

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/02/2023
NAME OF PROVIDER OR SUPPLIER Rosewood Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2045 Silverada Blvd Reno, NV 89512	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on observation, interview, clinical record review, and document review, the facility failed to ensure the privacy of resident health information was maintained for 3 of 3 residents whose names were visible under the wounds tab of the electronic health record (EHR) on an unstaffed and open computer screen (Residents #300, #309, and #311).</p> <p>Findings include:</p> <p>Resident #300</p> <p>Resident #300 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute kidney failure, unspecified, type two diabetes mellitus with hyperglycemia, and unspecified asthma, uncomplicated.</p> <p>Resident #309</p> <p>Resident #309 was admitted to the facility on [DATE], with diagnoses including displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, encounter for other orthopedic, aftercare, and emphysema, unspecified.</p> <p>Resident #311</p> <p>Resident #311 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy, acute and chronic respiratory failure with hypoxia, and type two diabetes mellitus with diabetic chronic kidney disease.</p> <p>On 10/30/23 at 1:53 PM, a computer on top of a treatment cart was located outside of room five. The computer was facing the hallway and there were no staff members in the hallway. The computer was logged in to the EHR and three resident names were visible. Residents #300, #309, and #311 were listed under the wounds tab. Two visitors walked by the open computer screen with the residents' names visible while the cart was unattended.</p> <p>On 10/30/23 at 1:55 PM, a Licensed Practical Nurse (LPN) returned to the cart and verbalized the LPN forgot to lock the screen when the LPN had walked away from the cart. The LPN verbalized the screen was supposed to be locked when unattended to maintain resident privacy.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/01/23 at 10:46 AM, the Director of Nursing (DON) verbalized the DON expected staff to log out or lock a screen when walking away from a computer to ensure resident information was not visible.</p> <p>The facility policy titled Use and Disclosure of Protected Health Information, revised 03/2016, documented protected health information would be used and disclosed in a secure, confidential manner.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739</p> <p>Based on clinical record review, interview and document review, the facility failed to prevent resident to resident abuse for 2 of 6 Facility Report Incident (FRI) residents (Resident #45 and #79) and failed to prevent resident neglect for 1 of 6 FRI residents (Resident #47).</p> <p>Findings include:</p> <p>FRI #NV00069544 documented on 09/28/23 a resident grabbed the arm of and tried to hit another resident.</p> <p>Resident #45</p> <p>Resident #45 was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder, anxiety disorder and unspecified convulsions.</p> <p>Resident #79</p> <p>Resident #79 was admitted to the facility on [DATE], with diagnoses including cognitive communication deficit, unspecified dementia, and anxiety disorder.</p> <p>A Nursing Progress Note dated 09/27/23, documented Resident #45 was slamming a door and cussing at Resident #79. Resident #45 tried to grab the arm and hit Resident #79. Both residents were separated. Resident #79 would be moved to a different room.</p> <p>On 11/02/23 at 8:18 AM, the Director of Nursing (DON) confirmed Resident #45 grabbed Resident #79's arm and tried to hit Resident #79. The DON verbalized staff had witnessed the altercation, and it was decided to separate the residents into different rooms.</p> <p>The facility policy titled, Abuse: Prevention of and Prohibition Against, reviewed 10/2022, documented each resident had the right to be free from abuse including abuse from other residents.</p> <p>FRI #NV00069544</p> <p>Cross referenced with tag F656.</p> <p>46301</p> <p>Resident #47</p> <p>Resident #47 was admitted to the facility on [DATE], with diagnoses including traumatic subdural hemorrhage without loss of consciousness, memory deficit following nontraumatic subarachnoid hemorrhage and muscle weakness.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An FRI dated 10/13/23, documented Resident #47 was found the morning of 10/13/23 soaked in urine and the call light was unplugged.</p> <p>On 10/30/23 at 1:42 PM, Resident #47 explained Resident #47 had used the call light the evening of 10/12/23, and the call light was being answered in the beginning of the evening and eventually staff stopped coming into the room even after pressing the call light. Resident #47 verbalized staff never came into the room to provide peri-care.</p> <p>On 11/02/23 at 8:44 AM, a Certified Nursing Assistant (CNA1) verbalized neglect was denying care to a person's needs or not responding to a call light. CNA1 explained on the date of the incident being the CNA coming on shift the morning of 10/13/23 and found Resident #47 soaked in urine. CNA1 verbalized Resident #47 was still in the same position CNA1 had left the resident in from the afternoon before. CNA1 explained having removed and replaced all bedding from the resident's bed and cleaned Resident #47. CNA1 immediately notified the floor nurse and reported the allegation of neglect.</p> <p>On 11/02/23 at 9:35 AM, the DON explained having received a report of Resident #47 being soaked in urine at the change of shift on 10/13/23. The DON confirmed CNA2 had neglected Resident #47 by not providing care for the resident.</p> <p>On 11/02/23 at 10:59 AM, the Administrator explained when the facility was aware of the allegation of neglect the staff was to report to the charge nurse. The Administrator verbalized an investigation was conducted into the allegation of neglect by interviewing staff and other residents. The facility substantiated the allegation of neglect, and CNA2 was terminated.</p> <p>The facility policy titled Abuse: Prevention of and Prohibition Against, reviewed 10/2022, documented each resident had the right to be free from abuse and neglect. The facility would monitor and ensure staff deliver care and services in a way which promotes and respects the rights of the residents to be free from abuse and neglect.</p> <p>Cross reference Tag F656</p> <p>FRI #NV00069641</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>31739</p> <p>Based on document review and interview, the facility failed to submit a Facility Reported Incident (FRI) final report to the State Survey Agency (State) within the five-day requirement for 1 of 7 FRIs investigated.</p> <p>Findings include:</p> <p>FRI# NV00069177 with the allegation a Certified Nursing Assistant had force fed a resident was submitted to the State on 08/09/23. A final investigation report was submitted to the State on 08/17/23, three days past the five-day requirement.</p> <p>On 11/02/23 at 8:33 AM, the Director of Nursing (DON) confirmed having been responsible for submitting the initial and final FRI reports to the State. The DON confirmed the final report for FRI# NV00069177 had been submitted late due to a miscalculation of the dates.