

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  325091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2024
NAME OF PROVIDER OR SUPPLIER  Silver City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3514 Fowler Ave Silver City, NM 88061	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49313</p> <p>Based on record review and interview, the facility failed to report to the State Survey Agency within five (5) days of the incident for 1 (R #21) of 1 (R #21) residents sampled for abuse. If the facility fails to report abuse to the State Agency, then corrective action may not be taken, and residents could likely continue to be abused and/or suffer serious bodily injury. The findings are:</p> <p>A. Record review of R #21's medical record revealed R #21 was admitted on [DATE] and discharged on [DATE].</p> <p>B. Record review of R #21's progress note, dated 01/27/24, revealed R #21 was stuffing trash in the toilet. When asked why, R #21 told staff, I hate this place and everyone in it, I don't want to be here. I have a gun at home and I just want to shoot up this place. I hope you die here and everyone, I wish my wife was here so she could kick you're ass, all of you. I'm going to call the police. I was a golden glove in the military, and I will kick you're ass and your workers, I also know how to use stuff to stab you guys if I wanted to. Resident was placed on one-to-one (staff observing resident one staff to one resident) for the safety of everyone. The nurse began to give R #21 plastic utensils for safety. Staff did not document how long R #21 remained on one-to-one.</p> <p>C. Record review of R #21's progress note, dated 02/01/24, revealed R #21 dumping out ashtrays and attempted to get cigarettes with two small sticks. When staff told R #21 to stop, R #21 told staff, You are a cunt bitch, I wish you were dead, you are violating my rights, I am a veteran, I am going to call my wife to kick you're ass. After the nurse picked up the ashtray, R #21 said, I'm just going to come back out here and do it again, I am going to make everyone's life a living hell around here, I hate this fucken place and everyone in it, I wish this place would burn down. It was documented that R #21 may have a lighter.</p> <p>D. Record review of R #21's progress note, dated 02/06/24, revealed R #21 threw a large amount of silverware, sugar packets, and other items at RN #21. RN #21 had reddened marks across her right ear, cheek, and neck. RN #21 called the police. When questioned by the police, R #21 denied allegations, until shown red marks on RN #21's face. R #21 said, Oh that . well, I didn't want to hurt her. The police determined R #21 had committed battery against a medical professional and arrested R #21.</p> <p>E. On 05/07/24 at 11:13 AM, during an interview with RN #21, she stated the following:</p> <p>1. R #21 was becoming very aggressive and was trying to leave the facility.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>2. R #21 was constantly throwing things like cups at staff and sometimes other residents.</p> <p>3. When R #21 threw the silverware at her face, she felt assaulted and believed that R #21 was creating an unsafe environment for other residents, so she decided to call the police. She was worried that the other residents would not be able to get away if R #21 did that to them.</p> <p>4. Other people saw R#21 throwing silverware at her. However, she was unsure who actually witnessed the incident.</p> <p>F. On 05/07/24 at 12:17 PM, during an interview, the DON confirmed that the facility had not reported R #21's assault on the nurse and arrest to the State Agency because the corporate quality clinical nurse said it did not meet criteria to make a report to the state agency since R #21 assaulted a staff.</p> <p>G. On 05/08/24 at 10:31 AM, during an interview with the Administrator, she confirmed that she was responsible for reporting to the state agency and she did not complete reports to the State Agency regarding R #21's threats, R #21 throwing things at other residents, or his assault on the nurse leading to R #21's arrest.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47510</p> <p>Based on record review and interview, the facility failed to revise the care plan for 2 (R #11 and R #21) of 4 (R #11, R #12, R #13, and R #21) residents reviewed for care plans when they failed to:</p> <ol style="list-style-type: none"> <li>1. Revise R #11's care plan to include her regular/liberalized dysphagia advanced diet (moist foods in bite-sized pieces).</li> <li>2. Have the required Interdisciplinary Team (IDT, team members from different disciplines working collaboratively, with a common purpose to set goals, make decisions, and share resources and responsibilities) members participate in the care plan meeting for R #21.