

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Coos Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2890 Ocean Blvd Coos Bay, OR 97420	

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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>35855</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were included in care planning for 1 of 2 sampled residents (#31) reviewed for care planning. This placed residents at risk for not being involved in the care planning process. Findings include:</p> <p>Resident 31 was admitted to the facility in 7/2022 with diagnosis including autism.</p> <p>A review of Resident 31's profile sheet revealed Witness 2 (Family Member) was Resident 31's responsible party and guardian.</p> <p>A review of Psychosocial Notes from 7/31/23 through 7/17/24 revealed the following:</p> <p>-10/26/23 Quarterly care conference held with Witness 2 via phone.</p> <p>-5/6/23 note did not indicate the meeting was a care conference and attendance did not include Witness 2. No documentation Witness 2 was invited to a care conference meeting.</p> <p>-7/17/24 late entry for 7/11/14 note did not indicate the meeting was a care conference meeting and did not include documentation Witness 2 was in attendance or was invited.</p> <p>No additional documentation was found in Resident 31's clinical record which indicated Witness 2 was invited or attended a care conference since 10/26/23.</p> <p>On 9/24/24 at 7:51 AM Witness 2 stated he was not invited or attended to a care conference for quite some time. Witness 2 stated it was before Staff 4 (Social Services Director) started working at the facility.</p> <p>A review of the facility's staff list revealed Staff 4 was hired on 4/23/24.</p> <p>On 9/26/24 at 12:56 PM Staff 2 (DNS) Staff 3 (Regional [NAME] President) and Staff 29 (Regional Nurse) stated they would look for additional information for care plan conferences. No additional documentation which indicated Witness 2 was invited or attended a care conference meeting since 10/26/23 was provided.</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 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>26991</p> <p>Based on interview and record review it was determined the facility failed to ensure residents' current advance directive information was reflected in clinical records for 3 of 5 sampled residents (#s 3, 45 and 51) reviewed for advance directives. This placed residents at risk for end of life choices not being honored. Findings include:</p> <p>1. Resident 3 admitted to the facility in 7/2024 with a diagnosis of rib fractures.</p> <p>A 7/9/24 admission MDS revealed Resident 3 was cognitively intact.</p> <p>A care plan initiated 7/16/24 indicated Resident 3 had an advance directive and staff were to honor her/his wishes.</p> <p>Resident 3's clinical record did not include a copy of her/his advance directive.</p> <p>On 9/25/24 at 10:00 AM Resident 3 stated she/he had an advance directive and her/his medical provider had a copy of the form.</p> <p>On 9/25/24 at 10:10 AM Staff 4 (Social Service Director) stated upon admission a resident was provided information related to advance directives. If a resident stated she/he had an advance directive staff were to follow-up and obtain a copy for the clinical record. Staff 4 acknowledged Resident 3's care plan indicated she/he had an advance directive and her/his clinical record did not include a copy. Staff 3 also stated the hospital clinical record indicated Resident 3 had an advance directive but the hospital also did not have a copy. Staff 3 stated he did not follow-up with Resident 3 to ensure her/his clinical record included a copy of her/his advance directive.</p> <p>On 9/25/24 at 11:16 AM Staff 2 (DNS) stated if a resident's care plan indicated she/he had an advance directive staff were to follow-up and obtain a copy or revise the care plan as needed if the care plan was not accurate.</p> <p>50930</p> <p>2. Resident 45 admitted to the facility in 2024 with diagnoses including diabetes and left-sided weakness.</p> <p>Review of Resident 45's medical record revealed no advanced directive.</p> <p>Review of progress notes revealed no information indicating she/he was offered an advanced directive.</p> <p>On 9/26/24 at 12:47 PM Staff 4 (Social Services Director) stated all residents were offered an advanced directive and it was discussed at care conferences. He acknowledged Resident 45 had no advanced directive and no documentation of one being offered or refused.