

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Columbia Basin Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 1015 Webber Street The Dalles, OR 97058	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>39632</p> <p>Based on observation and interview it was determined the facility failed to ensure resident care equipment was in good repair for 1 of 4 sampled residents (#3) reviewed for environment. This placed residents at risk for uncomfortable and unsanitary care equipment. Findings include:</p> <p>Resident 3 was admitted to the facility in 2017 with diagnoses including multiple sclerosis (a degenerative disease).</p> <p>Resident 3's 7/19/24 Quarterly MDS indicated the resident was cognitively intact and used a wheelchair.</p> <p>Observations from 8/26/24 through 8/29/24 between the hours of 7:00 AM and 5:30 PM revealed Resident 3 to sit in her/his wheelchair. The wheelchair's left armrest vinyl covering was torn open approximately five inches with protruding sharp, rough edges. The wheelchair's right armrest vinyl covering was torn and cracked with protruding sharp, rough edges. Resident 3 stated she/he used the wheelchair everyday and the armrests were ugly and rough on her/his skin.</p> <p>On 8/29/24 at 11:05 AM Staff 6 (CNA) stated if resident care equipment was in disrepair, it was reported to maintenance. Staff 6 stated she cared for Resident 3 for several days and had not noticed or reported any issues with the resident's wheelchair.</p> <p>On 8/29/24 at 11:13 AM Staff 21 (RNCM) stated staff were assigned to complete wheelchair inspections every evening. Staff 21 observed Resident 3's wheelchair armrests and confirmed they were torn and in disrepair.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>35855</p> <p>Based on interview and record review it was determined the facility failed to document and conduct a significant change MDS assessment for 1 of 5 sampled residents (#13) reviewed for medications. This placed residents at risk for unassessed care needs. Findings include:</p> <p>Resident 13 was admitted to the facility in 11/2023 with diagnoses including stroke and depression.</p> <p>Review of the 11/9/24 admission MDS for Resident 13 revealed the following:</p> <ul style="list-style-type: none"> -BIMS of 14 which indicated the resident was cognitively intact. -Substantial to maximal assistance with toileting hygiene, bathing self, sit to lying, lying to sitting, chair to bed transfer, toilet transfer, and shower transfer. -Partial to moderate assistance rolling left and right -Occasionally incontinent of bowel and bladder. -No physical restraints or alarms. <p>Review of a 2/15/24 Alert Note indicated Resident 13 had a seizure lasting approximately three to four minutes. A new physician's order for topiramate (anticonvulsant) was prescribed.</p> <p>Review of a 2/15/24 New Prescription report indicated Resident 13 was prescribed topiramate for epilepsy.</p> <p>Review of a 7/9/24 care plan revealed Resident 13 had a resident-to-resident altercation where Resident 13 and made physical contact with Resident 16.</p> <p>Review of the 7/26/24 quarterly MDS for Resident 13 revealed the following:</p> <ul style="list-style-type: none"> -BIMS of 10 which indicated moderate cognitive impairment. -Dependent for toileting hygiene, bathing self, sit to lying, lying to sitting, chair to bed transfer, toilet transfer, and shower transfer. -Substantial to maximal assistance rolling left and right. -Always incontinent of bowel and bladder. -WanderGuard (to alert staff when residents wander). <p>No significant change assessment was found in Resident 13's clinical record.</p> <p>(continued on next page)</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/28/24 at 7:31 AM Resident 13 stated she/he had good days and bad days with her/his cognition and she/he did not know why.</p> <p>On 8/28/24 at 8:13 AM Staff 4 (LPN) stated Resident 13 will randomly cuss the f bomb. Staff 4 stated she/he has behaviors after a family member visits the facility which was about every three weeks. Resident 13 verbally abuses staff and tries to hit them. Resident 13 will masturbate during showers then apologize after. Staff 4 stated Resident 13 hit Resident 16 in the head in 7/2024.</p> <p>On 8/30/24 at 8:44 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) confirmed Resident 13 should have a significant change MDS completed.