| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265727 | A. Building<br>B. Wing | 11/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Carmel Hills Wellness & Rehabilitation | 810 East Walnut<br>Independence, MO 64050 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>46519<br><br>Based on interview and record review, the facility failed to ensure the dignity of one sampled resident (Resident #104) out of 20 sampled residents. The facility census was 158 residents.<br><br>Review of the facility's policy titled Privacy and Dignity dated June 2020 showed:<br><br>-The facility promoted resident care in a manner and an environment that maintains or enhances dignity and respect, in full recognition of each resident's individuality.<br><br>-The staff assisted with the residents in maintaining self-esteem and self-worth.<br><br>-Staff were to treat residents with respect including respecting their social status, speaking respectfully, and listening carefully.<br><br>-Staff were to focus on residents as individuals when they speak to them and address residents as individuals when providing care and services.<br><br>1. Review of Resident #104's Admission Record showed he/she admitted to the facility with a diagnosis of legal blindness.<br><br>Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 12/16/24 showed the resident was cognitively intact.<br><br>Review of the resident's care plan dated 12/20/24 showed the resident was dependent on tobacco with the interventions to supervision while smoking.<br><br>Review of an Allegation of Staff to Resident Abuse Investigation completed by the facility on 1/11/25 showed:<br><br>-The incident involved the resident and Hospitality Aide (HA) B.<br><br>-The resident smoked cigarettes and due to his/her visual impairment, he/she was to wear a smoking apron (a fire retardant garment that protects the wearer from cigarette ash and debris) based of the recommendation of the smoking assessment completed 1/2/25.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -On 1/11/25 HA B observed the resident in the smoking area without his/her apron on.<br><br>-HA B knew that the resident needed to wear a smoking apron to ensure his/her safety.<br><br>-HA B then approached the resident and touched the back of the resident's head to get his/her attention and reminded him/her of the necessity to wear the apron while smoking.<br><br>-The resident had initially expressed that HA B had struck him/her.<br><br>-The facility removed HA B from all resident interactions.<br><br>-The nurse assessed the resident and found no signs of trauma or injury.<br><br>-The resident later clarified that the contact had not caused any injury or any mental anguish.<br><br>-The resident had not believed that HA B had touched him/her to willfully inflict injury.<br><br>-He/She stated that HA B should have just called his/her name.<br><br>-HA B had only intended to remind the resident to wear his/her apron and had no intent to harm the resident.<br><br>Review of the resident's written verbal statement collected from the resident by staff dated 1/11/25 showed:<br><br>-He/She had been out smoking and HA B hit him/her a couple of times in the back of the head.<br><br>-HA B had wanted him/her to come inside but he/she was not ready to go inside yet.<br><br>-HA B had not hurt him/her, HA B should not have hit him/her.<br><br>Review of an undated statement completed by HA B showed:<br><br>-He/She had touched the resident to let the resident know he/she had needed his/her smoking apron on while outside.<br><br>-The resident came in with him/her to get the resident's smoking apron and the resident went back outside.<br><br>-Everything seemed okay.<br><br>Review of a statement dated 1/11/25 completed by Registered Nurse (RN) A showed:<br><br>-The resident stated that HA B had walked up behind him/her and tapped him/her hard on the back of the head.<br><br>-The resident stated that it had not hurt him/her and felt that what HA B did was uncalled for and made him/her uncomfortable.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 1/15/25 at 12:22 P.M. the resident said:<br><br>-HA B had hit him/her softly to the back of his/her head and neck area.<br><br>-HA B had told him/her that it was too cold and that he/she needed to go inside.<br><br>-He/She had told HA B that it was not too cold to be outside and then HA B became aggravated after that.<br><br>During an interview on 1/15/25 at 3:25 P.M. the resident said:<br><br>-He/She felt safe at the facility.<br><br>-The whole incident just made him feel embarrassed and HA B had made him/her feel like a kid.<br><br>During a phone interview on 1/17/25 at 11:18 A.M. HA B said:<br><br>-The resident had needed his/her smoking apron.<br><br>-He/She had gone to the bathroom and when he/she came back outside, the resident was already outside and was not wearing his/her smoking apron.<br><br>-The resident had told HA B that he/she was not smoking, so he/she did not need a smoking apron.<br><br>-The resident then proceeded to move closer to the other residents that were smoking.<br><br>-He/She then tapped the resident on the back of his/her head to get his/her attention.<br><br>-He/She had not hit the resident.<br><br>-He/She knew that he/she should not have tapped the resident in the back of the head and should have tapped the resident's shoulder instead.<br><br>-He/She was just not thinking at the time and would never intentionally hurt a resident.<br><br>During a phone interview on 1/17/25 at 2:28 P.M. Certified Nurses Aide (CNA) K said:<br><br>-He/She had been walking down the hall when he/she overheard a resident say that Resident #104 had been hit in the back of the head.<br><br>-He/She had not seen anything expect for HA B assisting the resident's in his/her wheelchair to get the resident to come inside.<br><br>-The resident had said you don't have to hit me in the back of the head like I am a kid.<br><br>-HA B should not have approached the resident how he/she had.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The interaction between the resident and HA B made the resident feel embarrassed which indicated to him/her that HA B had showed the resident a lack of dignity.<br><br>During a phone interview on 1/21/25 at 8:06 A.M. Assistant Director of Nursing (ADON) A said:<br><br>-He/She was not sure what happened between HA B and the resident.<br><br>-HA B should not have touched the resident's back of head/neck area.<br><br>-He/She would have expected staff to have tapped the resident's shoulder to get his/her attention or to have brought over the smoking apron to the resident.<br><br>-The interaction was disrespectful towards the resident.<br><br>During a phone interview on 1/21/25 at 10:11 A.M. the Administrator said:<br><br>-The investigation determined the resident felt like his/her dignity was compromised.<br><br>-The incident between the resident and HA B was inappropriate because the resident did not want his/her back of head/neck area to be touched.<br><br>-He/She would have expected HA B to have gone in front of the resident to get his/her attention or to have touched him/her on the shoulder or hand. |

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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>46519<br><br>Based on observation, interview, and record review, the facility failed to obtain a physician order for self-administration of medication at bedside and failed to evaluate and document the ability to self-administer medication for one sampled (Resident #96) out of 35 sampled residents. The facility census was 151 residents.<br><br>Review of the facility's policy titled Self-Administration of Medication dated August 2020 showed:<br><br>-If a resident desired to self-administer medications, an assessment was conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process.<br><br>-The results of the interdisciplinary team assessment of the resident skills and of the determination regarding bedside storage were recorded in the resident's medical record on the care plan.<br><br>-If the resident demonstrated the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage was conducted.<br><br>1. Review of Resident #96's Admission Record showed he/she admitted to the facility with the following diagnoses:<br><br>-Chronic Obstructive Pulmonary Disease (COPD-a disease process that decreases the ability of the lungs to perform ventilation).<br><br>-Pulmonary Fibrosis (a diseases in which the lungs become scarred over time).<br><br>Review of the resident's admission Minimum Data Set (MDS- federally mandated assessment instrument completed by facility staff for care planning) dated 10/16/24 showed the resident was cognitively intact.<br><br>Review of the resident's care plan dated 10/21/24 showed:<br><br>-The resident had altered respiratory status/difficulty breathing related to COPD but did not indicate the use of an inhaler.<br><br>-There was not focus or intervention related to the self-administration of medication.<br><br>Review of the resident's Physician Order Sheet (POS) dated November 2024 showed:<br><br>-A physician's order for ProAir HFA Inhalation Aerosol Solution (Albuterol Sulfate- used to prevent and treat wheezing, difficulty breathing, chest tightness, and coughing caused by lung diseases such as COPD) 108 (90 Base) micrograms (mcg)/ actuation (ACT), one puff inhale orally every six hours as needed for wheezing.<br><br>-No physician's order for the ability to self-administer any medication.<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 | Observation on 11/19/24 at 2:09 P.M. of the resident's room showed an albuterol sulfate inhaler sitting by the resident's sink.<br><br>During an interview on 11/19/24 at 2:45 P.M. the resident said:<br><br>-He/She had been given the inhaler from an unknown staff member to keep in his/her room because he/she told staff that he/she only needed the inhaler whenever he/she was walking around the facility. -He/She was unsure of when the staff had given him/her the inhaler to keep in his/her room.<br><br>-The staff did not assess him/her to be able to self-administer the inhaler himself/herself.<br><br>During an interview on 11/19/24 at 2:51 P.M. Certified Medication Technician (CMT) B said:<br><br>-He/She was unsure if a self-administration assessment had been completed for the resident to use his/her inhaler.<br><br>-The Assistant Directors of Nursing (ADONs) were responsible for completing the self-administration assessments for residents to be able to self-administer medications.<br><br>-He/She was unaware that the resident had the albuterol inhaler in his/her room.<br><br>During an interview on 11/20/24 at 10:43 A.M. Registered Nurse (RN) A said:<br><br>-Residents were able to self-administer medications if they had an assessment for self-administration completed and a physician's order to do so.<br><br>-The resident did not have an order to be able to self-administer any medication.<br><br>-The inhaler should not have been kept in the resident's room due to the lack of the physician's order.<br><br>-Nurses were able to perform the self-administration of medication assessment and obtain a physician's order.<br><br>During an interview on 11/20/24 at 11:13 A.M. ADON A said:<br><br>-Residents were able to self-administer their own medication if an assessment for self-administration of medication was completed and a physician's order was in place to do so.<br><br>-If there was not an assessment in place, residents were not allowed to self-administer any medication and the staff were required to administer the medication.<br><br>-The resident did not have an order for self-administration for the inhaler.<br><br>-He/She would have expected the staff to notice the inhaler in the resident's room especially if it was on the resident's sink.<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 | -He/She would have expected the staff to have taken the inhaler out of the resident's room if they had seen it in the resident's room or get a nurse to take the inhaler out of the room.<br><br>During an interview on 11/20/24 at 11:51 A.M. the Director of Nursing (DON) said:<br><br>-The resident did not have a self-administration assessment for his/her albuterol sulfate inhaler.<br><br>-The staff were unaware the resident did not have an assessment for self-administration of his/her inhaler and there was not a physician's order in place for the resident to keep the inhaler at bedside.<br><br>-He/She would have expected staff to notify the ADONs an assessment needed to be completed for the resident to be able to self-administer medication.<br><br>-The staff should have noticed the inhaler in the resident's room, especially if it was on the resident's sink and have taken it out of the resident's room. |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150<br><br>Based on interview and record review, the facility failed to notify the resident and/or the resident's representative(s) of a transfer to a hospital, including the reasons for the transfer in writing for two sampled residents (Residents #137 and #109) out of 35 sampled residents. The facility census was 151 residents.<br><br>Review of the Facility's Transfer and Discharge Policy revised 06/2020 showed:<br><br>-The purpose of the policy was to ensure that residents are transferred and discharged from the facility in compliance with state and federal laws and to provide complete, safe, and appropriate discharge planning and necessary information to the continuing care provider.<br><br>-The facility may use Notice of Transfer/Discharge or another comparable form to provide the resident or his/her personal representative with advanced notice of transfer or discharge.<br><br>-When a resident is transferred/discharged , Social Services Staff include a copy of the written notice of transfer/discharge provided to the resident or his/her personal representative in the resident's medical record.<br><br>1. Review of Resident #137's Admission Record showed:<br><br>-The resident was admitted to the facility on [DATE].<br><br>-The resident was readmitted to the facility on [DATE].<br><br>Review of the resident's discharge Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 6/1/24, showed the resident was discharged to the hospital with his/her return anticipated.<br><br>Review of the resident's Electronic Medical Record (EMR) on 11/21/24 at 9:31 A.M., showed no transfer/discharge notice dated 6/1/24.<br><br>2. Review of Resident #109's Admission Record showed:<br><br>-The resident was initially admitted to the facility on [DATE].<br><br>-The resident was re admitted to the facility on [DATE].<br><br>Review of the resident's discharge MDS dated [DATE], showed the resident was discharged to the hospital with his/her return anticipated.<br><br>Review of the resident's EMR on 11/21/24 at 11:14 A.M., showed no transfer/discharge notice dated 1/17/24.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. During an interview on 11/21/24 at 1:53 P.M., Medical Records Staff said he/she could not locate a notice of transfer/discharge for Resident #137 or Resident #109 in the resident's medical records.<br><br>During an interview on 11/22/24 at 2:30 P.M., Registered Nurse (RN) B said:<br><br>-If a resident was transferred/discharged from the facility, the charge nurse was responsible for completing the notice of transfer/discharge.<br><br>-If a notice of transfer/discharge was completed on a resident, it would be uploaded and documented in the resident's electronic medical record by the charge nurse or the nurse manager.<br><br>-He/she was unaware of the process the facility used to ensure transfer notices were being completed.<br><br>During an interview with the Director Of Nursing (DON) on 11/25/24 at 11:10 A.M., said:<br><br>-The charge nurses or social services were responsible for completing the notice of transfer/ discharges.<br><br>- There should be documentation including details for reason of transfer, where, safe, and who was notified (physician, family) in the resident's medical record.<br><br>-If there was no documentation in the EMR of a notice of transfer for a resident, then he/she would say it was not completed. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150<br><br>Based on interview and record review, the facility failed to provide a bed hold notification to a resident and/or the resident's representative upon transfer or discharge for two sampled residents (Resident #137 and #109) out of 30 sampled residents. The facility census was 151 residents.<br><br>Review of the facility's Bed Hold Policy dated 6/2020 showed:<br><br>-The purpose of the policy was to ensure that the resident and/or their representative was aware of the facility's bed hold policy, and that such policy complies with state and federal law and regulations.<br><br>-When a resident was admitted to the facility, the facility informed the resident or his/her personal representative in writing that the facility had a bed hold policy.<br><br>-The facility notified the resident or his/her representative, in writing, of the bed hold policy any time the resident was transferred to general acute care hospital even if the facility has not met the occupancy requirements.<br><br>-Upon notice to the resident or his/her personal representative, the licensed nurse (or designee) will document how the resident, or his/her personal representative was notified.<br><br>1. Review of Resident #137's Admission Record showed:<br><br>-The resident was admitted to the facility on [DATE].<br><br>-The resident was re admitted to the facility on [DATE].<br><br>Review of the resident's discharge Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 6/1/24, showed the resident was discharged to the hospital with his/her return anticipated.<br><br>Review of the resident's electronic medical record on 11/21/24 at 9:31 A.M., showed no bed hold notice dated 6/1/24.<br><br>2. Review of Resident #109's Admission Record showed:<br><br>-The resident was admitted to the facility on [DATE].<br><br>-The resident was re admitted to the facility on [DATE].<br><br>Review of the resident's discharge Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 1/17/24, showed the resident was discharged to the hospital with his/her return anticipated.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's electronic medical record on 11/21/24 at 11:14 A.M., showed no bed hold notice dated 1/17/24.<br><br>During an interview on 11/21/24 at 1:53 P.M., Medical Records Staff said he/she could not locate a bed hold notice for resident #137 or resident #109 in the resident's medical records.<br><br>During an interview on 11/22/24 at 2:30 P.M., Registered Nurse (RN) B said:<br><br>-If a resident was transferred/discharged from the facility, the charge nurse was responsible for completing the bed hold notice.<br><br>-If a bed hold notice was completed on a resident, it would be uploaded and documented in the resident's electronic medical record.<br><br>-He/she was unaware of the process that the facility used to ensure that bed hold notices were being completed.<br><br>During an interview with the Director Of Nursing (DON) on 11/25/24 at 11:10 A.M., said:<br><br>-The charge nurses were responsible for completing the notice of discharges.<br><br>-Once a bed hold notice was completed, it would be documented in the resident's electronic medical record.<br><br>-If there was no documentation in the electronic medical record of a bed hold notice for a resident, then he/she would say that it was not completed. |

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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** 51303<br><br>Based on observation, interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) for two sampled residents (Residents #14, #98) out of 35 sampled residents. The facility census was 151 residents.<br><br>A policy was requested and not received from the facility.<br><br>1. Review of Resident #14's Admission Record showed he/she was admitted to the facility on [DATE] with the diagnosis of Need for Assistance with Personal Care.<br><br>Review of the resident's nursing Admission/Readmission Evaluation dated 8/24/23 showed he/she had broken and/or carious teeth.<br><br>Review of the resident's Nutrition Assessment-Registered Dietician Evaluation dated 1/20/23 showed the resident has his/her own teeth in fair condition.<br><br>Review of the resident's Order Summary Report (OSR) showed a physician's order dated 4/30/24 may be seen and treated by a dentist.<br><br>Review of the resident's Annual MDS dated [DATE] showed:<br><br>-He/She had moderate cognitive deficits and required support of facility staff.<br><br>-He/she had no missing teeth or cavities.<br><br>Review of the resident's care plan on 11/22/24 10:39 A.M. failed to show the need for dental care.<br><br>During an interview on 11/19/24 at 10:25 A.M. the resident said he/she didn't have many teeth.<br><br>Observation on 11/19/24 at 10:25 A.M. of the resident's mouth showed:<br><br>-Multiple teeth missing on both upper and lower jaw.<br><br>-One tooth on the lower right side was loose and pointed towards the tongue.<br><br>-A buildup of a yellow substance was on the remaining teeth.<br><br>2. Review of Resident #98's Admission Record showed he/she was admitted to the facility on [DATE] with the following diagnoses:<br><br>-Chronic Obstructive Pulmonary Disease (COPD - a disease process that decreases the ability of the lungs to perform ventilation.)<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265727 | A. Building<br>B. Wing | 11/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Carmel Hills Wellness & Rehabilitation | 810 East Walnut<br>Independence, MO 64050 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Chronic Respiratory Failure with hypoxia a condition where the lungs are unable to adequately exchange oxygen and carbon dioxide over a prolonged period, resulting in a persistently low levels of oxygen in the blood (Hypoxemia), which is a hallmark symptom of chronic respiratory failure; essentially, the body is not getting enough oxygen due to impaired lung function.<br><br>-Dependence on supplemental oxygen.<br><br>Review of the resident's nursing Admission MDS completed by facility staff dated 7/31/23 showed:<br><br>-He/She was cognitively intact.<br><br>-He/she had no missing teeth or cavities.<br><br>-Did not use a BiPAP machine.<br><br>Review of the resident's Annual MDS completed by facility staff dated 6/4/24 showed:<br><br>-He/She was cognitively intact.<br><br>-Oral/Dental Status showed no problem with missing teeth or cavities.<br><br>-Failed to show usage of the BiPAP.<br><br>During an interview on 11/19/24 at 8:51 A.M. the resident said he/she had quite a few broken teeth or with cavities.<br><br>Observation of the resident's mouth on 11/19/24 at 8:51 A.M. showed:<br><br>-He/She had multiple teeth missing.<br><br>-He/She had teeth with sharp edges and blackened areas on multiple teeth.<br><br>During an interview on 11/21/24 at 9:39 A.M. the resident said he/she had the Bilevel Positive Airway Pressure (BiPAP-a type of noninvasive ventilation that helps you breathe) machine for approximately seven years.<br><br>Observation on 11/21/24 at 9:39 A. M showed he/she was currently utilizing the BiPAP machine.<br><br>During an interview on 11/25/24 9:14 A.M. MDS Coordinator A said:<br><br>-He/She gathered information for the MDS on interview of resident and staff, observation, the clinical record, and the daily clinical meeting.<br><br>-He/She was aware of #14's cavities.<br><br>-He/She was not aware Resident #98's broken and missing teeth.<br><br>-Dental issues should be coded on the MDS.<br><br>(continued on next page) |

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| | 265727 | A. Building<br>B. Wing | 11/25/2024 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The BiPAP machine should be coded on the MDS.<br><br>-<br><br>During an interview on 11/25/24 9:14 A.M. the MDS Coordinator B said:<br><br>-He/She gathered information for the MDS on interview of resident and staff, observation, the clinical record, and the daily clinical meeting.<br><br>-He/She was not aware if Resident #14 had teeth issues.<br><br>-He/She was not aware Resident #98's broken and missing teeth.<br><br>-He/She stated #98 had never complained about dental concerns.<br><br>-He/She said the BiPAP machine should be coded on the MDS.<br><br>During an interview on 11/25/24 9:44 A.M. Assist Director of Nursing (ADON) B said:<br><br>-He/She was not aware of missed BiPAP order.<br><br>-He/She expected the MDS to be accurate.<br><br>-He/She expected dental issues to be coded on the MDS.<br><br>-He/She expected a BiPAP machine to be coded on the MDS.<br><br>During an interview on 9/11/24 at 11:47 A.M. the Director of Nursing (DON) said:<br><br>-He/She would expect the MDS nurse to capture the documentation from the clinical chart.<br><br>-He/She would expect the MDS nurse to conduct his/her own assessments.<br><br>-He/She was not aware Residents #14 and #98 had missing and/or broken teeth or cavities.<br><br>-He/She expected a BiPAP machine to be coded on the MDS.<br><br>-He/She was aware Resident #98 had a BiPAP.<br><br>3. Review of Resident #109's Admission Record showed:<br><br>-The resident was admitted to the facility on [DATE].<br><br>-The resident had a diagnosis of difficulty in walking.<br><br>Review of the resident's fall investigation dated 7/3/24 at 5:30 A.M., showed:<br><br>-The resident verbalized to the nurse that he/she fell while outside of the building smoking.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The resident landed on his right elbow and arm when he/she fell .<br><br>-The resident was complaining of right shoulder and elbow pain at a 7 on a 0-10 pain scale.<br><br>-The resident had an egg sized abrasion on his/her right elbow.<br><br>-The nurse on duty ordered a 2-view x ray of the right shoulder and elbow.<br><br>Review of the resident's fall investigation dated 7/17/24 at 2:33 P.M., showed:<br><br>-The resident fell outside in the smoking area.<br><br>-The resident hit his/her outer left foot on the concrete curb.<br><br>Review of the resident's annual MDS dated [DATE] showed:<br><br>-The resident was cognitively intact.<br><br>-The resident had not had any falls in the facility since admission or the prior assessment.<br><br>During an interview on 11/22/24 at 2:17 P.M., Registered Nurse (RN) B said the MDS coordinator was responsible for updating the MDS assessments when a resident falls.<br><br>During an interview on 11/22/24 at 2:40 P.M., MDS coordinator A and MDS coordinator B said:<br><br>-They were responsible for updating the MDS assessments after a resident fall.<br><br>-The clinical team has morning meetings each morning and this is when falls with residents are discussed.<br><br>-They were both aware of the resident.<br><br>-They both denied having knowledge of the resident having any falls since admission.<br><br>-The two falls should have been coded on the MDS.<br><br>During an interview on 11/22/24 at 3:00 P.M., ADON A said:<br><br>-When a resident falls, the MDS should be updated to reflect the fall to help prevent future falls.<br><br>-The MDS coordinators were responsible for updating the MDS after a resident had a fall.<br><br>During an interview on 11/25/24 at 11:10 A.M., the DON said:<br><br>-The MDS coordinator was responsible for updating the MDS assessments after a resident fall.<br><br>-The MDS assessment should capture a resident's fall when the next assessment was completed. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51303<br><br>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to address the residents' functional and health status, strengths and needs as related to dental services for two sampled residents, (Resident #14 and #98), failed to assess and care plan the usage of a Bilevel Positive Airway Pressure (BiPAP a non-invasive ventilation with two pressures settings, one for inhalation and one for exhalation, to assist with breathing) for one sampled resident, (Resident #98), and failed to assess and care plan two falls for one sampled resident (Resident #109) out of 35 sampled residents. The facility census was 151 residents.<br><br>Review of the facility policy Care Planning revised June 2020 showed:<br><br>-The purpose was to ensure the comprehensive person-centered care plan was developed for each resident based on individual assessed needs.<br><br>-The Facility's Interdisciplinary Team (IDT) would develop a comprehensive care plan for each resident in accordance with Omnibus Budget Reconciliation Act (OBRA) a United States federal law that was passed in 1987 and 1990 to improve the quality of care in long-term care facilities and nursing homes and Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) guidelines.<br><br>-The care plan serves as a course of action where the resident, resident's family and/or guardian or other legally authorized representative), resident's attending physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental, and psychosocial needs.<br><br>-A licensed nurse would initiate the care plan, and the plan will be finalized in accordance with OBRA/MDS guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgment on an as needed basis.<br><br>-Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.<br><br>1. Review of Resident #14's undated Admission Record Face Sheet showed he/she was initially admitted on [DATE] with the following diagnosis, Need for Assistance with Personal Care.<br><br>Review of the resident's nursing Admission/Readmission Evaluation dated 8/24/23 showed he/she had broken and/or carious teeth.<br><br>Review of the resident's Nutrition Assessment -Registered Dietician Evaluation dated 1/20/24 showed:<br><br>-He/She was on a regular diet and regular consistency<br><br>(continued on next page) |

