| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366328 | A. Building<br>B. Wing | 05/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Divine Rehabilitation and Nursing at Toledo | 1011 North Byrne Road<br>Toledo, OH 43607 |

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| F 0569<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816<br><br>Based on medical record review, review of resident fund account documentation, and staff interview, the facility failed to provide notification of a spend down when residents reached $200.00 less than their maximum Supplemental Security Income (SSI) benefit. This affected three (#18, #13, and #28) of five residents reviewed for resident funds in a facility census of 67.<br><br>Findings include:<br><br>1. According to the medical record, Resident #18 was admitted to the facility on [DATE]. Review of Resident #18's current fund account balance as of 05/23/24 was $3,590.32 and exceeded the total SSI limit by $1,790. 32. Further review revealed no documentation contained in the medical record indicated Resident #18 received a notice when reaching $200.00 less than the benefit limit.<br><br>2. According to the medical record, Resident #13 was admitted to the facility on [DATE]. Review of Resident #13's current fund account balance as of 05/23/24 was $2,399.27 and exceeded the total SSI limit by $599. 27. Further review revealed no documentation contained in the medical record indicated Resident #13 received a notice when reaching $200.00 less than the benefit limit.<br><br>3. According to the medical record, Resident #28 was admitted to the facility on [DATE]. Review of Resident #28's current fund account balance as of 05/23/24 was $1,910.00 and exceeded the total SSI limit by $310. 00. Further review revealed no documentation contained in the medical record indicated Resident #28 received a notice when reaching $200.00 less than the benefit limit.<br><br>On 05/23/24 at 12:22 P.M., interview with the Administrator verified Resident #13, Resident #18, and Resident #28 lacked spend down notification when exceeding the SSI benefit allowable balance. |



| 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815<br><br>Based on observation, resident and staff interview, and review of the facility policy, the facility failed to maintain a homelike environment for four (#7, #34, #51, and #54) of four residents reviewed for environmental concerns. The facility census was 67.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #7 revealed an admitted [DATE] with diagnoses of quadriplegia and type two diabetes mellitus.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had intact cognition.<br><br>Observation on 05/20/24 at 8:14 A.M. of Resident #7, who was lying in his bed, revealed a bed rail on the right side of his bed, none on the left, and a crooked headboard. Concurrent interview with Resident #7 revealed he appreciated using the bed rails and wished the right bed rail (against the wall) was replaced. Additionally, he was concerned his headboard was crooked and wished it was fixed.<br><br>Interview and observation on 05/20/24 at 10:55 A.M. with Licensed Practical Nurse (LPN) #281, in Resident #7's room, confirmed the bed rail on the wall side was hanging down below the bed, out of reach of Resident #7, and confirmed the headboard was crooked.<br><br>2. Review of the medical record for Resident #34 revealed an admitted [DATE] with a diagnosis of depression.<br><br>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #34 had intact cognition.<br><br>Observation and interview on 05/20/24 at 10:03 A.M. with Resident #34, who was lying in his bed, revealed a large brownish-colored stain on his privacy curtain. Resident #34 was in the bed furthest from the door and interview confirmed the resident used the privacy curtain frequently and Resident #34 stated the stain bothered him. Further observation revealed the stain was observed to be approximately 10 inches in diameter.<br><br>Interview and observation on 05/22/24 at 1:58 P.M. with Housekeeper #226 confirmed the soiled privacy curtain in Resident #34's room.<br><br>3. Review of the medical record for Resident #51 revealed an admitted [DATE] with a diagnosis of chronic kidney disease.<br><br>Review of the comprehensive MDS assessment dated [DATE] revealed Resident #51 had intact cognition.<br><br>Interview and observation on 05/20/24 at approximately 9:10 A.M. with Resident #51, in his room, revealed surface level paint was scraped off the wall alongside his bed. Resident #51 stated the lack of paint and scraped wall bothered him.<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 | Interview and observation on 05/22/24 at 3:58 P.M. with Director of Maintenance #219, in Resident #51's room, confirmed the wall alongside Resident #51's bed was scraped and the paint was scraped off down to the drywall. Director of Maintenance #219 stated the disrepair was not brought to his attention.<br><br>4. Review of the medical record for Resident #54 revealed an admitted [DATE] with a diagnosis of depression.<br><br>Review of the quarterly MDS assessment dated [DATE] revealed Resident #54 had impaired cognition.<br><br>Observation on 05/20/24 at approximately 8:10 A.M. revealed Resident #54 sleeping in bed. There were two holes visible in the resident's fitted sheet that were approximately both two inches in diameter.<br><br>Observation on 05/21/24 at 7:57 A.M. revealed staff entered Resident #54's room to provide his breakfast tray. Resident #54 was lying in bed and stated he was not ready for breakfast at that time. Further observation revealed the two holes remained in the fitted sheet to the resident's bed.<br><br>Observation and interview on 05/22/24 at 7:35 A.M. with Housekeeper #226 confirmed the two holes in Resident #54's fitted sheet were visible from the hallway. Housekeeper #226 stated she was in the room earlier in the week to deep clean and did not noticed the holes.<br><br>Review of the policy, Safe and Homelike Environment, dated 2023, revealed housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454<br><br>Based on medical record review and staff interview, the facility failed to ensure Minimum Data Set (MDS) assessments were completed accurately for two (#7 and #56) of three residents reviewed for urinary catheters. The facility census was 67.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #7 revealed an admitted [DATE] with a diagnosis of neuromuscular dysfunction of the bladder.<br><br>Review of a physician order dated 01/09/24 revealed Resident #7 had an indwelling urinary (Foley) catheter.<br><br>Review of the quarterly MDS assessment dated [DATE] revealed Resident #7 had intact cognition and did not have an indwelling urinary catheter.<br><br>Observation on 05/21/24 at 7:52 A.M. revealed Resident #7 was sleeping in bed with a covered Foley catheter hanging from the bed frame.<br><br>Interview on 05/23/24 at approximately 4:30 P.M. with Licensed Practical Nurse (LPN) #372 confirmed Resident #7 had a urinary catheter and confirmed the MDS assessment dated [DATE] indicated Resident #7 did not have a urinary catheter.<br><br>2. Review of the medical record for Resident #56 revealed an admitted [DATE] with a diagnosis of obstructive and reflux uropathy.<br><br>Review of the quarterly MDS assessment dated [DATE] revealed Resident #56 had impaired cognition and did not have a urinary catheter.<br><br>Observation on 05/21/24 at 1:05 P.M. revealed Resident #56 was ambulating in the hallway with a urinary catheter collection bag affixed to the wheelchair.<br><br>Interview on 05/23/24 at 2:07 P.M. with MDS Coordinator #392 confirmed Resident #56 had a urinary catheter and the MDS assessment dated [DATE] was completed in error. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815<br><br>Based on observation, staff and resident interview, medical record review, and policy review, the facility failed to ensure residents received timely and adequate assistance with activities of daily living tasks. This affected four (#10, #19, #26, and #43) of five residents reviewed for activities of daily living. The facility census was 67.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #10 revealed an admitted [DATE] with diagnoses of encephalopathy and paranoid schizophrenia.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 was cognitively intact and required supervision or touching assistance for personal hygiene.<br><br>Review of the current care plan revealed Resident #10 had an activities of daily living (ADLs) self care performance deficit. Interventions included Resident #10 required extensive assistance with personal hygiene. Further review of the care plan revealed Resident #10 was at risk for impaired skin integrity with an intervention to observe finger and toe nails on shower days to see if the nails need to be trimmed.<br><br>Observation at the nurses' desk on 05/22/24 at 11:09 A.M. revealed all of Resident #10's finger nails were long and the finger nails on the resident's right hand had a dark substance under them.<br><br>Observation on 05/22/24 at 1:59 P.M. revealed Resident #10 was at the nurses' desk and the resident's finger nails continued to be long with a dark substance under the finger nails on her right hand.<br><br>Interview with Resident #10 on 05/22/24 at 1:59 P.M., at the time of the observation, revealed she did not like her finger nails long or dirty.<br><br>Concurrent interview with State tested Nurse Aide (STNA) #304 on 05/22/24 at the time of the interview with Resident #10 confirmed Resident #10's finger nails were dirty and the finger nails on her right hand had a dark substance under them. STNA #304 could not verify what the substance under the resident's finger nails was.<br><br>2. Review of the medical record identified Resident #26 was admitted to the facility on [DATE]. Diagnoses included malignant neoplasm of the colon, chronic kidney disease, heart failure, and dementia.<br><br>Review of the quarterly MDS assessment dated [DATE] identified Resident #26 was assessed as cognitively impaired and was dependent on staff assistance for ADLs. Resident #26 had no refusals of care.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a plan of care dated 08/08/19 identified Resident #26 had an ADLs self-care performance deficit and required assistance with ADLs and mobility related to weakness, impaired mobility, impaired cognition, colon cancer, bowl/bladder incontinence, and diagnoses. Interventions included checking nail length and trimming and cleaning on bathing days and as necessary.<br><br>Review of the STNA task documentation from 04/22/24 through 05/20/24 identified Resident #26 was scheduled to receive assistance with bathing and finger nail care on Tuesdays and Fridays during the day shift. There was one documented refusal on 04/26/24. There were no other documented offerings, refusals, or assistance within this time period.<br><br>During an observation on 05/20/24 at 9:52 A.M., Resident #26's finger nails were nearly one-half inch past the resident's fingertips with debris noted under the nails. Resident #26 also had some finger nails which were beginning to curl and some which were jagged.<br><br>During an interview on 05/21/24 at 1:51 P.M., Resident #26's family member reported the facility did not offer to trim the resident's finger nails and that they needed trimmed.<br><br>During an observation on 05/22/24 at approximately 1:34 P.M., Licensed Practical Nurse (LPN) #261 confirmed the condition of Resident #26's finger nails. LPN #261 asked Resident #26 if staff could cut Resident #26's finger nails and the resident agreed.<br><br>3. Resident #43 admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, hypertension, aphasia, urinary retention, dysphagia, cerebral atherosclerosis, delirium, and major depressive disorder.<br><br>According to the most current MDS assessment dated [DATE] revealed Resident #43 was assessed with severe cognitive impairment, was dependent on staff for the completion of ADLs, had no behaviors or mood disturbance, was always incontinent of bowel and bladder, received nutrition via feeding tube, received speech, physical, and occupational therapy. On 05/21/24, a brief interview for mental status (BIMS) assessment was completed and assessed the resident with moderately impaired cognition.