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>46053</p> <p>Based on interview and record review it was determined the facility failed to ensure PASARR I (Pre-Admission Screening/Resident Review) screening was completed prior to admission for 1 of 1 sampled resident (#25) reviewed for PASARR. This placed residents at risk for inappropriate placement in a nursing facility and lack of needed services. Findings include:</p> <p>Resident 25 admitted to the facility in 7/2024 with diagnoses including multiple sclerosis (a chronic disease of the central nervous system that interrupts the flow of information within the brain and between the brain and body) and major depressive disorder (a mental health disorder characterized by persistently depressed mood causing significant impairment in daily life).</p> <p>A review of Resident 25's 7/23/24 admission MDS revealed she/he was cognitively intact and required substantial assistance/was dependent on staff for the completion of her/his ADLs.</p> <p>No evidence was found in Resident 25's health record to indicate the facility completed a PASARR I prior to her/his admission to the facility.</p> <p>On 8/28/24 at 9:17 AM Staff 3 (Social Services Director) stated every resident admitted to the facility needed a PASARR I because it justified their placement in a nursing facility. She stated she expected to have a PASARR I for every resident in the building either on the date of admission or by the following business day. Staff 3 confirmed Resident 25 was in the facility for more than a month and her/his PASARR I was not added to her/his electronic health record.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>35855</p> <p>Based on interview and record review it was determined facility staff failed to follow professional standards of practice for a diagnosis for 1 of 5 (#13) sampled residents reviewed for medications. Findings include:</p> <p>Resident 13 was admitted to the facility in 11/2023 with diagnoses including stroke and depression.</p> <p>A 11/9/23 Admission MDS indicated Resident 13 was cognitively intact and did not have a diagnosis of seizure disorder or epilepsy.</p> <p>A review of Resident 13's current comprehensive care plan revealed no documentation of seizure disorder or epilepsy.</p> <p>Review of Resident 13's Alert Notes revealed the following:</p> <p>-2/14/24 on alert for new medication olanzapine (antipsychotic).</p> <p>-2/15/24 had a seizure at 10:50 AM lasting approximately three to four minutes. A new physician order for topiramate (anticonvulsant) was prescribed.</p> <p>-2/16/24 had a seizure on dayshift. New orders to increase topiramate.</p> <p>-2/18/24 sent to the emergency department because of confusion, and slurred speech.</p> <p>A review a 2/15/24 New Prescription report indicated Resident 13 was prescribed topiramate for epilepsy.</p> <p>A 2/21/24 Hospitalist Discharge Summary revealed Resident 13 was admitted for sepsis due to UTI.</p> <p>A 7/26/24 quarterly MDS indicated Resident 13 did not have a diagnosis of seizure disorder or epilepsy.</p> <p>An 8/2024 MAR instructed staff to administer topiramate in the morning for convulsions with a start date of 2/16/24.</p> <p>No documentation was found in Resident 13's clinical record to indicate she/he had a history of epilepsy.</p> <p>On 8/28/24 at 6:32 AM Resident 13 stated when she/he was not administered gabapentin in a timely manner she/he would get muscle cramps from head to toe and they would appear as convulsions when the cramps became intense.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/28/24 at 11:59 AM Staff 9 (Pharmacist Consultant) stated the possibility was low for Resident 13 to have a seizure as a side effect for olanzapine. Staff 9 stated Resident 13 had COVID-19 in 1/2024 and sepsis in 2/2024 which also could have caused the seizure. Staff 9 stated there was a lot going on around that time for Resident 13.</p> <p>On 8/30/24 at 8:44 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated Staff 29 (Nurse Practitioner) should consult with the physician about the diagnosis of epilepsy.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>35855</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure dependent residents received required assistance with ADLs for 1 of 2 sampled residents (#13) reviewed for ADLs. This placed residents at risk for unmet needs. Findings include:</p> <p>Resident 13 was admitted to the facility in 11/2023 with diagnoses including a stroke and chronic pain.</p> <p>A 11/21/23 care plan indicated Resident 13 had a self-care deficit which required substantial assistance with ADL tasks including grooming.</p> <p>Review of the Documentation Survey Report on 8/26/24 revealed no documentation Resident 13 received personal hygiene on day shift or evening shift.