

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2024
NAME OF PROVIDER OR SUPPLIER Casa Arena Healthcare LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Moonglow Alamogordo, NM 88310	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>50497</p> <p>Based on observation and interview, the facility failed to provide reasonable accommodations of resident needs for 2 (R #102 and R #359) of 2 (R #102 and R #359) residents reviewed for care when the facility failed to ensure that resident's bedside table with frequently used items and call light were within the resident's reach. This deficient practice could result in the residents' needs not being met, leaving them at risk for accidents and falls. The findings are:</p> <p>R #359</p> <p>A. On 04/16/24 at 11:47 AM, during an observation and interview of R #359, revealed the call light was hanging on the back of the bed and was not within reach. R #359 confirmed she did not know where the call light was and had to get up to look for it.</p> <p>B. On 04/16/24 at 12:10 PM, during an interview the CNA #31 confirmed R #359 did not have the call light within resident's reach.</p> <p>R #102</p> <p>C. On 04/17/24 at 2:04 PM, during an observation of R #102 room revealed the bedside table with a pitcher was across the room and not within the resident's reach.</p> <p>D. On 04/17/24 at 2:06 PM during an interview the ADON #2 confirmed the bedside table for R #102 and the pitcher were not within reach.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313</p> <p>Based on record review and interview, the facility failed to notify the provider of a change in condition for 1 (R #108) of 1 (R #108) residents reviewed for change of condition, when they failed to notify the facility provider about R #108's nausea. This deficient practice could likely result in residents not receiving necessary care or a delay in treatment. The findings are:</p> <p>A. Record review of R #108's face sheet, revealed R #108 was admitted on [DATE].</p> <p>B. Record review of R #108's physician progress note dated 11/28/23, revealed resident had a diagnosis of chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should) stage 3 (mild to moderate loss of kidney function).</p> <p>C. Record review of R #108's physician's orders revealed Bactrim (an antibiotic used to treat ear infections, urinary tract infections, and other infections) 800-160 mg was started on 01/15/24 for a diagnosis of UTI.</p> <p>D. Record review of nursing progress note dated 01/15/24, revealed the following:</p> <ol style="list-style-type: none"> 1. The electronic medical record system triggered a drug protocol alert for a drug-to-drug interaction between Bactrim and spironolactone (a potassium-sparing diuretic that can treat high blood pressure, fluid retention (edema), and high levels of the hormone aldosterone. It prevents potassium levels from getting too low). 2. The electronic medical record indicated, coadministration of spironolactone oral tablet 25 mg and Bactrim DS oral tablet 800-160 mg may increase the risk of hyperkalemia (High potassium levels in your blood. While mild hyperkalemia is usually asymptomatic, high potassium levels may cause life-threatening cardiac arrhythmias (an abnormality in the timing or pattern of the heartbeat), muscle weakness, or paralysis). <p>E. Record review of nursing progress notes dated 01/20/24, revealed the following:</p> <ol style="list-style-type: none"> 1. R #108 ate 50% or less of two or more meals due to being nauseated and not wanting to eat (nausea and vomiting are symptoms of hyperkalemia). 2. R #108 had reported vomiting and was given Zofran (used to prevent nausea and vomiting) per standing order (allows nurses (LPNs and RNs) to fulfill routine requests for refills and physician orders without having to wait for a physician's approval). <p>F. Record review of the medical record revealed, staff did not notify the provider about R #108 having nausea and vomiting on 01/20/24.</p> <p>G. On 04/19/24 at 9:43 AM, during an interview with the Medical Director, she stated the following:</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ol style="list-style-type: none"> 1. She does not remember being notified about R # 108 having nausea or about the potential drug interactions identified by the electronic medical record. 2. If she had been notified about the interaction between Bactrim and Spironolactone, she would have either discontinued Spironolactone or ordered a different antibiotic to treat R #108's UTI. 3. Confirmed that coadministration of Bactrim and Spironolactone can cause a worsening of kidney disease and can cause elevated potassium levels. 4. Nausea and vomiting could be a symptom of elevated potassium levels. 5. Staff are expected to notify the provider about any potential drug interactions. 6. Staff are expected to document any communication with the provider in the medical record.

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>47510</p> <p>Based on observation and interview, the facility failed to safeguard resident medical record information for all 101 residents (residents were identified by the census provided by the Administrator on 04/15/24). This deficient practice could likely result in the residents' information being viewed by unauthorized residents, visitors, and staff. The findings are:</p> <p>A. On 04/15/24 at 2:35 PM, during an observation of the medication cart it revealed that the computer on the medication cart was open and the screen was not locked. All resident information was visible.</p> <p>B. On 04/15/24 at 2:39 PM, during an interview, LPN #11 confirmed that the computer was left open with resident information visible.</p> <p>C. On 04/24/24 at 5:05 PM, during an interview, the DON confirmed that the computer screen should be locked when not in the direct control of staff so that resident information is not accessible.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>49313</p> <p>Based on observation and interview the facility failed to provide a home-like environment for all 16 residents in the secure unit (residents were identified by the resident Matrix provided by the Administrator on 04/15/24) when they left resident meals and drinks on the serving trays during the lunch meal for all 16 residents. This deficient practice could likely cause residents to feel depressed and anxious that they are not living in a comfortable home-like environment. The findings are:</p> <p>A. On 04/15/24 at 11:59 AM, during an observation of the lunch meal on the secure unit revealed the following:</p> <ol style="list-style-type: none"> 1. CNA #21 and the Activities Assistant were passing out meals in the dining room. 2. CNA #21 and the Activities Assistant placed the plastic serving trays with meals, in front of each resident in the dining room. 3. CNA #21 and the Activities Assistant distributed meals to the resident's rooms. 4. CNA #21 and the Activities Assistant placed the plastic serving trays with meals, on the bedside table of each resident in the resident rooms. <p>B. On 04/15/24 at 12:13 PM, during an interview with the Activities Assistant, she confirmed the following:</p> <ol style="list-style-type: none"> 1. The serving trays were left in front of residents with meals on them in the dining room. 2. Meals are usually removed from the serving trays when serving meals in the main dining room. 3. In the Secure Unit, they typically leave the meals on the serving tray when serving meals. 4. Staff leave the plates and drinks on the serving trays because it is easier to clean up the plates when they are on the tray. <p>C. On 04/24/24 at 2:32 PM, during an interview with the DON, she confirmed the following:</p> <ol style="list-style-type: none"> 1. Plates should be removed from the serving trays and plates and drinks should be placed in front of residents to eat. 2. Staff have been leaving the serving tray with the meals on them when serving meals in the secure unit and when residents eat in their rooms. 		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>34303</p> <p>Based on record review and interview the facility failed to maintain a grievance policy that maintained records of grievances results for up to three years. This has the potential to affect all 101 residents in the facility (residents were identified by the resident matrix provided by the Administrator on 04/15/24). If the facility does not maintain a grievance policy, then resident concerns could go without resolution leaving residents depressed and anxious. The findings are:</p> <p>A. On 04/19/24 at 9:58 AM, during an interview the Social Services Director (SSD) was asked if she had grievances from the previous year 2023, The SSD stated that she throws out the grievances at the end of the calendar year. The SSD confirmed she did not have any grievances for the year 2023</p> <p>B. Record review of the facility's Grievances/Complaint, Filing Policy revised date April 2017, revealed the results of all grievances files investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>47510</p> <p>Based on record review and interview the facility failed to report an allegations of abuse or neglect within two hours to the State Agency (SA) for 1 (R #66) of 1 (R #66) residents sampled for abuse and accidents. If the facility fails to report allegations of abuse or neglect to the SA within two hours, then residents could likely continue to be abused or suffer serious bodily injury. The findings are:</p> <p>A. On 04/16/24 at 10:08 am, during an interview, R #66 said that she had been assaulted while sitting in her room. R #66 said she did not remember when.