| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366377 | A. Building<br>B. Wing | 05/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Tranquility of Richmond Heights | 562 Richmond Road<br>Richmond Heights, OH 44143 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| 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** 44457<br><br>Based on medical record review and staff interview, the facility failed to ensure residents were nutritionally assessed and monitored on a routine basis. This affected two residents (#30, and #46) of five residents reviewed for nutrition. The facility census was 48.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #30 revealed an admitted [DATE] and diagnoses including right dominant side hemiplegia and hemiparesis, diabetes mellitus, hypertension, diastolic congestive heart failure, chronic ischemic heart disease, and chronic kidney disease.<br><br>Review of the physician's order dated 12/12/24 revealed Resident #30 was on a regular diet with regular texture and thin liquids.<br><br>Review of the physician's order dated 02/13/25 revealed Resident #30 received 150 milliliters (ml) water flush every four hours via percutaneous endoscopic gastrostomy (PEG) tube (used for administration of enteral feeds).<br><br>Review of the physician's order dated 03/15/25 revealed Resident #30 received 400 ml bolus three times per day of Isosource 1.5 (enteral nutrition formula) via PEG tube.<br><br>Review of weights revealed Resident #30 had weight fluctuations and there was no evidence of weights recorded for November 2024 or March 2025.<br><br>Further review of the medical record revealed there had not been a nutritional assessment completed on Resident #30 from admission on 10/21/24 until 05/14/25.<br><br>Review of the dietary progress note dated 05/14/25 confirmed Resident #30 had not had a nutritional assessment since admission. The progress note indicated Resident #30 was at risk for malnutrition related to chronic disease, tube feedings, and dysphagia. It was noted Resident #30 had weight gain over five months of 12 percent (%) and weight maintenance was preferred.<br><br>Review of Resident #30's plan of care revealed a nutritional care plan was not initiated until 05/14/25 to reflect Resident #30's nutritional risk related to dysphagia, history of poor meal intake, and enteral feeding with PEG tube.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 05/21/25 at 10:05 A.M. with Registered Dietitian Supervisor (RDS) #700 revealed their company had been contracted at the facility for about two weeks and they had been documenting on residents remotely as of 05/12/25. RDS #700 indicated a permanent consultant was scheduled to start next week for routine on site visits. RDS #700 confirmed she was unable to locate any additional nutritional assessment of Resident #30. RDS #700 confirmed she would consider Resident #30 to be at high risk nutritionally and additional monitoring was needed.<br><br>Interview on 05/21/25 at 10:38 A.M. with the Administrator revealed there had been a couple month lapse in dietitian services. The Administrator indicated there was a corporate dietitian overseeing nutrition services during the lapse, but was unable to provide additional evidence of nutritional oversight of Resident #30.<br><br>2. Review of the medical record for Resident #46 revealed an admitted [DATE] and diagnoses including end stage renal disease, dependence on renal dialysis, diabetes mellitus, acute on chronic combined systolic and diastolic congestive heart failure, hypertension, blindness in both eyes, and peripheral vascular disease.<br><br>Review of physician's order dated 04/11/25 revealed Resident #46 went to dialysis every Tuesday, Thursday, and Saturday.<br><br>Review of weight records revealed Resident #46 had significant weight loss at 7.5 percent (%) loss from April 2025 at 130.6 pounds to May 2025 at 120.8 pounds.<br><br>Further review of the medical record revealed there had not been a nutritional assessment completed on Resident #46 from admission on 12/07/24 until 05/19/25.<br><br>Review of the Nutrition/Dietary Note dated 05/19/25 revealed Resident #46 triggered for significant weight loss and had body mass index (BMI) indicating underweight. The progress note confirmed Resident #46 had not had a nutritional evaluation since admission. It was noted there had been no communication with dialysis dietitian and facility dietitian was awaiting return communication. It was recommended to add pre- and post-dialysis weights, add four ounces of Novasource renal (nutritional) supplement twice daily, and continue to monitor as needed.<br><br>Review of Resident #46's plan of care revealed a nutritional care plan was not initiated until 05/19/25 to reflect Resident #46's nutritional risk related to dialysis, low BMI, and significant weight changes.<br><br>Interview on 05/21/25 at 10:05 A.M. with RDS #700 revealed their company had been contracted at the facility for about two weeks and they had been documenting on residents remotely as of 05/12/25. RDS #700 indicated a permanent consultant was scheduled to start next week for routine on site visits. RDS #700 confirmed she was unable to locate any additional nutritional assessment of Resident #46. RDS #700 confirmed she would consider Resident #46 to be at high risk nutritionally and need additional monitoring.