</li> </ol> <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 #11</p> <p>A. Record review of R #11's Speech Therapy (therapeutic treatment of impairments and disorders of speech, voice, language, communication, and swallowing) Evaluation dated 01/16/24 revealed dysphagia advanced diet due to edentulous (lacking teeth) state and poor cognition for safety with swallow.</p> <p>B. Record review of R #11's medical record dated 01/25/24 revealed an order for regular/liberalized diet, dysphasia advanced texture (moist foods in bite-sized pieces).</p> <p>C. Record review of R #11's care plan date 03/08/24, revealed that R #11's Dysphagia Advance diet was not included in R #11 care plan.</p> <p>D. On 05/07/24 at 12:40 PM, during an interview, the DON confirmed that R #11's dysphagia advanced diet was not documented in the care plan. R #11 should have their diet orders care planned according to the DON's expectation.</p> <p>R #21</p> <p>E. Record review of R #21's face sheet revealed he was admitted to the facility on [DATE].</p> <p>F. Record review of R #21's care plan meeting note, dated 08/29/23, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #21's wife attended the care plan meeting.</li> <li>2. The staff in attendance were the MDS coordinator, the Social Services Director (SSD), and the Activities Director.</li> </ol> <p>G. Record review of R #21's care plan meeting note, dated 11/28/23, revealed:</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>1. The resident or his family did not attend.</p> <p>2. The staff in attendance were the MDS coordinator, the Memory Care Director (current Social Services Director (SSD)), and the Activities Director.</p> <p>H. On 05/08/24 at 11:40 AM, during an interview with the SSD, she stated the following:</p> <ol style="list-style-type: none"> <li>1. The MDS coordinator schedules the Care Plan meetings.</li> <li>2. Staff that attended the care plan meetings were the SSD, Activities Director, the MDS Coordinator, and the Administrator.</li> <li>3. The resident and/or resident representative attend the care plan meetings.</li> <li>4. The provider does not attend care plan meetings.</li> <li>5. Nurses providing patient care do not attend care plan meetings.</li> <li>6. CNA's providing care for the residents do not attend care plan meetings.</li> </ol> <p>7. During care plan meetings, they review medications, code status, weight, diet, when physician visit took place, ADL's (Activites of Daily Living), continence, falls, skin, restraints, behaviors, activities, pain, psych medication, and if they want to transfer.</p> <p>I. On 05/08/24 at 11:49 AM, during an interview with the MDS coordinator, she confirmed the following:</p> <ol style="list-style-type: none"> <li>1. She schedules the care plan meetings.</li> <li>2. Staff that attend care plan meetings are the MDS Coordinator, the SSD, and the Activities Director. If the resident is receiving therapy, she invites therapy to attend.</li> <li>3. She is a nurse.</li> <li>4. She does not provide care for the residents. She would not be able to say what the resident's behaviors are like other than what is noted in the progress notes.</li> <li>5. She gets information for the care plan meeting from the MDS assessment.</li> <li>6. She confirmed the MDS assessment is only a 7 day look back and does not cover all information that occurred during the quarter.</li> <li>7. She does not invite a nurse that provides care for the residents to the care plan meeting.</li> <li>8. She does not invite a CNA that provides care for the residents to the care plan meeting.</li> <li>9. She does not invite the provider to the care plan meeting.</li> </ol> <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>10. She is unsure how the providers are aware of what occurred during the care plan meeting.</p> <p>11. She does not contact the physician for input prior to the care plan meeting.</p> <p>12. She does not contact the nurses or CNA's for input prior to the care plan meeting.</p> <p>49313</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49313</p> <p>Based on record review and interview, the facility failed to have a discharge summary that includes a summary of the resident's stay at the facility for 1 (R #22) of 3 (R #21, R #22, and R #23) residents reviewed for discharge. Failure to provide a complete discharge summary that includes a description of the resident's stay at the facility could likely result in the receiving facility or home health or home health agency not having the most current information to provide care to the residents. The findings are:</p> <p>A. Record review of the progress notes revealed that R #22 was discharged on [DATE].</p> <p>B. Record review of R #22's discharge summary, dated 04/22/24, revealed staff did not complete the following areas of the form:</p> <ol style="list-style-type: none"> <li>1. Dietary recommendation.</li> <li>2. Skin condition.</li> <li>3. Current infections.</li> <li>4. Hearing ability.</li> <li>5. Vision ability.</li> <li>6. Dental concerns.</li> <li>7. Speech pattern.</li> <li>8. Bowel and bladder continence.</li> <li>9. Assistance levels.</li> <li>10. Signs and symptoms of a change in condition for the resident.</li> <li>11. Therapy services that were received at the facility.</li> <li>12. Medication reconciliation.</li> <li>13. Any education provided and to whom it was provided.</li> <li>14. Other attachments.</li> <li>15. The form was not signed off by staff.</li> </ol> <p>C. On 05/07/24 at 12:17 PM, during an interview the DON confirmed the following:</p> <p>(continued on next page)</p>