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| | 265727 | A. Building<br>B. Wing | 11/25/2024 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She had his/her own teeth in fair condition.<br><br>Review of the resident's Order Summary Report (OSR) showed a physician's order dated 4/30/24 may be seen and treated by a dentist.<br><br>Review of the resident's Annual MDS dated [DATE] showed:<br><br>-He/She had moderate cognitive deficits and required support of facility staff.<br><br>-Oral/Dental Status showed no problem with missing teeth or cavities.<br><br>-He/She required supervision and touching assistance for oral hygiene.<br><br>During an interview on 11/19/24 at 10:25 A.M. the resident said:<br><br>-He/She didn't have many teeth.<br><br>-His/Her teeth sometimes hurt.<br><br>Observation on 11/19/24 at 10:25 A.M. of the resident's mouth showed:<br><br>-Multiple teeth missing in the upper and lower jaw.<br><br>-One tooth on lower right side loose and pointed towards the tongue.<br><br>-Buildup of a yellow substance on the remaining teeth.<br><br>Review of the resident's current care plan on 11/22/24 at 10:39 A.M. showed no dental care needs were identified.<br><br>Review of the resident's Quarterly MDS dated [DATE] showed no issues with teeth.<br><br>2. Review of Resident #98's Admission Record Face Sheet showed he/she was admitted on [DATE] with the following diagnoses:<br><br>-Chronic Obstructive Pulmonary Disease (COPD - a disease process that decreases the ability of the lungs to perform ventilation.)<br><br>-Chronic Respiratory Failure with hypoxia (a condition where the lungs are unable to adequately exchange oxygen and carbon dioxide over a prolonged period, resulting in a persistently low levels of oxygen in the blood (Hypoxemia), which is a hallmark symptom of chronic respiratory failure; essentially, the body is not getting enough oxygen due to impaired lung function).<br><br>-Dependence on supplemental oxygen.<br><br>Review of the resident's nursing Admission/Readmission Evaluation dated 7/25/23 showed:<br><br>-He/She had her own teeth.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The assessment question that stated broken or carious teeth was left blank.<br><br>Review of the resident's Admission MDS dated [DATE] showed:<br><br>-He/She was cognitively intact.<br><br>-Oral/Dental Status showed no problem with missing teeth or cavities.<br><br>-No order for the utilization of the BiPAP.<br><br>Review of the resident's Annual MDS dated [DATE] showed:<br><br>-He/She was cognitively intact.<br><br>-Oral/Dental Status showed no problem with missing teeth or cavities.<br><br>-No order for the utilization of the BiPAP.<br><br>Review of the resident's OSR dated November 2024 showed:<br><br>-No order for dental to consult and evaluate.<br><br>-No order for the utilization of the BiPAP.<br><br>During an interview on 11/19/24 at 8:51 A.M. the resident said:<br><br>-His/Her teeth hurt sometimes.<br><br>-He/She had quite a few broken teeth or with cavities.<br><br>-He/She was supposed to get all teeth pulled.<br><br>-He/She had been on the BiPAP for approximately 7 years.<br><br>Observation of the resident's mouth on 11/19/24 at 8:51 A.M. showed:<br><br>-He/She had multiple teeth missing.<br><br>-He/She had teeth with sharp edges and blackened areas on multiple teeth.<br><br>Observation on 11/21/24 at 9:39 A. M showed he/she was currently utilizing the BiPAP.<br><br>During an interview on 11/25/24 at 9:14 A.M. MDS Coordinator A said:<br><br>-He/She gathered information for the MDS on interview of resident and staff, observation, the clinical record, and the daily clinical meeting.<br><br>-He/She was aware of Resident #14's cavities.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She was not aware Resident #98 had broken and missing teeth.<br><br>-Dental issues should be captured on the MDS.<br><br>-A resident with dental issues should be care planned.<br><br>During an interview on 11/25/24 at 9:14 A.M. MDS Coordinator B said:<br><br>-He/She gathered information for the MDS on interview of resident and staff, observation, the clinical record, and the daily clinical meeting.<br><br>-He/She was not aware Resident #98 had broken and missing teeth.<br><br>-Resident #98 had never complained about dental concerns.<br><br>-The facility offered dental services.<br><br>-Dental issues should be captured on the MDS.<br><br>-A resident with dental issues should be care planned.<br><br>During an interview on 11/25/24 9:44 A.M. Assistant Director of Nursing (ADON) B said:<br><br>-He/She was not aware of Resident #98's missed BiPAP order.<br><br>-He/She expected the MDS to be correct.<br><br>-He/She expected dental issues to be captured on the MDS.<br><br>-He/She expected a BiPAP to be on the MDS.<br><br>-He/She expected dental issues and BiPAP to be care planned.<br><br>During an interview on 11/25/24 at 11:10 A.M. the Director of Nursing (DON) said:<br><br>-He/She expected the MDS nurse to capture the documentation from the clinical chart.<br><br>-He/She expected the MDS nurse to conduct his/her own assessments.<br><br>-He/She was not aware Residents #14 and #98 had missing and/or broken teeth or cavities.<br><br>-He/She expected dental concerns to be care planned.<br><br>-He/She expected a BiPAP to be on the MDS and care planned.<br><br>-He/She was aware Resident #98 had a BiPAP.<br><br>51150<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. Review of the facility policy Fall Evaluation and Prevention dated 08/2020, showed:<br><br>-The purpose of the policy was to ensure the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents.<br><br>-The facility will evaluate residents for their fall risk and develop interventions for prevention.<br><br>-A resident should be evaluated for their fall risk; on admission/re admission to the home, following any changes of status, following a fall, and quarterly.<br><br>Review of the facility policy Care Planning, with no date, showed:<br><br>-The purpose of the policy was to ensure that a comprehensive person-centered care plan was developed for each resident based their individual needs.<br><br>-A licenses nurse will initiate the care plan, and the plan will be finalized and updated as indicated for change in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgement on an as needed basis.<br><br>Review of Resident #109's face sheet, showed:<br><br>-The resident was admitted to the facility on [DATE].<br><br>-The resident had a diagnosis of difficulty in walking.<br><br>Review of the resident's fall investigation dated 7/3/24 at 5:30 A.M., showed:<br><br>-The resident verbalized to the nurse that he/she fell while outside of the building smoking.<br><br>-The resident landed on his right elbow and arm when he/she fell .<br><br>-The resident was complaining of right shoulder and elbow pain at a 7 on a 0-10 pain scale.<br><br>-The resident had an egg sized abrasion on his/her right elbow.<br><br>-The nurse on duty received an order for a 2-view x-ray of the right shoulder and elbow.<br><br>Review of the resident's fall investigation dated 7/17/24 at 2:33 P.M., showed:<br><br>-The resident fell outside in the smoking area.<br><br>-The resident hit his/her outer left foot on the concrete curb.<br><br>Review of the resident's psychiatric note dated 7/18/24, showed the resident's chief complaint was I am doing alright, I have foot pain from falling outside.<br><br>Review of the resident's quarterly MDS dated [DATE], showed:<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The resident was cognitively intact.<br><br>-The resident had not had any falls in the facility since admission or the prior assessment.<br><br>Review of the resident's care plan, revised 7/26/24, showed:<br><br>-No previous falls noted.<br><br>-No interventions for fall prevention noted.<br><br>Review of the resident's annual MDS dated [DATE], showed:<br><br>-The resident was cognitively intact.<br><br>-The resident had not had any falls in the facility since admission or the prior assessment.<br><br>During an interview on 11/20/24 at 9:38 A.M., the resident said:<br><br>-He/she fell twice outside a few months back.<br><br>-He/she continued to have pain in his/her right shoulder since the fall.<br><br>During an interview on 11/22/24 at 2:00 P.M., Certified Nurse Assistant (CNA) E said:<br><br>-The certified nurse assistants were made aware of when resident's fall from their charge nurse.<br><br>-He/she was familiar with the resident.<br><br>-He/she was not aware of the resident having any falls since admission.<br><br>During an interview on 11/22/24 at 2:17 P.M., Registered Nurse (RN) B said:<br><br>-The nurses were made aware when a resident fell from the electronic medical record.<br><br>-The charge nurse on duty at the time of a resident's fall was the one responsible for completing a fall investigation.<br><br>-He/she was familiar with the resident.<br><br>-He/she was not aware that the resident had any falls since admission.<br><br>-The MDS coordinator was responsible for updating the care plans when a resident fell .<br><br>During an interview on 11/22/24 at 2:40 P.M., MDS coordinator A and MDS coordinator B said:<br><br>-He/she was responsible for updating the MDS assessments after a resident fall.<br><br>(continued on next page) |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The clinical team had morning meetings each morning and this was when falls with residents were discussed.<br><br>-Both were aware of the resident.<br><br>-Both denied having knowledge of the resident having any falls since admission.<br><br>-The two falls should have been reflected in the updated MDS and care plan.<br><br>-Both were unaware of how the resident's two falls were overlooked.<br><br>During an interview on 11/22/24 at 3:00 P.M., ADON A said:<br><br>-When a resident fell , a risk management should be documented in the resident's medical record by the charge nurse.<br><br>-When a resident fell , the DON should be notified.<br><br>-He/she was familiar with the resident.<br><br>-He/she did recall one fall outside since the resident was admitted to the facility.<br><br>-He/she was unaware of who was responsible for completing the fall investigations.<br><br>-When a resident fell , the MDS and the care plan should be updated to reflect the fall to help prevent future falls.<br><br>-The MDS Coordinators were responsible for updating the MDS and care plans after a resident had a fall.<br><br>During an interview on 11/25/24 at 11:10 A.M., the DON said:<br><br>-The MDS coordinator was responsible for updating the MDS assessments and care plans after a resident fall.<br><br>-The MDS assessments were done quarterly and significant changes and care plans should be updated to reflect the MDS assessments.<br><br>-He/she would expect the MDS and care plan to reflect a resident who had two previous falls. |

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| | 265727 | A. Building<br>B. Wing | 11/25/2024 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51305<br><br>Based on interview and record review, the facility failed to update the care plan for an anticoagulant medication (a blood thinning medication) for one sampled resident (Resident #110) out of 35 sampled residents. The facility census was 151 residents.<br><br>Review of the facility's Comprehensive Care Plans and Revisions policy dated 6/2020 showed:<br><br>-The care plan was to be prepared by an Interdisciplinary Team (IDT) and Nursing Staff.<br><br>-The Facility's IDT will develop a comprehensive care plan for each resident in accordance with OBRA and MDS guidelines.<br><br>-A comprehensive person-centered Care Plan must be completed within 7 days after the Comprehensive Admission Assessment and must be periodically reviewed and revised by a team of qualified persons after each assessment, including the comprehensive and quarterly review assessments.<br><br>1. Review of Resident #110's Admission Record showed the resident was admitted on [DATE], with a diagnosis of Peripheral Vascular Disease (PVD, is a circulatory condition that occurs when blood vessels outside of the brain and heart narrow, block, or spasm).<br><br>Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 10/8/24 showed the resident:<br><br>-Was cognitively intact.<br><br>-Was on an anticoagulant.<br><br>Review of the resident's Care Plan dated 10/15/24, showed:<br><br>-The resident has altered cardiovascular status of PVD.<br><br>-There was no anticoagulant care plan.<br><br>Review of the resident's Order Summary Report (OSR) showed the following physician ordered medication dated on 10/19/24: Rivaroxaban 20 milligrams (mg) daily by mouth in the evening.<br><br>During an interview on 11/25/24 at 9:44 A.M. the resident said he/she did receive an AC medication daily.<br><br>During an interview on 11/25/24 at 10:04 A.M., Licensed Practical Nurse (LPN) B said:<br><br>-He/she expected resident #110 to have AC medication addressed in his/her care plan.<br><br>-The MDS Coordinators were responsible for care planning.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/25/24 at 10:29 A.M., MDS coordinator A and MDS coordinator B said:<br><br>-They were responsible for updating the residents' care plans.<br><br>-If a resident had an order for an AC, then the care plan should have addressed it.<br><br>-A care plan would have been created on the next assessment date when the medications were reviewed.<br><br>During an interview on 11/25/24 at 10:38 A.M., the Assistant Director of Nursing (ADON) B said he/she would had expected the resident's care plan to show that he/she was on an AC.<br><br>During an interview on 11/25/24 at 11:10 A.M., the Director of Nursing (DON) said:<br><br>-The MDS Coordinators were responsible for updating the care plans.<br><br>-The physician's orders should be monitored to ensure a care plan was created.<br><br>-He/she would expect care plans to be reviewed daily and updated as needed.<br><br>-He/she expected the resident to have an AC care plan. |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Plan the resident's discharge to meet the resident's goals and needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003<br><br>Based on interview and record review, the facility failed to document discharge planning prior to the resident's discharge from the facility and failed to complete a discharge summary for one discharged resident (Resident #201) who was discharged to home out of four discharged records. The resident sample was 35. The facility census was 151 residents.<br><br>Review of the facility's Discharge Planning policy and procedure dated 8/2020, showed:<br><br>-Discharge Planning will start on the day the resident was admitted to the facility.<br><br>-If the Interdisciplinary team and the attending physician determine that the resident may soon be discharged , Social Service staff will coordinate the discussion of discharge with the Interdisciplinary team, the resident, and the resident's representative.<br><br>-Social Services staff will document the discharge planning, preparation, and the resident's post-discharge needs in the resident's electronic health record.<br><br>-Social Services staff will assist in developing the Discharge Summary and Discharge Care plan that is developed with the interdisciplinary team.<br><br>-A copy of the discharge summary and care plan will be maintained in the resident's medical record.<br><br>-A post-discharge plan of care will be provided to the resident/resident representative detailing the arrangements the facility has made to address the resident's needs post discharge.<br><br>1. Review of Resident #201's Admission Record showed the resident was admitted to the facility on [DATE], with diagnoses including Leukoencephalopathy (a group of diseases that affect the white matter of the brain that can cause memory loss, muscle weakness, changes in behavior, language and vision changes), schizoaffective disorder (a mental health problem where you experience psychosis (hallucinations and delusions) as well as mood symptoms), bipolar disorder (a mental health condition that causes extreme mood swings), depression, and anxiety.<br><br>Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 8/9/24, showed the resident:<br><br>-The resident was alert and oriented with only minimal cognitive deficit.<br><br>-He/She had some loss of interests in doing things, feelings of depression, but had no behaviors of delusions, hallucinations, physical or verbal aggression, nor did he/she have any wandering or elopement behaviors during the look back period.<br><br>-Had no plan of discharge completed during the assessment and there was no plan for the resident to be discharged or to return to the community at this time.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's Care Plan dated 8/12/24, showed the resident used psychotropic medications related to Schizoaffective disorder, Bipolar disorder, and progressive leukoencephalopathy.<br><br>-The resident had a behavior of verbally asking staff and peers to have sex but has not physically touched anyone.<br><br>-Assist the resident to develop more appropriate methods of coping and interacting with staff and peers. Encourage the resident to express feelings appropriately.<br><br>-If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident.<br><br>-Minimize potential for the resident's disruptive behaviors by offering tasks which divert attention.<br><br>-Anticipate and meet The resident's needs.<br><br>-Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed.<br><br>-The care plan did not show any plans for discharge of the resident or seeking alternative placement based on discussions with the resident and/or responsible party.<br><br>Review of the resident's Psychiatric documentation showed:<br><br>-The resident was receiving weekly psychotherapy from 8/16/24 to 9/26/24.<br><br>-Documentation on 9/26/24 showed the therapist documented working with the resident on aggression/aggressive behaviors related to diagnoses.<br><br>-Notes did not show that the provider was working with the resident on transferring or a planned discharge from the facility (documentation showed there was prior discussion with family about transferring the resident closer to home 11/2023, but there was no current discussion documented in recent notes).<br><br>Review of the resident's Nursing Notes dated 10/22/24, showed:<br><br>-The nurse documented the resident was agitated and had behaviors of attempting to throw chairs, cursing and calling staff names. He/She was not redirectable despite several attempts. The nurse received a physician's order to send the resident the hospital for evaluation and treatment and made notifications to the resident's Power of Attorney and Director of Nursing (DON). The resident returned to the facility at 9:30 P.M. and was placed on one to one monitoring with no further incidents.<br><br>-There was no documentation showing the Social Worker had been contacting facilities for alternate placement/transfer of the resident or that there was a facility who was willing to accept the resident for placement. There was no documentation showing any active discharge planning.<br><br>Review of the resident's Social Service Notes on 10/22/24 showed:<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The Social Worker documented he/she spoke with a regional contact for a group of facilities that the resident could be transferred to and was informed that they had a bed available for the resident on the behavioral unit. The Social Worker documented he/she sent the referral and was waiting for confirmation and the facility would follow up to set up a time for an in-person assessment.<br><br>-There was no further documentation showing the Social Worker followed up with the resident or the resident's DPOA regarding a possible transfer of the resident. There was no documentation showing the current discharge plan for the resident.<br><br>Review of the resident's Nursing Notes showed:<br><br>-10/25/24 the nurse documented the resident had a confrontation with another resident that was observed by staff. The nurse notified the resident's DPOA, DON and Nurse Practitioner, who gave an order to send the resident out to the hospital for evaluation and treatment via ambulance.<br><br>-10/26/24 at 12:00 A.M., the resident returned to the facility and nursing staff placed him/her on one to one behavior monitoring with no further behaviors.<br><br>Review of the resident's Social Work Notes dated 10/26/24 showed:<br><br>-The Social Worker contacted the resident's DPOA and was informed they would be picking the resident up today (10/26/24) and he/she would not be returning to the facility. The Social Worker documented he/she notified the Administrator, DON and the Charge Nurse on the unit. The Social Worker documented he/she entered the physician's order to discharge the resident to home and send the resident with all his/her belongings and remaining medications to include 7 days of narcotics.<br><br>-There was no documentation showing the Social Worker informed the responsible party of the alternate placement that was found for the resident or of any aftercare services to be initiated for the resident. There was no documentation showing the Social Worker met with the resident's Interdisciplinary team regarding the plan to discharge the resident today and what aftercare services would be needed.<br><br>Review of the resident's Discharge Summary/Recapitulation Note dated 10/26/24 showed:<br><br>-The resident was discharged to home with his/her DPOA. The nurse documented he/she gave the resident's medications, medication sheet and face sheet to the resident's Power of Attorney. There was no additional information regarding the resident's discharge plan documented (follow up appointments or services provided).<br><br>During an interview on 11/22/24 at 12:04 P.M., with the Social Worker and the Regional Social Worker, the Social Worker said:<br><br>-He/She had been working at the facility for six weeks and was familiar with the resident and his/her behavioral concerns.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She had met with the resident's responsible party about the resident's behaviors and needs and they had decided that the locked dementia unit was not the most adequate place for the resident, due to his/her youth and activities (socialization with peers). The responsible party said they understood that he/she should be on a locked unit but one with residents who were closer to the resident's age and interests.<br><br>They had also discussed trying to find a placement closer to the resident's family.<br><br>-He/She had started looking for alternate placement for the resident and had called several facilities prior to the resident having the recent behaviors.<br><br>-He/She had gotten a response back from a facility that had a bed available, but at the time, the resident had a behavior and was sent to the hospital for evaluation (on 10/22/24). When the resident came back to the facility, he/she was in process of notifying the responsible party that he/she found an alternative placement and the resident had another behavior and was sent back out to the hospital on 10/25/24.<br><br>-When the resident returned to the facility on [DATE], he/she notified the resident's DPOA and the Power of Attorney and family said they were going to discharge the resident to their home and they decided to come and take the resident home that day.<br><br>-He/She did not inform the resident's DPOA he/she had found a facility that was willing to accept the resident.<br><br>-Once he/she was notified the resident would be going home, he/she did not try to obtain and services or make any referrals for the resident for after care.<br><br>-The resident's DPOA and another family member came in and collected the resident's belongings and the nurse notified the Nurse Practitioner who gave orders to send the resident with his/her medications (for a week) and the resident's responsible party took the resident home.<br><br>-He/She did not document the facilities he/she had been contacting for alternate placement of the resident and only documented the note on 10/22/24 of his/her efforts to assist the family. He/she had not documented the conversations he/she had with the resident's DPOA regarding the resident's discharge planning.<br><br>-He/She did not write a summary of the resident's discharge in the resident's electronic record.<br><br>-The Regional Social Worker said the Social Worker should have been documenting any/all efforts and contacts he/she made regarding the resident's plans to transfer to another facility. If there had been discharge plans before this Social Worker arrived, it should have been documented in the Social Work notes. There should have been a discharge summary completed by the interdisciplinary team documented in the resident's medical record and the Social Worker should have documented his/her part of the discharge summary. He/she did not see any evidence of discharge planning or a discharge summary in the resident's medical record.<br><br>During an interview on 11/22/24 at 2:02 P.M., Licensed Practical Nurse (LPN) F said:<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The resident resided on the locked unit and had behaviors that they were managing but he/she began having more intensive behaviors due to his/her diagnoses and delusions.<br><br>-The resident's family wanted to find another placement for the resident because they said they wanted a placement that was more age appropriate for the resident with more age appropriate activities and peers.<br><br>-They were trying to find another placement for the resident leading up to the day the resident discharged .<br><br>-He/She was not aware of any facilities that had been contacted or if there had been ay that had accepted the resident for placement.<br><br>-On 10/26/24 he/she received a call stating the resident's family was coming to take the resident home and the resident's physician had already been notified and they received orders to send the resident home with his/her medications.<br><br>-He/She wrote down the resident's medication list and prepared medications for 7 days.<br><br>-The resident's Power of Attorney and another relative came in and boxed up all of the resident's belongings, he/she went over the resident's medication list with the resident's Power of Attorney and provided the medication list and the family took the resident home.<br><br>-The resident was happy to be leaving the facility.<br><br>-He/She remembered writing a discharge note, but he/she did not remember writing a summary, so if there was no summary in the resident's medical record then he/she did not do it.<br><br>During an interview on 11/25/24 at 11:10 A.M., the Director of Nursing (DON) said:<br><br>-The discharge plan was interdisciplinary and started at the resident's admission.<br><br>-The nurses complete the clinical part (medication disposition where they are going and what they need to send with the resident) and the Social Worker determines the safety of the resident's discharge and should include notes showing the aftercare services (if provided).<br><br>-He/She would expect to find documentation of the resident's discharge plan, discharge location, who was notified (physician family), transportation, disposition of medication and belongings upon discharge.<br><br>-There should be notes in the residents medical record that should include a progress note completed by the nurse and should be detailed and the Social Work note should be detailed as well regarding the discharge plan.<br><br>-Any interventions/efforts leading up to a planned discharge should have been documented thoroughly.<br><br>(continued on next page) |

