| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366036 | A. Building<br>B. Wing | 09/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Glendora Health Care Center | 1552 North Honeytown Road<br>Wooster, OH 44691 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653<br><br>Based on medical record review and interview, the facility failed to ensure a resident's code status was consistent amongst documents. This affected one (Resident #21) of 16 residents reviewed for advanced directives.<br><br>Findings include:<br><br>Review of Resident #21's medical record revealed diagnoses including vascular dementia, basal cell carcinoma of the skin, chronic kidney disease, hypertension, cerebrovascular disease and anxiety disorder.<br><br>Review of a signed Do Not Resuscitate (DNR) form dated 10/06/23 revealed the option of Do Not Resuscitate Comfort Care (DNRCC) was chosen and was effective immediately.<br><br>Review of Resident #21's electronic health record revealed a heading with a code status of Do Not Resuscitate Comfort Care Arrest (DNRCC-A) (allows for the use of life-saving measures before cardiac or respiratory arrest, but only comfort care after).<br><br>Review of the facility's report sheet revealed code status was indicated on the report sheets. Resident #21's code status was listed as DNRCC-A.<br><br>Review of Resident #21's physician orders revealed an order dated 01/18/24 for a DNRCC-A code status.<br><br>A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #21 was sometimes able to make himself and was sometimes able to understand others. Resident #21 was assessed as moderately cognitively impaired. The MDS indicated Resident #21 was receiving hospice services.<br><br>On 09/18/24 at 8:25 A.M., the Administrator verified there was a discrepancy between the order entered into the electronic health record and the actual DNR form.<br><br>Review of a nursing note dated 09/18/24 at 8:54 A.M. revealed the code status of DNRCC was confirmed. Orders and the care plan were updated. |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>44808<br><br>Based on observation and interview, the facility failed to maintain comfortable temperatures on the [NAME] unit and South unit and failed to maintain resident equipment in good repair. This affected three residents (#6, #22, and #24) of three reviewed for environment The facility census was 36.<br><br>Findings include:<br><br>1.On 09/15/24 at 12:36 P.M., Residents #6, #22, and #24 were observed sitting in the common area by the [NAME] unit nurses station and they all stated it was freezing in the facility and they requested blankets.<br><br>On 09/15/24 at 12:46 P.M., an interview with State tested Nurse Aide (STNA) #125 confirmed it felt cold on the [NAME] unit and STNA #125 had to obtain blankets for Residents #6, #22, and #24.<br><br>On 09/15/24 at 12:50 P.M., an observation of facility air temperatures with Housekeeping Supervisor #156 revealed the temperature of the [NAME] unit common area by the nurses station was 70 degrees Fahrenheit (F). Further observations of air temperatures throughout the facility revealed the hallway of the South unit was 69 degrees F and spot checks of resident rooms on the South unit revealed air temperatures of 69 degrees F to 70 degrees F. These temperatures were verified by Housekeeping Supervisor #156 at the time of observation.<br><br>On 09/15/24 at 1:05 P.M., an interview with the Administrator stated the facility had adjusted the air conditioner to get ahead of the hot weather they were supposed to have that day.<br><br>2. An observation on 09/18/24 at 2:02 P.M. revealed Resident #24's bed in the lowest position located with the left side of the bed against the wall. The bed did not have a headboard attached to the bed frame and there were no bolts observed either in the bedframe or on the floor underneath the bed. The headboard for the bed was observed leaned against the wall between the bed and the wardrobe.<br><br>An observation on 09/19/24 at 9:05 A.M. revealed Resident #24 was lying in bed watching television with the left side of the bed against the wall and the bed was in lowest position. The headboard for Resident #24's bed was still leaning against the wall between the bed and the wardrobe with the securing brackets lying on the floor beside the headboard. Further observation revealed the baseboard heating unit located along the bottom of the wall where the left side of the bed was against. The front covering of the baseboard heating unit had been broken off from the securing brackets to the baseboard heating unit which allowed for the heating element to be exposed to the privacy curtain and the bed sheets and blanket. The baseboard heating unit was not in use at the time of the observation.<br><br>An interview on 09/19/24 at 9:05 A.M. with the Director of Maintenance (DOM) #116 confirmed Resident #24's bed did not have the headboard attached to the bedframe and the headboard was leaning against the wall between the bed and wardrobe. The DOM #116 also confirmed the front covering of the baseboard heating unit had been broken off the securing brackets exposing the heating element to the privacy curtain and the bed sheets and blanket.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's policy titled, Safe and Homelike Environment dated 02/23 revealed, In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and home like environment. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>22653<br><br>Based on medical record review and interview, the facility failed to ensure residents and their representatives were provided a summary of the baseline care plan. This affected one (Resident #32) of four residents reviewed for baseline care plans.<br><br>Findings include:<br><br>Review of Resident #32's medical record revealed diagnoses including epilepsy, depression, delirium, dementia, and mood disorder. Resident #32 was admitted to the facility 05/10/24. No baseline care plan was located.<br><br>On 09/18/24 at 11:48 A.M., the Administrator verified she was unable to find a baseline care plan or evidence a summary of a baseline care plan was provided to the resident/representative. The Administrator stated she would have the Director of Nursing search to determine if there was one located elsewhere.<br><br>On 09/18/24 at 1:26 P.M., the Administrator provided Resident #32's baseline care plan but no evidence a summary was provided to Resident #32 and his representative. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011<br><br>Based on observation, interview and record review, the facility failed to ensure individualized care plans were developed for two (Residents #1 and #6) of 14 residents reviewed for comprehensive care plans. The facility census was 36.<br><br>Findings include:<br><br>Record review for Resident #1 revealed an admitted [DATE]. Diagnosis included pneumonitis due to inhalation of food and vomit.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 was moderately cognitively impaired. Resident #1 required set up or clean up assistants with meals.<br><br>Review of the physician orders for Resident #1 revealed an order dated 05/21/24 for Heart Healthy diet, pureed texture, nectar consistency, Resident may request thin water 30 minutes after oral (PO) intake. No thin water with PO intake for aspiration precaution.<br><br>Review of the care plan updated 04/09/24 revealed Resident #1 was at nutritional risk. Interventions included to provide the diet as ordered. The care plan did not include nectar thickened liquids or instruction about thin liquids.<br><br>Review of the Nutritional Risk assessment dated [DATE] at 12:15 A.M. completed by Dietitian #164 revealed Resident #1 received a mechanically altered diet with thickened liquids related to difficulty swallowing, coughing with meals. Remains on Nectar-thick liquids.<br><br>Interview on 09/17/24 at 11:00 A.M. with Regional Clinical Director #161 confirmed Resident #1's care plan did not include nectar thickened liquids with additional direction to include may request thin water 30 minutes after PO intake. No thin water with PO intake for aspiration precaution.<br><br>44808<br><br>2. Review of the medical record for Resident #6 revealed an admitted [DATE] with diagnoses including adjustment disorder with depressed mood, dementia with anxiety, major depressive disorder, type two diabetes mellitus, and hypertension.<br><br>Review of the diabetes care plan, last revised 11/16/22, revealed Resident #6 had diabetes mellitus and an intervention to stop smoking was initiated on 11/16/22.<br><br>Review of the admission Minimum Data Set (MDS) Assessment, dated 11/18/22, indicated Resident #6 was not a tobacco user.<br><br>Review of the annual MDS Assessment, dated 11/07/23, indicated Resident #6 was not a tobacco user.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #6's comprehensive care plan was reviewed on 12/01/22, 03/31/23, 06/09/23, 09/15/23, 01/31/24, 05/03/24, and 08/09/24 and the intervention to stop smoking remained on the care plan.<br><br>On 09/15/24 at 4:55 P.M., an interview with the Administrator confirmed Resident #6's diabetes care plan included an intervention to stop smoking. The Administrator stated that to her knowledge, Resident #6 had never been a smoker. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011<br><br>Based on record review and interview, the facility failed ensure care plan revision for one resident, Resident #34 to reflect current functional abilities and weight bearing status. This affected one resident (Resident #34) of three residents reviewed for care plan revision. The facility census was 36.<br><br>Findings include:<br><br>Record review for Resident #34 revealed an admitted [DATE]. Diagnosis include fracture of the right femur, fracture of the shaft of the right tibia, fracture of shaft of right fibula, presence of right artificial wrist joint, displaced fracture of the shaft of first metacarpal bone, left hand.<br><br>Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #34 was cognitively intact. Resident #34 had impairment on both sides, upper and lower extremities. The resident used a wheelchair for mobility, was dependent for all activities of daily living (ADL) including eating, toileting, upper and lower body dressing, personal hygiene, sit to lying, lying to sit, and showers. Sit to stand and transfer was not attempted due to Resident #34's medical condition.<br><br>Review of the physician orders for Resident #34 dated 07/25/24 revealed an order for non-weight bearing to all extremities due to fractures. Review of the order dated 09/03/24 reveled non-weight bearing to right lower extremity, weight bearing as tolerated to right upper extremity and left upper extremity, and weight bearing as tolerated to the left lower extremity with knee immobilizer. Review of the order dated 09/10/24 revealed a hoyer lift with two assists (for transfers).<br><br>Review of the care plan dated 08/16/24 for Resident #34 revealed a functional abilities impaired/self-care and mobility deficit. Interventions included non-weight bearing to all extremities as ordered due to fractures. Review of the care plan revealed no revisions to reflect Resident #34's weight bearing status or assistance needed with care.<br><br>Observation on 09/17/24 at 2:34 P.M. revealed Resident #34 was sitting up in his wheelchair, Resident #34 was propelling himself in the chair, grooming himself with use of both upper extremities.<br><br>Interview on 09/17/24 at 2:38 P.M. with State tested Nursing Assistant (STNA) #107 revealed Resident #34 was able to feed himself with set up, washed his upper body independently and self-transferred at times even though he shouldn't.<br><br>Interview on 09/17/24 at 3:40 P.M. with the Administrator confirmed Resident #34's care plan for functional abilities was not revised to reflect his current weight bearing and transfer status. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011<br><br>Based on observation, interview, activity calendar review, activity director job description review and record review, the facility failed to provide individualized activities in accordance with assessments for five residents (#9, #12, #22, #27, and #32) of six residents reviewed for activities. The facility census was 36.