</p> <p>B. Record review of the Health Facility Incident Report dated 02/29/24, revealed the following:</p> <ol style="list-style-type: none"> 1. R #20 and R #66 got in an argument over a a water mug. 2. R #20 scratched R #66 on the face during the incident. 3. R #66 had scratch marks on her face. 4. The time of the incident was 02/28/24 at 1:00 pm. 5. Date the report was sent to the SA on 02/29/24 at 8:50 am (outside the two hours reporting time). <p>C. On 04/17/24 at 3:02 pm, during an interview, the Administrator said that an allegation of abuse must be reported within two hours. The Administrator confirmed that the allegation of abuse of R #66 was reported to him on 02/28/24 and he did not report it until 02/29/24.</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>49313</p> <p>Based on record review and interview the facility failed to ensure that residents and their representatives received a written notice of transfer as soon as practicable for 1 (R #89) of 3 (R #82, R #86, and R #89) residents reviewed for hospitalization . This deficient practice could likely result in the resident and/or their representative not knowing the reason or location the resident was discharged . The findings are:</p> <p>A. Record review of the nursing progress note dated 02/03/24, revealed R #89 was transferred to the hospital after a fall on 02/03/24.</p> <p>B. Record review of R #89's nursing progress note dated 04/06/24, revealed R #89 was transferred to the hospital on 04/06/24 due to bruising on chest and abdomen.</p> <p>C. Record review of the nursing progress note dated 04/09/24, revealed R #89 was transferred to the hospital on 04/09/24 for extreme agitation.</p> <p>D. Record review of R #89's medical record revealed staff did not provide a written transfer notice to R #89 or his representative for R #89's transfer to the hospital on 02/03/24, 04/06/24, and 04/09/24.</p> <p>E. On 04/23/24 at 9:48 AM, during an interview with the Social Services Director (SSD), she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #89 or his representative did not receive any written transfer notice, that included appeal information or how to contact the State Ombudsman, for his hospital transfers on 02/03/24, 04/06/24, and 04/09/24. 2. The transferring nurse typically gives the transfer notice to the resident at the time of transfer and places a copy of the notice in a bin for her to send a copy to the State Ombudsman. 3. The facility does not provide a written transfer notice to the resident's representative. <p>F. On 04/24/24 at 2:14 PM, during an interview with the DON, she confirmed the following:</p> <ol style="list-style-type: none"> 1. Transfer notices should be provided to the resident at the time of transfer by the transferring nurse. 2. The transferring nurse is expected to notify the resident's representative at the time of transfer. 		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>49313</p> <p>Based on record review and interview, the facility failed to ensure that residents and their representatives received a written notice of the bed hold policy which indicated the duration the bed would be held for 3 (R #82, R #86, and R #89) of 3 (R #82, R #86, and R #89) residents reviewed for hospitalization . This deficient practice could likely result in the resident and/or their representative being unaware of the bed hold policy upon return from the hospital. The findings are:</p> <p>R #82</p> <p>A. Record review of R #82's nursing progress note dated 03/21/24, revealed R #82 was transferred to the hospital for behavioral changes on 03/21/24.</p> <p>B. Record review of R #82's medical record revealed R #82's medical record did not contain a written notice of bed hold policy for the transfer on 03/21/24.</p> <p>C. On 04/23/24 at 9:33 AM, during an interview with the Administrator, he stated that R #82 did not receive a written bed hold notice for his transfer to the hospital on 03/21/24 because R #82 returned to the facility the same day.</p> <p>D. On 04/23/24 at 9:56 AM, during an interview with the Business Office Manager (BOM), she confirmed staff did not provide R #82 a written bed hold notice for the transfer to the hospital on 03/21/24.</p> <p>R #86</p> <p>E. Record review of R #86's nursing progress note dated 01/23/24, revealed R #86 was transferred to the hospital after a seizure on 01/23/24.</p> <p>F. Record review of R #86's progress note dated 02/03/24, revealed R #86 was transferred to the hospital after a seizure and fall on 02/03/24.</p> <p>G. Record review of the R #86's written bed hold notice, dated 01/23/24, revealed the form did not have the number of bed hold days available for R #86.</p> <p>H. Record review of R #86's medical record revealed that staff did not provide a written bed hold notice to R #86 and to his representative for R #86's transfer to the hospital on 02/03/24.</p> <p>I. On 04/23/24 at 1:30 PM, during an interview with the BOM, she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #86's bed hold notice, dated 01/23/24, did not have the number of bed hold days available. 2. R #86 and R #86's representative did not receive a bed hold notice for R #86's transfer to the hospital on 02/03/24. <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R #89</p> <p>J. Record review of the nursing progress note dated 02/03/24, revealed R #89 was transferred to the hospital after a fall 02/03/24.</p> <p>K. Record review of R #89's nursing progress note dated 04/06/24, revealed R #89 was transferred to the hospital on 04/06/24 due to bruising on chest and abdomen.</p> <p>L. Record review of the nursing progress note dated 04/09/24, revealed R #89 was transferred to the hospital on 04/09/24 for extreme agitation.</p> <p>M. Record review of R #89's medical record revealed, staff did not provide a written bed hold notice to R #89 and to his representative for R #89's transfers to the hospital on 02/03/24, 04/06/24, and 04/09/24.</p> <p>N. On 04/23/24 at 9:50 AM, during an interview with the BOM, she confirmed that the facility did not have any written bed hold notices for R #89's hospital transfers on 02/03/24, 04/06/24, and 04/09/24.</p> <p>O. On 04/23/24 at 1:30 PM, during an interview with the BOM, she confirmed the following:</p> <ol style="list-style-type: none"> 1. The transferring nurse was supposed to complete a bed hold notice and give it to the resident at the time of transfer. 2. The facility bed hold notice forms do not have a place to document the number of bed hold days available to residents. 3. The facility does not send the bed hold notice forms to the resident's representative. <p>P. On 04/24/24 at 2:14 PM, during an interview with the DON, she confirmed the following:</p> <ol style="list-style-type: none"> 1. Bed hold notices should be provided to the resident at the time of transfer by the transferring nurse. 2. The transferring nurse is expected to notify the resident's representative about the bed hold notice at the time of transfer. 		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755</p> <p>Based on record review and interview, the facility failed to complete and transmit (electronically sending encoded information) a Significant Change (major decline or improvement in the patient's health status) Minimum Data Set assessment within 14 days after the facility determined a significant change in the resident's physical or mental condition for 1 (R #30) of 2 (R #30 and R #31) residents reviewed for MDS assessment timing. This deficient practice could likely result in the resident not receiving the appropriate care and services they need. The findings are:</p> <p>A. Record review of R #6's Physician's Orders dated 02/24/24 revealed: admit to [name of company] hospice.</p> <p>B. Record review of R #6's change of condition MDS assessment dated [DATE], revealed that the MDS assessment was not completed and signed off by the Registered Nurse (RN) until 04/03/24.</p> <p>C. On 04/24/23 at 3:31 PM, during an interview with the MDS Coordinator and the Regional MDS(RMDS) coordinator, the RMDS confirmed that R #6's Significant change MDS assessment was opened on 02/26/24 and the RN signed the MDS assessment on 04/03/24. The RMDS Coordinator confirmed that facility staff did not complete R#6's MDS assessment within 14 days of the significant change of hospice admission.</p>