</p> <p>The facility policy titled, Abuse: Prevention of and Prohibition Against, reviewed 10/2022, documented the facility would follow the applicable reporting timeframes and regulations of the State or Federal agency for all reports of resident abuse.</p> <p>FRI# NV00069177</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31739</p> <p>Based on clinical record review, interview and document review, the facility failed to ensure Minimum Data Set (MDS) 3.0 assessments were transmitted timely for 5 of 5 sampled residents reviewed for Resident Assessment (Resident #8, #9, #11, #41, and #46).</p> <p>Findings include:</p> <p>Resident #8</p> <p>Resident #8 was admitted to the facility on [DATE], with a diagnosis of cerebral palsy.</p> <p>Resident #8's quarterly MDS assessment documented a start date of 09/26/23 and a completion date of 10/16/23.</p> <p>On 11/02/23 at 9:17 AM, the MDS Coordinator confirmed Resident #8's quarterly MDS assessment dated [DATE] should have been transmitted on 10/23/23 but had not yet been transmitted.</p> <p>Resident #9</p> <p>Resident #9 was admitted to the facility on [DATE], with a diagnosis of dementia.</p> <p>Resident #9's quarterly MDS assessment documented a start date of 09/20/23 and a completion date of 10/10/23.</p> <p>On 11/02/23 at 9:19 AM, the MDS Coordinator confirmed Resident #9's quarterly MDS assessment dated [DATE] should have been transmitted on 10/17/23 but was transmitted on 11/01/23, 15 days late.</p> <p>Resident #11</p> <p>Resident #11 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus with hyperglycemia.</p> <p>Resident #11's quarterly MDS assessment documented a start date of 09/24/23 and a completion date of 10/21/23.</p> <p>On 11/02/23 at 9:21 AM, the MDS Coordinator confirmed Resident #11's quarterly MDS assessment dated [DATE] should have been transmitted on 10/28/23 but had not yet been transmitted.</p> <p>Resident #41</p> <p>Resident #41 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus with diabetic neuropathy.</p> <p>(continued on next page)</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #41's quarterly MDS assessment documented a start date of 09/21/23 and a completion date of 10/11/23.</p> <p>On 11/02/23 at 9:23 AM, the MDS Coordinator confirmed Resident #41's quarterly MDS assessment dated [DATE] should have been transmitted on 10/18/23 but had not yet been transmitted.</p> <p>Resident #46</p> <p>Resident #46 was admitted to the facility on [DATE], with a diagnosis of type II diabetes mellitus with hyperglycemia.</p> <p>Resident #46's quarterly MDS assessment documented a start date of 09/21/23 and a completion date of 10/11/23.</p> <p>On 11/02/23 at 9:25 AM, the MDS Coordinator confirmed Resident #46's quarterly MDS assessment dated [DATE] should have been transmitted on 10/18/23 but was transmitted on 11/01/23, 14 days late.</p> <p>On 11/02/23 at 9:26 AM, the MDS Coordinator verbalized having followed the Resident Assessment Instrument (RAI) Manual timelines for transmission of assessments and quarterly assessments should be transmitted within seven days after the completion of the assessment.</p> <p>The facility policy titled, MDS Completion, Resident Assessment, reviewed 02/2020, documented the facility would follow the RAI Manual for assessment transmission timelines.</p> <p>The MDS 3.0 RAI Manual version 1.17.1, dated October 2019, Section 5.2: Timeliness Criteria, documented for quarterly assessments, transmission encoding must occur within seven days after the MDS assessment completion date.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310</p> <p>Based on clinical record review, interview and document review, the facility failed to ensure 1) care planned interventions related to cognitive functioning were completed and person centered, and care planned interventions related to communication were implemented for 1 of 18 sampled residents (Resident #26), 2) care planned interventions regarding psychotropic medications were medication specific and included the behaviors to be monitored for 1 of 18 sampled residents (Resident #40), 3) a care plan related to the use of bedrails was developed for 1 of 18 sampled residents (Resident #31), and 4) care plans were developed following resident abuse and neglect for 2 of 18 sampled residents (Resident #47 and #45).</p> <p>Findings include:</p> <p>Resident #26</p> <p>Resident #26 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of type II diabetes mellitus.</p> <p>Resident #26's Comprehensive Care Plan included a care plan related to impaired cognitive function/dementia initiated on 05/25/23. Care planned interventions included Needs supervision/assistance with all decision making (Specify) and Resident centered behavioral interventions (Please Specify). The care plan did not document any additional information following the ques to specify and please specify.</p> <p>Resident #26's Comprehensive Care Plan included a care plan related to the resident's risk for a communication problem due to a language barrier. The care plan documented Resident #26 had limited English proficiency (LEP) and interventions included use of a language (phone) line.</p> <p>On 11/02/23 at 8:22 AM, a Hospitality Aide (HA) verbalized the HA tried to speak as much of the resident's language as possible and used short sentences. The HA explained a member of the resident's family visited almost daily and helped some with communication but was rarely at the facility for very long. The HA did not use a language line.</p> <p>On 11/02/23 at 8:23 AM, a Licensed Practical Nurse (LPN) verbalized when the nurse needed to communicate with Resident #26, the LPN asked a CNA or anyone else who spoke Spanish to help. The LPN confirmed the LPN never used the language line to communicate with the resident, including during assessments.</p> <p>On 11/02/23 at 8:25 AM, a Certified Nursing Assistant (CNA), verbalized the CNA communicated with Resident #26 by using hand gestures and explained the resident pointed at things the resident wanted, such as a blanket.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/02/23 at 9:39 AM, the Director of Nursing (DON) verbalized a translation service was to be used when communicating with Resident #26. The DON verbalized when family came to visit and reported the resident had pain, the family could help translate the pain assessments. The DON confirmed translation services were to be used when communicating with the resident, especially when assessments were completed. The DON acknowledged using family, CNAs, and other non-clinical staff for translation during assessments could lead to an inaccurate assessment. The DON confirmed when care planned interventions included specify and please specify information specific to the resident was to be entered into the care plan and when not completed the care plan was incomplete and not person centered.</p> <p>Cross reference with tag F676</p> <p>46301</p> <p>Resident #40</p> <p>Resident #40 was admitted to the facility on [DATE], with diagnoses including major depressive disorder, type 2 diabetes mellitus without complications and restless legs syndrome.</p> <p>Resident #40's Resident Information sheet, from the facility, documented on 03/29/23 the onset diagnosis of schizoaffective disorder.