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| F 0660<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She saw the resident's medical record and there was no documentation regarding discharge planning or discharge summary and this was not what he/she would expect it to look like.<br><br>During an interview on 12/3/24 at 419 P.M. The resident's DPOA said:<br><br>-The resident had been in the facility for almost a year and he/she was on a locked unit due to his/her behaviors and elopement risk.<br><br>-He/She expressed concerns regarding the resident's quality of life there and spoke with the facility team about the appropriateness of the resident remaining there(age, socialization with peers) and they decided that they would assist with trying to find another placement for the resident to better meet his/her needs.<br><br>-He/She was also independently looking for another placement for the resident closer to family and he/she made the facility staff aware of this.<br><br>-He/She had also spoken to the current Social Worker about the resident but no one had ever informed him/her of any progression regarding discharge planning.<br><br>-They had not kept him/her informed of who they had been contacting or any efforts they had made toward this goal.<br><br>-When he/she was contacted about the resident's behaviors on 10/22/24, no one told him/her that they had found a placement for the resident and when he/she was notified on 10/26/24 the resident had another behavior, he/she thought that he/she did not have another choice but to take the resident out of the facility.<br><br>-He/She took the resident to the hospital, not home, at the suggestion of staff in the facility due to his/her behaviors at the time.<br><br>-He/She was still looking for placement for the resident.<br><br>MO00244724 |

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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>33409<br><br>Based on observation, interview and record review, the facility failed to obtain treatment and monitoring orders for a head laceration with staples for one sampled resident (Resident #45) out of 35 sampled residents. The facility census was 151 residents.<br><br>Review of the facility's Physician Orders policy revised on 6/2020 showed:<br><br>-The facility will ensure physician orders are complete and accurate.<br><br>-Medical records department will verify that physician order are complete, accurate and clarified as necessary.<br><br>-Physician order will include a description complete enough to ensure clarity of the physician plan of care.<br><br>1. Review of Resident #45's Admission Record showed was admitting on 8/5/24 with diagnosis include History of Falls, and Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses).<br><br>Review of the resident's Annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 9/20/24, showed he/she:<br><br>-Was severely cognitively impaired and was able to make his/her needs known.<br><br>-Required assistance from staff for transfers and personal cares.<br><br>Review of the resident's Fall Injury Report dated 11/13/24 at 2:59 P.M., showed:<br><br>-The resident had sustained a laceration to the back of his/her head, that measured 3.8 centimeters (cm).<br><br>-He/she was bleeding from the laceration, bright red blood.<br><br>-Nursing staff applied a pressure bandage and called emergency medical response team.<br><br>-The resident taken to hospital for evaluation.<br><br>Review of the resident's Hospital Discharge Summary dated 11/13/24 showed the resident:<br><br>-Had a scalp laceration with staples in place.<br><br>-Care staff were to monitor for signs and symptoms of infection.<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 | -Call the doctor if the scalp laceration staples were to come apart or staples fall out before seven days or if the wound edges reopen.<br><br>Review of the resident's Fall Care Plan revised on 11/13/24 showed:<br><br>-The resident had an actual fall with minor injury after falling from standing position.<br><br>-He/she was sent to the hospital for an evaluation.<br><br>-Intervention include: The resident went to hospital for evaluation.<br><br>-Physical therapy would screen the resident for gait/safety awareness.<br><br>-There was no documentation regarding the head laceration or removal of the staples.<br><br>Review of the resident's Physician Order Sheet (POS) as of 11/13/24 showed no physician's orders regarding the laceration to the scalp or when the staples needed to be removed.<br><br>Review of the resident's Nurse Practitioner (NP) note dated 11/17/24 showed the resident was to be seen by the wound nurse for follow-up on head laceration injury.<br><br>Review of the resident's Physician Note dated 11/18/24 at 5:16: P.M., showed:<br><br>-The resident was being seen for evaluated for post fall, that resulted in emergency room visit.<br><br>-He/she observed and evaluated the resident's laceration to the back of scalp with staples intact.<br><br>-The wound care staff were to monitor the laceration.<br><br>-The resident's scalp had a laceration with bruises at the area and staples noted.<br><br>Review on 11/19/24 at 11:54 A.M. of the resident's medical record showed:<br><br>-The resident did not have a physician order for monitoring or care of the resident head laceration.<br><br>-Did not have a resident's physician order for the removal of the staples.<br><br>-Did not find documentation by wound nurse for monitoring, assessment of the resident's head laceration.<br><br>During an observation on 11/20/24 at 2:44 P.M., showed the resident had a head laceration with one staple in place, the laceration had a slight redden area.<br><br>2. During an interview on 11/21/24 at 11:53 A.M., Certified Nursing Assistant (CNA) F said he/she was not aware of any special care orders for the resident head laceration.<br><br>During an interview on 11/21/24 at 11:56 A.M., with Licensed Practical Nurse (LPN) G said:<br><br>(continued on next page) |

