

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365770	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Cambridge		STREET ADDRESS, CITY, STATE, ZIP CODE 1471 Wills Creek Valley Drive Cambridge, OH 43725	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on medical record review, staff interview and review of the facility policy, the facility failed to notify physicians of significant weight changes. This affected one (Resident #50) of five residents reviewed for nutrition. The facility census was 68. Findings include: Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including anoxic brain injury damage, adult failure to thrive, unspecified protein-calorie malnutrition, gastrostomy, aphasia, dysphagia, contracture of left and right hand, drug induced dyskinesia, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #50 dated 03/20/24 revealed the resident had severely impaired cognition and was dependent on the assistance of staff for eating. Resident #50 had symptoms of a swallowing disorder including loss of liquids or solids from mouth when eating or drinking, holding food in mouth or residual food in mouth after meals, coughing or choking during meals or when swallowing medications, and complaints of difficulty or pain when swallowing. Resident #50 weighed 103 pounds with no significant weight changes. Resident #50 had a feeding tube and a mechanically altered diet. The feeding tube provided 51 percent (%) or more of total calories and 501 milliliters (ml) per day or more of fluids. Review of the weight records for Resident #50 revealed on 10/03/23 the resident weighed 108.8 pounds, and on 11/21/23 she weighed 102.2 pounds which was a 6.06 % weight loss over one month. Review of the medical record for Resident #50 revealed it did not include documentation of physician notification of the resident's significant weight loss. Interview on 05/15/24 at 3:40 P.M. with Dietitian #202 confirmed she was unsure if the physician was notified of Resident #50's significant weight loss. Interview on 05/16/24 at 10:00 A.M. with Regional Director of Clinical Services (RDCS) #201 verified there was no evidence the physician was notified of Resident #50's significant weight change. (continued on next page)		

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Notification of Changes dated 04/15/21 revealed the facility must inform the resident, consult with the physician, and notify the resident's family or legal representative when there was a change requiring notification. These changes included significant changes in the resident's physical, mental or psychological condition or circumstances that required a need to alter treatment.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on medical record review and staff interview, the facility failed to ensure resident Pre-Admission Screening and Resident Review (PASARR) documents accurately reflected resident diagnoses. This affected one (Resident #27) of two residents reviewed for PASARR documents. The facility census was 68 residents. Findings include: Review of the medical record for Resident #27 revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia with agitation, bipolar disorder, cognitive communication deficit, and alcohol abuse with encephalopathy. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #27 dated 03/09/24 revealed the resident had severely impaired cognition, and had diagnoses of dementia, anxiety disorder, depression, and bipolar disorder. Review of the PASSAR document for Resident #27 dated 04/11/17 revealed diagnoses of schizophrenia and mood disorder were listed. Review of the cumulative diagnosis list for Resident #27 revealed the diagnoses of anxiety disorder was added on 06/14/22. Interview on 05/15/24 at 10:13 A.M. with Social Services Designee (SSD) #106 confirmed Resident #27's PASARR document did not include the diagnosis of an anxiety disorder, and the document should have been updated.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on medical record review and staff interview, the facility failed to develop a care plan that addressed palliative care. This affected one (Resident #43) out of one resident reviewed for hospice. The facility census was 68. Findings include: Review of the medical record for Resident #43 revealed an admitted [DATE] with diagnoses including unspecified protein-calorie malnutrition, depression, atherosclerotic heart disease, spinal stenosis, adult failure to thrive, low back pain, cognitive communication deficit, osteoarthritis, anxiety disorder, and unspecified dementia. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment, dated 03/18/24, revealed Resident #43 was severely cognitively impaired. Review of the hospice visit, dated 12/04/23, revealed Resident #43's initial palliative assessment was completed. Review of Resident #43's physician order, dated 03/05/24, revealed an order for hospice palliative care. Review of Resident #43's plan of care, last reviewed 03/31/24, revealed Resident #43 receiving palliative care was not addressed in the care plan. Interview on 05/16/24 at 3:20 P.M. with MDS Nurse #116 verified Resident #43 admitted to palliative care in December 2023. She reported palliative care did not have it's own care area because they did not do care plans for palliative care.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure comprehensive resident care plans were updated with changes in treatment. This affected two (Residents #32 and #33) of 24 residents reviewed for care plans. The facility census was 68. Findings include: 1. Review of the medical record for Resident #32 revealed an admitted [DATE] with diagnoses including paraplegia, hypertensive heart disease, history of transient ischemic attack and cerebral infarction, hypoxemia, diabetes mellitus, and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment for Resident #32 dated 04/10/24 revealed the resident had moderate cognitive impairment. Review of the care plan for Resident #32 dated 09/03/22 revealed the resident experienced pain/discomfort related to paraplegia, wounds, and immobility. Interventions included the following: administer pain medications as ordered, observe for side effects and effectiveness. The care plan was not updated to reflect the resident's order for methadone. Review of the physician's orders for Resident #32 revealed an order dated 12/16/23 for methadone five milligram (mg) tablet by mouth three times a day for pain. Interview on 05/16/24 at 11:00 A.M. with Licensed Practical Nurse (LPN) #116 confirmed Resident #32's care plan did not reflect the use of methadone for pain management. Interview on 05/20/24 at 11:20 A.M. with the Director of Nursing (DON) confirmed Resident #32's care plan was not updated to reflect the use of methadone for pain management. Review of the facility policy titled Pain Management dated 08/22/22 revealed the interventions for pain management would be incorporated into the components of the comprehensive care plan, addressing conditions or situations that might be associated with pain or might be included as a specific pain management need or goal. 43064 2. Review of the medical record for Resident #33 revealed an admitted [DATE] with diagnoses including chronic kidney disease stage three, severe protein-calorie malnutrition, type two diabetes mellitus, depression, retention of urine, obstructive and reflux uropathy, and acute on chronic diastolic heart failure. Review of the quarterly MDS assessment for Resident #33 dated 03/25/24 revealed the resident had intact cognition. She received injections and insulin during the lookback period, antidepressants, anticoagulant, antibiotics, and diuretics. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the after-visit summary for Resident #33 dated 01/03/24 revealed the physician started the resident on Macrobid once daily for recurrent urinary tract infections (UTIs.) Review of the physician's orders for Resident #33 revealed an order dated 01/03/24 for Macrobid oral capsule 100 mg one capsule to be given one time a day for UTI. Review of Resident #33's plan of care on 05/16/24 revealed the care plan had not been updated to include the use of Macrobid for UTIs. Interview on 05/20/24 at 10:49 A.M. with Regional Director of Operations (RDCO) #203 confirmed Resident #33's care plan had not been updated to include the use of Macrobid for UTIs. Review of the facility policy titled Comprehensive Care Plans dated 08/22/22 revealed the facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on medical record review, observation, staff interview, resident interview and review of the facility policy, the facility failed to provide proper nail care to dependent residents. This affected two (Residents #23 and #32) of five residents reviewed for activities of daily living (ADL) care. The facility census was 68 residents. Findings include: 1. Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including diabetes mellitus, obsessive compulsive personality disorder, moderate intellectual disabilities, and muscle weakness. Review of the Minimum Data Set (MDS) assessment for Resident #23 dated 04/08/24 revealed the resident had severely impaired cognition and was dependent on staff assistance with bathing and personal hygiene. Review of the care plan for Resident #23 dated 04/29/24 revealed the resident was totally dependent and did not participate in any aspect of the tasks of personal hygiene. Interventions included staff would assist the resident as needed with daily hygiene. Observations on 05/13/24 at 9:58 A.M., 05/14/24 at 12:53 P.M., and 05/15/24 at 2:04 P.M. revealed Resident #23 had brown material caked underneath the nailbeds of all fingers on both hands. Interview on 05/15/24 at 2:04 P.M. with Licensed Practical Nurse (LPN) #144 confirmed Resident #23 had a brown substance underneath the nailbeds of all fingers on both hands. Interview on 05/16/24 at 12:07 P.M. with Resident #23 confirmed he would like to have his nails cleaned and trimmed. 2. Review of the medical record for Resident #32 revealed an admitted [DATE] with diagnoses including paraplegia, hypertensive heart disease, history of transient ischemic attack and cerebral infarction, hypoxemia, diabetes mellitus, and chronic kidney disease. Review of the MDS assessment for Resident #32 dated 04/10/24 revealed the resident had moderately impaired cognition and was dependent on staff for assistance with bathing and personal hygiene. Review of the care plan for Resident #32 dated 12/14/22 revealed the resident required staff assistance with ADLs. Interventions included staff to provide assistance for personal hygiene as the resident was totally dependent and did not participate in any aspect of the task. Observation on 05/13/24 at 2:22 P.M. of Resident #32 revealed the resident's fingernails were long and extended beyond the tip of his fingers. Interview on 05/15/24 at 2:15 P.M. with Resident #32 confirmed his nails were too long and he had asked the staff to cut them, but they had not done so. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/15/24 at 2:48 P.M. with State-tested Nursing Assistant (STNA) #151 confirmed Resident #32's nails were long and needed to be trimmed. STNA #151 stated the facility policy required a nurse to trim the nails of any resident who was diabetic, and she would notify the nurse. Interview on 05/15/24 at 2:58 P.M. with LPN #168 confirmed Resident #32's nails were long and needed to be trimmed. Review of the facility policy titled Resident Care revised June 2018 revealed facility staff would provide general care as necessary for each resident per their preferences when able, and per physician orders. Staff would assist dependent residents with cleaning and cutting of fingernails.		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on medical record review, review of hospital records, staff interview, and policy review, the facility failed to ensure fall interventions were implemented and residents were provided the appropriate level of assistance to prevent falls. This affected one (Resident #27) of six residents reviewed for accidents. The facility census was 68. Actual Harm occurred on 04/29/24 at approximately 4:30 A.M. when Resident #27, who was assessed to have severely impaired cognition, required physical assistance of one staff member for lower body dressing and was identified as a high fall risk, fell after having been instructed by staff (while in the shower room with the resident) to stand up and remove his pants, without staff assistance on a wet floor. Resident #27 sustained a displaced, comminuted (broken into several pieces) fracture of the left radius (one of the two large bones of the forearm) and a displaced fracture of the right ulna styloid process (small bony projection at the end of the ulna bone that maintains wrist stability and facilitates wrist movements). Findings include: Medical record review revealed Resident #27 was admitted to the facility on [DATE] with diagnoses including dementia with agitation, bipolar disorder, anxiety disorder, cognitive communication deficit, alcohol abuse with encephalopathy, cerebral atherosclerosis, and contracture of the left ankle. Review of the Care Plan, last reviewed 03/20/24, revealed Resident #27 was at risk for falls related to alcohol induced dementia, neuropathies, cognitive communication deficit, confusion, shuffling gait, poor communication/comprehension, unawareness of safety needs, medication use, and wandering with interventions which included ensuring the call light was always within reach and wearing non-skid footwear while out of bed. Review of the quarterly Minimum Data Set (MDS) assessment, dated 03/09/24, revealed the resident had severely impaired cognition, with no behaviors or rejection of care. The assessment further revealed the resident required moderate/partial physical assistance for lower body dressing and putting on/taking off footwear; and was dependent for showers and baths. The assessment indicated the resident had impairment, on one side of a lower extremity, and his mobility device was a wheelchair. Review of the Fall Risk Assessment, dated 04/02/24, revealed Resident #27 was determined to be a high fall risk. Review of a nursing progress note (authored by Licensed Practical Nurse (LPN) #205), dated 04/29/24 at 4:30 A.M., revealed while State-tested Nursing Assistant (STNA) #132 was getting the shower ready, Resident #27 stood up quickly to take his pants off, lost his balance, and landed on his left wrist/arm. The fall was witnessed. Resident #27 denied pain and stated he just fell over. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Incident Report and Fall Investigation, dated 04/29/24 at 4:30 A.M., revealed the incident location was the shower. While the STNA was getting the shower ready, Resident #27 stood up quickly to take his pants off and lost balance, landing on his left wrist/arm. The fall was witnessed with no head injury noted. The resident was assessed, and a darkened area was noted to the left wrist. The family and physician were notified. A mobile x-ray of the left wrist and shoulder was ordered by the physician. The incident report indicated at the time of the fall, the resident was alert and oriented to person only; the predisposing psychological factors were confusion and impaired memory; and the predisposing environmental factors were a wet floor and non-skid socks not being in place. Review of the Post-Fall Investigation form, dated 04/29/24, revealed Resident #27 fell on [DATE] at 4:30 A. M. The investigation form was completed by LPN #205 and the Director of Nursing (DON). The section on the form titled Care Plan Interventions in Place was blank. The new interventions listed for Resident #27 were an x-ray of the left upper extremity, and for the STNA to have the shower room ready. The bottom section of the form, which was completed by the DON, indicated with check marks that the intervention was appropriate and documented in the care plan. Review of a nursing progress note (authored by the DON), dated 04/29/24 at 8:20 A.M., revealed the interdisciplinary team (IDT) met and reviewed Resident #27's fall on 04/29/24 at 4:30 A.M. in the shower room. While STNA #132 was getting the shower ready, the resident stood up quickly to take his pants off and lost balance, landing on his left wrist/arm. The fall was witnessed with no head injury. The resident denied pain and stated he just fell over. Vital signs were obtained, and a skin assessment revealed a darkened area to the left wrist. The resident denied pain. A mobile x-ray was ordered of the left wrist. The post fall intervention put into place was for the STNA to have the shower ready for the resident prior to taking the resident into the shower room and the STNA was to assist the resident with removing his clothes. Review of the Emergency Department Provider Notes, dated 04/29/24 at 11:45 A.M., revealed Resident #27 presented after an outpatient x-ray obtained at his nursing facility indicated a left wrist fracture. The resident, who has a history of dementia, stated he did not remember when he sustained the injury. The resident complained of tenderness and pain to the left wrist. The musculoskeletal examination revealed significant edema, subacute ecchymosis, and tenderness to palpation without active or passive range of motion testing performed. The x-ray impression was an impacted intra-articular distal radius fracture with comminution and mild dorsal angulation resulting in posttraumatic ulnar positive variance and a small displaced ulnar styloid process fracture. X-rays were discussed and reviewed with orthopedic surgery who recommended splint placement and close follow-up at their office. A fiberglass splint was placed. Review of STNA #132's Witness Statement, dated 04/29/24, revealed she was in the southeast shower room with Resident #27 when he fell. STNA #132 stated Resident #27 was usually a partial/moderate assist with footwear but required supervision for upper and lower dressing. The STNA stated I told him to go ahead and stand up to get his pants off. After the resident stood up, he lost his balance and fell over, falling on his left side. STNA #27 stated the resident hit his wrist fairly hard, but he didn't hit his head. STNA #132 went to the hallway and yelled for the nurse. LPN #205 came and assessed the resident. The resident stated his wrist pain was a five out of 10 (zero was no pain and ten was the worst pain possible). (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of an in-service, dated 04/29/24, revealed the topic: STNA to have shower room set-up and ready for the resident prior to taking the resident to the shower room. The in-service was signed by 11 nursing staff members. Review of a Nurse Practitioner (NP) progress note, dated 05/01/24 and untimed, revealed a follow-up visit with Resident #27 for an acute left wrist fracture and previously identified neck mass. The assessment indicated Resident #27 had a fracture at wrist/and or hand level with the plan for surgical intervention with an open reduction and internal fixation (ORIF) or closed reduction with casting on 05/07/24. Resident #27 reported some mild pain in his left wrist. The resident fell on [DATE] in the shower with immediate pain that was progressive to the left wrist. Interview on 05/14/24 at 3:23 P.M. with the DON confirmed the fall investigation determined STNA #132 was getting the shower room ready when Resident #27 stood up and sustained a fall. The DON verified the investigation determined the predisposing factors were a wet floor, non-skid socks not in place, as well as the resident's confusion and his impaired memory. The DON confirmed following the incident, the intervention initiated was for staff to have the shower room ready prior to taking a resident into the shower room. The DON further confirmed some staff received an in-service on this topic. Interview on 05/14/24 at 4:34 P.M. with STNA #132 revealed prior to Resident #27's fall, she walked with him to the shower room. STNA #132 stated normally she will turn the shower on to have the water already running before bringing the resident into the shower room. STNA #132 stated she did not turn on the water ahead of time and prior to bringing the resident from his room because she had given two other showers that night and she was afraid the water would get too hot. STNA #132 stated, I turned around to turn the water on to let it heat up and I told him to pull his pants off. When I turned around, I saw that he was falling backwards, he fell on his side and tried to catch himself. STNA #132 revealed that she went to the shower room door and called for the nurse to come and help. Resident #27 complained that his wrist was hurting. The STNA stated when LPN #205 came to assess the resident, he was already completely undressed, and was not wearing non-skid socks. STNA #132 stated the resident's wrist was beginning to swell and he complained that it felt stiff. Interview on 05/15/24 at 7:40 A.M. with the DON confirmed STNA #132 should have had the shower room ready before bringing Resident #27 into the shower room. The DON confirmed STNA #132 should have assisted Resident #27 with removing his pants, and Resident #27 should have been wearing his non-skid socks. Interview on 05/15/24 at 8:17 A.M. with STNA #113 revealed Resident #27 required physical assistance from staff for lower body dressing and undressing. Interview on 05/20/24 at 8:10 A.M. with the DON revealed on Friday evening, 05/17/24, STNA #132 came to her and stated that in fact, Resident #27 had been wearing non-skid socks, the shower room floor was not wet, and she was facing the resident when he was removing his pants. The DON confirmed STNA #132's new statement had changed from her post-fall witness statement and did not reflect the information documented in the facility's fall investigation. Interview on 05/20/24 at 9:38 A.M. with STNA #114 verified Resident #27's call light was not within reach, and she would place it on his bedrail. Interview on 05/20/24 at 11:28 A.M. with the DON confirmed a care planed fall intervention for Resident #27 was for the call light to be within reach. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a second interview on 05/20/24 at 9:52 A.M., STNA #132 stated on Friday evening, 05/17/24, she spoke with the DON about Resident #27's fall. STNA #132 stated prior to Resident #27's fall, the floor was not wet, and the resident was wearing non-skid socks. When asked by the state surveyor why her second interview was inconsistent and differed from her first interview regarding Resident #27's fall, STNA #132 stated the whole incident had made her nervous and about 30 minutes prior to her first interview with the state surveyor, the DON called her and spoke to her about the incident. STNA #132 stated at the time of her first interview, nothing was fresh in my mind, but once I read my statement, it refreshed my memory, and it wasn't that I lied in my first statement. STNA #132 stated she walked with the resident from his room into the shower room. While the resident started to remove his shirt, she placed a bath blanket on a floral chair and then told the resident to sit down. The resident sat down in the chair and then she told him to remove his pants. Next, the resident then stood up to remove his pants. STNA #132 stated prior to the fall, she was standing in front of Resident #27 when he started stumbling. The resident was able to regain his balance and then removed his pants. The resident started stumbling again and lost his balance and fell to the side and hit his wrist. STNA #132 stated, I completely remember being with him. I didn't think to have him sit back down when he started stumbling, I felt bad. I felt terrible. STNA #132 further stated that following the fall and assessment by LPN #205, Resident #27 did complain of wrist pain, however, she proceeded to give him his shower. Following the shower, she dressed him and walked him back to his room. STNA #132 stated she was not told of any new fall intervention after the fall and did not receive an in-service regarding the incident. Interview on 05/20/24 at 11:56 A.M. with LPN #205 revealed STNA #132 activated the shower room's call light and he responded. LPN #205 observed the resident sitting on the floor beside a white shower chair and the resident was naked. LPN #205 stated he did not see any non-skid socks and assumed the resident had not been wearing any, which is why he indicated this in his nursing progress note following the fall; however, following a subsequent conversation with STNA #132 on Friday evening, 05/17/24, she told him that Resident #27 had been wearing his non-skid socks prior to the fall. LPN #205 stated following Resident #27's fall, he observed the shower room's floor to be wet (as documented in his nursing progress note), and the room was hot and steamy. LPN #205 stated the immediate fall intervention initiated was to make sure the shower room floors were dry before taking a resident into the shower room and for Resident #27 to be assisted by two staff members for showers. Review of the facility policy titled, Fall Prevention Program, dated 07/19/23, revealed each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Fall interventions may include call light and frequently used items to be within reach and to encourage residents to wear shoes or slippers with non-slip soles when ambulating. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care, interventions will be monitored for effectiveness.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on medical record review, review of a tray ticket, observation, staff interview, and policy review, the facility failed to ensure residents who were not supposed to receive liquids by mouth were not provided liquids by mouth and failed to ensure nutritional supplements were provided as ordered. This affected one resident (#50) out of five residents reviewed for nutrition. The facility census was 68. Findings include: Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including anoxic brain injury damage, adult failure to thrive, unspecified protein-calorie malnutrition, gastrostomy, aphasia, dysphagia, contracture of left and right hand, drug induced dyskinesia, and cognitive communication deficit. Review of Resident #50's quarterly Minimum Data Set 3.0 assessment, dated 03/20/24, revealed the resident had severely impaired cognition and was dependent on staff for eating. Resident #50 had symptoms of a swallowing disorder including loss of liquids or solids from mouth when eating or drinking, holding food in mouth or residual food in mouth after meals, coughing or choking during meals or when swallowing medications, and complaints of difficulty or pain when swallowing. She weighed 103 pounds with no significant weight changes. She had a feeding tube and mechanically altered diet. The tube feeding was coded as providing 51% or more of total calories and 501 cc/day or more of fluids. Review of Resident #50's plan of care, dated 04/04/23, revealed she had a potential alteration in nutrition or hydration status related to impaired chewing and swallowing function, significant weight loss prior to admission, a body mass index (BMI) that indicated she was underweight, and dependence on enteral support. Interventions included medications according to physician orders, monitoring weight every month and as needed, providing diets as ordered, she was to receive a modified meal tray of one pureed item, providing meal assistance as needed, providing supplements as ordered, dietitian evaluation, and referring to speech therapy. Review of Resident #50's physician order, dated 01/03/23 to 05/13/24, revealed the resident was on a pureed texture diet and she was to receive one cold item at breakfast, lunch, and dinner. There was no order for liquids. Review of Resident #50's weights, from 12/05/23 to 05/06/24, revealed on 12/05/23 she weighed 104.0 pounds, on 01/02/24 she weighed 102.0 pounds, on 02/05/24 she weighed 104.0 pounds, on 03/01/24 she weighed 103.0 pounds, on 04/01/24 she weighed 102.6 pounds, and on 05/06/24 she weighed 103.2 pounds. As of 05/06/23, Resident #50's BMI was 17.7 which indicated she was underweight. Review of Resident #50's active physician order, dated 12/05/23, revealed an order for Magic Cup (nutritional supplement) three times daily with meals. Review of Resident #50's active physician order, dated 02/27/24, revealed an order for bolus tube feeds of Isosource 1.5 calorie, give 375 milliliters (ml) every six hours at 6:00 A.M., 12:00 P.M., 6:00 P.M., and 12:00 A.M. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/13/24 at 12:25 P.M. of the lunch meal revealed State tested Nursing Assistant (STNA) #119 approached Resident #50 to assist her with her meal. STNA #119 was observed telling STNA #103 that she was told Resident #50 drank thin liquids. STNA #119 left Resident #50 and obtained a glass of lemonade. STNA #119 was observed giving Resident #50 two sips of the thin liquid. Resident #50 was observed holding the lemonade in her mouth with it leaking down the sides of her mouth. STNA #119 reported the resident was holding the liquid and stopped feeding her. Resident #50 was served applesauce and a bowl of a pureed item as the lunch meal. STNA #119 was observed feeding the resident and when Resident #50 was done eating, STNA #119 walked away from the table. Observation of Resident #50's tray ticket revealed a magic cup was not indicated on the tray ticket and liquids were not listed on the tray ticket. Interview on 05/13/24 following the 12:25 P.M. observation, with STNA #119 verified Resident #50's tray ticket did not address orders for liquids. STNA #119 reported she had been told the resident could tolerate thin liquids, so she gave them to her. STNA #119 verified she had given Resident #50 thin liquids and she had not tolerated them. The interview verified Resident #50 had not been given a magic cup. STNA #119 additionally verified Resident #50 had an order for a magic cup however it was not on the tray ticket. Interview on 05/13/24 following the 12:25 P.M. observation with Registered Nurse (RN) #164 revealed she did not think Resident #50 was supposed to get any liquids as she received liquids through the tube feeding and water flushes. RN #164 verified Resident #50 did not