</p> <p>On 8/26/24 at 10:55 AM, 8/27/24 at 12:44 PM and 8/28/24 at 9:16 AM Resident 13 was observed with a brown stain going from the left side of her/his mouth down to the bottom of her/his chin approximately one-half inch wide.</p> <p>On 8/28/24 at 9:19 AM Staff 8 (RCM Assistant) confirmed Resident 13's brown stain on her/his chin.</p> <p>On 8/30/24 at 8:42 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated the expectation of staff were to clean Resident 13's face.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>50926</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure implementation of care plan interventions for 1 of 1 sampled resident (#23) reviewed for falls. This placed residents at risk for injury. Findings include:</p> <p>Resident 23 was admitted to the facility in 5/2019 with diagnoses including fracture of left lower leg, dementia, and high blood pressure.</p> <p>Resident 23's 7/24/24 quarterly MDS revealed the resident had a history of a fall.</p> <p>A review of progress notes revealed the resident reported an unwitnessed fall on 4/27/24. No injuries were noted.</p> <p>Review of Resident 23's Care Plan initiated 3/27/24 identified the resident was at risk for falls. Intervention revisions on 4/30/24 included a fall mat at the side of the bed. This intervention was also on the in room care plan.</p> <p>Observations on 8/26/24, 8/27/24, and 8/28/24 between 6:23 AM and 12:42 PM revealed a fall mat was not placed at the side of the bed.</p> <p>On 8/27/24 and 8/28/24 at 12:57 PM, 3:48 PM, and 9:24 AM Staff 19 (CNA), Staff 22 (NA), and Staff 23 (CNA) stated Resident 23 had an in room care plan checked daily. They did not know there was supposed to be a fall mat at bedside.</p> <p>On 8/28/24 at 9:43 AM Staff 12 (RNCM) confirmed the intervention for a fall mat at bedside was on the Care Plan and the in room care plan. She confirmed the fall mat was not placed at bedside.</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39632</p> <p>Based on observation, interview and record review it was determined the facility failed to obtain a physician order and provide PICC (peripherally inserted central catheter) dressing care for 1 of 1 sampled resident (#146) reviewed for intravenous (IV) medications. This placed residents at risk for central catheter-related infections. Findings include:</p> <p>The 2011 CDC (Centers for Disease Control) guidelines on how to handle and maintain central lines specified to perform routine dressing changes every two to seven days and the CDC's Checklist for Prevention of Central Line Associated Blood Stream Infections specified to change semipermeable dressings at least every seven days.</p> <p>The facility's 3/2022 Peripheral and Midline IV Dressing Changes Policy and Procedure specified the following:</p> <ul style="list-style-type: none"> - Maintain sterile dressing (transparent semi-permeable membrane [TSM] dressing for all peripheral catheter sites. - Change the dressing at least every seven days for TSM dressing. <p>Resident 146 was admitted to the facility on [DATE] with diagnoses including lung abscess with pneumonia.</p> <p>Resident 146's 8/2024 admission MDS indicated the resident was cognitively intact.</p> <p>Resident 146's 8/14/24 Admission Orders included the following:</p> <ul style="list-style-type: none"> - Central Venous Access Care (PICC), per facility protocol. <p>Review of Resident 146's 8/14/24 through 8/26/24 health record revealed no physician order or resident-specific protocol for PICC dressing care. There was no documentation which indicated Resident 146's PICC dressing care was provided during the 12 day period from 8/14/24 to 8/26/24.</p> <p>On 8/26/24 at 1:15 PM Resident 146's left upper arm was observed with a PICC and TCM dressing. The PICC dressing was dated 8/26/24. Resident 146 stated the dressing was changed today and had not been changed since she/he was admitted to the facility on [DATE].</p> <p>On 8/27/24 at 1:11 PM Staff 24 (RN) stated she changed Resident 146's PICC dressing on 8/26/24 after she noticed it had not been changed since the resident's admission on 8/14/24. Staff 24 acknowledged she did not document the PICC dressing care was completed and confirmed there was no physician order or protocol in Resident 146's health record.</p> <p>On 8/27/24 at 1:16 PM Staff 21 (RNCM) stated the PICC dressing care facility protocol and PICC care standard of practice included to ensure PICC dressings were changed every 7 days and as needed. Staff 21 stated Resident 146's PICC dressing care was not provided until 8/26/24, 12 days after the resident's admission.