the resident lay in bed, and his/her catheter hung on the right side of bed. The catheter tube was looped upward with approximately two feet of dark amber colored urine in the tube that failed to drain into the bag. There was approximately 200 cc of amber colored urine in the drainage bag.<br><br>-On 4/5/24 at 12:11 P.M., the resident lay in bed, and his/her catheter hung on the right side of the bed. The catheter tube was looped upward with approximately 15 inches of urine in the tube that failed to drain into the drainage bag. The drainage bag was on the floor with a privacy cover.<br><br>During an interview on 4/9/24 at 9:01 A.M., the DON said she expected the resident's catheter tubing to be straight so urine can fully drain into the bag. The catheter tube should not have any loops and should not be on the floor. The drainage bag should not be on the floor. The drainage bag is expected to be emptied every eight hours or as needed. She expected staff to notify the nurse with any changes in the urine.<br><br>3. Review of Resident #23's admission MDS, dated [DATE], showed:<br><br>-admitted [DATE];<br><br>-Cognitively intact;<br><br>-Indwelling urinary catheter (a sterile tube inserted into the bladder to drain urine), always incontinent of bowel;<br><br>-Diagnoses included end stage renal disease (ESRD), atrial fibrillation (a-fib, irregular heart rhythm), pneumonia, asthma, hip fracture, and UTI;<br><br>The resident's urinary catheter removed on 3/12/24.<br><br>Observation on 4/5/24 at approximately 9:35 A.M., showed Certified Nursing Assistant (CNA) W and CNA I entered the resident's room with supplies to provide perineal care. CNA W and CNA I donned gloves. CNA W unfastened the resident's brief and wiped the resident's front area. CNA W rolled the resident to his/her right side and wiped the resident's buttock area from front to back. CNA W asked CNA I for a plastic trash bag. CNA W removed his/her gloves and grabbed a bag from CNA I's pocket. CNA W did not perform hand hygiene and donned new gloves, then placed the soiled brief in the plastic trash bag. With the same gloves, CNA W tucked a clean brief under the resident. CNA W and CNA I rolled the resident to his/her back and fastened the resident's brief. Both CNAs removed gloves and washed their hands, picked up the trash and left the resident's room.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 04/05/24 at 12:00 P.M., showed LPN H and CNA J entered the resident's room. CNA J gathered supplies to provide perineal care for the resident. LPN H and CNA J donned gloves. The resident was transferred into bed. LPN H unfastened the resident's brief and assisted the resident to his/her left side. LPN H told the resident they figured out the resident had a urinary tract infection (UTI) and will start antibiotics soon. The resident was rolled to his/her left side. CNA J wiped the resident from front to back and tucked the soiled brief under the resident. CNA J took the new brief and placed it under the resident, then rolled the resident to his/her back and wiped the resident front to back. CNA J did not remove gloves or perform hand hygiene. The new brief has a brown smudge of stool. LPN H removed his/her gloves and left the room. He/She did not perform hand hygiene. LPN H returned with a clean brief. He/She donned gloves and assisted the resident to his/her left side. CNA J wiped the resident's buttock area again as LPN H placed a new brief under resident while wearing the same gloves. The resident was turned to the right and then to his/her back and positioned. LPN H and CNA J secured the resident's brief. CNA J adjusted the resident's blanket to cover the resident with the same gloves. CNA J repositioned the resident. CNA J grabbed the trash with one gloved hand and then adjusted the resident's bed control with the other gloved hand. CNA J set the trash bag down on the floor and went into the bathroom. He/She removed his/her gloves and washed his/her hands. LPN H removed his/her gloves, took the trash and left the room.<br><br>4. Review of Resident #3's POS showed an order, dated 12/21/23, for hidradenitis suppurative wounds (a chronic wound cause by inflammation and infection of the sweat glands), cleanse wounds with hypochlorous acid (skin cleanser commonly used for acne), do not rinse, protect peri-wound (skin sounding the wound) with skin protectant, apply self-adherent super absorbent dressing, change dressing daily and as needed when soiled.<br><br>Review of the resident's care plan, in use at the time of the survey, showed:<br><br>-Focus: The resident has actual impairment to skin integrity related to diagnosis of hidradenitis suppurativa;<br><br>-Goal: The resident will have no complications related to the alteration of the skin integrity;<br><br>-Interventions: follow facility protocols for treatment of injury.<br><br>Observation on 4/4/24 at 11:45 A.M., showed LPN O cleaned and applied medication to the resident's wound and then with the same gloved hands, went to the dressing cart to retrieve a different dressing. LPN O returned to the resident to complete the dressing change with the same gloved hands.<br><br>During an interview on 4/9/24 at approximately 12:00 P.M., the DON said nurses should remove gloves prior to retrieving a dressing from the dressing cart. Nurses should follow the policy and procedure to remove gloves, retrieve dressings, sanitize their hands, and apply new gloves prior to completing dressing changes.