

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Rio Rancho Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4210 Sabana Grande SE Rio Rancho, NM 87124	

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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46064</p> <p>Based on record review and interview, the facility failed to promote resident choices for 4 (R #14, 49, 59 and 71) of 4 (R #14, 49, 59 and 71) residents reviewed for choices when staff failed to:</p> <ol style="list-style-type: none"> 1. Offer R #14, R #49 and R #59 showers per their preference 2. Offer R #71 to have his bed at his preferred height <p>These deficient practices are likely to result in the resident's personal choices not being honored. The findings are:</p> <p>R #14</p> <p>A. On 02/17/25 at 11:15 AM, during an interview with R #14, he stated, Showers are an issue; I haven't had a shower in a while. It's been bed baths, but I prefer showers.</p> <p>B. Record review of the shower schedule for R #14's hall revealed R #14 should get showers two times a week on Monday and Thursday.</p> <p>C. Record review of R #14's shower sheets dated December 2024, January 2025, and February 2025, revealed staff gave R #14 thirteen bed baths and no showers.</p> <p>D. On 02/20/25 at 11:45 AM, during an interview with the Director of Nursing (DON), she stated The expectation is that if the resident prefers showers, he should be given showers.</p> <p>E. On 02/24/25 at 10:11 AM, during an interview with Certified Medication Aide (CMA) #3, she stated R #4 prefers showers over bed baths.</p> <p>R #59</p> <p>F. On 02/18/25 at 2:08 PM, during an interview with R #59, she stated she only had three bed baths since admission on 12/31/24. She further stated that she would like more because she's the type of person who showered every day at home.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>G. Record review of the shower schedule for R #59's hall revealed R #59 should get showers two times a week on Monday and Thursday.</p> <p>H. Record review of R #59's shower sheets revealed that four bed baths were given to R #59 between her date of admission of 12/31/24 and 02/20/24.</p> <p>I. On 02/20/25 at 11:46 AM, during an interview with the DON, she confirmed that R #59 should have had more than four bed baths, but she did not.</p> <p>39509</p> <p>R #49</p> <p>J. Record review of R #49's face sheet dated 02/24/25 revealed she was admitted to the facility on [DATE] with the following multiple diagnoses:</p> <ul style="list-style-type: none"> -Chronic Kidney Disease-Stage 3 (advanced failure of the kidneys). -Bed Confinement. -Muscle Weakness. -Other abnormalities of gait (ability to stand and walk) and mobility. <p>K. Record review of R #49's Minimum Data Set (MDS: a set of evaluations and review that provide an overall picture of a persons needs and abilities)</p> <p>Section C: Brief Interview of Mental Status (BIMS:assessment used to monitor cognition; 0 to 7 points equals severely impaired cognition, 8 to 12 points equals moderately impaired cognition, and 13 to 15 points equals intact cognition) revealed a score of 15/15 indicating normal cognitive abilities.</p> <p>Section G: indicated impairment of the one side of the body that limits daily functioning. Required substantial/maximal assistance times 3 with toileting, bathing and dressing of upper and lower body.</p> <p>L. Record review of R #49's Bathing Schedule dated December 2024, January 2025 and February 2025 revealed R #49 was to be offered a bath on Wednesday and Saturday evenings of each week.</p> <p>M. Record review of R #49's Shower Sheets (a documentation of each resident's offered bath event) revealed the following:</p> <p>On 12/18/24 bed bath provided and completed.</p> <p>On 01/29/25 bed bath provided and completed.</p> <p>On 02/12/25 bed bath provided and completed.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 02/19/25 bed bath provided and completed.</p> <p>N. On 02/21/25 at 1:55 pm during an interview with R #49, she stated she never gets showered. She stated this was her choice as she felt very unsafe being transferred onto a shower bed (a bed on wheels that is specifically designed to be used when providing a shower to an immobile person) and then being taken to the shower room. R #49 further stated she much preferred to receive a bed bath. She stated she had told all the Certified Nurses Aides (CNA) of this preference. She stated that last time she had a bed bath was about three days before 02/21/25. She stated she could recall once in January and once in December that she had been provided with a bed bath.</p> <p>O. On 02/24/25 at 11:29 am during interview with the Assistant Director of Nursing (ADON), she stated she expects staff to provide bathing to all residents as scheduled. She stated that with each bath, the CNA is to complete a shower sheet and provide to the nurse who then signs the shower sheets and turns it in to her (ADON). ADON further stated she reviewed all the shower sheets for the months of December 2024 and January, and February 2025, ADON was able to find four shower sheets for R #49 that were dated 12/18/24, 01/29/25, 02/12/25 and 02/19/25. She could not find any other documentation that R #49 had received any other showers or baths except those provided. ADON described R #49 as alert, oriented and able to recognize her needs, make her preferences known and recall her past care.</p> <p>41988</p> <p>R #71:</p> <p>P. Record review of R #71's face sheet revealed R #71 was admitted into the facility on [DATE].</p> <p>Q. Record review of R # 71's Minimum Data Set revealed Section C: Cognitive Patterns- Brief Interview for Mental Status (BIMS) dated 01/21/25 revealed R #71 was scored as 15.</p> <p>R. Record review of R #71's nursing progress notes dated 02/24/25 revealed, R #71 refused to put his bed at the lowest position as part of the fall prevention policy.</p> <p>S. Record review of the facility's fall management protocol (facility falls management/prevention policies and procedures) dated 03/15/24 revealed the protocol did not have any indication that all resident beds must be left in the lowest position when not in use to prevent other residents from falling.</p> <p>T. On 02/24/25 at 11:15 am during an interview with R #71, he stated when he leaves his room, he likes to raise his bed to the highest position to prevent other residents from taking things from his bed or lying on his bed. R #71 also stated the facility told him recently (several days prior) that he cannot do that because residents that wander into his room are at risk for falling, if they get on his bed at the highest position. R #71 confirmed that he could operate his bed remote control on his own and he was very upset that the Nurse Educator (NE) #1 just went into his room the day prior to lower his bed to the lowest position when he was leaving his room. R #71 also stated the facility nursing staff told him to lower his bed today.