<br><br>On 04/03/24 a nursing plan of care was implemented to address Resident #43's ADLs self-care performance deficit related to hemiplegia and stroke. Interventions included the resident was totally dependent on staff to provide bath/shower twice weekly and as necessary and totally dependent on one staff for personal hygiene and oral care.<br><br>Observation on 05/20/24 at 9:40 A.M. noted Resident #43 in bed with heavy facial hair. Interview with Resident #43 at the time of the observation revealed he preferred to be clean shaven and wanted the facial hair removed.<br><br>Additional observations on 05/21/24 at 6:24 A.M. and 9:55 A.M. noted Resident #43 in bed with heavy facial hair growth.<br><br>On 05/21/24 at 9:56 A.M. interview with STNA #308 revealed she provided Resident #43 with a shower on Friday, 05/17/24; however, no razor was available in facility to shave the resident. STNA #308 verified Resident #43 had heavy facial growth and preferred to be clean shaven.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. Review of the medical record for Resident #19 revealed an admitted [DATE] with a diagnosis of cerebral infarction (stroke).<br><br>Review of the quarterly MDS assessment dated [DATE] revealed Resident #19 had intact cognition.<br><br>Review of a physician order dated 01/09/24 revealed Resident #19 should wear a palm protector on her left hand daily to maintain skin integrity.<br><br>Review of the current care plan revealed Resident #19 had limited physical mobility related to a contracture of the left hand.<br><br>Interview on 05/22/24 at 9:31 A.M. with Licensed Practical Nurse (LPN) #260, during observation of Resident #19's left hand, revealed there was dried skin and debris inside the palm of Resident #19's left hand. Resident #19's skin was intact. LPN #260 confirmed it appeared Resident #19's palm was not free of dried skin build-up.<br><br>Review of the facility policy titled, Activities of Daily Living (ADLs), dated February 2023, revealed care and services would be provided for ADLs including but not limited to bathing, dressing, and grooming. Residents who were unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>44454<br><br>15816 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816<br><br>Based on observation, medical record review, and staff interview, the facility failed to provide resident-centered activity opportunities. This affected one (#35) of 24 residents reviewed for the provision of activities in a facility census of 67.<br><br>Findings include:<br><br>Review of Resident #35's medical record revealed an admitted to the facility on [DATE] with the diagnoses including dementia with mood disturbance, generalized anxiety disorder, type two diabetes mellitus, chronic obstructive pulmonary disease, panic disorder, retention of urine, major depressive disorder, peripheral vascular disease, and hypertension.<br><br>Review of the most current Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #35 with severe cognitive impairment, no behaviors exhibited, required partial to moderate assistance with activities of daily living, was incontinent of bowel and bladder, received a therapeutic diet, had no risk for pressure ulcer development, and received antianxiety, antidepressant, antiplatelet and hypoglycemic medications.<br><br>Review of the medical record revealed a plan of care developed on 02/21/24 to address Resident #35's placement on a memory care unit due to impaired cognitive function secondary to a diagnosis of dementia or impaired thought processes. Interventions included for staff to ask yes/no questions in order to determine the resident's needs, communicate with the resident/family/caregivers regarding the resident's capabilities and needs, cue, reorient, and supervise as needed, discuss concerns about confusion, disease process, nursing home placement with resident/family/caregivers, and the resident will receive specialized programing based of her cognitive ability and physical limitation.<br><br>Further review of the medical record noted an additional plan of care dated 02/27/24 to address Resident #35 having little or no activity involvement related to anxiety, depression, disinterest, immobility, physical limitations, poor adjustment to the facility/unit, and the resident wishes not to participate. Interventions included the resident will participate in activities of choice two to three times per week by review date, invite and encourage the resident's family members to attend activities with resident in order to support participation, remind the resident that the resident may leave activities at any time and was not required to stay for entire activity, and the resident preferred to socialize with staff and family.<br><br>Observation on 05/20/24 at 12:03 P.M. noted Resident #35 residing on a secured memory care unit with six additional residents. Resident #35 was propelling throughout the unit in a wheelchair. The resident was tearful at times and attempted to exit the facility by pulling on exit doors. Interview with Licensed Practical Nurse (LPN) #261 at the time of observation revealed no additional staff was working on the memory care unit. LPN #261 indicated she was unable to provide activities to the residents due to being busy with providing care. LPN #261 was unaware regarding Resident #35 activity interest.<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 - Few | On 05/21/24 at 6:05 A.M. interview with State tested Nurse Aide (STNA) #368 revealed she assumed care of the residents residing on the memory care unit the previous evening (05/20/24) at approximately 8:00 P.M. STNA #368 stated during the evening Resident #35 attempted to exit the facility through the exit doors. STNA #368 attempted to give verbal prompts to the resident to gain the resident's attention and the resident became aggressive. STNA #368 stated she had no specific training to work on memory care unit including specific resident interest for activities or training to address resident behaviors.<br><br>Observations continued on 05/21/24 at 7:30 A.M., 9:02 A.M., 10:25 A.M., and 11:25 A.M. with no resident specific activity engagement offered or provided to Resident #35.<br><br>On 05/21/24 at 10:35 A.M. interview with STNA #340 confirmed there were no specific activities or programs to addressed memory care placement for Resident #35.<br><br>On 05/21/24 at 10:41 A.M. interview with LPN #261, during review of Resident #35 medical record, confirmed there were no specific or specialized programing to address Resident #35 cognitive ability and physical limitations. Resident# 35 was noted sitting in a wheelchair with no activity engagement at that time.<br><br>On 05/21/24 at 11:11 A.M. interview with Licensed Practical Nurse (LPN) #501, during a review of Resident#35 plan of care, revealed the entry related to program plan, and LPN #501 confirmed there was no specific program contained in the medical record.<br><br>Observation on 05/21/24 at 12:54 P.M. and on 05/21/24 at 1:02 P.M., revealed Resident #35 was noted to be tearful and attempting to exit facility. LPN #264 was attempting to redirect and the resident became more verbally agitated. On 05/21/24 at 1:05 P.M. interview with LPN #264, during review of medical record, confirmed there were no specific intervention or activities were listed to assist with de-escalating the resident's exit-seeking behavior.<br><br>On 05/22/24 at 5:50 A.M. interview with Licensed Social Worker (LSW) #385 requested protocol, policy, criteria, service plan for residents residing on memory care unit. LSW #385 verified Resident #35's plan of care indicated there were resident specific program interventions; however, no resident specific program interventions or activities were contained in the medical record as being completed.<br><br>On 05/22/24 06:05 A.M., interview with STNA #365 stated she assumed care of Resident #35 and residents residing on the memory care unit on 05/21/24 at 10:30 P.M. through 05/22/24 at 6:30 A.M. STNA #365 stated no specific interventions were provided to her to address resident behaviors or activity needs. STNA #365 was informed Resident #35 was exit-seeking when assuming care from the previous shift; however, no interventions were provided to address the behavior. STNA #365 verified no specific plan of care or program activity was available as a resource when Resident #35 or other residents needed behavioral or psychosocial support. At approximately 5:00 A.M., STNA #365 observed Resident #35 in her room seated in her chair with no clothing from the waist down and clothing on the floor. STNA #365 asked if she could assist Resident #35 with removing the clothing from the floor and Resident #35 became agitated and began yelling at STNA #365. STNA #365 proceeded to exit the room and did not return. There was no opportunity to assist the resident with toileting or potential incontinence care was not provided during the shift due to potential behaviors and Resident #35 becoming aggressive or agitated with the staff interactions.<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 - Few | Review of facility activity calendar for 05/20/24 noted at 11:00 A.M. exercise and at 2:00 P.M. bowling activities were to occur. On 05/21/24 at 11:00 A.M. coffee and donuts and at 2:00 P.M. memory game activities were to occur.<br><br>On 05/22/24 at 1:45 P.M. interview with Activity Director #170, during a review of the facility activity calendar, revealed she attempted to complete the same scheduled activities for the resident residing outside the memory care unit. AD #170 indicated there were no assigned activity staff to provide activities specific to the level of the residents residing on the memory care unit, and many times the nursing staff are responsible for providing activities when not providing resident care. |

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| Divine Rehabilitation and Nursing at Toledo | 1011 North Byrne Road<br>Toledo, OH 43607 |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454<br><br>Based on medical record review, observation, resident interview, and staff interview, the facility failed to ensure ancillary services were provided to residents with hearing impairments. This affected one (#170) of one residents reviewed for hearing. The facility census was 67.<br><br>Findings include:<br><br>Review of the medical record identified Resident #170 was admitted to the facility on [DATE]. Diagnoses included heart failure, hypertension, hyperlipidemia, and depression.<br><br>Review of the quarterly Minimum Data Set assessment dated [DATE] identified Resident #170 was cognitively intact and was dependent on staff assistance for a majority of the activities of daily living. Resident #170 did not use hearing aids.<br><br>Review of the social service progress notes dated 12/22/22 identified Resident #170 was seen by audiology who reported a physician consult for wax removal and for a medical consult to obtain medical clearance for hearing aids.<br><br>Review of the hearing instrument medical clearance form dated 12/22/22 identified Resident #170 had severe to profound hearing loss in the right ear and moderate to profound hearing loss in the left ear. Hearing aids were recommended for both ears to allow the resident to enjoy attending activities more frequently; to help the resident to hear and understand nursing staff, therapists, family, religious services, or staff better; to help increase the resident's level of social interaction; and to help the resident to become as independent as possible through improved understanding and safety.<br><br>Review of Resident #170's medical record, including audiology provider notes, on 05/21/24 identified no evidence the resident was ever referred for or received hearing aids. Resident #170 had a physician order dated 04/03/24 for an audiology consult for hearing aids.