</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>39632</p> <p>Based on interview and record review it was determined the facility failed to ensure a resident's total program of care was reviewed and documented for 3 of 5 sampled residents (#s 4, 21 and 23) reviewed for medications. This placed residents at risk for unassessed medical needs and adverse side effects of medication. Findings include:</p> <p>1. Resident 4 was admitted to the facility in 2020 with diagnoses including neuralgia (nerve pain).</p> <p>Resident 4's 3/2024, 5/2024 and 7/2024 provider visits, conducted and documented by Staff 29 (Gerontology Nurse Practitioner) were reviewed. The provider visit documentation lacked sufficient evidence to indicate the provider evaluated Resident 4's condition and reviewed the resident's total program of care.</p> <p>On 8/29/24 at 3:57 PM staff 29 stated she visited the residents at the scheduled times and as needed and was not sure where the documentation ended up in the residents' electronic health record. Staff 29 did not provide additional information in regard to her reviews, evaluations and documentation of Resident 4's total program of care.</p> <p>On 8/30/24 at 10:02 AM Staff 1 (Administrator) and Staff 2 (DNS) reviewed Staff 29's provider notes. Staff 2 stated the notes could be better and stated Staff 29's notes were not comprehensive.</p> <p>43691</p> <p>2. Resident 21 was admitted to the facility in 2/2023 with diagnoses including chronic pain and dementia.</p> <p>Resident 21's provider visit notes from 4/2024, 6/2024 and 8/2024 by Staff 29 (Gerontology Nurse Practitioner) were reviewed. The provider visit documentation lacked sufficient evidence to indicate the provider evaluated Resident 21's condition or reviewed the resident's total program of care.</p> <p>On 8/29/24 at 3:57 PM Staff 29 stated she visited the residents at the scheduled times and as needed and was not sure where the documentation ended up in the residents' electronic health record. Staff 29 did not provide additional information in regard to her reviews, evaluations and documentation of Resident 21's total program of care.</p> <p>On 8/30/24 at 10:02 AM Staff 1 (Administrator) and Staff 2 (DNS) reviewed Staff 29's provider notes. Staff 2 stated the notes could be better and stated Staff 29's notes were not comprehensive.</p> <p>50926</p> <p>3. Resident 23 was admitted to the facility in 5/2019 with diagnoses including dementia, hypertension, and high blood pressure.</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 23's provider visit notes from 6/21/24, 7/12/24 and 8/16/24 by Staff 29 (Gerontology Nurse Practitioner) were reviewed. The provider visit documentation lacked sufficient evidence to indicate the provider evaluated Resident 23's condition or reviewed the resident's total program of care.</p> <p>On 8/29/24 at 3:57 PM Staff 29 stated she visited the residents at the scheduled times and as needed and was not sure where the documentation ended up in the residents' electronic health record. Staff 29 did not provide additional information in regard to her reviews, evaluations and documentation of Resident 23's total program of care.</p> <p>On 8/30/24 at 10:02 AM Staff 1 (Administrator) and Staff 2 (DNS) reviewed Staff 29's provider notes. Staff 2 stated the notes could be better and stated Staff 29's notes were not comprehensive.</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>35855</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were seen by a physician for 1 of 5 sampled residents (#13) reviewed for medications. This placed residents at risk for unmet medical needs. Findings include:</p> <p>Resident 13 was admitted to the facility in 11/2023 with diagnoses including a stroke and chronic pain.</p> <p>A review of Resident 13's clinical record indicated there were no physician visits documented since his/her admission.</p> <p>On 8/28/24 at 12:45 PM Staff 1 (Administrator) and Staff 3 (Social Services Supervisor) confirmed there was no physician visit for Resident 13 since admission.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>50926</p> <p>Based on interview and record review it was determined the facility failed to ensure the Direct Care Staff Daily Report (DCSDR) postings were accurate for 16 of 27 days reviewed for staffing. This placed residents and visitors at risk for inaccurate staffing information. Findings include:</p> <p>Review of the 8/1/24 through 8/27/24 DCSDR indicated the following days when the number of hours CNAs and/or NAs worked were inaccurate on the daily postings:</p> <p>8/1, 8/2, 8/3, 8/4, 8/5, 8/6, 8/9, 8/10, 8/11, 8/14, 8/19, 8/20, 8/23, 8/25, 8/26, and 8/27.