</p> <p>A Physician's Order for Resident #40 originally dated 02/02/23, and order renewed 10/25/23, documented Seroquel tablet, 50 milligrams (mg), give by mouth two times a day related to schizoaffective disorder, unspecified.</p> <p>Resident #40's Comprehensive Care Plan lacked documentation of Seroquel, behaviors to monitor, completed assessments, and the diagnosis associated with Seroquel.</p> <p>Resident #40's clinical record lacked documented evidence of an assessment to determine the resident's change of condition and new diagnosis of schizoaffective disorder requiring the use of psychotropic medications.</p> <p>On 11/01/23 at 9:29 AM, the DON confirmed the care plan was not medication specific and was missing specifics to make the care plan person centered.</p> <p>The facility policy titled, Psychotropic Drug Use, reviewed 08/2017, documented new physician's orders for psychotropic medication would be communicated to the Social Services department for appropriate care planning to ensure updated information in the resident's psychosocial care plan.</p> <p>Cross reference with tag F658 and F758</p> <p>Resident #31</p> <p>Resident #31 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including unspecified cirrhosis of liver, difficulty in walking and unsteadiness of feet.</p> <p>On 10/30/23 at 2:42 PM, Resident #31's bed had half bedrails up on both sides and was in the lowest position.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/01/23 at 3:51 PM, Resident #31 verbalized using the bed rails to get out of bed.</p> <p>Resident #31's physician's order dated 10/02/23, documented bilateral quarter size bed side rails for improved safety/stability during mobility and to decrease risk of falls.</p> <p>Resident #31's Bed Rail Safety Evaluation, dated 10/03/23, documented full bed precautions with low bed and fall mats for injury prevention given the resident's risk of falling.</p> <p>Resident #31's Comprehensive Care Plan lacked documented evidence of a care plan for bedrails, to include the risks, benefits, and evidence of alternatives tried and failed. Resident #31's clinical record lacked documented evidence of an evaluation of the ability to raise and lower the bed rails.</p> <p>On 11/02/23 at 2:04 PM, the DON confirmed a care plan for bed rails was not developed for Resident #31 and should include the risks, benefits, and evidence of alternatives tried and failed.</p> <p>Cross reference with tag F700</p> <p>Resident #47</p> <p>Resident #47 was admitted to the facility on [DATE], with diagnoses including traumatic subdural hemorrhage without loss of consciousness, memory deficit following nontraumatic subarachnoid hemorrhage and muscle weakness.</p> <p>A Facility Reported Incident (FRI) dated 10/13/23, documented Resident #47 was found the morning of 10/13/23 soaked in urine and the call light was unplugged.</p> <p>Resident #47's Comprehensive Care Plan lacked documentation of a care plan related to employee to resident neglect.</p> <p>On 11/02/23 at 9:35 AM, the DON confirmed Resident #47's care plan lacked documentation of employee to resident neglect.</p> <p>Cross reference with tag F600</p> <p>FRI #NV00069641</p> <p>31739</p> <p>Resident #45</p> <p>Resident #45 was admitted to the facility on [DATE], with diagnoses including unspecified convulsions and anxiety disorder.</p> <p>FRI #NV00069544 documented an allegation of a resident-to-resident altercation on 09/28/23 with Resident #45.</p> <p>Resident #45's Care Plan lacked documented evidence of the resident-to-resident altercation and any changes in services or care and outcomes related to the altercation.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/02/23 at 8:18 AM, the DON confirmed Resident #45 had been involved in a resident-to-resident altercation with the resident's roommate resulting in the roommate having been relocated to another room. The DON confirmed Resident #45's Care Plan had not been updated but should have included the altercation outcome and any interventions to prevent further resident to resident altercations.</p> <p>The facility policy titled, Abuse: Prevention of and Prohibition Against, reviewed 10/2022, documented upon the conclusion of a resident-to-resident altercation investigation, the facility would determine what changes would be needed to prevent further occurrences.</p> <p>The facility policy titled, Comprehensive Person-Centered Care Planning, reviewed 01/2022, documented a person centered care plan would be developed to include resident care, objectives, instructions, and outcomes to ensure the quality and proper care of each resident.</p> <p>FRI #NV00069544</p> <p>Cross referenced with tag F600</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on observation, interview, clinical record review, and document review, the facility failed to ensure professional standards of practice were followed during medication preparation and administration for 2 of 3 residents observed during medication administration (Residents #56 and #7) and the practitioner adhered to professional standards of quality for assessing and diagnosing a resident with schizoaffective disorder for 1 of 18 sampled residents (Resident #40).</p> <p>Findings include:</p> <p>Resident #56</p> <p>Resident #56 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including unspecified osteoarthritis, unspecified site and opioid dependence, uncomplicated.</p> <p>On 11/01/23 at 7:30 AM, Resident #56 asked a Licensed Practical Nurse (LPN) for oxycodone. The LPN administered 10 milligrams (mg) of oxycodone to Resident #56. The LPN then asked the resident to rate the pain and where the pain was located.</p> <p>An Order Review History Report for Resident #56 documented oxycodone oral tablet 10 mg, give one tablet by mouth every three hours as needed (prn) for chronic pain for 30 days with a start date of 10/12/23.</p> <p>The Care Plan for Resident #56, initiated 08/10/23, documented the resident was on pain medication therapy and pain medication would be administered as ordered.</p> <p>On 11/01/23 at 8:19 AM, the LPN confirmed the LPN had administered the prn pain medication prior to assessing the location and severity of the resident's pain. The LPN verbalized the LPN was supposed to ask before administering the medication to assess the resident's pain level and location prior to receiving pain medication.</p> <p>On 11/01/23 at 10:42 AM, the Director of Nursing (DON) verbalized the pain level was supposed to be assessed prior to administration.</p> <p>The facility policy titled Pain Recognition and Management, revised 01/2022, documented it was the policy of the facility to ensure pain management was provided to residents who required such services consistent with professional standards of practice. Pain status would be monitored, and the Interdisciplinary Care Plan would reflect the location and type of pain.</p> <p>Resident #7</p> <p>Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type two diabetes mellitus with diabetic neuropathy, unspecified and type two diabetes mellitus with hyperglycemia.</p> <p>(continued on next page)</p>