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>U. On 02/24/25 at 5:13 pm during an interview with Registered Nurse (RN) #1, she stated she was instructed by the NE #1 to keep all residents bed at the lowest position when residents are not in their rooms or in their beds. RN #1 also stated that lowering the beds were implemented to prevent wandering residents from falling. RN #1 confirmed R #71 was alert and could operate his be remote control on his own, and he became very upset when told that his bed must remain in a low position when he is not using it.</p> <p>V. On 02/25/25 at 10:22 am during an interview with the NE #1, she stated she was educating all nursing staff to ensure residents bed were at the lowest positions when not in use to prevent other wandering residents from falling out of a bed that was not theirs. The NE #1 stated she explained this new fall policy to R #71 prior to her lowering his bed, and R #71 became very upset. The NE #1 confirmed R #71 can get himself in and out of bed, and the Administrator (ADM) and Director of Nursing (DON) told her to implement this practice several days prior. The NE #1 also confirmed the lowering of residents beds when the beds were not in use, was not documented in the current facility fall policy and procedures.</p> <p>W. On 02/25/25 at 11:48 am during an interview with the ADM, she stated she would find empty beds left in the high position and she did not want the beds on the highest position because it puts other residents at risk for falling if they wandered into that room. The ADM stated this process was intended to be for vacant rooms and not rooms that residents reside in. The ADM confirmed she spoke with R #71 and he was upset with this new process. The new process was not in the current facility fall protocol. The ADM also confirmed she spoke with NE #1 and informed NE #1 to not go into residents rooms and lower their beds without the consent to do so.</p>		

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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>Keep residents' personal and medical records private and confidential.</p> <p>34439</p> <p>Based on observation and interview the facility failed to safeguard clinical record information by leaving Private Health Information (PHI) where unauthorized persons had access to the PHI for 1 (R #49) of 1 (R #49) residents reviewed during random observation. If resident's clinical information is not sufficiently safe guarded, resident's PHI is likely to be viewed by unauthorized residents, visitors and staff. The findings are:</p> <p>A. On 02/24/25 11:15 am during observation Certified Medication Aide (CMA) #1 left the computer screen opened and the narcotic book was visible to R #49's personal information and she left an individual patient's narcotic record face up on the counter at the nurses station.</p> <p>B. On 02/24/25 at 11:16 am during interview, Licensed Practical Nurse (LPN) #1 confirmed the computer screen was opened and the narcotic book was left open and visible to unauthorized residents, visitors and staff. She further confirmed that a narcotic record was left face up at the nurses station. LPN #1 stated that none of these items should have been left out in the open to be viewed by any person that passed by.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</p> <p>Based on observation, record review, and interview, the facility failed to complete a thorough investigation for an allegation of abuse for 1 (R #46) of 1 (R #46) residents reviewed for incidents.</p> <p>If the facility is not adequately investigating allegations of abuse, then corrective action is not implemented to prevent other residents from similar abuse which puts residents at risk of adverse serious outcomes. The findings are:</p> <p>A. Record review of R #46's face sheet revealed R #46 was admitted into the facility on [DATE].</p> <p>B. On 02/21/25 at 1:17 pm during a lunch observation, R #46 told Certified Nursing Assistant (CNA) #2 that the night shift CNA from the night before (02/20/25) was hateful towards him and he was upset by that.</p> <p>C. On 02/21/25 at 1:19 pm during an interview with R #46, he stated the night shift CNA was hateful towards him and told him he could not use his call light for the rest of the night. R #46 confirmed he was upset by that, and he felt bad.</p> <p>D. On 02/21/25 at 1:21 pm during an interview with CNA #2, she stated she reported R #46's allegation of abuse to the Unit Manager (UM) #1, and UM #1 would be talking to R #46 soon.</p> <p>E. Record review of R #46's nursing progress notes reviewed on 02/24/25 revealed no documentation related to the allegation of abuse with the night shift CNA and R #46.</p> <p>F. On 02/24/25 at 11:27 am during an interview with Licensed Practical Nurse (LPN) #1, she stated she was unaware of any incident involving a night shift CNA and R #46. LPN #1 confirmed all allegations of abuse should be reported to the UM #1.</p> <p>G. On 02/24/25 at 4:35 pm during an interview with the Director of Nursing (DON), she stated she was not aware of any incident involving a night shift CNA and R #46. The DON confirmed that all allegations of abuse should be reported so they can be investigated thoroughly by the facility administrative staff.</p> <p>H. On 02/24/25 at 4:55 pm during an interview with UM #1, she stated she was never made aware of the incident involving R #46 and the night shift CNA. The UM confirmed this allegation by R #46 should have been reported to her immediately so the facility could begin an investigation, and the allegation was not reported to her.</p> <p>I. On 02/25/25 at 11:46 am during an interview with the Administrator (ADM), she stated nursing staff should have reported the allegation of abuse involving R #46 and the night shift CNA immediately to her because she is the abuse coordinator and she could begin a thorough investigation. The allegation was not reported to her. The ADM confirmed her investigation and reporting expectations were not met with this allegation of abuse.</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988</p> <p>Based on record review and interview, the facility failed to provide sufficient preparation for discharge for 2 (R #104 and #122) of 2 (R #104 and #122) residents reviewed by:</p> <ol style="list-style-type: none"> 1. Not ensuring the referral for services had been received, accepted and was scheduled to provide care for the resident upon discharge home for R #104. 