<br><br>Findings include:<br><br>1. Record review for Resident #9 revealed an admitted [DATE]. Diagnosis included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Aphasia following cerebral infarction, cognitive communication deficit and need for assistants with personal care.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 was cognitively intact. The resident had impairment on both sides of the upper and lower extremities and required assistants for all activities of daily living (ADL).<br><br>Review of the care plan dated 08/09/24 for Resident #9 included the resident had little or no group activity involvement related to cerebral vascular accident, cognitive communication deficit, and anxiety. Interventions included activities staff will orient and re-orient Resident #9 to facility's activity programming and encourage him to attend facility programming as well as self-directed activities. Offer Resident #9 one on one (1:1) visits as needed and when preferred such as sensory activities for end-of life care, music, massage, and spiritual. Provide Resident #9 with a monthly activity calendar in his room.<br><br>Interview on 09/15/24 at 4:54 P.M. with Resident #9 revealed staff do not offer activities for him. Resident #9 confirmed he rarely left his room or got out of bed due to his stroke and revealed he would like to do some activities in his room.<br><br>Observation and interview on 09/16/24 at 11:34 A.M. with Scheduler/Medical Records #122 revealed activities have been offsince the middle of August 2024. The Dietary Manager and the Maintenance man tried to help when they could. Observation with Scheduler/Medical Records #122 while in Resident #9's room revealed Resident #9 did not have an Activity calender posted in his room. Scheduler/Medical Records #122 looked throughout Resident #9's room with Resident #9's permission and found an activity Calender on a stand from July 2024, under some papers, across the room from where Resident #9 was lying in his bed. Scheduler/Medical Records #122 confirmed Resident #9 was unable to see or even reach the calender and verified the calendar was from July 2024.<br><br>An interview with Resident #9, during the observation, confirmed he never received an updated activity calender.<br><br>Interview on 09/16/24 at 11:41 A.M. with Dietary Manager #163 revealed she helped fill in while the Activity Director was out. Dietary Manager #163 revealed she tried to do both departments, but it was difficult. Sometimes in the morning while passing by residents rooms, she would try to poke her head in the door and say hi to residents.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 09/16/24 at 11:54 A.M. with the Administrator confirmed the Activities Director had not been at the facility since 08/19/24. The Administrator confirmed Resident #9 rarely got out of bed or left his room. Review of the July 2024 Participation Record for Resident #9 revealed Resident #9 had daily, one on one visits, two to five times a week Monday through Friday. Review of the August and September 2024 Activity Participation Record with the Administrator for Resident #9 revealed no 1:1 visit were made with Resident #9. The Activity Participation Record indicated if the resident refused, document refusals on the other side. Administrator confirmed Resident #9 did not have any refusals of activities documented for August or September 2024.<br><br>22653<br><br>2. During an interview on 09/15/24 at 10:36 A.M., Resident #12 stated he was unaware of any activities except bingo once. Resident #12 indicated he would be interested in attending activities if they offered activities he was interested in. Resident #12 stated he had heard there were activities held off the secure unit.<br><br>Review of Resident #12's medical record revealed diagnoses including heart disease, history of mini stroke and stroke, hearing loss in bilateral ears, age-related physical debility, visual loss in both eyes, depression and cognitive communication deficit. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 was able to make himself and was able to understand others. Resident #12 was assessed as cognitively intact. The MDS indicated it was very important to Resident #12 to listen to music he liked, to be around animals such as pets, to keep up with the news, do things with groups of people, do favorite activities, and go outside to get fresh air when weather was good.<br><br>An activity interest data collection tool dated 08/09/24 indicated Resident #12 preferred to spend time with others. Resident #12 indicated preference for independent and group activities. Naps were part of Resident #12's daily activity routine. Interests included voting, fishing, hunting, baseball, basketball, football, restaurants, listening to music, garden club, television, movies, cooking/baking, board games, cards, bingo, word puzzles, books, magazines, walking, talking/conversing, phone use, live music/entertainment, holiday parties, Bible study, devotions, worship services, animals/pets, and clubs/organizations.<br><br>Review of a care plan initiated 08/09/24 indicated Resident #12 was dependent on staff for meeting his emotional, intellectual, physical, and social needs due to cognitive deficits, immobility, and physical limitations. Interventions included ensuring the activities Resident #12 was attending were compatible with physical and mental capabilities, compatible with known interests and preferences, adapted as needed, compatible with individual needs and abilities and age appropriate. Interventions also included inviting and reminding Resident #12 to scheduled activities, providing Resident #12 with a monthly activity calendar in his room, and providing Resident #12 with supplies for individual activity participation as needed.<br><br>Review of the August 2024 activity participation record revealed bingo was offered eight times and refused every time. Resident #12 participated in exercise activities five times with no refusals noted. Resident #12 was recorded as visiting with peers/socializing 21 days. Rolling/walking was recorded 27 days. One social/party/special event was offered/attended. Resident #12 refused four offers of trivia and watched television every day.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the September 2024 activity participation record revealed bingo was offered three times. Staff recorded Resident #12 was sleeping when arts and crafts were offered on 09/16/24. No exercise/sports were offered. going outside was offered once and refused. Peer visits/socializing was documented 11 days out of 15 days. Rolling/walking was recorded 13 of 15 days. Resident #12 watched television every day.<br><br>Observations on 09/15/24 at 9:45 A.M. revealed Resident #12 was lying in bed with his eyes closed. The television was playing. At 10:14 A.M., Resident #12 was sitting on the side of the bed. Although the television was playing Resident #12 was not paying attention to it. At 10:52 A.M., Resident #12 ambulated to the room directly across from his and in less than ten seconds ambulated back to his room. At 2:08 P.M. Resident #12 was observed lying in bed with his eyes closed. At 2:55 P.M., Resident #12 again ambulated to the room across the hall but did not stay.<br><br>Observations on 09/16/24 at 8:07 A.M. revealed Resident #12 was sitting in a stationary chair in his room feeding himself. Resident #12 was exhibiting no interest in the television which was playing. At 8:36 A.M., Resident #12 carried clothing to the doorway and placed them on the floor in the hall. Resident #12 looked toward the room across the hall where the resident was in bed. At 8:54 A.M., Resident #12 ambulated to the room across the hall where he spoke with a resident who was still in bed and conversed briefly before returning to his room. At 11:15 A.M., Resident #12 ambulated to the room across from his, sat on the resident's bed and asked if she needed anything. Resident #12 then stated he was going back to his room. At 11:22 A.M. Resident #12 was lying in his bed with his eyes closed. At 12:10 P.M., Resident #12 ambulated back to the room across the hall. At 12:12 P.M., Resident #12 ambulated back to his room. At 12:127 P.M., Resident #12 was sitting in his room alone eating. At 1:34 P.M., 11 residents were observed in the main activity area playing bingo. At 1:50 P.M., Resident #12 ambulated to the room across the hall and asked if the resident had a good nap. At 1:52 P.M. Resident #12 ambulated back to his room and laid in bed.<br><br>During an interview on 09/16/24 at 1:37 P.M., State tested Nursing Assistant (STNA) #155 stated she worked the secure unit three to four days a week. The Activity Director had been off work for about three weeks but was uncertain of her last day worked. STNA #155 stated other staff tried to pitch in and do activities. The Activity Director used to have some activities on the secure unit or would offer to take residents from the secure unit to activities off the unit. STNA #155 stated there was no separate activity calendar for residents on the secure dementia unit. STNA #155 reported she was uncertain if residents were being offered activities off the unit and indicated she had not seen staff offering to take residents to bingo which was occurring at the time but stated maybe she was off the unit when offered. (There was only one aide scheduled for the unit and one nurse who went between the secure unit and another hall.) Resident #12 would participate in porch time. The facility used to have church services on the secure unit but the services had not been offered for a while. STNA #155 stated there were coloring papers residents could do. STNA #155 stated Resident #12 had refused activity participation in the past.<br><br>During an interview on 09/16/24 at 1:57 P.M., Licensed Practical Nurse (LPN) #151 stated she worked part time and worked various units. LPN #151 stated many of the residents on the secure unit had coloring supplies and some would do math worksheets. LPN #151 had not witnessed anybody offer to take residents to bingo that afternoon.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 09/16/24 at 3:26 P.M. the Administrator stated the Activity Director had been out on Family Medical Leave (FMLA) with her last day worked 08/19/24. It was anticipated the activity director would be off work for a full 12 weeks. The Administrator indicated Recreational Therapist #200 was helping to cover duties of the activity director remotely. Recreational Therapist #200 assisted with developing calendars and training staff. The Administrator stated there were no specific activities held on the secure unit such as lavender scents, calming music, and therapeutic stuffed animals. The DON indicated Resident #12 had resided on the non-secured unit but he was exit seeking. Observations were shared regarding lack of activities offered to residents on the secure unit.<br><br>During an interview on 09/17/24 at 10:01 A.M., Recreational Therapist #200 stated she had been providing off-site assistance with the facility's activity program. Recreational Therapist #200 assisted in creating calendars, helped with care plans and monitor to ensure staff were keeping up with assessments and progress notes. Recreational Therapist #200 stated she would inform staff what needed done and then would review the information. A resident's had assessments to determine preferences when they were admitted . Recreational Therapist #200 stated she had spoken to the facility's Activity Director who was on leave to determine what kind of activities she had been offering and conversed with the Administrator for input on activities to place on the calendar. The activity calendars were discussed with two to three activities scheduled per day. Recreational Therapist #200 stated sometimes she leaves the listed activity vague and will schedule an activity of choice in which residents who show up determine what they would like to do or will schedule cards and the residents choose which game they want to play at the beginning of the activity. Recreational Therapist #200 stated two activities were scheduled most days because she was told residents liked one activity in the morning and one in the afternoon. Some days volunteers would provide additional activities. Recreational Therapist #200 verified there was only one activity calendar for the entire facility as residents did not necessarily need lower function activities for dementia residents. Staff just provide additional assistance. The observations on 09/15/24 and 09/16/24 on the secure unit were discussed. Recreational Therapist #200 stated because she was not on-site all she could do was review and help plan activities.