

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265627	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Garden View Care Center of Chesterfield		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 Chesterfield Pointe Parkway Chesterfield, MO 63017	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290</p> <p>Based on observation, interview and record review, the facility failed to ensure staff treated residents with dignity and respect when staff stood over residents (Residents #32 and #23) while providing feeding assistance, and interacted with other employees rather than the resident receiving feeding assistance (Resident #32). The sample was 12. The census was 84 with 46 in certified beds.</p> <p>Review of #23's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/4/25, showed:</p> <ul style="list-style-type: none"> -Resident rarely/never understood; -Partial/moderate assistance required for eating; -Diagnoses included aphasia (language disorder that affects how a person communicates), Alzheimer's disease, anxiety and depression. <p>Review of Resident #32's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> -Resident rarely/never understood; -Dependent for eating; -Diagnoses included malnutrition, aphasia, Alzheimer's disease with late onset, dementia, anxiety, depression and psychotic disorder. <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 1/9/25 at 8:51 A.M., showed a plate of breakfast placed in front of Resident #32. Activities Assistant (AA) E stood next to the table and moved the plate away from the resident. With gloved hands, he/she picked up a hard-boiled egg and held it to the mouth of Resident #23. While standing next to Resident #23, AA E fed the resident the hard-boiled egg. At 8:53 A.M., AA E walked to the kitchenette and brought another plate of food to the table, placing it in front of Resident #32. He/She picked up the remaining hard-boiled egg from Resident #23's plate, and while standing, AA continued feeding Resident #23. At 8:57 A.M., Certified Nurse Aide (CNA) F approached the table and offered AA E a chair so he/she could sit while providing feeding assistance. AA E declined and CNA F offered to sit and feed Resident #23. CNA F pulled up a chair, sat next to Resident #23, and began providing feeding assistance. AA E walked away from the table, changed his/her gloves, and reapproached the table. While standing, AA E buttered a biscuit on the plate in front of Resident #32, then began feeding the resident bites of hard-boiled egg. At 9:00 A.M., AA E sat in a chair next to Resident #32, facing the resident, and began providing feeding assistance. AA E began talking with AA C, who stood behind AA E. AA E engaged in conversation with AA C and CNA F, turning his/her head away from the resident while talking to the other staff. AA E held a utensil filled with food midair in front of the resident, while his/her head was turned away from the resident. AA C sat down at the table with AA E and CNA F, and the employees continued to engage in conversation with each other about television shows. At 9:03 A.M., AA E asked Resident #32 if his/her food was good, then continued to engage in conversation with the other employees. AA E intermittently scooped bites of food into the resident's mouth while the resident's mouth was still full from the previous bite, and after giving each bite, he/she turned his/her head away from the resident to continue conversing with the other staff. At 9:09 A.M., AA C and CNA F left the table and AA E finished assisting the resident with his/her meal.</p> <p>During an interview on 1/9/25 at 9:13 A.M., AA E said Residents #23 and #32 need to be hand-fed. It doesn't matter if staff stand or sit while providing feeding to the residents, as long as staff can reach the resident to feed them. When providing feeding assistance, staff should make sure the resident has swallowed before offering the next bite. He/She knows Resident #32's mouth is full if the resident pulls his/her head away. AA E received training on feeding assistance from watching a video and the rest is common sense.</p> <p>During an interview on 1/9/25 at 2:52 P.M., CNA G said Residents #23 and #32 are confused and require feeding assistance. When providing feeding assistance, staff should sit down next to the residents. This is a dignity issue, and CNA G would not want someone standing over him/her while eating. Staff should ensure the resident has finished chewing and has swallowed their food before offering the next bite.