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/01/23 at 7:36 AM, the LPN began preparing insulin for Resident #7. The LPN applied the needle to the insulin pen and did not scrub the rubber stopper with alcohol prior to applying the needle.</p> <p>On 11/01/23 at 7:38 AM, the LPN confirmed the LPN did not scrub the rubber stopper prior to applying the needle. The LPN verbalized the LPN believed the stopper to already be sterile.</p> <p>On 11/01/23 at 7:46 AM, the LPN administered the insulin to Resident #7. The resident's empty breakfast tray was in front of the resident and the resident asked for a Certified Nursing Assistant to remove the tray.</p> <p>An Order Review History Report for Resident #7 documented insulin Lispro injection solution, inject as per sliding scale, subcutaneously before meals and at bedtime for diabetes mellitus for 30 days.</p> <p>The November 2023 Medication Administration Record for Resident #7 documented insulin Lispro injection solution, inject as per sliding scale subcutaneously before meals and at bedtime. The morning insulin dose was due at 6:30 AM.</p> <p>On 11/01/23 at 10:38 AM, the LPN verbalized the LPN had administered the insulin late and after the resident had eaten breakfast.</p> <p>On 11/01/23 at 10:43 AM, the DON verbalized the rubber stopper on an insulin pen should have been wiped with alcohol to sterilize it prior to inserting the needle. The DON verbalized insulin ordered to be administered prior to meals should have been given before the resident ate breakfast to ensure the insulin was active before eating to effectively lower the blood sugar.</p> <p>The facility policy titled Insulin, Administering, revised 03/2023, documented it was the facility policy to administer all insulin injections in an organized and safe manner. The procedure included checking the physician's order and swabbing the rubber cap with an alcohol sponge.</p> <p>Cross reference with tags F697, F759, and F880</p> <p>46301</p> <p>Resident #40</p> <p>Resident #40 was admitted to the facility on [DATE], with diagnoses including major depressive disorder, type 2 diabetes mellitus without complications and restless legs syndrome.</p> <p>Resident #40's Resident Information sheet, from the facility, documented on 06/04/22 the onset diagnosis of unspecified mood disorder and on 03/29/23 the onset diagnosis of schizoaffective disorder.</p> <p>A Physician's Order for Resident #40 originally dated 02/02/23, and order renewed 10/25/23, documented Seroquel tablet, 50 milligrams (mg), give by mouth two times a day related to schizoaffective disorder, unspecified.</p> <p>The Care Plan for Resident #40 lacked documentation of the Seroquel, behaviors to monitor, completed assessments, and the diagnosis associated with Seroquel.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #40's clinical record lacked documented evidence of an assessment to determine the resident's change of condition and new diagnosis of schizoaffective disorder requiring the use of psychotropic medications.</p> <p>On 11/02/23 at 9:29 AM, the DON verbalized the diagnosis of schizoaffective disorder required an assessment completed prior to the administration of psychotropic medications. The DON confirmed Resident #40's clinical record lacked documentation of an assessment completed documenting the resident's need for the use of a psychotropic medications.</p> <p>On 11/02/23 at 11:32 AM, the Physician verbalized knowing the resident prior to the resident's admission to the facility and had no documentation of an assessment completed prior to the use of Seroquel.</p> <p>The facility policy titled Psychotropic Drug Use, revised 08/2017, documented the definition of indication for use was the identified documented clinical rationale for administering a medication based upon an assessment of the resident's condition.</p> <p>Cross reference with tags F656 and F758</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310</p> <p>Based on observation, interview, clinical record review and document review, the facility failed to offer a non-English speaking resident a communication device and/or provide translation services for 1 of 18 sampled residents (Resident #26).</p> <p>Findings include:</p> <p>Resident #26</p> <p>Resident #26 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of type II diabetes mellitus.</p> <p>Resident #26's Comprehensive Care Plan documented Resident #26 had limited English proficiency (LEP) and interventions included use of a language (phone) line.</p> <p>On 11/02/23 at 8:22 AM, a Hospitality Aide (HA) verbalized the HA tried to speak as much of the resident's language as possible and used short sentences. The HA explained a member of the resident's family visited almost daily and helped some with communication but was rarely at the facility for very long. The HA did not use a language line.</p> <p>On 11/02/23 at 8:25 AM, a Certified Nursing Assistant (CNA), verbalized the CNA communicated with Resident #26 by using hand gestures and explained the resident pointed at things the resident wanted such as a blanket.</p> <p>On 11/02/23 at 8:23 AM, a Licensed Practical Nurse (LPN) verbalized when the nurse needed to communicate with Resident #26, the LPN asked a CNA or anyone else who spoke Spanish to help. The LPN confirmed the LPN never used the language line to communicate with the resident, including during assessments.</p> <p>On 11/02/23 at 9:39 AM, the Director of Nursing (DON) verbalized a translation service was to be used when communicating with Resident #26. The DON verbalized when family came to visit and reported the resident had pain, the family could help translate the pain assessments. The DON confirmed translation services were to be used when communicating with the resident, especially when assessments were completed. The DON acknowledged using family, CNAs, and other non-clinical staff for translation during assessments could lead to an inaccurate assessment.</p> <p>(continued on next page)</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility document titled Language Access Plan (LAP), undated, documented the purpose of the LAP was to describe how the facility provided equitable and meaningful access to the facility's services to individuals with Limited English Proficiency (LEP) in accordance with all applicable laws, including section 1557 of the affordable Care Act (ACA) of 2010. The facility effectively assessed and identified the needs and capacity of residents and informed the resident of the language accessible programs, services and activities offered. Staff were trained in how to access written translations and/or oral language assistance services effectively, accurately, and impartially communicate with individuals with LEP. Individuals were not required to provide interpreters. The facility did not rely on minors to serve as interpreters, and adult friends or family were not required to serve as interpreters.</p> <p>Cross reference with tag F656.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on observation, interview, clinical record review, and document review, the facility failed to ensure resident care was coordinated with a hospice agency for a resident receiving hospice services for 1 of 18 sampled residents (Resident #34).</p> <p>Findings include:</p> <p>Resident #34</p> <p>Resident #34 was admitted to the facility on [DATE], with diagnoses including tubulo-interstitial nephritis, not specified as acute or chronic, quadriplegia, unspecified, and personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits.</p> <p>On 10/30/23 at 10:50 AM, Resident #34 expressed concern the facility did not do what hospice told them.</p> <p>A Physician's order for Resident #34, dated 07/10/23, documented to admit to hospice.</p> <p>The Task: Bathing documented Not Applicable for the dates of 10/20/23 through 10/29/23, in response to the question What type of bathing activity was completed?.</p> <p>A hospice Plan of Care Update Report, dated 10/05/23, documented the resident was receiving home health aide services.</p> <p>The facility Care Plan for Resident #34, initiated 07/10/23, documented the resident was admitted under the care of hospice. The Hospice Nurse would visit two times a week, the hospice aide would visit two times a week, and the hospice social worker would visit one time per month. Nursing and Social Services were responsible for working cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met.</p> <p>On 11/01/23 at 1:08 PM, Resident #34 verbalized the hospice aide came at least twice a week and gave the resident a bed bath.</p> <p>On 11/01/23 at 1:27 PM, the Certified Nursing Assistant (CNA) for Resident #34 verbalized the hospice aides gave the resident bed baths but did not report to the facility CNA after the visit. The CNA verbalized the hospice aide would report to the facility nurse and document care provided in the resident's binder.</p> <p>On 11/01/23 at 1:29 PM, the Licensed Practical Nurse (LPN) for Resident #34 verbalized the LPN did not know how often hospice visited the resident. The LPN verbalized the Licensed Social Worker (LSW) was the hospice coordinator and would know where hospice staff documented care.</p> <p>On 11/01/23 at 1:33 PM, the LSW verbalized the hospice binder was located at the nurse's station and the communication from hospice should have been in the binder.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/01/23 at 1:45 PM, the LSW verbalized the hospice agency had visited Resident #34 earlier in the day and confirmed there was no documentation in the binder indicating what care was provided to the resident. The LSW verbalized the hospice agency was supposed to check in with the facility staff and provide a note in the binder so the facility staff would know what care was provided by hospice staff. The LSW confirmed the binder lacked documentation of any care provided by hospice aides.</p> <p>On 11/01/23 at 3:14 PM, the Director of Nursing (DON) verbalized documentation of care provided by the hospice agency would be in the hospice binder or scanned under the miscellaneous tab in the electronic health record (EHR). The DON confirmed the binder lacked documentation of care provided and the most recent documentation from hospice in the EHR was a nursing visit note dated 10/16/23.</p> <p>The Hospice Services Agreement, effective 06/20/23, documented each party would designate one or more liaisons to facilitate cooperation and communication between the parties to ensure the resident's needs were met. The facility would provide orientation on the policies and procedures of the facility, including appropriate forms and record keeping requirements to hospice staff furnishing care to facility residents under the Agreement.</p> <p>The facility policy titled End of Life Care; Hospice and/or Palliative Care, revised 05/2023, documented hospice services would be integrated into the overall individualized, interdisciplinary plan of care. Collaboration with hospice would include processes for orienting staff to facility policies and procedures including documentation and record keeping requirements.</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on observation, interview, clinical record review, and document review, the facility failed to ensure a resident's pain level and location was assessed prior to the administration of an as needed (prn) narcotic pain medication for 1 of 3 residents observed for medication administration (Resident #56).</p> <p>Findings include:</p> <p>Resident #56</p> <p>Resident #56 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including polyneuropathy, unspecified, unspecified osteoarthritis, unspecified site, and opioid dependence, uncomplicated.</p> <p>On 11/01/23 at 7:30 AM, a Licensed Practical Nurse (LPN) administered 10 milligrams (mg) of oxycodone to Resident #56. After the resident had taken the medication, the LPN asked the resident for the pain level and location of the pain.</p> <p>An Order Review History Report and the November 2023 Medication Administration Record for Resident #56 documented the following:</p> <p>- oxycodone hydrochloride oral tablet 10 mg, give one tablet by mouth every three hours as needed for chronic pain.</p> <p>On 11/01/23 at 8:19 AM, the LPN confirmed the LPN had asked the resident to rate the resident's pain and for the location of the resident's pain after the LPN had already administered the medication. The LPN verbalized the LPN was supposed to ask prior to administering the medication to determine the resident's pain level.</p> <p>On 11/01/23 at 10:42 AM, the Director of Nursing (DON) verbalized a resident's pain level was supposed to be assessed prior to administration of prn pain medications to ensure the medication was appropriate to address the resident's pain.</p> <p>The facility policy titled Pain Recognition and Management, revised 01/2022, documented the facility would assist residents with pain management by interviewing the resident to determine if pain was present and evaluating pain.</p> <p>Cross reference with tags F658 and F759</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46301</p> <p>Based on observation, interview, clinical record review, and document review, the facility failed to ensure residents with bedrails had appropriate alternatives attempted and implemented prior to usage for 1 of 18 sampled residents (Resident #31).</p> <p>Findings include:</p> <p>Resident #31</p> <p>Resident #31 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including unspecified cirrhosis of liver, difficulty in walking and unsteadiness of feet.</p> <p>On 10/30/23 at 2:42 PM, Resident #31's bed had half bedrails up on both sides and was in the lowest position.</p> <p>On 11/01/23 at 3:51 PM, Resident #31 verbalized using the bed rails to get out of bed.</p> <p>Resident #31's physician's order dated 10/02/23, documented bilateral quarter size bed side rails for improved safety/stability during mobility and to decrease risk of falls.</p> <p>Resident #31's Bed Rail Safety Evaluation, dated 10/03/23, documented full bed precautions with low bed and fall mats for injury prevention given the resident's risk of falling.</p> <p>On 11/01/23 at 3:19 PM, the Director of Nursing (DON) explained therapy would complete an evaluation and consent prior to a resident using bed rails. The DON confirmed Resident #31's clinical record lacked documented evidence of alternatives tried and failed.</p> <p>The facility policy titled Bedrail Assessment, revised 08/2017, documented the facility would use appropriate alternatives prior to installing a side or bed rail.</p> <p>Cross reference with tag F656</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46301</p> <p>Based on interview, clinical record review, and document review, the facility failed to ensure a resident on a psychotropic medication had an assessment addressing why the medication was prescribed for 1 of 18 sampled residents (Resident #40).