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>34303</p> <p>Based on record review and interview, the facility failed to ensure that an Minimum Data Set (MDS) was completed every three months for 3 (R #13, R #68, and R #73) of 5 (R #13, R #29, R #58, R #68, and R #73) resident reviewed for MDS assessments, when they failed to complete quarterly MDS assessments timely (completed 14 days after the assessment reference date (ARD)). This failed practice could result in residents assessments being outdated and residents not receiving care and treatment that meets their current needs. The findings are:</p> <p>A. Record review of R #13's quarterly MDS assessment revealed the following:</p> <ol style="list-style-type: none"> 1. ARD date of 03/08/24. 2. Completion date 04/10/24. <p>B. Record review of R #68's quarterly MDS assessment revealed the following:</p> <ol style="list-style-type: none"> 1. ARD date of 03/08/24. 2. Completion date 04/10/24. <p>C. Record review of R #73's quarterly MDS assessment revealed the following:</p> <ol style="list-style-type: none"> 1. ARD date of 03/07/24. 2. Completion date 04/10/24. <p>D. On 04/23/24 at 1:14 PM, during an interview, the Regional MDS Coordinator (RMSC) confirmed that R #13's, R 36's, and R #73's MDS assessments were not completed on time.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755</p> <p>Based on record review and interview, the facility failed to ensure the Minimum Data Set Assessment was accurate for 1 (R #31) of 5 (R #2, R #6, R #22, R #31, and R #32) residents review for MDS assessment accuracy. This deficient practice could likely result in the facility not having an accurate assessment of the residents' needs. The findings are:</p> <p>A. Record review of R #31's Admission Record revealed the following diagnoses:</p> <ol style="list-style-type: none"> 1. Huntington's disease (a condition that leads to progressive degeneration of nerve cells in the brain that affects movement, cognitive functions, and emotions). 2. Need for assistance with personal care (assistance and provided to individuals in performing daily living tasks and maintaining personal hygiene). 3. Reduced mobility (decrease in the ability to move or alternate positions). <p>A. Record review of R #31's physician orders revealed the following:</p> <ol style="list-style-type: none"> 1. Order date 01/19/24, NPO (nothing by mouth) diet. 2. Order date 01/23/24, Jevity 1.2 (calorically dense, high-protein, fiber-fortified liquid formula given through feeding tube) 60 cc (milliliters) per hour for 24 hours per G-tube (surgically placed tube used to give direct access to the stomach). <p>B. Record review of R #31's change of condition MDS assessment dated [DATE] revealed: section GG0130A Eating: was answered substantial/maximal assistance (staff provide more than half the effort [resident is able to assist])</p> <p>C. On 04/24/23 at 3:35 PM, during an interview with the MDS Coordinator and the Regional MDS(RMDS) Coordinator, the RMDS confirmed that R #31 was dependent on staff for administration of his tube feeding and question GG0130A was answered incorrectly. The RMDS confirmed that question GG0130A should be answered as dependent (staff does all the effort).</p>		

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NAME OF PROVIDER OR SUPPLIER Casa Arena Healthcare LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Moonglow Alamogordo, NM 88310	

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49313</p> <p>Based on record review and interview, the facility failed to develop a baseline care plan within 48 hours, that accurately reflected the resident's current condition for 2 (R #100 and R #359) of 3 (R #100, R #359 and R #310) residents sampled for baseline care plans. This deficient practice could likely result in residents not receiving the appropriate care and services and may place residents at risk of an adverse event (an event, preventable or nonpreventable, that caused harm to a patient as a result of medical care or lack of medical care) or worsening of current condition after admission. The findings are:</p> <p>R #100</p> <p>A. Record review of R #100's face sheet revealed, R #100 was admitted on [DATE].</p> <p>B. Record review of Baseline Care Plan dated 03/04/24, revealed the plan was initiated (effective) on 03/04/24 (not within 48 hours of admission).</p> <p>C. On 04/24/24 at 12:16 PM, during an interview with the MDS Nurse, she confirmed the following:</p> <ol style="list-style-type: none"> 1. The baseline care plan should be created upon admission by the admitting nurse. 2. R #100's baseline care plan was created on 03/04/24. 3. R #100's baseline care plan was not completed within 48 hours of admission. <p>D. On 04/24/24 at 2:28 PM, during an interview with the DON, she confirmed the following:</p> <ol style="list-style-type: none"> 1. Baseline care plans should be completed between 48-72 hours after admission. 2. Upon admission the admitting nurse starts baseline care plan, then unit managers like dietary and activities meet with the resident within 48-72 hours of admission to complete the baseline care plan. 3. R #100 was admitted to the facility on [DATE]. 4. R #100's baseline care plan was initiated (effective) on 03/04/24. Was this care plan 5. R 100's baseline care plan was not completed within 48 hours of admission. <p>R #359</p> <p>E. Record review of R #359's medical record revealed R #359 was admitted to facility on 04/10/24.</p> <p>F. Record review of R #359's baseline care revealed it was initiated on 04/11/24.</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>G. Record review of R #359's physician orders dated 04/11/24 revealed the following:</p> <ol style="list-style-type: none"> 1. R #359 is taking Seroquel (Quetiapine Fumarate) Oral Tablet 100 MG (milligram) 1 tablet by mouth in the evening for bipolar disorder. 2. Seroquel (Quetiapine Fumarate) Oral Tablet 25 MG (milligram) 1 tablet by mouth every 12 hours PRN (as needed) for bipolar disorder (serious mental illness characterized by extreme mood swings, that can include extreme excitement episodes or extreme depressive feelings) for 14 Days. <p>H. On 04/24/24 at 12:25 PM MDS Coordinator confirmed R #359 psychotropic medications are not listed on the baseline care plan.</p> <p>50497</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 49313</p> <p>Based on record review and interview, the facility failed to develop a comprehensive care plan for 2 (R #9, and R #108) of 2 (R #9, and R #108) residents sampled for care plans. This deficient practice could likely result in staff being unaware of the needs of residents. The findings are:</p> <p>R #9</p> <p>A. On 04/15/24 at 11:35 AM, during an interview, R #9 revealed the following:</p> <ol style="list-style-type: none"> 1. She said she wears dentures, and they feel uncomfortable and fit her loosely. She does not wear them and stores them in her drawer. 2. She said she has glaucoma (group of eye conditions that damage the optic nerve) and it has been getting worse since a year and a half ago. She has eye drops. R #9 said the nurse eye drops are given by the nurse more than twice a day. <p>B. Record review of R #9's physician's order revealed the following:</p> <ol style="list-style-type: none"> 1. 09/16/23 Xalatan Ophthalmic Solution 0.005 %, one drop in both eyes at bedtime for pre-glaucoma. <p>C. Record review of R #9's care plan dated 03/11/24 revealed the following:</p> <ol style="list-style-type: none"> 1. Staff did not document R #9's denture in her care plan. 2. Staff did not document R #9's pre-glaucoma or the Xalatan Ophthalmic eye drops. <p>D. On 04/24/24 at 12:34 PM, during an interview with the MDS Coordinator, she confirmed R #9's care plan did not mention anything related to her pre-glaucoma or dentures.</p> <p>R #108</p> <p>E. Record review of R #108's face sheet, revealed R #108 was admitted on [DATE].</p> <p>F. Record review of R #108's admission MDS assessment dated [DATE] revealed R #108 had a diagnosis of acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood).</p> <p>G. Record review of R #108's care plan 02/07/24 revealed that R #108's diagnosis of acute kidney failure was not included in R #108's Care Plan.</p> <p>H. On 04/24/24 at 12:07 PM, during an interview with the MDS Nurse, she confirmed the following:</p> <ol style="list-style-type: none"> 1. Care plans are input by the MDS nurse. <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 - Some</p>	<p>2. R #108's medical record indicated R #108 had a diagnosis of acute kidney failure, dated 10/11/23.</p> <p>3. R #108's care plan did not include R #108's diagnosis of acute kidney failure.</p> <p>4. R #108's care plan should have included R #108's diagnosis of acute kidney failure and any interventions the facility provided to prevent worsening of her condition.</p> <p>50497</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** 34303</p> <p>Based on record review, observation, and interview, the facility failed to ensure that the care plan had been revised for 4 (R #66, R #86, R #88, and R #108) of 5 (R #62, R #66, R #86, R #88, and R #108) residents reviewed by:</p> <ol style="list-style-type: none"> 1. Not revising R #66's care plan to reflect that she was not in the secured unit. 2. Not revising R #86's care plan to include his diagnosis of seizures. 3. Not revising R #88's care plan to include medications and orders for wounds. 4. Not revising R #108's care plan to include her diagnosis of urinary tract infection (UTI, an infection in any part of the urinary system). <p>This deficient practice could likely result in staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are:</p> <p>R #66</p> <p>A. Record review of R #66's care plan 02/06/24 revealed, R #66 was care planned for being in the secured unit.</p> <p>B. Record review of R #66's medical record not dated revealed:</p> <ol style="list-style-type: none"> 1. R #66 was admitted on [DATE] 2. R #66 no longer on the secure unit. <p>C. On 04/18/24 at 1:18 PM, during an interview, Social Services (SS) confirmed that R #66 has moved out of the secured unit. SS confirmed that the care plan should have been updated to document the current information for R #66.</p> <p>R #86</p> <p>D. Record review of R #86's face sheet, revealed he was admitted to the facility on [DATE].