</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Resident 51 admitted to the facility in 2024 with diagnoses including chronic obstructive pulmonary disease and surgical amputation of her/his left leg above the knee.</p> <p>Review of Resident 51's medical chart revealed no advanced directive.</p> <p>An undated facility Conference/DC Planning form revealed Resident 51 was provided information regarding an advanced directive.</p> <p>Review of progress notes revealed no follow up information for the advanced directive.</p> <p>On 9/26/24 at 12:47 PM Staff 4 (Social Services Director) stated all residents were offered an advanced directive and it was discussed at care conferences. He acknowledged Resident 51 had no advanced directive and there was no follow up documentation for the advanced directive previously offered.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>26991</p> <p>Based on interview and record review it was determined the facility failed to ensure a resident representative was notified of hospitalization s for 1 of 2 sampled residents (#33) reviewed for notification. This placed resident representatives at risk for lack of care decisions. Findings include:</p> <p>Resident 33 admitted to the facility in 4/2023 with a diagnosis of dementia.</p> <p>Resident 33's clinical record indicated Witness 6 (Family Member) was Resident 33's first emergency contact.</p> <p>On 9/23/24 at 3:52 PM Witness 6 stated in the recent past she/he was not notified when Resident 33 was admitted to the hospital.</p> <p>Progress Notes revealed on 8/17/24 Resident 33 had a change of condition and was transported to the hospital for evaluation and treatment. There was no indication Witness 6 was notified.</p> <p>On 9/25/24 at 1:58 PM a request was made to Staff 24 (LPN IP) to provide documentation Witness 6 was notified of Resident 33's hospitalization . No additional information was received.</p>

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>35855</p> <p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>Based on interview and record review it was determined the facility failed to provide written notification regarding a change in coverage for 1 of 3 sampled residents (#9) reviewed for Medicare notification of non-coverage. This placed residents and their representatives at risk for unknown financial liabilities. Findings include:</p> <p>Resident 25 was admitted to the facility in 7/2024 with diagnosis including fracture of the left leg.</p> <p>A review of the 7/16/24 Admission MDS indicated Resident 9's BIMS was 9 which indicated moderate cognitive impact.</p> <p>A NOMNC (Notice of Medicare Non-Coverage) form was signed by Resident 9 on 7/22/24. It was not documented if her/his responsible party was contacted or made aware of the form and the effective date Medicare would no longer pay for skilled nursing services, which was 7/25/24, or how to appeal the decision if they disagreed.</p> <p>On 9/26/24 at 10:39 AM Witness 1 (Family Member) stated she was Resident 9's responsible party and she/he was able to understand the NOMNC form. Witness 1 stated the facility did not contact her regarding the NOMNC form, and she wondered why as the facility knew she was Resident 9's responsible party.</p> <p>On 9/26/24 at 10:59 AM and 11:58 AM Staff 21 (Social Services Director) and Staff 27 (Business Office) stated the protocol for the NOMNC form for a cognitively impaired resident was to notify and have the family representative present during the signing of the form. Staff 21 stated he would review a resident's BIMS score and if the resident was their own responsible party. Staff 27 stated she had Resident 9 sign the NOMNC form and she did not review Resident 9's clinical record for a responsible party.</p> <p>In an interview on 9/26/24 at 12:52 PM Staff 2 (DNS), Staff 3 (Regional [NAME] President) and Staff 29 (Regional Nurse) stated the expectation of staff was residents who were cognitively intact signed the NOMNC and/or a resident's representative.</p>		