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| | 265727 | A. Building<br>B. Wing | 11/25/2024 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The resident did not have physician's orders for removal of the staples or care of head laceration.<br><br>-The wound nurse would have been responsible for oversite and monitor the resident's head laceration site.<br><br>-A that time, the resident only had one staple intact. The resident had been picking at the site and lost the staple.<br><br>-He/she would expect to have physician's order for care or monitoring of the laceration site.<br><br>-The hospital does not always send discharge summary or orders with the resident.<br><br>-Resident with staples were normally removed in 10 days with a physician order.<br><br>During an interview on 11/25/24 at 11:10 A.M., Director of Nursing (DON) said:<br><br>-He/she would expect a physician's order for monitoring and treatment of the resident head laceration.<br><br>-He/she would expect the physician's order to include when the staples were to be removed and any after care needed.<br><br>-He/she would expect the charge nurse to ensure to have review and transcribed any new physician order from the hospital to the resident POS and TAR.<br><br>-The charge nurse or wound care nurse would be responsible for documentation of the monitoring of the resident's head laceration wound/staples.<br><br>-He/she would expect to have a physician order transcribed to ensure have documentation by nursing staff for the monitoring and treatment of the resident head laceration. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51303<br><br>Based on observation, interview and record review, the facility failed to supervise, assess, and investigate a burn related to smoking for one sampled resident (Resident #104) out of 35 sampled residents. The facility census was 151 residents.<br><br>Review of the facility's Incident Investigation policy revised in August 2020 showed:<br><br>-The purpose was to ensure the facility tracked incidents that take place at the facility to increase the quality of care provided to residents.<br><br>-The facility would have a licensed nurse fill out the Incident/Accident report as soon as possible.<br><br>-An incident included but was not limited to the following:<br><br>--Burns.<br><br>-In the event of an incident a licensed nurse or the individual who first encountered or witnessed an incident would complete the Incident/Accident report.<br><br>-As appropriate, interviews with staff members and other witnesses would be documented.<br><br>-The Director of Nursing (DON) and/or designee, would review the information and Incident log every month.<br><br>-The Director of Nursing and/or designee would submit the monthly Incident log to the Quality Assessment and Assurance (QAA) Committee.<br><br>1. Review of Resident #104's Admission MDS dated [DATE] showed he/she was cognitively intact and required supervision and/or touching assistance with activities of daily living (ADLs).<br><br>Review of the resident's the Smoking assessment dated [DATE] showed the resident required direct supervision and required a fire-resistant smoking apron (a flame-retardant garment that protects the wearer from burns and hot ashes while smoking) while smoking.<br><br>Review of the resident's care plan revised 11/12/24 for smoking showed:<br><br>-The resident was dependent on tobacco.<br><br>-The resident would have minimized risk of injury from unsafe smoking practices.<br><br>-Interventions showed:<br><br>--Observe clothing and skin for signs of cigarette burns.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | --The resident required supervision while smoking.<br><br>-Provide appropriate safety equipment:<br><br>--Smoking apron.<br><br>Observation on 11/19/24 at 2:34 P.M. showed:<br><br>-The resident was outside on the smoking patio.<br><br>-A staff member was outside but was not near by the resident.<br><br>-He/She had on a smoking apron<br><br>-He/She had a burn, approximately 2 centimeters (cm) by 1 cm on the back of his/her middle finger on his/her right hand.<br><br>During an interview on 11/19/24 at 2:34 P.M. the resident said:<br><br>-He/She burned his/her finger while smoking.<br><br>-He/She had neuropathy in his fingers (diabetic neuropathy damage to the nerves resulting in sensory loss in the extremities).<br><br>Review of the resident's Order Summary Report (OSR) on 11/22/24 showed no physician's orders to treat the resident's burn to the finger.<br><br>Review of the resident's medical record on 11/22/24 showed no incident report of the resident's burn to his/her finger.<br><br>During an interview on 11/22/24 at 12:39 P.M. Assistant Director of Nursing (ADON) B said:<br><br>-He/She could not find an incident report for the resident.<br><br>-He/She found no documentation in the nursing progress notes.<br><br>During an interview on 11/22/24 at 1:15 P.M. Hospitality Aide (HA) A said:<br><br>-He/She received smoking interventions from the Director of Nursing (DON) or the Administrator.<br><br>-He/She was aware of the burn to resident #104's finger.<br><br>-He/She did not remember when the incident occurred.<br><br>-He/She did not report the incident.<br><br>-He/She was aware the resident was to wear a smoking apron.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/25/24 at 9:08 A.M. Licensed Practical Nurse (LPN) B said:<br><br>-The nurse, ADON, the DON and sometimes the Administrator would inform the staff of interventions.<br><br>-Once notified of an incident and/or burn, an incident report, a skin assessment, and a smoking assessment would be completed.<br><br>-Notifications would be made to DON, primary care physician (PCP), and to responsible party if required.<br><br>-He/She would educate the resident to have supervised smoking.<br><br>-He/She was unaware of the resident's burn to his/her finger.<br><br>During an interview on 11/25/24 at 9:44 A.M. ADON B said:<br><br>-The Infection Preventionist (IP) supervised smoking attendants and would inform staff of smoking interventions for residents.<br><br>-The IP met with staff for huddle daily at 3:00 P.M.<br><br>-The process when a burn happened would be to complete the incident report, assess the site, clean the wound, obtain a treatment order, notify the wound nurse, DON, Nurse Practitioner (NP) and put a progress note not into the clinical record.<br><br>-Interdisciplinary Team (IDT) would review and determine interventions if not already in place.<br><br>During an interview on 11/25/24 at 11:10 A.M. the DON said:<br><br>-He/She had just put in place the IP to supervise the HAs.<br><br>-He/She expected nurses and nurse managers to inform HAs of what interventions smokers required.<br><br>-He/She expected the HAs to notify the nurse immediately if an incident occurred.<br><br>-He/She was aware resident #104 had an intervention to wear an apron.<br><br>-He/She was not aware of the burn to the resident's finger. |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33409<br><br>Based on interview and record review, the facility failed to ensure to obtain comprehensive physician order for a Suprapubic (S/P) catheter (a urinary bladder catheter inserted through the skin about one inch above the symphysis pubis) include type, size and care required and failed to ensure plan of care updated with the new Suprapubic catheter care and care of the stoma site for one sampled resident (Resident #15) out of 35 sampled resident. The facility census of 151 resident.<br><br>Review of the facility policy Physician Orders dated 6/2020, showed:<br><br>-The purpose of the policy was to ensure that all physician orders are completed and accurate.<br><br>-Documentation pertaining to physician's orders will be maintained in the resident's medical record.<br><br>-The licensed nurse receiving the physicians order will be responsible for documenting and implementing the order.<br><br>1. Review of Resident #15's Admission Record showed the resident was admitted to the facility on [DATE] with the following diagnoses:<br><br>-Benign Prostatic Hyperplasia (a condition in which the prostate gland grows larger than normal, but the growth is not caused by cancer).<br><br>-Chronic kidney disease stage II (kidney disease indicates a mild loss of kidney function).<br><br>-Genitourinary-after care (A procedure that redirects urine flow from the kidneys to a bag outside the body).<br><br>Review of the resident's re-admission progress notes dated 10/10/24 at 6:29 P.M. showed:<br><br>-The resident was readmitted to facility following a hospitalization due to blood in urine.<br><br>-The resident had a diagnosis of prostate cancer.<br><br>-A S/P catheter was placed on 10/9/24 at the hospital.<br><br>Review of the resident's Admission assessment dated [DATE] showed:<br><br>-The resident had a S/P catheter.<br><br>-The catheter tubing size was 16.5 french (catheters are sized by a universal system that measures the diameter of the tube).<br><br>-There was no further information regarding the resident's newly placed S/P catheter.<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 | Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 10/13/24, showed he/she:<br><br>-Was moderately cognitively impair able to make his/her needs known.<br><br>-Had an indwelling catheter.<br><br>Review of the resident's Physician Order Sheet (POS) 11/2024 showed:<br><br>-Physician's orders for his/her previous indwelling catheter (or Foley catheter, is a tube with retaining balloon passed through the urethra into the bladder to drain urine).<br><br>-Did not have any detailed physician's orders specifically for the resident's new S/P catheter, to include the care and monitoring of S/P catheter stoma site.<br><br>Review of the resident's care plan on 11/22/24 showed no information regarding the resident's S/P catheter.<br><br>2. During interview on 11/21/24 at 9:24 A.M., Certified Nursing Assistant (CNA) F said:<br><br>-The resident had a catheter leg drainage bag.<br><br>-The CNAs would only empty the resident's urine drainage bag.<br><br>-The nursing staff would complete supra pubic catheter care of stoma site (an opening on the abdomen that can be connected to your urinary system to allow urine to be diverted out of your body).<br><br>During an interview on 11/25/24 at 9:56 A.M., with Licensed Practical Nurse (LPN) G said:<br><br>-He/she would expect to have a physician's order to include the specific care, size and monitoring for the S/P catheter.<br><br>-He/she had been providing S/P catheter care without a physician order to include cleaning of the around the S/P stoma site.<br><br>-Would expect the S/P catheter to in his/her plan of care.<br><br>During an interview on 11/25/24 at 11:10 A.M., Director of Nursing (DON) said:<br><br>-He/she would expect to have completed physician's order to include location, size of catheter, any dressing changes schedule of the S/P catheter.<br><br>-He/she would expect the charge nurse ensure have transcribed physician's order to physician order sheet for the new S/P catheter.<br><br>-He/she would expect the resident's care plan S/P catheter including the size of the catheter and specific care required for a S/P catheter. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150<br><br>Based on interview, and record review, the facility failed to ensure accurate documentation of refusal of enteral feeding via a Gastrostomy Tube also known as a feeding tube-surgical creation of a permanent opening into the stomach through the skin for the introduction of nourishment and fluids through a tube for one sampled resident (Resident #116) out of 35 sampled residents. The facility census was 151 residents.<br><br>Review of the facility policy Physician Orders dated 6/2020, showed:<br><br>-The purpose of the policy was to ensure that all physician orders are completed and accurate.<br><br>-Documentation pertaining to physician's orders will be maintained in the resident's medical record.<br><br>-The licensed nurse receiving the physicians order will be responsible for documenting and implementing the order.<br><br>A policy for enteral tube feeding was requested but not provided by the facility.<br><br>1. Review of Resident #116's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 9/12/24, showed:<br><br>-The resident was admitted to the facility on [DATE].<br><br>-The resident was cognitively intact.<br><br>-The resident was at risk for malnutrition.<br><br>-The resident had difficulty swallowing.<br><br>-The resident was receiving enteral tube feedings on admission.<br><br>Review of the resident's care plan dated 9/13/24, showed:<br><br>-The resident had a diagnosis of dysphagia (difficulty in swallowing and/or feeding).<br><br>-The resident had a diagnosis of adult Failure To Thrive (FTT: A syndrome of weight loss, decreased appetite, poor nutrition, and inactivity).<br><br>-The resident's eating was dependent on enteral feedings.<br><br>-Note: There was no resident refusal of enteral feedings mentioned in the resident's care plan.<br><br>Review of the Physicians Order Sheet (POS) dated 10/2024, showed:<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Vital 1.5 400 ml bolus 4 times per day via PEG as tolerated (provide 1600 ml of formula).<br><br>-Routine water flush 240 ml 4 times per day via PEG. (provide 960 ml of free water).<br><br>Review of the resident's Treatment Administration Record (TAR) dated 10/1/24-10/31/24, showed:<br><br>-Enteral feed order every day shift, ordered 9/09/24.<br><br>-A physician's order to administer Jevity 1.5 Cal/Fiber oral liquid. Give 400 ml bolus 4 times per day via G-tube to provide 1600 milliliter (ml) of formula daily.<br><br>-Give feeding with 240 ml water bolus.<br><br>-14 of the 84 ordered enteral feeding opportunities were left blank.<br><br>-Note: 2 of the 14 blank opportunities were documented by the nursing staff as refusals by the resident.<br><br>-12 of the 14 blank opportunities showed no documentation of refused in the resident's electronic medical record.<br><br>Review of the nurses TAR dated 11/1/2024-11/21/2024, showed:<br><br>-A physician's order to administer Jevity 1.5 Cal/Fiber oral liquid. Give 400 ml bolus 4 times per day via G-tube to provide 1600 ml of formula daily.<br><br>-A physician's order to administer Vital 1.5 400 ml bolus 4 times per day via PEG tube.<br><br>-21 of the 68 ordered enteral feeding opportunities were left blank.<br><br>-Note: 0 of the 21 ordered enteral feeding blank opportunities were documented by the nursing staff as a refusal in the resident's electronic medical record.<br><br>During an interview on 11/22/24 at 2:17 P.M., Registered Nurse (RN) B said:<br><br>-The resident was supposed to receive enteral feeding four times per day.<br><br>-The resident went through a period of time where he/she was refusing the enteral feedings and/or requesting half of the order due to having diarrhea.<br><br>-When the resident refused his/her feedings, the nurse on duty at the time should have documented the refusal in the resident's electronic medical record.<br><br>-When the resident refused his/her feedings, the nurse should have went back and attempted to give the feeding an additional time and also documented that outcome in the resident's electronic medical record.<br><br>During an interview on 11/22/24 at 2:30 P.M., the resident said:<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/she was only wanting half of his/her feedings for a while due to the feedings giving him/her diarrhea.<br><br>-He/she has not been refusing his/her enteral feedings lately.<br><br>-His/her diarrhea has subsided.<br><br>During an interview on 11/22/24 at 2:49 P.M., the Nurse Practitioner (NP) said:<br><br>-The resident refused many of his/her feedings for a while.<br><br>-He/she would have expected the nursing staff to document in the resident's medical record when the resident refused his/her enteral feedings.<br><br>-An empty spot in the resident's TAR and/or nurse administration record would indicate that the physicians order was not completed.<br><br>During an interview on 11/22/24 at 3:00 P.M., The Director of Nursing (DON) said:<br><br>-The charge nurses were responsible for implementing ordered enteral feedings to the resident.<br><br>-The resident went through a period where he/she was refusing some of his/her enteral feedings.<br><br>-He/she would expect the nurse to have documented in the resident's electronic medical record when the resident refused his/her enteral feedings.<br><br>-When the enteral feedings were implemented, the TAR and nurse administration record would have had the nurse's initials in the indicated box.<br><br>-When a box was left blank on a TAR and/or nurses TAR, it indicated that the enteral feeding was not completed. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003<br><br>Based on observation, interview and record review, the facility failed to ensure suction and oxygen equipment were kept covered to prevent cross contamination for one sampled resident (Resident #95) who had a tracheostomy (a surgically created hole, also called a stoma, in your windpipe, also known as your trachea. This hole allows air to pass into your windpipe); failed to ensure oxygen face masks and nasal cannulas (a medical device that provides supplemental oxygen to patients through two prongs that sit inside the nostrils) were covered for two sampled resident (Resident #126 and Resident #19) who had respiratory concerns; failed to ensure necessary respiratory care related to oxygen tubing and/or a bilevel positive airway pressure (BiPAP a non-invasive ventilation with two pressures settings, one for inhalation and one for exhalation, to assist with breathing) tubing, and mask bagged when not in use and the concentrators external filters to be free of buildup of dust for two residents (Resident #14 and #98); and failed to follow physician orders for tracheostomy care on one sampled resident (Resident #116) out of 35 sampled residents. The facility census was 151 residents.<br><br>Review of the facility's Physician Order policy dated 06/2020, showed:<br><br>-The purpose of the policy was to ensure that all physicians orders were complete and accurate.<br><br>-Documentation pertaining to the physician's order would be maintained in the resident's medical record.<br><br>Review of the facility's policy Tracheostomy-Care of dated 06/2020, showed:<br><br>-The purpose of the policy was to ensure airway patency by keeping the tube free from mucous buildup and to maintain mucous membrane and skin integrity.<br><br>-Tracheotomy care would be performed as ordered by the attending physician.<br><br>-No information regarding storage of equipment.<br><br>Review of the facility's Oxygen Administration policy revised 06/2020 showed the oxygen items would be stored in a plastic bag when not in use at the resident's bedside to protect the equipment from dust and dirt when not in use.<br><br>1. Review of Resident #95's Face Sheet showed the resident was admitted on [DATE], with diagnoses including respiratory failure, sleep apnea (a sleep disorder that causes breathing to repeatedly stop or become shallow during sleep), heart failure, and tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck. A person with a tracheostomy breathes through a tracheostomy tube inserted in the opening).<br><br>Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 9/27/24, showed the resident:<br><br>-Was alert and oriented without confusion.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Had coughing or choking during meals.<br><br>-Received oxygen therapy, suctioning and tracheostomy care.<br><br>Review of the resident's Physician's Order Sheet (POS) dated [DATE], showed physician's orders for:<br><br>-High Humidity Tracheostomy Collar: at 28 percent, every shift for shortness of air, change in condition (9/24/24).<br><br>-Change oxygen tubing and set, including drainage bag every night shift every 7 days for shortness of air, change in condition (9/24/24).<br><br>-Change disposable inner cannula size 5 every day shift for shortness of air, change in condition and as needed (9/24/24).<br><br>-Keep at bedside for emergency use: a disposable ambu bag (a device used to provide respiratory support to patients in emergency and non-emergency situations), a back up complete tracheostomy set and suction machine (9/24/24).<br><br>Review of the resident's Care Plan dated 9/24/24, showed the resident had a tracheostomy due to impaired breathing. Interventions showed staff should:<br><br>-Give humidified oxygen as prescribed.<br><br>-Keep extra tracheostomy tube and obturator (a thin, rigid, and curved rod that helps guide the outer cannula into the trachea) at bedside. If tube is coughed out, open stoma (an artificial opening made into a hollow organ, especially one on the surface of the body leading to the gut or trachea) with hemostat (a tool used to control bleeding).<br><br>Observation on 11/18/24 at 11:22 A.M., showed there was a nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) on a dresser against the wall. The face mask was uncovered, sitting beside the machine. Next to it was the resident's humidifier machine that showed an undated/unlabeled humidifier bottle containing a clear fluid. The mask and tubing that were connected to it was laying on the surface uncovered. Beside the humidifier machine was the resident's suction machine and the tubing was coiled around the machine and was uncovered.<br><br>Observation on 11/19/24 at 9:40 A.M., showed the resident's suctioning machine was sitting on a dresser beside the resident's bed and the tubing and mask was uncovered. There was a humidifier machine that was across from his/her bed on a dresser. The humidifier bottle was unlabeled/undated and the tubing and mask were uncovered. There was a nebulizer on the dresser and the face mask was sitting next to the humidifier machine uncovered.<br><br>Observation and interview on 11/19/24 at 1:40 P.M., showed the resident's nebulizer was across from the resident's bed and the face mask was uncovered, the resident's humidifier machine was on a dresser across from the resident's bed and the tubing and mask was still uncovered and the suction machine tubing was coiled up and around the machine and was also uncovered.<br><br>During an interview on 11/22/24 at 10:37 A.M., the Infection Control Preventionist said:<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The resident's humidifier mask and tubing and the resident's suction tubing should both be in a plastic bag.<br><br>-He/She would have to discard the current masks and tubing and replace them since they were exposed.<br><br>-Whenever they use any oxygen equipment they should store it in a bag after use and the suction tubing should be replaced.<br><br>2. Review of Resident #126's Face Sheet showed the resident was admitted to the facility on [DATE] with diagnoses including respiratory failure, sleep apnea and Chronic Obstructive Pulmonary Disease (COPD- a group of lung diseases that damage the airways and air sacs, making it difficult to move air in and out of the lungs).<br><br>Review of the resident's POS dated [DATE] showed the following physician's orders:<br><br>-Oxygen at 3 liters per minute via nasal cannula continuously every shift and as needed (10/3/23).<br><br>-Bilevel positive airway pressure (BIPAP-a machine that helps people breathe by delivering pressurized air into their airways)in BIPAP mode at bedtime and as needed for COPD and shortness of air (4/22/24).<br><br>-Change nebulizer tubing, mask and holding bag and date new tubing per protocol and as needed (every week) every evening shift on Wednesday (7/3/23).<br><br>-Change oxygen tubing weekly, label each component with date and initials every evening shift every Wednesday (7/3/23).<br><br>Review of the resident's quarterly MDS dated [DATE] showed the resident:<br><br>-Was alert and oriented without confusion.<br><br>-Used oxygen therapy. It did not show the resident used BiPAP therapy.<br><br>Review of the resident's Care Plan dated 11/14/24, showed the resident had altered respiratory status/difficulty breathing related to respiratory failure, COPD, obstructive sleep apnea, and hypoventilation (a condition where breathing is too slow or shallow, which prevents the body from getting enough oxygen and getting rid of enough carbon dioxide).<br><br>Observation on 11/18/24 at 10:56 A.M., showed in the resident's room, on the resident's nightstand was a nebulizer machine with a mask on top of it that was uncovered, the re was a BIPAP machine sitting beside it with a face mask that was laying on top of it that was uncovered, and there was an oxygen concentrator sitting beside his bed on the floor. The nasal cannula and tubing was draped around the concentrator, also uncovered. The humidifier bottle was not labeled or dated and there was no bag or covering for any of the oxygen equipment observed. On the vanity was a portable oxygen container that had a nasal cannula and tubing that was wrapped around it uncovered.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 11/19/24 at 9:35 A.M., showed on his/her nightstand was his/her nebulizer machine. The face mask was laying on top of the machine uncovered. The portable oxygen machine was sitting on the vanity with the oxygen tubing and nasal cannula coiled around the machine uncovered.<br><br>Observation and interview on 11/21/24 at 9:47 A.M. showed:<br><br>-On the vanity was a portable oxygen machine without any tubing attached. On the nightstand beside his/her bed was his/her nebulizer and his/her BIPAP machine. The face masks for both machines were sitting on top of the machines uncovered. The oxygen concentrator was on the floor next to his/her bed and it was on and running. The nasal cannula and tubing were laying on his bed linen, uncovered. The resident said that he/she had just removed his/her nasal cannula. He/She said:<br><br>-He/She wore his/her BIPAP every night and the nursing staff have never provided any covering for his/her BIPAP face mask.<br><br>-He/She usually took the BIPAP mask off and placed it on the nightstand beside his bed.<br><br>-Nursing staff replaced the mask and tubing when he/she requested it.<br><br>-He/She used his/her portable oxygen when he/she goes out of the building or during showers. Staff have never given him/her a covering/bag for the oxygen tubing or nasal cannula.<br><br>-He/She had breathing treatments as needed and there was no covering for the face mask for his/her breathing treatment machine, so he/she usually laid it on top of the machine or on the dresser.<br><br>-He/She had a lot of respiratory issues and was unaware that nursing staff was supposed to provide him/her with any bag or covering for any of his oxygen equipment to prevent cross contamination.<br><br>3. During an interview on 11/21/24 at 10:26 A.M., Certified Medication Technician (CMT) C said:<br><br>-They have plastic bags they use to store oxygen nasal cannulas, face masks and other respiratory in and they usually put them on the oxygen concentrator or beside the breathing treatment machine.<br><br>-The bags should be labeled and dated and the nasal cannulas, face masks and any oxygen equipment should be stored in the bags when the equipment is not being used.<br><br>-Usually the oxygen tubing, humidifier bottles and face masks are changed out on Tuesdays and Thursdays on the night shift by the night shift CMTs and they also label and date the equipment and bags.<br><br>-Nursing staff round every two hours and if they know a resident is on oxygen, they should be checking to ensure the resident's oxygen equipment is stored in the bags if it is not in use.<br><br>During an interview on 11/25/24 at 9:42 A.M., Registered Nurse (RN) A said:<br><br>-All oxygen supplies to include face masks, oxygen tubing, nasal cannulas should be stored in a bag when not in use.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Central supply provides the bag and the night shift change out the supplies and they are to provide the bags in each resident room.<br><br>-The nursing staff who go in and out of the rooms daily are supposed to check to ensure the bag is in the room and the oxygen supplies are stored in the bag.<br><br>-With residents who are more independent and able to remove their oxygen masks they should check to see if the masks are in the bag when not in use and remind the resident to put it in the bag when they remove it.<br><br>33409<br><br>4. Review of Resident #19's Admission Face Sheet showed had diagnosis of COPD.<br><br>Review of the resident's Annual MDS dated [DATE] showed he/she:<br><br>-Was cognitively intact.<br><br>-Was able to understand others and make his/her needs known.<br><br>-Required assistant for staff for all cares and transfer.<br><br>-Did not have documentation related to the use of oxygen (O2).<br><br>Review of the resident's care plan revised on 10/24/24 showed;<br><br>-The resident had chronic lung disease related to COPD.<br><br>-The nursing staff were to monitor the resident for sign and symptoms of shortness of breath.<br><br>-Note: He/she did not have a care plan for use of oxygen.<br><br>Review of the resident's POS dated 11/1/24 to 11/21/24 showed:<br><br>-Oxygen flow rate of 2 Liter per minute (LPM) per Nasal Cannula. Titrate oxygen to keep oxygen saturation (O2 SATs, which is a measure of how much oxygen is in your blood) above 90%, as needed for Shortness of Breath (SOB).<br><br>-Albuterol Sulfate Nebulization Solution 3 ml inhaled orally via a nebulizer machine every four hours as needed for shortness of breath, ordered on 11/23/24.<br><br>Observation on 11/18/24 at 12:02 P.M., the resident's room showed:<br><br>-An O2 concentrator with an uncovered nasal cannula tubing coiled on top of the O2 concentrator machine.<br><br>-The nebulizer mask was on the dresser not stored in a plastic bag.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 11/19/24 at 9:13 A.M., of the resident room showed he/she had O2 and nebulizer tubing not covered at that time.<br><br>During interview 11/19/24 at 9:18 A.M., the resident said:<br><br>-He/she had used O2 and nebulizer treatment when had respiratory infection.<br><br>-He/she was not currently using O2 or the nebulizer.<br><br>Observation on 11/20/24 at 10:15 A.M., of the resident room showed:<br><br>-He/she had the O2 tubing left uncovered on top his/her O2 concentrator.<br><br>-The nebulizer mask was uncovered on his/her bedside table.<br><br>Observation on 11/21/24 at 10:40 A.M. of the resident room showed:<br><br>-He/she had uncovered O2 tubing coiled on top the oxygen concentrator machine.<br><br>-His/her nebulizer mask was uncovered on the bedside table.<br><br>-There were no dates on the oxygen tubing or nebulizer mask and tubing.<br><br>-No bags were in the areas to place the mask or tubing in when not in use.<br><br>51303<br><br>5. Review of Resident #14's Admission Record showed he/she was admitted on [DATE] with the following diagnoses:<br><br>-Acute and chronic respiratory failure with hypoxia (Respiratory failure occurs when the lungs have difficulty exchanging oxygen and carbon dioxide with the blood, resulting in hypoxia (low oxygen) or hypercapnia (high carbon dioxide) .<br><br>-Chronic respiratory failure.<br><br>-Chronic Obstructive Pulmonary Disease.<br><br>Review of the resident's OSR orders dated 05/05/24 showed the following physician's orders:<br><br>-Oxygen at 3 liters via nasal cannula continuously or to keep O2 sat greater than 90%.<br><br>-Oxygen tubing to be changed weekly, label each component with date and initials every Sunday.<br><br>Review of the resident's annual MDS dated [DATE] showed the resident:<br><br>-Was moderately cognitively impaired.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Was on oxygen.<br><br>Review of the resident's care plan on 11/19/24 showed:<br><br>-Administer oxygen therapy as ordered.<br><br>-Change tubing per protocol.<br><br>Observation on 11/19/24 at 10:35 A.M. showed:<br><br>-The concentrator was noted with dirt and debris on it and the external filter had a buildup of dust.<br><br>-No bag was observed for the resident to take off the nasal cannula and place in a bag when he/she left the room.<br><br>Observation on 11/20/24 at 9:07 A.M. showed:<br><br>-The oxygen concentrator had dirt and debris on it and the filter had a buildup of dust.<br><br>-There was no oxygen bag for when resident went outside to smoke or left the room.<br><br>Observation on 11/21/24 at 8:48 A.M. showed the oxygen concentrator was on and the nasal cannula was draped across the top drawer of nightstand.<br><br>Observation on 11/21/24 at 12:38 P.M. showed the oxygen concentrator remained on and noted with dirt and debris on it and the external filter had a buildup of dust. The nasal cannula was draped across top drawer of nightstand not bagged.<br><br>Observation on 11/25/24 at 10:34 A.M. showed:<br><br>-The oxygen concentrator was noted with dirt and debris on it and the external filter had a buildup of dust.<br><br>-The resident returned to his/her room and retrieved the nasal cannula from the top drawer of nightstand.<br><br>6. Review of Resident #98's Admission Record showed he/she was initially admitted on [DATE] with the following diagnoses:<br><br>- Chronic Obstructive Pulmonary Disease<br><br>-Chronic respiratory failure<br><br>-Dependence on supplemental oxygen.<br><br>Review of the resident's Annual MDS dated [DATE] showed:<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -He/She was cognitively intact.<br><br>-Did not show the usage of oxygen or the BiPAP.<br><br>Review of the resident's OSR dated 6/23/24 showed the following physician's orders:<br><br>-Oxygen and nebulizer tubing change weekly, label each component with date and initials weekly on Sunday.<br><br>-Did not show an order for the BiPAP machine, how and when to use, clean, and for the storage.<br><br>Review of the resident's nursing Admission MDS dated [DATE] showed:<br><br>-He/She was cognitively intact<br><br>-He/She was on oxygen.<br><br>-Did not show the usage of the BiPAP.<br><br>Observation on 11/21/24 at 9:39 A.M. showed he/she was lying on her bed and had the BiPAP mask over his/her mouth.<br><br>Observation on 11/21/24 at 12:44 P.M. showed:<br><br>-The resident with oxygen on via nasal cannula attached to the concentrator.<br><br>-An oxygen tank in an cylinder cart by dresser with the oxygen tubing wrapped around the top by the handle and not dated or bagged.<br><br>-The BiPAP was set on the dresser with tubing and mask laid over the machine and not bagged.<br><br>-The concentrator was noted with dirt and debris and external filter had a buildup of dust.<br><br>Interview on 11/22/24 at 12:10 P.M. with Certified Nursing Assistant (CNA) A said:<br><br>-The nurses change the oxygen tubing.<br><br>-The nurses clean the filters.<br><br>-Oxygen tubing was to be put in a bag when not in use.<br><br>-He/She was aware Resident #98 used a BiPAP machine.<br><br>-He/She did not but store the mask when not in use.<br><br>7. During an interview on 11/21/24 at 10:26 A.M., Certified Medication Technician (CMT) C said:<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -They have plastic bags they use to store oxygen nasal cannulas, face masks and other respiratory in and they usually put them on the oxygen concentrator or beside the breathing treatment machine.<br><br>-The bags should be labeled and dated and the nasal cannulas, face masks and any oxygen equipment should be stored in the bags when the equipment is not being used.<br><br>-Usually the oxygen tubing, humidifier bottles and face masks are changed out on Tuesdays and Thursdays on the night shift by the night shift CMTs and they also label and date the equipment and bags.<br><br>-Nursing staff round every two hours and if they know a resident is on oxygen, they should be checking to ensure the resident's oxygen equipment is stored in the bags if it was not in use.<br><br>-The bag should be labeled with resident name and with date when tubing was change.<br><br>During an interview on 11/22/24 at 2:12 P.M. CMT D said:<br><br>-The nurse or resident would take off the nasal cannula.<br><br>-Oxygen tubing was supposed to be stored in a bag when not in use.<br><br>-The night shift nurses changed the tubing once a week and as needed.<br><br>-Central Supply staff or the oxygen provider would clean the concentrators and filters.<br><br>During an interview on 11/25/24 at 9:08 A.M. with Licensed Practical Nurse (LPN) B said:<br><br>-Oxygen tubing was to be changed weekly on night shift.<br><br>-There would be an order for oxygen.<br><br>-There would be an order for changing the tubing.<br><br>-Central Supply staff would clean the concentrators and filters.<br><br>-There may not be an order for cleaning concentrators and filters since central supply did it himself/herself.<br><br>-The respiratory specialist would enter the order for when to use, clean, store the BiPAP.<br><br>-The oxygen tubing and BiPAP mask should be in bag when not in use.<br><br>During an interview on 11/25/24 at 9:33 A.M. the Central Supply Manager said:<br><br>-The night nurses were to change and date oxygen tubing weekly and as needed.<br><br>-The oxygen tubing/BIPAP mask was to be stored in a bag when not in use.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The CNA, the nurse, or any staff could place tubing or mask in the bag.<br><br>-The nurse would clean filters when oxygen tubing was changed.<br><br>-The CNA would clean the concentrators.<br><br>-The Infection Control Preventionist was responsible for monitoring the process of oxygen tubing and storage.<br><br>During an interview on 11/25/24 at 9:44 A.M. Assistant Director of Nursing (ADON) B said:<br><br>-The night nurses were responsible to change and date oxygen tubing.<br><br>-That the ADONs monitored that oxygen tubing was changed and dated.<br><br>-The oxygen tubing was to be placed in plastic bag when not in use.<br><br>-The central supply staff cleaned the concentrators and filters.<br><br>-The ADONs would audit the process.<br><br>-He/She expected there would be an order to change tubing and clean filters weekly.<br><br>During an interview on 11/25/24 at 11:10 A.M. the Director of Nursing (DON) said:<br><br>-Oxygen tubing, nasal cannulas, masks, tracheostomy tubing, BIPAP machines and supplies should be in a bag labeled and dated.<br><br>-He/She expected a physician's order for the concentrators, BIPAPs, and filters to be cleaned.<br><br>-He/She expected oxygen tubing to be dated and bagged when not in use.<br><br>-The Infection Preventionist (IP) was responsible to change oxygen tubing, but nurses could also change.<br><br>-The Infection Control Preventionist was responsible for making rounds and following up with the nurses for education on when equipment should be changed.<br><br>-The nurses should check for dates when they provided a breathing treatment.<br><br>-He/She expected the CNA to wipe down concentrator before giving to a resident.<br><br>-He/She expected filters to be cleaned by nurses.<br><br>-Oxygen equipment and supplies were usually changed at night.<br><br>-The nursing staff should be checking to ensure the oxygen equipment is stored in bags as they are in an out of the resident's rooms, and during cares.<br><br>(continued on next page) |