</p> <p>On 8/29/24 at 8:24 AM Staff 17 (Staffing Coordinator) stated she did not fully understand how to complete the DCSDR and did not update the report to reflect changes that occurred in the schedules.</p> <p>On 8/29/24 at 10:10 AM Staff 1 (Administrator) stated she expected the DCSDR to be accurate.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39632</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure the provision of prescribed medications for 1 of 8 sampled residents (#147) reviewed for medications. This placed residents at risk for not receiving prescribed medications. Findings include:</p> <p>Resident 147 was admitted to the facility on [DATE] with diagnoses including pelvis fracture.</p> <p>Resident 147's 8/22/24 Physician Orders included the following:</p> <ul style="list-style-type: none"> - Preservision AREDs 2 oral capsule by mouth in the morning; - Psyllium oral capsule 0.52 grams, 2 capsules in the evening; - Tolterodine Tartrate ER capsule 4 mg in the morning. <p>Resident 147's 8/2024 MAR revealed Preservision AREDs 2 oral capsule, psyllium oral capsule and the tolterodine tartrate were marked 9 on 8/22/24, 8/23/24, 8/24/24, 8/25/24 and 8/26/24.</p> <p>On 8/27/24 at 9:44 AM Staff 7 (CMA) stated the 9 documented on the MAR meant the medication was not available. Staff 7 stated the pharmacy should be notified and the facility should get the medications as soon as possible. Staff 7 stated she had not contacted the pharmacy to notify the medications were not available for five days since the resident admitted and was unsure if the physician was notified.</p> <p>On 8/27/24 at 10:00 AM Staff 12 (RNCM) stated medications should be available when a resident admits to the facility. Staff 12 stated if a medication was unavailable, staff needed to check the cubex (supply of back up medications) and if the medication was not in the cubex, the pharmacy was called to deliver the medications right away. Staff 12 reviewed Resident 147's MAR and stated she was unaware the medications were not available. Staff 12 stated she expected staff to call the pharmacy and notify the physician within one day of recognizing a medication was not available.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>35855</p> <p>Based on interview and record review it was determined the facility failed to follow up on pharmacy recommendations for 1 of 5 sampled residents (#13) reviewed for medications. This placed residents at risk for adverse medication reactions. Findings include:</p> <p>Resident 13 was admitted to the facility in 11/2023 with diagnoses including insomnia.</p> <p>Resident 13's 6/7/24 Pharmacist's Report to Nursing revealed the following recommendation:</p> <p>-Resident 13 was ordered trazodone (to treat depression) at bedtime for insomnia and to administer one extra tablet if not asleep within one hour. Recommendations were to discontinue the current trazodone order and re-enter the order with scheduled and PRN portions separated so the administration could be charted on each portion.</p> <p>Resident 13's 6/2024 MAR revealed trazodone continued as previously ordered and the pharmacist's recommendations were not implemented.</p> <p>Resident 13's 7/8/24 Pharmacist's Report to Nursing revealed the following recommendation:</p> <p>-Resident 13 was ordered trazodone (to treat depression) at bedtime for insomnia and to administer one extra tablet if not asleep within one hour. Recommendations were to discontinue the current trazodone order and re-enter the order with scheduled and PRN portions separated. A handwritten note on the report revealed done 7/15/24.</p> <p>Resident 13's 7/2024 MAR revealed trazodone continued as previously ordered. On 7/16/24 the same order for trazodone was added to the PRN section of the MAR. The Consultant Pharmacist's recommendations were not fully implemented.</p> <p>On 8/30/24 at 8:53 AM Staff 1 (Administrator) and Staff 2 (Interim DNS) stated they would like pharmacy recommendations implemented within a week.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>35855</p> <p>Based on interview and record review it was determined the facility failed to adequately monitor psychotropic medications for 1 of 5 sampled residents (#13) reviewed for medications. This placed residents at risk for lack of effective medication management. Findings include:</p> <p>Resident 13 was admitted to the facility in 11/2023 with diagnoses including insomnia, depression and pain.