</p> <p>During an interview on 1/9/25 at 2:59 P.M., Licensed Practical Nurse (LPN) D said Residents #23 and #32 are confused and require feeding assistance. Resident #32 swings and hits at people, so for staff's safety, they may want to stand while feeding him/her. For other residents, staff should sit down while providing feeding assistance so it's not intimidating and staff can focus and engage more with the resident. Staff should make sure residents are chewing and swallowing before offering the next bite.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/9/25 at 4:05 P.M. with the Administrator, Director of Nurses (DON), MDS Coordinator, Chief Executive Officer (CEO) A and CEO B, the Administrator said staff should sit next to residents so they are at eye level while providing feeding assistance. This is so staff are not standing over residents while feeding them, which is a dignity issue. The DON said staff should also be seated next to the residents so they can see their ability to chew and swallow. Staff should sit next to residents while providing feeding assistance, regardless of the resident's cognitive status. Staff should ensure residents have completely swallowed their food before giving them the next bite of food. Staff should engage and interact with the residents while providing feeding assistance.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290</p> <p>Based on observation, interview, and record review, the facility failed to maintain hot water temperatures between 105 and 120 degrees Fahrenheit (F) in resident rooms and resident-accessible common areas. The sample was 12. The census was 84 with 46 in certified beds.</p> <p>Review of the facility's Safety of Water Temperatures policy, dated 2001, showed:</p> <p>-Policy Statement: Tap water in the facility shall be kept within a temperature range to prevent scalding of residents;</p> <p>-Policy Interpretation and Implementation:</p> <p>-Water heaters that service resident rooms, bathrooms, and common areas, and tub/shower areas shall be set to temperatures of no more than 120 degrees Fahrenheit (F), or the maximum allowable temperature per state regulation.</p> <p>1. Observation of the bathroom in room [ROOM NUMBER] ([NAME] unit), a room shared by two residents, on 1/8/25 at 10:13 A.M., showed a calibrated digital thermometer used to take the temperature of the hot water from the sink. The hot water faucet on the sink was turned on and water ran continuously from 10:13 A.M. to 10:15 A.M. The water from the faucet reached a high temperature of 128.6 degrees F.</p> <p>Observation of room [ROOM NUMBER]'s bathroom on 1/8/25 at 11:17 A.M., showed two calibrated digital thermometers were used to take the temperature of the hot water from the sink. The hot water faucet on the sink was turned on and water ran continuously from 11:17 A.M. to 11:19 A.M. The water from the faucet reached a high temperature of 125.0 degrees F on one thermometer, and 124.7 degrees F on the other thermometer.</p> <p>2. Observation of the bathroom in room [ROOM NUMBER] ([NAME] unit), a room occupied by one resident, on 1/8/25 at 10:13 A.M., showed a calibrated digital thermometer was used to take the temperature of the hot water from the sink. The hot water faucet on the sink was turned on and water ran continuously from 10:13 A.M. to 10:15 A.M. The water from the faucet reached a high temperature of 128.1 degrees F.</p> <p>Observation of room [ROOM NUMBER]'s bathroom on 1/8/25 at 11:20 A.M., showed two calibrated digital thermometers were used to take the temperature of the hot water from the sink. The hot water faucet on the sink was turned on and water ran continuously from 11:20 A.M. to 11:22 A.M. The water from the faucet reached a high temperature of 125.0 degrees F on one thermometer, and 125.6 degrees F on the other thermometer.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Observation of the bathroom in room [ROOM NUMBER] ([NAME] unit), a room shared by two residents, on 1/8/25 at 10:05 A.M., showed a calibrated digital thermometer was used to take the temperature of the hot water from the sink. The hot water faucet on the sink was turned on and water ran continuously from 10:05 A.M. to 10:07 A.M. The water from the faucet reached a high temperature of 126.5 degrees F.</p> <p>Observation of room [ROOM NUMBER]'s bathroom on 1/8/25 at 11:38 A.M., showed two calibrated digital thermometers were used to take the temperature of the hot water from the sink. The hot water faucet on the sink was turned on and water ran continuously from 11:38 A.M. to 11:40 A.M. The water from the faucet reached a high temperature of 127.5 degrees F on one thermometer, and 127.4 degrees F on the other thermometer.