2. R #122 discharged without and not accepted back to the facility without notice or without other interventions for their behaviors. <p>These deficient practices could likely result in resident not receiving needed services and having to navigate referral process for services unassisted. The findings are:</p> <p>A. Record review of R #104's face sheet revealed R #104 was admitted into the facility on [DATE] and was discharged on [DATE] with Home Health Services (medical care delivered in the patient 's home).</p> <p>B. Record review of R #104's physician orders dated 02/04/25, revealed R #104 was to discharge home with home health care services or outpatient therapy services to provide skilled nursing, wound care, and therapy services.</p> <p>C. Record review of R #104's care plan meeting progress notes dated 02/05/25, revealed the facility's Social Services Director (SSD) was to send a home health care referral for R #104 prior to R #104 discharge.</p> <p>D. Record review of R #104's customer notes history (messages between the facility's SSD, Social Services Assistant (SSA), and a third party social worker used for resident discharge services) revealed the following:</p> <ul style="list-style-type: none"> - 02/06/25 at 5:22 pm: Third party social worker informed the facility's SSD and SSA that home health care was ordered for R #104. - A follow-up note was not provided until 02/21/25, which stated R #104 had been accepted by the home health agency, but a start date was not confirmed. <p>E. Record review of R #104's undated facility discharge transition plan revealed R #104 was to begin home health services with an estimated start date of 02/13/25.</p> <p>F. On 02/21/25 at 1:50 pm during an interview with R #104, she stated she was discharged without any home health services and she needed them. R #104 stated the facility just sent me home, that's it.</p> <p>G. On 02/21/25 at 1:53 pm during an interview with R #104's son, he confirmed R #104 did not have home health services set up when she was discharged from the facility. R #104's son stated R #104 needed home health services.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>H. On 02/21/25 at 2:48 pm during an interview with the facility's SSD, she stated the facility used a third party company to assist with setting up home health services for residents when the residents are discharged from the facility. The SSD also stated that the social worker used by the third party company is required to communicate with the facility if there are any changes involving a resident that discharges and home health services. The facility SSD or SSA should also check to ensure a resident had home health services in place prior to discharge.</p> <p>I. On 02/21/25 at 3:10 pm during an interview with the Home Health Patient Care Coordinator (PCC), she stated they did not accept R #104's insurance (on 02/06/25) and therefore R #104 was never provided home health services with them as expected by the facility.</p> <p>J. On 02/24/25 at 11:46 am during an interview with the facility's SSD, she stated the home health agency that was selected for R #104 did in fact reject R #104's insurance and was not providing home health services as expected. The facility's SSD confirmed that both the facility SSD and SSA, as well as the third party company were all responsible for R #104 not having home health services upon her discharge from the facility. The facility's SSD confirmed home health services should have been established for R #104 when R #104 discharged from the facility and home health services were not set up.</p> <p>K. On 02/25/25 at 11:51 am during an interview with the Administrator (ADM), she stated her expectation is for the facility's SSD and/or SSA to follow up with the home health provider to ensure a resident has home health services established prior to being discharged from the facility.</p> <p>46064</p> <p>L. Record review of R #122's facesheet revealed re-admitted [DATE] and was discharged on [DATE].</p> <p>M. Record review of the facility's staff note dated 11/21/24 at 5:13 am revealed (Backnote for 11/20-21 approx 2045 to 0130) (8:45 pm to 1:30 am) Resident called 911 on her own phone and provider was made aware. No orders but request for notification if resident goes to hospital. Police and fire and rescue arrived at 0115 (1:15 am) and transported per stretcher to [name of local hospital] at 0130 (1:30 am).</p> <p>N. On 02/24/25 at 1:52 PM during an interview with the Director of Nursing (DON), she stated R #122 had been sent out to the emergency room due to physical aggression toward staff and her understanding was that R #122 was discharged home when she left the hospital. DON confirmed that the facility was not going to allow R #122 back to the facility because of her behaviors.</p> <p>O. On 02/25/25 at 10:17 am during an interview, the Hospice Registered Nurse (HRN) stated [name of R #122] called 911 herself because she was not feeling well. R #122) said the facility was not doing anything.</p> <p>P. On 02/25/25 at 11:15 am during an interview with R #122's son, he stated his mother (R # 122) had called him and said she was in the ER. R #122 informed him that the facility was not take her back and they had given her a discharge notice. He further stated he had called [name of facility] and was told that his mother was given an immediate discharge notice due to her behaviors and they would not allow her back into the facility.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Q. On 02/25/25 at 12:19 pm during interview with the Administrator (ADMIN), stated R #122 called 911 herself. R #122 made the decision to go to the hospital. She was provided an immediate discharge notice at the hospital and was told the discharge was due to The safety of individuals in the facility is endangered due to the clinical behavioral status of the resident and would not be allowed to return to the facility.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46064</p> <p>Based on record review and interviews, the facility failed to ensure staff revised the care plans for 6 (R #'s 4, 14, 31, 61, 104, and 108) of 6 (R #'s 4, 14, 31, 61, 104, and 108) residents reviewed when staff failed to:</p> <ol style="list-style-type: none"> 1. Update R #4's plan of care to include Hospice Care. 2. Conduct a quarterly care plan meeting as required for R #14 in accordance with his admitted and Minimum Data Set (MDS)assessment. 3. Update R #31's plan of care to include dialysis (artificial way to eliminate waste and excess fluid from the body). 