</p> <p>A 5/12/24 revised care plan indicated Resident 13 received psychotropic drugs which included fluoxetine for depression, trazodone for insomnia and olanzapine for depression. Interventions included to monitor and document the side effects and effectiveness of the medications every shift.</p> <p>No documentation was found in Resident 13's clinical record to indicate her/his medications' side effects and medication effectiveness were documented every shift.</p> <p>A review of Resident 19's signed Physician Order Summary Report dated 8/1/24 revealed the following medications:</p> <ul style="list-style-type: none"> -Trazodone (for depression) 50 mg at bedtime for insomnia. -Olanzapine (an antipsychotic to treat severe agitation) 2.5 mg two times a day for depression. -Fluoxetine (antidepressant) 20 mg in the morning for depression. <p>On 8/28/24 at 8:13 AM Staff 4 (LPN) stated when the facility switched systems to track clinical records resident side effect monitoring was no longer added to their records. Staff 4 stated she notified management of the needed monitoring, but it was not added.</p> <p>On 8/28/24 at 12:45 PM Staff 1 (Administrator) and Staff 3 (Social Services Supervisor) confirmed there was no monitoring for antipsychotic and antidepressant medications.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46053</p> <p>Based on observation, interview, and record review it was determined the facility failed to store and handle food in a manner to minimize cross contamination in 1 of 1 kitchen and 1 of 2 snack refrigerators reviewed for sanitary conditions. This placed residents at risk for foodborne illness. Findings include:</p> <p>1. On 8/26/24 at 10:16 AM during the initial tour of the facility's kitchen, the following was observed in the walk in refrigerator and dry storage area:</p> <ul style="list-style-type: none"> -Raw meat stored in the walk in refrigerator on a wire rack shelf directly above eggs and cartons of liquid whole eggs; and -Plastic handled scoops stored in the brown sugar, powdered sugar, white sugar and dry pasta storage bins. The scoops' handles touched the food in the bins. <p>On 8/26/24 at 10:24 AM Staff 30 (Food Service Director) stated the meat in the refrigerator should be stored on the bottom shelf to avoid it dripping on the food below it and the scoops should be stored in their holsters to avoid cross contamination. Staff 30 stated, somebody just got lazy.</p> <p>2. On 8/28/24 at 11:39 AM while plating foods for lunch service, Staff 31 (Dietary Cook) opened the oven door to remove a cooked chicken breast and placed it on a plate. He then picked up a dinner roll with the same gloved hand he used to open the oven door and placed it on a resident's lunch plate and did not change gloves.</p> <p>On 8/28/24 at 11:40 AM Staff 31 stated he did not change his gloves after touching the oven door handle and that created an opportunity for cross contamination. He stated, That was my mistake. I could have used tongs to plate the dinner roll.</p> <p>On 08/28/24 12:05 PM Staff 30 (Food Service Director) stated he expected staff to change gloves after touching potentially contaminated equipment and before touching food being served.</p> <p>3. Review of the US FDA 2022 Food Code revealed:</p> <ul style="list-style-type: none"> -food prepared and held cold must be clearly marked with date prepared or by day which the food shall be consumed or discarded with a maximum of seven days if held at 41 degrees F. <p>On 8/27/24 at 10:20 AM two plastic mugs with sip lids were observed in the snack refrigerator within the 2nd floor Kitchenette / Nurse station. The mugs were not labeled and they contained a brown thickened liquid.</p> <p>On 8/27/24 at 10:24 AM Staff 21 (RNCM) stated the drinks needed to be labeled and she removed them from the refrigerator.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 8/27/24 at 10:35 AM Staff 30 (Food Service Director) stated he did not know who placed the mugs in the refrigerator. He stated, Everything brought up from the kitchen to any of the snack fridges should be labeled and dated to make sure we know when it was added and when it should be removed. Also if it is for a specific resident, staff need to know that.