</p> <p>E. Record review of R #86's medical diagnoses, revealed R #86 had a diagnosis of unspecified convulsions (a sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles and associated especially with brain disorders such as epilepsy (A disorder in which nerve cell activity in the brain is disturbed, causing seizures) the presence of certain toxins (substances created by plants and animals that are poisonous to humans) or other agents in the blood, or fever in children) added on 08/31/23.</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>F. Record review of R #86's Quarterly MDS assessment dated [DATE], revealed R #86's diagnosis of seizures was included.</p> <p>G. Record review of R #86's care plan 01/25/24 revealed staff did not revise R #86's care plan to include his diagnosis and treatment of seizures (unspecified convulsions).</p> <p>H. On 04/24/24 at 12:07 PM, during an interview with the MDS Nurse, she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #86 had a diagnosis of unspecified convulsions. 2. R #86's care plan 01/25/24 did not include convulsions. 3. R #86's care plan should have been revised to include his diagnosis of seizures and the treatment that was being provided for him. <p>R #88</p> <p>I. Record review of R #88's physician's orders revealed the following:</p> <ol style="list-style-type: none"> 1. On 04/12/2024 Mirtazapine (antidepressant) 7.5 MG, 1 tablet by mouth one time a day related to depression. 2. On 12/14/2023 Eliquis (anticoagulant) 5 MG 1 tablet by mouth two times a day. 3. On 12/14/2023 levetiracetam (Anticonvulsant can treat seizures) 500 MG, 1 tablet by mouth two times a day for seizures. <p>J. On 04/16/24 at 1:56 PM, an observation of R #88's legs revealed wounds on both legs.</p> <p>K. Record review of R #88's care plan dated 03/18/24 revealed the staff did not address on R #88's Care plan the following:</p> <ol style="list-style-type: none"> 1. Adverse side effects, effectiveness, and precautions for the Mirtazapine, 2. Adverse side effects, effectiveness, and precautions for the Eliquis, 3. Adverse side effects, effectiveness, and precautions for the Levetiracetam, 4. R #88's seizure diagnosis. 5. The interventions for R #88's wounds. <p>L. On 04/24/24 at 12:00 PM, during an interview with the MDS Coordinator, confirmed that staff should have but did not care plan for R #88's:</p> <ol style="list-style-type: none"> 1. antidepressant, 2. anticoagulant, <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>3. anticonvulsant medications,</p> <p>4. R #88's seizures.</p> <p>M. On 04/24/24 at 10:17 AM, during an interview, the Wound Care Nurse (WCN) confirmed, R #88 had two surgical wounds, one on each leg and a pressure wound to his right heel. The WCN confirmed that R #88's wounds were not care planned.</p> <p>R #108</p> <p>N. Record review of R #108's face sheet revealed R #108 was admitted on [DATE].</p> <p>O. Record review of R #108's physicians order revealed: R #108 was prescribed Bactrim, an antibiotic used to treat ear infections, urinary tract infections, and other infections, for a diagnosis of UTI.</p> <p>P. Record review of R #108's care plan dated 02/07/24, revealed R #108's diagnosis of UTI was not included in R# 108's care plan.</p> <p>Q. On 04/24/24 at 12:07 PM, during an interview with the MDS Nurse, she confirmed the following:</p> <ol style="list-style-type: none"> 1. Care plans are updated by the MDS nurse for anything chronic or identified during the MDS assessments. 2. Care plans are updated by the nurses or ADON's for any acute changes like UTI's or falls. 3. R #108's care plan did not include R #108's diagnosis of UTI that was identified on 01/15/24. 4. R #108's care plan should have included R #108's diagnosis of UTI and any interventions the facility was providing to treat her condition. <p>47510</p> <p>49313</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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** 34303</p> <p>49313</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (R #108) of 2 (R #78 and R #108) residents when they failed to:</p> <ol style="list-style-type: none"> 1. Notify the provider about R #108's abnormal lab values (high potassium). 2. Notify the provider about potential drug-to-drug interactions for R #108. 3. Monitor potassium levels for R #108 who had elevated potassium blood levels, chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), and an order for medications that can cause hyperkalemia (elevated potassium blood levels). 4. Notify the provider about R #108 experiencing nausea and vomiting. <p>These deficient practices likely lead to R #108's death. The findings are:</p> <p>R #108</p> <p>A. Record review of R #108's face sheet, revealed R #108 was admitted on [DATE].</p> <p>B. Record review of R #108's admission MDS assessment dated [DATE], revealed R #108 had a diagnosis of Acute Kidney Failure.</p> <p>C. Record review of R #108's physician progress note dated [DATE], revealed R #108 had a diagnosis of chronic kidney disease, stage 3 (mild to moderate loss of kidney function).</p> <p>D. Record review of R #108's laboratory test results dated [DATE], revealed the following:</p> <ol style="list-style-type: none"> 1. Elevated Potassium- 7.5 (normal levels 3XXX,d+[DATE].2) [too much potassium is very common if you have kidney disease or kidney failure]. 2. High Blood Urea Nitrogen (BUN)- 71 (normal levels ,d+[DATE] [high levels indicates kidneys are not working well, or can be due to dehydration or urinary tract obstruction] 3. High Creatinine- 3.5 (normal levels 0XXX,d+[DATE].3) [high levels may be due to kidney problems, such as kidney damage or failure, infection, reduced blood flow, or loss of body fluid]. 4. Low Glomerular Filtration Rate (GFR)- 12.73 (normal level 60 or higher) [low levels means the kidneys are not filtering blood as well as they should. If the number is below 15, it indicates kidney failure]. 5. Elevated potassium and BUN results called into [name of nurse at facility]. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>E. Record review of nursing progress notes not dated, revealed staff did not contact the provider to notify about R #108's laboratory test results with an elevated potassium and BUN received on [DATE].</p> <p>F. Record review of nursing progress note dated [DATE] at 2:48 PM, revealed the following:</p> <ol style="list-style-type: none"> 1. R #108 was seen by the Medical Director (MD) on [DATE]. 2. Laboratory results from [DATE] was reviewed by MD. 3. Additional laboratory tests ordered. 4. Referral for nephrologist (kidney doctor). 5. R #108 encouraged to increase fluids due to lab results and poor kidney function. <p>G. Record review of R #108's laboratory results, dated [DATE], revealed the following:</p> <ol style="list-style-type: none"> 1. Elevated potassium-7.1, 2. High BUN- 73, 3. High Creatinine- 3.46, 4. Low GFR non-African American- 12.90 5. Elevated potassium and BUN results were called to [name of staff at MD office] on [DATE] at 5:01 PM [after R #108 was seen by provider on [DATE]]. <p>H. Record review of R #108's physician's order [DATE] revealed Bactrim (an antibiotic used to treat ear infections, urinary tract infections, and other infections) was started on [DATE] for a diagnosis of UTI.</p> <p>I. Record review of nursing progress note from ADON #1 dated [DATE], revealed the following:</p> <ol style="list-style-type: none"> 1. The electronic medical record (EMR) system triggered a drug protocol alert for a drug-to-drug interaction between Bactrim and spironolactone (a potassium-sparing diuretic that can treat high blood pressure, fluid retention (edema), and high levels of the hormone aldosterone. It prevents potassium levels from getting too low). 2. The EMR system indicated, coadministration of Spironolactone oral tablet 25 mg and Bactrim DS oral tablet ,d+[DATE] mg may increase the risk of hyperkalemia (High potassium levels in your blood. While mild hyperkalemia is usually asymptomatic, high potassium levels may cause life-threatening cardiac arrhythmias, muscle weakness, or paralysis). <p>J. Record review of R #108's [DATE] Medication Administration Record revealed the following:</p> <ol style="list-style-type: none"> 1. R #108 received Spironolactone every morning between [DATE] and [DATE]. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. R #108 received Bactrim on:</p> <ul style="list-style-type: none"> a. [DATE] in the evening b. [DATE] in the morning c. [DATE] in the evening d. [DATE] in the morning e. [DATE] in the evening f. [DATE] in the morning g. [DATE] in the evening h. [DATE] in the morning i. [DATE] in the evening j. [DATE] in the morning k. [DATE] in the evening <p>K. Record review of nursing progress notes dated [DATE] at 3:54 PM, revealed the following:</p> <ul style="list-style-type: none"> 1. R #108 ate 50% or less of two or more meals due to being nauseated and not wanting to eat (nausea and vomiting are symptoms of hyperkalemia). 2. R #108 had reported vomiting and was given Zofran (used to prevent nausea and vomiting) per standing order (means a written medical protocol in which a medical director determines in advance the medical criteria that allows nurses (LPNs and RNs) to fulfill routine requests for refills and physician orders without having to wait for a physician's approval). <p>L. Record review of R #108's physician's orders dated [DATE], revealed an order for Zofran 4 mg, every 6 hours as needed for nausea.</p> <p>M. Record review of facility standing orders, no date, revealed for nausea and vomiting, give Zofran 4 mg, 1 tablet by mouth every 4 hours as needed, and/or Phenergan (medication used to treat nausea and vomiting) 12.5 mg 1 tablet by mouth as needed, and increase fluid intake to make sure they don't get dehydrated.