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| | 265727 | A. Building<br>B. Wing | 11/25/2024 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 51150<br><br>8. Review of Resident #116's POS dated 9/10/24, showed:<br><br>-Tracheostomy care every shift, two times per day and as needed.<br><br>Review of the resident's admission form dated 9/12/24, showed:<br><br>-The resident was admitted to the facility on [DATE].<br><br>-The resident was cognitively intact.<br><br>-The resident had a diagnosis of respiratory failure (a serious condition that makes it difficult to breathe on your own. Respiratory failure develops when the lungs can't get enough oxygen into the blood).<br><br>-The resident received tracheostomy care daily.<br><br>Review of the resident's care plan dated 9/13/24, showed:<br><br>-The resident had potential for impairment to skin integrity.<br><br>-The resident had altered respiratory status and difficulty breathing related to chronic respiratory failure, tracheostomy, and oxygen dependent.<br><br>Review of the resident's Treatment Administration Record (TAR) dated 9/1/24-9/30/24, showed:<br><br>-A physician's order for tracheostomy care every shift, two times per day and as needed.<br><br>-Two of the 43 ordered tracheostomy care opportunities were left blank.<br><br>Review of the resident's TAR dated 10/1/24-10/31/24, showed:<br><br>-A physician's order for tracheostomy care every shift.<br><br>-Eight of the 62 ordered tracheostomy care opportunities were left blank.<br><br>Review of the resident's TAR dated 11/1/24-11/18/24, showed:<br><br>-A physician's order for tracheostomy care every shift, two times per day and as needed.<br><br>-Three of the 36 ordered tracheostomy care opportunities were left blank.<br><br>During an interview on 11/22/24 at 2:17 P.M. RN B said:<br><br>-The resident had a physician's order to get tracheostomy care twice daily.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -When a nurse performed tracheostomy care, the nurse documented implementation of the order in the resident's medical record.<br><br>-If tracheostomy care was completed, the TAR would reflect the nurse's initials.<br><br>-If a box on the TAR was blank, that would indicate that the tracheostomy care was not performed.<br><br>During an interview on 11/22/24 at 3:00 P.M., ADON A said:<br><br>-The resident had a physician's order to get tracheostomy care daily.<br><br>-He/she performed the tracheostomy care on the resident when he/she worked the floor.<br><br>-When tracheostomy care was done, the nurse that performed the care should have documented it being done.<br><br>-When tracheostomy care was completed, the box on the TAR would have the nurse's initials.<br><br>-A blank box on a resident's TAR would indicate that a physician's order was not completed.<br><br>During an interview with the DON on 11/25/24 at 11:10 A.M., said:<br><br>-The charge nurses provided tracheostomy care.<br><br>-The nurse managers and the ADON monitor to ensure physician's orders are completed.<br><br>-He/she would expect nurses to document in the TAR when tracheostomy care was completed.<br><br>-If there were blank areas in a resident's TAR, the tracheostomy cares were not done.<br><br>-He/she would expect the nurse to document in the resident's medical record a rationale as to why a tracheostomy care was not completed. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003<br><br>Based on observation, interview and record review, the facility failed to follow physician's orders for assessing the resident's Dialysis (a procedure that removes waste products and excess fluid from the blood when the kidneys are unable to function properly) shunt (a surgically created connection between an artery and a vein that allows for direct access to the bloodstream for Dialysis) consistently, and failed to ensure Dialysis communication was received and documented after each Dialysis treatment for continuum of care, for two sampled residents (Resident #7 and #97) out of 35 sampled residents. The facility census was 151 residents.<br><br>Review of the facility's Dialysis Care policy dated June 2020, showed:<br><br>-The policy is to provide care for residents diagnosed with renal disease requiring ongoing dialysis treatments.<br><br>-The facility would be responsible for the overall care delivered to the resident, monitoring of the resident prior to and after the completion of each Dialysis treatment, providing for all non-Dialysis needs of the resident including during the time period when the resident was receiving Dialysis.<br><br>-The nursing staff, Dialysis provider staff, and the attending physician would collaborate on a regular basis concerning the resident's care as follows:<br><br>--Nursing staff would communicate pertinent information in writing to the Dialysis staff which may include:<br><br>---Any medication changes, changes in condition, and the resident's tolerance of Dialysis procedures.<br><br>--Nursing staff use Nurse Dialysis Communication Record or comparable form in the Electronic Medical Record (EMR) to convey information to the dialysis provider.<br><br>1. Review of Resident #7's Face Sheet showed the resident was admitted to the facility on [DATE], with cognitive impairment, diabetes, peripheral vascular disease (a chronic condition that occurs when blood vessels outside of the brain and heart narrow or become blocked), high blood pressure, communication deficit, and end stage renal failure (ESRD a medical condition where the kidneys have permanently lost their ability to function, requiring regular dialysis or a kidney transplant to survive).<br><br>Review of the resident's Treatment Administration Record (TAR) dated August 2024, showed the resident attended Dialysis every Tuesday, Thursday and Saturday. The nursing staff was to check the resident's shunt site for bruising bleeding and signs of infection twice daily. There were checkmarks showing the dates when the resident attended Dialysis and when the shunt site was checked. Documentation showed:<br><br>-There were 14 scheduled Dialysis visits during the month.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The resident did not attend Dialysis on 8/3/24, 8/17/24 and 8/31/24.<br><br>-Nursing staff did not check the resident's shunt site as ordered on 8/2/24, 8/3/24, 8/4/24, 8/17/24, 8/26/24 and 8/31/24 when it was only checked as completed once daily.<br><br>Review of the resident's Nursing Notes dated 8/1/24 to 8/31/24 showed:<br><br>-The resident refused Dialysis on 8/17/24.<br><br>-The resident, once at Dialysis, refused treatment on 8/24/24.<br><br>Review of the resident's Documentation of Dialysis Communication from 8/1/24 to 8/31/24 showed on the document were areas for the facility nursing staff to document the resident's vital signs, location of his/her access site, whether there is a thrill (a vibration caused by blood flowing through the shunt) and bruit (a whooshing sound from blood flowing through the shunt) (monitoring) and if there was a dressing, any recent medication changes and if there were any change in condition prior to attending dialysis. There was an area for the Dialysis site to document on the form the resident's vital signs and weight, any lab results and dietary concerns, post Dialysis vital signs weights and any special instructions. At the bottom of the form was an area for Nursing Facility staff to document the resident's post Dialysis vital signs, location of the access site, whether there was a thrill and bruit completed, if there was a dressing any new orders and documentation of the assessment. Review of the documents showed on dates the resident went to dialysis:<br><br>-There were no Dialysis communication sheets documented from 8/1/24 to 8/10/24.<br><br>-Monitoring of thrill and bruit were not documented as completed prior to or after Dialysis on 8/10/24 and 8/20/24.<br><br>-Out of 14 Dialysis visits during the month there were no corresponding communication sheets for 11 dates.<br><br>Review of the resident's TAR dated September 2024, showed the resident attended Dialysis every Tuesday, Thursday and Saturday. It showed the nursing staff was to check the resident's shunt site for bruising bleeding and signs of infection twice daily. There were checkmarks showing the dates when the resident attended Dialysis and when the shunt site was checked. Documentation showed:<br><br>-There were 12 scheduled Dialysis visits during the month.<br><br>-The resident did not attend Dialysis on 9/14/24 and 9/28/24.<br><br>-Nursing staff did not check the resident's shunt site as ordered on 9/12/24 and 9/24/24 when it was only checked as completed once daily.<br><br>Review of the resident's Social Service Notes showed on 9/10/24 Social Services Worker (SSW) called the resident's family to discuss Hospice services. The resident continued to refuse Dialysis. The responsible party said he/she would notify their attorney so he/she could notify the courts that Hospice was being recommended. SSW advised that SSW would leave information about some Hospice providers with the business office for their review.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's Nursing Notes dated 9/1/24 to 9/30/24, showed:<br><br>-The resident, once at Dialysis, refused treatment on 9/7/24.<br><br>-The resident refused to go to Dialysis on 9/26/24.<br><br>Review of the resident's Documentation of Dialysis Communication from 9/1/24 to 9/30/24 showed on the document were areas for the facility nursing staff to document the resident's vital signs, location of his/her access site, whether there is a thrill and bruit (monitoring) and if there was a dressing, any recent medication changes and if there were any change in condition prior to attending Dialysis. There was an area for the Dialysis site to document on the form the resident's vital signs and weight, any lab results and dietary concerns, post Dialysis vital signs weights and any special instructions. At the bottom of the form was an area for Nursing Facility staff to document the resident's post Dialysis vital signs, location of the access site, whether there was a thrill and bruit completed, if there was a dressing any new orders and documentation of the assessment. Review of the documents showed on dates the resident went to Dialysis:<br><br>-Monitoring of thrill and bruit were not documented as completed prior to or after Dialysis on 9/14/24, 9/17/24, 9/21/24, and 9/26/24.<br><br>-Monitoring of thrill and bruit was not documented as completed after Dialysis on 9/3/24 and 9/21/24.<br><br>-Out of 12 Dialysis visits scheduled during the month, there were no communication sheets completed for six dates.<br><br>Review of the resident's TAR dated October 2024, showed the resident attended Dialysis every Tuesday, Thursday and Saturday. It showed the nursing staff was to check the resident's shunt site for bruising bleeding and signs of infection twice daily. There were checkmarks showing the dates when the resident attended Dialysis and when the shunt site was checked. Documentation showed:<br><br>-There were 11 scheduled Dialysis visits during the month through to 10/26/24.<br><br>-The resident did not attend Dialysis on 10/12/24.<br><br>-Nursing staff did not check the resident's shunt site as ordered on 10/1/24, 10/2/24, 10/3/24 and 10/4/24 (there was no documentation), 10/8/24, 10/11/24, 10 /12/24, 10/13/24 and 10/16/24 when it was only checked as completed once daily.<br><br>Review of the resident's Nursing Notes from 10/1/24 to 10/31/24 showed:<br><br>-The resident, once at Dialysis, refused treatment on 10/5/24 and 10/10/24.<br><br>-10/10/24 the resident refused to do Dialysis treatment while at the Dialysis center. Nurse at the center said if he/she was going to refuse, do not send the resident. Conversation with resident and education provided regarding Dialysis. Resident said he/she was not going to do Dialysis treatments. Spoke with SSW for meeting with the resident's Guardian. Spoke with family member yesterday and family was not receptive to education or situation of resident refusal of Dialysis.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's Documentation of Dialysis Communication from 10/1/24 to 10/31/24 showed on the document were areas for the facility nursing staff to document the resident's vital signs, location of his/her access site, whether there is a thrill and bruit (monitoring) and if there was a dressing, any recent medication changes and if there were any change in condition prior to attending Dialysis. There was an area for the Dialysis site to document on the form the resident's vital signs and weight, any lab results and dietary concerns, post Dialysis vital signs weights and any special instructions. At the bottom of the form was an area for Nursing Facility staff to document the resident's post Dialysis vital signs, location of the access site, whether there was a thrill and bruit completed, if there was a dressing any new orders and documentation of the assessment. Review of the documents showed on dates the resident went to Dialysis:<br><br>-Monitoring of thrill and bruit was not documented as completed after Dialysis on 10/5/24 and 10/15/24.<br><br>-There were no Dialysis communication sheets documented from 10/15/24 to 10/21/24.<br><br>-Out of 11 Dialysis visits scheduled during the month, there were no communication sheets documented for nine dates.<br><br>Review of the resident's Social Service Notes showed:<br><br>-10/10/24 SSW called and left voice mail for responsible party to return writers call regarding setting up a care plan meeting to discuss the resident refusing Dialysis after being sent to appointments as scheduled. The resident told the staff at the Dialysis treatment center that he/she would not be accepting treatment at all, and would continue to refuse treatment. Family/Guardian were saying they wanted him/her not to refuse and that this facility should keep sending him/her to Dialysis. Dialysis center was saying they could use that chair time if the resident was not going to accept treatment.<br><br>-10/18/2024 SSW held care plan conference with the resident's Guardian on phone. Resident continued to refuse Dialysis treatments and said he/she would not change his/her mind even if the facility continued to send him/her. Resident was also refusing medication for the last week. Hospice attended care plan and Guardian had decided to use Hospice services. They would be at the facility to complete paperwork on 10/21/24 and admit the resident to services. The resident would still go to Dialysis on Saturday 10/19/21 until he/she was completely admitted to Hospice.<br><br>Review of the resident's Significant Change Minimum Data Set (MDS a federally mandated assessment tool to be completed by facility staff for care planning) dated 10/28/24 showed the resident needed supervision for eating, moderate to maximum assistance for toileting, bathing and dressing; needed moderate assist for transfers and used a wheelchair for mobility.<br><br>-Received Dialysis treatments.<br><br>Review of the resident's Care Plan dated 10/28/24, showed the resident had Dialysis treatments three times weekly on Tuesday, Thursday and Saturday. It showed the location and contact information for the Dialysis treatment center. It showed the resident had a behavior problem related to frequently refusing Dialysis or having behavior problems when at Dialysis. Interventions showed nursing staff would:<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Anticipate and meet the resident's needs.<br><br>-Provide opportunity for positive interaction, attention. Stop and talk with him/her when passing by.<br><br>-Explain all procedures to the resident before starting and allow the resident time to adjust to changes.<br><br>-If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident.<br><br>-Will have no signs or symptoms of complications from Dialysis through the review date.<br><br>-Monitor/document/report as needed any sign or symptom of infection to access site (redness, swelling, warmth or drainage).<br><br>-Monitor/document/report as needed for signs or symptoms of renal insufficiency (changes in level of consciousness, changes in skin turgor, oral, changes in heart and lung sounds).<br><br>Review of the resident's Physician's Order Sheet (POS) dated November 2024, showed physician's orders for:<br><br>-Monitor left upper extremity shunt site for bruising, bleeding and signs/symptoms of infection. If bleeding noted, apply direct pressure until bleeding is controlled and notify physician for further directions (12/17/23).<br><br>-Upon return from Dialysis palpate shunt for thrill and listen for the bruit. Repeat twice within eight hours post Dialysis. If either was absent, notify the physician and document the findings, check thrill and bruit every shift routinely (12/17/23).<br><br>-Admit to Hospice services (10/21/24).<br><br>Review of the resident's Nursing Notes showed on 11/5/24 Dialysis vendor notified this nurse regarding follow up on the resident. Nurse informed Dialysis vendor the resident was currently on Hospice services at this time.<br><br>Observation and interview on 11/19/24 at 9:25 A.M., showed the resident was laying in bed with his/her call light within reach. He/She was not wearing a shirt and his/her Dialysis access site was on his/her upper left arm. There was no redness, bruising or sign of infection. The resident was alert and oriented and said:<br><br>-He/She did not go to Dialysis anymore because he/she was now on Hospice.<br><br>-He/She was educated on discontinuing Dialysis and the consequence of that choice and he/she did not want to go to Dialysis.<br><br>-He/She did not remember when his/her last visit to Dialysis was and said he/she did not remember if staff assessed his/her Dialysis site after Dialysis or daily.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/25/24 at 9:36 A.M., showed Registered Nurse (RN) A said:<br><br>-They did not do anything with the resident's shunt now, they did not check it or monitor it.<br><br>-They stopped checking and monitoring the resident's shunt once he/she decided to no longer go to Dialysis and was placed on Hospice, but up until the resident started Hospice, they had been monitoring his/her shunt.<br><br>-They would check for the thrill and bruit and symptoms of infection and take his/her vital signs before and after Dialysis and document their findings on the Dialysis communication form.<br><br>-Usually, the Dialysis center would document their findings on the form and return it, and the nurse would then document the monitoring of the resident's shunt after Dialysis.<br><br>-For some time before the resident stopped Dialysis, he/she would go to Dialysis and then refuse treatment.<br><br>-There should have been documentation showing they checked the resident's shunt (thrill and bruit) before and after each Dialysis treatment and it should have been on the Dialysis communication form.<br><br>-They also were supposed to check the thrill and bruit twice daily and document it on the TAR, but they were primarily supposed to document on the Dialysis Communication Form and place the form in the resident's Dialysis book or scan it into the resident's medical record.<br><br>During an interview on 11/25/24 at 11:10 A.M., the Director of Nursing (DON) said:<br><br>-He/She would expect the Dialysis communication form to be filled out completely on each day the resident attended Dialysis.<br><br>-The nurses should complete and document vital signs and check the resident's thrill and bruit on the resident before and after the Dialysis treatments.<br><br>-The most accurate documentation should be found in the resident's medical record.<br><br>-Even if Resident #7 refused treatments, once he/she returned from Dialysis, the nurses should have continued to monitor the thrill and bruit, check for signs and symptoms of infection and document their findings on the Dialysis communication form.<br><br>51305<br><br>2. Review of Resident #97's Admission Record showed the resident was admitted on [DATE], with a diagnosis of ESRD.<br><br>Review of the resident's Annual MDS dated [DATE] showed the resident:<br><br>-Was cognitively intact.<br><br>-Had renal insufficiency, renal failure, or ESRD.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's POS dated 11/1/24 showed:<br><br>-Check and record weight pre and post dialysis two times a day every Monday, Wednesday, and Friday for Dialysis health maintenance.<br><br>-Dialysis Center on Monday, Wednesday, and Friday.<br><br>Review of the resident's Care Plan dated 10/14/24, showed:<br><br>-Received Dialysis related to renal failure.<br><br>-Had ESRD.<br><br>Review of the resident's Dialysis Communication Forms dated October 2024 showed:<br><br>-The resident had 13 Dialysis appointments scheduled for the month.<br><br>-The Dialysis communication forms were not completed 13 out of 13 times.<br><br>Review of the resident's Dialysis Communication Forms dated 11/1/24 to 11/22/24 showed:<br><br>-The resident had 10 scheduled Dialysis appointments.<br><br>-The Dialysis communication forms were not completed 10 out of 10 times.<br><br>During an interview on 11/25/24 at 10:15 A.M., RN A said:<br><br>-Before a resident would go to Dialysis the charge nurse would fill out a form of the resident's weight and vital signs (blood pressure, pulse) and send it with the resident to the Dialysis facility.<br><br>-The Dialysis facility would fill out the form and return it back with the resident.<br><br>-The forms were how the facility and the Dialysis facility communicated the resident's condition.<br><br>-The form should be filled out every time the resident went to Dialysis.<br><br>-The charge nurses were responsible for weights and vitals before and after the Dialysis treatment.<br><br>-The charge nurses would review the form when the resident returned from Dialysis.<br><br>During an interview on 11/25/24 at 10:38 A.M., Assistant Director of Nursing (ADON) B said:<br><br>-The charge nurse was responsible for completing the Dialysis communication form and would send it with the resident to the Dialysis center.<br><br>-When the resident returned from Dialysis the charge nurse was responsible for reviewing the communication form.<br><br>(continued on next page) |

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| | 265727 | A. Building<br>B. Wing | 11/25/2024 |

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| Carmel Hills Wellness & Rehabilitation | 810 East Walnut<br>Independence, MO 64050 |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -No one was monitoring to ensure the form was returned and reviewed for changes.<br><br>-The charge nurse should take weights and vitals before and after the Dialysis treatment.<br><br>During an interview on 11/25/24 at 11:00 A.M. the resident said he/she was given the Dialysis communication form to take from the facility to the Dialysis facility sometimes.<br><br>During an interview on 11/25/24 at 11:10 A.M., the DON said:<br><br>-The Dialysis forms should be filled out for each date the resident received Dialysis.<br><br>-The charge nurse was responsible to weigh the resident and check their vital signs before and after the Dialysis treatment.<br><br>-The charge nurse was responsible for reviewing and monitoring the Dialysis communication forms. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150<br><br>Based on interview and record review, the facility failed to ensure the resident's physician responded with a rationale to the pharmacist's recommendation for a Gradual Dose Reduction (GDR) of the resident's psychotropic medications (drugs which affect psychic function, behavior, or experience) on the Drug Regimen Review (DRR) for one sampled resident (Resident #137) out of 35 sampled residents. The facility census was 151 residents.<br><br>Review of the facilities Medication Management policy dated August 2020, showed:<br><br>-In order to optimize the therapeutic benefit of medication therapy and minimize or prevent potential adverse consequences, facility, the attending physician/prescriber, and the consultant pharmacist perform on going monitoring for appropriate, effective, and safe medication use.<br><br>-When selecting medications and non-pharmacological interventions, members of the interdisciplinary team participate in the care process to identify, assess, address, advocate, for, monitor, and communicate the resident's needs and changes in condition.<br><br>-If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility should attempt a GDR in two separate quarters within the first year unless clinical contraindicated. After the first year, a GDR must be attempted annually.<br><br>-A GDR is considered contraindicated if the continued use is in accordance with relevant current standards of practice and the physician documents clinical rationale for why any additional attempted dose reduction would impair the resident's function, increase distressed behavior, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.<br><br>1. Review of Resident #137's Admission Record, showed:<br><br>-The resident was admitted to the facility on [DATE].<br><br>-The resident had a diagnosis of Bipolar (formerly called manic depression, is a mental health condition that causes extreme mood swings).<br><br>-The resident had mild cognitive impairment.<br><br>-The resident had a diagnosis of depression (a common and serious mental disorder that negatively affects how you feel, think, act, and perceive the world).<br><br>-The resident had a diagnosis of insomnia (a sleep disorder in which you have trouble falling and/or staying asleep).<br><br>Review of the resident's admission Minimum Data Set (MDS-A federally mandated assessment tool required to be completed by facility staff for care planning) dated 4/18/24, showed:<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The resident had a diagnosis of depression.<br><br>-The resident was taking an antipsychotic (a group of psychoactive drugs (pertaining to a drug or other agent that affects such normal mental functioning as mood, behavior, or thinking processes) commonly but not exclusively used to treat psychosis) medication.<br><br>-A GDR had not been completed on the resident's antipsychotic medication.<br><br>-A GDR had not been documented by a physician as being contraindicated.<br><br>-Note: The MDS did not reflect that the resident had bipolar disorder, as mentioned on the admission record.<br><br>Review of the resident's care plan dated 4/20/24, showed:<br><br>-The resident used psychotropic medications related to behavior management.<br><br>-The resident was at high risk for side effects from psychotropic medications.<br><br>-The resident should be monitored for side effects and effectiveness of psychotropic medications.<br><br>Review of the resident's Consultant Pharmacist Recommendation to Physician dated 10/15/24, showed:<br><br>-The resident had been taking Aripiprazole (Abilify an antipsychotic medication used to treat mental health conditions bipolar disorder) 15 milligram (mg) every day since 4/15/24 without a GDR.<br><br>-The pharmacist recommended reducing the dose of Aripiprazole to 10 mg every day.<br><br>-The physician responded with no.<br><br>-The physician did not give a rationale for his/her response to the recommendation.<br><br>Review of the resident's Physician Order Sheet (POS) dated 11/13/24, showed:<br><br>-Aripiprazole Oral Tablet 15 mg. Give 1 tablet by mouth one time per day for bipolar disorder.<br><br>-Trazadone (antidepressant) Oral Tablet 100 mg. Give 0.5 tablet by mouth at bedtime for<br><br>Sleep.<br><br>During an interview on 11/22/24 at 2:30 P.M., Registered Nurse (RN) B said:<br><br>-He/she was unaware of the facility policy or the facility process for medication reviews and GDR's.<br><br>-He/she was unaware of who in the facility took care of the GDR request from the pharmacist.<br><br>-He/she had not done any GDR request in a long time.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/22/24 at 3:00 P.M., Assistant Director of Nursing (ADON) A said:<br><br>-The Director of Nursing (DON) was responsible for medication reviews and ensuring that the GDR's were completed.<br><br>-When a GDR was completed, it should be documented in the resident's Electronic Medical Record (EMR).<br><br>-If a physician did not complete a GDR that was recommended by the pharmacist, the physician should have documented a rationale as to why the GDR was not completed.<br><br>During an interview on 11/25/24 at 11:10 A.M., the DON said:<br><br>-The pharmacy reviewed the medication carts and medication records and then sent GDR recommendations to himself/herself.<br><br>-He/she was responsible for printing off the GDR recommendations and discussing them with the physician.<br><br>-He/she would enter a progress note in the resident's EMR and change orders as needed once a decision was made about a GDR recommendation.<br><br>-He/she would expect the physician to document a rationale if a GDR recommendation was not initiated.<br><br>-He/she would expect all rationales from GDR's to be documented in a resident's EMR. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>46519<br><br>Based on observation, interview, and record review, the facility failed to ensure a medication error rate under five percent for one sampled resident (Resident #96). The medication error rate was eight percent. The facility census was 151 residents.<br><br>1. Review of Resident #96's face sheet showed he/she admitted to the facility with the following diagnoses:<br><br>-Chronic Obstructive Pulmonary Disease (COPD-a disease process that decreases the ability of the lungs to perform ventilation).<br><br>-Pulmonary Fibrosis (a diseases in which the lungs become scarred over time).<br><br>Review of the resident's admission Minimum Data Set (MDS- federally mandated assessment instrument completed by facility staff for care planning) dated 10/16/24 showed the resident was cognitively intact.<br><br>Review of the resident's Physician Order Sheet (POS) dated November 2024 showed an order for Symbicort (a medication used to treat COPD) Inhalation Aerosol 160-4.5 micrograms (mcg)/actuation (act), two puffs inhale orally two times a day for COPD.<br><br>Observation on 11/18/24 at 9:36 A.M. of medication administration completed by Certified Medication Technician (CMT) A showed he/she documented the resident received his/her dose of Symbicort but had not watched the resident take the medication or given the medication to the resident for him/her to take.<br><br>During an interview on 11/18/24 at 9:48 A.M. CMT A said he/she would not have done anything differently during the medication pass.<br><br>During an interview on 11/19/24 at 2:09 P.M. the resident said he/she was unaware that he/she had an order for the Symbicort, and the inhaler had not been given to him/her on 11/18/24.<br><br>During an interview on 11/19/24 at 2:51 P.M. CMT B said:<br><br>-CMT's were responsible for giving scheduled inhaler administration to the residents.<br><br>-The CMT should not have just documented that the resident received the medication without verifying that the resident took it or gave it to the resident himself/herself.<br><br>During an interview on 11/20/24 at 10:43 A.M. Registered Nurse (RN) A said:<br><br>-CMT's were responsible for administering scheduled inhalers.<br><br>-CMT's were to watch the resident take the inhaler or assist in the administration of the inhaler.<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 - Few | -The CMT should not have documented that the resident received his/her Symbicort.<br><br>During an interview on 11/20/24 at 11:13 A.M. Assistant Director of Nursing (ADON) A said:<br><br>-CMT's were responsible for administering scheduled inhalers.<br><br>-The CMT should have given the inhaler for the resident to take or assisted in the administration of the inhaler.<br><br>-The CMT should not have documented that the resident received his/her Symbicort because he/she had not administered the medication.<br><br>During an interview on 11/20/24 at 11:51 A.M. the Director of Nursing (DON) said:<br><br>-CMT's could administer scheduled doses of inhalers.<br><br>-The CMT should have watched the resident take the inhaler or assisted in the administration of the inhaler.<br><br>-The CMT should not have documented that the resident received his/her Symbicort because he/she had not administered the medication.<br><br>50579<br><br>2. Review of the facility policy titled Insulin Administration, dated September 2014, showed:<br><br>-The type of insulin should have been verified prior to administration to ensure it corresponded with the physician order.<br><br>-The nurse was to notify the DON or physician of any discrepancies.<br><br>Review of Resident #120's POS, dated 11/19/24, showed an order for Fiasp (Insulin Aspart with Niacinamide) 17 units subcutaneously (under the skin into fatty tissue) with meals for Diabetes Mellitus.<br><br>Observation on 11/18/24 at 12:16 P.M., showed:<br><br>-RN A did not have a computer or immediate access to the resident's medical record.<br><br>-RN A opened the medication cart and retrieved a multi-dose vial of Insulin Lispro with no resident identifiers on the vial.<br><br>-RN A measured 17 units of the Insulin Lispro and, without verifying the accuracy of the order, administered the insulin to the resident.<br><br>During an interview on 11/18/24 at 2:18 P.M., RN A said the resident should have received Fiasp instead of the Insulin Lispro.<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 - Few | Review of the resident's medical record on 11/19/24, showed no documentation or follow up of the medication error of the resident receiving Insulin Lispro instead of Fiasp.<br><br>During an interview on 11/19/24 at 1:27 P.M., the DON said:<br><br>-He/She would not expect a resident to receive an Insulin other than what was ordered.<br><br>-He/She would expect Insulin to be given from a vial that was marked with the resident's name.<br><br>-He/She would expect staff to verify physician orders from the resident's medical record before administering a medication. |