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39632</p> <p>Based on observation, interview, and record review it was determined the facility failed to implement appropriate Enhanced Barrier Precautions (EBP) and failed to ensure appropriate use of PPE for 3 of 3 sampled residents (#s 3, 146, and 296) reviewed for infection control. This placed residents at risk for the spread of infection. Findings include:</p> <p>1. The CDC's 4/3/24 website, section titled, Transmission Based Precautions, specified Contact Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens.</p> <p>Resident 146 was admitted to the facility in 8/2024 with diagnoses including abscess of the lung with pneumonia.</p> <p>Observations on 8/26/24 and 8/27/24 between the hours of 7:45 AM and 3:50 PM revealed Contact Precautions signage was posted on the wall adjacent to Resident 146's door. A trash receptacle, labeled PPE DISPOSAL was located outside Resident 146's room. Multiple staff were observed at various times to enter Resident 146's room and provide care. Staff did not don PPE prior to entering the room.</p> <p>On 8/26/24 at 12:46 PM Staff 26 (NA) stated she was unsure what PPE she needed to don prior to entering Resident 146's room.</p> <p>On 8/27/24 at 8:28 AM Resident 146 stated since her/his admission to the facility, staff did not consistently don PPE while providing care.</p> <p>On 8/29/24 at 11:42 AM Staff 21 (RNCM) stated there was confusion regarding the Contact Precautions placed on Resident 146.</p> <p>On 8/29/24 at 1:39 PM Staff 1 (Administrator) and Staff 2 (DNS) were notified of the findings of this investigation. Staff 2 acknowledged Contact Precautions indicated staff should don PPE prior to entering the resident's room.</p> <p>43691</p> <p>2. Resident 43 was admitted to the facility in 7/2024 with diagnoses including an infected right leg wound.</p> <p>A 7/30/24 Physician Order stated wound care which included wound cleaning and redressing for Resident 43's infected right leg wound.</p> <p>A 8/9/24 cognitive assessment determined Resident 43 to have normal cognitive function.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/26/24 from 11:00 AM through 3:00 PM staff were observed entering rooms throughout the facility determined to require enhanced barrier precautions without wearing gloves and/or gowns. Staff were observed leaving these same rooms after providing brief changes with plastic bags which included soiled briefs and other fluid exposed materials.</p> <p>On 8/26/24 at 2:55 PM Staff 32 (LPN) stated she provided Resident 43's dressing change that day. Staff 32 stated she wore gloves and a mask, but did not wear a gown. Staff 32 stated she had never been instructed to wear a gown when providing wound care.</p> <p>On 8/26/24 at 2:59 PM Resident 43 stated staff who provided hands on care had worn gloves when providing care, but had never worn a gown.</p> <p>On 8/29/24 at 9:08 AM Staff 33 (CNA) stated containers with PPE have been located outside of resident rooms with EBP, including Resident 43, but PPE had not previously been worn when providing contact care with these residents.</p> <p>On 8/29/24 at 9:34 AM Staff 34 (Infection Preventionist) stated she was not aware gowns were required to be worn when providing hands on care to residents on EBP. Staff 34 confirmed enhanced barrier precautions were required for residents with open wounds or any tubes used for fluid drainage, including Resident 43.</p> <p>3. On 08/26/24 at 11:17 AM the following observations were made of rooms requiring enhanced barrier precautions:</p> <ul style="list-style-type: none"> - A container labeled as PPE disposal was located outside of rooms [ROOM NUMBERS]. Used PPE was observed inside both of these containers. - No PPE disposal container was observed outside or inside room [ROOM NUMBER]. <p>On 8/26/24 at 3:07 PM Staff 1 (Administrator) and Staff 2 (DNS) were shown the current infection control practices regarding disposal of used PPE in rooms with enhanced barrier precautions and confirmed the incorrect practices were being performed.</p> <p>50926</p> <p>4. Resident 296 was admitted to the facility in 8/2024 with diagnoses including a leg fracture requiring a leg immobilizer and history of a stroke.</p> <p>Resident 296's 8/20/2024 Admission MDS revealed the resident used an indwelling catheter.</p> <p>An observation on 8/26/24 at 10:49 AM revealed Resident 296 had a catheter drainage bag on the side of the bed. The resident confirmed she/he used an indwelling catheter. There were no Enhanced Barrier Precautions in place.</p> <p>On 8/29/24 at 1:59 PM Staff 21 (RNCM) confirmed resident 296 should have been on Enhanced Barrier Precautions due to his/her indwelling catheter.</p>		