</p> <p>4. Observation of the bathroom in room [ROOM NUMBER] (Birch unit), a room shared by two residents, on 1/8/25 at 10:16 A.M., showed a calibrated digital thermometer was used to take the temperature of the hot water from the sink. The hot water faucet on the sink was turned on and water ran continuously from 10:16 A.M. to 10:18 A.M. The water from the faucet reached a high temperature of 125.5 degrees F.</p> <p>Observation of room [ROOM NUMBER]'s bathroom on 1/8/25 at 11:33 A.M., showed two calibrated digital thermometers were used to take the temperature of the hot water from the sink. The hot water faucet on the sink was turned on and water ran continuously from 11:33 A.M. to 11:36 A.M. The water from the faucet reached a high temperature of 125.6 degrees F on one thermometer, and 125.3 degrees F on the other thermometer.</p> <p>5. Observation of the bathroom in room [ROOM NUMBER] (Birch unit), a room occupied by one resident, on 1/8/25 at 10:12 A.M., showed a calibrated digital thermometer was used to take the temperature of the hot water from the sink. The hot water faucet on the sink was turned on and water ran continuously from 10:12 A.M. to 10:14 A.M. The water from the faucet reached a high temperature of 123.7 degrees F.</p> <p>Observation of room [ROOM NUMBER]'s bathroom on 1/8/25 at 11:42 A.M., showed two calibrated digital thermometers were used to take the temperature of the hot water from the sink. The hot water faucet on the sink was turned on and water ran continuously from 11:42 A.M. to 11:44 A.M. The water from the faucet reached a high temperature of 125.2 degrees F on one thermometer, and 125.0 degrees F on the other thermometer.</p> <p>6. Observation of the bathroom in room [ROOM NUMBER] (Magnolia unit), a room occupied by one resident, on 1/8/25 at 10:15 A.M., showed a calibrated digital thermometer used to take the temperature of the hot water from the sink. The water from the faucet reached a high temperature of 124.2 degrees F.</p> <p>Observation of room [ROOM NUMBER]'s bathroom on 1/8/25 at 11:39 A.M., showed a calibrated digital thermometer used to take the temperature of the hot water from the sink. The water from the faucet reached a high temperature of 123.2 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. Observation of the bathroom in room [ROOM NUMBER] (Magnolia unit), a room shared by two residents, on 1/8/25 at 10:13 A.M., showed a calibrated digital thermometer used to take the temperature of the hot water from the sink. The water from the faucet reached a high temperature of 125.0 degrees F.</p> <p>8. Observation of the bathroom in room [ROOM NUMBER] (Magnolia unit), a room occupied by one resident, on 1/8/25 at 9:59 A.M., showed a calibrated digital thermometer used to take the temperature of the hot water from the sink. The water from the faucet reached a high temperature of 124.7 degrees F.</p> <p>9. Observation of the bathroom in room [ROOM NUMBER] (Magnolia unit), a room shared by two residents, on 1/8/25 at 10:09 A.M., showed a calibrated digital thermometer used to take the temperature of the hot water from the sink. The water from the faucet reached a high temperature of 124.4 degrees F.</p> <p>10. Observations on 1/8/25 between 9:00 A.M. and 10:30 A.M., showed:</p> <p>-At 9:00 A.M., in the lobby resident-accessible men's restroom, the water temperature at the sink measured 123.8 degrees F, using a calibrated digital thermometer;</p> <p>-At 9:30 A.M., in the kitchenette of the activities room adjacent to the great room, the water temperature at the sink measured 128.9 degrees F, using a calibrated digital thermometer;</p> <p>-At 9:35 A.M., in the resident-accessible women's restroom, off the great room, the water temperature at the sink measured 123.6 degrees F, using a calibrated digital thermometer;</p> <p>-At 9:40 A.M., in the resident-accessible men's restroom, off the great room, the water temperature at the sink measured 122.7 degrees F, using a calibrated digital thermometer;</p> <p>-At 10:00 A.M., in the Magnolia unit nourishment office, where the door was open and resident-accessible, the water temperature at the sink measured 127.2 degrees F, using a calibrated digital thermometer;</p> <p>-At 10:10 A.M., in the kitchenette of the Aspen dayroom at the end of the hall, the water temperature at the northwest sink by the microwave, measured 126.6 degrees F, using a calibrated digital thermometer. The northeast sink near the refrigerators measured 126.6 degrees F, using a calibrated digital thermometer;</p> <p>-At 10:20 A.M., in the Aspen unit unlocked soiled utility room, next to resident room [ROOM NUMBER], the water temperature at the wash sink measured 126.7 degrees F, using a calibrated digital thermometer;</p> <p>-At 10:25 A.M., in the Aspen unit shower/bathing room, next to the Birch Hall doors, the water temperature at the toilet room sink measured 126.9 degrees F, using a calibrated digital thermometer. The water temperature at the shower measured 124.9 degrees F, using a calibrated digital thermometer.