4. Ensure care plan was updated to reflect R #61's current diet. 5. Update R #104's plan of care to include diabetic management and insulin use, pain management and narcotic use, and oxygen (O2) use. 6. Update R #108's plan of care to include O2 use. <p>This deficient practice is likely to result in staff not being aware of residents' care needs and preferences, and residents not receiving the needed care. The findings are:</p> <p>R #4:</p> <ol style="list-style-type: none"> A. Record review of R #4's electronic medical record (EMR) revealed a physicians order dated 11/27/24, R #4 was admitted to [name of hospice provider]. B. Record review of R #4's most recent Care Plan dated 01/30/25 revealed Hospice Care was not care planned. C. On 02/20/25 at 11:40 AM, during an interview with the Director of Nursing (DON), she verified R #4's Hospice Care was not care planned and should be. D. Record review of EMR revealed R #4's Hospice Services were not care planned. <p>R #14</p> <ol style="list-style-type: none"> E. On 02/17/25 at 11:29 AM, during an interview with R #14, he stated he has not had a care plan meeting in over a year. F. On 02/20/25 at 12:08 PM, during an interview with the Social Services Director (SSD), she stated R #14's last care plan meeting was on 8/18/23. She further stated R #14's care plan meeting was overdue and care plan meetings should take place quarterly. <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>G. On 02/25/25 at 12:15 PM, during an interview with the Administrator (ADMIN), she stated care plan meetings should be done quarterly.</p> <p>34439</p> <p>R #61</p> <p>H. Record review of R #61's care plan created on 08/16/24 revealed double portion breakfast.</p> <p>I. Record review of R #61's Nutritional assessment dated [DATE] revealed [name of R #61] .has declined any dietary intervention at this time.</p> <p>J. Record review of R #61's current Physicians orders dated 01/27/25 revealed, regular/liberalized diet, Regular Texture, standard thin liquids consistency</p> <p>K. On 02/24/25 at 1:06 pm during an interview with the Dietary Manager (DM), she stated. He [R#61] does not always eat very good, so I give him double portions, he needs to eat. The dietician is aware of this and he was on double portions before. When R #61 went to the hospital those orders for double portions came off the orders, but I continue to serve him double portions. If we are offering double portions it has to be ordered through the dietician for weight gain. I am serving him double portions without an order. DM further stated. The care plan should be updated to reflect what he is ordered.</p> <p>41988</p> <p>R #31:</p> <p>L. Record review of R #31's face sheet revealed R #31 was admitted into the facility on [DATE].</p> <p>M. Record review of R #31's physician orders dated 02/05/25, revealed R #31 received dialysis on Tuesday, Thursday, and Saturday.</p> <p>N. Record review of R #31's care plan dated 02/17/25 revealed dialysis services was not care planned.</p> <p>O. On 02/25/25 at 11:24 am during an interview with Registered Nurse (RN) #1, she confirmed R #31 received dialysis three times a week.</p> <p>P. On 02/25/25 at 12:04 pm during an interview with the DON, she stated that dialysis was not care planned for R #31 and should have been.</p> <p>R #104:</p> <p>Q. Record review of R #104's face sheet revealed R #104 was admitted into the facility on [DATE] with the following diagnoses:</p> <p>1. Diabetes.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Pain.</p> <p>3. Rheumatoid Arthritis (a chronic autoimmune disease that causes pain, swelling, stiffness, and loss of function in joints).</p> <p>R #104 was discharged on [DATE].</p> <p>R. Record review of R #104's physician orders dated 01/14/25, revealed the following:</p> <p>1. Insulin Glargine-yfqn injector 100 unit/milliliter (ml); inject 10 units at bedtime.</p> <p>2. Oxycodone (narcotic) oral tablet 5 milligram (mg); give one tablet by mouth every four hours as needed for pain.</p> <p>3. O2 at 0.5 to 1.5 liters per minute (LPM) via nasal cannula (thin, flexible tube that provides O2 through ones nose) continuously.</p> <p>S. Record review of R #104's care plan dated 01/17/25, revealed R #104's diabetic management and insulin use, pain management and narcotic use, and O2 use was not care planned.</p> <p>T. On 02/24/25 at 4:43 pm during an interview with the DON, she confirmed R #104's diabetic management and insulin use, pain management and narcotic use, and O2 use was not care planned and should have been.</p> <p>R #108:</p> <p>U. Record review of R #108's face sheet revealed R #108 was admitted into the facility on [DATE], and was discharged on [DATE].</p> <p>V. Record review of R #108's physician orders dated 02/11/25, revealed R #108 used O2 as needed at 2 LPM via nasal cannula.</p> <p>W. Record review of R #108's care plan dated 02/03/25, revealed R #108's O2 use was not care planned.</p> <p>X. On 02/24/25 at 4:45 pm during an interview with the DON, she confirmed R #108's O2 use was not care planned and should have been.</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** 41988</p> <p>Based on record review and interview, the facility failed to meet professional standards of quality for 1 (R #46) of 1 (R #46) residents when hospice services (a type of compassionate care provided to individuals who are in the final stages of a terminal illness) were provided without physician orders.</p> <p>If the facility is not obtaining physician orders prior to initiating hospice services, then residents are likely to not receive the therapeutic benefits and care needed. The findings are:</p> <p>A. Record review of R #46's face sheet revealed R #46 was admitted into the facility on [DATE].</p> <p>B. Record review of R #46's care plan dated 01/07/25 revealed R #46 was receiving hospice care services.</p> <p>C. Record review of R #46's physician orders revealed physician orders were not present for hospice care services.</p> <p>D. On 02/24/25 at 4:35 pm during an interview with the Director of Nursing (DON), she stated R #46 started hospice services on 02/01/25. The DON also stated that there should have been physician orders for hospice care prior to R #46 starting, and there was not.</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** 39509</p> <p>Based on observations, record review and interview, the facility failed to ensure that 1 (R #114) of 1 (R #114) resident was provided treatment and care to maintain her overall well-being. The facility failed to ensure that resident's brief was changed and she was repositioned to prevent the development of a wound. The findings are:</p> <p>A. On 02/18/25 at 9:30 am during observation of the long term care unit, R #114 sat in her room, in her wheelchair with her son sitting next to her. She was non-responsive and slumped over to her right side while sitting in her wheelchair.