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<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>35855</p> <p>Based on observation and interview it was determined the facility failed to provide a building in good repair 2 of 3 sampled residents (#s 11 and 20) reviewed for environment. This placed residents at risk for unsafe and unhomelike environment. Findings include:</p> <p>Resident 11 admitted to the facility in 12/2023 with diagnoses of vertigo (sense of spinning when someone is still) and unsteadiness on feet.</p> <p>Resident 20 was admitted to the facility in 3/2024 with diagnoses including muscle weakness and unsteadiness on feet.</p> <p>A review of the 8/30/24 MDS indicated revealed Resident 11's BIMs score was 13 which indicated Resident 11 was moderately cognitively impaired.</p> <p>A review of the 9/5/24 MDS indicated revealed Resident 20's BIMs score was 15 which indicated Resident 20 was cognitively intact.</p> <p>On 7/5/24 a public complaint was received which indicated the floor of Resident 11's room was so uneven that her/his bedside table would roll across the room.</p> <p>On 9/24/24 at 10:11 AM Resident 11 stated her/his room was going downhill, and staff had to engage the brakes on everything in her/his room or the items would roll downhill. A visible slope was observed in the room with appearance of the room sloping up from the window of the room to the doorway.</p> <p>On 9/26/24 at 6:54 AM and 6:59 AM Staff 20 (Maintenance Director) stated the facility was going to have someone come and find out what the slope of the rooms were and what was happening. Staff 20 stated when outside the building it appeared to have a U shape. Staff 20 stated Resident 20 requested blocks under one side of her/his bed to make the bed more level in her/his room.</p> <p>On 9/26/24 at 7:19 AM Staff 8 (CNA) stated when she went into the rooms numbered in 40's range it was like oh my goodness. Staff 8 stated she had to be cautious when she walked and watch her footing as she felt like she could lose her balance.</p> <p>On 9/26/24 at 7:58 AM Resident 20 stated there was one block under her/his bed but the one at the head of the bed came out and staff were to come and fix it. Resident 20 stated she/he felt like she/he was going downhill in her/his room. Resident 20 was observed to have a wood block approximately 1/2 to 1 inch thick under one side of the leg of the at the foot of the bed.</p> <p>In an interview on 9/26/24 at 1:08 PM Staff 2 (DNS), Staff 3 (Regional [NAME] President) and Staff 29 (Regional Nurse) stated the rooms were inspected and another company was coming to inspect the rooms. Staff 3 stated there was no structural damage to the building and they would be moving the residents who were affected to other rooms.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>35855</p> <p>Based on interview and record review the facility failed to protect residents' rights to be free from verbal and physical abuse by Staff for 1 of 2 sampled residents (#56) reviewed for abuse. This placed residents at risk for abuse. Findings include:</p> <p>Resident 56 admitted to the facility in 7/2024 with diagnoses including kidney disease and diabetes.</p> <p>A review of Resident 56's MDS and cognitive loss dementia CAA dated 6/5/24 revealed Resident 56's BIMS was 10 which indicated moderate cognitive impairment. The CAA revealed contributing factors to Resident 56's cognitive loss included dementia, change in mental status, and short and long-term memory loss.</p> <p>A review of Resident 56's care plan dated 6/12/24 revealed Resident 56 had impaired cognitive ability with a score of 10 on her/his BIMS assessment. Interventions included allow extra time for the resident to respond to questions and instructions, ask yes and no questions to determine the resident's needs, identify yourself at each interaction, face Resident 56 when speaking and make eye contact, reduce any distractions. The care plan also indicated Resident 56 understood consistent, simple, and direct sentences, to provide the resident with necessary cues and stop and return if Resident 56 became agitated, and to try and provide a consistent routine and caregivers as much as possible to decrease confusion.</p> <p>On 7/5/24 the State Survey Agency received a public complaint which indicated on 6/15/24, during the night shift, Staff 15 (Agency LPN) came out into the hallway from Resident 56's room and bragged about his interaction with Resident 56. Staff 15 stated Resident 56 pushed her/his bedside table into Staff 15 , which upset Staff 15, and he grabbed Resident 56's bed covers into a ball, pushed down on Resident 56's chest and told her/him to never do that again. On 6/16/24 Resident 56 made a comment about the incident, and it was reported. Resident 56 reported she/he was scared to even mention it. Resident 56's family was notified. Staff 15 was removed from the schedule and did not return to the facility.