</p> <p>Findings include:</p> <p>Resident #40</p> <p>Resident #40 was admitted to the facility on [DATE], with diagnoses including major depressive disorder, type 2 diabetes mellitus without complications and restless legs syndrome.</p> <p>Resident #40's Resident Information sheet, from the facility, documented on 03/29/23 the onset diagnosis of schizoaffective disorder.</p> <p>A Physician's Order for Resident #40 originally dated 02/02/23, and order renewed 10/25/23, documented Seroquel tablet, 50 milligrams (mg), give by mouth two times a day related to schizoaffective disorder, unspecified.</p> <p>The Care Plan for Resident #40 lacked documentation of the Seroquel, behaviors to monitor, completed assessments, and the diagnosis associated with Seroquel.</p> <p>Resident #40's clinical record lacked documented evidence of an assessment to determine the resident's change of condition and new diagnosis of schizoaffective disorder requiring the use of psychotropic medications.</p> <p>On 11/02/23 at 9:29 AM, the Director of Nursing (DON) verbalized the diagnosis of schizoaffective disorder required an assessment completed prior to the administration of psychotropic medications. The DON confirmed Resident #40's clinical record lacked documentation of an assessment completed documenting the resident's need for the use of a psychotropic medication.</p> <p>The facility policy titled Psychotropic Drug Use, revised 08/2017, documented residents who have not used psychotropic drugs were not given these drugs unless the medication was necessary. The definition of indication for use was the identified documented clinical rationale for administering a medication based upon an assessment of the resident's condition. Psychotropic medications would not be considered only after non-pharmacological interventions had been attempted and failed.</p> <p>Cross reference with tag F656 and F658</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on observation, interview, clinical record review and document review the facility failed to ensure medication was administered with an error rate of less than 5 percent (%). There were 33 opportunities and 11 medication errors. The medication error rate was 33.33%.</p> <p>Findings include:</p> <p>Resident #56</p> <p>Resident #56 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including polyneuropathy, unspecified, unspecified osteoarthritis, unspecified site, and opioid dependence, uncomplicated.</p> <p>On 11/01/23 at 7:30 AM, a Licensed Practical Nurse (LPN) administered 10 milligrams (mg) of oxycodone to Resident #56. After the resident had taken the medication, the LPN asked the resident for the pain level and location of the pain.</p> <p>An Order Review History Report and the November 2023 Medication Administration Record (MAR) for Resident #56 documented the following:</p> <ul style="list-style-type: none"> - oxycodone hydrochloride oral tablet 10 mg, give one tablet by mouth every three hours as needed (prn) for chronic pain. <p>On 11/01/23 at 8:19 AM, the LPN confirmed the LPN had asked the resident to rate the resident's pain and for the location of the resident's pain after the LPN had already administered the medication. The LPN verbalized the LPN was supposed to ask prior to administering the medication to determine the resident's pain level.</p> <p>On 11/01/23 at 10:42 AM, the Director of Nursing (DON) verbalized a resident's pain level was supposed to be assessed prior to administration of prn pain medication to ensure the medication was appropriate to address the resident's pain.</p> <p>On 11/01/23 at 8:08 AM, the LPN administered two tablets of Geri-Kot to Resident #56. The LPN verbalized the resident had an order for senna and Geri-Kot was the same thing.</p> <p>The Order Review History Report and November 2023 MAR documented the following:</p> <ul style="list-style-type: none"> - Senna Plus oral tablet 8.6-50 mg, give two tablets by mouth one time a day for bowel management. <p>The Geri-Kot label documented the following:</p> <ul style="list-style-type: none"> - Each tablet contained Sennosides 8.6 mg. <p>On 11/01/23 at 10:36 AM, the LPN reviewed the MAR and medication label and confirmed the Geri-Kot was not the same medication as senna plus and should not have been administered to the resident.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #7</p> <p>Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type two diabetes mellitus with diabetic neuropathy, unspecified and type two diabetes mellitus with hyperglycemia.</p> <p>On 11/01/23 at 7:36 AM, the LPN began preparing insulin for Resident #7. The LPN applied the needle to the insulin pen and did not scrub the rubber stopper with alcohol prior to applying the needle.</p> <p>On 11/01/23 at 7:38 AM, the LPN confirmed the LPN did not scrub the rubber stopper prior to applying the needle.</p> <p>On 11/01/23 at 7:46 AM, the LPN administered the insulin to Resident #7. The resident's empty breakfast tray was in front of the resident and the resident asked for a Certified Nursing Assistant to remove the tray.</p> <p>An Order Review History Report for Resident #7 documented insulin Lispro injection solution, inject as per sliding scale, subcutaneously before meals and at bedtime for diabetes mellitus for 30 days.</p> <p>The November 2023 MAR for Resident #7 documented insulin Lispro injection solution, inject as per sliding scale subcutaneously before meals and at bedtime. The morning insulin dose was due at 6:30 AM.</p> <p>On 11/01/23 at 10:38 AM, the LPN verbalized the LPN had administered the insulin late and after the resident had eaten breakfast.</p> <p>On 11/01/23 at 10:43 AM, the DON verbalized the rubber stopper on an insulin pen should have been wiped with alcohol to sterilize it prior to inserting the needle. The DON verbalized insulin ordered to be administered prior to meals should have been given before the resident ate breakfast to ensure the insulin was active before eating to effectively lower the blood sugar.</p> <p>The Order Review History Report and November 2023 MAR for Resident #7 documented the following medications were ordered to be administered at 7:00 AM and had not been administered on time:</p> <ul style="list-style-type: none"> - calcium 600 plus D oral tablet, 600-5 mg - micrograms (mcg), give one tablet by mouth one time a day for supplement. - loratadine tablet 10 mg, give one tablet by mouth one time a day for allergy. - probiotic oral capsule, give one capsule by mouth one time a day for supplement. - docusate sodium oral capsule 100 mg, give 100 mg by mouth two times a day for constipation. - famotidine oral tablet 20 mg, give 20 mg by mouth two times a day for dyspepsia. - potassium chloride extended-release tablet, 20 milliequivalents (mEq), give one tablet by mouth two times a day for hypokalemia. <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- gabapentin capsule 300 mg, give one capsule by mouth three times a day for neuropathy.</p> <p>- nystatin powder, apply to groin topically four times a day for yeast rash.</p> <p>On 11/01/23 at 10:38 AM, the LPN confirmed the LPN had not yet administered the 7:00 AM medications and the medications were late.