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> <li>1. R #22's discharge summary was incomplete.</li> <li>2. Staff are expected to complete the entire discharge summary document prior to the resident being discharged .</li> <li>3. Staff are expected to complete a medication reconciliation (process of comparing a patient's medication orders to all of the medications that the patient has been taking).</li> <li>4. Staff are expected to provide a copy of the discharge summary document and medication reconciliation to the resident, their representative, and/or the home health agency prior to the resident leaving the facility.</li> </ol>

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<p>F 0689</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47510</p> <p>Based on observation, and interview the facility failed to keep the residents free from accidents for all 61 residents on the 100 and 200 Units (Residents were identified by the resident Census provided by the Administrator on 05/6/24), when they failed to keep treatment carts (a movable piece of equipment used in healthcare facilities to store, transport, and dispense treatment supplies and tools) locked when not supervised by staff. This deficient practice could likely result in injury to residents obtaining medical equipment which can cause injury/death. The findings are:</p> <p>A. On 05/06/24 at 2:30 PM, during an observation of the 100 Unit, the treatment cart was unlocked and opened, the cart had hydrocortisone lotions (medicated lotion, ointment or solution that treats eczema and other skin conditions, scissors, and lancets (a small sharp object used to prick the skin). Staff were not present.</p> <p>B. On 05/06/24 at 2:34 PM, during an interview, LPN #1 confirmed the treatment cart was unlocked and opened.</p> <p>C. On 05/07/24 at 8:58 AM, during an observation of the 200 Unit, the treatment cart was unlocked and opened, the cart had hydrocortisone lotions, scissors, and lancets. Staff were not present.</p> <p>D. On 05/07/24 at 9:00 AM, during an interview, the Unit Manager confirmed the treatment cart was unlocked and opened, even though it is supposed to be locked.</p> <p>E. On 05/07/24 at 12:19 PM, during an interview, the Administrator confirmed that the expectation is that treatment carts should be locked when they are not in use.</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49313</p> <p>Based on record review and interview, the facility failed to provide mental health services for 1 (R #21) of 1 (R #21) residents reviewed for mental health concerns, when the facility failed to provide mental health services for R #21 after the provider placed an order for mental health services.</p> <p>This deficient practice could likely result in worsening of behaviors and worsening of behavioral or mental health conditions causing increased depression and anxiety. The findings are:</p> <p>A. Record review of R #21's face sheet revealed R #21 was admitted on [DATE].</p> <p>B. Record review of R #21's medical diagnoses revealed R #21 had a diagnosis of dementia, depression, and anxiety.</p> <p>C. Record review of R #21's admission referral from hospital, dated 05/06/23, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #21 took Depakote Sprinkles (medication used to treat mental/mood conditions) 125 milligram (mg, unit of measure) twice a day.</li> <li>2. R #21 took Escitalopram (antidepressant medication used to treat depression and anxiety) 10 mg once a day.</li> </ol> <p>D. Record review of R #21's Physician's orders, multiple dates, revealed the following:</p> <ol style="list-style-type: none"> <li>1. An order dated 05/10/23, for Depakote 125 mg twice a day for mood stabilizer.</li> <li>2. An order dated 05/10/23, for Escitalopram Oxalate 10 mg once a day for mood stabilizer.</li> <li>3. An order dated 05/15/23, for Medi-tele care (online service that allows residents to see healthcare provider from home) to evaluate and treat for psychiatric and psychological health.</li> </ol> <p>E. Record review of R #21's entire medical record revealed R #21 did not receive mental or behavioral health services.