<br><br>Interview on 05/21/25 at 10:38 A.M. with The Administrator revealed there had been a couple month lapse in dietitian services. The Administrator indicated there was a corporate dietitian overseeing nutrition services during the lapse but was unable to provide additional evidence of nutritional oversight of Resident #46.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | This deficiency represents noncompliance investigated under Complaint Number OH00161627. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52013<br><br>Based on resident record reviews, staff interviews, and review of facility policy, the facility failed to ensure communication and monitoring between the facility and dialysis center was completed and maintained. This affected one resident (#46) of one resident reviewed for dialysis. The facility census was 48.<br><br>Findings include:<br><br>Record review for Resident #46 revealed the resident was admitted to the facility on [DATE] and had diagnoses including end stage renal disease (ESRD), acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, blindness in both eyes, and dependence on renal dialysis.<br><br>Review of Resident #46's care plan dated 12/09/24 revealed the resident received dialysis treatments on Tuesdays, Thursdays, and Saturdays. Listed interventions included to auscultate (listen to) lungs sounds as ordered and monitor for edema, check for new orders upon return from dialysis, maintain communication staff with dialysis staff and physician, monitor dressing to vascular catheter/shunt, monitor left arm fistula for bruit and thrill and signs of infection, and monitor labs and report to the physician.<br><br>Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #46 has a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Resident #46 was noted on the assessment as receiving dialysis treatments.<br><br>Review of the medical record for Resident #46 revealed there was only dialysis communication documentation recorded for 01/09/25 and 01/16/25. There was no additional evidence of dialysis communication contained in the resident's medical record or the facility's dialysis communication book.<br><br>Interview on 05/21/2025 at 9:10 A.M. with Registered Nurse (RN) #582 revealed Resident #46 did not want his vital signs taken and consistently would refuse prior to leaving for dialysis treatments. RN #582 refused to take his dialysis communication record with him to the off-site dialysis center. RN #582 further confirmed that when Resident #46 returned from dialysis, he did not provide any communication or documentation from the dialysis center and would refuse to have his vital signs taken.<br><br>Interview on 05/21/25 at 10:00 A.M. with the Director of Nursing (DON) revealed there was a communication book for the nurses to read and record on residents that go out to dialysis treatments. The DON stated Resident #46 would take the dialysis communication sheets with him to dialysis but would not return them. The DON confirmed the facility did not retain a copy of the sheets sent with the resident, and there was no evidence that the facility had reached out to the dialysis center directly to collaborate or communicate.<br><br>Review of the policy titled Hemodialysis Catheters - Access and Care of with revised date September 2024 revealed that nurses should document every shift for location of catheter, condition of dressing, if dialysis was done during shift, any part of report from dialysis nurse post-dialysis being given, and observations post-dialysis. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44457<br><br>Based on medical record review and staff interview, the facility failed to ensure pharmacy recommendations were timely reviewed and addressed by the physician. This affected three residents (#18, #30, and #34) of five residents reviewed for unnecessary medications. The facility census was 48.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #30 revealed an admitted [DATE] and diagnoses including right dominant side hemiplegia and hemiparesis, Diabetes mellitus, essential hypertension, diastolic congestive heart failure, chronic ischemic heart disease, and chronic kidney disease.<br><br>Review of the pharmacy Consultation Report dated 10/23/24 revealed the pharmacist recommended to obtain a complete blood count (CBC) and basic metabolic panel (BMP) lab draw on next lab day due to Resident #30 receiving Eliquis (an anticoagulant medication). There was no evidence provided that this pharmacy recommendation was addressed by a physician. A BMP and CBC were not obtained until 11/21/24.<br><br>Review of an additional pharmacy Consultation Report dated 10/23/24 revealed the pharmacist recommended discontinuing as needed Methocarbamol (a muscle relaxant medication) due to the strong, sedating anticholinergic properties. There was no evidence provided that this pharmacy recommendation was addressed by a physician. Resident #30 remained on the medication until 03/06/25.<br><br>Review of the pharmacy Consultation Report dated 01/27/25 revealed the pharmacist indicated Resident #30 was on duplicate therapy including Doxazosin Mesylate (an antihypertensive medication and can also be used to treat benign prostatic hyperplasia) for hypertension and Tamsulosin Hydrochloride for benign prostatic hyperplasia. The pharmacist recommended to re-evaluate and consider an alternative antihypertensive to Doxazosin. The pharmacy recommendation was not addressed by a physician until 03/03/25.