<br><br>During an observation and interview on 05/20/24 at 9:18 A.M., Resident #170 had difficulty responding to interview questions due to difficulty hearing. Resident #170 reported being at the facility for years and had not had an examination for hearing aids although the resident felt there was a need for them. Resident #170 reported being able to communicate with staff but it was difficult not being able to hear well and that people had to yell for the resident to hear.<br><br>During an interview on 05/22/24 at 11:38 A.M., Social Services Director (SSD) #385 confirmed the facility was unaware of Resident #170's medical clearance and recommendation for hearing aids dated 12/22/22 and were also unaware of the physician's order dated 04/03/24 for an audiology consult for hearing aids until identified during the survey. SSD #385 also confirmed Resident #170 had not been referred, seen, or evaluated for hearing aids since the recommendation was made on 12/22/22. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816<br><br>Based on observation, medical record review, resident and staff interview, and review of the facility wound treatment policy, the facility failed to ensure resident pressure ulcer treatments were applied in accordance with physician orders. This affected two (#25 and #65) of two sampled residents reviewed for pressure ulcer treatment in a facility census of 67.<br><br>Findings include:<br><br>1. Review of the medical record revealed Resident #25 admitted to the facility on [DATE] with the diagnoses including osteomyelitis of the right ankle and foot, cerebral infarction, chronic embolism and thrombosis of the deep veins in the lower extremity, chronic hepatitis, hypertension, encephalopathy, and osteoarthritis.<br><br>Review of the most current Minimum Data Set (MDS) assessment dated [DATE] Resident #25 was assessed with severe cognitive impairment, was dependent on staff for the completion of activities of daily living, was incontinent of bowel and bladder, received nutrition via tube feeding, and was on a mechanically altered diet.<br><br>Review of a pressure sore risk assessment dated [DATE] revealed Resident #25 at very high risk of pressure sore development.<br><br>Review of a weekly wound evaluation documented on 03/26/24 revealed Resident #25 had a pressure ulcer to the buttock assessed as present on admission. The wound was described as a stage four wound (full-thickness skin and tissue loss) measuring 1.8 centimeters (cm) long by(x) 1.9 cm wide x 0.3 cm deep. A small amount of blood tinged (serosanguinous) drainage was noted.<br><br>On 03/26/24 Resident #25 received a physician order for the treatment of the wound to be cleansed with normal saline, pat dry, apply hydrofera blue, cover with foam adhesive dressing, and change every three days and as needed for soiling.<br><br>Review of wound physician wound evaluation and management summary documentation on 04/23/24 recorded the right buttock wound as a healing stage four pressure ulcer measuring 0.2 cm long x 0.3 cm wide x 0.1 cm deep with moderate serous drainage. According to wound physician orders the dressing was to be continued with no changes.<br><br>Observation on 05/21/24 at 10:47 A.M., during wound evaluation with Licensed Practical Nurse (LPN) #372, the nurse removed Resident #25's adult brief and discovered no dressing was applied to the buttock wound. Wound Center Physician #1 proceeded to assess and measured the right buttock stage four pressure ulcer at 0.2 cm long x 0.3 cm wide x 0.1 cm deep with moderate serous exudate. LPN #372 was unaware the dressing had been removed and was not in place as ordered by the physician.<br><br>On 05/21/24 at 11:12 A.M. interview with State tested Nurse Aide (STNA) #308 revealed Resident #25 was provide morning activities of daily living by a hospice nurse aide. STNA #308 was not informed the resident did not have the dressing applied to the buttock wound.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Review of the medical record for Resident #65 revealed an admitted [DATE] with diagnoses of severe protein-calorie malnutrition, anxiety, and depression. Further review revealed Resident #65 was admitted to the facility under the care of hospice.<br><br>Review of the admission MDS assessment completed 02/27/24 revealed Resident #65 had intact cognition. Resident #65 was not at risk for developing pressure injuries, no pressure injury was present on admission, and a pressure reducing mattress was in place.<br><br>Review of the quarterly Braden Scale for predicting pressure sore risk assessment dated [DATE] revealed Resident #65 was at risk for developing pressure sores.<br><br>Review of the skin observation tool completed on 04/25/24 revealed Resident #65's skin was intact.<br><br>Review of a progress note dated 04/29/24 revealed Resident #65 was found with an open area on her coccyx and two areas on the left buttocks, one area measuring 1.0 cm long x 1.0 cm wide and the other area measuring 0.5 cm long x 0.5 cm wide. Depth of the wounds was not included in the progress note.<br><br>Review of a Wound Care Physician progress note dated 05/01/24 revealed Resident #65 was found with two stage three pressure ulcers (full thickness skin loss) to her left buttock. One pressure ulcer (Site #1) measured 0.4 cm long x 0.3 cm wide x 0.1 cm deep with moderate serous exudate and 40 percent (%) granulation tissue. The other pressure ulcer (Site #2) measured 1.0 cm long x 0.5 cm wide x 0.1 cm deep with moderate serous exudate and 40% granulation tissue.<br><br>Review of the physician orders for Resident #65 dated 05/04/24 revealed treatment orders for the left buttock to cleanse both wounds with normal saline, pat dry, apply hydrofera blue to the wound bed, cover with foam dressing, and change three times per week and as needed.<br><br>Review of a nursing treatment progress note dated 05/18/24 revealed Resident #65 was found with no dressing on her left buttock wounds.<br><br>Review of wound measurements provided by Wound Care LPN #372 revealed both stage three pressure ulcers were measured on 05/01/24, 05/08/24, and 05/15/24, and both wounds decreased in size.<br><br>Interview on 05/20/24 at 10:46 A.M. with Resident #65 revealed she had no concerns with her care and treatment and further stated her buttock wounds were healed.<br><br>Interview on 05/21/24 at 3:46 P.M. with Wound Care LPN #372 confirmed she performed wound care and took weekly measurements on Resident #65's wounds. Wound Care LPN #372 stated the wound care physician rounded once monthly to observe the wounds and conduct measurements as Resident #65 was under hospice care.<br><br>Interview on 05/22/24 at 11:19 A.M. with State tested Nurse Aide (STNA) #344 revealed Resident #65 wore pull-up briefs and usually used the restroom independently.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation of Resident #65's wound care on 05/22/24 at 2:05 P.M. with Wound Care LPN #372 revealed Resident #65 had no dressing in place on her left buttock. Concurrent interview with Wound Care LPN #372 confirmed no dressing was in place. Further observation revealed the left buttock wounds were healing and no concerns were identified during wound care. Measurements obtained during the observation for Site #1 revealed 0.5 cm long x 0.3 cm wide x 0.1 cm deep and for Site #2 revealed 0.3 cm long x 0.4 cm wide x 0.1 cm deep.<br><br>Review of the policy Wound Treatment Management, dated 2023, revealed wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. Dressings may be provided outside the frequency parameters in certain situations such as the following; feces has seeped underneath the dressing; the dressing has dislodged; or the dressing is soiled otherwise or is wet.<br><br>44815 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816<br><br>Based on observation, medical record review, staff interview, and facility policy review, the facility failed to ensure residents received sufficient services to promote incontinence needs were provided suprapubic catheter care and maintenance as needed. This affected two (#11 and #65) of five sampled residents reviewed for incontinence and urinary bladder needs in a facility census of 67.<br><br>Findings include:<br><br>1. Review of Resident #11's medical record revealed the resident admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, type two diabetes mellitus, coronary artery disease, paranoid schizophrenia, neuromuscular dysfunction of bladder, retention of urine, benign prostatic hyperplasia with lower urinary tract symptoms, supra-pubic urinary catheter, history of urinary tract infection, bipolar disorder, anxiety disorder, hypertension, and anemia.<br><br>Review of the most current Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #11 with intact cognition, was dependent on staff for the completion of activities of daily living, utilized an indwelling catheter related to urination, was continent of bowel, and received no specialized or modified diet.<br><br>On 04/01/24 a physician order was implemented for Resident #11's suprapubic catheter with an 18 french 10 cubic centimeter (cc) balloon to dependent drainage. Instructions were to change the catheter if dislodged or plugged and unable to clear with irrigation. There was no documentation contained in the medical record to address maintenance and care of the suprapubic catheter or insertion site.<br><br>On 04/10/24 a nursing plan of care was initiated to address Resident #11 impaired immunity related to the suprapubic catheter. Interventions included the resident will not display any complications related to immune deficiency, provide care separately from roommate, and staff dispose of my trash in regular containers or as visibly soiled. There were no interventions listed addressing maintenance and care of the suprapubic catheter.<br><br>According to physician progress notes dated 04/25/24 at 11:59 P.M. Resident #11 was evaluated due to staff reporting blood in the urine. Resident #11 had an indwelling urinary catheter and blood was noted in the collection bag last night. The resident stated that he has had small amounts of blood in his catheter in the past as well. The resident denied fever, chills, burning, abdominal pain, chest pain, and dyspnea. There was no blood noted in the resident's collection bag nor tubing that morning, and the urine was yellow and clear. Resident #11 did not have a leg strap on holding the catheter tubing from getting pulled. The resident stated the catheter did get pulled at times. The physician requested a nurse to put a leg strap on the resident and ensure adequate amount of slack in tubing to prevent from pulling.<br><br>Review of nurses notes dated 05/17/24 at 2:14 P.M. revealed Resident #11 arrived from hospital following treatment for urinary tract infection.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 05/21/24 at 7:14 A.M. with Licensed Practical Nurse (LPN) #281 noted Resident #11 suprapubic insertion site was exposed without a dressing and the catheter tubing unsecured with no leg strap in place. The insertion site was discovered with a small amount of yellow drainage with site tissue red in color. LPN #281 proceeded to cleanse the site, applied a dressing, and secured the catheter tubing to the resident's leg.<br><br>On 05/21/24 at 8:00 A.M. interview with LPN #281, during review of the medical record, verified no physician orders were contained in the record related to care or treatment of Resident #11 suprapubic catheter system or insertion site.<br><br>Review of the undated facility suprapubic catheterization policy the care and maintenance of suprapubic catheters shall be in accordance with physician orders and secure the catheter to the abdomen.<br><br>2. Review of the medical record for Resident #65 revealed an admitted [DATE] with diagnoses of severe protein-calorie malnutrition, anxiety, and depression. Further review revealed Resident #65 was admitted under the care of hospice.<br><br>Review of the admission MDS assessment completed 02/27/24 revealed Resident #65 had intact cognition. Further review revealed Resident #65 was always continent of bowel and bladder and was independent for all activities of daily life (ADLs) including transfers and mobilized independently using a manual wheelchair.