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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>50579<br><br>Based on observation, interview and record review, the facility failed to ensure residents were free from significant medication errors when staff administered the incorrect insulin (a synthetic hormone used to lower blood glucose levels) for one sampled resident (Resident #120) out of 35 sampled residents. The facility census was 151 residents.<br><br>Review of the facility's Insulin Administration policy dated September 2014 showed:<br><br>-The type of insulin should have been verified prior to administration to ensure it corresponded with the physician's order.<br><br>-The nurse was to notify the Director of Nursing (DON) or physician of any discrepancies.<br><br>1. Review of Resident #120's Annual Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff for care planning) dated 9/20/24 showed the resident had a diagnosis of Type II Diabetes Mellitus (a condition in which the body is unable to use insulin appropriately).<br><br>Review of the resident's Physician Order Summary (POS), dated 11/19/24, showed an order for Fiasp (Insulin Aspart with Niacinamide) 17 units subcutaneously (under the skin into fatty tissue) with meals for Diabetes Mellitus (a disease affecting the body's usage of natural insulin).<br><br>Review of the resident's Care Plan, dated 9/23/24, showed:<br><br>-The resident used insulin for diabetes.<br><br>-Staff were to administer diabetes medication (insulin) as ordered by the doctor.<br><br>Observation on 11/18/24 at 12:16 P.M., showed:<br><br>-Registered Nurse (RN) A was using the nurse medication cart to check glucose levels and administer insulin.<br><br>-RN A did not have a computer or immediate access to the resident's medical record.<br><br>-RN A opened the medication cart and retrieved a multi-dose vial of Insulin Lispro with no resident identifiers on the vial.<br><br>-RN A said this must belong to the resident, measured 17 units of the Insulin Lispro and, without verifying the accuracy of the order, administered the insulin to the resident.<br><br>During an interview on 11/18/24 at 2:18 P.M., RN A said the resident should have received Fiasp instead of the Insulin Lispro.<br><br>Review of the resident's medical record showed no documentation or follow up of the medication error.<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 | During an interview on 11/19/24 at 1:27 P.M., the DON said:<br><br>-He/She would not expect a resident to receive an insulin other than what was ordered.<br><br>-He/She would expect insulin to be given from a vial that was marked with the resident name.<br><br>-He/She would expect staff to verify physician orders from the resident's medical record before administering a medication. |

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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>46519<br><br>Based on observation, interview and record review, the facility failed to ensure the appropriate storage and labeling of medications throughout the facility's medication carts and medication storage rooms. This deficient practice had the potential to affect all residents within the facility. The facility census was 151 residents.<br><br>Review of the facility's policy titled Storage of Medications dated August 2020 showed:<br><br>-Nurses were not to transfer medications from one container to another or return partially used medication to the original container.<br><br>-All medications dispensed by the pharmacy were to be stored in the pharmacy container with the pharmacy label.<br><br>-Outdated, contaminated, or deteriorated medications and those in containers that were cracked, soiled, or without secure closures were to be immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order existed.<br><br>-Expirations dates (beyond-use dates) of dispensed medications should be determined by the pharmacist at the time of dispensing.<br><br>-The nurse would check the expirations date of each medications before administering it.<br><br>-All expired medications would be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining.<br><br>1. Observation on 11/18/24 at 1:59 P.M. of the Certified Medication Technician (CMT) cart for 300 hall showed a Fluticasone Propionate Nasal Spray (Flonase- used to treat allergies and non-allergic nasal symptoms) and a Fluticasone Propionate and Salmeterol (Advair- used to treat asthma (a condition in which a person's airways become inflamed, narrow, swell, and produce extra mucus, which makes it difficult to breathe) or Chronic Obstructive Pulmonary Disease (COPD- a disease process that decreases the ability of the lungs to perform ventilation) stored in the same box.<br><br>2. Observation on 11/18/24 at 2:07 P.M. of the nurse cart for 100/200 hall showed:<br><br>-A vial of Lidocaine 1% (typically used to cause numbness or loss of feeling for patients having certain medical procedures) half-used, outside of its original container, with a label that appeared to have been ripped off.<br><br>-A bottle of Dakin's solution (used to prevent and treat skin and tissue infections) that expired October 2024.<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 | 3. Observation of on 11/18/24 at 2:17 P.M. the medication storage rooms on the Long-Term Care (LTC) side of the facility showed:<br><br>-A box of liquid skin preparation (prepares damaged or intact skin for attachment sites, tapes, films, and adhesive dressings) that expired 5/17/24.<br><br>-12 Dermaview II transparent film wound dressings with label (a moisture-vapor permeable transparent dressing that aids in the prevention of bacterial contamination) that expired 5/6/23.<br><br>-Two boxes of Curad oil emulsion dressings (a dressing that is ideal for lightly draining wounds including minor burns, lacerations, and abrasions) that expired on 7/7/2024.<br><br>-A carton of thickened water that had been opened on 6/21/24 and had expired on 10/22/24.<br><br>-A carton of thickened cranberry cocktail that had been opened on 7/4/24 and had expired on 11/14/24.<br><br>-A Tuberculin purified protein derivative (PPD) (Aplisol- used in a skin test to help diagnose tuberculosis (TB- a serious infectious bacterial disease that mainly affects the lungs) stored in the fridge outside of its original container and unreadable open date.<br><br>-An intravenous (IV) administration set that expired on 10/27/24.<br><br>-Two needleless connectors that expired on 9/13/23.<br><br>-A foley catheter (a device that drains urine from the bladder into a collection bag) insertion tray that expired on 9/29/24.<br><br>4. Observation on 11/18/24 at 3:15 P.M. of the CMT cart for 100 hall showed a bottle of liquid iron supplement that expired in September 2024.<br><br>5. During an interview on 11/19/24 at 2:54 P.M. CMT B said:<br><br>-The CMT and nurse carts were checked about three times a week.<br><br>-He/She thought the facility policy was for the CMT and nurse carts to be checked once a week.<br><br>-CMTs were responsible for checking the CMT carts for expired medications and the appropriate storage and labeling of medications.<br><br>-Nurses were responsible for checking the nurse carts for expired medications and the appropriate storage and labeling of medications.<br><br>-The Assistant Directors of Nursing (ADONs) were responsible for ensuring completion of the CMT carts and nurse carts checks for expired medications and the appropriate storage and labeling of medications.<br><br>-All medications including inhalers and nasal sprays needed to be stored in their own container.<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 | -He/She was aware that the Flonase and Advair had been stored in the same container.<br><br>-The Flonase and Advair had been sent to the facility that way and he/she never asked for a new container for the Flonase.<br><br>-Expired medications should not be in any cart that holds medications.<br><br>-If expired medications were found in any medication cart, then the medication should be removed and thrown away/destroyed.<br><br>- The CMTs and nurses were responsible for going through the medication storage rooms to check for expired medications and the appropriate storage and labeling of medications.<br><br>-The ADONs were responsible for ensuring completion of the medication storage room checks.<br><br>-The ADONs were responsible for checking the medication storage rooms for expired medical supplies.<br><br>-Expired medical supplies should not be stored in the medication storage rooms and should be removed and disposed of appropriately.<br><br>During an interview on 11/20/24 at 10:47 A.M. Registered Nurse (RN) A said:<br><br>-The staff who get into the medication carts should be checking expiration dates of medications every time they are in the cart and pulling medications out of the cart.<br><br>-The nursing supervisors were responsible for checking the CMT and nurse carts for expired medications and the proper storage and labeling of medication.<br><br>-All medications including nasal sprays and inhalers should be stored in their own container.<br><br>-The Lidocaine 1% vial should not be used if the label was illegible or ripped off.<br><br>-The Lidocaine 1% vials were not multi-use vials and were supposed to be labeled for a specific resident.<br><br>-The Lidocaine 1% vial needed to be removed from the cart and appropriately disposed of.<br><br>-Expired medications should not be in any medication carts and should be removed from the carts and appropriately disposed of.<br><br>-Nurses and nursing supervisors were responsible for checking the medication storage rooms for expired medications/supplies and the appropriate storage and labeling of medications.<br><br>-Nursing supervisors were responsible for ensuring the checks were getting completed.<br><br>-Expired medical supplies should not be stored in medication storage rooms and should be removed and appropriately despised of.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 265727 | A. Building<br>B. Wing | 11/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Carmel Hills Wellness & Rehabilitation | 810 East Walnut<br>Independence, MO 64050 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Any staff who use the thickened liquid cartons should be checking for expiration anytime the carton is used.<br><br>-The staff should have noticed that the thickened liquid cartons had expired and should have thrown them away after they had expired.<br><br>-The Tuberculin PPD solution should have been stored in its original container.<br><br>-If the open date of the Tuberculin PPD solution was illegible, the staff should have appropriately disposed of the vial.<br><br>During an interview on 11/20/24 at 11:19 A.M. ADON A said:<br><br>-Anyone who were able to access medication carts were responsible for checking them for expired medications and the appropriate storage and labeling of medications.<br><br>-This included CMTs, nurses, and nurse managers.<br><br>-The nurse managers were responsible for ensuring the completion of the checks and it was normally completed once a week.<br><br>-The medication storage rooms were also checked once a week for expired medications/medical supplies and was completed by the nursing managers.<br><br>-Expired medications should never be stored in medication carts and if found they should be removed and appropriately disposed of.<br><br>-All medications including nasal sprays and inhalers needed to be stored in their own container.<br><br>-Lidocaine 1% vials were not multi-use vial and usually labeled with the designated resident's name.<br><br>-The Lidocaine 1% vial should have been labeled and stored in its original container.<br><br>-The staff should have removed the Lidocaine 1% vial and appropriately disposed of it.<br><br>-Expired medical supplies should not be stored in medication storage rooms.<br><br>-Any expired medical supplies found should be removed and be appropriately disposed of.<br><br>-The dietary staff were the staff who usually opened the cartons of thickened liquids and would be responsible for the appropriate labeling of the cartons.<br><br>-The nurses and dietary staff were able to check expiration dates of the thickened liquid cartons.<br><br>-The expired thickened liquid cartons should have removed and thrown away.<br><br>-The Tuberculin PPD solution should not have been outside of its original container.<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 | -If the Tuberculin PPD solution open date could not be read and the original container could not be found then the vial should be removed and appropriately disposed of.<br><br>During an interview on 11/20/24 at 11:57 A.M. the Director of Nursing (DON) said:<br><br>-The medication carts should be checked daily for expired medications and the appropriate storage and labeling of medications.<br><br>-The ADONs were responsible for completing a weekly audit of the medication carts and ensuring all expired medications were removed from the cart and all medications in the cart were appropriately stored and labeled.<br><br>-All medications should be stored in their own container including nasal sprays and inhalers.<br><br>-The Lidocaine 1% vial should have been labeled with the resident's name and stored in its own container.<br><br>-The Lidocaine 1% should have been removed form the nurse cart and appropriately disposed of since the label had been ripped off.<br><br>-Anyone who enters the medication storage rooms can check for expired medications/supplies and the appropriate storage and labeling of medications.<br><br>-The ADONs were responsible for ensuring the completion of medication storage rooms checks.<br><br>-Expired medical supplies should not be stored in medication storage rooms and any expired medical supplies should be removed and appropriately disposed of.<br><br>-If the thickened liquid carton comes from the kitchen, then the dietary staff would be responsible for checking the expirations dates.<br><br>-Once the thickened liquid cartons were opened and stored in nursing areas, then nursing staff would be responsible for checking the expiration dates.<br><br>-The night nurses were responsible for checking the medication room refrigerators and they would be the ones responsible for ensuring that everything stored in the fridge was not expired and stored/labeled appropriately.<br><br>-The Tuberculin PPD solution should not have been stored outside of its original container.<br><br>50579<br><br>6. Observation on 11/18/24 at 1:58 P.M., a medication cart for the 500 hall showed:<br><br>Expired medication on the cart included:<br><br>-Docusate (a stool softener) liquid, expired 8/2024.<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 | -Pro-stat (a liquid protein supplement), with an opened date of 5/15/24 and manufacturer instructions printed on the bottle to discard three months after opening.<br><br>- Iron supplement liquid, expired 8/2024.<br><br>-Pro-stat, expired 2/2024.<br><br>-Meclizine (a nausea medication), expired 3/2024.<br><br>Other medications noted to be stored or labeled incorrectly included:<br><br>-Insulin Lispro multi dose vial with no resident identifier.<br><br>-Albuterol inhaler with no date or resident identifier.<br><br>-A medication cup with several partially dissolved pills and a pink gel sitting in a medication drawer of the cart.<br><br>7. During an interview on 11/18/24 at 2:18 P.M., Registered Nurse (RN) A said:<br><br>-He/She would expect expired medications to be removed from the cart.<br><br>-He/She would expect all medications to be labeled appropriately with a resident name.<br><br>-He/She did not know what medications were partially dissolved in the medication cup or when they were placed on the medication cart.<br><br>During an interview on 11/19/24 at 1:27 P.M., the Director of Nursing (DON) said:<br><br>-He/She would not expect expired medications to be kept on the medication cart.<br><br>-He/She would expect medications to be labeled appropriately.<br><br>-He/She would expect proper storage of all medications.<br><br>During an interview on 11/19/24 at 2:54 P.M. CMT B said:<br><br>-The CMT and nurse carts were checked about three times a week.<br><br>-He/She thought the facility policy was for the CMT and nurse carts to be checked once a week.<br><br>-CMTs were responsible for checking the CMT carts for expired medications and the appropriate storage and labeling of medications.<br><br>-Nurses were responsible for checking the nurse carts for expired medications and the appropriate storage and labeling of medications.<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 | -The Assistant Directors of Nursing (ADONs) were responsible for ensuring completion of the CMT carts and nurse carts checks for expired medications and the appropriate storage and labeling of medications.<br><br>-All medications including inhalers and nasal sprays needed to be stored in their own container.<br><br>-He/She was aware that the Flonase and Advair had been stored in the same container.<br><br>-The Flonase and Advair had been sent to the facility that way and he/she never asked for a new container for the Flonase.<br><br>-Expired medications should not be in any cart that holds medications.<br><br>-If expired medications were found in any medication cart, then the medication should be removed and thrown away/destroyed.<br><br>- The CMTs and nurses were responsible for going through the medication storage rooms to check for expired medications and the appropriate storage and labeling of medications.<br><br>-The ADONs were responsible for ensuring completion of the medication storage room checks.<br><br>-The ADONs were responsible for checking the medication storage rooms for expired medical supplies.<br><br>-Expired medical supplies should not be stored in the medication storage rooms and should be removed and disposed of appropriately.<br><br>During an interview on 11/20/24 at 10:47 A.M. Registered Nurse (RN) A said:<br><br>-The staff who get into the medication carts should be checking expiration dates of medications every time they are in the cart and pulling medications out of the cart.<br><br>-The nursing supervisors were responsible for checking the CMT and nurse carts for expired medications and the proper storage and labeling of medication.<br><br>-All medications including nasal sprays and inhalers should be stored in their own container.<br><br>-The Lidocaine 1% vial should not be used if the label was illegible or ripped off.<br><br>-The Lidocaine 1% vials were not multi-use vials and were supposed to be labeled for a specific resident.<br><br>-The Lidocaine 1% vial needed to be removed from the cart and appropriately disposed of.<br><br>-Expired medications should not be in any medication carts and should be removed from the carts and appropriately disposed of.<br><br>-Nurses and nursing supervisors were responsible for checking the medication storage rooms for expired medications/supplies and the appropriate storage and labeling of medications.<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 | -Nursing supervisors were responsible for ensuring the checks were getting completed.<br><br>-Expired medical supplies should not be stored in medication storage rooms and should be removed and appropriately despised of.<br><br>-Any staff who use the thickened liquid cartons should be checking for expiration anytime the carton is used.<br><br>-The staff should have noticed that the thickened liquid cartons had expired and should have thrown them away after they had expired.<br><br>-The Tuberculin PPD solution should have been stored in its original container.<br><br>-If the open date of the Tuberculin PPD solution was illegible, the staff should have appropriately disposed of the vial.<br><br>During an interview on 11/20/24 at 11:19 A.M. ADON A said:<br><br>-Anyone who were able to access medication carts were responsible for checking them for expired medications and the appropriate storage and labeling of medications.<br><br>-This included CMTs, nurses, and nurse managers.<br><br>-The nurse managers were responsible for ensuring the completion of the checks and it was normally completed once a week.<br><br>-The medication storage rooms were also checked once a week for expired medications/medical supplies and was completed by the nursing managers.<br><br>-Expired medications should never be stored in medication carts and if found they should be removed and appropriately disposed of.<br><br>-All medications including nasal sprays and inhalers needed to be stored in their own container.<br><br>-Lidocaine 1% vials were not multi-use vial and usually labeled with the designated resident's name.<br><br>-The Lidocaine 1% vial should have been labeled and stored in its original container.<br><br>-The staff should have removed the Lidocaine 1% vial and appropriately disposed of it.<br><br>-Expired medical supplies should not be stored in medication storage rooms.<br><br>-Any expired medical supplies found should be removed and be appropriately disposed of.<br><br>-The dietary staff were the staff who usually opened the cartons of thickened liquids and would be responsible for the appropriate labeling of the cartons.<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 | -The nurses and dietary staff were able to check expiration dates of the thickened liquid cartons.<br><br>-The expired thickened liquid cartons should have removed and thrown away.<br><br>-The Tuberculin PPD solution should not have been outside of its original container.<br><br>-If the Tuberculin PPD solution open date could not be read and the original container could not be found then the vial should be removed and appropriately disposed of.<br><br>During an interview on 11/20/24 at 11:57 A.M. the Director of Nursing (DON) said:<br><br>-The medication carts should be checked daily for expired medications and the appropriate storage and labeling of medications.<br><br>-The ADONs were responsible for completing a weekly audit of the medication carts and ensuring all expired medications were removed from the cart and all medications in the cart were appropriately stored and labeled.<br><br>-All medications should be stored in their own container including nasal sprays and inhalers.<br><br>-The Lidocaine 1% vial should have been labeled with the resident's name and stored in its own container.<br><br>-The Lidocaine 1% should have been removed form the nurse cart and appropriately disposed of since the label had been ripped off.<br><br>-Anyone who enters the medication storage rooms can check for expired medications/supplies and the appropriate storage and labeling of medications.<br><br>-The ADONs were responsible for ensuring the completion of medication storage rooms checks.<br><br>-Expired medical supplies should not be stored in medication storage rooms and any expired medical supplies should be removed and appropriately disposed of.<br><br>-If the thickened liquid carton comes from the kitchen, then the dietary staff would be responsible for checking the expirations dates.<br><br>-Once the thickened liquid cartons were opened and stored in nursing areas, then nursing staff would be responsible for checking the expiration dates.<br><br>-The night nurses were responsible for checking the medication room refrigerators and they would be the ones responsible for ensuring that everything stored in the fridge was not expired and stored/labeled appropriately.<br><br>-The Tuberculin PPD solution should not have been stored outside of its original container. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51303<br><br>Based on observation, interview, and record review, the facility failed to ensure routine and emergency dental services to meet the needs of residents were offered to two sampled residents, (Residents #14 and #98) out of 35 sampled residents. The facility census was 151 residents.<br><br>Review of the facility's undated Dental Services policy showed:<br><br>-Refer and/or assist residents to obtain dental services as indicated for routine and emergency dental care including making appointments for the residents, if needed or requested and arrange transportation to and from the dentist's office.<br><br>--Routine services include but are not limited to:<br><br>---Annual inspections.<br><br>---Dental cleaning, fillings, and x-ray as needed.<br><br>---Minor dental plate adjustments.<br><br>---Smoothing of broken teeth.<br><br>--Emergency dental services include but are not limited to:<br><br>---Acute or intolerable pain in teeth, gums, palate.<br><br>---Broken, damaged teeth, or dentures.<br><br>1. Review of Resident #14's Admission Record showed he/she was admitted to the facility on [DATE] with the diagnosis of Need for Assistance with Personal Care.<br><br>Review of the resident's nursing Admission/Readmission Evaluation dated 8/24/23 showed he/she had broken and/or carious (cavities) teeth.<br><br>Review of the resident's Nutrition Assessment Registered Dietician Evaluation dated 1/20/24 showed:<br><br>-He/She was on a regular diet and regular consistency.<br><br>-He/She had his/her own teeth in fair condition.<br><br>Review of the resident's Order Summary Report (OSR) showed a physician's order dated 4/30/24, that the resident may be seen and treated by a dentist.<br><br>Review of the resident's Annual Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 8/28/24 showed:<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She had moderate cognitive deficits and required support of facility staff.<br><br>-He/She had no missing teeth or cavities.<br><br>-He/She performed oral care with supervision and/or touching assistance by staff.<br><br>Observation on 11/19/24 at 10:25 A.M. of the resident's mouth showed:<br><br>-Multiple teeth missing in the upper and lower jaw.<br><br>-One tooth on the lower right side was loose and pointed towards the tongue.<br><br>-A buildup of a yellow substance on the remaining teeth.<br><br>During an interview on 11/19/24 at 10:25 A.M. the resident said:<br><br>-He/She was unsure the last time he/she had seen a dentist.<br><br>-He/She had not seen a dentist since admission.<br><br>-He/She didn't have many teeth.<br><br>-Sometimes his/her teeth hurt, but he/she was able to eat a regular diet.<br><br>Review of the resident's current care plan showed no mention of the resident requiring a need for dental care.<br><br>Review of the resident's Quarterly MDS dated [DATE] showed no missing teeth or cavities.<br><br>2. Review of Resident #98's Admission Record showed he/she was admitted on [DATE].<br><br>Review of the resident's nursing Admission/Readmission Evaluation dated 7/25/23 showed:<br><br>-He/She had his/her own teeth.<br><br>-The assessment question that stated broken or carious teeth was left blank.<br><br>Review of the resident's care plan dated 8/1/23 showed staff were to monitor oral hygiene and notify MD of abnormal findings or concerns. Refer to a dentist as indicated.<br><br>Review of the resident's Annual MDS dated [DATE] showed:<br><br>-He/She was cognitively intact.<br><br>-Oral/Dental Status showed no problem with missing teeth or cavities.<br><br>Review of the resident's dental evaluation dated 6/25/24 showed:<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Tooth #25 was now a root tip.<br><br>-Missing teeth included #1, 2, 5, 6, 10, 13, 14, 15, 16, 17, 18, 19, 29, and 32.<br><br>-He/She had root tips on #7, 8, 9, 11, 12, 20, 25, 30, and 31.<br><br>-Doctor of Dental Surgery (DDS) recommended full mouth extraction of remaining natural teeth.<br><br>-The resident wanted teeth extracted and wanted to get dentures.<br><br>During an interview on 11/21/24 at 9:39 A.M. the resident said:<br><br>-His/Her teeth hurt sometimes.<br><br>-He/She was supposed to get all teeth pulled.<br><br>Observation of the resident's mouth on 11/21/24 at 9:39 A. M showed:<br><br>-He/She had multiple teeth missing.<br><br>-He/She had teeth with sharp edges and blackened areas on multiple teeth.<br><br>3. During an interview on 11/21/24 9:36 A.M. the Social Worker (SW) said:<br><br>-The facility had a provider for dental care.<br><br>-The dental provider came frequently, approximately every other month.<br><br>-He/She would receive a list from the dental provider with the residents' names for the next visit.<br><br>-He/She said nursing would be informed of new admissions or changes that needed to be addressed.<br><br>-He/She was not aware Resident #14 had missing teeth or had not seen a dentist.<br><br>-He/She said #14 had not been seen by a dentist.<br><br>-He/She said #98 had seen the dentist in 6/2024 but could not find paperwork and would have to request the information from dental provider.<br><br>During an interview on 11/25/24 at 9:14 A.M. MDS Coordinator A said:<br><br>-He/She gathered information for the MDS on interview of resident and staff, observation, the clinical record, and the daily clinical meeting.<br><br>-He/She said he/she was aware of #14's cavities.<br><br>-He/She was not aware Resident #98's broken and missing teeth.<br><br>(continued on next page) |