<br><br>Interview on 05/21/25 at 2:24 P.M. with the Director of Nursing (DON) confirmed she was unable to locate additional evidence pharmacy recommendations were addressed by a physician. The DON indicated these recommendations occurred prior to her becoming the DON.<br><br>32650<br><br>2. Resident #18 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, Multiple Sclerosis, gastroparesis, anxiety, and morbid obesity.<br><br>Review of the physician's orders for Resident #18 revealed the resident received the following medications:<br><br>- Ativan (used to treat anxiety) 1 milligram (mg) orally every six hours as needed<br><br>- Clonazepam (used to treat anxiety) 1 mg orally twice a day<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Buspirone (used to treat anxiety) 20 mg orally twice a day<br><br>- Bupropion (an antidepressant) 150 mg twice a day<br><br>- Fluoxetine (an antidepressant) 40 mg orally every day<br><br>- Seroquel (an antipsychotic used to treat bipolar disorder) 400 mg orally every evening<br><br>- Eliquis (an anticoagulant) 5 mg orally twice a day<br><br>Review of the pharmacist recommendations for Resident #18 revealed on 06/25/24 and 09/23/24 revealed the resident was receiving Eliquis twice a day, baby aspirin daily, and Naproxen (an anti-inflammatory) twice a day. The pharmacist recommended consideration of discontinuing the Naproxen as it could lead to potentially fatal bleeding. The physician did not provide a response to the recommendation. Review of the current physician's orders revealed Resident #18 no longer had an order for Naproxen.<br><br>Review of the pharmacist recommendations for Resident #18 revealed on 03/14/25 the resident had an order for Ativan 1 mg orally every six hours as needed for anxiety. There was no date provided for when the medication should be discontinued. The recommendation for all non-antipsychotic medications ordered as needed should be limited to 14 days unless otherwise noted by the physician. The physician did not respond to the recommendation until 04/28/25 when a discontinuation date of six months was provided.<br><br>Review of the pharmacist recommendations for Resident #18 revealed on 03/14/25 the resident had an order for aspirin and eliquis (an anticoagulant medication) and had not had a complete blood count (CBC) completed in the past six months. The pharmacist recommended the resident have a CBC drawn every six months to monitor for the possibility of gastrointestinal bleeding. The physician did not respond to the recommendation until 04/28/25.<br><br>Interview with the Administrator on 05/21/25 at 5:00 P.M. revealed she did not know why the physician did not respond to the pharmacist recommendations in a timely manner as he was present in the facility weekly.<br><br>38523<br><br>3. Review of the medical record for Resident #34 revealed an admitted [DATE] and diagnoses including chronic and peripheral venous insufficiency, adjustment disorder with mixed anxiety and depressed mood and recurrent major depressive disorder and generalized anxiety disorder.<br><br>Review of the Pharmacy Consultation Report dated 01/01/25 revealed the pharmacist recommended a gradual dose reduction (GDR) of trazodone 50 milligrams (mg) at hour of sleep (HS) to trazodone 25mg at HS, a medication used to treat depression and is used as a sleep aid. The pharmacy recommendation was not addressed by a physician until 03/03/25.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of an additional Pharmacy Consultation Report dated 01/01/25 revealed the pharmacist recommended re-evaluating and consider discontinuing Doxazosin Mesylate 2 mg HS for hypertension (HTN) and Tamsulosin Hydrochloride 0.4 mg HS for benign prostatic hyperplasia (BPH) consider alternative antihypertensive therapy if necessary. The pharmacy recommendation was not addressed by the physician until 03/03/25.<br><br>Interview on 05/21/25 at 2:24 P.M. with the DON confirmed she was unable to locate additional evidence pharmacy recommendations were addressed by a physician. The DON indicated these recommendations were prior to her becoming the DON. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Dispose of garbage and refuse properly.<br><br>44457<br><br>Based on observation and staff interview, the facility failed to maintain the dumpster area in a sanitary manner. This had the potential to affect all residents residing in the facility. The facility census was 48.<br><br>Findings include:<br><br>Observation on 05/18/25 at 8:25 A.M. with Dietary Manager (DM) #419 revealed the lid to the dumpster was open and the enclosure to the dumpster was left open. There was significant debris surrounding the dumpster inside the enclosure including cups, plastic wrap, gloves, and food wrappers.<br><br>Interview on 05/18/25 at 8:25 A.M. with DM #419 confirmed findings of the dumpster area and indicated the maintenance director was responsible for maintaining the dumpster area. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808<br><br>Based on record review, observation, interview, review of the Centers for Disease Control and Prevention (CDC) guidance on enhanced barrier precautions in nursing homes, and facility policy review, the facility failed to implement enhanced barrier precautions which required the use of gowns and gloves during care for residents with wounds or indwelling medical devices, which affected nine residents (#5, #12, #20, #23, #30, #34, #36, #45, and #46) out of 10 reviewed for transmission-based precautions (TBP) and enhanced barrier precautions. In addition, the facility failed to develop and implement a water management program and Legionella risk assessment, which had the potential to affect all residents residing in the facility. The facility census was 48.