<br><br>Review of the bladder incontinence data collection tool dated 02/23/24 revealed Resident #65 was wet less than daily during the daytime and nighttime and used absorbent products. Further review revealed Resident #65 was independent for transfers and ambulation. No teaching or training was provided to Resident #65.<br><br>Review of the current care plan for Resident #65 revealed no guidance regarding the amount of assistance she required for toileting.<br><br>Observation on 05/22/24 at 10:50 A.M. revealed Resident #65 was sleeping in bed and a strong smell of urine was noticeable in the doorway.<br><br>Interview on 05/22/24 at 11:17 A.M. with State tested Nurse Aide (STNA) #304 revealed she was not assigned to Resident #65 and had not provided any care, but was aware Resident #65 was recently declining and staff was offering the resident more assistance with ADLs.<br><br>Interview on 05/22/24 at 11:19 A.M. with STNA #344 revealed she was assigned to care for Resident #65. STNA #344 stated she was familiar with Resident #65 who wore pull-up briefs and usually went to the bathroom herself. STNA #344 stated Resident #65 would use the call light if she wanted assistance and had not asked for assistance that day. STNA #344 stated she provided no personal care for Resident #65 during her shift on 05/22/24.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview and observation of wound care for Resident #65 on 05/22/24 at 1:59 P.M. with Wound Care LPN #372 revealed a strong urine odor in Resident #65's room. During care, Resident #65 was noted to be heavily soiled of urine per adult pull-up brief. Wound Care LPN #372 confirmed Resident #65 was heavily soiled with urine, and further stated Resident #65 was declining in her ADLs and not asking for assistance. Further observation of Resident #65's wheelchair revealed the seat contained a folded blanket, wash cloths, and a thin pillow. The items appeared soiled with a yellow tint.<br><br>Follow-up interview on 05/22/24 at 2:29 P.M. with STNA #344 verified did not provide any personal care to Resident #65 and stated she was just educated that Resident #65 required increased checks for incontinence and was not aware prior to that afternoon Resident #65 had an increased need to be checked.<br><br>Interview on 05/23/24 at approximately 4:00 P.M. with Registered Nurse Chief Operating Officer #391 verified Resident #65's care plan contained no care area for ADLs or incontinence needs.<br><br>44815 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454<br><br>Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure nutrition assessments were completed upon admission and quarterly. This affected one (#22) of two residents reviewed for nutrition. The facility census was 67.<br><br>Findings include:<br><br>Review of the medical record for Resident #22 revealed an admitted [DATE] with diagnoses of chronic kidney disease, type two diabetes mellitus, delusional disorders, hyperlipidemia, and a body mass index indicating the resident was overweight.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had intact cognition.<br><br>Review of the current care plan revealed Resident #22 was at risk for malnutrition related to a diagnoses of chronic kidney disease, diabetes mellitus, and bipolar disorder. Interventions included to update food preferences and provide supplement as ordered.<br><br>Review of the weight history for Resident #22 revealed non-significant weight gain of five pounds over five months.<br><br>Review of the medical record revealed no nutritional assessment was completed for Resident #22 since admission.<br><br>Interview on 05/21/24 at 9:39 A.M. with Regional Registered Dietitian (RRD #388) stated initial nutritional assessments should be completed within 72 hours of admission and quarterly nutritional assessments should be completed quarterly thereafter. Further interview with RRD #388 confirmed no nutritional assessments were completed for Resident #22. RRD #388 stated Resident #22 went to the hospital shortly after admission and the brief discharge to the hospital disrupted the way nutritional assessments were assigned in her chart. RRD #388 confirmed Resident #22 was not at nutrition risk.<br><br>Review of the undated policy titled, Nutritional Management, revealed a comprehensive nutritional assessment will be completed by a dietitian within 72 hours of admission and follow-up assessments will be completed as needed. |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816<br><br>Based on observation, medical record review, staff interview, personnel file review, and memory care unit criteria documentation review, the facility failed to ensure residents with diagnosis of dementia received appropriate care and services and staff working with those resident were provided sufficient education to ensure those care and services needs were met to ensure the residents maintained their highest practicable physical, mental, and psychosocial well-being. This affected one (#35) of one residents reviewed for dementia related behavioral services in a facility census of 67.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #35 admitted to the facility on [DATE] with the diagnoses including dementia with mood disturbance, generalized anxiety disorder, type two diabetes mellitus, chronic obstructive pulmonary disease, panic disorder, retention of urine, major depressive disorder, peripheral vascular disease, and hypertension.<br><br>Review of the most current Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #35 with severe cognitive impairment, no behaviors exhibited, required partial to moderate assistance with activities of daily living, was incontinent of bowel and bladder, received a therapeutic diet, was at no risk for pressure ulcer development, and received antianxiety, antidepressant, antiplatelet and hypoglycemic medications.<br><br>On 02/21/24 a physician order was obtained to admit Resident #35 to the memory care unit.<br><br>Review of the medical record revealed a plan of care developed on 02/21/24 to address Resident #35 placement on a memory care unit due to diagnosis of impaired cognitive function secondary to diagnosis of dementia or impaired thought processes. Interventions included to ask yes/no questions in order to determine the resident's needs, communicate with the resident/family/caregivers regarding residents capabilities and needs, cue, reorient, and supervise as needed, discuss concerns about confusion, disease process, and nursing home placement with resident/family/caregivers, and the resident received specialized programing based of her cognitive ability and physical limitation.<br><br>Further review of the medical record noted an additional plan of care dated 02/27/24 to address Resident #35 having little or no activity involvement related to anxiety, depression, disinterest, immobility, physical limitations, poor adjustment to the facility/unit, and the resident wished not to participate. Interventions included the resident will participate in activities of choice two to three times per week by the review date, invite/encourage the resident's family members to attend activities with resident in order to support participation, remind the resident that the resident may leave activities at any time and is not required to stay for entire activity, and the resident preferred to socialize with staff and family.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 05/11/24 at 8:37 P.M. transfer form documentation noted Resident #35 had been having a behavioral meltdown since the beginning of the shift and tried to attack one of the other residents. The physician was notified and agreed to send Resident #35 to a geriatric psychiatric hospital evaluation. According to the medical record Resident #35 was returned to the facility the same evening with no new orders or interventions.<br><br>On 05/13/24 physician progress notes revealed staff to report Resident #35 was having increased anxiety and agitation for the last week. The resident was wandering into other resident's rooms, lashing out verbally, pacing up and down the hallway, and was crying/tearful. A new order to increase the antianxiety medication hydroxyzine to 50 milligrams (mg) twice daily due to increased agitation and anxiety. No non-pharmacological intervention was indicated.<br><br>Observation on 05/20/24 at 12:03 P.M. noted Resident #35 residing on a secured memory care unit with six additional residents. Resident #35 was propelling throughout the unit in a wheelchair. The resident was tearful at times and attempted to exit the facility by pulling on exit doors. Interview with Licensed Practical Nurse (LPN) #261 at the time of observation revealed no additional staff were working on the memory care unit. LPN #261 indicated she was unable to provide activities to the residents due to being busy with providing care. LPN #261 was unaware regarding Resident #35 activity interest.<br><br>On 05/21/24 at 6:05 A.M. interview with State tested Nurse Aide (STNA) #368 revealed she assumed care of the residents residing on the memory care unit the previous evening (05/20/24) at approximately 8:00 P.M. STNA #368 stated during the evening Resident #35 attempted to exit the facility through the exit doors. STNA #368 attempted to give verbal prompts to the resident to gain the resident's attention and the resident became aggressive. STNA #368 stated no specific training to work on memory care unit, including specific resident interest for activities was provided to her as well as no specific interventions to address behaviors. STNA #368 indicated she observed the resident during the night; however, no interactions occurred due to fear of causing Resident #35 to become aggressive.<br><br>Observations continued on 05/21/24 at 7:30 A.M., 9:02 A.M., 10:25 A.M., and 11:25 A.M. no resident specific engagement was offered or provided to Resident #35.<br><br>On 05/21/24 at 10:35 A.M. interview with STNA #340 confirmed no specific programs or interventions to addressed memory care placement for Resident #35.<br><br>On 05/21/24 at 10:41 A.M. interview with LPN #261, during review of Resident #35 medical record, confirmed no specific or specialized programing to address Resident #35 cognitive ability and physical limitation. Resident# 35 was noted sitting in wheelchair with no activity engagement.<br><br>On 05/21/24 at 11:11 A.M. interview with Licensed Practical Nurse (LPN) #501, during a review of Resident #35 plan of care, revealed the entry related to program plan. LPN #501 confirmed there was no specific program contained in the resident's medical record.<br><br>Observation on 05/21/24 at 12:54 P.M. and on 05/21/24 at 1:02 P.M. revealed Resident #35 was noted to be tearful and attempting to exit facility. LPN #264 was attempting to redirect and the resident became more verbally agitated. On 05/21/24 at 1:05 P.M. interview with LPN #264, during review of medical record, confirmed no specific interventions or activities were listed to assist with de-escalating the exit seeking behavior.<br><br>(continued on next page) |