<br><br>Review of the activity director job description revealed the activity director was responsible for directing the development, implementation, supervision and ongoing evaluation of the activities program designed to meet the social, psychosocial and therapeutic needs of the resident. This included the completion and/or directing/delegating the completion of the activities component of the comprehensive assessment and contributing to and/or directing/delegating the contribution to the comprehensive care plan goals and approaches that were individualized to match the skills, abilities and interests/preferences of each resident in compliance with Federal and State regulations.<br><br>3. Review of Resident #27's medical record revealed diagnoses including dementia with behavioral disturbance, hypertension, heart disease, anxiety disorder, restlessness and agitation.<br><br>An activities interest data collection tool dated 01/19/24 indicated Resident #27 preferred to spend his time alone. Activity participation preference was independent. Naps were part of the resident's daily activity routine. Interests included fishing, hunting, baseball, basketball, football, entertainment, listening to music, singing, television, movies, checkers, books, news, magazines, reminiscing, exercise, talking/conversing, live music/entertainment, socials, holiday parties, worship services, and animals/pets.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A care plan initiated 06/14/24 indicated Resident #27 was dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits. Interventions included ensuring the activities Resident #27 attended were compatible with physical and mental capabilities, compatible with known interests and preferences, adapted as needed, compatible with individual needs and abilities and age appropriate.<br><br>Interventions also included establishing and recording Resident #27's prior level of activity involvement and interests by talking with residents, caregivers, and family on admission and as necessary, introducing Resident #27 to residents with similar backgrounds, interests and encouraging/facilitating interaction. The care plan instructed staff to invite, encourage and assist Resident #27 to group activities of potential interests. Supplies were to be provided for individual activity participation as needed.<br><br>An annual MDS dated [DATE] indicated Resident #27 had moderate difficulty hearing, was usually able to make himself understood and was sometimes able to understand others. Cognitive skills were not assessed. The MDS indicated Resident #27 had delusions and had behavioral symptoms directed toward others one to three days. The MDS indicated it was somewhat important for Resident #27 to listen to music he liked, be around animals such as pets, keep up with the news, and go outside for fresh air.<br><br>Observation on 09/15/24 at 9:44 A.M., 10:19 A.M., 11:29 A.M., 11:55 A.M., 2:06 P.M. and 2:58 P.M. revealed Resident #27 lying in bed with his eyes closed. Other than medication administration and meals, no interaction was observed.<br><br>Observations on 09/16/24 at 8:07 A.M., 11:10 A.M., and 12:29 P.M. revealed Resident #27 was lying in bed with no evidence of activities being offered/provided. At 1:54 P.M., Resident #27 was semi-sitting on the side of the bed. No involvement or offering of activities was observed. Items available in the dining area of the secure unit were notebooks with coloring pages, puzzles, word searches, Bibles, a ball, a bowling set without a bowling ball, and a television. No residents were observed utilizing the items.<br><br>An activity calendar posted outside the secured unit indicated bingo and popcorn was scheduled at 2:00 P. M. in the main activity room. Observations on 09/16/24 at 1:34 P.M. revealed bingo was already occurring. No residents from the secure unit were observed.<br><br>During an interview on 09/16/24 at 1:37 P.M., State tested Nursing Assistant (STNA) #155 indicated she had not personally observed staff offering to take residents from the secure unit to play bingo.<br><br>During an interview on 09/16/24 at 1:57 P.M., Licensed Practical Nurse (LPN) #151 indicated she had not personally observed staff offering to take residents from the secure unit to play bingo.<br><br>4. During an interview on 08/16/24 at 10:00 A.M., Resident #32's representative stated the facility's activity director had broken her leg about a month before the survey and there had not been many activities since.<br><br>Review of Resident #32's medical record revealed diagnoses including epilepsy, dysphagia, depression, delirium, dementia, and mood disorder.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An activities interest data collection tool dated 05/14/24 indicated Resident #32 preferred to spend time alone. His activity participation preference was independent. Naps were part of Resident #32's daily activity routine. Community activities included baseball, basketball, and football. creative activities included crafts, listening to music, television, and movies. Educational /cognitive interests included checkers, news. mystery, and western books- needed large print. Social activities included talking/conversing, live music/entertainment, holiday parties, Bible study, and clergy visits. Resident #32 was also interested in animals/pets and traveling.<br><br>An Admission MDS dated [DATE] indicated Resident #32 was sometimes able to make himself understood and sometimes understood others. Resident #32 was assessed as severely cognitively impaired with delusions. Resident #32 had exhibited physical and verbal behavioral symptoms directed toward others 1-3 days and other behavioral symptoms not directed towards others 1-3 days. The behaviors significantly interfered with Resident #32's care and significantly disrupted care or living environment of others. The MDS indicated the behaviors did not interfere with participation in activities or social interactions. Resident #32 had inattention and disorganized thinking which fluctuated. Resident #32 provided information for the activity portion of the MDS and reported it was very important for him to have reading material, listen to music he liked, and be around animals such as pets. It was somewhat important to keep up with news, do things with groups of people, do favorite activities, go outside and get fresh air when weather was good, and participate in religious services or practices.<br><br>Observations on 09/15/24 at 9:40 A.M. revealed Resident #32 was propelling himself in the wheelchair in the halls of the secure unit. Licensed Practical Nurse (LPN) #113 redirected Resident #32 back toward the middle of the hall. At 10:10 A.M., Resident #32 was sitting in a wheelchair by the nursing station. LPN #113 encouraged Resident #32 to stay near her. At 11:58 A.M., Resident #32 was sitting in the wheelchair by the nursing station to eat lunch. At 2:05 P.M., Resident #32 was sitting in the wheelchair by the nursing station. Resident #32 was alert but forgetful, unable to state staff names telling them he did not know them. At 3:00 P. M. Resident #32 was sitting in the wheelchair by the nursing station. Other than eating, the only activity Resident #32 was involved with during the observations was watching people pass and responding when spoken to.<br><br>Observations on 09/16/24 at 11:12 A.M. revealed Resident #32 was lying in bed. Resident #32 appeared to be restless with his legs moving around. The television was playing. The left side of Resident #32's bed was placed against the wall. The door to the room (from the hall) was open blocking Resident #32 from seeing the television. At 11:45 A.M., Resident #32 was propelled from his room and placed by the nursing station. Fluids were provided. At 1:53 P.M., Resident #32 remained by the nursing station with his only activity being watching staff.<br><br>On 09/16/24 at 1:37 P.M., STNA #155 verified when the door was open Resident #32 was unable to see the television while he lay in bed.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observations on 09/17/24 at 8:40 A.M., Resident #32 was observed sitting in the dining area of the secure unit. The television on. Resident #32 exhibited no interest in watching the program but was watching other residents in the dining room. At 11:28 A.M., Resident #32 was sitting in the wheelchair in the hall by the nursing station. As Resident #32 started to move his wheelchair, STNA #155 stated Resident #32 needed to stay by her and he could not follow another resident into her room. There were no signs of stimulation or activity provided. Resident #32 stayed in the hall. At 11:40 A.M., STNA #155 propelled Resident #32 into the dining area where the television was playing. Resident #32 exhibited no interest in the program but started focusing on the exit door pushing on the bar to exit. STNA #155 had walked up the hall and started delivering trays. When Resident #32 would start toward or push on the door STNA #155 would call Resident #32's name or state no and he would move away from the door. No activities were offered to distract the behavior. At 12:00 P.M., after Resident #32's tray was delivered he sat at the table and ate feeding himself. At 2:15 P. M., Resident #32 sat in the wheelchair by the nursing station. Resident #32 was alert with no signs of an activity being offered.<br><br>44808<br><br>5. Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses including traumatic brain injury, age-related physical debility, intracranial injury with loss of consciousness, post traumatic stress disorder, depression, and anxiety.<br><br>Review of the activities interest data collection tool, dated 01/19/24, revealed Resident #22 interests included rides, children/youth, baseball, basketball, football, entertainment, restaurants, library, crafts, poetry, listening to music, singing, garden club, television, movies, cooking/baking, word games, trivia, books, news, discussions, reminisce, exercise, humor, conversing, live music/entertainment, socials, holiday parties, worship services, animals/pets, and traveling.<br><br>Review of the progress note, dated 08/29/24 at 2:32 P.M., revealed Resident #22 enjoyed both independent and group activities, including arts and crafts, cards, games, television, resident council, and special events. The note further indicated Resident #22 was dependent on staff for wheelchair mobility and activities staff would continue to encourage participation.<br><br>Review of the activities care plan, revised 09/03/24, revealed Resident #22 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits and physical limitations. Interventions included encourage ongoing family involvement, invite resident to attend monthly resident council meetings, invite resident to scheduled activities, provided one-on-one bedside and in-room visits when unable to attend out of room activities, preference for rock and classical music radio stations, preference for animal planet and nickelodeon television viewing, provide with supplies for individual activity participation as needed, escort to activity functions, and preference for watching television and visiting with peers when not participating in an activity.