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11. Observation of the sink in the activities room, off the great room, on 1/8/25 at 12:25 P.M., showed the Maintenance Director placed his digital thermometer in the water and the temperature measured 129.0 degrees F. The Maintenance Director said the activities room was not on the main valve and he had not thought to take temperatures in the activities room.</p> <p>12. Observation of the shower/bathing room on the Aspen unit near the Birch unit entrance on 1/8/25 at 12:30 P.M., showed the Maintenance Director placed his digital thermometer in the water at the toilet room sink and the temperature measured 123.4 degrees F. He placed his digital thermometer in the water at the shower and the temperature measured 126.0 degrees F. The Maintenance Director said the gauges on the boilers were very tricky and it was hard to get the temperature exactly right so that it did not go below 106 degrees F or above 120 degrees F. None of the residents complained about the water being too hot.</p> <p>13. Observation of the day room kitchenette at the end of the Aspen unit on 1/8/25 at 12:35 P.M., showed the Maintenance Director placed his digital thermometer in the water at the sink near the refrigerators. The temperature measured 126 degrees F.</p> <p>14. Observation on 1/8/25 at 12:10 P.M., of the hot water boilers in the mechanical room, in the service hallway, showed:</p> <ul style="list-style-type: none"> -Two vertical hot water boilers (which heat the water) with pipes running to a large storage tank which stored the water; -The first hot water boiler's digital thermometer read, 155 degrees F; -The second hot water boiler's digital thermometer read, 160 degrees F; -The large storage tank did not have a visible thermometer; -A pipe from the storage tank ran to a mixing valve; -The mixing valve's thermometer read, 119 degrees F; -Pipes from the mixing valve ran through the walls and distributed the water throughout the facility. <p>During an interview on 1/8/25 at 12:15 P.M., the Maintenance Director said the hot water boilers in the maintenance room were the only ones to service the whole building. The hot water boilers also provided water to the kitchen and the temperatures needed to be higher in there. He checked water temperatures daily using a digital thermometer and recorded them in a log. He took a temperature on a different hall in a different room each day. He had not calibrated the digital thermometer because it was brand new. He knew the temperatures were high on the boilers but thought the mixing valves regulated them before being distributed to the pipes through the facility.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>15. During an interview on 1/9/25 at 4:05 P.M. with the Administrator, Director of Nurses (DON), Chief Executive Officer (CEO) A and CEO B, the Administrator said the Maintenance Director does weekly audits to check water temperatures. He checks different areas during each audit. It is expected for the method of obtaining water temperatures to be consistent. It is expected for the thermometer to be held under the running water for a period of time, not removed quickly, in order to get an accurate reading. It is expected that hot water temperatures should not exceed 120 degrees F to ensure residents are not burning themselves.</p> <p>42795</p> <p>46888</p>		

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<p>F 0620</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide.</p> <p>40290</p> <p>Based on interview and record review, the facility failed to ensure its admission policy did not request or require residents or potential residents to waive potential facility liability for losses of personal property. This deficient practice had the potential to affect all residents. The sample was 12. The census was 84 with 46 in certified beds.