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| | 366328 | A. Building<br>B. Wing | 05/23/2024 |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 05/22/24 at 5:50 A.M. interview with Licensed Social Worker (LSW) #385 requested protocol, policy, criteria, and service plan for residents residing on the memory care unit. LSW #385 verified Resident #35's plan of care indicated resident specific program interventions; however, no resident specific program interventions were noted as completed the medical record.<br><br>On 05/22/24 6:05 AM interview with STNA #365 stated care of Resident #35 and residents residing on the memory care unit was assumed on 05/21/24 at 10:30 P.M. through 05/22/24 at 6:30 A.M. STNA #365 stated no specific interventions were provided to her to address resident behaviors or activity needs. STNA #365 was informed Resident #35 was exit seeking when assuming care from staff on the previous shift; however, no interventions were provided to address the behavior. STNA #365 verified no specific plan of care or program activity was available as a resource when Resident #35 or other residents needed behavioral or psychosocial support. At approximately 5:00 A.M., STNA #365 observed Resident #35 in her room seated in her chair with no clothing from the waist down and clothing on the floor. STNA #365 asked if she could assist Resident #35 with removing the clothing from the floor and Resident #35 became agitated and began yelling at STNA#365. STNA #365 proceeded to exit the room and did not return as there was no opportunity to assist the resident with toileting or potential incontinence care due to potential behaviors and Resident #35 becoming aggressive or agitated with the interaction from staff.<br><br>Review of facility Memory Care Unit (MCU) documentation noted the secure unit was designed to serve those with specific memory impairment related to dementia. The unit differs from other units due to being secure, and most residents are at risk for elopement and wear a wandering device to alert staff if they come to close to an exit or attempt to leave the unit unattended. There is limited access of others to the unit making for a restful and calmer environment. The staffing on the unit differs as the needs of the individuals with dementia require more interaction, diversion, and redirection to maintain not only safety by contentment. Each resident has their own special box which contains items that help to calm, allowing reminiscing, or bring joy. Items of meaning. The box is used when a resident is upset, showing signs of frustration and staff needs to offer one on one time to assist the resident in obtaining a non-distressed demeanor. Medications are usually limited to essential medications only.<br><br>Review of STNA #368's personnel file noted a hire date of 04/25/24 as a State tested Nurse Aide. No information or documentation contained in the medical record revealed specific training or orientation to work on the memory care unit (MCU) or with the residents residing on the MCU.<br><br>On 05/23/24 at 10:08 A.M. interview with the Administrator, during a review of STNA #368's personnel file, confirmed no information or documentation contained in the medical record revealed STNA #368 received specific training or orientation to work with residents on the MCU. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** 15816<br><br>Based on observation, resident and staff interview, medical record review, and policy review, the facility failed to ensure resident medications were properly labeled and stored. This affected five (#2, #32, #35, #41, and #52) of 15 residents reviewed for medication storage in a facility census of 67.<br><br>Findings include:<br><br>1. Observation on [DATE] at 11:41 A.M. with Licensed Practical Nurse (LPN) #261, during review of the 500 hall medication storage cart, revealed Resident #35's Lispro insulin pen was dispensed on [DATE] with no date marked when it was opened and Resident #32's Lantus insulin pen was open lacking a open date. In addition Resident #32 had a Lispro insulin opened with no date and a second pen open on [DATE] that expired on [DATE].<br><br>Interview with LPN #261 at the time of observation verified insulin pens are to have appropriate date marking when open and verified Resident #35 and Resident #32's insulin was not properly stored<br><br>2. Observation on [DATE] at 1:58 P.M. with Registered Nurse (RN) #297, during review of the 400 Hall medication storage cart, discovered two Admelog/Lispro insulin pens open with no date for Resident #41. Interview with RN #297 at the time of the observation verified Resident #41's insulin was not stored properly and stated insulin pens are to be marked when opened and after opening expire in 28 days.<br><br>On [DATE] at 2:05 P.M. observation with LPN #258 identified a brimonidine tartrate ophthalmic solution 0.2% bottle prescribed to Resident #52 on [DATE]. The bottle was not marked when open. A second bottle of the ophthalmic solution was discovered for Resident #52 prescribed on [DATE] and was open but not marked or dated when open. Interview with LPN #258 at the time verified Resident #52's ophthalmic solution was not properly stored and stated ophthalmic solutions are to be marked with a date when opened.<br><br>According to facility labeling of medication and biological policy, dated 2024, all medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices.<br><br>Review of facility undated pharmacy medication storage guidance noted ophthalmic products indicated products are to be dated when opened.<br><br>Review of facility undated pharmacy storage recommendations for injectable diabetes medications noted Lispro, Lantus, and Admelog Insulin Pens to expire unopened or opened in 28 days.<br><br>On [DATE] at 11:55 A.M. interview with Regional Registered Nurse (RRN) #390, during review of the facility policy and associated pharmacy guidance, confirmed the insulin pens and ophthalmic solutions were not properly stored.<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 - Some | 3. Review of the medical record for Resident #2 revealed an admitted [DATE] with diagnoses of cerebral infarction, hemiplegia, and paraplegia.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had intact cognition.<br><br>Review of the most recent medication self-administration safety screen, dated [DATE], revealed Resident #2 was determined to be unsafe to self-administer medications.<br><br>Review of the current care plan revealed no guidance regarding Resident #2 self-administrating of medication.<br><br>Observation on [DATE] at 11:36 A.M. revealed Resident #2 lying in bed with his overbed table within reach. Upon his overbed table was a medicine cup containing six tablets at bedside in the cup. Concurrent interview with Resident #2 revealed he had not yet taken his medication because he was waiting for the pain medication Tylenol.<br><br>Interview and observation on [DATE] at approximately 11:37 A.M. with Housekeeper #226 confirmed Resident #2 had six tablets in a medicine cup on his overbed table and a nurse was not in the room.<br><br>Interview on [DATE] at 11:45 A.M. with Licensed Practical Nurse (LPN) #281 confirmed she provided medications to Resident #2 but believed he had consumed the medications. LPN #281 stated Resident #2 lifted the medicine cup toward his mouth and then asked LPN #281 to bring him Tylenol.<br><br>Observation on [DATE] at 8:20 A.M. revealed Resident #2 lying in bed eating breakfast from a plate on his overbed table. Also observed on the table was a medicine cup with seven tablets in it. Concurrent interview with Resident #2 revealed he planned to eat more of the meal before taking his medications.<br><br>Observation and interview on [DATE] at approximately 8:21 A.M. with Registered Nurse (RN) #290 confirmed Resident #2 had a medicine cup on his overbed table with seven tablets it in. RN #290 confirmed he left the medication at bedside and closed Resident #2's door. RN #290 stated Resident #2 asked to eat some breakfast before he took his medication and RN #290 left the medications unattended at bedside. RN #290 stated standard of practice in the facility was to wait at bedside and watch residents consume their medications.<br><br>44815 |

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| F 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454<br><br>Based on review of the pharmacy recommendations, review of the medical record, and staff interview, the facility failed to ensure laboratory tests were completed per pharmacist recommendations or physician orders. This affected three (#7, #10, and #35) of five residents reviewed for unnecessary medications. The facility census was 67.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #7 revealed an admitted [DATE] with diagnoses of quadriplegia, type two diabetes mellitus, depression, and venous thrombosis (blood clots).<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had intact cognition.<br><br>Review of a pharmacy recommendation dated 03/28/24 revealed Resident #7 should have laboratory tests drawn for a basic metabolic panel (BMP), complete blood count (CBC), and Hemoglobin A1C upon receipt of the recommendation and every six months.<br><br>Review of a physician order dated 04/24/24 revealed Resident #7 should have laboratory tests drawn for Hemoglobin A1c, BMP, and CBC on 04/25/23 and every six months.<br><br>Review of a physician order dated 04/24/24 revealed Resident #7 should have a laboratory test drawn for a fasting lipid panel.<br><br>The facility was unable to provide evidence of laboratory tests results or refusals for Resident #7 since 04/24/24.<br><br>Interview on 05/23/24 at approximately 3:30 P.M. with MDS Coordinator #392 confirmed she could find no results or refusal of laboratory blood draws for Resident #7 since 04/24/24.<br><br>2. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included type II diabetes mellitus with diabetic neuropathy, major depressive disorder, paranoid schizophrenia, hypertension, and encephalopathy.<br><br>Review of the quarterly MDS assessment dated [DATE] identified Resident #10 was cognitively intact.<br><br>Review of pharmaceutical recommendation made to the attending physician for Resident #10 on 09/12/23 stated to please monitor glycated Hemoglobin A1C on the next convenient laboratory day and every six month if meeting goals, or every three months if therapy has changed or goals are not being met. The physician signed, accepting the recommendation on 09/21/23 with an order to complete the Hemoglobin A1C with the next laboratory draw, and if none scheduled to complete in one week. A second copy of the recommendation noted the facility lost their phlebotomy services and replacement services were being sought.<br><br>(continued on next page) |

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| F 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #10's medical record revealed there was no laboratory work including Hemoglobin A1C levels completed until 12/13/23.<br><br>During an interview on 05/22/24 at 8:42 A.M., Regional Registered Nurse #390 verified Resident #10's Hemoglobin A1C levels were not checked timely per the recommendation and physician order.<br><br>3. Review of the medical record revealed Resident #35 admitted to the facility on [DATE] with the diagnoses including dementia with mood disturbance, generalized anxiety disorder, type two diabetes mellitus, chronic obstructive pulmonary disease, panic disorder, retention of urine, major depressive disorder, peripheral vascular disease, and hypertension.<br><br>Review of the most current MDS assessment dated [DATE] assessed Resident #35 with severe cognitive impairment, no behaviors exhibited, required partial to moderate assistance with activities of daily living, was incontinent of bowel and bladder, received a therapeutic diet, had no risk for pressure ulcer development, and received antianxiety, antidepressant, antiplatelet and hypoglycemic medications.<br><br>Review of the medical record revealed Resident #35 was ordered a urinalysis with culture and sensitivity (U/A C&S), CBC, and BMP on time for increased agitation and verbal aggression towards staff on 02/22/24, on 02/24/24 the resident was to have Hemoglobin A1C laboratory values now and every six months, on 03/13/24 Resident #35 was to have a U/A C&S completed one time for dysuria, on 03/27/24 the resident was to have Hemoglobin A1C obtained with instructions to please print requisition and place in laboratory book or the laboratory would not draw it for diabetes mellitus (DM), on 04/28/24 the resident was ordered a lipid panel now and every year, Hemoglobin A1C, CBC, and complete metabolic profile (CMP) now and every six months, and was ordered a UA C&S one time only to collect on Sunday, 5/12/24, for Monday pick-up.<br><br>Further review of Resident #35's medical record lacked documentation indicating the laboratory testing was obtained as ordered.