</p> <p>B. Record review of R #114's Face Sheet dated 02/24/25 revealed R #114 was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Cerebral Infarction (stroke) due to embolism (blockage of a blood vessel). -Dysphagia (difficulty swallowing). -Encephalopathy (a brain disease that alters brain function or structure). <p>C. Record review of R #114's Minimum Data Set (MDS:a set of assessments that provides an overall review of a resident's needs and abilities) quarterly item set dated 01/23/25, revealed the following:</p> <ul style="list-style-type: none"> -Section C Cognitive Patterns (thoughts and memory) Brief Interview for Mental Status (BIMS) score 00/15 (indicates significant impairment of recall) -Section G Functional Abilities (ability to perform daily care needs) Mobility devices-wheelchair, Eating-Substantial/Maximal Assistance (helper does more than half the effort), Toileting-Dependent (helper does all the effort. Shower/Bath-Substantial/Maximal Assistance, Personal Hygiene-Dependent. <p>Mobility-Roll left and right-Substantial/Maximal Assistance, Sit to Lying-Substantial/Maximal Assistance, Lying to Sitting on side of bed-Substantial/Maximal Assistance.</p> <ul style="list-style-type: none"> -Section H Bladder and Bowel (continence status) Urinary continence-always incontinent, Bowel continence-always incontinent <p>D. Record review of R #114's care plans revealed the following:</p> <ul style="list-style-type: none"> -12/05/24 (name of R #114) is at risk for decreased ability to perform ADL's (Activities of Daily Living: daily care needs necessary for each person every day to maintain health and well-being). Bed mobility max (maximum) assist, eating max assist, Oral hygiene max assist, Resident is an extensive assist for feeding, Shower/bath max assist, toilet hygiene dependent assist. <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>-12/05/24 (name of R #114) is at risk for skin breakdown related to limited mobility. [NAME] (in-house acquired) MASD (Moisture Associated Skin Damage) (Skin damaged by excess moisture in a specific location) left gluteus (buttock). Apply barrier cream with each cleansing, assist resident in turning and reposition prn (as needed).</p> <p>-02/12/25 R #114 is incontinent of urine and is unable to cognitively or physically participate in a retraining program. Assist with perineal (area of the body between the genitals and anus) care as needed, Monitor for skin redness/irritation and report as indicated. Use absorbent products (briefs, diaper) as needed.</p> <p>E. On 02/18/25 at 9:30 am during an interview with R #114 and her son, her son stated that he and his sister visited R #114 almost daily and spend at least an hour with her for each visit. He reported that he had on several occasions come to visit and found his mother lying in bed or sitting in her wheelchair with an odor of urine. He stated he usually asks the staff to change her brief as needed.</p> <p>F. On 02/19/25 at 2:19 pm during interview with Wound Care Nurse (WCN), he stated he was a Registered Nurse who was trained and qualified to assess and treat wounds as needed. He stated he was familiar with R #114. WCN stated R #114 had been admitted to the facility following a stroke. He stated she was significantly impaired and she was now incontinent of bowel and bladder leading the her using a brief at all times. He stated that from his assessment, R #114 had developed a wound to the gluteus/buttock area that was first identified on or about 02/12/25 and first measured as 11.67 x 14.4 centimeters (cm). He stated this wound was the result of moisture that was allowed to build up and collect in her brief between brief checks and changes. He stated the wound had been assessed and was being treated successfully. He stated the wound most likely developed because R #114 was not assisted with changing positions in her bed or wheelchair-moving from one side to another-and due to staff not checking and changing her brief as frequently as necessary.</p> <p>G. On 02/24/25 at 1:54 pm during interview with R #114's daughter, she stated she frequently visited her mother. She stated she had often arrived for visits to find that her mother was wearing a wet/soiled brief. Daughter stated she has always asked staff to check her, but she does not believe this is happening as frequently as necessary.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509</p> <p>Based on observation, record review and interview the facility failed to ensure that 1 (R#58) of 1 (R #58) resident was provided with a device to reduce injury from falling. The facility failed to provide a fall mat (a soft cushion placed on the floor next to the bed to help absorb the impact of a fall and reduce injury) at the side of R #58's bed is likely to result in a resident incurring greater injury should he fall.</p> <p>The findings are:</p> <p>A. Record review of R #58's face sheet dated 02/25/25, revealed R #58 was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Diabetes Mellitus (failure of the body to properly mange blood sugars). -Repeated Falls. -Acquired Absence of Left Leg Above Knee (amputated left leg). <p>B. Record review of R #58's daily care notes dated 12/10/24, 12/17/24, 01/22/25, 01/27/25 and 02/12/25, revealed R #58 had falls from his bed to the floor.</p> <p>C. Record review of R #58's care plan dated 12/12/24 revealed R #58's plan to prevent falls included a fall mat.</p> <p>D. On 02/18/25 at 10:06 am during observation of R #58 in his room, R # 58 laid in bed in with a special beveled mattress (a mattress that is shaped with upturned edges to prevent a person from rolling out of bed). Next to his bed was a wheelchair. A fall mat was not on the floor of either side of the bed.</p> <p>E. On 02/20/25 at 1:00 pm during observation of R #58's room and interview with Director of Nursing (DON), R #58 laid in his bed, a fall mat was not on the floor. DON confirmed there was not a fall mat on the floor beside R #58's bed.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>34439</p> <p>Based on record review and interview, the facility failed to ensure a portable oxygen tank was filled with oxygen for 1 (R #61) of 1 (R #61) residents reviewed for respiratory care (use of oxygen). This deficient practice is likely to affect residents with COPD (chronic obstructive pulmonary disease), shortness of breath and dependence on supplemental oxygen by not supplying enough oxygen in order to prevent hypoxia (decreased oxygen to the body). The findings are:</p> <p>A. On 02/17/25 at 11:22 AM, during an interview, R #61 stated the portable oxygen tank leaks, does not hold oxygen and he is unable to use it. He further stated he has mentioned the oxygen tank leak to several staff, but nothing has been done about it. He would like it to be available in case he were to need the oxygen.