</p> <p>N. Record review of nursing progress note dated [DATE] at 4:03 PM, revealed the electronic medical record system triggered a drug protocol alert for a drug-to-drug interaction between:</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Zofran and Desvenlafaxine (medication used to treat depression), indicating a potential for additive serotonergic effects (too much serotonin in the blood that causes signs and symptoms that can range from mild (shivering and diarrhea) to severe (muscle rigidity, fever and seizures) which may increase the risk of developing serotonin syndrome (caused by medications that build up high levels of serotonin in the body. Severe serotonin syndrome can cause death if not treated).</p> <p>2. Zofran and Trazadone (medication used to treat depression), indicating a potential for additive serotonergic effects, which may increase the risk of developing serotonin syndrome.</p> <p>O. Record review of the medical record revealed the following:</p> <ol style="list-style-type: none"> Staff did not notify the provider about R #108 having nausea and vomiting. Staff did not notify the provider about the potential drug interaction between Zofran, Desvenlafaxine, and Trazadone. <p>P. Record review of a nursing progress note dated [DATE] at 7:12 PM, revealed:</p> <ol style="list-style-type: none"> R #108 had reported nausea and vomiting at lunch time. Nurse placed a standing order for Zofran 4 mg, sublingual (under the tongue). CNA obtained vital signs from R #108 around 3:00 PM, that were within normal limits (WNL) [no vital signs provided]. Around 4:00 PM, R #108 was offered another Zofran, which she refused. CNA took R #108 her dinner tray and she was sitting on the side of the bed. CNA went to remove R #108's dinner tray and R #108 was unresponsive. Insert times Nurse assessed R #108 and there were no signs of life. Post mortem assessment was performed and R #108 was pronounced deceased . <p>Q. Record review of R #108's EMR revealed, staff did not complete a vital sign assessment for R #108 on [DATE].</p> <p>R. On [DATE] at 11:43 AM, during an interview with ADON #1, she stated the following:</p> <ol style="list-style-type: none"> She was unsure if the EMR system notified staff about a contraindication (drug-drug interactions) between medications. She has not seen any alerts about a contraindication (drug-drug interactions) between medications. Pharmacy will call the nurses' station if there is a contraindication between medications. <p>S. On [DATE] at 11:47 AM, during an interview with RN #21, she stated the following:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. If there is a contraindication between medications a box pops up on the computer screen that you must acknowledge prior to processing and completing the order.</p> <p>2. If she [nurse] determines that it is not a significant contraindication she will acknowledge without contacting the provider (RN #21 did not specify what constituted a significant contraindication).</p> <p>3. If it is a significant contraindication she [nurse] will contact the provider.</p> <p>4. She documents in medical record any time she contacts the provider.</p> <p>T. On [DATE] at 12:59 PM, during an interview with LPN #21, she stated the following:</p> <p>1. If there is a contraindication between medications a box pops up that you must acknowledge prior to processing and completing the order.</p> <p>2. She [nurse] will usually notify the provider about a contraindication.</p> <p>3. She would document contact with provider if she remembers [to write a note].</p> <p>U. On [DATE] at 11:52 AM, during an interview with the DON, she confirmed the following:</p> <p>1. When an order is first created, if there is a contraindication between medications, it will notify the staff member that there is a contraindication alert (via a window on the computer screen) that must be acknowledged prior to completing the order.</p> <p>2. The EMR system will not allow you to sign the order unless it is acknowledged.</p> <p>3. Nurses are expected to notify the physician for all alerts.</p> <p>4. Nurses shouldn't acknowledge the order until the MD approves it.</p> <p>5. She would not expect the nurse to document their discussion with the provider.</p> <p>V. On [DATE] at 9:43 AM, during an interview with the Medical Director, she revealed the following:</p> <p>1. Staff are expected to notify the provider about any potential drug interactions.</p> <p>2. Staff are expected to document any communication with the provider in the medical record.</p> <p>3. Staff should have notified the provider about the drug interaction notification between Spironolactone and Bactrim.</p> <p>4. She does not remember being notified about R #108 the potential drug interaction between Bactrim and Spironolactone.</p> <p>5. If she had been notified about the interaction between Bactrim and Spironolactone, she would have either discontinued Spironolactone or ordered a different antibiotic to treat R #108's UTI.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>6. She usually would hold Spironolactone while a resident is on Bactrim if they have chronic kidney disease or their GFR is not good.</p> <p>7. Spironolactone has the potential to increase potassium in the blood, combined with Bactrim, it can cause a worsening of kidney disease and could cause elevated potassium.</p> <p>8. Nausea could be a symptom of elevated potassium.</p> <p>9. She would have expected staff to assess vital signs when R #108 reported nausea.</p> <p>10. Staff should have notified the provider about the drug interaction notification between Zofran, Desvenlafaxine, and Trazadone.</p> <p>11. She does not remember being notified about R #108 having nausea or about the potential drug interactions identified by the electronic medical record.</p> <p>12. Elevated potassium could cause death.</p> <p>13. She was unsure what R #108's potassium level was after [DATE].</p> <p>The above findings resulted in an Immediate Jeopardy that was called on [DATE] at 12:44 PM.</p> <p>The facility was verified to have fully implemented this approved plan on [DATE] at 11:44 AM.</p> <p>Upon implementation of the Plan of Removal the Immediate Jeopardy was lifted on [DATE].</p> <p>Plan of Removal</p> <p>Facility will review the last 30 days of labs for all current residents. If abnormal lab is discovered, facility will check to see if MD/provider was notified. If not, we will notify MD/ Provider and follow any orders given. An identification audit will be completed by the DON/designee. The identification audit will be reported to MD/provider for further interventions based on findings. The DON/ designee will communicate orders given by MD/provider for implementation. This will be completed by end of day on [DATE].</p> <p>Facility will look at current resident charts for current drug to drug interactions on spironolactone and residents with chronic kidney disease. The DON/designee will check to see if MD/provider was notified. If not, MD/provider will be notified and follow any orders given. An identification audit will be completed by the DON/designee. The identification audit will be reported to MD/provider for further interventions based on findings. The DON/designee will communicate orders given by MD/provider for implementation. This will be completed by end of day on [DATE].</p> <p>Facility will educate current nursing staff regarding the process for reviewing labs which is:</p> <p>When new lab results are returned to the center, the nurse will review the lab results to determine if any abnormal lab results are present. The nurse will then notify the MD/provider of the abnormal lab result, follow orders given and document the notification in the medical record.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Education also to include what to do for drug-to-drug interaction notification in PCC. When the nurse is entering new resident orders into PCC and a notification comes up for a drug-to-drug interaction the nurse is to notify the MD/provider of the interaction, follow orders given and document the notification in PCC.</p> <p>-DON/designee will complete the education for staff on shift today, [DATE]. Staff not present will receive education before start of their shift.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>50497</p> <p>Based on interview and record review, the facility failed to ensure residents received proper treatment to maintain vision for 1 (R #9) of 2 (R #9 and R #30) residents reviewed for vision and hearing. This deficient practice could likely result in residents losing some independence if they cannot see, compromising their quality of life. The findings are:</p> <p>A. Record review of R #9's medical record revealed R #9's diagnosis of pre-glaucoma.</p> <p>B. On 04/15/24 at 11:35 AM, during an interview R #9 revealed the following:</p> <p>1. She said she has glaucoma (group of eye conditions that damage the optic nerve) and it has been getting worse since a year in a half ago. She has not seen a eye doctor.</p> <p>C. On 04/18/24 at 11:10 AM, during an interview with Social Services (SS) confirmed she has not made any appointments for R #9 to see the eye doctor. SS confirmed that R #9 has not had any eye doctor appointments.