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the activities calendar for August 2024 revealed there was no documentation of participation or refusals for arts and crafts, beauty shop, cards, coffee talk, current events/morning news, exercise/sports, games, gardening/outside/patio, independent phone/computer, movie, nail care, people watching, puzzles, word puzzles, radio, music listening, reading, relaxation, reminiscing, rolling/walking, sensory stimulation, resident council, social/party/special events, trivia, mail, music and memory program, outings, pet visits, and one-on-one visits. Resident #22 participated in family visits daily, participated in peer socialization for 20 out of 31 days, participated in television viewing for 24 out of 31 days, refused bingo four times and was sleeping at the time of bingo four additional times, and Resident #22 was sleeping for all three religious activities documented.<br><br>Review of the activities calendar for September 2024 revealed there was no documentation of participation or refusals for arts and crafts, beauty shop, cards, coffee talk, current events/morning news, exercise/sports, gardening/outside/patio, independent phone/computer, movie, nail care, people watching, puzzles, word puzzles, radio, music listening, reading, relaxation, reminiscing, rolling/walking, sensory stimulation, resident council, social/party/special events, trivia, mail, music and memory program, outings, and one-on-one visits. Resident #22 participated in family visits daily, participated in peer socialization for 15 out of 17 documented days, participated in television viewing for 15 out of 17 documented days, participated in one pet visit, participated in one game, refused bingo one time and was sleeping at the time of bingo two additional times.<br><br>On 09/15/24 and 09/16/24, random intermittent observations of Resident #22 revealed she was sitting in her wheelchair in the common area by the nurse's station with a tablet that was not turned on. Resident #22 was not observed participating in any scheduled activities.<br><br>On 09/16/24 at 12:35 P.M., an interview with the Administrator confirmed the activities documented on the activities logs for Resident #22. The Administrator stated there were additional activities records that the Activities Director had completed prior to being on emergency medical leave in August 2024.<br><br>On 09/16/24 at 1:57 P.M., an interview with the Administrator stated she was unable to locate any additional documentation of activities for August 2024 for Resident #22. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653<br><br>Based on observations, medical record review, and interview, the facility failed to implement fall interventions per resident care plans for one (Resident #12) of three residents reviewed for accidents. The facility also failed to ensure one resident, Resident #1 received thickened liquids as ordered. This affected one resident, Resident #1, of three residents reviewed for nutrition. The facility census was 36.<br><br>Findings include:<br><br>1. Review of Resident #12's medical record revealed diagnoses including atherosclerotic heart disease, hypertension, history of falling, depression, visual loss in both eyes, mild dementia, generalized muscle weakness and abnormalities of gait and mobility. Review of a care plan initiated 08/05/24 revealed Resident #12 was at risk for falls related to confusion and lack of awareness of safety needs. An intervention was initiated for a fall mat to the exit side of the bed and to verify placement. On 08/23/24 an order was written for a fall mat to the exit side of bed and to verify placement every shift. A fall risk assessment dated [DATE] revealed Resident #12 remained at risk for falls. Risk factors identified included a history of falls in the prior 90 days, behaviors, need for assistance with elimination, use of devices for ambulation, co-morbidities and medication use.<br><br>Observations on 09/15/24 at 10:14 A.M. and 2:08 P.M. and on 09/16/24 at 11:22 A.M. revealed Resident #12 was lying in a low bed. No mat was observed on either side of the bed. On 09/16/24 at 12:27 P.M., Resident #12 was able to identify other fall interventions but stated he did not use mats on the floor. On 09/16/24 at 1:52 P.M., Resident #12 was lying in bed without fall mats in place.<br><br>On 09/16/24 at 12:35 P.M., State tested Nursing Assistant (STNA) #155 verified there was no fall mat in Resident #12's room. STNA #155 stated she was unaware there was an order for a fall mat. STNA #155 stated aides used report sheets to inform them of care and special instructions for residents' care. Review of the report sheet with STNA #155 revealed there was no instructions to use a fall mat for Resident #12.<br><br>2. Record review for Resident #1 revealed an admitted [DATE]. Diagnosis included pneumonitis due to inhalation of food and vomit.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 was moderately cognitively impaired. Resident #1 required set up or clean up assistants with meals.<br><br>Review of the care plan updated 04/09/24 revealed Resident #1 was at nutritional risk. Interventions included to provide the diet as ordered.<br><br>Review of the physician orders for Resident #1 revealed an order dated 05/21/24 for Heart Healthy diet, pureed texture, nectar consistency, Resident may request thin water 30 minutes after PO intake. No thin water with PO intake for aspiration precaution.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Nutritional Risk assessment dated [DATE] at 12:15 A.M. completed by Dietitian #164 revealed Resident #1 received a mechanically altered diet with thickened liquids related to difficulty swallowing, coughing with meals. Remains on Nectar-thick liquids.<br><br>Observation on 09/18/24 at 11:49 A.M. revealed Resident #1 was in the dining room for the lunch meal. Observation revealed State tested Nursing Assistant (STNA) #136 was passing the residents their drinks while in the dining room. STNA #136 asked Resident #1 what she would like to drink, juice or chocolate milk.<br><br>Interview on 09/18/24 at 11:51 A.M. with STNA #136 revealed Resident #1 could have any fluids she wanted to drink; she was not on thickened liquids.<br><br>Interview on 09/18/24 at 1:00 P.M. with Resident #1 revealed she use to get thickened liquids, but she didn't like it, she had not received thickened liquids for long time. Resident #1 had a glass of ice water next to her on her bedside table.<br><br>Interview on 09/18/24 at 1:10 P.M. with STNA #144 confirmed she refilled Resident #1's ice water cup while Resident #1 was in the dining room. STNA #144 revealed Resident #1 did not receive thickened liquids. LPN #137, who was nearby and overheard the conversation, confirmed Resident #1 was to receive nectar thickened liquids.<br><br>Interview on 09/18/24 at 2:00 P.M. with STNA #124 revealed she frequently cared for Resident #1 and Resident #1 received thin liquids including with her meals. STNA #124 revealed it was not in her task (electronic medical record for STNA's) that Resident #1 was to have any thickened liquids. Review of the task record confirmed Resident #1 did not have thickened liquids documented in the task record.<br><br>Interview on 09/18/24 at 2:04 P.M. with STNA #136 revealed Resident #1 was on thickened liquids for one day only 06/25/24 through 06/26/24. STNA #136 revealed the order hasn't been changed so we give her regular liquids, she can have regular liquids, the diet card she gets with her meals hasn't been updated, it says nectar thick liquids, but she can have regular.<br><br>Observation on 09/23/23 at 8:55 A.M. revealed Resident #1 was sitting up in bed eating her breakfast. Resident #1 had a partially filled glass of water on her breakfast tray. The water was not thickened.<br><br>Interview on 09/23/24 at 8:56 A.M. with STNA #119 confirmed Resident #1's water was not thickened.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00157039. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>22653<br><br>Based on medical record review, review of pharmacy recommendations, policy review and interview, the facility failed to ensure all pharmacy recommendations were addressed by physicians. This affected one (Resident #27) of five residents reviewed for medication use.<br><br>Findings include:<br><br>Review of Resident #27's medical record revealed diagnoses including dementia with behavioral disturbance, hypertension, hyperlipidemia, heart disease, presence of coronary angioplasty implant and graft, anemia, anxiety disorder, restlessness and agitation.<br><br>Review of a medication regimen review dated 09/22/23 revealed Resident #27 was receiving two antipsychotic medications, olanzapine and risperidone. The pharmacist asked for a diagnosis to support use. The pharmacist also indicated the medical record indicated the olanzapine and risperidone were used for psychosis and asked if the physician would consider discontinuing one of the medications to avoid duplicative therapy. The response dated 09/29/23 had a notation to change the diagnosis to dementia. The request regarding considering discontinuing one of the medications was not addressed. Although the response indicated the physician agreed, there was no order to discontinue either of the medications or why it would be contraindicated.<br><br>Review of a medication regimen review dated 10/06/23 revealed Resident #27 had an order for olanzapine and risperidone to be administered on an as necessary basis. The pharmacist addressed Centers for Medicare and Medicaid regulations regarding use of antipsychotic medications being limited to 14 days. The pharmacist instructed, if continued treatment was needed, a prescriber must evaluate to determine if the continued use of the antipsychotic ordered on an as necessary basis was warranted. A new order could be issued after evaluation for a maximum of 14 days. The pharmacist also addressed, due to the use of antipsychotics olanzapine, risperidone and seroquel, Abnormal Involuntary Movements (AIMS) testing should be completed upon initiation of an antipsychotic medication and every six months thereafter. At the time of the review an AIMS test was not available in the electronic health record. The pharmacist suggested nursing complete an AIMS test at their earliest convenience. A response dated 10/29/24 simply indicated the physician agreed with the recommendation.<br><br>During an interview on 09/18/24 at 9:35 A.M., the Director of Nursing (DON) verified the pharmacy reviews for September 2023 and October 2023 were not fully responded to. The DON stated once she received a physician response to the pharmacy recommendations she only looked at the response and did not review the recommendations to ensure they were being fully addressed. The DON stated she would research to determine if there were any further orders/documentation corresponding with the recommendations to reveal the recommendations were addressed. An additional interview on 09/18/24 at 10:00 A.M., with the DON verified she was unable to locate any additional information to indicate the pharmacy recommendations from September 2023 and October 2023 were addressed.<br><br>Review of the facility's Medication Regimen Review policy (implementation date not documented) revealed facility staff were required to act upon all recommendations according to procedures for addressing medication regimen review irregularities. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22653<br><br>Based on medical record review, policy review, and interview, the facility failed to ensure psychotropic medications were only administered when needed, failed to ensure approval for gradual dose reductions were addressed in a timely manner, and failed to ensure monitoring of target symptoms were documented. This affected three (Residents #10, #21 and #27) of five residents whose records were reviewed for medication use.<br><br>Findings include:<br><br>1. Review of Resident #10's medical record revealed diagnoses including schizoaffective disorder (bipolar type), affective mood disorder, mild cognitive impairment, anxiety disorder, dementia with mood disorder, and depression. A significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #10 was usually able to make herself understood and was usually able to understand others. The memory/cognitive skills were not assessed. The MDS indicated Resident #10 had exhibited behavioral symptoms not directed toward others one to three days. The behaviors pur Resident #10 at significant risk for physical illness or injury, significantly interfered with Resident #10's care, and put others at significant risk of injury. The MDS indicated this was a worsening of behaviors. The MDS indicated Resident #10 received antipsychotics on a routine basis only and had no gradual dose reductions (GDR) attempted. Resident #10 also received anti-anxiety medications.<br><br>a. Review of physician orders revealed an order for trazodone 25 milligrams (mg) every night at bedtime.<br><br>Review of a medication regimen review (MRR) dated 01/09/24 indicated Resident #10 had been receiving hypnotic therapy with trazodone 25 milligrams (mg) every night at bedtime for some time without a GDR. The pharmacist inquired if a reduction or discontinuation could be attempted. If no GDR was warranted, the pharmacist requested documentation be added to the medical record as to why a reduction might be detrimental to the resident's mental or physical health.<br><br>A response by a certified nurse practitioner (CNP) dated 01/30/24 revealed it was okay for a GDR. However, there was no order on how to proceed with the gradual dose reduction No change in orders were found.<br><br>Review of a MRR dated 04/08/24 revealed the pharmacist addressed the ongoing use of trazodone without a GDR. The pharmacist asked if an attempt could be made to reduce the trazodone to 25 mg every other night or if there could be a note made regarding why a reduction was contraindicated.<br><br>On 04/16/24 the trazodone was increased to 50 mg every night at bedtime.<br><br>Review of the response dated 04/27/24 revealed an order was given to discontinue the trazodone.<br><br>(continued on next page) |