</p> <p>B. Record review of R #61's physicians order dated 02/01/25, revealed 2l (liters) via NC (nasal cannula-tube used to deliver the oxygen) to keep O2(oxygen) SATS (saturation-the percentage of oxygen in your blood) greater than 92% (percent) PRN (as needed).</p> <p>C. Record review of R #61's medical diagnosis revealed COPD (Chronic Obstructive Pulmonary Disease-lung condition caused by damage to the lungs).</p> <p>D. On 02/21/25 at 11:06 AM, during an interview, Certified Medication Aide (CMA) #2 stated He (R #61) hardly ever uses the oxygen and does not use oxygen very often. He further stated the portable tank should be full at all times and ready for use. He thought R #61's portable tank was full at the time of this conversation and confirmed the oxygen tank was empty.</p> <p>E. On 02/21/25 at 11:24 AM, during an interview and observation with Registered Nurse (RN) #1, RN #1 confirmed R #61's portable oxygen tank was empty. RN #1 confirmed oxygen tanks should always be full and available for the residents use.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509</p> <p>Based on record review and interview, the facility failed to ensure drug regimen review were completed for 3 (R #7, R #27, and R #67) of 5 (R #7, R #13, R #27, R #67, and R #89) residents reviewed.</p> <p>The failure to review and consider resident medication regimens each month could result in residents receiving unnecessary or ineffective medications. The findings are:</p> <p>R #7</p> <p>A. Record review of R #7's face sheet dated 02/24/25, revealed R #7 was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Diabetes mellitus (a chronic disease in which the body is unable to properly process sugars in the blood). -Pain. -Schizophrenia (a chronic psychiatric disease that affects a person's ability to think and feel rationally). -Bipolar Disorder (a chronic psychiatric disease that affects a person's mood). -Paranoid Personality (a psychiatric disease that causes a person to be suspicious and fearful without reason or cause). -Overactive Bladder. <p>B. Record review of R #7's pharmacist recommendation dated 03/29/24, revealed the recommendation for modification of medications for Eliquis (a medication prescribed to manage mood and depression) and Aspirin (a medication prescribed to reduce blood clotting) review by the provider to determine the therapeutic value of continuing the medications together. The document does not indicate the recommendation was reviewed by the provider and did not contain a signature confirming that the provider received the recommendation or responded to the recommendation.</p> <p>C. Record review of R #7's pharmacist recommendation dated 04/30/24, revealed the recommendation for Prazosin (a medication prescribed to behaviors and Post Traumatic Stress Disorder), 1 milligram (mg), three times daily should be reviewed and considered for gradual dose reduction (GDR: modest reduction in the daily dosage of a medication). The document did not indicate the recommendation was reviewed by the provider and did not contain a signature confirming that the provider received the recommendation or responded to the recommendation.</p> <p>(continued on next page)</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>D. Record review of R #7's pharmacist recommendation dated 07/30/24, revealed the recommendation for Pantoprazole (a medication prescribed for treatment of excess stomach acid) 40 mg, twice daily, recommended to reduce the high daily dose. The document did not indicate the recommendation was reviewed by the provider and did not contain a signature confirming the provider received the recommendation or responded to the recommendation.</p> <p>E. Record review of R #7's pharmacist recommendation dated 07/30/24, revealed the recommendation for the provider to consider an order for blood sample to measure HgbA1C (a lab that indicates the efficacy of blood sugar monitoring and treatment) to monitor resident's diabetic therapy. The document did not indicate the recommendation was reviewed by the provider and did not contain a signature confirming that the provider received the recommendation or responded to the recommendation.</p> <p>F. Record review of R #7's pharmacist recommendation dated 09/25/24, revealed the recommendation for Pantoprazole (a medication prescribed for treatment of excess stomach acid) 40 mg twice daily to reduce the high daily dose. The document did not indicate the recommendation was reviewed by the provider and did not contain a signature confirming that the provider received the recommendation or responded to the recommendation.</p> <p>G. Record review of R #7's pharmacist recommendation dated 09/25/2, revealed the recommendation for the provider to consider an order for blood sample to measure HgbA1C to monitor resident's diabetic therapy. The document did not indicate the recommendation was reviewed by the provider and did not contain a signature confirming that the provider received the recommendation or responded to the recommendation.</p> <p>R #27</p> <p>H. Record review of R #27's pharmacist recommendation dated 05/31/24, revealed the recommendation for Quetiapine (a medication prescribed to manage depression) 50 mg and Prazosin 2 mg should be reviewed and considered for GDR. The document did not indicate the recommendation was reviewed by the provider and did not contain a signature confirming the provider received the recommendation or responded to the recommendation.</p> <p>R #67</p> <p>I. Record review of R #67's pharmacist recommendation dated 04/30/24, revealed the recommendation for Hydroxyzine (a medication prescribed to reduce anxiety) 50 mg should be reviewed and considered for GDR. The document did not indicate the recommendation was reviewed by the provider and did not contain a signature confirming the provider received the recommendation or responded to the recommendation.</p> <p>J. Record review of R #67's pharmacist recommendation dated 08/29/24, revealed the recommendation for Hydroxyzine prescribed PRN cannot exceed 14 days without a renewal order and rationale to continue. The document did not indicate the recommendation was reviewed by the provider and did not contain a signature confirming the provider received the recommendation or responded to the recommendation.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>K. Record review of R #67's pharmacist recommendation dated 09/26/24, revealed the recommendation for the provider to consider an order for blood sample to measure HgbA1C (a lab that indicates the efficacy of blood sugar monitoring and treatment) to monitor resident's diabetic therapy. The document did not indicate the recommendation was reviewed by the provider and did not contain a signature confirming the provider received the recommendation or responded to the recommendation.