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>47510</p> <p>Based on interview and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight for 1 (R #62) of 2 (R #25 and R #62) residents sampled for nutrition, when they failed to follow dietitian's order. This deficient practice could likely result in residents losing weight without the facility being aware causing physical and mental health issues. The findings are:</p> <p>A. Record review of R #62's Nutrition Assessment by the Registered Dietician (A resident's attending physician may delegate the task of writing dietary orders to a qualified dietitian or other clinically qualified nutrition professional.) dated 03/06/24, revealed the following:</p> <ol style="list-style-type: none"> 1. R #62 had a decreased oral intake. 2. A health shake was order three times a day. <p>B. Record review of R #62's medical record revealed, the record did not contain an order for a health shake, three times a day.</p> <p>C. On 04/22/24 at 3:48 PM, during an interview, the Dietary Manager (DM) confirmed that the health shake for R #62 was not ordered, and that R #62 was not getting the health shake three times a day.</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 41755</p> <p>Based on record review and interview, the facility failed to effectively (use of different techniques and medication to reduce and control the amount of pain a person experiences) manage pain for 1 (R #22) of 1 (R #22) residents reviewed for pain when staff did not assess for pain and provide pain treatment. This deficient practice could likely result in residents experiencing unnecessary pain. The findings are:</p> <p>A. On 04/16/24 at 10:58 AM, during an interview, R #22 stated she had not taken her pain medication (Tylenol #4; acetaminophen with codeine combination opioid medication used to treat moderate to severe pain) since the beginning of April and had been seen by the pain specialist on 04/15/24. R #22 stated I have pain all the time. R #22 stated her pain level was currently at a 7, and ranges from 5-10 daily, (1 to 10 scale: 1 least and 10 worst pain).</p> <p>B. On 04/18/24 at 5:53 PM, during an interview, R #22 stated pain scale is currently at a 6. The pain usually averages at five and can be at 10 when she does not take pain meds. R #22 stated the pain doctor put her on Tylenol #3 (acetaminophen with codeine opioid combination medication with less codeine than Tylenol #4 used to treat moderate pain) instead of Tylenol #4, but no one discussed lowering the dose with her. R #22 stated she finally received a dose of Tylenol #3 last night (04/17/24).</p> <p>C. Record review of R #22's face sheet, revealed R #22 was admitted into the facility on [DATE] with the following diagnosis:</p> <ol style="list-style-type: none"> 1. Chronic pain (pain that lasts more than three months) 2. Type 2 Diabetes Mellitus with diabetic neuropathy (condition where the body develops insulin resistance resulting in high blood sugar levels that cause nerve damage that leads to pain) 3. Reduced mobility 4. Muscle weakness 5. Muscle spasm (involuntary contraction of muscle that causes stiffness, tightening and pain) <p>D. Record review of R #22's physician orders revealed the following:</p> <ol style="list-style-type: none"> 1. Order date 05/03/23, monitor pain level every shift; 0-No Pain, 1-4-Mild Pain, 5-7-Moderate Pain, 8-10-Severe Pain related to pain. 2. Order date 04/03/23: lidocaine external patch (medicine that numbs and reduces the sensation of pain in the area where it is applied) 4% (strength of medication) applied to lower back one time a day related to pain. 3. Order date 05/26/23, acetaminophen-codeine (Tylenol #4) 300-60 milligrams (strength of medication), give one tablet by mouth every four hours as needed for pain. Discontinued on 04/16/24. <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Order date 04/02/24, gabapentin (medication used to relieve nerve pain) 300 milligrams (strength of medication) one capsule by mouth four times a day, for neuropathy (a type of nerve damage that can occur if you have diabetes and causes painful burning and tingling).</p> <p>5. Order date 04/17/24, acetaminophen-codeine (Tylenol #3) 300-30 milligrams give one tablet by mouth every four hours as needed for pain.</p> <p>E. Record review of R #22's care plan, date 08/06/23, revealed:</p> <p>1. Focus (area of concern): R #22 has frequent pain related to diabetic neuropathy and muscle spasms.</p> <p>2. Approaches (actions staff will take):</p> <p>-Anticipate R #22's need for pain relief and respond immediately to any complaint of pain.</p> <p>-Monitor/record pain characteristics as ordered and needed: quality (description of pain; sharp, burning); Severity. anatomical location (where on the body); onset; duration (continuous, intermittent); aggravating factors; relieving factors.</p> <p>-Monitor/document for probable cause of each pain episode. Remove/limit causes where possible.</p> <p>F. Record review of R #22's treatment administration record (TAR; the form used to document nursing treatments and monitoring of resident conditions), dated February 2024, revealed:</p> <p>1. Monitor pain level every shift: 0-No Pain, 1-4-Mild Pain, 5-7-Moderate Pain, 8-10- severe pain. The TAR was check marked, but no pain levels (numbers indicating pain level) were documented.</p> <p>2. A separate order for pain medication with an area for documentation of resident's pain level when given. Acetaminophen-Codeine (Tylenol #4) 300-60 mg, give one tablet by mouth every 4 hours for pain. Documentation on the TAR revealed that R #22 received Tylenol #4 39 times, and 15 of the doses were for severe pain (levels of 8 or more).</p> <p>G. Record review of R #22's nursing progress notes, for February 2024 revealed that the medical director, who is the resident's attending physician, was not contacted to advise of R #22 reports of sever pain (as indicated per pain scale documentation at the time of administration of Tylenol #4).</p> <p>H. Record review of R #22's TAR dated March 2024, revealed:</p> <p>1. Monitor pain level every shift; 0-No Pain, 1-4-Mild Pain, 5-7-Moderate Pain, 8-10- severe pain, the TAR was check marked but no pain levels (numbers indicating pain level at the time of assessment were documented).</p> <p>2. A separate order for pain medication with area for documentation of the resident's pain level when given. Acetaminophen-Codeine (Tylenol #4) 300-60 mg, give one tablet by mouth every 4 hours as needed for pain. Documentation in the MAR revealed that R #22 received Tylenol #4 39 times, and 10 of the doses were for severe pain levels of 8.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>I. Record review of R #22's nursing progress notes, for March 2024 revealed no contact made to the medical director to advise of R #22's reports of severe pain.</p> <p>J. Record review of R #22's MAR dated April 2024 revealed:</p> <ol style="list-style-type: none"> 1. R #22 received her last dose of Tylenol #4 on 04/01/24 at 4:40 AM. 2. R #22 did not receive any doses of Tylenol #4 between April 2nd and April 16th; therefore, there were no numerical pain scales documented for R #22 for a 2-week period. 3. R #22 did not start Tylenol #3 until 04/17/24 at 7:26 PM. <p>K. On 04/16/24 11:05 AM, during an interview, LPN #1 confirmed that R #22's pain levels were not documented every shift using the numerical pain scale as ordered, and there is no documentation that R #22's reports of severe pain were reported to the medical director.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>49313</p> <p>Based on record review and interview, the facility failed to ensure staff adequately monitored medications for 1 (R #86) of 5 (R #1, R #86, R #88, R #89, and R #359) residents reviewed for unnecessary medications, when they failed to monitor R #86's antiseizure medication levels as ordered by the physician. If the facility is not adequately monitoring medication levels in the blood, then residents are likely to be at risk of agitation, drowsiness, difficulty breathing, and/or behavior changes. The findings are:</p> <p>A. Record review of R #86's physician's orders revealed the following:</p> <ol style="list-style-type: none"> 1. An order dated 01/26/24, for levetiracetam (medication used alone or together with other medicines to help control certain types of seizures in the treatment of epilepsy) oral tablet 1000 milligram (mg, unit of mass equal to 1/1000 gram) twice a day for seizure disorder. 2. An order dated 01/26/24, for oxcarbazepine (medication used in the treatment of partial seizures) oral tablet 300 mg, twice a day, for epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures). 3. An order, dated 02/06/24, for Keppra (levetiracetam) level (level of Keppra in the blood) and Trileptal (oxcarbazepine) level (level of Trileptal in the blood) every month starting on the 4th, for epilepsy. <p>B. Record review of R #86's medication administration record (MAR) revealed the following:</p> <ol style="list-style-type: none"> 1. March 2024, MAR revealed on 03/04/24 was left blank for Keppra and Trileptal levels to be drawn. 2. April 2024 MAR revealed on 04/04/24 was blank for Keppra and Trileptal levels to be drawn. <p>C. Record review of the medical record revealed that the levels for Keppra or Trileptal were not included in the record.</p> <p>D. On 04/24/24 at 2:22 PM, during an interview with the DON, she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #86 had a Physician order for Keppra and Trileptal levels to be drawn on the 4th of every month. 2. As ordered, Keppra and Trileptal levels were not drawn for R #86 on 03/04/24 and 04/04/24.