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|---|---|
| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She stated dental issues would be captured on the MDS and be care planned.<br><br>During an interview on 11/25/24 at 9:16 A.M. MDS Coordinator B said:<br><br>-He/She gathered information for the MDS on interview of resident and staff, observation, the clinical record, and the daily clinical meeting.<br><br>-He/She was not aware Resident #98's broken and missing teeth.<br><br>-He/She stated Resident #98 had never complained about dental concerns.<br><br>-He/She stated the facility offered dental services.<br><br>-He/She stated dental issues would be captured on the MDS and be care planned.<br><br>During an interview on 11/25/24 9:44 A.M. Assistant Director of Nursing (ADON) B said:<br><br>-He/She would expect a resident with multiple teeth missing and/or caries to be seen by the dentist.<br><br>-He/She said he/she would notify the SW of new residents or residents with issues to add to the schedule.<br><br>-He/She expected dental documentation/recommendations to be provided by end of day before the dentist leaves.<br><br>-The recommendations went to the SW and would give to the appropriate ADON for processing.<br><br>-He/She expected a resident would be seen by a dentist within one month.<br><br>-A referral for teeth extraction would be scheduled within one week after the dental provider recommended the resident have his/her teeth pulled.<br><br>During an interview on 11/25/24 11:10 A.M. the Director of Nursing (DON) said:<br><br>-The facility had a dental provider.<br><br>-He/She expected a resident with multiple missing teeth or with caries on admission would be seen by dental.<br><br>-He/She expected the dental evaluation to be available to the facility within a day or two.<br><br>-The SW followed up on dental recommendations.<br><br>-He/She expected a new resident would be seen within 30 days.<br><br>-Residents could be sent out for emergency dental services.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She was not aware Resident #14 had missing teeth.<br><br>-He/She was not aware of Resident #98's broken, missing, and carious teeth.<br><br>-He/She expected a resident with multiple missing teeth on admission would be seen by dental. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51150<br><br>Based on observation, interview and record review, the facility failed to ensure residents were provided food that was at a safe and appetizing temperature for three sampled residents (Residents #109, #91 and #139) out of 35 sampled residents. The facility census was 151 residents.<br><br>Review of the facility's Food Temperature policy, dated December 2020, showed:<br><br>-The purpose of the policy was to prove the nutrition services department with guidelines for food preparation and service temperatures.<br><br>-Food prepared and served in the facility would be served at proper temperatures to ensure food safety.<br><br>-Acceptable serving temperatures were: Above or equal to 135-degree Fahrenheit (F) for; eggs, vegetables, potatoes, pasta, meats, casseroles, and entrees.<br><br>-If temperatures do not meet applicable serving temperatures, reheat the product to a temperature of 164-degree F for hot foods for 15 seconds.<br><br>-If temperatures are not acceptable levels and cannot be corrected in time for meal services, an appropriate substitution should be implemented.<br><br>-Do not put food on the tray line until 30 minutes prior to meal services.<br><br>-Heated hot plates may be used to maintain warm temperatures.<br><br>1. Review of Resident #109's Admission Record, showed the resident was admitted to the facility on [DATE].<br><br>Review of the resident's annual MDS (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 10/24/24, showed the resident was cognitively intact.<br><br>During an interview on 11/20/24 at 9:49 A.M., the resident said:<br><br>-He/she ate most all meals in his/her room and was served room trays.<br><br>-His/her food was always served cold.<br><br>-He/she did not eat many meals, due to the temperature of the served food being unappetizing.<br><br>-He/she had complained about the cold food to the nurses and dietary staff many times.<br><br>Observation on 11/20/24 at 1:00 P.M., showed:<br><br>-Staff handed out the first room tray.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Room trays were all stacked on a rolling cart.<br><br>Observation on 11/20/24 at 1:35 P.M., showed:<br><br>-Staff brought the resident's room tray in to his/her room.<br><br>-The resident said his/her food was not warm.<br><br>-The resident's ham was 100-degree F.<br><br>-The resident's baked potatoes was 114 degree F.<br><br>-The resident's steamed carrots were 101-degree F.<br><br>During an interview on 11/21/24 at 8:52 A.M., the resident said:<br><br>-His/her breakfast was cold.<br><br>-He/she was served, scrambled eggs, toast, and oatmeal.<br><br>-He/she did not eat his/her breakfast due to unappetizing temperatures.<br><br>2. Review of Resident #91's Admission Record, showed the resident was admitted to the facility on [DATE].<br><br>Review of the resident's admission MDS dated [DATE], showed the resident was cognitively intact.<br><br>During an interview on 11/20/24 at 10:30 A.M., the resident said:<br><br>-He/she ate in his/her room and was served room trays.<br><br>-He/she was often served cold food.<br><br>-He/she refused to eat many of his/her meals due to unappetizing serving temperatures.<br><br>-He/she had reported the cold temperatures to the nurses.<br><br>During an interview on 11/22/24 at 10:47 A.M., the resident said he/she did not eat his/her breakfast that morning due to the temperature of the food served being cold.<br><br>3. Review of Resident #139's Admission Record, showed the resident was admitted to the facility on [DATE].<br><br>Review of the resident's admission MDS dated [DATE], showed the resident was cognitively intact.<br><br>During an interview on 11/21/24 at 9:09 A.M., the resident said:<br><br>-He/she ate in his/her room and was served room trays.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/she many times was served cold food.<br><br>-His/her breakfast was barely warm on that day and he/she was served oatmeal and scrambled eggs.<br><br>Observation on 11/21/24 at 12:37 P.M., showed residents on the hall were getting served drinks.<br><br>Observation on 11/21/24 at 12:43 P.M., showed residents on the hall were getting served appetizers and desserts.<br><br>Observation on 11/21/24 at 1:01 P.M., showed:<br><br>-Residents on the hall were getting served lunch room trays.<br><br>-Room trays were all stacked on a rolling cart.<br><br>Observation on 11/21/24 at 1:11 P.M., showed:<br><br>-Staff brought the resident's room tray in to his/her room.<br><br>-The resident said his/her food was not warm.<br><br>-The resident's peas were 100-degrees F.<br><br>-The resident's mashed potatoes were 120-degrees F.<br><br>-The resident's Salisbury steak was 120-degrees F.<br><br>4. During an interview on 11/22/24 at 2:00 P.M., Certified Nurse Assistant (CNA) E said:<br><br>-It generally took about 7-8 minutes to get all of the food trays passed per hall.<br><br>-He/she had received complaints from residents about the food not being warm.<br><br>-He/she had reported the resident complaints to the Director of Nursing (DON).<br><br>-He/she tried to offer alternatives when the food was not to the residents liking.<br><br>-He/she had never witnessed a staff member monitoring food temperatures on any of residents room trays.<br><br>-He/she was unaware of the food temperature policy.<br><br>During an interview on 11/22/24 at 2:30 P.M., Registered Nurse (RN) A said:<br><br>-It generally took around 5 minutes for room trays to be passed in a hall.<br><br>-He/she had residents complain about the food temperature.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/she notified the kitchen staff when the residents had a food complaint.<br><br>-He/she often warmed the food up for the residents due to the food being served cold.<br><br>During an interview on 11/22/24 at 3:00 P.M., Assistant Director of Nursing (ADON) A said:<br><br>-Room trays were passed to the residents in their room within 5 minutes of coming from the kitchen.<br><br>-He/she had received complaints from residents about food temperatures.<br><br>-He/she would expect a residents room tray to meet the facility's temperature policy.<br><br>-He/she had spoken to the kitchen manager about the room temperature complaints.<br><br>-He/she had filed grievances on the residents behalf for cold food.<br><br>During an interview on 11/25/24 at 9:00 A.M., Dietary Manager said:<br><br>-The dining room was served before the room trays were served.<br><br>-The 100-200-300-400 halls all had a hotbox for room trays.<br><br>-The 600-700 halls were served from the steam table directly.<br><br>-The 500 hall was served from the main dining room steam table and the trays were taken to the residents, one or two at a time, to maintain temperatures.<br><br>-He/she monitored the room tray temperatures.<br><br>-He/she checked the room tray temperatures daily, rotating the meal.<br><br>-He/she walked the facility and ensured room trays were being passed timely.<br><br>-He/she had not heard of any resident concerns regarding the temperatures of the food trays.<br><br>-He/she had heard resident complaints that were being served last.<br><br>-Note: Observation above showed all of the room trays being passed at once from a rolling cart.<br><br>During an interview on 11/25/24 at 11:10 A.M. the Director of Nursing (DON) said:<br><br>-100-400 hall room trays were served from a dietary hotbox.<br><br>-500 hall room trays were served from a rolling cart.<br><br>-He/she was unaware of the facility policy for room tray temperatures.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/she was unaware of who was responsible for monitoring room tray temperatures.<br><br>-He/she was aware that there had been concerns voiced regarding the room tray temperatures. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26996<br><br>Based on observation, interview, and record review, the facility failed to properly screen new employees for Tuberculosis (TB a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) for five sampled new employees (Employee F, G, H, I, and J,) out of ten sampled new employees. This practice had the potential to affect all residents, employees, and visitors to the facility; the facility failed to ensure appropriate hand hygiene, glove usage, and barrier placement was appropriately used during medication administration, blood glucose (sugar) test, and insulin (a hormone produces in the pancreas which regulates the amount of glucose in the blood) administration for one sampled resident (Resident #84) and for one supplemental resident (Resident #132) out of five supplemental residents; failed to ensure enhanced barrier precautions (EBP-an infection control method that uses personal protective equipment (PPE-clothing or equipment that protects the wearer from injury or the spread of infection or illness) to reduce the spread of multidrug-resistant organisms) were used and failed to use handwashing/sanitizing to prevent cross contamination when providing care for six sampled residents (Resident #95, #84, #72, #19, #40, and #116) out of 35 sampled residents; The facility census was 151 residents.<br><br>Review of 19 Code of State Regulations (CSR) 20-20.100 TB testing for residents and workers in long-term care facilities, paragraph three, showed:<br><br>-All new long-term care facility employees who work ten or more hours per week should have the first of two TB skin tests (TST) within one month prior to starting employment in the facility.<br><br>-The results of the TSTs should be read within 48-72 hours from administration.<br><br>-If the initial TST result is zero to nine millimeters (mm) induration, the second test should be administered as soon as possible within three weeks after employment begins, unless documentation is provided indicating a two-step TST was completed in the past and at least one subsequent annual test within the past year.<br><br>Review of the facility's Employee TB Screening and Interpretation of TST's policy revised 6/2020 showed:<br><br>-After a TST test was administered, the TST test must be read within 48 to 72 hours by a qualified nurse or health practitioner in mm of induration.<br><br>1. Review of Employee F's employee file showed:<br><br>-The employee was hired on 5/9/24 as a Certified Medication Technician (CMT).<br><br>-The first step TB test was administered 5/9/24 and read as 0 millimeter (mm). There was no date showing when the TST was read.<br><br>-The second step TB test was administered 5/20/24 and read as 0 mm. There was no date showing when the TST was read.<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 - Many | Review of Employee G's employee file showed:<br><br>-The employee was hired on 6/7/24 as a Registered Nurse (RN).<br><br>-The first step TB test was administered 6/7/24 and read as 0 mm. There was no date showing when the TST was read.<br><br>-The second step TB test was administered 6/20/24 and read as 0 mm. There was no date showing when the TST was read.<br><br>Review of Employee H's employee file showed:<br><br>-The employee was hired on 8/16/24 as a Licensed Vocational Nurse (LVN).<br><br>-The first step TB test was administered 8/2/24 and read as 0 mm. There was no date showing when the TST was read.<br><br>-The second step TB test was administered 8/12/24 and read as 0 mm. There was no date showing when the TST was read.<br><br>Review of Employee I's employee file showed:<br><br>-The employee was hired on 9/4/24 as a Certified Nursing Assistant (CNA).<br><br>-The first step TB test was administered 9/4/24 and read as 0 mm. There was no date showing when the TST was read.<br><br>-The second step TB test was administered 9/13/24 and read as 0 mm. There was no date showing when the TST was read.<br><br>Review of Employee J's employee file showed:<br><br>-The employee was hired on 10/23/24 as a Cook.<br><br>-The first step TB test was administered 10/23/24 and read as 0 mm. There was no date showing when the TST was read.<br><br>-The second step TB test was administered 11/1/24 and read as 0 mm. There was no date showing when the TST was read.<br><br>During an interview on 11/22/24 at 2:14 P.M. the Human Resources Coordinator said:<br><br>-When an employee was hired, he/she would let Assistant Director of Nursing (ADON) A know the new employee needed TB testing.<br><br>-ADON A would complete the TB testing for the new employee.<br><br>-The TB testing should show a date when the TB test was read in mm of induration.<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 - Many | During an interview on 11/22/24 at 2:27 P.M. ADON A said:<br><br>-He/she was responsible for completing the TB testing for the new employees.<br><br>-He/she would administer the TST then read the TST within 48-72 hours.<br><br>-The TB form did not have a space for the date read so it did not prompt him/her to write a date down.<br><br>-He/she had not been documenting the date the TB test was read.<br><br>-When a TB test was read, a date should be listed along with the mm of induration.<br><br>During an interview on 11/25/24 at 11:10 A.M. the Director of Nursing (DON) said:<br><br>-Nursing staff were responsible for ensuring new employee TB testing was completed.<br><br>-TST's should be read within 48-72 hours after administration.<br><br>-He/she expected the date the TB test was read to be documented on the TB testing form.<br><br>-The ADON's should be monitoring for completion and accuracy.<br><br>46519<br><br>2. Review of the facility's policy titled Personal Protective Equipment dated June 2020 showed hands were to be washed before and after glove usage.<br><br>Review of the facility's policy titled Blood Glucose Monitoring dated June 2020 showed:<br><br>-Staff were to wash their hands and put on gloves before performing the test.<br><br>-Staff were to remove their gloves and wash their hands after completing the procedure.<br><br>-The policy did not include the use of a barrier for placing supplies during the test.<br><br>Review of the facility's undated policy titled Hand Hygiene showed:<br><br>-Facility staff were to wash hands with soap and water in between glove changes.<br><br>-Facility staff were to use alcohol-based hand hygiene products:<br><br>--Immediately upon entering a resident occupied area regardless of glove use.<br><br>--Immediately upon exiting a resident occupied area regardless of glove use.<br><br>--Before moving from one resident to another in a multi-bedroom or procedure area regardless of glove use.<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 - Many | --After removing PPE and before moving to another resident in the same room or exiting the room.<br><br>-The use of gloves did not replace hand hygiene procedures.<br><br>Review of the facility's undated policy titled Medication Administration showed staff were to wash hands before and after medication administration.<br><br>Review of Resident #84's face sheet showed he/she admitted to the facility with the following diagnoses:<br><br>-Displaced Trimalleolar (ankle) Fracture of Left Lower Leg.<br><br>-Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).<br><br>Review of the resident's Physician Order Sheet (POS) dated November 2024 showed:<br><br>-An order for blood glucose monitoring.<br><br>-An order for Hydrocodone-Acetaminophen Oral Tablet (pain medication) 5-325 milligrams (mg), give one tablet by mouth every four hours as needed for pain.<br><br>-An order for Novolog Injection Solution (Insulin Aspart- a short acting insulin) 100 unit/milliliters (ml), inject 20 units subcutaneously (situated or applied under the skin) before meals for DMII.<br><br>Observation on 11/19/24 at 8:39 A.M. of the resident's medication administration, blood glucose test, and insulin administration completed by Licensed Practical Nurse (LPN) A showed:<br><br>-LPN A did not sanitize his/her hands prior to the medication pass.<br><br>-He/She put on gloves and then got his/her keys out of his/her pocket and unlocked the medication cart.<br><br>-He/She then removed his/her gloves and walked away from the cart without sanitizing his/her hands.<br><br>-He/She returned to the medication cart and put on new gloves without sanitizing his/her hands.<br><br>-He/She sanitized the glucometer (glucose meter- a medical device used to determine the approximate concentration of glucose in the blood), set the glucometer down on a barrier, then removed his/her gloves.<br><br>-He/She then entered the resident's room to give the resident his/her pain medication and washed his/her hands before exiting the room.<br><br>-He/She walked out of the room and applied new gloves.<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 - Many | -He/She unlocked the medication cart and removed the other supplies needed for the blood glucose test.<br><br>-He/She then entered the resident's room with the same pair of gloves on and performed the blood glucose test.<br><br>-During the test LPN A placed the glucometer on the resident's bedside table without using a barrier.<br><br>-He/She removed his/her gloves and exited the resident's room.<br><br>-He/She returned to the medication cart and put on new gloves without sanitizing his/her hands.<br><br>-He/She then unlocked the medication cart and touched multiple different bags that held insulin pens in order to find the resident's insulin.<br><br>-He/She needed to get the resident a new insulin pen and removed his/her gloves without sanitizing his/her hands after the removal.<br><br>-He/She left the medication cart and walked to the medication room to get the resident a new insulin pen.<br><br>-Once LPN A was back at the medication cart, he/she did not sanitize his/her hands prior to getting a needle for the insulin pen out of the medication cart.<br><br>-He/She sanitized the insulin pen hub and placed the needle on the insulin pen without using gloves.<br><br>-He/She then put on new gloves without sanitizing his/her hands and walked into the resident's room to administer the insulin.<br><br>-He/She administered the insulin, removed his/her gloves, and walked out of the resident's room.<br><br>3. Review of Resident #132's face sheet showed he/she admitted to the facility with a diagnosis of DM II.<br><br>Review of the resident's POS dated November 2024 showed:<br><br>-An order for blood glucose monitoring before meals and at bedtime.<br><br>-An order for Humalog Injection Solution (Insulin Lispro- a short acting insulin), inject 15 units subcutaneously with meals for DM II.<br><br>Observation on 11/19/24 at 9:05 A.M. of the resident's blood glucose test and insulin administration completed by LPN A showed:<br><br>-LPN A transported the resident via his/her wheelchair to the medication cart.<br><br>(continued on next page) |