</p> <p>Review of the facility's Admission policy, reviewed 1/9/25, showed:</p> <ul style="list-style-type: none"> -The facility shall not be responsible for clothing, jewelry, money, or other valuable retained by Resident except as described under the lost and found and denture policy of the facility; -Attached hereto and incorporated herein, included Exhibits C and F; -Exhibit C, Admission Authorizations: <ul style="list-style-type: none"> -Waiver of liability - personal belongings: It is hereby acknowledged that the Resident and/or Responsible Party has been advised that the facility is not responsible or liable for loss or accidental damage of personal belongings such as but not limited to: hearing aids, dentures, eyeglasses, jewelry, money, clothing, personal effects such as provided in the policies and procedures; -Exhibit F, Lost and Found Policy: <ul style="list-style-type: none"> -The facility can only ensure against loss of valuable items (such as jewelry or money) if they are deposited with management for safekeeping. The Resident or designee will be given a receipt for items held by the facility. The facility will not be liable for the loss of such valuable items if the Resident or designee refuses to keep valuables with the management for safekeeping; -Resident and/or Responsible Party, have read, been informed of, understand and agree to all terms and conditions of the above Agreement, Resident Rights and Responsibilities and all other documents attached hereto and incorporated herein. <p>During an interview on 1/9/25 at 3:13 P.M., the Admissions Coordinator said all residents admitted to the facility are provided with the same Admission policy, with some slight variances based on payor source. All residents are provided with the exhibit documents that are referenced in the packet. She did not realize the admission policy required residents to waive the facility's liability for lost personal items.</p> <p>During an interview on 1/9/25 at 3:22 P.M. with the Administrator, Chief Executive Officer (CEO) A, and CEO B, they said the same admission policy is given to all residents admitted to the facility. The policy was developed by the facility's corporate attorney. While any report of lost items would be investigated, they understand the verbiage in the admission policy should be reviewed by corporate.</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290</p> <p>Based on interview and record review, the facility failed to ensure all staff certified in cardiopulmonary resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating) received their CPR certification through a provider whose training includes hands-on practice and in-person skills assessment. One week was reviewed for staff CPR certification (21 shifts), and problems were found with 12 shifts. The resident sample was 12. The census was 84 with 46 in certified beds.</p> <p>Review of the facility's Emergency Procedure - CPR policy, revised [DATE], showed:</p> <p>-Policy statement: Personnel have completed training on the initiation of CPR and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest;</p> <p>-Preparation for CPR included;</p> <p>-Obtain and/or maintain American Red Cross or American Heart Association certification in BLS/CPR for key clinical staff members who will direct resuscitative efforts, including non-personnel.</p> <p>Review of the facility's resident code status report, dated [DATE], showed five residents with full code status.</p> <p>Review of the CPR certifications for the Director of Nurses (DON), Registered Nurse (RN) H, and Certified Medication Technician (CMT) M, showed the CPR certifications obtained through a provider that only offers online CPR certification.</p> <p>Review of the facility's staffing sheets from [DATE] through [DATE], showed:</p> <p>-On [DATE] from 7:00 A.M. to 3:00 P.M., DON was the only CPR-certified staff scheduled;</p> <p>-On [DATE] from 3:00 P.M. to 11:00 P.M., DON and CMT M were the only CPR-certified staff scheduled;</p> <p>-On [DATE] from 7:00 A.M. to 3:00 P.M., DON was the only CPR-certified staff scheduled;</p> <p>-On [DATE] from 7:00 A.M. to 3:00 P.M., DON was the only CPR-certified staff scheduled;</p> <p>-On [DATE] from 3:00 P.M. to 11:00 P.M., DON and CMT M were the only CPR-certified staff scheduled;</p> <p>-On [DATE] from 11:00 P.M. to 7:00 A.M., RN H was the only CPR-certified staff scheduled;</p> <p>-On [DATE] from 7:00 A.M. to 3:00 P.M., DON was the only CPR-certified staff scheduled;</p> <p>-On [DATE] from 11:00 P.M. to 7:00 A.M., DON was the only CPR-certified staff scheduled;</p> <p>-On [DATE] from 7:00 A.M. to 3:00 P.M., the DON was the only CPR-certified staff scheduled;</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On [DATE] from 7:00 A.M. to 7:00 P.M., the DON was the only CPR-certified staff scheduled.