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #5 revealed an admitted [DATE] with diagnoses including neuromuscular dysfunction of bladder, dementia, and anxiety disorder.<br><br>Review of the care plan, dated 04/11/25, revealed Resident #5 had an indwelling foley catheter. Interventions included changing foley catheter as needed (initiated 04/11/25) and providing catheter care every shift and as needed (initiated 04/11/25),<br><br>Review of the physician's orders for Resident #5 identified an order dated 04/24/25 for enhanced barrier precautions related to the presence of a Foley (indwelling urinary) catheter.<br><br>2. Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses including prostate cancer, neuromuscular dysfunction of bladder, hematuria, and reduced mobility.<br><br>Review of the physician's orders for Resident #12 identified an order dated 01/08/25 for catheter care every shift, an order dated 02/15/25 to change the resident's suprapubic (surgically-created opening in the abdomen through which a catheter is placed for urinary elimination) catheter on the 15th of every month and as needed. Resident #12's physician's orders did not include an order for enhanced barrier precautions.<br><br>Review of the catheter care plan, dated 01/09/25, revealed Resident #12 had an indwelling foley catheter. Interventions included providing catheter care each shift and as needed and changing catheter monthly.<br><br>Review of the wound care progress note, dated 05/19/25, revealed Resident #12 had a stage four pressure ulcer to the left heel which had been present since admission and measured 2.0 centimeters (cm) in length, 3.0 cm in width, and 0.2 cm in depth with moderate serous exudate. Treatments included apply alginate calcium dressing once daily for nine days, collagen sheet once daily and as needed for 16 days, abdominal (ABD) pad once daily for nine days, and gauze roll once daily for nine days.<br><br>3. Review of the medical record for Resident #20 revealed an admitted [DATE] with diagnoses including end stage renal disease, anxiety disorder, and dependence on renal dialysis.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the physician's orders for Resident #20 identified an order dated 11/05/24 to check Resident #20's right chest dialysis catheter for signs and symptoms of bleeding and apply pressure if bleeding was noted after dialysis treatment, and an order dated 11/06/24 for dialysis treatments three times weekly on Monday, Wednesday, and Friday. Resident #20's physician's orders did not include an order for enhanced barrier precautions.<br><br>Review of the care plan, dated 02/03/25, revealed Resident #20 required enhanced barrier precautions due to the dialysis catheter. Interventions included maintain enhanced barrier precautions, notify the physician of changes, and observe for changes in mental and physical health.<br><br>4. Review of the medical record for Resident #23 revealed an admitted [DATE] with diagnoses including chronic venous hypertension with ulcer of right lower extremity, osteomyelitis, cellulitis of the right finger, and need for assistance with personal care.<br><br>Review of the physician's orders for Resident #23 identified an orders dated 04/24/25 to observe the peripherally inserted central catheter (PICC) line (an intravenous line used to administer fluids and/or medication directly into an individual's bloodstream) site and document every shift, change intravenous (IV) dressing every seven days and as needed, and maintain enhanced barrier precautions related to the presence of Resident #23's left arm PICC line.<br><br>Review of the care plan, dated 04/29/25, revealed Resident #23 required enhanced barrier precautions for intravenous therapy and wound care with interventions including activities staff to visit resident and decide on activities of choice for the resident during isolation period, enhanced barrier precautions to be maintained by staff during acute infection period, and staff to monitor resident for signs and symptoms of depression. Further review of the care plan revealed Resident #23 required IV antibiotics due to a right finger infection with interventions including administer IV medications as prescribed and monitor results, change dressing to IV site as ordered and per facility policy, maintain occlusive dressing to IV site, and check the IV site for redness and swelling every shift and as needed for signs of infiltration and infection.<br><br>Review of the wound care progress note, dated 05/19/25, indicated Resident #23 had a stage three pressure ulcer to the left buttock which had been present for more than 70 days and measured 4.0 centimeters (cm) in length, 1.5 cm in width, and 0.1 cm in depth with light sero-sanguineous exudate (drainage). Treatments included apply house barrier cream twice daily for 23 days, alginate calcium dressing twice daily for 16 days, and superabsorbent gelling fiber with silicone border twice daily and as needed for nine days.<br><br>5. Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses including dysphagia, neuromuscular dysfunction of bladder, chronic kidney disease, gastrostomy status, and presence of urogenital implants.<br><br>Review of the catheter care plan, dated 10/22/24, revealed Resident #30 had an indwelling Foley catheter. Interventions included providing catheter care each shift and as needed and to change the catheter monthly.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the physician's orders for Resident #30 revealed orders dated 12/12/24 to change Resident #30's Foley catheter as needed and for Foley catheter care to be completed every shift and as needed. An additional order dated 05/21/25 called for Resident #30 to receive bolus tube feedings via Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube used for administration of enteral feeds) with Isosource 1.5 at 400 milliliters (ml) three times daily after each meal. Resident #30's physician's orders did not include an order for enhanced barrier precautions.<br><br>Review of the tube feeding care plan, dated 05/14/25, revealed Resident #30 required a feeding tube related to dysphagia and poor intake. Interventions included administer enteral feedings and fluids via PEG tube, administer treatment to PEG tube site as ordered, and observe PEG tube site for signs and symptoms of infection such as redness, warmth, edema, and drainage.<br><br>6. Review of the medical record for Resident #34 revealed an admitted [DATE] with diagnoses including venous insufficiency, muscle weakness, major depressive disorder, and anxiety disorder.<br><br>Review of the physician's orders for Resident #34 revealed there were no orders for enhanced barrier precautions.<br><br>Review of the care plan, dated 04/21/25, revealed Resident #34 required enhanced barrier precautions and/or contact isolation related to vascular wounds. Interventions included maintaining isolation precautions and/or enhanced barrier precautions, notify the physician of any changes, and observe for changes in mental and physical health.<br><br>Review of the wound care progress note dated 05/19/25 revealed Resident #34 had a venous ulcer of the left leg which had been present for more than 197 days and measured 7.0 cm in length, 1.0 cm in width, and 0.1 cm in depth with light serous exudate. Treatments included apply Santyl (a debriding ointment used to remove dead or damaged tissue from wounds) once daily and as needed for 30 days, Xeroform (a non-adherent dressing that helps maintain moisture, aids in debridement, and helps prevent infection) dressing once daily and as needed for 30 days, abdominal (ABD) pad once daily and as needed for nine days, kerlix (gauze) roll once daily for 30 days, and skin prep once daily for 16 days.<br><br>7. Review of the medical record for Resident #36 revealed an admitted [DATE] with diagnoses including end stage renal disease, hydronephrosis, muscle weakness, and need for assistance with personal care.<br><br>Review of the physician's orders for Resident #36 identified an order dated 10/15/22 to check for thrill of arteriovenous (AV) fistula every shift, an order dated 10/01/23 to monitor Resident #36's AV fistula site for warmth, redness, tenderness, and edema every shift, and an order dated 01/04/24 for dialysis three times weekly on Monday, Wednesday, and Friday. Additional orders included an order dated 02/06/24 for apply calmoseptine to the buttocks, coccyx, and scrotal areas twice daily and as needed and an order dated 02/13/25 to apply betadine and a small piece of Aquacel to the left fourth toe with bandaid twice daily. Resident #36's physician's orders did not include an order for enhanced barrier precautions.<br><br>Review of the care plan, dated 02/03/25, revealed Resident #36 required enhanced barrier precautions due to the dialysis catheter. Interventions included maintaining enhanced barrier precautions, notify the physician of any changes, and observe for changes in physical and mental health.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 8. Review of the medical record for Resident #45 revealed a re-admitted [DATE] with diagnoses including Parkinson's disease, neuromuscular dysfunction of bladder, retention of urine, and presence of urogenital implants.<br><br>Review of the care plan, dated 10/21/24, revealed Resident #45 had an indwelling suprapubic catheter. Interventions included providing catheter care each shift and as needed, change catheter monthly, and change catheter as needed per physician order.<br><br>Review of the physician's orders for Resident #45 revealed there were no orders for enhanced barrier precautions.<br><br>9. Review of the medical record for Resident #46 revealed an admitted [DATE] with diagnoses including end stage renal disease, type two diabetes mellitus, and dependence on renal dialysis.<br><br>Review of the physician's orders for Resident #46 identified an order dated 12/09/24 for monitoring left upper arm AV shunt for bruit and thrill every shift and an order dated 05/22/25 for dialysis on Tuesday, Thursday, and Saturday. Resident #46's physician's orders did not include an order for enhanced barrier precautions.<br><br>Review of the care plan, dated 02/03/25, revealed Resident #46 required enhanced barrier precautions due to the dialysis catheter. Interventions included maintain enhanced barrier precautions, notify the physician of any changes, and observe for changes in mental and physical health.