</p> <p>F. On 05/07/24 at 11:13 AM, during an interview with RN #21, she stated the following:</p> <ol style="list-style-type: none"> <li>1. R #21 would go into other residents rooms and would take things.</li> <li>2. Staff would have to redirect R #21 and get the items to give back to the other residents.</li> <li>3. R #21 was constantly throwing things at staff and other residents.</li> <li>4. R #21 was becoming very aggressive and was trying to leave the facility.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. R #21 lost his smoking privileges at least twice, due to R #21 not following the smoking policy.</p> <p>6. Intervention for R #21's behaviors was to redirect and remove anything that could be over stimulating.</p> <p>7. R #21 would talk to himself and have full conversations and argue with himself.</p> <p>8. R #21 did not receive any mental health services in the facility.</p> <p>G. On 05/07/24 at 9:23 AM, during an interview with the DON, she confirmed the following:</p> <p>1. Medi-Teli care stopped providing services at the facility last year, she was unsure of the date.</p> <p>2. She was unsure if R #21 ever received behavioral health services in the facility.</p> <p>3. There was no documentation that R #21 received behavioral health services while at the facility.</p> <p>H. On 05/07/24 at 11:41 AM, during an interview with the Medical Director (resident #21's primary physician), she stated the following:</p> <p>1. She was unsure what mental health services are being provided to residents at the facility.</p> <p>2. She did not remember R #21.</p> <p>3. She did not remember if she had ever been notified about R #21's behaviors.</p> <p>4. If a resident was having increasing behaviors, it would depend on what services are available at facility, but the staff can notify on-call about increased behaviors.</p> <p>5. If she was notified about increasing behaviors, she would order labs and UA, would look into medications, and social services concerns, and would start medications if the resident was not hurting self or others.</p> <p>6. If resident was showing signs of aggressions that would put residents or staff at risk she would send the resident out for psychiatric evaluation.</p> <p>I. On 05/07/24 at 12:17 PM, during an interview with the DON, she confirmed the following:</p> <p>1. R #21 was never sent to the hospital due to behavioral health issues.</p> <p>2. R #21 was never referred to behavioral health hospitals.</p> <p>3. She was aware that resident would talk to himself.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>49313</p> <p>Based on record review and interview, the facility failed to ensure that staff received the appropriate behavioral health training and have the skills to provide behavioral health services for 1 (R #21) of 1 (R #21) residents reviewed for behavioral health concerns. This deficient practice is likely to result in residents not getting the care and assistance they need. The findings are:</p> <p>A. Record review of R #21's progress notes, revealed the following:</p> <ol style="list-style-type: none"> <li>1. On 01/26/24, R #21 was attempting to break into the ashtray in the smoking area using a metal fork, knife, and toenail clippers. R #21 was found taking things from other residents rooms and staff belongings. When staff discussed with R #21, he stated, I hate it here and want to leave, just let me leave out the door. Resident yelled at staff, you're a bitch and just want to keep me here for the money. When the nurse asked for the silverware, resident reluctantly gave it to the nurse and stated, I'm not going to stop, I plan on making everyone's life a living hell here.</li> <li>2. On 01/27/24, R #21 was stuffing trash in the toilet. When asked why, R #21 told staff, I hate this place and everyone in it, I don't want to be here. I have a gun at home and I just want to shoot up this place. I hope you die here and everyone, I wish my wife was here so she could kick your ass, all of you. I'm going to call the police. I was a golden glove in the military, and I will kick you're ass and your workers, I also know how to use stuff to stab you guys if I wanted to. Resident was placed on one-to-one for the safety of everyone. Nurse began to give R #21 plastic utensils for safety.</li> <li>3. On 01/31/24, R #21 took eating utensils from the kitchen. R #21 refused to give staff the utensils.</li> <li>4. On 02/01/24, R #21 is having a lot of behaviors related to smoking and stealing. R #21 was informed that he had been denied admission into all skilled nursing facilities due to his behaviors. R #21 said, I'll just go home with my wife. R #21 was told that his wife was unwilling to take him home due to his behaviors. R #21 said he will have his wife send his gun and he will shoot up the place.</li> <li>5. On 02/01/24, R #21 was writing on the walls and yelling curse words at staff.