</p> <p>During an interview on [DATE] at 12:49 P.M., the DON said her CPR certification was completed online. She was not aware that all CPR-certified staff must receive their certification through a provider whose training includes hands-on practice and in-person skills assessment.</p> <p>During an interview on [DATE] at 1:00 P.M., the Administrator said the facility was getting their staff certified through a particular provider who is no longer offering the certification at this time. The facility is working on getting connected to a new provider for CPR certification.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49992</p> <p>Based on observation, interview and record review, the facility failed to ensure the respiratory services provided were consistent with professional standards of practice for one resident (Resident #9) when staff failed to follow the physician orders for the rate of the oxygen. The sample size was 12. The census was 84 with 46 in certified beds.</p> <p>Review of the facility's Departmental (Respiratory Therapy) - Prevention of Infection policy, revised November 2011, showed:</p> <ul style="list-style-type: none"> -The purpose of this procedure is to guide prevention of infection associated with respiratory therapy task and equipment including ventilators among residents and staff; -Change the oxygen cannula (a tubing that is placed in the nose) and tubing every seven days or as needed <p>Review of the Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 12/6/24, showed:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Moderate cognitive impairment; -Requires oxygen therapy; -Diagnosis include Alzheimer's disease, respiratory failure, stroke, and high blood pressure. <p>Review of the resident's care plan, in use at the time of survey, showed it did not address the resident's respiratory care needs.</p> <p>Review of the resident's physician orders, showed:</p> <ul style="list-style-type: none"> -An order dated 7/1/24 to change oxygen tubing once a week, every Sunday for infection control; -An order dated 11/12/24 to check and replace oxygen tank on resident's wheelchair one time a day, every Tuesday and Saturday for oxygen management; -An order dated 11/28/24 for continuous oxygen at 4 liters (L). <p>Review of the resident's medication administration record, dated December 2024, showed continuous oxygen at 4 L.</p> <p>Review of the resident's medication administration record, dated January 2025, reviewed on 1/8/25, showed continuous oxygen at 4 L.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 1/8/25 at 9:43 A.M., showed the resident received oxygen at 3.5 L/via a nasal cannula (NC). At 12:43 P.M., the resident received oxygen at 5 L/NC.</p> <p>Observation on 1/9/25 at 7:35 A.M., showed the resident received oxygen at 3.5 L/NC.</p> <p>During an interview on 1/9/25 at 10:40 A.M., Certified Nurse Assistant (CNA) K said that the resident's oxygen should be at 5 L/NC.</p> <p>Observation on 1/9/25 at 10:42 A.M., showed the resident received oxygen at 4.5 L/NC.</p> <p>During an interview on 1/9/25 at 10:59 A.M., CNA L said the resident's oxygen rate should be 2.5-3 L/NC.</p> <p>Observation on 1/9/25 at 12:04 P.M., showed the resident receiving oxygen at 5 L/NC.</p> <p>During an interview on 1/9/25 at 2:51 P.M., CNA L said if he/she is unsure about the rate of oxygen, he/she would review the electronic medical record or ask the charge nurse.</p> <p>During an interview on 1/9/25 at 2:54 P.M., with Registered Nurse (RN) H and Certified Medication Technician (CMT) J, both agreed the oxygen rate should be as ordered by the physician. If the resident receives the wrong rate of oxygen the resident could be getting too little or too much and could have harmful effects.</p> <p>During an interview on 1/9/25 at 4:06 P.M., the Director of Nursing (DON) said that the expectation of the nurses is to follow physician orders for oxygen.</p> <p>During an interview on 1/9/25 at 4:06 P.M., the Administrator said staff should follow the policies for physician orders and oxygen therapy.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>49992</p> <p>Based on interview and record review, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation. The facility failed to ensure accuracy and monitoring for controlled substances for one of one narcotic count books reviewed. The census was 84 with 46 in certified beds.</p> <p>Review of the facility's Controlled Substance policy, dated June 2024, showed:</p> <p>-Garden View Care Center(s) shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule 2 and other controlled substances, in accordance with state and federal laws;</p> <p>-Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse coming off duty. The Director of Nursing (DON) shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties and shall give the Administrator/Quality Assurance and Performance Improvement (QAPI) committee a written report of such findings.