<br><br>On 05/21/25 from 8:56 A.M. to 9:10 A.M., an observation of the facility revealed there was only one resident room (Resident #1) in the entire building with a sign indicating precautions were in place. Resident #1's signage outside the door called for contact isolation precautions and a container with personal protective equipment (PPE) was present outside the door. There were no signs or PPE containers to indicate any other residents were on isolation precautions or that any residents in the facility were on enhanced barrier precautions.<br><br>On 05/21/25 at 9:11 A.M., an interview with Laundry Staff #502 stated they were unaware of any residents on isolation precautions in the facility. Laundry Staff #502 further stated when handling isolation laundry, only gloves were used and the non-porous aprons that were hanging on the wall were hardly ever used.<br><br>On 05/21/25 at 10:11 A.M., an observation of wound care on Resident #23 with Licensed Practical Nurse (LPN) #517 revealed there was no sign indicating enhanced barrier precautions were in place, there was no container of PPE available, and LPN #517 did not don a gown prior to providing Resident #23's wound care.<br><br>On 05/21/25 at 11:09 A.M., an observation of tube feed administration for Resident #30 with Registered Nurse (RN) #582 revealed there was no sign indicating enhanced barrier precautions were in place, there was no container of PPE available, and RN #582 did not don a gown while administering the tube feed.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 05/21/25 at 2:41 P.M., an observation of catheter care on Resident #12 with Certified Nursing Assistant (CNA) #611 revealed there was no sign indicating enhanced barrier precautions were in place, there was no container of PPE available, and CNA #611 did not don a gown prior to providing catheter care. An interview with CNA #611 at the time of observation verified the proper PPE was not worn during catheter care. CNA #611 stated when residents had catheters or feeding tubes, the nurses used to put PPE on the door for staff to don before going into the rooms of those on enhanced barrier precautions and that was not being done now.<br><br>On 05/21/25 at 2:58 P.M., an interview with Infection Preventionist (IP) #511 confirmed Resident #1 was on isolation precautions for a skin infection. IP #511 also verified there were no residents currently on enhanced barrier precautions in the facility and that enhanced barrier precautions should have been implemented prior to 05/21/25. IP #511 stated staff were going around the building at this time to put signs up for enhanced barrier precautions.<br><br>Review of the Centers for Disease Control and Prevention (CDC) guidance titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 07/12/24, revealed nursing home residents with wounds and indwelling medical devices were at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities was indicated, when contact precautions did not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. High-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing or showering, transferring, providing hygiene care, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy or ventilator), and care of wounds requiring a dressing.<br><br>44457<br><br>10. Interview on 05/21/25 at 2:22 P.M. with Maintenance Director #609 confirmed he was unable to provide a Legionella risk assessment or a water management plan. Maintenance Director #609 confirmed there was a Centers for Disease Control (CDC) toolkit available to them in their maintenance system for use to develop a risk assessment and plan, but he had not done so yet. Maintenance Director #609 indicated he did check water temperatures every Friday on each hall.<br><br>Interview on 05/212/25 at 3:48 P.M. with the Administrator confirmed she was unable to locate any additional information regarding a Legionella risk assessment or water management plan.<br><br>Review of facility policy Water Management Program undated revealed it was the policy of the facility to establish water management plans for reducing the risk of legionnaires and other opportunistic pathogens in the water system. A risk assessment would be conducted by the water management team annually to identify where Legionella could grow and spread.<br><br>Review of CDC Toolkit for Controlling Legionella in Common Sources of Exposure (Legionella Control Toolkit) dated 01/13/21 revealed the purpose of the document was to help evaluate hazardous conditions associated with potable water systems. The toolkit provided education, guidelines, and recommendations for development of a water management plan. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808<br><br>Based on record review, staff interview, and review of facility policy, the facility failed to ensure education on immunization risk and benefits were provided and failed to obtain written consent for influenza and pneumococcal immunizations. This affected five residents (#1, #30, #37, #45, and #46) of five residents reviewed for immunizations. The facility census was 48.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including hypertension, dementia, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, major depressive disorder, cerebral infarction, and aphasia following unspecified cerebrovascular disease.