</li> <li>6. On 02/01/24, R #21 was stealing belongings from other residents, taking utensils from the kitchen, and stuffing his commode with trash, gloves, trash bags, sugar, and creamer wrappers.</li> <li>7. On 02/01/24, R #21 threw down ashtrays and was attempting to get cigarettes with two small sticks. When told to stop, R #21 told staff, You are a cunt bitch, I wish you were dead, you are violating my rights, I am a veteran, I am going to call my wife to kick you're ass. After the nurse picked up the ashtray, R #21 said, I'm just going to come back out here and do it again, I am going to make everyone's life a living hell around here, I hate this fucken place and everyone in it, I wish this place would burn down. R #21 was documented to possibly have a lighter.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8. On 02/02/24, R #21 attempted to use the phone at the nurses' station. When told to put the phone back, R #21 threw the phone on the floor.</p> <p>9. On 02/06/24, R #21 tipped over the ashtray and was using utensils to get cigarette butts out of ashtray. R #21 denied trying to get cigarette butts. R #21 was reeducated on infection prevention and smoking policies.</p> <p>10. On 02/06/24, R #21 was banging the back of his wheelchair into the door. R #21 was educated not to destroy company property. R #21 became agitated and asked why they keep him there. Staff asked R #21 if he didn't want to be in the facility. R #21 told staff he has been wanting to get out. Staff asked R #21 if he would like to be discharged to the local homeless shelter. R #21 said, yes, get me out of here.</p> <p>11. On 02/06/24, R #21 was yelling at staff, fuck you bastards, I'll kick you're ass. R #21 threatened staff and other residents. R #21 was caught stealing from other residents, hoarding spoons, forks, and knives.</p> <p>12. On 02/06/24, R #21 threw a large amount of silverware, sugar packets, and other items at RN #21. RN #21 had reddened marks across her right ear, cheek, and neck. RN #21 called the police. When questioned by the police, R #21 denied allegations, until shown red marks on RN #21's face, and R #21 said, Oh that . well, I didn't want to hurt her. The police determined R #21 had committed battery against a medical professional and arrested R #21.</p> <p>B. Record review of R #21's entire medical record revealed the record did not have any documentation that the provider was notified about R #21's behaviors.</p> <p>C. On 05/07/24 at 11:13 AM, during an interview with RN #21, she stated the following:</p> <ol style="list-style-type: none"> <li>1. R #21 would go into other residents rooms and would take things.</li> <li>2. Staff would have to redirect R #21 and get the items to give back to the other residents.</li> <li>3. R #21 was constantly throwing things at staff and other residents.</li> <li>4. R #21 was becoming very aggressive and was trying to leave the facility.</li> <li>5. Intervention for R #21's behaviors was to redirect and remove anything that could be over stimulating.</li> <li>6. R #21 would talk to himself and have full conversations and argue with himself.</li> <li>7. R #21 did not receive any mental health services in the facility.</li> <li>8. The facility had not provided her with any training on dealing with residents with behavioral health issues or aggressive behaviors.</li> </ol> <p>D. Record review of RN #21's trainings revealed RN #21 had not completed any trainings related to behavioral health and dealing with aggressive residents.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>E. On 05/08/24 at 10:55 AM, during an interview with the DON, she confirmed the following:</p> <ol style="list-style-type: none"> <li>1. The Social Services Director (SSD) completed a training with several CNA's.</li> <li>2. The training included how to handle residents with dementia and how to handle behavioral health issues.</li> <li>3. The rest of the facility has not received the behavioral health training.</li> <li>4. Staff did not receive behavioral health training when R #21 was becoming physically and verbally aggressive.</li> <li>5. Staff do not complete any skills competencies for dealing with behavioral health and verbal and assaultive behaviors.</li> <li>6. RN #21 did not have behavioral health training.</li> </ol> <p>F. On 05/08/24 at 11:08 AM, during an interview with the SSD, she confirmed the following:</p> <ol style="list-style-type: none"> <li>1. The training she provided was an 8-hour training to CNA's for the management of aggressive behaviors and teaches de-escalation of aggressive behavior (training was on multiple dates).</li> <li>2. The training on management of aggressive behaviors provides staff with the skills they need to handle a resident with physical and verbally aggressive behaviors.</li> <li>4. She has provided the training on management of aggressive behaviors to some of the CNA's on multiple dates.