<br><br>On 05/22/24 at 1:38 P.M. interview with Licensed Practical Nurse (LPN) #501, during record review, confirmed no laboratory results for Resident #35 were available for review or contained in the medical record.<br><br>15816<br><br>44815 |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>44815<br><br>Based on observation, staff interview, and review of the menu, spreadsheet, and facility recipe, the facility failed to ensure pureed meals were prepared according to the recipe. This affected four (#25, #42, #44, and #62) of four residents ordered a pureed texture diet. The facility census was 67.<br><br>Findings include:<br><br>Review of the menu for the lunch meal on 05/21/24 revealed residents on a regular textured diet received chicken enchiladas, mexican rice, roasted corn, and pudding. Further review revealed residents on a pureed diet would receive pureed enchiladas, pureed rice, pureed lima beans, and pudding.<br><br>Observation and interview on 05/21/24 at 10:00 A.M. revealed [NAME] #195 preparing pureed food for the lunch meal. [NAME] #195 placed 10 chicken breasts into the food processor and pureed them until smooth. [NAME] #195 added an unmeasured amount of chicken broth to thin the chicken. [NAME] #195 stated four (#25, #42, #44, and #62) residents received pureed diets and some received double portions, so she consistently made extra portions of pureed foods.<br><br>Continued observation revealed [NAME] #195 placed an unmeasured amount of cooked green beans into the food processor and blended until smooth. Further interview with [NAME] #195 confirmed the residents who received puree foods would receive only chicken and green beans for the lunch meal.<br><br>Observation during meal service on 05/21/24, beginning at 11:35 A.M. revealed residents who received the pureed meal received chicken, green beans, and pudding for dessert.<br><br>Interview on 05/21/24 at 12:58 P.M. with Dietary Manager #216, during concurrent review of the lunch menu spreadsheet, confirmed [NAME] #195 should have pureed the prepared chicken enchiladas and the rice and provided all food items to residents on a pureed diet.<br><br>Interview on 05/22/24 at 1:44 P.M. with [NAME] #195 confirmed she was aware there were recipes and directions on how to puree the meals for residents. [NAME] #195 confirmed she did not follow the recipe for pureed enchiladas on 05/21/24 and pureed only chicken breasts. [NAME] #195 stated it was a very busy day and could provide no further explanation why she did not follow the recipe.<br><br>Review of the recipe/procedure for preparing for pureed chicken enchiladas revealed staff should place prepared chicken enchiladas in the food processor and add fluid and blend until smooth. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815<br><br>Based on observation, resident and staff interview, medical record review, and review of a facility policy, the facility failed to ensure pureed foods were served at an appropriate texture and failed to ensure residents received diets at an appropriate texture to meet their needs. This affected four (#25, #42, #44, and #62) of four residents ordered a a pureed texture diet and one (#11) of two residents reviewed for nutrition. The facility census was 67.<br><br>Findings include:<br><br>1. Observation and interview on 05/21/24 at 10:00 A.M. revealed [NAME] #195 was preparing pureed food for the lunch meal. [NAME] #195 placed 10 chicken breasts into the food processor and pureed them until smooth. [NAME] #195 added an unmeasured amount of chicken broth to thin the chicken. [NAME] #195 stated four (#25, #42, #44, and #62) residents received pureed diets and some received double portions, so she consistently made extra portions of pureed foods.<br><br>Observation during meal service on 05/21/24, beginning at 11:35 A.M. revealed [NAME] #195 serving pureed chicken covered in enchilada sauce. The texture of the chicken appeared firm and crumbly.<br><br>Interview on 05/21/24 at 12:09 P.M. with Regional Registered Dietitian (RRD) #388 revealed the kitchen staff was recently educated on preparation of pureed foods.<br><br>Interview at the end of meal service on 05/21/24 at approximately 12:35 P.M. with [NAME] #195 revealed she identified no concerns with the pureed chicken texture and further stated she added enchilada sauce to the chicken for additional moisture.<br><br>Review of a pureed test tray on 05/21/24 at 12:40 P.M. with RRD #388 confirmed the pureed chicken crumbled and did not have a uniform, cohesive texture, even after mixing with the provided enchilada sauce. RRD #388 confirmed the pureed chicken was not an appropriate texture to provide to residents on a pureed diet.<br><br>2. Review of the medical record revealed Resident #11 admitted to the facility on [DATE] with the diagnoses including chronic obstructive pulmonary disease, type two diabetes mellitus, coronary artery disease, paranoid schizophrenia, neuromuscular dysfunction of bladder, retention of urine, benign prostatic hyperplasia with lower urinary tract symptoms, suprapubic urinary catheter, history of urinary tract infection, bipolar disorder, anxiety disorder, hypertension, and anemia.<br><br>Review of the most current Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #11 with intact cognition, was dependent on staff for the completion of activities of daily living, utilized an indwelling catheter related to urination, was continent of bowel, and received no specialized or modified diet.<br><br>Review of physician orders revealed on 04/01/24 Resident #11 was ordered a regular diet, regular texture, and thin consistency.<br><br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 04/10/24 a nursing plan of care was implemented to address Resident #11 potential/actual impairment to skin integrity related to fragile skin. Interventions also included nutritional support to encourage good nutrition and hydration in order to promote healthier skin.<br><br>Observation and interview on 05/20/24 at 12:38 P.M. noted Resident #11 attempting to eat lunch. Resident #11 was noted without teeth or dentures. The resident was unable to eat the slice of pork tenderloin due to having no teeth. The resident stated since his admission he was leaving his dentures with his son due to not wanting to loose them in the facility.<br><br>Observation and interview on 05/21/24 at 7:50 A.M. noted Resident #11 was seated in the unit lounge and eating breakfast independently. The resident ate scrambled eggs and hot cereal; however, Resident #11 stated he was unable to eat a slice of ham during interview.<br><br>On 05/21/24 at 7:52 A.M. interview with State tested Nurse Aide (STNA) #308 during observation noted Resident #11's with a sliced portion of ham remaining on plate and unable to consume due to lack of teeth or dentures. STNA #308 confirmed the resident was not able to eat the piece of ham.<br><br>On 05/21/24 at 12:45 P.M. interview with RRD #388 stated she was unaware Resident #11 was not wearing dentures and had requested a diet texture modification. RRD#388 also indicated the speech and language pathologist was not aware of the resident's diet texture status.<br><br>Review of the policy titled, Puree Food Preparation, dated 2024, revealed the goal texture for pureed foods is a soft, homogenous (uniform) consistency similar to soft mashed potatoes. |

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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>44815<br><br>Based on observation, staff interview, and review of a facility policy, the facility failed to use appropriate hand hygiene while preparing and serving food items. This directly affected all residents with the exception of two (#5 and #43) residents who were identified to receive no food from the kitchen. The facility census was 67.<br><br>Findings include:<br><br>1. Observation on 05/21/24 at 11:28 A.M. at the beginning of meal service revealed [NAME] #195 washed her hands and put on disposable gloves. [NAME] #195 then removed lids from the steam table and put on oven mitts to remove food from the oven. [NAME] #195 removed the oven mitts, picked up a food thermometer, and took the temperature of a pan of enchilada sauce. [NAME] #195 then used a towel to pick the pan of sauce back up, opened the oven door, and placed the pan inside the oven.<br><br>Continued observation revealed [NAME] #195, wearing the same pair of disposable gloves, sat out meal tickets and beginning to plate food. [NAME] #195 touched the spatula for the enchiladas and the scoops for beans, rice, and enchilada sauce. Continued observation on 05/21/24 at 11:36 A.M. revealed [NAME] #195, wearing the same pair of disposable gloves, and using her fingers to help slide the enchilada off the spatula and onto the plate, then [NAME] #195 scooped rice, corn, and enchilada sauce onto the plate. [NAME] #195 then picked up a new plate, used her gloved hand to slide the enchilada onto another plate, and served rice, corn, and enchilada sauce.<br><br>Interview on 05/21/24 at approximately 11:38 A.M. with Dietary Aide #198 revealed the two residents whose meals [NAME] #195 just plated were for Resident #29 and Resident #59.<br><br>Interview on 05/21/24 at 11:38 A.M. with [NAME] #195 confirmed she had not changed her gloves since the beginning of meal service, touched the steam table lids, touched the serving utensils, and put her gloved hands into the oven mitts before touching the enchiladas during plating. [NAME] #195 stated the enchilada was about to fall off the plate and therefore she was trying to keep the food in place.<br><br>2. Observation on 05/21/24 at approximately 11:55 A.M. revealed Dietary Manager (DM) #216 telling kitchen staff Resident #38 requested a turkey sandwich.<br><br>Observation on 05/21/24 at 12:03 P.M. revealed [NAME] #193 was wearing disposable gloves and opened the walk-in refrigerator using a gloved hand on the handle. [NAME] #193 came out from the walk-in refrigerator carrying a large container of mayonnaise. [NAME] #193 opened the mayonnaise jar then used a knife to spread mayonnaise on a piece of bread while holding the bread with the other hand. [NAME] #193 then picked up a slice of cheese, placed it on the sandwich, picked up the bread, put the slice on top of the turkey sandwich, and held the sandwich it place while he cut it in half before placing it on a plate. [NAME] #193, wearing the same disposable gloves, then walked to a large bag of chips and reached inside for a handful of chips and placed them on the plate with the sandwich.<br><br>(continued on next page) |

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|---|---|---|---|
| | 366328 | A. Building<br>B. Wing | 05/23/2024 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview on 05/21/24 at 12:09 P.M. with [NAME] #193 confirmed he did not change his gloves at any time after entering the walk-in refrigerator, touching the mayonnaise, touching the knife, and before he touched the sandwich and chips for Resident #38. [NAME] #193 was not aware he should not handle foods with the same gloves used to touch unsanitized kitchen items.<br><br>3. Observation on 05/22/24 at 1:43 P.M. revealed [NAME] #192 was preparing side salads and chef salads. [NAME] #192 was observed to reach her bare hand into a large container of shredded cheese and sprinkle the cheese onto the salads. Interview at that time with [NAME] #192 revealed she felt it was safe and appropriate to touch the cheese with her bare hands.<br><br>Interview on 05/22/24 at 1:45 P.M. with Dietary Manager #216 confirmed staff should not be using bare hands when preparing ready-to-eat food for residents.<br><br>Review of the policy titled, Dietary Employee Personal Hygiene, dated 2024, revealed hands must be washed after engaging in activities that contaminate the hands, and further revealed gloves were to be worn and changed appropriately to reduce the spread of infection. Additionally, employees should never use bare hand contact with any foods, ready-to-eat or otherwise. |