</p> <p>On 9/24/24 at 10:40 AM Witness 4 (Family Member) and Resident 56 stated the nurses at the facility reported to Witness 4 Staff 15 put his hands on Resident 56. Witness 4 stated Staff 15 woke Resident 56 up at 4:00 AM in the morning and it startled Resident 56. Witness 4 stated if Resident 56 was woken up in the wrong way she/he had a negative reaction. Resident 56 stated she/he did not remember pushing her/his bedside table against a staff member and she/he did not remember a staff member touching her/him.</p> <p>On 9/25/24 at 11:07 AM Staff 12 (CNA) stated on the night shift of 6/15/24 Staff 15 reported Resident 56 pushing her/his bedside table into Staff 15 and grabbing Resident 56 and telling her/him to not do that again. Staff 12 stated Staff 15 reported this information to all the staff who were working the night shift.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 9/27/24 at 8:28 AM Staff 15 stated he went into Resident 56's room on 6/15/24 and Resident 56 started yelling and shoved the bedside table into Staff 15's groin. Staff 15 stated he was loud, stern and pointed at Resident 56 and told her/him to not do that. Staff 15 stated it made him mad and he wanted to hit Resident 56 but did not lay hands on him. Staff 15 stated he documented the incident in nurse's notes, but notes and incident reports come up missing at the facility.</p> <p>On 9/27/24 at 10:02 AM Staff 13 (RN) stated Staff 15 came in to work on 6/15/24 upset about the schedule and ranting and raving. Staff 15 was swearing, and Staff 13 told him to relax. Staff 13 stated Staff 15 reported Resident 56 pushed the bedside table into Staff 15 and Staff 15 grabbed Resident 56's shirt and pulled him toward Staff 15 and told Resident 56 to knock it off. Staff 15 reported to Staff 13 that he was fucking out of here and left the facility. Staff 13 stated Staff 15 cussed a lot while at work.</p> <p>On 9/27/24 at 10:13 AM Staff 3 (Regional [NAME] President) stated he did not feel it was abuse. While Resident 56 was in the facility staff reported she/he was cognitively intact, and Resident 56 reported she/he was not abused. Staff 3 stated Staff 1 (Administrator) came into the facility and spoke with staff and the resident regarding the incident. No investigation regarding abuse on 6/15/24 was provided.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35855</p> <p>Based on interview and record review it was determined the facility failed to report to the State Survey Agency an allegation of abuse for 1 of 2 sampled residents (#56) reviewed for abuse. This placed residents at risk for abuse. Findings include:</p> <p>Resident 56 admitted to the facility in 7/2024 with diagnoses including kidney disease and diabetes.</p> <p>A review of Resident 56's MDS and cognitive loss dementia CAA dated 6/5/24 revealed Resident 56's BIMS was 10 which indicated moderate cognitive impairment. The CAA revealed contributing factors to Resident 56's cognitive loss included dementia, change in mental status, and short and long-term memory loss.</p> <p>On 7/5/24 the State Survey Agency received a public complaint which indicated on 6/15/24, during the night shift, Staff 15 (Agency LPN) came out into the hallway from Resident 56's room and bragged about his interaction with Resident 56. Staff 15 stated Resident 56 pushed her/his bedside table into Staff 15, which upset Staff 15, and he grabbed Resident 56's bed covers into a ball, pushed down on Resident 56's chest and told her/him to never do that again. On 6/16/24 Resident 56 made a comment about the incident, and it was reported. Resident 56 reported she/he was scared to even mention it. Resident 56's family was notified. Staff 15 was removed from the schedule and did not return to the facility.</p> <p>No documentation was found indicating the facility reported the alleged abuse from Staff 15 to Resident 56 on 6/15/24 to the State Survey Agency.</p> <p>On 9/24/24 at 10:40 AM Witness 4 (Family Member) and Resident 56 stated the nurses at the facility reported to Witness 4 staff put his hands on Resident 56. Witness 4 stated Staff 15 woke Resident 56 up at 4:00 AM in the morning and he startled Resident 56. Witness 4 stated if Resident 56 was woken up in the wrong way she/he had a negative reaction.