<br><br>5. Review of Resident #20's quarterly MDS, dated [DATE], showed:<br><br>-Cognitively intact;<br><br>-Occasionally incontinent of bowel and bladder;<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Is resident at risk of developing pressure ulcers: Yes;<br><br>-Does resident have 1 or more unhealed pressure ulcer at stage 1 or higher: No<br><br>-Foot Problems: None;<br><br>-Skin and ulcer treatments: Pressure reducing device for chair and pressure reducing device for bed;<br><br>-Diagnoses included anemia (body does not have enough healthy red blood cells), diabetes, depression and respiratory failure.<br><br>Review of the resident's electronic Physician Order sheet (ePOS) showed:<br><br>-An order, revised 4/4/24, Cleanse left heel with vashe (wound cleanser that contains pure Hypochlorous Acid). Apply Santyl (ointment used in the healing of burns and skin ulcers), calcium alginate (highly absorptive dressing) and border gauze every day for wound care;<br><br>-An order, revision date 4/6/24 and start date 4/7/24, Cleanse left heel with vashe. Apply Santyl, calcium alginate and border gauze every day for wound care.<br><br>Observation on 4/4/24 at 4:00 P.M., showed LPN O entered the resident's room. He/She donned gloves and removed the resident's sock to assess the resident's left heel wound. The dressing was soiled with brown/red drainage. LPN O removed the dressing, removed his/her gloves and left the room. LPN O went to the treatment cart that sat outside the resident's room. He/She did not perform hand hygiene or wash his/her hands. LPN O donned gloves at the cart. He/She opened the treatment cart and grabbed supplies. LPN O entered the resident's room and moved a chair next to the side of the resident's bed while wearing the same gloves. He/She went to the resident's bathroom and grabbed a paper towel from the bathroom dispenser and placed the paper towel on the resident's bedside table. He/She then placed the supplies on the paper towel. LPN O did not change his/her gloves. LPN O sat down and had the resident place his/her foot on the LPN's knee. LPN O cleaned the wound and removed his/her gloves. LPN O donned new gloves. He/She did not perform hand hygiene. He/She took the tube of Santyl and a cotton tipped applicator off the paper towel. LPN O pushed up the cream with one hand while he/she held a cotton tip applicator in his/her other hand. LPN O put Santyl on the cotton tip applicator then placed it on the resident's wound. He/She picked up the scissors on the paper towel, grabbed and cut a piece of calcium alginate, then it placed on the resident's heel. LPN O secured with it bordered gauze. He/She cleaned up his/her trash and removed his/her gloves. LPN O did not perform hand hygiene. He/She took the Santyl and put it in the treatment cart. LPN O did not perform hand hygiene after he/she put the Santyl ointment in the treatment cart.<br><br>Observation on 4/5/24 at 9:59 A.M., showed LPN H donned gloves and entered the resident's room with the treatment cart. LPN H said he/she needed assistance. LPN H walked to the hall and returned to the resident's room when no staff member was available. LPN H did not change his/her gloves. LPN H removed his/her gloves and left the room again. LPN H returned to the room with CNA J and donned gloves. He/She did not wash his/her hands or use hand sanitizer. The dressing appeared to be soiled with a brown and red substance. LPN H said this is treatment was changed daily. LPN H cleaned the wound. LPN H did not remove his/her gloves before he/she applied Santyl, covered it with calcium alginate, and secured it with a bordered gauze.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/9/24 at 12:37 P.M., Regional Nurse M said staff should change their gloves when going from dirty to clean when they provide wound care or perineal care. Hand hygiene should also be performed in between glove changes. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement a program that monitors antibiotic use.<br><br>44950<br><br>Based on interview and record review, the facility failed to follow their antibiotic stewardship policy by failing to collect data regarding residents' antibiotic treatments and reviewing and documenting that data on the facility approved antibiotic surveillance tracking form. This deficient practice had the potential to affect all residents receiving antibiotics. The census was 41.<br><br>On 4/9/24 at 2:10 P.M., the facility's Antibiotic Stewardship policy was requested from the Director of Nursing (DON) who is the facility's Infection Preventionist. The policy was never provided.<br><br>Review of the facility's Infection Prevention and Control Program policy, revised 9/1/23, included the following:<br><br>Antibiotic Stewardship:<br><br>Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections;<br><br>Antibiotic Stewardship:<br><br>-An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program;<br><br>-Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program;<br><br>-The Infection Preventionist, with oversight from the DON, serves as the leader of the antibiotic stewardship program;<br><br>-The Medical Director, consultant pharmacist, and laboratory manager will serve as resources for the antibiotic stewardship program.<br><br>During an interview on 04/09/24 at 12:07 P.M., the DON, who is the Infection Preventionist, said they have not done an antibiotic stewardship program. She provided an infection log for December, January, and February but reported she did not have an antibiotic stewardship program set up. The infection log she provided is the one the facility had been using. She adapted to this facility and used the infection log she was provided when she started working at the facility but realized that log does not cover the antibiotic tracking. She said she finds things they should have done but were not.<br><br>During an interview on 4/9/24 at 12:37 P.M., Regional Nurse M said he/she expected the facility to have an antibiotic stewardship program in place. |