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|---|---|---|---|
| | 366036 | A. Building<br>B. Wing | 09/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 09/23/24 at 11:15 A.M., the response from 01/30/24 as well as the lack of an order was addressed with the Administrator and Director of Nursing (DON). The Administrator and DON were informed no documentation was located indicating staff attempted to call the physician or CNP to clarify the response that a GDR was approved.<br><br>On 09/23/24 at 11:37 A.M., the Administrator verified there was no evidence of a GDR of trazodone being attempted on 01/30/24 after the CNP review of the MRR conducted 01/09/24. The Administrator stated the CNP visited Resident #10 on 01/10/24 (prior to the response) and had made no changes to the trazodone dosage. The Administrator stated the DON indicated she was trying to get a clarification order for the approval for a GDR but verified there was documentation of any attempts to clarify the response. Between 11:37 A.M. and 5:30 P.M., the Administrator provided a psychiatry note dated 01/16/24 which indicated an evaluation of psychotropic medications with no GDR recommended. The Administrator verified this occurred before the 01/30/24 response to the MRR which indicated an agreement to a GDR of the trazodone. The Administrator then provided a psychiatry note dated 02/26/24 which indicated a reduction in the trazodone was contraindicated. The Administrator verified there had been a gap in the time the response for reduction was received on 01/30/24 and 02/26/24 in which Resident #10 continued to receive the trazodone.<br><br>b. Review of physician orders revealed between 08/30/24 and 09/07/24, Resident #10 had an order for ativan (anti-anxiety) 1 mg every four hours as necessary. Between 09/07/24, Resident #10 had an order for ativan 1 mg every two hours as necessary.<br><br>Review of the September 2024 Medication Administration Record (MAR) revealed the ativan ordered on an as necessary basis was administered 25 times. There was no evidence of non-pharmacological interventions being attempted prior to its administration 12 of the 25 times administered.<br><br>On 09/30/24 at 10:45 A.M., the Administrator verified there was inconsistent documentation of non-pharmacological interventions being attempted prior to the use of the ativan ordered on an as necessary basis.<br><br>2. Review of Resident #27's medical record revealed diagnoses including dementia with behavioral disturbance, heart disease, anxiety disorder, restlessness and agitation. An annual MDS dated [DATE] indicated Resident #27 was usually able to make himself understood and was sometimes able to understand others. Cognitive skills were not assessed. The MDS indicated Resident #27 had delusions and had verbal behavioral symptoms directed toward others 1-3 days.<br><br>A care plan initiated 09/25/23 indicated Resident #27 used psychotropic medications related to dementia with psychosis. Interventions included monitoring and recording the occurrence of target behavior symptoms such as pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression toward staff/other etc and document per facility policy.<br><br>A care plan initiated 08/01/24 indicated Resident #27 was receiving anti-anxiety medications related to anxiety disorder. Interventions included monitoring and recording the occurrence of target behavior symptoms such as pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression toward staff/other etc and document per facility policy.<br><br>Review of physician orders included:<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 08/15/24-08/27/24 seroquel (anti-psychotic) 25 mg twice a day<br><br>08/27/24 - increase seroquel to 50 mg twice a day<br><br>08/12/24 ativan 0.5 mg every six hours as necessary for restlessness, anxiety or agitation<br><br>Review of the September 2024 MAR revealed 24 doses of the ativan ordered on an as necessary basis had been administered.<br><br>Comparison of the September 2024 MAR and progress notes revealed ativan ordered on an as necessary basis was administered the following dates/times without documentation of non-pharmacological interventions being attempted prior to administration: 09/01/24 at 8:24 P.M., 09/02/24 at 7:37 P.M., 09/03/24 at 7:48 P.M., 09/07/24 at 9:00 P.M., 09/16/24 at 7:34 A.M., and 09/17/24 at 10:38 A.M.<br><br>On 09/18/24 at 10:00 A.M., the Director of Nursing (DON) verified there was inconsistent documentation of non-pharmacological interventions being attempted prior to the use of the ativan ordered on an as necessary basis. The DON also verified there was no documentation regarding monitoring for the antipsychotic use in regard to target symptoms or how often they were identified unless they were in the progress notes.<br><br>Review of the facility's Use of Psychotropic Medication policy (implementation date unknown) revealed the indications for use of any psychotropic drug would be documented in the medical record. Psychotropic medications shall be initiated only after medical, physical, functional, psychosocial and environmental causes had been identified and addressed. Non-pharmacological interventions that had been attempted and the target symptoms for monitoring shall be included in the documentation. Residents who used psychotropic drugs shall received gradual dose reductions unless clinically contraindicated, in an effort to discontinue the drugs. Residents who used psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the drugs.<br><br>47569<br><br>3. A review of the medical record for Resident #24 revealed admitted [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the left side, high blood pressure, major depressive disorder, and history of falling. Resident #24 had impaired cognition with a Brief Interview of Mental Status (BIMS) score of 9 out of 15 indicating moderate cognitive impairment and is dependent on staff for assistance with transfers, bed mobility and activities of daily living (ADL) task completion.<br><br>A review of the physician orders for Resident #24 revealed an order dated 04/30/24 for medication Depakote extended release (ER) oral tablet 250 milligrams (MG) give one tablet two times a day related to mood disorder due to known physiological condition, an order dated 08/14/23 for antianxiety medication Buspirone oral tablet 15 mg give one tablet by mouth two times a day for anxiety, an order dated 08/19/23 for antidepressant medication Zoloft oral tablet 100 mg give one tablet by mouth in the morning for depression, and an order dated 09/18/24 for antianxiety medication lorazepam 0.5 mg give one tablet by mouth every 12 hours as needed for anxiety for 14 days.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident #24's medication administration record (MAR) dated 09/01/24 to 09/19/24 revealed the medications Depakote, Buspirone, and Zoloft had been administered per orders. The medication lorazepam had not been administered as needed for anxiety. Further review revealed there was no documentation on Resident #24's behaviors marked or monitored and there was no documentation on any non-pharmacological interventions implemented for Resident #24 behaviors.<br><br>A review of the care plan for Resident #24 revealed the anxiety disorder care plan dated 08/16/24 with interventions including to monitor for effectiveness, the depression disorder care plan dated 08/16/24 with interventions including to monitor for effectiveness.<br><br>A review of Resident #24's Point of Care (POC) tasks section for dated 08/19/24 to 09/19/24 revealed there were no entries or documentation implemented for daily monitoring Resident #24's behaviors.<br><br>An interview on 09/18/24 at 9:50 A.M. with State tested Nursing Assistant (STNA) #119 revealed resident behaviors are sometimes documented in POC tasks, if the resident does not have a task for documenting behaviors, then the nurse is notified of any type of behavior which is documented in the progress notes by the nurse.<br><br>An interview on 09/18/24 at 10:03 A.M. with the Director of Nursing (DON) confirmed the was no documentation of non-pharmacological interventions or any type of daily documentation of behaviors for Resident #24.<br><br>4. A review of the medical record for Resident #21 revealed admitted [DATE] with diagnoses including vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, chronic kidney disease, high blood pressure, restlessness, and agitation. Resident #21 had impaired cognition and required limited to moderate assistance from staff to complete Activities of Daily Living (ADL) tasks. Resident #21 was receiving hospice services for end stage chronic kidney disease.<br><br>A review of the physician orders for Resident #21 revealed an order dated 07/17/24 for anti-anxiety medication Ativan 0.5 milligram oral tablet give one tablet by mouth every four hours as needed for anxiety or agitation for six months, an order dated 08/15/24 for anti-anxiety medication Ativan 0.5 mg oral tablet give one tablet by mouth in the morning for anxiety, agitation or restlessness and give one tablet by mouth in the evening for anxiety, and order dated 08/16/24 for antipsychotic medication Seroquel 25 mg oral tablet give 0. 5 tablet (12.5 mg) by mouth in the afternoon related to vascular dementia with agitation, and an order dated 08/15/24 for antipsychotic medication Seroquel 25 mg oral tablet give 0.5 tablet (12.5 mg) by mouth two times a day related to vascular dementia with agitation.<br><br>A review of Resident #21's Medication Administration Record (MAR) dated 08/01/24 to 08/31/24 revealed the medications Seroquel and Ativan had been administered per physician orders. The anti-anxiety medication Ativan had been given as needed on 08/09/24, 08/13/24, 08/14/24, 08/16/24, 08/19/24, 08/20/24, 08/22/24, 08/25/24, 08/26/24, 08/27/24, 08/28/24, 08/30/24, and 08/31/24 for anxiety and restlessness. Further review of Resident #21's MAR revealed there were no entries or documentation reflecting Resident #21's behaviors or non-pharmacological interventions attempted prior to the administration of the anti-anxiety medication Ativan as needed. A review of Resident #21's Treatment Administration Record (TAR) dated 08/01/24 to 08/31/24 revealed there were no entries or documentation reflecting Resident #21's behaviors or non-pharmacological interventions attempted by staff.