</p> <p>Review of the facility's Narcotics Book for Magnolia/Aspen on 1/9/25 at 6:22 A.M., showed:</p> <p>-The sheet contains fifteen columns: Date, Time, Number of Packages, Oncoming Nurse, and Off Going Nurse;</p> <p>-The sheet prompted for a 7am-3pm, 3pm-11pm, and 11pm-7am count for each shift change.</p> <p>-The controlled substance shift change count sheet, starting date 1/1/24 and ending date 1/8/25:</p> <p>-No 7 A.M. - 3 P.M. count completed for two of 24 opportunities;</p> <p>-No 11 P.M. - 7 A.M. count completed for five of 24 opportunities;</p> <p>-On 1/4/25 at 11 P.M. no nurse signatures for the 11 P.M. - 7 A.M. shift for 24 opportunities.</p> <p>During an interview on 1/9/25 at 7:35 A.M., Registered Nurse (RN) H said the process for counting narcotics is to count the number of packages first, then to review each individual package for the number of medications present. The narcotics should be counted at each shift change and the oncoming and off going nurse should initial in the book. RN H said sometimes that did not happen.</p> <p>During an interview on 1/9/25 at approximately 9:45 A.M., the DON presented the Magnolia/Aspen narcotic count sheets for November and December 2024. She said there was a problem with the narcotic count between shifts when she assumed the role three months prior. At that time, she initiated a new process of counting the number of packages at the change of shift as well. At 4:06 P.M., the DON said narcotics should be counted at the change of each shift. The count should include the number of packages present for count.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/9/25 at 4:06 P.M., the Administrator said she expected nursing staff to follow the policy for counting narcotics.</p>

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49992</p> <p>Based on observation, interview and record review, the facility failed to ensure laboratory services to meet the needs of the residents by failing to ensure quality control solution for blood sugar testing machines, in house Covid tests, and other supplies used for laboratory testing and medication administration, stored in the nurse's medication cart, were not expired. The census was 84 with 46 in certified beds.</p> <p>Review of the facility's Centers for Medicare and Medicaid Services Clinical laboratory Improvement Amendment (CLIA) certificate of waiver, effective date [DATE] through [DATE], showed:</p> <p>-The facility name and address listed as the Laboratory name and address;</p> <p>-The above named laboratory located at the address shown hereon may accept human specimens for the purpose of performing laboratory examination or procedures.</p> <p>Review of the facility's Storage of Medication policy, revised [DATE], showed:</p> <p>-Policy: The facilities shall store all drugs and biologicals in a safe, secure, and orderly manner;</p> <p>-Policy interpretation and guidelines: the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.</p> <p>Review of the Assure Dose Control Solution (solution used to calibrate blood sugar machines to ensure accurate blood sugar test results) manufacturers recommendations showed use before the expiration date printed on the bottle.</p> <p>Review of the IntelliSwab COVID-19 Rapid test (in house test for the COVID-19 virus) manufacturers recommendations showed do not use test kit if passed expiration date.</p> <p>Review of the Binax Now COVID-19 test (in house test for the COVID-19 virus) manufacturers recommendations showed do not use test kit if passed expiration date.</p> <p>Observation and interview on [DATE] at 6:10 A.M., of the Birch/[NAME] medication room, showed:</p> <p>-Assure Dose Control Solution, expired [DATE];</p> <p>-OcuSoft Lid Scrub (eyelid cleansing wipes used to cleanse and decrease inflammation of the eye), expired , d+[DATE];</p> <p>-Alcohol prep pads, expired ,d+[DATE];</p> <p>-InteliSwab COVID-19 rapid test, expired [DATE];</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-BinaxNow COVID-19 test, expired [DATE].</p> <p>-The Director of Nursing verified the expired items and removed them from the cart. She said that expired medication supplies should not be left in the medication carts. Nurses should check the expiration date prior to administering medications or tests.</p> <p>During an interview on [DATE] at 4:06 P.M., the Administrator said that she would expect staff to follow facility policies.</p>		