have an order for liquids. RN #164 asked STNA #190 what kind of liquids Resident #50 was supposed to receive, and STNA #190 reported Resident #50 was supposed to get thickened liquids. Interview with STNA #103 on 05/13/24 following the observation at 12:25 P.M., revealed Resident #50 used to receive a magic cup but had not received a magic cup in months and she was unsure why it had stopped. Interview on 05/15/24 at 9:39 A.M. with Dietary Manager #149 revealed the kitchen had not been sending Resident #50 magic cup since Speech Therapist #176 told them she could only get one cold item per meal. She reported she was aware of the observation on 05/13/24 and that it had since been clarified to do one bowl of a pureed item and a magic cup at meals. Dietary Manager #149 verified liquids were not on Resident #50's tray ticket because she was told by the speech therapist not to give them. Interview on 05/15/24 at 10:00 A.M. with Speech Therapist #176 revealed Resident #50 should only receive one item per meal. She reported a magic cup could be that item, however, she only recommended one item as the resident fatigued quickly. Speech Therapist #176 reported it had been a while since she made that recommendation, and when referring to the 01/03/23 diet order, Speech Therapist #176 said it was probably around then. Speech Therapist #176 indicated Resident #50 was not to receive any liquids by mouth. Interview on 05/15/24 at 10:11 A.M. with STNA #190 revealed she was familiar with Resident #50. She reported it had been a long time since she saw Resident #50 receive a magic cup. Interview on 05/15/24 at 3:40 P.M. with Dietitian #202 revealed she expected Resident #50's cold item at meals to be the magic cup. She was unaware the kitchen had not been sending it. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Use of Nutritional Supplements, revised July 2018, revealed supplements may be added to meals, snacks or used with medication administration. Products will be provided by the kitchen on the meal tray, or kept on the unit to be distributed by staff.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50008 Based on medical record review, observation, staff interview and review of the facility policy, the facility failed to label, date, and initial an enteral formula for a resident receiving enteral nutrition. This affected one (Resident #62) of three facility-identified residents who received tube feedings. The facility census was 68 residents. Findings include: Review of the medical record for Resident #62 revealed an admitted [DATE] with diagnoses including acute dilation of stomach, partial intestinal obstruction, iron deficiency anemia, esophagitis with bleeding, dysphagia, bipolar disorder, and gastroesophageal reflux disease. Observation on 05/13/24 at 9:12 A.M. of Resident #62 revealed a bag of tube feeding was infusing via pump at a rate of 60 milliliters per hour (ml/hr.) The disposable enteral feeding bag was not labeled, dated, or initialed. Interview on 05/13/24 at 9:32 A.M. of Licensed Practical Nurse (LPN) #125 confirmed she had hung the tube feeding bag for Resident #62 on 05/13/24 at 6:00 A.M. but she had not labeled, dated, or initialed the bag to indicate information regarding the type of tube feeding, date and time of hanging the bag, and the initials of the nurse hanging the bag. LPN #125 confirmed the nurse should label, date, and initial the bag when initiating the tube feeding. Review of the facility policy titled Nursing Services Policy and Procedure Manual for Long Term Care Under General Guidelines, Preventing Contamination revised May 2014 revealed when administering a tube feeding the nurse should label the formula, document initials of the nurse hanging the formula and write the date and time the formula was hung/administered on the bag or tube feeding container. The nurse should also check the information on the bag/container of tube feeding against the physician's order for tube feeding.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33019 Based on medical record review, observation, staff interview, and review of the facility policy the facility failed to ensure resident oxygen flow rates were set as ordered by the physician and failed to ensure the humidifier bottles were emptied and changed weekly. This affected one (Resident #32) of three residents reviewed for respiratory care. The facility identified seven residents receiving oxygen therapy. The facility census was 68 residents. Findings include: Review of the medical record revealed Resident #32 was admitted to the facility on [DATE]. Diagnoses included paraplegia, hypertensive heart disease, history of transient ischemic attack and cerebral infarction, hypoxemia, diabetes mellitus, and chronic kidney disease. Review of the care plan for Resident #32 dated 12/12/22 revealed the resident had an alteration in cardiac output with the intervention to administer oxygen as ordered by the physician. Review of the physician's orders for Resident #32 revealed an order dated 08/04/23 for oxygen at three liters per minute to be infused continuously via nasal cannula as needed. Review of the Minimum Data Set (MDS) assessment for Resident #32 dated 04/10/24 revealed the resident had moderately impaired cognition and received oxygen therapy. Observation on 05/13/24 at 12:43 P.M. revealed Resident #32 was receiving oxygen via nasal canula with the oxygen flow rate set at four liters per minute. There was an empty oxygen humidification bottle attached to the oxygen concentrator which was dated 04/08/24. Interview on 05/13/24 at 12:45 P.M. with Licensed Practical Nurse (LPN) #163 confirmed Resident #32's oxygen flow rate was incorrectly infusing at four liters per minute and should be infusing at 3 liters per minute as ordered by the physician. LPN #163 further confirmed the oxygen humidifier bottle was empty and had not been changed since 04/08/24 as indicated on the humidifier bottle. Review of the facility policy titled Oxygen Administration undated revealed oxygen was administered to residents who needed it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen was administered under orders of a physician. The humidifier bottle should be changed when empty, every 72 hours or per facility policy, or as recommended by the manufacturer.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on medical record review, staff interview and review of the facility policy the facility failed to residents were assessed for the safe use of bed rails prior to implementation. This affected one (Resident #50) of two residents reviewed for skin impairment. The facility census was 68 residents. Findings include: Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including anoxic brain injury damage, adult failure to thrive, unspecified protein-calorie malnutrition, gastrostomy, aphasia, dysphagia, contracture of left and right hand, drug induced dyskinesia, and cognitive communication deficit. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #50 dated 03/20/24 revealed the resident had severely impaired cognition. Review of the plan of care for Resident #50 dated 10/16/23 revealed the resident required assistance for activities of daily living (ADLs) related to cognitive impairment, poor safety awareness, and contracture to bilateral hands. Interventions included the following: assist with oral care per facility policy, apply bilateral geri sleeves, keep the call light in reach while the resident in bed. Review of the physician's orders for Resident #50 revealed an order dated 04/24/24 for an all-care bed with side rails with a perimeter mattress. The order was discontinued on 05/06/24. Review of the medical record for Resident #50 from 04/24/24 to 05/06/24 revealed it did not include a side rail assessment. Review of the progress note for Resident #50 dated 04/26/24 revealed during State tested Nursing Assistant (STNA) rounds the resident was noted to have new bruising to the right hand, left cheek near her ear, and above the left eyebrow. The STNA indicated the resident had been noted earlier to have rolled onto her left side and had her face against the side rail on the bed. The bruising was consistent with the resident hitting her face and hand on the side rail of the bed. The new intervention was to have side rails padded at all times to prevent recurrence. Review of the facility skin alteration investigation for Resident #50 dated 04/26/24 revealed the STNA noted resident had bruising to her hand, left cheek, and above the left eyebrow related to the resident rolling onto her left side and having her face against the side rail of the bed. Resident #50 was oriented to person only, was nonverbal, and moved frequently in her bed and was able to roll from side to side. Further review of the facility investigation revealed the predisposing situational factors that led to Resident #50's bruises included bilateral side rails to the bed. Predisposing physiological factors included history of falls, gait imbalance, psychotropic medications, and recent changes in medications. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the non-pressure skin grid for Resident #50 dated 04/26/24 revealed the resident had bruising above her left eye, her left upper eye, left cheek, and right hand. Review of the progress note for Resident #50 dated 04/26/24 revealed the interdisciplinary team met and reviewed the resident's new bruised areas. The team agreed to implement padding to bilateral side rails to prevent injury. Review of Resident #50's physician order dated 04/29/24 revealed the bilateral siderails on the bed were to be padded to prevent injury. Review of plan of care for Resident #50 revised 04/29/24 revealed the resident had the potential for alteration in skin integrity and required protective or preventable skin care maintenance related to incontinence, decreased mobility, impaired cognition, and presence of gastrostomy. Interventions included the following: apply house moisture barrier as ordered, assist with transfers as needed, conduct weekly skin assessments, pressure reducing mattress and cushion to chair, padding to bilateral side rails (added 04/29/24). Interview on 05/14/24 at 3:08 P.M. with the Director of Nursing (DON) confirmed Resident #50 received a new bed with side rails on 04/24/24 to assist with her falls. The DON confirmed bed rail assessments should be completed upon on admission and with a change in beds. The DON confirmed the facility did not complete a bed rail assessment for Resident #50 when the resident received her new bed with side rails on 04/24/24. The DON further confirmed the facility attempted padding Resident #50's bed rails on 04/29/24 because the resident sustained bruises to her face and hands on 04/26/24 related to the bed rails. The DON confirmed Resident #50's bruises had healed, and the facility had decided to discontinue Resident #50's bedrails on 05/06/24. Review of the facility policy titled Proper Use of Bed Rails dated 10/01/22 revealed as part of the resident's comprehensive assessment, the following components were to be considered when determining the resident's needs, and whether or not the use of bed rails met those needs: medical diagnosis, conditions, symptoms, and/or behavioral symptoms, size and weight, sleep habits, medication, acute and medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, cognition, communication, mobility, risk of falling. Additionally, the resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of bed rails and how these alternatives failed to meet the resident's assessed needs. The resident assessment must also assess the resident's risk from using bed rails. These potential risks included accident hazards, barrier to residents from safely getting out of bed, physical restraint, decline in function, skin integrity issues, and other potential negative psychosocial outcomes.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure medications were not left at the bedside unattended. This affected two (Resident #3 and #37) of six residents reviewed for accidents. The facility census was 68 residents. Findings include: 1. Review of the medical record for Resident #3 revealed an admitted [DATE] with diagnoses including human immunodeficiency virus disease, atrial fibrillation, hypertension, major depressive disorder, chronic pain syndrome, and chronic obstructive pulmonary disease (COPD.) Review of the Minimum Data Set (MDS) assessment for Resident #3 dated 03/22/24 revealed the resident had intact cognition. Review of the May 2024 physician's orders for Resident #3 revealed an order dated 03/22/24 for an Incruse Ellipta inhaler. Resident #3 did not have an order to self-administer the inhaler nor to leave it at the bedside. Observation of Resident #3's room on 05/13/24 at 9:30 A.M. revealed there was an Incruse inhaler unattended by staff on the resident's bedside stand. Interview on 05/13/24 at 9:35 A.M. with Licensed Practical Nurse (LPN) #116 confirmed Resident #3 had an unattended inhaler at the bedside with no order for the inhaler to be at bedside nor for the resident to be able to self-administer. 2. Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including vertigo, COPD, major depressive disorder, anxiety disorder hypothyroidism, asthma, and cerebral infarction. Review of the quarterly MDS for Resident #37 dated 03/05/24 revealed revealed the resident had moderately impaired cognition. Review of the May 2024 physician's orders for Resident #37 revealed an order for revealed an order for Flonase nasal spray. Resident #37 did not have an order to self-administer the nasal spray nor to leave it at the bedside. Observation of Resident #37's room on 05/13/24 at 9:32 A.M. revealed there was a bottle of Flonase nasal spray unattended by staff on the resident's bedside stand. Interview on 05/13/24 at 9:35 A.M. with LPN #116 confirmed Resident #37 had an unattended bottle of nasal spray at the bedside with no order for the medication to be at bedside nor for the resident to be able to self-administer. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Self-Administration of Medication dated 12/26/23 revealed the resident had the right to self-administer medications if the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure residents received timely dental care. This affected one (Resident #15) of one residents reviewed for dental services. The facility census was 68 residents. Findings include: Review of the medical record for Resident #15 revealed an admitted [DATE] with diagnoses including cerebral infarction, major depression, epilepsy, hemiplegia of the right side, and dementia with psychotic disturbance. Review of the progress note for Resident #15 dated 10/13/23 timed at 5:36 P.M. revealed the resident requested to see the dentist. Review of the dentist report for Resident #16 dated 10/23/23 revealed the resident lost his partial for his front teeth and the dentist recommended extraction of tooth number seven so they could make a new partial for teeth numbers seven, eight, and nine. There was no pathology, but the resident had extensive decay. Review of the plan of care for Resident #15 dated 01/13/24 revealed the resident had impaired dental status related to loss of natural teeth. Interventions included the following: arrange for periodic dental consultation, follow visits by dentistry, inspect oral mucous membranes and dental status during oral hygiene, look for changes in weight. Review of the physician's clearance for dental treatment for Resident #15 dated 03/09/24 revealed the resident was cleared for tooth extraction of the number seven tooth. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #15 dated 04/11/24 revealed the resident had moderately impaired cognition. Observation on 05/13/24 at 9:45 A.M. revealed Resident #15 had a decayed lateral incisor (number seven tooth) with only half of the tooth left. Interview on 05/13/24 at 9:45 A.M. with Resident #15 confirmed they had been awaiting a tooth extraction for a long time. Interview on 05/14/24 at 3:30 P.M. with Social Service Director (SSD) #106 confirmed the dentist visited the facility quarterly. SSD #106 confirmed Resident #15 needed to have a tooth removed, but the resident the resident had not yet had the extraction. Interview on 05/14/24 at 3:55 P.M. with SSD #106 confirmed she called the dental provider who confirmed they had seen Resident #15 in October 2023, and told the resident a tooth extraction was needed. SSD #106 confirmed the dental company had been in the facility for the first quarter of 2024, but they did not see Resident #15 and were unsure why the resident had not been seen at that time. (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Dental Services revealed routine and emergency dental services were available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on medical record review, review of a meal ticket, observation, and staff interview, the facility failed to ensure residents received adaptive equipment with meals as ordered. This affected one (Resident #48) of five residents reviewed for nutrition. The census was 68. Findings include: Review of Resident #48's medical record revealed Resident #48 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, diabetes, acute kidney failure, dysphagia, anxiety disorder, depression, obstructive sleep apnea, hypertension, metabolic encephalopathy, and atherosclerotic heart disease. Review of the quarterly Minimum Data Set assessment, dated 03/02/24, revealed Resident #48 had moderately impaired cognition and required set up assistance with eating. Review of the Resident #48's physician order, dated 03/16/24, revealed an order to have built up utensils and a divided plate with meals. Review of the plan of care, dated 03/16/24, revealed Resident #48 had a potential alteration in nutrition and/or hydration related to cognitive compromise related to cerebral infarction, dysphagia, and diabetes. Interventions included to provide built up utensils and a divided plate. Review of the undated meal ticket revealed Resident #48 was on a pureed regular diet with nectar thick liquids. Resident #48's adaptive equipment included built-up utensil handles and a divided plate. He may have one mechanical soft item at each meal. Review of the undated Kardex revealed Resident #48 required extensive assist with eating and required built-up utensils for meals. Observation on 05/13/24 at 12:45 P.M. revealed Resident #48 was rolled up in bed with his lunch tray on his over the bed table which was in front of him. He had dropped his spoon onto his chest, and his fork and knife were still on his tray. The utensils were not built-up utensils however, his meal ticket stated he was to have built-up utensils. Interview at the time of the observation with State tested Nursing Assistant #119 confirmed Resident #48 was not provided with built-up utensils for his meal. Observation on 05/14/24 at 5:28 P.M. revealed Resident #48 was in bed eating and Resident #48's utensils were not built-up utensils. Interview at the time of the observation with Licensed Practical Nurse #116 confirmed Resident #48 did not have his physician ordered built-up utensils on his meal tray. (continued on next page)		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/15/24 at 9:15 A.M. with Dietary Manager #149 revealed she was watching the tray line closer to make sure Resident #48 received built-up silverware as ordered. She stated he would take the built-up foam pieces off his utensils sometimes but she verified they had not been sent out on his trays. Review of the undated facility policy titled, Adaptive Devices, revealed all residents that were assessed to require adaptive equipment to enhance self-feeding and independence at meals would be provided adaptive equipment as ordered by the physician.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35765 Based on observation, staff interview and review of the facility policy, the facility failed to ensure staff performed proper hand hygiene while distributing meal trays to the residents. This affected eight (Resident #3, #20, #30, #37, #38, #52, #57, and #65) out of the 26 residents (#3, #13, #15, #20, #21, #25, #30, #35, #37, #38, #41, #43, #44, #46, #48, #50, #51, #52, #54, #57, #58, #60, #61, #65, #67, and #224) residents residing on the Northwest Unit who ate their meals in their rooms. Additionally, the facility failed to ensure residents were not provided milk that was past the best by date. This affected one resident (Resident #3) out of 67 residents who received food from the facility kitchen. Resident #270 was identified as not receiving meals from the kitchen. The facility census was 68. Findings include: 1. Observation of staff delivering meal trays on [DATE] at 12:35 P.M. revealed State tested Nursing Assistant (STNA) #119 started to pass out the trays on the Northwest Unit. She went into Resident #52's room and set the tray down on the bedside stand and moved the bedside stand over to the resident, took the lid and base off the plate and took them out into the hallway and placed them on the three-tiered cart. She then got the tray off the cart for Resident #65 and took it into the room and placed it in Resident #65's wheelchair and took Resident #65's breakfast tray off her over the bed table and put her lunch tray on her over the bed table then she took the breakfast tray out of the room and placed it on the three-tiered cart in the hallway. She then retrieved the meal tray off the meal cart for Resident #57 and took it into the room and placed it on her over the bed table and removed the lid and base and took them out of the room and placed them on the three-tiered cart. She then took the meal tray into the room of Resident #30 and placed it on the over the bed table and moved the over the bed table up to the resident, removed the lid and base, and went back out into the hallway and placed it on the three-tiered cart. She took the next meal tray off the meal cart and took it into Resident #20's room and placed it on the over the bed table, moved the over the bed table up to Resident #20 and took the bed remote and raised the head of Resident #20's bed up. STNA #119 then took the lid and base off the meal and took them out to the three-tiered cart. STNA #119 then took the meal tray into the room for Resident #37 and placed it on her over the bed table and removed the lid and base, and took it out and placed it on the three-tiered cart. STNA #119 then took the meal tray into the room for Resident #3 and placed it on Resident #3's bed to remove his breakfast tray. STNA #119 then placed the breakfast tray onto the bed and put the lunch tray on Resident #3's bedside stand. STNA #119 then removed the lid and base from Resident #3's lunch tray and went out into the hallway and placed them on the three-tiered cart. Next, STNA #119 took Resident #38's meal tray into Resident #38's room and placed the meal tray on his bed. STNA #119 then removed Resident #38's breakfast tray from his over the bed table, placed it on his bed then placed his lunch tray on his over the bed table. STNA #119 removed the lid and base, and took them out of the room. STNA #119 never washed her hands or used hand sanitizer at any point during the observation of her distributing the meal trays to the residents. Interview on at [DATE] at 12:50 P.M. with STNA #119 verified she had not washed or sanitized her hands at any point while distributing meal trays to the residents in their rooms. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Handwashing/Hand Hygiene, revised [DATE], revealed the facility considered hand hygiene the primary means to prevent the spread of infection. Use an alcohol-based hand rub containing at least 62 percent alcohol or alternatively, soap and water before and after assisting a resident with meals. 2. Review of Resident #3's medical record revealed Resident #3 was admitted to the facility on [DATE]. Diagnoses included human immunodeficiency virus disease, atrial fibrillation, hypertension, major depression disorder, viral hepatitis C, chronic pain syndrome, cardiac murmur, insomnia, and chronic obstructive pulmonary disease. Review of the Significant Change Minimum Data Set assessment, dated [DATE], revealed Resident #3 had intact cognition and required set up assistance for all activities of daily living. Observation on [DATE] at 9:30 A.M. revealed Resident #3's breakfast tray was on the over-the-bed table and it was untouched. Interview with Resident #3 at that time revealed he stated his milk was expired and was dated [DATE]. Interview on [DATE] at 9:35 A.M. with Licensed Practical Nurse #116 confirmed Resident #3's milk was dated [DATE].		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on medical record review and staff interview, the facility failed to ensure medications were accurately documented as administered. This affected one resident (#50) of six residents reviewed for behaviors and/or medications. The facility census was 68. Findings include: Review of the medical record for Resident #50 revealed an admitted [DATE] with diagnoses including anoxic brain injury damage, adult failure to thrive, unspecified protein-calorie malnutrition, gastrostomy, aphasia, dysphagia, contracture of left and right hand, drug induced dyskinesia, and cognitive communication deficit. Review of Resident #50's quarterly Minimum Data Set 3.0 assessment, dated 03/20/24, revealed the resident had severely impaired cognition. Review of Resident #50's physician orders revealed an order, dated 10/10/22, for Bromcriptine Mesylate 2.5 milligrams (mg) two times a day. Review of Resident #50's physician orders revealed an order, dated 10/10/22, for Melatonin (used to regulate sleep/wake cycles) 10 mg at bedtime. Review of Resident #50's physician orders revealed an order, dated 10/10/22, for Gabapentin (anticonvulsant medication) 300 mg at bedtime. Review of Resident #50's physician orders revealed an order, dated 10/11/22, for Vitamin D (supplement) tablet 2000 units one time a day. Review of Resident #50's physician orders revealed an order, dated 11/19/22, for Ingrezza Capsule 80 mg one capsule one time a day. Review of Resident #50's physician orders revealed an order, dated 03/14/23, for Prozac (antidepressant medication) 20 mg one time a day. Review of Resident #50's physician orders revealed an order, dated 05/22/23, for Senna (medication used to treat constipation) oral tablet 8.6 mg two tablets at bedtime. Review of Resident #50's physician orders revealed an order, dated 05/23/23, for Gabapentin oral capsule 100 mg. Review of Resident #50's physician orders revealed an order, dated 03/02/24, for Famotidine (medication used to decrease the amount of acid in the stomach) oral suspension five milliliters (ml) by mouth one time a day. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #50's physician orders revealed an order, dated 03/05/24, for Trazodone (antidepressant medication) oral tablet 25 mg by mouth at bedtime. Review of Resident #50's physician orders revealed an order, dated 03/23/24, for Lorazepam (medication used to relieve anxiety) 0.5 mg three times a day. Review of Resident #50's Medication Administration Record (MAR) for April 2024 revealed the following medications were not documented as having been administered for their early dose on 04/18/24, 04/19/24, 04/21/24, 04/23/24, and 04/28/24: Famotidine five ml, Ingrezza Capsule 80 mg, Prozac 20 mg, Vitamin D 2000 units, Bromocriptine Mesylate 2.5 mg, and Gabapentin 100 mg Review on 05/13/24 of Resident #50's MAR for May 2024 revealed the following medications were not documented as having been administered for their early dose on 05/12/24: Famotidine five ml, Ingrezza 80 mg, Prozac 20 mg, Vitamin D 2000 units, Bromocriptine Mesylate, and Gabapentin 100 mg. The following medications were not documented as having been administered for their 6:00 P.M. dose on 05/12/24: Melatonin 10 mg, senna 8.6 mg, Trazodone 25 mg, Gabapentin 300 mg. Additionally, Lorazepam 0.5 mg was not documented as having been administered on 05/12/24 at 10:00 P.M. Interview on 05/14/24 at 2:10 P.M. with the Director of Nursing (DON) revealed she was aware of the 05/12/24 missing documentation. She reported she had talked to the nurse and he had been unable to log medications in the electronic medical record but had administered them. She verified he did not use alternate methods of documentation available to him such as printing off a paper administration record or creating a progress note. Additional interviews on 05/15/24 at 4:30 P.M. with the DON verified the missing April 2024 medication administration documentation. She reported she had spoken to each nurse responsible and the nurses administered the medication but did not document it.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 35765 Based on observation and staff interview, the facility failed to ensure the laundry room was maintained in a safe, functional and sanitary conditon. This had the potential to affect all the residents in the facility. The facility census was 68. Findings include: Observation in the laundry room with Laundry Aide #120 on 05/14/24 at 1:10 P.M. revealed the eyewash station was not functioning and was in pieces, the front of the washing machine was off and leaning up against the side of the washing machine, there was a large hole in the wall beside the hot water tank from a metal railing which was separating the laundry barrels from the hot water heater, the dry wall behind the washing machine was crumbling and had large holes in it, the water facet behind the washing machine was leaking into a bucket and the bucket was overflowing onto the floor, the four air vents in the ceiling were covered with a greyish substance and debris. Additionally, one of the air vents had a leaf sticking out of it, there was a drainage pipe coming out of the wall to the left of the washing machines and there was a large amount of dirt buildup under it and the pellets the detergent was stored on had a large amount of built up dirt under them. An interview with Laundry Aide #120 at that time revealed the laundry room had been this way for awhile. Interview on 05/15/24 at 11:02 A.M. with Regional Maintenance Director #204 verified all the above findings except for the eye wash station which had been fixed by the time of the interview.		