</p> <p>On 9/25/24 at 11:07 AM Staff 12 (CNA) stated on the night shift of 6/15/24 Staff 15 reported Resident 56 pushing her/his bedside table into Staff 15 and grabbing Resident 56 and telling her/him to not do that again.</p> <p>On 9/27/24 at 8:28 AM Staff 15 stated he went into Resident 56's room on 6/15/24 and Resident 56 started yelling and shoved the bedside table into Staff 15's groin. Staff 15 stated he was loud, stern and pointed at Resident 56 and told her/him to not do that. Staff 15 stated it made him mad and he wanted to hit Resident 56 but did not lay hands on him.</p> <p>On 9/27/24 at 10:02 AM Staff 13 (RN) stated Staff 15 reported Resident 56 pushed the bedside table into Staff 15 and he grabbed Resident 56's shirt, pulled the resident toward him and told Resident 56 to knock it off.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>35855</p> <p>Based on interview and record review it was determined the facility failed to investigate an allegation of abuse for 1 of 2 sampled residents (#56) reviewed for abuse. This placed residents at risk for abuse. Findings include:</p> <p>Resident 56 admitted to the facility in 7/2024 with diagnoses including kidney disease and diabetes.</p> <p>A review of Resident 56's MDS and cognitive loss dementia CAA dated 6/5/24 revealed Resident 56's BIMS was 10 which indicated moderate cognitive impairment. The CAA revealed contributing factors to Resident 56's cognitive loss included dementia, change in mental status, and short and long-term memory loss.</p> <p>On 7/5/24 the State Survey Agency received a public complaint which indicated on 6/15/24 during the night shift Staff 15 (Agency LPN) came out into the hallway from Resident 56's room and bragged about his interaction with Resident 56. Staff 15 stated Resident 56 pushed her/his bedside table into Staff 15, which made Staff 15 mad, and he grabbed Resident 56's bed covers into a ball and pushed down on Resident 56's chest and told her/him to never do that again. On 6/16/24 Resident 56 made a comment about the incident, and it was reported. Resident 56 reported she/he was scared to even mention it. Resident 56's family was notified. Staff 15 was removed from the schedule and did not return to the facility.</p> <p>No documentation was found the facility completed an investigation for the alleged allegation of abuse on 6/15/24 from Staff 15 to Resident 56.</p> <p>On 9/24/24 at 10:40 AM Witness 4 (Family Member) and Resident 56 stated the nurses at the facility reported to Witness 4 staff put his hands on Resident 56. Witness 4 stated Staff 15 woke Resident 56 up at 4:00 AM in the morning and it startled Resident 56. Witness 4 stated if Resident 56 was awoken in the wrong way she/he had a negative reaction.</p> <p>On 9/25/24 at 11:07 AM Staff 12 (CNA) stated on the night shift of 6/15/24 Staff 15 reported Resident 56 pushing her/his bedside table into Staff 15 and grabbing Resident 56 and telling her/him to not do that again.</p> <p>On 9/27/24 at 8:28 AM Staff 15 stated he went into Resident 56's room on 6/15/24 and Resident 56 started yelling and shoved the bedside table into Staff 15's groin. Staff 15 stated he was loud, stern and pointed at Resident 56 and told her/him to not do that. Staff 15 stated it made him mad and he wanted to hit Resident 56 but did not lay hands on him.</p> <p>On 9/27/24 at 10:02 AM Staff 13 (RN) stated Staff 15 reported Resident 56 pushed the bedside table into him, and Staff 15 grabbed Resident 56's shirt and pulled the resident toward him and told Resident 56 to knock it off.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 9/26/24 at 1:02 PM and 9/27/24 at 10:13 AM Staff 2 (DNS), Staff 3 (Regional [NAME] President) and Staff 29 (Regional Nurse) stated they expected staff to report allegations of abuse to the State Survey Agency and to law enforcement. Staff 3 stated Staff 1 (Administrator) came into the facility and spoke with staff and the resident. No investigation regarding the incident was provided.</p> <p>Refer to F600</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26991</p> <p>Based on observation, interview and record review it was determined the facility failed to update the care plan for 3 of 7 sampled residents (#s 3, 9, and 43) reviewed for positioning and pressure ulcers. This placed residents at risk for unmet care needs. Findings include:</p> <p>1. Resident 3 admitted to the facility in 7/2024 with a diagnosis of fractured ribs.