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| F 0825<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or get specialized rehabilitative services as required for a resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816<br><br>Based on observation, medical record review, and staff interview, the facility failed to provide ongoing rehabilitation services or restorative services to address range of motion and contracture prevention. This affected one (#43) of one residents reviewed for rehabilitation and range of motion in a facility census of 67.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #43 admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, hypertension, aphasia, urinary retention, dysphagia, cerebral atherosclerosis, delirium, and major depressive disorder.<br><br>Review of the most current Minimum Data Set assessment dated [DATE] revealed Resident #43 was assessed with severe cognitive impairment, was dependent on staff for the completion of activities of daily living, had no behaviors or mood disturbance, was always incontinent, received nutrition via feeding tube, and received speech, physical, and occupational therapy.<br><br>Review of Resident #43's medical record revealed a plan of care was initiated on 04/03/24 addressing activity of daily living (ADL) self-care performance deficit related to hemiplegia and stroke with a goal to improve the current level of function. Interventions included Resident #43 was totally dependent on staff to provide bath/shower twice weekly and as necessary; use short, simple instructions such as hold washcloth in hand, put soap on washcloth, wash face to promote independence; the resident was totally dependent for bed mobility; Resident #43 had contractures of the right side with staff too provide skin care routinely to keep clean and prevent skin breakdown; and physical therapy (PT)/occupational therapy (OT) evaluation and treatment as per physician (MD) orders.<br><br>Review of a PT discharge summary dated between 03/19/24 and 04/05/24 revealed Resident #43 was discharged per physician or case manager. The resident reached maximum potential with skilled services. A restorative program or functional maintenance was not indicated at that time. On 04/05/24 the resident was recorded as dependent with wheelchair mobility with flaccid right hemiplegia. There was no documentation indicating Resident #43 was evaluated for contractures or related preventative treatment to promote extremity range of motion.<br><br>Review of an OT discharge summary dated between 03/19/24 and 04/06/24 noted Resident #43 was discharged from therapy due to exhausted benefits, and the patient/responsible party declined treatment. Discharge recommendations included long term care with staff assistance. A restorative program or functional maintenance was not indicated at this time. A prognosis was given to maintain current level of function good with consistent staff follow-through. Resident #35 progress and response to treatment noted the resident made consistent progress with skilled interventions and consistent progress throughout the plan of treatment. Resident #43's right arm, hand, leg was assessed as dependent. There was no documentation indicating Resident #43 was evaluated for contractures or related preventative treatment to promote extremity range of motion.<br><br>(continued on next page) |

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| F 0825<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 05/21/24 at 6:24 A.M., on 05/22/24 at 5:43 A.M. and 7:45 A.M., and on 05/23/24 at 6:25 A.M. noted Resident #43 in bed with the right upper extremity in the flexed position across the resident's chest. Resident #43's right wrist was flexed and fifth finger of right hand (little finger) in the flexed position.<br><br>On 05/21/24 at 12:02 P.M. interview with State tested Nurse Aide (STNA) #308 stated Resident #43 does not have a specific range of motion (ROM) program. STNA #308 stated the resident reported some pain in the wrist as time went by following the stroke. STNA #308 confirmed the resident's right wrist was remaining in the flexed position.<br><br>Additional observation on 05/22/24 at 9:03 A.M. discovered Resident #43 in bed with right leg movement from the edge of the mattress to the center of the bed.<br><br>On 05/21/24 at 12:15 P.M. interview with Physical Therapy Director (PTD) #401 was unaware Resident #43 reported pain in the right arm. PTD #401 confirmed Resident #43 right upper and lower extremities were flaccid due to a cerebral vascular accident (CVA) when discharged from therapy between 04/05/24 and 04/06/24 with no recommendations for maintenance including the promotion of range of motion. PTD #401 stated she was unaware Resident #43 was reporting feeling and associated pain in the right arm. PTD #401 stated with the reported change the resident would be evaluated by therapy to determine a potential treatment. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815<br><br>Based on observation, medical record review, resident and staff interviews, and review of a facility policy, the facility failed to ensure each resident's electronic medical record was complete and accurate. This affected two (#19 and #220) of 19 resident records reviewed. The facility census was 67.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #19 revealed an admitted [DATE] with diagnoses of type two diabetes mellitus and peripheral vascular disease.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 had intact cognition and had no wounds at the time of the assessment.<br><br>Review of a wound care service provider note dated 04/30/24 revealed Resident #19 had a skin tear on the left foot, second toe. Review of a provider note dated 05/07/24 revealed the skin tear on the left foot, second toe was scabbed. Further review of the provider notes from 05/14/24 and 05/21/24 revealed the wound on the left foot, second toe continued to be monitored by wound care.<br><br>Review of discontinued physician orders dated 05/02/24 to 05/14/24 and 05/16/24 to 05/21/24 revealed Resident #19 received treatment to a wound on the right toe, second digit.<br><br>Review of a current physician order dated 05/22/24 revealed Resident #19 received treatment to a wound on the right toe, second digit.<br><br>Review of the treatment administration record (TAR) dated May 2024 for Resident #19 revealed staff were signing off treatment was completed to the right toe, second digit.<br><br>Interview and observation on 05/22/24 at 7:43 A.M. with Licensed Practical Nurse (LPN) #260 confirmed Resident #19's wound was on her left foot, the second toe. LPN #260 confirmed the order was incorrect as it indicated it was for the right toe. LPN #260 was familiar with the wound and had provided treatment to the second toe on the left foot.<br><br>2. Review of the medical record for Resident #220 revealed an admitted [DATE] with diagnoses of paraplegia, chronic obstructive pulmonary disease, congestive heart failure and chronic respiratory failure, and neuromuscular dysfunction of the bladder.<br><br>Review of the nursing assessment completed 05/16/24 revealed Resident #220 was alert and oriented to person, place, time, and situation and had intact cognition. Further review revealed Resident #220 had a diagnoses of neurogenic bladder and had an indwelling urinary (Foley) catheter.<br><br>Review of Resident #220's progress notes on 05/22/24 at 3:47 P.M. revealed the most recent progress note was dated 05/20/24.<br><br>(continued on next page) |

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| | 366328 | A. Building<br>B. Wing | 05/23/2024 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with Resident #220 on 05/20/24 at 10:24 A.M. revealed Resident #220 was satisfied with her care and had no concerns. Concurrent observations also revealed no concerns regarding care.<br><br>Interview on 05/22/24 at approximately 9:30 A.M. with LPN #260 revealed Resident #220 went to the hospital the previous evening.<br><br>Interview on 05/22/24 at 10:01 A.M. with the Interim Director of Nursing (DON) confirmed Resident #220's record did not include any information regarding Resident #220's transfer to the hospital the previous evening.<br><br>Interview on 05/22/24 at 10:26 A.M. with LPN #372 revealed the medical record should include nursing documentation of a change in condition and an e-interact transfer-out form. LPN #372 confirmed the documents were not completed for Resident #372.<br><br>Review of the policy titled, Documentation in Medical Record, dated 2024, revealed each resident's medical record shall contain an accurate representation of the actual experiences of the resident through complete, accurate, and timely documentation. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454<br><br>Based on observation, record review, staff interview, hospice staff interview, and review of the facility policy, the facility failed to ensure communication and coordination of care occurred between the facility and the hospice provider. This affected one (#65) of one residents reviewed for hospice care. The facility census was 67.<br><br>Findings include:<br><br>Review of the medical record for Resident #65 revealed an admitted [DATE] with diagnoses of severe protein-calorie malnutrition, anxiety, and depression. Further review revealed Resident #65 was admitted under the care of hospice.<br><br>Review of the admission Minimum Data Set (MDS) assessment completed 02/27/24 revealed Resident #65 had intact cognition. Resident #65 was not at risk for developing pressure injuries, no pressure injury was present on admission, and a pressure reducing mattress was in place.<br><br>Review of the quarterly Braden Scale for predicting pressure sore risk assessment dated [DATE] revealed Resident #65 was at risk for developing pressure sores.<br><br>Review of the skin observation tool completed on 04/25/24 revealed Resident #65's skin was intact.<br><br>Review of a progress note dated 04/29/24 revealed Resident #65 was found with an open area on her coccyx and two areas on the left buttocks, one measuring 1.0 centimeters (cm) long by 1.0 cm wide and the other measuring 0.5 cm long by 0.5 cm wide.<br><br>Review of a wound care physician progress note dated 05/01/24 revealed Resident #65 was found with two stage three pressure ulcers (full-thickness skin loss) to her left buttock. One of the pressure ulcers measured 0.4 cm long by 0.3 cm wide by 0.1 cm deep with moderate serous exudate and 40 percent (%) granulation tissue The other pressure ulcer measured 1.0 cm long by 0.5 cm wide by 0.1 cm deep with moderate serous exudate and 40% granulation tissue. Recommendations included the addition of a Group-2 mattress (non-powered pressure-reducing mattress), upgrade the offloading chair cushion, offload the wounds, and reposition per facility protocol.<br><br>Review of a progress note dated 05/02/24 revealed Resident #65's wounds on her left buttock were assessed as stage three pressure ulcers and the area on her left buttock was moisture-associated skin damage (MASD). Further review revealed Resident #65 required a low-air-loss mattress and a cushion to her wheelchair to be supplied by hospice.<br><br>Review of the physician orders for Resident #65 dated 05/04/24 revealed treatment orders for the left buttock to cleanse both wounds with normal saline, pat dry, apply hydrofera blue to the wound bed, cover with foam dressing, and change three times per week and as needed.<br><br>Further review of physician orders revealed there were no orders for a specialty mattress or a cushion to Resident #65's wheelchair were entered at the time of review on 05/22/24.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the current care plan revealed Resident #65 was at risk for potential/actual skin impairment related to fragile skin. Interventions included monitoring and documenting location, size, and treatment of skin injury.<br><br>Interview on 05/20/24 at 10:46 A.M. with Resident #65 revealed she had no concerns with her care and treatment and further stated her buttock wounds were healed.