</li> <li>5. She has not provided the training on the management of aggressive behaviors to the nurses or other clinical staff.</li> </ol>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49313</p> <p>Based on interview and record review, the facility failed to provide social services for 1 (R #21) of 1 (R #21) residents reviewed for behavioral/emotional health, when they failed to provide timely referrals for R #21 to other long term nursing facilities after R #21 requested to be transferred.</p> <p>This deficient practice could likely lead to residents to feel that their wishes are not important and not attaining, or maintaining, their highest practicable mental and psychosocial well-being. The findings are:</p> <p>A. Record review of R #21's face sheet revealed he was admitted to the facility on [DATE].</p> <p>B. Record review of R #21's progress note, dated 06/05/23, revealed R #21 stated that R #21 wanted to be moved to [name town] near his wife.</p> <p>C. Record review of R #21's progress note, dated 08/07/23, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #21 stated that he wanted to leave the facility.</li> <li>2. R #21 stated that he wanted to go home and live with his wife.</li> <li>3. R #21 stated that if he could not live with his wife he would like to go to a veterans nursing facility.</li> <li>4. R #21's wife told the Social Service Director (SSD), that she did not want R #21 moving in with her, but it was okay if they found another facility in [name of town] where she lived.</li> </ol> <p>D. Record review of R #21's progress note, dated 09/18/23, revealed the following:</p> <ol style="list-style-type: none"> <li>1. Staff spoke with R #21's wife.</li> <li>2. R #21's wife said she could not take R #21 in.</li> <li>3. The facility said they would send referrals to other nursing home facilities.</li> </ol> <p>E. Record review of R #21's progress note, dated 09/25/23, revealed R #21 wanted to go to a facility in [name of town] where his wife lives because they will help him get a leg. Staff said they would send referrals.</p> <p>F. Record review of R #21's progress note, dated 10/17/23, revealed staff and family had a discharge meeting and discussed sending referrals close to where R #21's wife and daughter lived.</p> <p>G. Record review of R #21's physician's orders, dated 10/19/23, revealed an order to transfer R #21 to a long-term care facility closer to R #21's home.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>H. Record review of R #21's progress note, dated 11/28/23, revealed the following:</p> <ol style="list-style-type: none"> <li>1. R #21 wanted to go home.</li> <li>2. R #21's wife and daughter determined that it was not possible for R #21 to return home.</li> <li>3. R #21's wife and daughter said they wanted R #21 to be moved to a nursing home closer to them.</li> </ol> <p>I. Record review of R #21's referral packet, dated 01/17/24, revealed a referral packet was faxed to a long-term care facility for veterans that was 148 miles away from [name of town] where R #21's wife and daughter lived.</p> <p>J. Record review of R #21's DON progress note, dated 02/01/24, revealed facility said they had contacted multiple SNF facilities to have R #21 transferred, but had been denied due to his behaviors. The progress note did not specify which facilities had been contacted.</p> <p>K. Record review of progress note, dated 02/06/24, revealed the local homeless shelter was contacted and they did not have any beds available for R #21.</p> <p>L. On 05/08/24 at 9:59 AM, during an interview with the SSD, she confirmed the following:</p> <ol style="list-style-type: none"> <li>1. She was responsible for making referrals for transfers to other long term care facilities if the resident or their family requested to be transferred.</li> <li>2. She was aware that R #21 wanted to go home or be transferred to a long-term care facility closer to his wife and daughter.</li> <li>3. She provided one referral packet for R #21, dated 01/17/24, to a long-term care facility.</li> <li>4. She was unable to find any other referral packets for R #21 to other long term care facilities.</li> <li>5. She was unable to specify what other facilities she had sent referral packets for R #21 to transfer to.</li> </ol> <p>M. Record review of R #21's entire medical record revealed the record did not contain any documentation that R #21 had been referred to other nursing facilities prior to the one referral made on 01/17/24.