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>49313</p> <p>Based on record review and interview, the facility failed to ensure residents did not receive unnecessary psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) for 3 (R #86, R #89 and R #359) of 5 (R #1, R #86, R #88, R #89, and R #359) residents reviewed for unnecessary medications when they failed to document appropriate diagnosis in the resident medical record for psychotropic medications. This deficient practice is likely to result in residents being administered medications they do not need and could likely suffer from adverse side effects (unwanted, harmful, or abnormal result). The findings are:</p> <p>R #86</p> <p>A. Record review of R #86's physician's orders revealed the following:</p> <ol style="list-style-type: none"> 1. R #86 had an order dated 04/05/24, for Seroquel (an antipsychotic medication used to manage psychosis (A mental disorder characterized by a disconnection from reality)) 25 milligram, twice a day for agitation/anxiety. 2. R #86 had an order dated 03/11/24, for mirtazapine (antidepressant medication used in the treatment of major depressive disorder), 15 mg once a day for depression. 3. R #86 had an order dated 01/26/24 for risperidone (antipsychotic medication) 0.25 mg, twice a day, for cognitive communication deficit (difficulty with thinking and how someone uses language). <p>B. Record review of R #86's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. R #86 did not have a psychiatric diagnosis that would indicate the need for antipsychotic medications. 2. R #86 did not have a psychiatric diagnosis that would indicate the need for antidepressant medication. <p>C. On 04/24/24 at 2:22 PM, during an interview with the DON, she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #86 had a medication order for Seroquel for anxiety/agitation. 2. She was unsure if anxiety/agitation is an appropriate diagnosis for the use of Seroquel. 3. R #86 had an order for risperidone for cognitive communication deficit. 4. She was unsure if cognitive communication deficit is an appropriate diagnosis for the use of risperidone. 5. R #86 had an order for mirtazapine for depression. <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. R #86 did not have a diagnosis of depression.</p> <p>R #89</p> <p>D. Record review of R #89's physician's orders revealed the following:</p> <ol style="list-style-type: none"> 1. R #89 had an order dated 04/18/24 for Seroquel 25 mg twice a day for dementia. 2. R #89 had an order dated 2/18/24 for fluoxetine (antidepressant medication used to treat depression) 20 mg once a day for depression. <p>E. Record review of R #89's medical record revealed the following:</p> <ol style="list-style-type: none"> 1. R #89 did not have a psychiatric diagnosis that would indicate the need for antipsychotic medications. 2. R #89 did not have a psychiatric diagnosis that would indicate the need for antidepressant medication. <p>F. On 04/24/24 at 2:17 PM, during an interview with the DON, she confirmed the following:</p> <ol style="list-style-type: none"> 1. R #89 had an order for Seroquel for dementia. 2. She was unsure if dementia is an appropriate diagnosis for the use of Seroquel. 3. R #89 had an order for fluoxetine for depression. 4. R #89 did not have a diagnosis of depression. <p>R #359</p> <p>G. Record review of R #359's medical record revealed a diagnosis of major depressive disorder, recurrent, unspecified.</p> <p>H. Record review of R #359 hospital record dated 04/05/24 revealed. R #359 did not have have a diagnosis of bipolar disorder.</p> <p>I. Record review of R #359's physicians orders dated 04/11/24, revealed:</p> <ol style="list-style-type: none"> 1. R #359 had an active order for Seroquel (Quetiapine Fumarate) Oral Tablet 100 MG, one tablet by mouth in the evening for bipolar disorder. 2. Seroquel (Quetiapine Fumarate) Oral Tablet 25 MG (milligram) one tablet by mouth every 12 hours PRN (as needed) for bipolar disorder (serious mental illness characterized by extreme mood swings, that can include extreme excitement episodes or extreme depressive feelings) for 14 Days with an end date of 04/25/24. <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>J. Record review of R #359's MDS assessment, section I-active diagnoses revealed that staff did not document the diagnosis of bipolar disorder.</p> <p>K. On 04/18/24 at 3:30 PM, during an interview with RN #32, she confirmed R #359 had a diagnosis of depression and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest) several times throughout the medical record but not bipolar disorder. Seroquel is an antipsychotic medication is used to treat certain mental/mood disorders such as schizophrenia, bipolar disorder, sudden episodes of mania or depression associated with bipolar disorder)</p> <p>L. On 04/23/24 at 10:48 AM, during an interview with the DON, she was asked about R #359's orders for prescribing Seroquel for bipolar disorder. The DON stated she was unsure about the diagnosis of bipolar disorder when using Seroquel.</p> <p>50497</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>47510</p> <p>Based on record review, observation and interview, the facility failed to ensure the nutritional needs and preferences were met for 1 (R #66) of 4 (R #25, R #62, R #66 and R #87) residents by not following the menu. This deficient practice is likely to result in resident weight loss and frustration. The findings are:</p> <p>A. Record review of R #66's food ticket (what the resident was served for that meal) for 04/18/24 revealed:</p> <ol style="list-style-type: none"> 1. Egg Salad 2. Crackers 3. Cucumber Dill Salad 4. Soft Chocolate Chip Cookie Bar <p>B. On 04/18/24 at 5:54 PM, during an observation of dinner service R #66 was not served crackers and a soft chocolate chip cookie bar. (R #66 is blind and not able to see what she is served to notice what is missing).</p> <p>C. On 04/18/24 at 6:02 PM, during an interview, LPN #11 confirmed R #66 only had egg salad and cucumber dill salad on her tray. LPN #11 confirmed that R #66 was supposed to have crackers and a soft chocolate chip cookie bar.</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>47510</p> <p>Based on observation and interview, the facility failed to provide a clean, sanitary area for food storage and preparation of food and a holding temperature for puree cold foods at 41 degrees Fahrenheit or lower. This deficient practice is likely to affect all 100 residents (residents were identified by the census provided by the Administrator on 04/15/24) could likely lead to foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) if: food is stored or prepared in unsanitary conditions and is not held at a temperature outside the danger zone (the temperature range where bacteria grow at a rapid rate, between 41 degrees () Fahrenheit (F) and 140 F). The findings are:</p> <p>Kitchen Cleanliness</p> <p>A. On 04/15/24 at 10:21 am, during an observation of the kitchen revealed:</p> <ol style="list-style-type: none"> 1. Ice machine was dirty with yellowish stains on door. 2. Staff did not have the ice machine cleaning logs (to show the facility is cleaning the ice machine). 3. Oil on fryer with food crumbs inside and around the edges. 4. Two brownish sticky substances on floor and underneath the racks of stock room. <p>B. On 04/18/24 at 11:37 am, during an interview with the kitchen supervisor, he confirmed the following:</p> <ol style="list-style-type: none"> 1. One brownish sticky substance on floor, underneath one of the racks. 2. Ice machine had yellowish calcified (to make or become stony by deposit of calcium salts) salt build up on the inside. 3. An outside agency comes once month to clean ice machine, and the kitchen staff do a daily-wipe down. 4. The fryer had crumbs of food and oil stains <p>R #16</p> <p>C. On 04/18/24 at 6:18 pm, an observation of dinner service, R #16 was served a dinner of the following:</p> <ol style="list-style-type: none"> 1. Puree Egg salad, 2. Puree diced tomato salad, <p>(continued on next page)</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>3. Puree crackers.</p> <p>D. On 04/18/24 at 6:18 pm, during an interview, the Dietary Manager was asked to measure the temperature of the food on R #16's tray. The temperatures measured as follows:</p> <ol style="list-style-type: none"> 1. Puree Egg salad 88.5 F. 2. Puree diced tomato salad 84.7 F. 3. Puree crackers 93.3 F. <p>E. On 04/18/24 at 6:19 pm, during an interview, the Dietary Manager stated the the following:</p> <ol style="list-style-type: none"> 1. The temperature for cold foods should be held at 45 degrees for cold foods [the DM was incorrect: cold food should be held at 41 F]. 2. The temperature of the puree crackers should be at room temperature. <p>F. On 04/24/24 at 4:08 pm, during an interview with the Kitchen Supervisor, he confirmed the cleaning logs for the ice machine were not posted on the side of the ice machine and should have been (the cleaning logs are the way of the facility showing they cleaned the ice machine).