<br><br>Observation of Resident #65's bed and wheelchair with Wound Care Licensed Practical Nurse (LPN) #372 revealed Resident #65 had a standard mattress and in her wheelchair was a folded bed blanket, white washcloths, and a thin pillow. There was no cushion observed in the chair. Interview with LPN #372 confirmed the special pressure-reducing mattress and gel cushion were not in place for Resident #65.<br><br>Interview on 05/22/24 at 11:23 A.M. with Hospice Triage Nurse (HTN) #393 revealed hospice received communication from the facility on 05/03/24 requesting an alternating cushion for Resident #65's wheelchair. HTN #393 stated hospice was able to provide a wheelchair cushion but not an alternating one. HTN #393 further stated hospice did not provide a mattress for Resident #65, but had an order dated 05/03/24 for a gel cushion to be sent to the facility.<br><br>Review of the policy titled, Coordination of Hospice Services, dated 2023, revealed the facility will coordinate and provide care in cooperation with hospice staff to the resident's highest practicable physical, mental, and psychosocial well-being. The facility will monitor for medical supplies to ensure they are provided by hospice as indicated in the place of care. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>44454<br><br>Based on review of previous survey results, medical record review, and staff interview, the facility failed to established an effective Quality Assessment and Assurance committee to identify quality deficiencies and take action to ensure these deficiencies were properly reviewed and acted upon. This had the potential to affect all 67 residents in the facility. The facility census was 67.<br><br>Findings include:<br><br>Review of the facility's previous survey results revealed the facility received a deficiency for failing to provide residents with the necessary assistance with activities of daily living (ADLs) during complaint surveys completed on 10/13/22, 02/14/23, 04/14/23, 09/06/23, 02/22/24, and 03/25/24.<br><br>Review of the medical records for four (#10, #19, #26, and #43) residents during the annual survey conducted 05/20/24 through 05/23/24 revealed the facility failed to provide timely and adequate assistance with ADLs which was confirmed through observation and interviews.<br><br>During an interview on 05/23/24 at 4:21 P.M., the Administrator verified the facility had received deficiencies for not providing necessary assistance with resident ADLs on numerous occasions since the previous annual survey. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>44454<br><br>Based on review of Quality Assessment and Assurance (QAA) committee sign-in sheets and staff interview, the facility failed to ensure all required members of the QAA committee attended meetings at least quarterly. This had the potential to affect all 67 residents residing in the facility. The facility census was 67.<br><br>Findings include:<br><br>Review of the QAA committee meeting sign-in sheets for 2023 revealed the Medical Director or designee did not attend any meetings for the second quarter between April and June 2023.<br><br>During an interview on 05/23/24 at 2:19 P.M., the Administrator verified there was no evidence the Medical Director or designee attended any QAA committee meetings in the second quarter between April and June 2023. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44454<br><br>Based on observation, staff interview, medical record review, review of a facility policy, and review of the Centers for Disease Control and Prevention (CDC) guidance, the facility failed to ensure infection control procedures were followed regarding enhanced barrier precautions (EBP) and failed to ensure urinary catheter drainage bags were maintained in a manor to prevent infection. This affected eight (#7, #11, #16, #25, #56, #65, #171, and #220) of eight residents reviewed for infection control. The facility census was 67.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #7 revealed an initial admitted [DATE] with diagnoses including dysphagia, hypertension, and hyperlipidemia.<br><br>Review of physician orders revealed Resident #7 had an order in place dated 01/09/24 for an indwelling (Foley) catheter. The resident also had a physician order initiated for EBP during the survey on 05/20/24 with a start date of 05/21/24. The resident had no previous orders for EBP.<br><br>Review of the medical record for Resident #11 revealed an admitted [DATE] with diagnoses including type II diabetes mellitus, bipolar disorder, and heart failure.<br><br>Review of physician orders revealed Resident #11 had an order in place dated 04/01/24 for a suprapubic catheter. The resident also had a physician order initiated for EBP during the survey on 05/20/24 with a start date of 05/21/24. The resident had no previous orders for EBP.<br><br>Review of the medical record for Resident #16 revealed an admitted [DATE] with diagnoses including retention of urine, spinal stenosis, and hypertension.<br><br>Review of physician orders revealed Resident #16 had an order in place dated 05/07/24 for a Foley catheter. The resident also had a physician order initiated for EBP during the survey on 05/20/24 with a start date of 05/21/24. The resident had no previous orders for EBP.<br><br>Review of the medical record for Resident #25 revealed an admitted [DATE] with diagnoses including hypertension, spinal stenosis, and osteoarthritis.<br><br>Review of physician orders revealed Resident #25 had an order in place dated 03/29/24 to cleanse a wound with normal saline, pat dry, apply hydrofera blue, cover with foam adhesive dressing. change every three days and as needed for soiling. The resident also had a physician order initiated for EBP during the survey on 05/20/24 with a start date of 05/21/24. The resident had no previous orders for EBP.<br><br>Review of the medical record for Resident #56 revealed an admitted [DATE] with a diagnosis of obstructive and reflux uropathy.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366328 | A. Building<br>B. Wing | 05/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Divine Rehabilitation and Nursing at Toledo | 1011 North Byrne Road<br>Toledo, OH 43607 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a physician order dated 01/08/24 revealed Resident #56 had a urinary catheter. Resident #56 also had a physician order initiated during the survey on 05/20/24 with a start date of 05/21/24 for EBP. The resident had no previous orders for EBP.<br><br>Review of the medical record for Resident #65 revealed an admitted [DATE] with diagnoses of severe protein-calorie malnutrition, anxiety, and depression.<br><br>Review of a physician order dated 05/02/24 revealed Resident #65 had scheduled wound treatments. Review of the physician order initiated during the survey on 05/20/24 with a start date of 05/21/24 revealed Resident #65 was on EBP.<br><br>Review of the medical record for Resident #171 revealed an admitted [DATE] with diagnoses including malignant neoplasm of urinary organ, encounter for palliative care, and malignant neoplasm.<br><br>Review of physician orders revealed Resident #171 had an order in place dated 04/29/24 for a Foley catheter and change as needed if dislodged, plugged, or unable to clear with irrigation. The resident also had an order dated 05/01/24 to cleanse a coccyx wound with normal saline, pat dry, hydrofera blue to the wound bed, cover with boarder foam, change three times per week and as needed. The resident also had a physician order initiated for EBP during the survey on 05/20/24 with a start date of 05/21/24. The resident had no previous orders for EBP.<br><br>Review of the medical record for Resident #220 revealed an admitted [DATE] with a diagnosis of neuromuscular dysfunction of bladder<br><br>Review of physician orders revealed Resident #220 had an order dated 05/15/24 for a Foley catheter. Resident #220 also had a physician order initiated during the survey on 05/20/24 with a start date of 05/21/24 for EBP. The resident had no previous orders for EBP.<br><br>Observation during a tour of the facility on 05/20/24 from 7:00 A.M. to 8:24 A.M. revealed there were no residents with EBP signage on the doors of their rooms or with personal protective equipment (PPE) readily available for use in resident rooms.<br><br>Interview on 05/20/24 at approximately 2:15 P.M. with State tested Nurse Aide (STNA) #344 verified the staff member provided care for Resident #220 without wearing any PPE. Additionally, STNA #344 confirmed no PPE was available near the room and no signage was posted on the door.<br><br>Observations on 05/21/24 from approximately 7:30 A.M. through approximately 8:15 A.M. revealed Resident #7, Resident #11, Resident #16, Resident #56, Resident #65, and Resident #220 had carts containing PPE outside of their rooms and no signage indicating whether they were on infection control precautions. Resident #25 and Resident #171 had carts containing PPE outside of their rooms and signage posted on their doors indicating they were on EBP.<br><br>Interview on 05/21/24 at approximately 8:40 A.M. with Licensed Practical Nurse (LPN) #255 verified Resident #7, Resident #11, Resident #16, Resident #56, Resident #65, and Resident #220 were on EBP and confirmed none of the rooms had signage on the doors indicating what type of precautions were in place. LPN #255 also confirmed there had been no residents in the facility on EBP prior to 05/20/24 or 05/21/24 during the survey.<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 - Some | Interview on 05/23/24 at 10:54 A.M. with Wound Care Manager #372 verified EBP had not been implemented for residents as required or per facility policy.<br><br>Review of the facility policy titled Enhanced Barrier Precautions, not dated, revealed it was the facility's policy to implement EBP for the prevention of transmission of multi-resistant organisms. EBP referred to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a multi-resistant organism as well as those at increased risk of multi-resistant organism acquisition such as residents with wounds or indwelling medical devices. An order for EBP would be obtained for any residents with wounds and/or indwelling medical devices (including urinary catheters). Gowns and gloves would be made available immediately outside of the resident's room. EBP would be used for the duration of the affected resident's stay in the facility or until the wound healed or the indwelling medical device was removed.<br><br>Review of the CDC Guidance titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multi-resistant Organisms (MDROs), dated 04/02/24, revealed EBP expanding the use of gown and gloves for high-contact resident care activities was indicated when contact precautions did not otherwise apply, for all nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. When implementing contact precautions or EBP, clear signage should be posted on the door or wall outside of the resident room indicating the type of precautions and required PPE. EBP signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. PPE including gowns and gloves should be made available immediately outside of the resident room.<br><br>2. Additional review of Resident #56's medical record revealed a quarterly Minimum Data Set (MDS) assessment dated [DATE] which indicated the resident had impaired cognition.<br><br>Observation on 05/21/24 at 1:05 P.M. revealed Resident #56 was in a manual wheelchair propelling himself down the hallway. An uncovered catheter drainage bag was dragging on the floor between the wheels of the resident's wheelchair.<br><br>Interview and observation on 05/21/24 at approximately 1:07 P.M. with LPN #255 confirmed Resident #56's uncovered catheter drainage bag was dragging on the floor. LPN #255 picked Resident #56's bag from the floor and hung it under the seat of his wheelchair and proceeded to propel Resident #56 outside to smoke. LPN #255 further stated the catheter drainage bag should not be in contact with the floor.<br><br>Interview on 05/23/24 at approximately 4:30 P.M. with Registered Nurse Chief Operating Officer #391 confirmed the facility's policy stated catheter bags should be maintained in a clean, safe manner, including not touching the floor.<br><br>44815 |