</p> <p>The facility policy titled Administration of Medications, revised 01/2022, documented medication would be administered as prescribed by the resident's physician and as indicated on the MAR. Routine medications would be administered per the facility time ranges within one hour before and one hour after the ordered time frame. Prior to administering the resident's medication, the nurse would compare the drug and dosage schedule on the resident's MAR with the drug label.</p> <p>Cross reference with tags F658, F697, F880</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46301</p> <p>Based on observation, interview and document review, the facility failed to ensure a high temp dishwasher was operating appropriately, and expired food items were discarded. This had the potential to affect the entire facility census.</p> <p>Findings include:</p> <p>Sanitizing Dishwasher</p> <p>On [DATE] at 8:10 AM, during the initial kitchen tour, the dishwasher was making a noise and the dishwasher final rinse cycle rinsed at 178 degrees Fahrenheit.</p> <p>On [DATE] at 8:12 AM, a Cook verbalized all dietary staff was responsible for dishwashing. The Cook verbalized the lower dishwasher sprayers were not working correctly and would get stuck together due to being loose. The Cook was unsure if a work order had been submitted.</p> <p>On [DATE] at 8:43 AM, the Dietary Supervisor verbalized there was no work order for the dishwasher and explained the need to ensure the dishwasher was working properly to sanitize all dishes to avoid illness in the facility. The Dietary Supervisor confirmed the dishwasher final rinse was not getting to 180 degrees Fahrenheit and confirmed the dishes were not being sanitized appropriately if the sprayers were stuck together.</p> <p>Expired Foods</p> <p>On [DATE] at 8:10 AM, in the reach-in refrigerator, there was one container of homemade macaroni salad and was labeled with a prepared date of [DATE].</p> <p>On [DATE] at 8:25 AM, in the dry storage room, there were 12 containers of grits with a use by date of [DATE].</p> <p>On [DATE] at 8:43 AM, the Dietary Supervisor verbalized kitchen staff was responsible for discarding expired foods within three days for leftovers and dry goods to be discarded within three months. The Dietary Supervisor confirmed the macaroni salad should have been discarded by [DATE] and the containers of grits should have been discarded.</p> <p>The facility policy titled, Storage of Food Leftovers, revised ,d+[DATE], documented refrigerated leftover would be used within 48 hours of the original date.</p> <p>The facility policy titled, Dry Storage of Food, revised ,d+[DATE], documented dry goods shall be stored for a period not to exceed three months.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>30748</p> <p>Based on observation, document review, and interview, the facility's Quality Assessment and Performance Improvement (QAPI) committee failed to identify influenza vaccines were not administered in a timely manner after receiving the influenza vaccine supplies. The facility's failure to identify areas in need of performance improvement related to resident vaccinations resulted in 45.11 percent (%) of the facility's residents not being vaccinated for influenza with the potential to affect the health and safety of the residents during the influenza season.</p> <p>Findings include:</p> <p>On 11/02/23 at 1:50 PM, the Administrator confirmed the QAPI committee failed to identify 45.11% of the facility's residents had not been screened for influenza vaccination or had been screened and desired to receive the influenza vaccine and the vaccine was not administered.</p> <p>The facility policy titled, QAPI Plan, dated 2022-2023, documented the QAPI plan was ongoing and comprehensive. The purpose was to correct identified deficiencies in quality series and put mechanisms in place to ensure performance was consistently improved. The plan involved all segments of service and type of care provided by all departments of the facility, including services that impacted clinical care, quality of life, and resident choices.</p> <p>Cross reference with tag F883</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41848</p> <p>Based on observation, interview, clinical record review, and document review the facility failed to ensure appropriate infection control practices were adhered to when preparing an insulin pen for insulin administration for 1 of 3 residents observed for medication administration (Resident #7).</p> <p>Findings include:</p> <p>Resident #7</p> <p>Resident #7 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type two diabetes mellitus with diabetic neuropathy, unspecified and type two diabetes mellitus with hyperglycemia.</p> <p>On 11/01/23 at 7:36 AM, a Licensed Practical Nurse (LPN) began preparing insulin for Resident #7. The LPN applied the needle to the insulin pen and did not scrub the rubber stopper with alcohol prior to applying the needle.</p> <p>On 11/01/23 at 7:38 AM, the LPN confirmed the LPN did not scrub the rubber stopper prior to applying the needle. The LPN verbalized the LPN believed the stopper to already be sterile.</p> <p>On 11/01/23 at 10:43 AM, the DON verbalized the rubber stopper on an insulin pen should have been wiped with alcohol to sterilize it prior to inserting the needle.</p> <p>The facility policy titled Insulin, Administering, revised 03/2023, documented preparing the injection involved swabbing the rubber cap with an alcohol sponge.</p> <p>Cross reference with tags F658 and F759</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310</p> <p>Based on clinical record review, interview, and document review the facility failed to ensure 1) 2 of 5 sampled residents (Resident #308 and #55) were administered a pneumonia vaccine after the vaccine was requested by the residents, 2) 25 of 82 residents residing in the facility were screened for eligibility to receive a pneumococcal vaccination, education regarding the vaccine was provided to the resident and/or the Resident Representative, and the vaccine was offered and either administered or declined, and 3) 12 of 82 residents requesting to receive an influenza vaccine were administered the vaccine. The failure resulted in 45.11 percent (%) of the facility's residents either not being screened and offered the vaccine or not receiving the vaccine after eligibility was determined and the vaccine was requested. This failure had the potential to result in a facility wide outbreak of influenza.</p> <p>Findings include:</p> <p>Pneumonia</p> <p>Resident #308</p> <p>Resident #308 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including encounter for orthopedic after care following surgical amputation, pulmonary hypertension, unspecified, and heart failure unspecified.</p> <p>A document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination, signed by Resident #308's representative on 10/27/23, documented the resident wished to receive a pneumococcal vaccine.</p> <p>Resident #308's facility Immunization Report, dated 10/31/23, documented consent for vaccination with a pneumococcal vaccine was obtained. The Immunization Report lacked documented evidence the vaccine was administered.