</p> <p>Resident 3's admission MDS revealed she/he was cognitively intact.</p> <p>On 9/23/24 at 12:02 PM Resident 3 was observed with a wound dressing on her/his right shin. Resident 3 stated there was an open area on her/his shin for at least one month.</p> <p>Resident 3's care plan initiated on 7/16/24 was not revised to address her/his shin wound.</p> <p>On 9/25/24 at 11:12 AM Staff 2 (DNS) acknowledged Resident 3's care plan was not revised to address her/his skin issue.</p> <p>2. Resident 43 admitted to the facility in 2/2024 with a diagnosis of kidney disease.</p> <p>A 2/9/24 admission MDS revealed Resident 43 was cognitively impaired and had a left hand contracture.</p> <p>An Occupational Therapy Discharge Summary dated 3/18/24 revealed Resident 43 had a left hand contracture and she/he was dependent on staff to place a soft hand roll.</p> <p>On 9/24/24 at 2:51 PM Resident 43 was observed with a soft hand roll in her/his left hand.</p> <p>A care plan initiated 2/22/24 was not revised to include staff were to assist Resident 43 with the soft hand roll.</p> <p>On 9/25/24 at 11:12 AM Staff 2 (DNS) acknowledged Resident 43's care plan was not revised to include staff were to assist her/him with the soft hand roll.</p> <p>50930</p> <p>3. Resident 9 admitted to the facility in 2024 with diagnoses including sepsis (severe infection) and diabetes.</p> <p>An Admission MDS dated [DATE] indicated Resident 9 was cognitively impaired. The MDS revealed Resident 9 was at risk for pressure injuries.</p> <p>A 9/1/24 provider order revealed staff were to cleanse the left ankle wound and place a foam dressing every three days and as needed.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 9/4/24 provider order revealed staff were to place sheepskin (a type of padding) between the leg brace and left inner ankle to decrease pressure.</p> <p>Review of the resident's care plan, revised 9/23/24, revealed no goals or interventions for the left ankle wound.</p> <p>On 9/24/24 at 2:36 PM Resident 9 was observed to a thigh to ankle leg brace with sheepskin tucked between the left ankle and the brace. A small foam wound dressing was observed on the inner left ankle under the sheepskin.</p> <p>On 9/27/24 at 11:36 AM Staff 2 (DNS) acknowledged Resident 9's care plan did not contain goals or interventions for the left ankle wound. She also acknowledged the care plan was not updated properly.</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>26991</p> <p>Based on observation, interview and record review it was determined the facility failed to provide shaving for 1 of 3 sampled residents (#43) reviewed for ADLs. This placed residents at risk for lack of self esteem. Findings include:</p> <p>Resident 43 admitted to the facility in 2/2024 with a diagnosis of a stroke.</p> <p>On 9/23/24 at 12:45 PM and 9/24/24 at 2:51 PM Resident 43 was observed to have long facial hair .</p> <p>A 2/9/24 admission MDS revealed Resident 43 was cognitively impaired, was able to make needs known, and required assistance for most ADLs.</p> <p>On 9/23/24 at 3:30 PM Witness 7 (Family Member) stated Resident 43 preferred to have no facial hair.</p> <p>On 9/24/24 at 3:06 PM Staff 31 (CNA) stated residents were shaved on shower days. Resident 43 had a shower on the day shift, she was not sure the reason Resident 43 was not shaved, and acknowledged her/his facial hair was likely not shaved for several days.</p> <p>On 9/24/24 at 3:45 PM Resident 43 stated she/he usually liked to not have facial hair. Resident 43 also stated her/his facial hair was so long she/he required a weed whacker to shave.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>26991</p> <p>Based on observation, interview and record review it was determined the facility failed to provide care to a non-pressure skin injury and failed to provide preparation for a medical procedure for 2 of 2 sampled residents (#s 3 and 21) reviewed for non-pressure skin conditions and medical procedures. This placed residents at risk for delayed care needs and treatment. Findings include:</p> <p>1. Resident 3 was admitted to the facility with a diagnosis of heart disease.</p> <p>On 9/23/24 at 12:02 PM Resident 3 was observed to have a wound dressing on her/his right shin. Resident 3 stated there was an open area on her/his shin for at least one month.</p> <p>Weekly Skin Integrity Data Collection forms reveled on 8/14/24 and 9/16/24 Resident 3 was assessed to have scabs to the right shin.