</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>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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47510</p> <p>Based on record review and interview, the facility failed to ensure residents did not receive psychotropic medications unless the medication was necessary to treat a specific psychiatric diagnosis and was documented in the medical record for 1 (R #12) of 3 (R #11, R #12 and R #13) residents reviewed for unnecessary psychotropic medications. This deficient practice could likely result in residents receiving medications without a medical reason and being at a higher risk of adverse side effects (unwanted, harmful, or abnormal result). The findings are:</p> <p>A. Record review of R #12's admission record, not dated, revealed an admitted [DATE] for R #12.</p> <p>B. Record review of R #12's Physician's orders revealed an order, dated 02/05/24, for Risperidone (an antipsychotic medication used to treat schizophrenia and bipolar disease) tablet, 0.5 mg two times a day for psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality).</p> <p>C. Record review of R #12's Medical Administration Record (MAR) for April 2024, documented R #12 was taking Risperidone as prescribed.</p> <p>D. Record review of R #12's care plan dated 03/20/24, revealed to monitor R #12 for changes in mental status and functional level and report to MD as indicated.</p> <p>E. Record review of R #12's entire medical record revealed R #12 does not have a documented diagnosis of psychosis or a psychiatric diagnosis to indicate the need for an antipsychotic.</p> <p>F. On 05/07/24 at 12:26 PM, during an interview, the DON confirmed R #12 does not have a documented diagnosis of psychosis. The DON said that R #12 was sent out for a psychiatric evaluation on 01/20/22 and that R #12 was prescribed Risperidone at that time. The DON stated that that based on the psychiatric evaluation that the medication was needed. The DON confirmed that the psychiatric evaluation did not document a diagnosis of psychosis. The DON confirmed that R #12 did not have a psychiatric diagnosis on documented for the antipsychotic medication.</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>47510</p> <p>Based on observation, record review, and interview the facility failed to provide a therapeutic diet (a diet ordered by a physician or delegated registered or licensed dietitian as part of treatment for a disease or clinical condition, or to eliminate or decrease specific nutrients in the diet) as ordered by a physician for 1 (R #11) of 3 (R #11, R #12, R #13) residents reviewed for dietary services. If the facility fails to provide a diet as ordered, then residents are likely to experience weight loss due to not receiving their prescribed nutritional caloric intake and may be at risk for choking. The findings are:</p> <p>A. Record review of R #11's physician order dated 01/25/24, revealed an order for regular/liberalized diet, dysphagia advanced texture (bite sized foods that are moist with the exception of crunchy, sticky or very hard foods).</p> <p>B. On 05/07/24 at 11:59 AM, during an observation, R #11's was served whole chicken nuggets, whole French fries (not chopped).</p> <p>C. On 05/07/24 at 12:15 PM, during an interview, CNA #11 confirmed that R #11 was served whole chicken nuggets and whole French fries.</p> <p>D. On 05/07/24 at 12:40 PM, during an interview, the DON confirmed that R #11 is on a dysphagia advanced diet. The DON said R #11 should be served mechanical soft, chopped bite size, and soft fruit and vegetables. The DON confirmed that R #11's chicken nuggets and French fries should have been chopped.</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 store, and serve food under sanitary conditions in accordance with professional standards of food service safety for 77 residents that eat food prepared in the kitchen in the facility (residents were identified on the resident matrix provided by the Administrator on 09/11/23), when they failed to:</p> <ol style="list-style-type: none"> <li>1. Wear facial hair coverings and hairnets in the kitchen.</li> <li>2. Store food in a sanitary manner.</li> </ol> <p>If the facility fails to adhere to safe food handling practices, hygiene practices, and safe food storage, residents could likely to be exposed to foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). The findings are:</p> <p>A. On 05/06/24 at 12:41 PM, during an observation of the kitchen revealed the following:</p> <ol style="list-style-type: none"> <li>1. Six frozen hamburger patties sitting on top of a microwave. The hamburger patties were not in a wrapper, or on a plate or in a container.</li> <li>2. The Dietary Manager (DM) #11 did not have a facial net covering his moustache and he did not have a hairnet on.</li> </ol> <p>B. On 05/06/24 at 12:42 PM, during an interview, the DM confirmed that the hamburger patties should not be left out without being in a container or on a plate. The DM said that the cook had put the hamburger patties there because she was about to cook them. The DM confirmed that he was not wearing hair coverings. The DM confirmed that hair should be covered in the kitchen.</p>