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| | 265727 | A. Building<br>B. Wing | 11/25/2024 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -He/She put on gloves without sanitizing his/her hands.<br><br>-He/She performed the blood glucose test on the resident.<br><br>-The glucometer read an error and LPN A needed to re-perform the test.<br><br>-He/She grabbed new supplies from the cart with the same gloves and performed the test again.<br><br>-He/She then removed his/her gloves, sanitized his/her hands, removed the resident's insulin from the cart and put on new gloves.<br><br>-He/She removed insulin from the resident's insulin vial and administered the resident's insulin.<br><br>-He/She removed his/her gloves and did not sanitize his/her hands before continuing the resident's medication pass.<br><br>During an interview on 11/19/24 at 9:14 A.M. LPN A said:<br><br>-He/She would not have done anything differently during the medication administration, blood glucose tests, and insulin administrations for either resident.<br><br>-He/Should would normally perform hand hygiene after each glove removal.<br><br>-There was not a specific reason as to why he/she had not done that during the observation.<br><br>-He/She would normally sanitize his/her hands before and after any type of resident care including medication administration, when going from task to task during resident care, and after glove removal.<br><br>4. During an interview on 11/20/24 at 10:55 A.M. RN A said:<br><br>-Hand hygiene was to be performed before and after each resident during medication pass.<br><br>-The nurse should not have worn gloves when gathering supplies at the cart and going into the cart and should not have worn them into Resident #84's room.<br><br>-The nurse had not performed hand hygiene correctly throughout Resident #84's care.<br><br>-The nurse should have sanitized his/her hands before gloves were put on and taken off.<br><br>-The nurse should have placed a clean barrier between the resident's bedside table and the glucometer during the blood glucose test.<br><br>-The nurse should have removed his/her gloves before going into the resident's room.<br><br>-Upon entering the resident's room, the nurse should have sanitized his/her hands and put on new gloves before performing the blood glucose test.<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 - Many | -The nurse had not performed appropriate hand hygiene during Resident #132's care.<br><br>-The nurse should have sanitized his/her hands after touching the resident's wheelchair.<br><br>-The nurse should have removed his/her gloves, sanitized/washed his/her hands, and put on new gloves before redoing the resident's blood glucose test.<br><br>-Gloves were not a substitute for hand hygiene.<br><br>During an interview on 11/20/24 at 11:36 A.M. ADON A said:<br><br>-He/She expected staff to perform hand hygiene before and after each medication pass.<br><br>-He/She expected staff to perform hand hygiene before entering and after exiting resident rooms.<br><br>-Gloves were not a replacement for hand hygiene.<br><br>-LPN A did not perform appropriate hand hygiene during Resident 84's and Resident #132's care.<br><br>-LPN A should have washed/sanitized his/her hands after each glove removal and before putting on gloves.<br><br>-LPN A should not have worn gloves into Resident #84's room.<br><br>-LPN A should not have kept the same pair of gloves on to redo Resident #132's blood glucose test.<br><br>-LPN A should have removed his/her gloves, washed his/her hands, and put on new gloves before re-performing Resident #132's blood glucose test.<br><br>-LPN A should have placed a barrier on Resident #84's bedside table during Resident #84's blood glucose test.<br><br>During an interview on 11/20/24 at 12:07 P.M. the DON said:<br><br>-He/She expected staff to sanitize their hands between each resident during medication pass.<br><br>-Gloves were not a substitution for hand hygiene.<br><br>-Staff were expected to wash/sanitize their hands before and after glove use.<br><br>-Staff were expected wash/sanitize their hands before and after any resident care.<br><br>-Staff were expected to wash/sanitize their hands when entering and exiting resident rooms.<br><br>-LPN A had not performed appropriate hand hygiene during Resident #84's and Resident #132's care.<br><br>-LPN A should not have worn gloves into Resident #84'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 - Many | -LPN A should have placed a barrier down between Resident #84's bedside table and the glucometer.<br><br>-Gloves were not to be worn when accessing non-medical supplies.<br><br>-LPN A should not have worn the same gloves after Resident #132's first blood glucose test.<br><br>-LPN A should have removed his/her gloves, washed his/her hands, and put on new gloves when he/she performed Resident #132's blood glucose test again.<br><br>21003<br><br>5. Review of the undated policy Understanding Enhanced Barrier Precautions showed:<br><br>-When using PPE staff members wear a clean gown and gloves while performing high contact resident care activities with residents who are at increased risk of carrying a resistant organism. This includes all residents with any of the following:<br><br>--Known infection or colonization with a resistant organism when Contact Precautions do not otherwise apply.<br><br>--Wounds or indwelling medical devices like central line, urinary catheters, feeding tube, tracheostomy, or ventilator.<br><br>-High contact resident care activities were typically bundled care activities that were provided either during the morning or evening care to include:<br><br>--Dressing.<br><br>--Bathing/showering.<br><br>--Changing linens.<br><br>--Changing briefs or assisting with toileting.<br><br>--Caring for or using an indwelling medical device like central venous catheter, urinary catheter, feeding tube care, tracheostomy, or ventilator care.<br><br>--Performing wound care.<br><br>-Unlike Contact Precaution which are used by some types of facilities while treating a resident with a resistant organism, EBP:<br><br>--Was intended to be used for the duration of the resident's stay in the facility.<br><br>--Did not require isolation in the room or exclusion from participation in group activities.<br><br>--Provided long term protection for residents and staff even after the infection is resolved.<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 - Many | --These residents could still serve as a source of transmission even after the infection had resolved.<br><br>Review of Resident #95's Face Sheet showed the resident was admitted on [DATE], with diagnoses including respiratory failure, high blood pressure, anxiety, severe obesity, sleep apnea (a sleep disorder that causes breathing to repeatedly stop or become shallow during sleep), heart failure, and tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck. A person with a tracheostomy breathes through a tracheostomy tube inserted in the opening).<br><br>Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 9/27/24, showed the resident:<br><br>-Was alert and oriented without confusion.<br><br>-Was dependent or needed substantial assistance with transferring, bed mobility, ambulation, toileting, bathing and dressing.<br><br>-Had coughing or choking during meals.<br><br>-Received oxygen therapy, suctioning and tracheostomy care.<br><br>Review of the resident's POS dated [DATE], showed physician's orders for:<br><br>-Tracheostomy care every shift and as needed on every shift (9/24/24).<br><br>-High Humidity Tracheostomy Collar: FIO2 28 percent, every shift for shortness of air, change in condition (9/24/24).<br><br>-Clean the non-disposable inner cannula every day shift for shortness of air, change in condition and as needed (9/24/24).<br><br>-Tracheostomy change as needed for shortness of air, change in condition (9/24/24).<br><br>-Change oxygen tubing and set, including drainage bag every night shift every 7 day(s) for shortness of air, change in condition (9/24/24).<br><br>-Suction Tracheostomy as needed for shortness of air, change in condition (9/24/24).<br><br>-Complete Tracheostomy care every shift and as needed for shortness of air (9/24/24).<br><br>-Change disposable inner cannula size 5 every day shift for shortness of air, change in condition and as needed (9/24/24).<br><br>-Keep at bedside for emergency use: a disposable ambu bag (a device used to provide respiratory support to patients in emergency and non-emergency situations), a back up complete tracheostomy set and suction machine (9/24/24).<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 - Many | Observation on 11/18/24 at 11:22 A.M., showed:<br><br>-There was no sign outside of the resident's door identifying the room as needing EBP and there was no PPE outside of the residents door but there was a PPE cart containing gowns and gloves down the hallway.<br><br>-The resident was laying on his/her back in bed with the head of his/her bed up.<br><br>-He/She was alert and oriented with his/her call light within reach.<br><br>-The resident's tracheostomy was clean and the surrounding skin was clean and intact.<br><br>-There was a breathing treatment machine on a dresser against the wall. Next to it was the resident's humidifier machine and beside the humidifier machine was the resident's suction machine.<br><br>During an interview on 11/18/24 at 11:22 A.M. the resident said:<br><br>-The nurse came in cleaned around and checked his/her tracheostomy this morning and it was okay.<br><br>-Nursing staff had changed his/her tracheostomy last night.<br><br>-The nurse said he/she would come back later today to see if he/she needed to be suctioned, but he/she had a breathing treatment this morning and was not congested.<br><br>-He/She only received oxygen as needed, not continuously.<br><br>Observation on 11/21/24 at 10:26 A.M. showed:<br><br>-There was no EBP signage on or by the resident's door and no PPE cart by the resident's door but there was a PPE cart containing gowns and gloves in the hallway.<br><br>-CMT C went into resident room and placed a blood pressure cuff on the resident's wrist. He/She removed it and then gave the resident a cup with medication inside. The resident took his/her medication. CMT C left the room to put the blood pressure cuff away, then grabbed a pair of gloves, re-entered the residents room, applied the gloves and applied the residents pain patch. CMT C then left the resident's room, discarded the gloves at the med cart then re-entered the resident's room and washed his/her hands.<br><br>During an interview on 11/21/24 at 10:26 A.M. CMT C said:<br><br>-They were supposed to wash their hands prior to entering the resident's room and before leaving.<br><br>-Usually if there was a need for EBP the resident had a sign on the door and there was a cart with PPE gowns, gloves, and red bags if needed.<br><br>-If the resident had an infection, they were to gown, glove and if needed use the face mask and eye protection they would wash or sanitize their hands prior to putting gloves on.<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 - Many | -When they had completed care, they were to discard the PPE and sanitize or wash their hands upon leaving the room.<br><br>-They would use EBP on residents with any infections.<br><br>-He/She was not sure they needed to use PPE with residents with catheters, tracheotomies, tube feedings or wounds.<br><br>-He/She did not know that he/she should use PPE or that the resident should be on EBP.<br><br>-He/She usually did sanitize his/her hands prior to entering the resident's room, but he/she hadn't sanitized his/her hands prior to entering the resident's room.<br><br>-He/She usually had gloves on his/her cart, but someone took them and he/she had to go get gloves off of the linen cart and did not sanitize his/her hands upon re-entering the resident's room.<br><br>Observation on 11/21/24 at 11:00 A.M., showed:<br><br>-CNA C sanitized his/her hands then entered the resident's room without gowning or gloving.<br><br>-He/She began assisting the resident and informed him/her they would be getting him/her up after they completed his/her bed bath.<br><br>-CNA C sanitized his/her hands before he/she left the resident's room to get a brief from the linen cart then re-entered the resident's room without washing/sanitizing his/her hands, gowning or gloving.<br><br>-CNA D sanitized his/her hands and entered the resident's room to assist with care without putting on a gown or gloves.<br><br>-At 11:15 A.M., both CNA's exited the resident's room and sanitized their hands. They said they were going to transfer the resident but they went to get the resident's sling and would be back.<br><br>During an interview on 11/22/24 at 9:35 A.M., CNA C said:<br><br>-Usually he/she knew who was on EBP and who was not.<br><br>-They learn who was on EBP from the nurses during their morning meeting and the CNA staff from the prior shift would also inform them during rounds.<br><br>-There was usually a sign on the resident's door and a PPE cart outside the door for those residents on EBP.<br><br>-When they saw the sign on the door they had to sanitize their hands, gown and glove prior to entering the resident's room, and then remove their PPE and sanitize or wash their hands before leaving the 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 - Many | -He/She did not think the resident was on EBP because the nurses did not tell them that EBP was needed and there was no sign on the resident's door or PPE cart indicating EBP was needed.<br><br>6. Review of Resident #84's Face Sheet showed the resident was admitted to the facility on [DATE], with fracture, high cholesterol, depression, and diabetes.<br><br>Review of the resident's quarterly MDS dated [DATE], showed the resident:<br><br>-Was alert and oriented without confusion,<br><br>-Needed moderate to maximum assistance with bathing, dressing and mobilized with a wheelchair.<br><br>-Had no history of or current pressure sores, no other wounds or skin issues, no unhealed pressure sores during lookback period.<br><br>Review of the resident's POS dated [DATE], showed physician's orders for treatment to apply skin prep (a waterproof skin barrier which protects the skin from irritation and trauma resulting from tape or dressing applications) to the resident's left heel and leave it open to air, every day shift for wound care and as needed if dressing becomes soiled or comes off (11/18/24).<br><br>Review of the resident's Wound Care Consult notes dated 11/20/24 showed:<br><br>-The resident was being seen for follow up to a left heel wound.<br><br>-The resident's assessment showed the resident's wound was doing better.<br><br>-There was a scab still present. The plan of care was to continue cleaning with wound cleanser, apply skin prep and leave open to air, wear soft booties, change daily and as needed if dislodged, saturated or soiled.<br><br>-Educated nursing team and/or patient to assess and communicate any significant changes in wound status, noting evidence of wound infection, or acute changes and notify wound provider or primary care provider accordingly.<br><br>-If no evidence of healing within 2 to 4 weeks, re-evaluate plan of care and patient adherence.<br><br>Observation and interview on 11/19/24 at 10:36 A.M., showed the resident was laying down in bed watching tv and resting. The resident said:<br><br>-He/She had a wound on his/her left heel that resulted from being in an immobilizer boot while in the hospital for a fracture.<br><br>-He/She did not have any other wounds.<br><br>-The wound was almost healed and there was only a scab there.<br><br>Observation on 11/20/24 at 9:45 A.M., showed:<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 - Many | -There was no signage showing the resident was on EBP precautions and there was no PPE cart outside of the resident's door.<br><br>-LPN C sanitized his/her hands and LPN D sanitized their hands and went into the resident's room without putting on a gown.<br><br>-Both gloved and LPN C informed the resident they were going to complete his/her wound treatment.<br><br>-LPN C removed the resident's sock on his/her left foot and cleaned the resident's wound then LPN D opened a skin prep packet, raised the resident's left foot and wiped the heel with the skin prep.<br><br>-LPN C discarded his/her gloves, washed his/her hands, re-gloved, then placed the resident's sock back on.<br><br>-LPN D discarded the skin prep packet and wipe and his/her gloves then washed his/her hands.<br><br>-LPN C then discarded her gloves and washed his/her hands.<br><br>7. During an interview on 11/25/24 at 9:42 A.M., RN A said:<br><br>-They just started training on EBP and they were not using the protocols regarding EBP until last Thursday.<br><br>-They did not have an Infection Control Nurse until just recently and the prior Infection Control Nurse did not provide the training on EBP so they were unaware of the new protocols.<br><br>-Anyone with a tracheostomy, tube feeding, catheter, ostomy of any kind, or opening in the body, they were considered to be on EBP and staff was to use a gown, gloves and masks before entering the room.<br><br>-They were only using gowns, and face masks with residents who had infections.<br><br>-They learned they would need to place a sign on the resident's door and PPE cart available.<br><br>During an interview on 11/25/24 at 11:10 A.M., the DON said:<br><br>-Training with staff regarding EBP was just started with the nursing staff and had not been completed with the nursing staff prior to now.<br><br>-Residents with tracheotomies, extensive wounds, and catheters should be on EBP.<br><br>-He/She did not know if they have had an EBP training with the staff yet.<br><br>-They have not been using EBP with residents.<br><br>51303<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 - Many | 8. Review of Resident #72's Admission Record showed he/she initially admitted to the facility 12/24/19 with the following diagnoses:<br><br>-Gastrostomy (surgical creation of a permanent opening into the stomach through the skin for the introduction of nourishment and fluids through a tube).<br><br>-Need for assistance with personal care.<br><br>Review of the resident's care plan with a start date of 12/24/19 showed:<br><br>-The problem of required tube feeding for nutritional needs related to history of cerebrovascular accident (CVA/stroke), Cerebral artery occlusion with infarct (a blockage in the one or more of the arteries supplying blood to the brain resulting in a stroke).<br><br>-He/She was to have Nothing By Mouth (NPO).<br><br>-Activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting) care plan showed a problem the resident was dependent to complete ADLs. The resident was dependent with dressing, bathing, incontinence, and transfers.<br><br>-The care plan did not show EBP precautions with cares.<br><br>Review of the resident's Significant Change MDS dated [DATE] showed:<br><br>-He/She was severely cognitively impaired and required total support from staff.<br><br>-He/She had a gastrostomy tube (G Tube).<br><br>-He/She was dependent for incontinent care, hygiene, shower/bathing, transferring, and dressing.<br><br>Review of the resident's POS dated November 2024 showed:<br><br>-Enteral Feed order as needed. (1/13/20).<br><br>-Enteral Feed Order every 24 hours as need for tube feeding (enteral) Complete tube site care with warm water and soap. (12/24/19).<br><br>-Enteral Feed Order every day and night shift check and record residuals every shift. Hold feeding for 1 hour if greater than 100 Milliliters (mls). Contact physician if residual exceeded 100 mls for three consecutive checks. (1/13/20).<br><br>-Enteral Feed order every day and night shift check tube placement before initiation of formula and medication administration. (1/13/20).<br><br>-Enteral Feed Order every day and night shift for tube feeding complete tube site care with warm water and soap. (12/24/19).<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 - Many | -Enteral Feed order every night shift change syringe tube feeding administration set up and graduate. (1/13/20).<br><br>-Enteral Feed Order NPO, administer Osmolite (nutrition that provides complete, balanced nutrition for long- or short-term tube feeding) 1.5 at 40 mls per hour nocturnally (at night) for 12 hours as tolerated (from 7:00 P. M. to 7:00 A.M.) to provide 480 mls of formula. Routine water flush 30 mls an hour during duration of enteral feeding (12 hours) and routine flush 150 mls at start and completion of enteral feed. (9/62/24).<br><br>-Elevate head of bed (HOB) at 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feed had stopped. (1/13/20).<br><br>-Flush G Tube with 45 to 60 mls before and after administration of medications. (1/25/23).<br><br>-There was not an order for Enhanced Barrier Precautions with cares.<br><br>Observation on 11/18/24 at 11:04 A.M. showed there was no sign on the resident's door for EBP.<br><br>Observation on 11/20/24 at 12:53 P.M. showed LPN B:<br><br>-Had the bedside table set up with supplies for G Tube site care and flush.<br><br>-Spoke to resident and explained the procedure.<br><br>-Performed hand hygiene at sink and donned gloves.<br><br>-ADON B entered room and asked resident if it would be ok to observe care.<br><br>-The head of bed was up at a 30-degree angle.<br><br>-He/She left the room and reentered and performed hand hygiene and donned new gloves.<br><br>-He/She obtained the syringe and pulled back 20 mls air. LPN B then cleaned the G Tube hub and placed syringe into hub and expelled the air with stethoscope close to G Tube site to check for placement.<br><br>-He/She then pulled back on the syringe plunger to assess residual. No residual noted.<br><br>-He/She pulled water into the syringe and pushed the water into the G Tube hub.<br><br>-He/She thanked resident. Rinsed syringe and graduate and set them out to dry upside down.<br><br>-He/She gathered trash, removed gloves, and performed hand hygiene.<br><br>-He/She put on gloves and removed trash from the room then returned, removed gloves and performed hand hygiene again.<br><br>-LPN B did not put on a gown for EBP.<br><br>(continued on next page) |

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|---|---|---|---|
| | 265727 | A. Building<br>B. Wing | 11/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Carmel Hills Wellness & Rehabilitation | 810 East Walnut<br>Independence, MO 64050 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -No sign for EBP noted on the door.<br><br>During an interview on 11/20/24 at 1:02 P.M. LPN B said this was how he/she completed a G Tube flush and care daily.<br><br>Observation on 11/25/24 10:12 A.M. of the resident's door showed no EBP signage and no PPE cart observed on the hall.<br><br>9. Review of Resident #40's Admission Record showed he/she initially admitted to the facility 11/21/18 with the following diagnoses:<br><br>-Quadriplegia (paralysis of all four extremities and usually the trunk)<br><br>-Methicillin Resistant Staphylococcus Aureus (MRSA - a type of bact |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50579<br><br>Based on interview and record review, the facility failed to ensure pneumococcal pneumonia vaccines (a vaccine to protect against pneumococcal disease caused by the bacteria Streptococcus pneumoniae) were offered, administered, or documented for one sampled resident (Resident #95) and failed to ensure an influenza vaccine (an annual vaccine to protect against the influenza virus) was offered, administered, or documented for one sampled resident (Resident #48) out of five residents sampled for vaccination provision. The facility census was 151 residents.<br><br>Review of a facility policy titled Pneumococcal Disease Prevention, dated June 2020 showed:<br><br>-Residents that reside in nursing homes are recommended to have the pneumococcal vaccine.<br><br>-Residents would be assessed for and offered pneumococcal vaccinations.<br><br>-Any vaccine refusals or administrations would be documented in the residents' medical record.<br><br>-Any consent or refusal would be documented in the resident record.<br><br>Review of an undated facility policy titled Influenza Prevention and Control showed:<br><br>-Residents would be offered the influenza immunization during flu season.<br><br>-Any consents or refusals would be documented in the resident record.<br><br>-The vaccine administration would be documented in the medical record of the resident.<br><br>Review of the Centers for Disease Control and Prevention (CDC) Pneumococcal Vaccine Timing for Adults, revised 10/26/24, showed the CDC recommended pneumococcal vaccination for adults [AGE] years old and older.<br><br>Review of the CDC influenza vaccine guidelines, dated 10/3/24, showed the CDC recommended influenza vaccines for everyone 6 months and older each flu season (October through April) with everyone being ideally vaccinated by the end of October.<br><br>1. Review of Resident #95's Admission Record showed:<br><br>-The resident was older than [AGE] years old.<br><br>-The resident had an admitted [DATE].<br><br>-Risk factors of infectious respiratory infections including a diagnosis of respiratory failure and use of a tracheostomy (an implanted device used to assist in getting air into the lungs).<br><br>Review of the resident's immunization report showed:<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -No evidence of pneumococcal vaccination administration dates.<br><br>-The report lacked documentation of education, consent or refusal and administration of the pneumococcal vaccine for which the resident was recommended per the CDC.<br><br>2. Review of Resident #48's Admission Record showed.<br><br>-The resident had an admitted [DATE].<br><br>Review of the resident's immunization report showed:<br><br>-No evidence of influenza vaccination administration dates.<br><br>-The report lacked documentation of education, consent or refusal and administration of the influenza vaccine.<br><br>During an interview on 11/19/24 at 9:29 A.M., the Infection Preventionist (IP) said:<br><br>-Residents should have been screened for pneumococcal immunizations on admission.<br><br>-Influenza vaccines should have been offered to all residents eligible to receive it.<br><br>-The facility had already offered the influenza vaccine to current residents.<br><br>-All administered immunizations should have been documented in the resident medical record.<br><br>-Any refusals should have been signed and documented in the resident's medical record.<br><br>-Residents that were recommended pneumococcal vaccines should have been offered the vaccine by the facility.<br><br>-He/She was responsible for ensuring resident's vaccine status along with refusals were documented and they were offered recommended vaccines.<br><br>During an interview on 11/19/24 at 1:27 P.M., the Director of Nursing (DON) said:<br><br>-Residents should have been screened for pneumococcal immunizations on admission.<br><br>-Residents should be offered the influenza vaccine annually.<br><br>-All administered immunizations should have been documented in the resident medical record.<br><br>-Any refusals should have been signed and documented in the resident's medical record.<br><br>-Residents that were recommended vaccines should have been offered the vaccines by the facility. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50579<br><br>Based on interview and record review, the facility failed to provide education to the resident or the resident's representative and obtain signed consent or refusal of the Coronavirus Disease 2019 (COVID-19), and failed to administer recommended vaccines for three sampled residents (Residents #71, #93 and #95) out of five sampled residents. The facility census was 139 residents.<br><br>Review of the Centers for Disease Control (CDC) Clinical Considerations for COVID-19 Vaccines, dated 10/31/24, showed:<br><br>-Unvaccinated residents (residents who did not receive a multidose vaccine series) should receive a two dose vaccine series.<br><br>-The Moderna COVID-19 vaccine is a two-dose initial vaccine series with recommended boosters thereafter.<br><br>1. Review of Resident #71's medical record showed:<br><br>-An admitted [DATE].<br><br>-A single dose of Moderna COVID-19 vaccine administered 10/27/23.<br><br>-No other COVID-19 vaccine doses.<br><br>-No evidence of a COVID-19 vaccine being offered or administered by the facility.<br><br>-No signed consent or refusal for the COVID-19 vaccine.<br><br>-No evidence of COVID-19 vaccine education provided to the resident or resident ' s representative.<br><br>2. Review of Resident #93's medical record showed:<br><br>-An admitted [DATE].<br><br>-A single dose of Moderna CO3. VID-19 vaccine administered 1/31/24.<br><br>-No other COVID-19 vaccine doses.<br><br>-No evidence of a COVID-19 vaccine being offered or administered by the facility.<br><br>-No signed consent or refusal for the COVID-19 vaccine.<br><br>-No evidence of COVID-19 vaccine education provided to the resident or resident's representative.<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. Review of Resident #95's medical record showed:<br><br>-An admitted [DATE].<br><br>-No COVID-19 vaccination history.<br><br>-No evidence of a COVID-19 vaccine being offered or administered by the facility.<br><br>-No signed consent or refusal for the COVID-19 vaccine.<br><br>-No evidence of COVID-19 vaccine education provided to the resident or resident ' s representative.<br><br>During an interview on 11/19/24 at 9:29 A.M., the Infection Preventionist (IP) said:<br><br>-He/she was responsible for ensuring the completion of COVID-19 vaccinations for residents.<br><br>-Vaccine history was reviewed on admission, including the state vaccine registry.<br><br>-The facility would offer the vaccine to residents able to consent and send letters to the medical representatives of those who were not.<br><br>-Residents that were recommended the COVID-19 vaccine should have received the vaccine.<br><br>-The facility was trying to catch up on offering the vaccine to residents.<br><br>During an interview on 11/19/24 at 1:27 P.M., the Director of Nursing (DON) said:<br><br>-The IP was tasked with infection control, including ensuring the completion of the COVID-19 vaccinations of residents.<br><br>-The IP responsible for ensuring the resident ' s received education, the facility obtained a signed consent, administered the COVID-19 vaccine as appropriate and documented the resident's COVID-19 vaccination status in the medical record.<br><br>-He/she would expect education, signed consents, vaccination administration information and the offering of the COVID-19 vaccination as appropriate to be completed and documented by the facility. |