</p> <p>L. Record review of R #67's pharmacist recommendation dated 10/29/24, revealed the recommendation for Olanzapine (a medication prescribed to manage psychiatric conditions) 5 mg daily should be reviewed and considered for GDR. The document did not indicate the recommendation was reviewed by the provider and did not contain a signature confirming the provider received the recommendation or responded to the recommendation.</p> <p>M. On 02/24/25 at 3:50 pm during interview, the Director of Nursing (DON) stated she would expect all pharmacist recommendations to have been reviewed by the provider and that the provider would enter a response to each recommendation and then sign each recommendation. DON confirmed that the pharmacist recommendations that were reviewed and cited did not contain the required provider responses or signatures.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>39509</p> <p>Based on observation, record review and interview the facility failed to administer medications for 2 (R #49 and R #67) of 4 (R #49, R #67, R #85 and R #105) residents with an error rate less than 5%. The facility administered 15 of 33 observed medications late for an error rate of 45.45%.</p> <p>Failure to administer medications without error could result in residents not receiving maximum benefit of their prescribed medications. The findings are:</p> <p>R #49</p> <p>A. On 02/21/25 at 8:34 am, during an observation of R #49 morning medications administration, R #49 received Methacarbamal (a medication prescribed to muscle spasms) 500 mg (milligram).</p> <p>B. Record review of R #49's Medication Administration Record (MAR) dated February 2025, revealed methacarbamal was to be administered at 7:00 am.</p> <p>C. On 02/21/25 at 8:34 am, during interview, Certified Medication Aide (CMA) #1 stated methacarbamal was to be administered at 7:00 am and the medication would be considered late if administered more than one hour after the assigned administration time. She confirmed giving the medication at 8:34 am would be late administration.</p> <p>R #67</p> <p>D. On 02/ 24/25 at 8:55 am, during an observation of R #67 morning medications administration, R #67 received the following medications:</p> <ul style="list-style-type: none"> -Amlodipine (a medication prescribed to treat blood pressure) 5 mg. -Baclofen (a medication prescribed to treat muscle spasms) 10 mg. -Dorzolomide Optic Solution (a medication prescribed to treat eye conditions) one drop each eye. -Brimonidine Optic Solution (a medication prescribed to treat eye conditions) one drop each eye. -Claritin (a medication prescribed to treat allergies)10 mg. -Cranberry Capsule (a medication prescribed to prevent urinary tract infection) 425 mg. -Duloxetine (a medication prescribed to treat depression) 60 mg. -Finasteride (a medication prescribed to treat enlarged prostate) 5 mg. -Fluticasone Nasal Spray (a medication prescribed to treat nasal congestion) one spray each nostril. <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 - Some</p>	<p>-Gabapentin (a medication prescribed to treat pain) 300 mg.</p> <p>-Keppra (a medication prescribed to treat seizure disorder) 500 mg.</p> <p>-Losartan (a medication prescribed to treat blood pressure) 50 mg.</p> <p>-Lubiprostone (a medication prescribed to treat gastritis) 24 micrograms (mcg).</p> <p>-Senna (a medication prescribed to prevent constipation) 8.6 mg.</p> <p>E. Record review of R #67's MAR dated February 2025 revealed each of the following medications were scheduled to be administered at 7:00 am:</p> <p>-Amlodipine 5 mg,</p> <p>-Baclofen 10 mg,</p> <p>-Dorzolomide Optic,</p> <p>-Brimonidine Optic,</p> <p>-Claritin 10 mg,</p> <p>-Cranberry Capsule 425 mg,</p> <p>-Duloxetine 60 mg,</p> <p>-Finasteride 5 mg,</p> <p>-Fluticasone Nasal Spray,</p> <p>-Gabapentin 300 mg,</p> <p>-Keppra 500 mg,</p> <p>-Losartan 50 mg,</p> <p>-Lubiprostone 24 mcg,</p> <p>-Senna 8.6 mg.</p> <p>F. On 02/24/25 at 8:55 am during interview, CMA #2 stated she was late with all medications administered to R #67. She stated the medications are to be administered no later than one hour past the due time and the listed medications should have been administered no later than 8:00 am. CMA #2 stated she was the only nurse administering medications to her units and she had no help to administer the residents medications. She further stated this was not an uncommon occurrence and she is frequently late administering medications because of staffing.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>34439</p> <p>Based on observation and interview, the facility failed to ensure medications were:</p> <ol style="list-style-type: none"> 1. Stored properly 2. Narcotics given when signed out on the narcotic book. <p>These deficient practices are likely to result in inaccurate medication counts and residents not getting the desired therapeutic results if medications are not administered as ordered. The findings are:</p> <p>A. On 02/24/25 at 11:01 am, during an observation of the south side medication cart revealed five unidentified loose pills on the bottom of the second drawer. During a count of the narcotic's kept in the medication cart there was a medication Pregabalin (used to treat pain) that had been signed out as administered to R #49 and medication was still present in the medication card.</p> <p>B. During interview with Certified Medication Aide (CMA) #, she confirmed there were five loose unidentified medications in medication cart and they should not be there, CMA #1 further confirmed that she had signed out the Pregabalin as administered to R #49 and she had not administered the medication as the Medication Administration Record (MAR) indicated.</p> <p>B. On 02/24/25 at 4:26 pm during an interview, the Director of Nursing (DON), stated the medication carts should be checked daily and all loose medication should be discarded immediately, she further confirmed that any medication not given should be reported and documented in the resident medical record and the provider should be notified, it is considered a medication error.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>47031</p> <p>Based on observation and interview, the facility failed to ensure meals were served at an appetizing temperature for 1 (R #97) of 1 (R #97) residents reviewed for meal quality.</p> <p>This deficient practice may decrease the resident's quality of life and have the potential to cause weight loss due to the food not being the proper temperature. The findings are:</p> <p>A. On 02/18/25 at 1:18 pm, during an interview, R #97 stated the food is cold a lot of times for lunch when it is delivered to his room.