</p> <p>On 11/01/23 at 9:58 AM, the Infection Preventionist (IP) confirmed Resident #308's Resident Representative signed consent requesting the facility to administer a pneumococcal vaccine to the resident and confirmed a pneumococcal vaccine had not been administered to Resident #308.</p> <p>Resident #55</p> <p>Resident #55 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnosis of nontraumatic ischemic infarction of muscle, right lower leg.</p> <p>A document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination, signed by Resident #55 on 09/21/23, documented the resident wished to receive a pneumococcal vaccine.</p> <p>Resident #55's facility Immunization Report, dated 10/31/23, documented consent for vaccination with a pneumococcal vaccine was obtained. The Immunization Report lacked documented evidence the vaccine was administered.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/01/23 at 10:04 AM, the IP confirmed Resident #55 signed consent and requested to receive a pneumococcal vaccine and a pneumococcal vaccine was not administered.</p> <p>The facility policy titled Immunizations - Residents, last reviewed on 07/2023, documented the facility offered and administered pneumococcal immunizations to eligible residents after providing education and obtaining consents. Vaccination administration details were documented in the residents' medical record when the vaccine was administered.</p> <p>Influenza</p> <p>A facility vaccination status list for influenza, printed on 11/02/23, documented residents' vaccinations status as either received, refused, consented, or screen. Residents marked as consented had been screened and had signed consents requesting the vaccine, but the vaccine had not been administered. Residents marked as screen had not yet been screened for eligibility and the vaccine had not been offered.</p> <p>The form documented 12 of 82 residents (14.63%) had been screened and consented to receive an influenza vaccine and the influenza vaccine was not administered.</p> <p>The form documented 25 of 82 residents (30.48 %) had not been screened or offered vaccination with an influenza vaccine.</p> <p>On 11/01/23 at 10:06 AM, the IP confirmed the facility received the influenza vaccine from the pharmacy on 09/22/23 and confirmed all residents should have been screened and offered the vaccine and/or received the vaccine as requested. The IP confirmed 25 of 82 residents had not been screened for eligibility to receive the vaccine and had not been offered or administered the vaccine. The IP confirmed 12 of 82 residents were screened for eligibility and requested to receive the vaccine and the vaccine was not administered.</p> <p>On 11/02/23 at 1:50 PM, the Administrator confirmed all residents should have been screened and offered the influenza vaccine, and the vaccine should have been administered to residents requesting the vaccine. The Administrator verbalized the Administrator was not aware of the number of residents who had not been screened and was not aware of the number of residents who requested but had not received the influenza vaccine.</p> <p>The facility policy titled Immunizations - Residents, last reviewed on 07/2023, documented the facility offered and administered influenza immunizations to eligible residents after providing education and obtaining consents. Residents were screened at the time of admission and annually during flu season. Each eligible resident was offered a seasonal influenza immunization. Vaccination administration details were documented in the residents' medical record when the vaccine was administered.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43310</p> <p>Based on clinical record review, interview, and document review the facility failed to ensure a COVID-19 (COVID) vaccine was administered as requested for 1 of 5 residents sampled for vaccination administration (Resident #308).</p> <p>Finding include:</p> <p>Resident #308</p> <p>Resident #308 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including encounter for orthopedic after care following surgical amputation, pulmonary hypertension, unspecified, and heart failure unspecified.</p> <p>A document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination, signed by Resident #308's representative on 10/27/23, documented the resident wished to receive a COVID vaccine.</p> <p>Resident #308's facility Immunization Report, dated 10/31/23, documented consent for vaccination with a COVID vaccine was obtained. The Immunization Report lacked documented evidence the vaccine was administered.</p> <p>On 11/01/23 at 9:58 AM, the Infection Preventionist (IP) confirmed Resident #308's Resident Representative signed consent requesting the facility to administer a COVID vaccine to the resident and confirmed the COVID vaccine had not been administered to Resident #308.</p> <p>The facility policy titled Immunizations - Residents, last reviewed on 07/2023, documented the facility offered and administered COVID immunizations to eligible residents after providing education and obtaining consents. Vaccination administration details were documented in the residents' medical record when the vaccine was administered.</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>34524</p> <p>Based on personnel record review, interview, and document review, the facility failed to ensure elder abuse training was completed timely for 7 of 20 sampled employees (Employee #4, #12, #20, #21, #22, #23, and #24).</p> <p>Findings include:</p> <p>Employee #4</p> <p>Employee #4 was hired as the Infection Preventionist on 01/31/23.</p> <p>Employee #4's personnel record documented elder abuse training was completed on 02/02/23.</p> <p>Employee #12</p> <p>Employee #12 was hired as a Certified Nursing Assistant (CNA) on 04/06/23.</p> <p>Employee #12's personnel record documented elder abuse training was completed on 04/13/23.</p> <p>Employee #20</p> <p>Employee #20 was hired as the Registered Dietician on 01/01/23.</p> <p>Employee #20's personnel record lacked documented evidence elder abuse training completed.</p> <p>Employee #21</p> <p>Employee #21 was hired as a Registered Nurse on 01/20/23.</p> <p>Employee #21's personnel record documented elder abuse training was completed on 02/09/23.</p> <p>Employee #22</p> <p>Employee #22 was hired as a Licensed Practical Nurse (LPN) on 03/24/23.</p> <p>Employee #22's personnel record documented elder abuse training was completed on 04/14/23.</p> <p>Employee #23</p> <p>Employee #23 was hired as an LPN on 05/26/23.</p> <p>Employee #23's personnel record documented elder abuse training was completed on 06/29/23.</p> <p>Employee #24</p> <p>(continued on next page)</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employee #24 was hired as a CNA on 05/04/23.</p> <p>Employee #24's personnel record documented elder abuse training was completed on 05/22/23.</p> <p>On 11/01/23 at 3:38 PM, the Human Resources Representative verbalized elder abuse training was to be completed in employee orientation and annually thereafter. The HR Representative confirmed Employees #4, #12, #20, #21, #22, #23, and #24 lacked timely elder abuse training.</p> <p>The facility policy titled Abuse: Prevention of and Prohibition Against, reviewed 10/2022, documented the facility would engage in training and orienting new and existing nursing staff on topics such as prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation.</p>