<br><br>Review of the influenza vaccine consent form dated 11/28/24 for Resident #1 indicated the vaccination was declined. The form indicated the declination was verbal, there was no indication as to whether the decision was made by the resident or by a resident representative, and there was no signature on the form to indicate education had been provided on the risks and benefits.<br><br>There was no consent form in Resident #1's medical record for the pneumococcal vaccination.<br><br>2. Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses including dysphagia, neuromuscular dysfunction of bladder, chronic kidney disease, gastrostomy status, major depressive disorder, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.<br><br>Review of the influenza vaccine consent form dated 11/15/24 for Resident #30 indicated the vaccination was declined. The form indicated the declination was verbal, there was no indication as to whether the decision was made by the resident or by a resident representative, and there was no signature on the form to indicate education had been provided on the risks and benefits.<br><br>Review of the pneumococcal vaccine consent form dated 11/15/24 for Resident #30 indicated the vaccination was declined. The form indicated the declination was verbal, there was no indication as to whether the decision was made by the resident or by a resident representative, and there was no signature on the form to indicate education had been provided on the risks and benefits.<br><br>Review of the immunization records revealed Resident #30 received the pneumococcal vaccination on 11/16/24.<br><br>There was no signed consent form in Resident #30's medical record indicating consent was received to administer the pneumococcal vaccination.<br><br>3. Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dementia with behavioral disturbance, and major depressive disorder.<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the influenza vaccine consent form dated 11/27/24 for Resident #37 indicated consent was received to administer the vaccination. The form indicated the consent was verbal, there was no indication as to whether the decision was made by the resident or by a resident representative, and there was no signature on the form to indicate education had been provided on the risks and benefits.<br><br>Review of the pneumococcal vaccine consent form, which was not dated, for Resident #37 indicated consent was received to administer the vaccination. The form indicated the consent was verbal, there was no indication as to whether the decision was made by the resident or by a resident representative, and there was no signature on the form to indicate education had been provided on the risks and benefits.<br><br>Review of the immunizations record for Resident #37 indicated the pneumococcal vaccine was administered on 11/24/24 and the influenza vaccine was administered on 12/19/24.<br><br>4. Review of the medical record for Resident #45 revealed a re-admitted [DATE] with diagnoses including Parkinson's disease, neuromuscular dysfunction of bladder, retention of urine, schizophrenia, hyperlipidemia, and hypothyroidism.<br><br>Review of the influenza vaccine consent form dated 11/28/24 for Resident #45 indicated consent was received to administer the vaccination. The form indicated the consent was verbal, there was no indication as to whether the decision was made by the resident or by a resident representative, and there was no signature on the form to indicate education had been provided on the risks and benefits.<br><br>Review of the pneumococcal vaccine consent form, which was not dated, for Resident #45 indicated consent was received to administer the vaccination. The form indicated the consent was verbal, there was no indication as to whether the decision was made by the resident or by a resident representative, and there was no signature on the form to indicate education had been provided on the risks and benefits.<br><br>Review of the immunizations record for Resident #45 indicated the pneumococcal vaccine was administered on 11/16/24 and the influenza vaccine was administered on 12/19/24.<br><br>5. Review of the medical record for Resident #46 revealed an admitted [DATE] with diagnoses including end stage renal disease, type two diabetes mellitus, and dependence on renal dialysis.<br><br>There was no consent form in Resident #46's medical record for the influenza vaccination or the pneumococcal vaccination.<br><br>On 05/21/25 at 2:58 P.M., an interview with Infection Preventionist (IP) #511 stated immunizations were supposed to be offered to residents and consent forms signed. IP #511 refused to confirm that the vaccination consent forms for Residents #1, #30, #37, #45, and #46 were not signed.<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 05/21/25 at 3:10 P.M., an interview with Licensed Practical Nurse (LPN) #517 verified the immunization consent forms did not have any indication as to who provided the vaccine consent or declination and the forms were not signed by the residents or their representatives. LPN #517 stated the former Director of Nursing (DON) had instructed her to just write verbal or verbally on the forms and that would be sufficient. LPN #517 also verified Resident #30's pneumococcal vaccine consent form indicated the vaccine was declined on 11/15/24 and Resident #30's medical record indicated he received the pneumococcal vaccination on 11/16/24.