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident #21's behavioral care plan dated 06/17/24 revealed Resident #21 will refuse to eat. Resident #21's psychotic medication care plan dated 07/30/24 revealed intervention including to monitor/record occurrence of the target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. Resident #21's anti-anxiety medication care plan dated 06/17/24 revealed intervention including to monitor/record occurrence of the target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others.<br><br>A review of Resident #21's Point of Care (POC) task documentation listing dated 09/19/24 revealed there were no tasks implemented for staff to document Resident #21's behaviors daily.<br><br>An interview on 09/18/24 at 9:50 A.M. with State tested Nursing Assistant (STNA) #119 revealed resident behaviors are sometimes documented in POC tasks, if the resident does not have a task for documenting behaviors, then the nurse is notified of any type of behavior which is documented in the progress notes by the nurse.<br><br>An interview on 09/18/24 at 10:03 A.M. with the Director of Nursing (DON) confirmed the was no documentation of non-pharmacological interventions or any type of daily documentation of behaviors for Resident #21.<br><br>A review of the facility's policy titled, Use of Psychotropic Medication dated 02/23 revealed, Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>22653<br><br>Based on observation, review of physician orders, policy review, and interview, the facility failed to ensure medications were administered in accordance with physician orders and policy. This affected two (Residents #15 and #138) of seven residents observed receiving medication. Two errors of 30 opportunities for error were identified resulting in a medication error rate of 6.6%.<br><br>Findings include:<br><br>1. On 09/15/24 at 9:00 A.M., Registered Nurse (RN) #109 was observed administering medication to Resident #15. Among medication administered was colace (stool softener) 100 milligrams (mg).<br><br>Review of Resident #15's physician orders revealed no order for colace 100 mg. There was an order dated 10/04/23 for two sennosides-docusate sodium 8.6-50 mg to be administered every morning for constipation that was not observed to be administered.<br><br>On 09/15/24 at 12:40 P.M., RN #109 verified she had administered colace instead of sennosides-docusate as ordered.<br><br>Review of the facility's Medication Administration policy (implementation date not recorded) revealed instructions to ensure the right drug was administered.<br><br>2. On 09/15/24 at 11:22 A.M., Licensed Practical Nurse (LPN) #113 was observed administering medication to #138. An insulin lispro 100 units per milliliter pen was used while preparing the drug. The insulin pen was undated as to when it was opened. LPN #113 verified this and continued to prepare the insulin for administration. LPN #113 prepared to administer the insulin after a needle was applied to the pen and she dialed the pen to two units. The pen was not primed. LPN #113 was stopped and stated she believed the pen automatically primed itself without further action needed on her part.<br><br>Review of the facility's Insulin Pen policy (implementation date not documented) revealed a new needle would be used for each injection. Insulin pens were to be primed prior to each use to avoid collection of air in the insulin reservoir. Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation.<br><br>Review of manufacturer information revealed insulin lispro kwik pens should be used within 28 days or discarded. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011<br><br>Based on observation, interview, and review of the facility policy, the facility failed to store and monitor medications in a safe manner. This had the potential to affect all residents residing in the facility. The facility census was 36.<br><br>Findings include:<br><br>1. Observation on [DATE] at 3:43 P.M. with the Director of Nursing (DON) of the west medication storage room revealed two boxes (100 per box) of bisacodyl (10 milligram) suppositories. Each partially used box had an expiration date of ,d+[DATE]. The DON confirmed the suppositories were a stock medication for residents as needed and they were expired. Observation of the refrigerator revealed multiple boxes of influenza vaccines (stock), six tuberculin vials (stock) 28 haldol injections vials and multiple resident insulin pens.<br><br>2. Record review of the refrigerator temperature log for [DATE] for the [NAME] medication room revealed the refrigerator temperature were not monitored for the A.M. or P.M. on [DATE] or [DATE]. The temperature was also not monitored for the P.M. on [DATE], the A.M. on [DATE], or the P.M. on [DATE]. The temperature log also revealed on [DATE] the refrigerator temperature was 48 degrees Fahrenheit. The temperature was signed by Licensed Practical Nurse (LPN) #137. The DON confirmed the temperature logs were not completed daily. The temperature logs were used to ensure the refrigerator temperature was held within the required safe temperature for medication storage. The DON confirmed she was not made aware when the refrigerator temperature was out of range on [DATE] at 48 degrees Fahrenheit.<br><br>Interview on [DATE] at 8:34 A.M. with LPN #137 confirmed on [DATE] the refrigerator temperature in the [NAME] medication room was 48 degrees. LPN #137 revealed she did not report the temperature to the DON or Maintenance Personnel.<br><br>3. Observation on [DATE] at 4:00 P.M. with the DON of the medication storage refrigerator located in the Alixa medication storage room revealed the freezer (located in the upper portion inside the refrigerator) was greater than 50 % solid ice. The ice also built up four to six inches under the freezer base (located directly above residents stored medications). Inside the refrigerator was intravenous medications including vancomycin and ampicillin, 14 insulin pens, and three boxes of apisol injections (used for stock). Observation of the refrigerator temperature logs revealed the last log completed for the medication storage refrigerator was [DATE]. The log for [DATE] revealed nine days that had no temperature documented for either shift. The DON revealed if the refrigerator temperature were monitored, they would be documented on the refrigerator temperature log. The DON confirmed there was no documentation of the temperature being monitored for the Alixa medication storage refrigerator since [DATE].<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the facility policy titled, Medication Storage undated revealed it was the policy of the facility to ensure all medications housed on the premises will be stored in the pharmacy and or medication rooms according to the manufacturer's recommendations and sufficient ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. All drugs and biological's will be stored in locked compartments (i.e. , medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. Temperatures are maintained within 36 to 46 degrees F. Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee. In the event that a refrigerator is malfunctioning, the person discovering the malfunction must promptly report such findings to maintenance department for emergency repair.<br><br>22653<br><br>4. On [DATE] at 11:22 A.M., Licensed Practical Nurse (LPN) #113 was observed administering medication to Resident #138. An insulin lispro 100 units per milliliter pen was used while preparing the drug. The insulin pen was undated as to when it was opened. This was verified by LPN #113 at that time.<br><br>Review of the facility's Insulin Pen policy (implementation date not documented) revealed insulin pens should be disposed of after 28 days or according to manufacturer's recommendation.<br><br>Review of manufacturer information revealed insulin lispro kwik pens should be used within 28 days or discarded. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>44808<br><br>Based on observation, interview, review of the temperature logs, and review of facility policy, the facility failed to ensure food items were stored and labeled appropriately, refrigerator temperatures were monitored and recorded, and spoiled foods were discarded appropriately. This had the potential to affect all 36 residents in the facility.<br><br>Findings include:<br><br>1. On 09/15/24 at 9:41 A.M., during the initial tour of the kitchen, the following were observed in the dry storage room: one opened bag of raspberry gelatin mix with no label indicating the open date, one open bag of dry pasta unsealed and with no label indicating the open date, one open bag of dry pasta with a paperclip holding it closed and no label indicating the open date, two plastic storage containers labeled bread crumbs with no label indicating the open date, and one unopened bag of rolls on the bread rack with visible green mold. These observations were verified by [NAME] #127 at the time of observation.<br><br>2. On 09/16/24 at 10:40 A.M., an observation of the refrigerator in the nurse's station on the [NAME] unit revealed both staff and resident foods were stored in the refrigerator, there was significant ice crystalization in the freezer, and there was a brown substance spilled on the bottom of the freezer and in the freezer door. These observations were verified by Registered Nurse (RN) #109 at the time of observation.<br><br>3. On 09/16/24 at 10:56 A.M., an observation of the refrigerator in the servery on the South unit revealed both staff and resident foods were stored in the refrigerator, there was a plastic container of food with no label or date, there was an open popsicle covered in ice crystals in the freezer, and the temperature log on the freezer for September 2024 only had temperatures recorded for 09/15/24, there were no temperatures documented for 09/01/24 through 09/14/24.<br><br>On 09/16/24 between 11:03 A.M. and 11:06 A.M., interviews with [NAME] #111, Licensed Practical Nurse (LPN) #151, and State tested Nurse Aide (STNA) #155 verified the observations of the South unit refrigerator. [NAME] #111 stated he did not even know there was a refrigerator on that unit and he thought [NAME] #146 was responsible for monitoring and recording refrigerator temperatures. LPN #151 stated she thought it was the responsibility of nursing staff to record refrigerator temperatures.<br><br>On 09/16/24 at 11:46 A.M., an interview with the Administrator stated staff food was supposed to be stored in the break room refrigerator and not in the refrigerators on the units.<br><br>On 09/16/24 at 3:05 P.M., an interview with Registered Dietitian (RD) #162 said staff have specific refrigerators designated for storage of staff food and staff should not store food in the refrigerators on the units. RD #162 confirmed the policy on storage of foods brought in from the outside indicated that common use refrigerators on the units would have temperatures monitored and recorded by dietary staff daily, which RD #162 stated was inaccurate and further stated it was actually housekeeping staff's responsibility to monitor and record those temperatures.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the facility's policy titled Food Brought in from Outside the Community, not dated, indicated the facility would designate a single refrigerator for residents and families to use for storage of foods brought in from outside the facility. If a common use refrigerator is used, a thermometer will be placed inside the refrigerator and the temperature would be recorded daily by the dietary staff on a temperature log. In addition, dietary staff would check common use refrigerators weekly to wipe up any spills and discard any foods that were not dated or that were seven days old. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011<br><br>Based on observation, interview, record review, and review of the facility policy, the facility failed to maintain infection control practices to include Enhanced Barrier Precautions (EBP) for six residents, Resident #5, #8, #9, #12, #27, and #187 of six residents reviewed for EBP and the facility failed to ensure infection control practices were maintained during laundry services which had the potential to affect all 36 residents residing at the facility and the facility failed to disinfect the glucometer used to assess Resident #138's blood sugar prior to and after use. This affected one resident, Resident #138 of one resident reviewed for blood sugar assessments. The facility census was 36.<br><br>Findings include:<br><br>1. Record review for Resident #12 revealed an admitted [DATE]. Diagnosis included colostomy status, personal history of malignant neoplasm of large intestine, and need for assistants with personal care.<br><br>Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #12 was cognitively intact. Resident had an ostomy, used a walker for mobility, required partial/moderate assistants for toileting, bathing and set up or clean up assistants for personal hygiene.<br><br>Review of the care plan for Resident #12 dated 08/20/24 revealed the resident had an alteration in gastro-intestinal status related to presence of colostomy. Interventions included to change the colostomy bag/wafer as ordered and colostomy care as ordered. The care plan did not include an intervention for use of Personal Protective Equipment (PPE) related to stoma care.<br><br>Review of the physician orders dated 08/07/24 to empty and clean colostomy bag every shift and as needed. Gentle cleanse stoma site with mild soap and water, pat dry. The physician orders revealed no orders for Enhanced Barrier Precautions (EBP) related to the stoma/care.<br><br>Interview on 09/15/24 at 2:57 P.M. with the Director of Nursing (DON) revealed the facility had three residents on Enhanced Barrier Precautions (EBP), Resident #12, #27 and #187. The DON confirmed she was also the Infection Preventionist.<br><br>Observation on 09/15/24 at 3:00 P.M. with the DON verified Resident #12 did not have an isolation bin or any PPE in his room or outside his entrance doorway. The DON verified there was no trash can in Resident #12's room for disposing of used PPE and there was no sign inside or outside identifying Resident #12 was on EBP.<br><br>2. Record review for Resident #27 revealed an admitted [DATE]. Diagnosis included benign prostate hyperplasia with lower urinary tract symptoms, neuromuscular dysfunction of the bladder and unspecified dementia, severe.<br><br>Review of the Annual MDS dated [DATE] revealed Resident #27 had an indwelling catheter and was dependent for personal hygiene.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the care plan revealed Resident #27 had impaired immunity related to indwelling foley catheter and history of multi-drug resistant organisms (MRDO's). Interventions included to provide care separately from the roommate. Perform foley catheter care. The care plan did not include an intervention for use of PPE related to the indwelling catheter care.<br><br>Review of the physician orders for Resident #27 revealed an order dated 08/19/24 EBP, staff to use appropriate PPE when assisting resident with high contact care activities such as dressing, hygiene, bathing/showering, transferring, linen changes, bowel/bladder care, device care/use or wound care every shift for history of methicillin resistant staphylococcus aureus (MRSA) in urine with indwelling foley catheter. Perform foley catheter care every shift dated 09/25/23 and monitor and record urine output every shift dated 02/27/24.<br><br>Observation on 09/15/24 at 3:03 P.M. with the DON verified Resident #27 did not have a sign inside or outside identifying Resident #12 was on EBP.<br><br>Observation on 09/16/24 at 6:30 A.M. of catheter care provided by STNA #157 for Resident #27 revealed STNA #157 did not donn any isolation gown prior to or during catheter care. STNA #157 provided catheter care without an isolation gown, picked up the soiled washcloths then left the room with the soiled gloves still on carrying the soiled washcloths.<br><br>Interview on 09/16/24 at 6:43 A.M. with STNA #157 revealed she never had to gown while providing catheter care unless the resident had an infection and Resident #27 did not have an infection. STNA #157 confirmed she did not remove her gloves or wash her hands prior to leaving Resident #27's room after providing care.<br><br>3. Record review for Resident #187 revealed a readmitted [DATE]. Diagnosis included orthopedic aftercare following surgical amputation, acquired absence of other right toes, osteomyelitis right ankle and foot, peripheral vascular angioplasty status with implants and grafts, muscle weakness and need for assistants with personal care.<br><br>Review of the Medicare five-day MDS dated [DATE] revealed Resident #187 was cognitively intact. Resident #187 had a surgical wound and an infection of the foot. Resident #187 received surgical wound care.<br><br>Review of the care plan for Resident #187 revealed the resident has infection of the right lower extremity related to osteomyelitis. Interventions included to maintain universal precautions when providing resident care. Resident is at risk potential for skin impairment related to muscle weakness impaired mobility development history of toe amputation and osteomyelitis. Interventions included to administer treatments as ordered and monitor for effectiveness.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Record review of the physician orders for Resident #187 revealed monitor peripherally inserted central catheter (PICC) line insertion site for signs and symptoms infection, bleeding and dislocation. Change needleless connector every night shift every seven days dated 08/16/24, Gently cleanse right foot wound with normal saline, pat dry, apply dakins soaked gauze, cover with four by four, secure with kerlix and apply post splint and secure with ACE wrap until healed every night shift dated 09/13/24. Additional orders included EBP staff to use appropriate PPE when assisting resident with high contact care activities such as dressing, hygiene, bathing/showering, transferring, linen changes, bowel/bladder care, device care/use or wound care every shift for increased risk of MDRO acquisition related to PICC line dated 08/19/24.<br><br>Observation on 09/15/24 at 3:06 P.M. with the DON verified Resident #187 did not have an isolation bin or any PPE in his room or outside his entrance doorway. The DON verified there was no trash can in Resident #187's room for disposing of used PPE and there was no sign inside or outside identifying Resident #187 was on EBP.<br><br>Interview on 09/15/24 at 3:10 P.M. with State tested Nursing Assistant (STNA) #107 revealed Resident #187 did not require EBP during personal/incontinent care.<br><br>Interview on 09/15/24 at 3:18 P.M. with Registered Nurse (RN) #109 confirmed she was Resident #187's charge nurse. Resident #187 had a surgical wound, osteomyliyis and gangrene and he had intravenous (IV) antibiotics. RN #109 revealed Resident #187 did not require isolation including EBP during wound care or IV administration. RN #109 revealed night shift usually provided the wound care for Resident #109.<br><br>Interview on 09/16/24 at 5:56 A.M. with Licensed Practical Nurse (LPN) #159 (night shift nurse for Resident #187) revealed she had already completed the wound care for Resident #187 to his foot. LPN #159 revealed she provided wound care/dressing changes to Resident #187's foot on several nights that she worked and she never wore or was required (prior to 09/15/24) to wear an isolation gown during his wound care.<br><br>4. Record review for Resident #5 revealed an admitted [DATE]. Diagnosis included neuromuscular dysfunction of the bladder.<br><br>Review of the quarterly MDS for Resident #5 dated 07/01/24 revealed Resident #5 was cognitively intact. Resident #5 had an indwelling catheter and was dependent with personal hygiene.<br><br>Review of the care plan dated 04/16/23 for Resident #5 revealed the resident had a suprapubic catheter. Interventions included to change the urinary catheter drainage bag every week and as needed, gently cleanse around suprapubic catheter site with normal saline, apply drain sponge and secure with paper tape as ordered. The care plan did not include an intervention for use of PPE related to the catheter.<br><br>Review of the physician orders dated 01/17/24 for Resident #5 revealed gently cleanse area around suprapubic catheter site with normal saline, pat dry, apply drain sponge and secure with paper tape every night shift for catheter care and as needed. Urinary output every shift. Review of the physician orders revealed no orders for enhanced barrier precautions.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 09/15/24 at 306 P.M. with DON confirmed Resident #5 was not on EBP and had no PPE for staff use in or near her room. The DON confirmed there was also no trash container for soiled PPE in or near the residents rooms including their bathrooms.<br><br>Observation on 09/15/24 at 3:53 P.M. revealed STNA #107 placed gloves on and emptied Resident #5' catheter drainage bag. STNA #107 did not donn an isolation gown prior to emptying the urine from the catheter bag and did not wash his hands after emptying the urine from the catheter bag. STNA #107 then assisted STNA #125 transfer Resident #5 to bed via a sit to stand mechanical lift. Neither STNA #107 nor #125 donned an isolation gown. STNA #107 put gloves on then provided catheter care, cleaning the insertion (suprapubic catheter site) for Resident #5 and provided peri care. Both STNA #107 and #125 then transferred Resident #5 back to her chair from the bed, (STNA #125 did not remove her gloves from peri/catheter care and neither STNA's washed their hands after providing personal care or prior to the transfer). STNA #125 collected the soiled linen, still wearing the same gloves and both STNA's exited the room without washing their hands.<br><br>Interview on 09/15/24 between 4:16 P.M. and 4:18 P.M. with STNA #125 and #107 revealed staff were not required to wear PPE except for gloves during catheter care. STNA #125 and #107 revealed staff only wore PPE if a resident was on isolation and Resident #5 did not require isolation. STNA #125 confirmed she did not remove her gloves or wash her hands before leaving Resident #5's room. STNA #107 also confirmed he did not wash his hands prior to leaving the room.<br><br>5. Record review for Resident #9 revealed an admitted [DATE]. Diagnosis included neuromuscular dysfunction of the bladder dated 02/26/24.<br><br>Review of the quarterly MDS dated [DATE] revealed Resident #9 was cognitively intact. Resident #9 had an indwelling catheter and was dependent for personal hygiene.<br><br>Review of the care plan for Resident #9 dated 08/19/24 revealed Resident #9 had impaired immunity related to the suprapubic catheter. Interventions included provide care separately from my roommate. SP catheter care as ordered with gauze dressing and paper tape. The care plan did not include an intervention for use of PPE related to the indwelling catheter.<br><br>Review of the physician orders for Resident #9 dated 07/16/24 cleanse s/p catheter site with normal saline, apply new gauze sponge and secure with paper tape as needed for drainage. May change catheter if dislodged, leaking or obstructed dated 02/26/24 and measure and record output every shift. The physician orders revealed no orders for Enhanced Barrier Precautions (EBP) related to the catheter.<br><br>Interview on 09/15/24 at 306 P.M. with the DON confirmed Resident #9 was not on EBP and had no PPE for staff use in or near his room.<br><br>Observation on 09/15/24 at 3:17 P.M. confirmed Resident #9 had a catheter.<br><br>Interview on 09/15/24 at 3:19 P.M. with RN #109 confirmed she was Resident #9's charge nurse. Resident #9 had an indwelling catheter. RN #109 revealed Resident #9 did not require isolation including EBP during catheter care.<br><br>6. Record review for Resident #8 revealed an admitted [DATE]. Diagnosis included multiple sclerosis, neuromuscular dysfunction of the bladder and colostomy status.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the quarterly MDS dated [DATE] revealed Resident #8 was cognitively intact. Resident #8 had an indwelling catheter and an ostomy. Resident #8 was dependent for bathing and personal hygiene.