</p> <p>50497</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 34303</p> <p>49313</p> <p>Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 2 (R #1 and R #108) of 2 (R #1 and R #108) residents reviewed for documentation accuracy. This deficient practice has the potential to negatively impact the care staff provide to meet residents' needs due to missing or inaccurate records. The findings are:</p> <p>R #1</p> <p>A. Record review of R #1's physician's orders, dated 03/18/24, revealed an order for Eliquis (medication used to treat and prevent blood clots and to prevent stroke) Oral Tablet 5 MG related to acute embolism (blockage of an artery) and thrombosis (blood clot) of superficial veins of left upper extremity (region of the body that includes the arm, forearm, wrist and hand).</p> <p>B. On 04/24/24 at 3:09 PM, during an interview with the DON, she confirmed the following: R #1 has a history of CVA (cerebrovascular accident) (stroke) and coronary artery disease (CAD) and presence of coronary angioplasty implant (treats vessels, called coronary arteries, which deliver blood to heart muscles) and that is why she is taking Eliquis. The DON did not stated the Eliquis was for an acute embolism and thrombosis of superficial veins of left upper extremity.</p> <p>R #108</p> <p>C. Record review of R #108's face sheet, revealed R #108 was admitted on [DATE].</p> <p>D. Record review of R #108's medical diagnoses, not dated, revealed R #108 had a diagnosis of acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood).</p> <p>E. Record review of R #108's physician progress note, dated 11/28/23, revealed that the resident had a diagnosis of chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should) stage 3 (mild to moderate loss of kidney function).</p> <p>F. On 04/24/24 at 12:07 PM, during an interview with the MDS Nurse she confirmed the following:</p> <ol style="list-style-type: none"> 1. The MDS nurse updates the diagnoses in the medical record. 2. The provider progress note, dated 11/28/23, indicated R #108 had a diagnosis of chronic kidney disease, stage 3. 3. R #108's diagnoses indicated that she had Acute kidney failure entered on 10/11/23. 4. R #108's medical record (nowhere in it) does not reflect R 108's diagnosis of chronic kidney disease stage 3. <p>(continued on next page)</p>		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Staff should have updated R #108's medical record to reflect that R #108 has a diagnosis of chronic kidney disease, stage 3 50497

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34303</p> <p>Based on record review, observation and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 6 (R #25, R #30, R #82, R #94, R #109, and R #359) of 6 (R #25, R #30, R #82, R #94, R #109, and R #359) when they failed to have:</p> <p>1) PPE (personal protective equipment equipment designed to protect from infection) was available for R #25, R #30, R #82, R #94, and R #109, who were on enhanced barrier precautions (refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (bacteria that are resistant to three or more classes of antimicrobial drugs) that require gown and glove use during high contact resident care activities).</p> <p>2) Staff wear eye protection when entering R #359 room who had Covid-19 (is an infectious disease caused by the SARS-CoV-2 virus).</p> <p>3) Staff document findings made during process surveillance (the review of practices by staff directly related to resident care. The purpose is to identify whether staff implement and comply with the facility's IPCP (infection prevention and control program) policies and procedures.</p> <p>If the facility fails to maintain an effective infection control program, then infections could spread to residents throughout the facility, resulting in illness. The findings are:</p> <p>PPE</p> <p>A. Record review of the list of residents on enhanced barrier precautions list revealed R #25, R #30, R #82, R #94, and R #109 were on enhanced barrier precautions.</p> <p>B. On 04/18/24 at 12:00 PM, during an interview, the ICN confirmed that R #25, R #30, R #82, R #94, and R #109 were on enhanced barrier precautions.</p> <p>C. On 04/18/24 at 12:03 PM, an observation of R #109's room revealed no PPE available for staff in or outside the room.</p> <p>D. On 04/18/24 at 12:04 PM, during an interview, the ICN confirmed that PPE was not available for staff to use for R #109 in or outside the room. The ICN confirmed that he expected staff should have PPE in the room.</p> <p>E. On 04/18/24 at 12:07 PM, an observation of R #30's room revealed no PPE available for staff in or outside the room.</p> <p>F. On 04/18/24 at 12:08 PM, during an interview the ICN confirmed PPE was not available for staff to use for R #30.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>G. On 04/18/24 at 12:18 PM, an observation of R #25's room revealed no PPE available for staff in or outside of the room.</p> <p>H. On 04/18/24 at 12:19 PM, during an interview the ICN confirmed PPE was not available for staff to use for R #25 in or outside the room.</p> <p>I. On 04/18/24 at 12:22 PM, an observation of R #82's room revealed no PPE available for staff in or outside the room.</p> <p>J. On 04/18/24 at 12:22 PM, during an interview the ICN confirmed PPE was not available for staff to use for R #82 in or outside the room.</p> <p>K. On 04/18/24 at 12:23 PM, an observation of R #94's room revealed no PPE for staff in or outside of the room.</p> <p>L. On 04/18/24 at 12:23 PM, during an interview, the ICN confirmed PPE was not available for staff to use for R #94 in or outside the room.</p> <p>R #359</p> <p>M. Record review R #359's physician's orders dated 04/10/24 revealed that R #359 is on isolation precautions for ten days for Covid-19.</p> <p>N. On 04/18/24 at 12:00 PM, during an interview, the ICN confirmed that R #359 was on droplet precautions (masks and goggles, or a mask with a face shield, to prevent exposure) for Covid-19.</p> <p>O. On 04/18/24 at 12:01 PM, an observation of R #359's room (with the ICN) revealed a bin with PPE outside R #359's room. In the PPE bin was the eye protection staff are to use when entering R #359's room. LPN #3 walked out of R #359's room not wearing any eye protection.</p> <p>P. On 04/18/24 at 12:01 PM, during an interview, the ICN confirmed that LPN #3 was not wearing eye protection. The ICN confirmed that the eye protection was located in the bin of PPE outside of R #359's room.</p> <p>Routine Surveillance</p> <p>Q. Record review of the facility Infection Prevention and control Program policy revised date June 2020 revealed the following:</p> <p>E. Documentation . Findings made during routine surveillance of the workplace for compliance work practices and use of protective clothing or equipment and actions taken in case of noncompliance .</p> <p>R. On 04/24/24 at 4:07 PM, during an interview with the ICN and the DON, the DON stated that the facility is conducting routine surveillance for the infection control program. The DON and ICN confirmed that they do not document that they are conducting routine surveillance or document their findings from the routine surveillance.</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>34303</p> <p>Based on record review and interview, the facility failed to offer Covid-19 (is an infectious disease caused by the SARS-CoV-2 virus) vaccinations to 1 (R #1) of 5 (R #1, R #60, R #71, R #82, and R #88) residents sampled for Covid-19 vaccination. This deficient practice could result in residents getting Covid-19 resulting in other illnesses or death. The findings are:</p> <p>A. Record review of R #1's entire medical record, revealed that the staff failed to document that they offered Covid-19 vaccinations to R #1.</p> <p>B. On 04/24/24 at 3:28 PM, during an interview, the DON confirmed that the staff did not document if R #1 was offered the Covid-19 vaccination.</p>

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>47510</p> <p>Based on record review and interview, the facility failed to ensure that nursing staff have completed the mandatory QAPI (Quality Assurance/Performance Improvement) training for 5 (ADON #1, ADON #2, CNA #21, LPN #24, and CNA #31) of 5 (ADON #1, ADON #2, CNA #21, LPN #24, and CNA #31) staff randomly sampled for staffing. This deficient practice could likely result in staff being unable to identify opportunities for improvement, address gaps in systems or processes, develop and implement an improvement or corrective plan, and continuously monitor the effectiveness of interventions. The findings are:</p> <p>A. Record review of the employee training file undated revealed that ADON #1 did not complete QAPI training.</p> <p>B. Record review of the employee training file undated revealed that ADON #2 did not complete QAPI training.</p> <p>C. Record review of the employee training file undated revealed that CNA #21 did not complete QAPI training.</p> <p>D. Record review of the employee training file undated revealed that LPN #24 did not complete QAPI training.</p> <p>E. Record review of the employee training file undated revealed that CNA #31 did not complete QAPI training.</p> <p>F. On 04/24/24 at 4:26 PM, during an interview, the Administrator confirmed that he does not have any documentation that QAPI training has been provided to facility staff. He said that staff is aware of the policy, but the Administrator said he doesn't provide a training.</p>		