<br><br>Review of the facility policy titled Influenza Vaccine, dated October 2019, revealed all residents without clinical contraindications would be offered the influenza vaccine annually, education on the risks and benefits of the vaccine would be provided to the resident or resident's legal representative, and consent or declination of the vaccine would be documented in the resident's medical record.<br><br>Review of the facility policy titled Pneumococcal Vaccine, dated October 2019, revealed all residents would be offered the pneumococcal vaccine within 30 days of admission, education on the risks and benefits of the vaccine would be provided to the resident or resident's legal representative, provision of the education would be documented in the resident's medical record, and refusals of the vaccine would be documented in the resident's medical record. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44808<br><br>Based on record review, staff interview, and review of facility policy, the facility failed to ensure education on immunization risk and benefits were provided and failed to obtain written consent for COVID-19 immunizations. This affected five residents (#1, #30, #37, #45, and #46) of five residents reviewed for immunizations. The facility census was 48.<br><br>Findings include:<br><br>1. Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including hypertension, dementia, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, major depressive disorder, cerebral infarction, and aphasia following unspecified cerebrovascular disease.<br><br>Review of the COVID-19 vaccination consent form, which was not dated, for Resident #1 indicated the vaccination was declined. The form indicated the declination was verbal, there was no indication as to whether the decision was made by the resident or by a resident representative, and there was no signature on the form to indicate education had been provided on immunization risks and benefits.<br><br>2. Review of the medical record for Resident #30 revealed an admitted [DATE] with diagnoses including dysphagia, neuromuscular dysfunction of bladder, chronic kidney disease, gastrostomy status, major depressive disorder, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.<br><br>Review of the COVID-19 vaccination consent form, which was not dated, for Resident #30 indicated the vaccination was declined. The form indicated the declination was verbal, there was no indication as to whether the decision was made by the resident or by a resident representative, and there was no signature on the form to indicate education had been provided on immunization risks and benefits.<br><br>3. Review of the medical record for Resident #37 revealed an admitted [DATE] with diagnoses including Alzheimer's disease, dementia with behavioral disturbance, and major depressive disorder.<br><br>Review of the COVID-19 vaccination consent form, dated 03/06/25, for Resident #37 indicated the vaccination was declined. The form indicated the declination was verbal, there was no indication as to whether the decision was made by the resident or by a resident representative, and there was no signature on the form to indicate education had been provided on immunization risks and benefits.<br><br>4. Review of the medical record for Resident #45 revealed a re-admitted [DATE] with diagnoses including Parkinson's disease, neuromuscular dysfunction of bladder, retention of urine, schizophrenia, hyperlipidemia, and hypothyroidism.<br><br>Review of the immunizations record for Resident #45 indicated the resident was not eligible for the COVID-19 vaccination on 12/29/23.<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | There was no evidence in Resident #45's medical record that the COVID-19 vaccine had been offered or administered.<br><br>5. Review of the medical record for Resident #46 revealed an admitted [DATE] with diagnoses including end stage renal disease, type two diabetes mellitus, and dependence on renal dialysis.<br><br>Review of the COVID-19 vaccination consent form, which was not dated, for Resident #46 indicated the vaccination was declined. The form indicated the declination was verbal, there was no indication as to whether the decision was made by the resident or by a resident representative, and there was no signature on the form to indicate education had been provided on immunization risks and benefits.<br><br>On 05/21/25 at 2:58 P.M., an interview with Infection Preventionist (IP) #511 stated immunizations were supposed to be offered to residents and consent forms signed. IP #511 refused to confirm that the vaccination consent forms for Residents #1, #30, #37, #45, and #46 were not signed.<br><br>On 05/21/25 at 3:10 P.M., an interview with Licensed Practical Nurse (LPN) #517 verified the immunization consent forms did not have any indication as to who provided the vaccine consent or declination and the forms were not signed by the residents or their representatives. LPN #517 stated the former Director of Nursing (DON) had instructed her to just write verbal or verbally on the forms and that would be sufficient.<br><br>Review of the facility policy titled COVID-19 Prevention, Response, and Reporting, dated 07/01/24, revealed the facility would offer resources and counseling to residents on the importance of receiving the COVID-19 vaccine and staying up to date on with all recommended COVID-19 vaccine doses. |