<br><br>Review of the care plan for Resident #8 dated 05/17/24 revealed Resident #8 had an indwelling catheter related to neurogenic bladder. Interventions included to monitor and document intake and output. The care plan did not include an intervention for use of PPE related to the indwelling catheter or ostomy.<br><br>Review of the physician orders for Resident #8 revealed orders to gently cleanse stoma site with mild soap and water, pat dry, change ostomy bag and wafer every night shift every Sunday and as needed dated 08/07/24. Provide catheter care every shift and may irrigate foley catheter with 60 ml sterile water PRN for occlusion dated 04/15/24.<br><br>Interview on 09/15/24 at 3:07 P.M. with the DON confirmed Resident #8 was not placed on EBP and had no PPE for staff use in or near his room.<br><br>Observation on 09/15/24 at 3:18 P.M. confirmed Resident #8 had an indwelling catheter.<br><br>Interview on 09/15/24 at 3:20 P.M. with RN #109 confirmed she was Resident #8's charge nurse. Resident #8 had an indwelling catheter and ostomy. RN #109 revealed Resident #8 did not require isolation including EBP during catheter/ostomy care.<br><br>7. Observation on 09/19/24 at 9:51 A.M. of the washing laundry area revealed in the small room was two washing machines. Laundry Aid #134 revealed the washing machine closest to the wall was not working. Both washing machines sat side by side. Next to the working washing machine (on the opposite side of the broken one) was a large overflowing container of soiled laundry. Approximately three feet out from the working washing machine (directly in front of the machine) was another large overflowing container of soiled laundry and a small container of soiled laundry. Behind the large container of soiled laundry (approximately two to three feet was a large trash can barrel partially filled with trash and no lid. In front of the broken washing machine was an additional large container of overflowing soiled laundry. Observation revealed Laundry Aid #134 brought an empty laundry cart in the room, rubbing the sides against the soiled laundry and the trash can as she was moving the cart to the washer door. Laundry Aid #134 then emptied the linens into the laundry cart from the washing machine. Laundry Aid #134 backed the cart up against soiled laundry cart, (soiled clothes touching clean linen) and the trash can. Laundry Aid #134 then pulled a soiled barrel of linen up to the washing machine door, took out each piece of linen and shook each piece of soiled linen out over the soiled linen barrel sitting directly up against the clean cart which had the linen just removed from the washer.<br><br>Interview on 09/19/24 at 10:52 A.M. with Housekeeping Laundry Supervisor #156 revealed the biggest challenge in the laundry room was space. Housekeeping Laundry Supervisor #156 revealed clean and dirty laundry should never touch, the clean cart should have been removed before loading the next load in the washer. Housekeeping Laundry Supervisor #156 revealed the second washing machine in the room had been broken for the previous six to seven years which created a challenge to keep up with the soiled laundry.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the policy titled, Enhanced Barrier Precautions undated revealed an order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g., chronic wounds such as pressure ulcers, diabetic ulcers, surgical wounds, and chronic venous stasis ulcers), and indwelling medical devices, (e.g., central lines, urinary catheters, feeding tubes, tracheostomies, PICC lines and midline catheters) even if the resident is not known to be infected or colonized with a MDRO. Make gowns and gloves available immediately near or outside of the residents room. Position a trash can inside the resident room and near the exit for discarding the PPE after removal. PPE for EBP is only necessary when performing high contact care activities (dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, PICC lines or midline catheters). EBP should be used for the duration of the affected residents stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. Therapist should also gown and glove when working with residents on EBP.<br><br>22653<br><br>8. On 09/08/24 at 11:16 A.M., Licensed Practical Nurse (LPN) #115 was observed monitoring the blood sugar of Resident #138. A glucometer was withdrawn from the top drawer of the medication cart with no indication it was used for a single resident. After Resident #138's blood glucose level was read the glucometer was placed back into the top medication cart drawer without cleaning/sanitizing it. The glucometer was removed from the drawer to check the results and placed on top of the medication cart. LPN #115 placed the glucometer back into the drawer at 11:25 A.M.<br><br>On 09/15/24 at 11:25 A.M., LPN #115 verified the glucometer could potentially be used for another resident but stated only Resident #138 had routine blood glucose monitoring ordered. LPN #115 stated the glucometer was cleaned once a shift. LPN #115 then removed the glucometer from the drawer and wiped it with an alcohol pad.<br><br>On 09/15/24 at 1:36 P.M., the Director of Nursing (DON) stated bleach wipes were supposed to be utilized in cleaning and disinfecting glucometers.<br><br>Review of the facility's glucometer disinfection policy (implementation date not recorded) revealed blood glucometers would be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. If the manufacturers were unable to provide information specifying how the glucometer should be cleaned and disinfected then the meter would not be used for multiple residents. The glucometers would be disinfected with a wipe pre-saturated with an Environmental Protection Agency (EPA) registered healthcare disinfectant that was effective against HIV, Hepatitis C and Hepatitis B virus. Glucometers would be cleaned and disinfected after each use regardless of whether they were intended for single resident or multiple resident use. The procedure indicated two disinfectant wipes were to be utilized. The first wipe was to clean to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer. After cleaning, the second wipe was to be used to disinfect the glucometer thoroughly.<br><br>Although requested, no manufacturer guidelines were provided. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>22653<br><br>Based on medical record review, review of infection surveillance records, policy review and interview, the facility failed to address use of a prophylactic antibiotic for a resident with recent use of multiple antibiotics. This affected one (Resident #27) of five residents revealed for medication use.<br><br>Findings include:<br><br>Review of Resident #27's medical record revealed diagnoses including dementia with behavioral disturbance, benign prostatic hypertrophy (BPH), neuromuscular dysfunction of the bladder and heart disease. Review of physician orders since admission on 09/21/23 revealed the following orders for antibiotics:<br><br>02/16/24: cipro 500 milligrams (mg) twice a day for ten days for a urinary tract infection (UTI)<br><br>04/07/24: bactrim DS 800-160 mg every 12 hours for benign prostatic hyperplasia (BPH) with lower urinary tract symptoms for seven days<br><br>04/10/24 nitrofurantoin 100 mg twice a day for seven days for infection in the urine<br><br>04/12/24 nitrofurantoin 100 mg twice a day for urinary tract infection for seven days<br><br>04/13/24: cipro 500 mg twice a day for 14 administrations for BPH with lower urinary tract symptoms<br><br>06/01/24 amoxicillin 875 mg twice daily for seven days for dental use<br><br>06/04/24: amoxicillin 875 mg twice a day for nine administrations for oral infection<br><br>06/12/24: amoxicillin-potassium clavulanate 875 875-125 mg twice a day for ten days for oral infection<br><br>06/15/24: macrobid 100 mg twice a day for seven days for cystitis<br><br>06/28/24: amoxicillin-potassium clavulanate 875-125 mg twice a day for ten days for dental/oral infection<br><br>07/29/24: cephalexin 500 mg twice for 14 administrations for UTI<br><br>09/13/24 cephalexin 500 mg three times a day for infection prevention until 09/28/24<br><br>09/15/24 cephalexin 500 mg three times a day for 13 days for infection prevention<br><br>Review of infection surveillance records revealed a McGeer criteria for infection surveillance checklist dated 09/15/24 criteria was not met.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 09/18/24 at 12:15 P.M., the order for cephalexin for infection prevention for a laceration post fall, along with history of antibiotic use, and risk for multi-drug resistant organisms was discussed with the Director of Nursing (DON). The DON stated Resident #27 returned from the hospital with the order for the antibiotic to be given short term. The DON was asked about the facility's policy regarding use of prophylactic antibiotics for infection prevention and stated she would have to look for it.<br><br>On 09/18/24 at 12:50 P.M. the DON provided a policy regarding Antibiotic Prescribing Practices (implementation date not listed) and stated it did not address the use of prophylactic antibiotics. The DON verified when she looked at McGeer Criteria for infection related to the cephalexin ordered prophylactically Resident #27 did not meet the criteria for infection. The DON indicated she had not addressed the use of the prophylactic antibiotic with the physician or nurse practitioner prior to the survey because it was ordered by a physician. Regardless of the risk for a multi-drug resistant organism, if a physician ordered the antibiotic she did not question its use.<br><br>Review of the facility's Antibiotic Prescribing Practices policy (implementation date not recorded) indicated the decision to prescribe an antibiotic would be guided by medical knowledge, best practices and professional guidelines.<br><br>Review of the Antibiotic Stewardship Program (implementation date not recorded) revealed the DON's role in antibiotic stewardship was to use their influence as nurse leaders to help ensure antibiotics were prescribed only when appropriate. Antibiotic orders obtained from consulting, specialty or emergency providers shall be reviewed for appropriateness. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>42011<br><br>Based on observation, interview and review of the facility policy, the facility failed to ensure call lights were in place in three restrooms that were available for resident's use. This had the potential to affect seven residents, Resident #2, #3, #6, #15, #19, #28, and #30 who were identified by the facility as independent with mobility and transfers. The facility census was 36.<br><br>Findings include:<br><br>Observation on 09/15/24 at 9:11 A.M. revealed two restrooms located near the middle of the extended hall open to residents with a vending machine for Resident use at the end of the hall. A third restroom was located on the [NAME] residential hall. All three restrooms were identified as male or female restrooms and was wheelchair accessible, no further information was posted on the doors. Multiple observations from 09/15/24 through 09/19/24 revealed all three restrooms were unlocked at all times except when in use and none had a call system in place.<br><br>Observation and interview on 09/19/24 at 8:32 A.M. with Maintenance Director #116 verified all three restrooms were kept unlocked at all times except when in use. None of the three restrooms were identified by who could use them other than male/female and they were identified as wheelchair accessible. Maintenance Director #116 confirmed all three restrooms locked from the inside. Maintenance Director #116 confirmed there was no call system in place in any of the three restrooms and residents had easy access to enter and use the restrooms.<br><br>Review of the facility policy titled, Call Lights: Accessibility and Timely Response undated, revealed the purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistants. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. |