</p> <p>B. On 02/24/25 at 1:22 pm, during an observation of lunch, revealed the following temperatures for the lunch test tray pulled for R #97:</p> <ul style="list-style-type: none"> -Tamale was at 117 degrees Fahrenheit -Black beans was at 110 degrees Fahrenheit -Coleslaw was at 112 degrees Fahrenheit <p>C. On 02/24/2025 at 1:22 pm, during an interview with the DC, she stated the temperatures taken for R #97 were not at the appropriate temperatures.</p> <p>D. On 02/24/25 at 1:22 pm, during an interview, the Dietary Manager (DM) confirmed the food tested for R #97 at 1:22 pm was not at the correct temperature. The DC confirmed the food should have been 135 degrees Fahrenheit or higher.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>47031</p> <p>Based on observation, record review, and interview, the facility failed to ensure food preference was followed for 1 (R#97) of 1 (R #97) observed for dining observation., This deficient practice could result in the resident not eating and losing weight.</p> <p>A. On 02/18/25 at 1:24 pm, during interview, R #97 stated I don't like eggs and they keep giving me eggs that are cold for breakfast.</p> <p>B. On 02/19/25 at 8:45 am, during an observation of R #97's breakfast, there were eggs on his breakfast plate which he had not eaten.</p> <p>C. Record review of R #97's meal ticket revealed the meal tick did not have any indication of R #97 disliking eggs.</p> <p>D. On 02/24/25 at 1:52 pm during an interview, Dietary Manager (DM) stated she interviews residents upon admission and she reviews their preferences every quarterly, or as needed. She confirmed that she did not know R #97 did not like eggs.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46064</p> <p>Based on a record review and interview, the facility failed to ensure medical records were complete for 1 (R #89) of 1 (R #89) residents reviewed. This deficient practice is likely to result in staff not having the information they need to provide competent, comprehensive care and services to residents. The findings are:</p> <p>A. Record review of R #89's face sheet revealed R #89 was admitted into the facility on [DATE].</p> <p>B. Record review of R #89's Electronic Medical Record (EMR) revealed a Pre-Admission Screening and Resident Review (PASRR: a federally required screening of any individual who applies to or resides in a Medicaid-certified nursing facility) was not available for review in the EMR.</p> <p>C. On 02/20/25 at 11:32 AM, during an interview, the Director of Nursing (DON) confirmed there was not a PASRR in R #89's EMR available for review and PASSR should be included in any admission to a medicaid certified nursing facility.</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>46064</p> <p>Based on record review and interview, the facility failed to ensure there was collaboration between the facility and hospice services for 1 (R #4) of 1 (R #4) residents reviewed for hospice services by not developing a coordinated plan of care for the resident. This deficient practice is likely to result in the residents not receiving the services needed. The findings are:</p> <p>A. Record review of R #4's admission Minimum Data Set (MDS: a set of evaluations and review that provide an overall picture of a persons needs and abilities) Section O, Special Treatments, Procedures and Programs revealed the resident was on hospice care.</p> <p>B. On 02/19/25 at 1:42 PM, during an interview, the Director of Nursing in Training (DON-IT) stated a hospice binder (a binder that contains written communication between the facility and the hospice provider to include the coordinated plan of care) should be kept at the nurse's station or in medical records for R #4 so that staff are aware of the care that's needed/provided by the hospice provider.</p> <p>C. On 02/20/25 at 11:40 AM, during an interview, the Director of Nursing (DON) stated there has not been any hospice communication documentation in the medical record and there should be.</p>

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>41988</p> <p>Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) received the required in-service training of at least 12 hours per year for 3 (CNAs #1, #3, and #4) of 5 (CNAs #1, #2, #3, #4, and #5) CNAs randomly reviewed for required in-service training.</p> <p>This deficient practice is likely to result in the nurses aides not receiving the necessary training to meet the care needs of the residents. The findings are:</p> <p>CNA #1:</p> <p>A. Record review of the facility staffing list revealed CNA #1 was hired on 06/06/22.</p> <p>B. Record review of CNA #1's annual in-service training, dated 06/06/23 through 06/06/24, revealed CNA #1 did not complete at least 12 hours of required in-service training.</p> <p>C. Record review of the facility staffing schedule, dated 01/25/25 through 02/25/25, revealed CNA #1 worked sixteen CNA shifts in the facility during that timeframe.</p> <p>D. On 02/25/25 at 10:22 am during an interview with the Nurse Educator (NE) #1, she confirmed CNA #1 did not complete the required 12 hours of in-service training, but should have.</p> <p>CNA #3:</p> <p>E. Record review of the facility staffing list revealed CNA #3 was hired on 10/16/20.</p> <p>F. Record review of CNA #3's annual in-service training, dated 10/16/23 through 10/16/24, revealed CNA #3 did not complete at least 12 hours of required in-service training.</p> <p>G. Record review of the facility staffing schedule, dated 01/25/25 through 02/25/25, revealed CNA #3 worked sixteen CNA shifts in the facility during that timeframe.</p> <p>H. On 02/25/25 at 10:22 am during an interview with the NE #1, she confirmed CNA #3 did not complete the required 12 hours of in-service training, but should have.</p> <p>CNA #4:</p> <p>I. Record review of the facility staffing list revealed CNA #4 was hired on 08/25/17.</p> <p>J. Record review of CNA #3's annual in-service training, dated 08/25/23 through 08/25/24, revealed CNA #4 did not complete at least 12 hours of required in-service training.</p> <p>K. Record review of the facility staffing schedule, dated 01/25/25 through 02/25/25, revealed CNA #4 worked fifteen CNA shifts in the facility during that timeframe.</p> <p>(continued on next page)</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>L. On 02/25/25 at 10:22 am during an interview with the NE #1, she confirmed CNA #4 did not complete the required 12 hours of in-service training, but should have.</p> <p>M. On 02/25/25 at 12:21 pm during an interview with the Director of Nursing (DON), she stated all CNAs should have their 12 hours of in-service training completed if they are working on the floor with residents.</p>		