</p> <p>Resident 3's clinical record did not indicate the shin wound was measured, assessed to determine cause, or treatment orders were obtained, and her/his care plan initiated on 7/16/24 was not revised to address her/his shin wound.</p> <p>A 9/25/24 Skin Related Injury investigation revealed Resident 3 reported to the a State surveyor she/he had an open area to the right shin. It was determined Resident 23's walker caused friction to the leg when she/he walked. Staff adjusted the walker to prevent continued injury.</p> <p>On 9/25/24 at 9:59 AM Staff 32 (CNA) stated for approximately one week Resident 3's shin bled and a nurse applied a dressing.</p> <p>On 9/25/24 at 11:12 AM Staff 2 (DNS) acknowledged Resident 3's care plan was not revised to address her/his skin issue and there was no orders or assessments to indicate when the skin issue developed.</p> <p>2. Resident 21 admitted to the facility in 7/2018 with a diagnosis of a stroke.</p> <p>Per medlineplud.gov (web based resource) a sigmoidoscopy was a procedure used to see inside the colon and rectum. To preprepare for this procedure a patient must empty their bowels by using enema (medicine inserted rectally resulting in bowel movements.) and must not eat before the procedure.</p> <p>7/3/24 hospital discharge orders revealed Resident 21 was to follow up with a general surgeon on 7/25/24.</p> <p>A facility calendar revealed Resident 21 went to the general surgeon on 7/22/24.</p> <p>A Progress Notes dated 9/3/24 revealed Resident 21 returned from an appointment and she/he was transported for sigmoidoscopy (bowel scope) procedure, without prep. Will arrange for re-scheduling/repeat clinic visit .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/26/24 at 3:25 PM Witness 10 (Medical Assistant) stated Resident 21 was seen on 7/22/24. She/he was to return to do a follow up procedure on 9/3/24 to diagnose the reason Resident 21 was bleeding. Witness 20 stated Resident 21 was not prepped and her/his diagnostic tests were delayed.</p> <p>On 9/25/24 at 4:24 PM Staff 2 (DNS) stated Resident 21 had multiple emergency room visits for her/his bleeding. Staff 2 acknowledged Resident 21 was not prepped for a diagnostic procedure on 9/3/24. No additional information related to this concern was provided.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>26991</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure treatment was provided to a resident's contracture for 1 of 4 sampled residents (#36) reviewed for positioning. This placed residents at risk for worsening contractures. Findings include:</p> <p>Resident 36 admitted to the facility in 4/2023 with a diagnosis of Parkinson's disease.</p> <p>An 4/19/24 annual MDS indicated Resident 36 was confused at times, required staff assistance for ADLs, and was able to make needs known.</p> <p>On 9/23/24 at 4:19 PM Witness 8 (Family Member) stated Resident 36 had a contracture to her/his hands and was not aware if staff provided ROM.</p> <p>On 9/26/24 at 9:55 AM Resident 36 was not able to straighten her/his third and fourth fingers on both hands. Resident 36 stated her/his hands hurt to straighten.</p> <p>On 9/26/24 at 4:30 PM Staff 2 (DNS) acknowledged resident 36 had contractures of her/his hand and there was no treatment in place.</p>

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<p>F 0689</p> <p>Level of Harm - 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49677</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure residents were free from accidents and update care plans after accidents for 3 of 4 sampled residents (#s 21, 36 and 48) reviewed for accidents and non-pressure wounds. Resident 21 fell from a mechanical lift resulting in a left arm fracture and hospitalization . Findings include:</p> <p>1. Resident 21 admitted to the facility in 2018 with diagnoses including left side paralysis and depression. A FRI and associated investigation dated 6/8/24 revealed Staff 43 (CNA) and Staff 44 (CNA) transferred Resident 21 using a mechanical lift that did not have required safety clips attached. As a result the left leg strap of the lift sling came off the arm of the mechanical lift and Resident 21 fell and landed on her/his left arm. Resident 21 was transferred to a local hospital and was identified to have a fractured arm.</p> <p>A 9/6/24 quarterly MDS indicated Resident 21 had moderate cognitive impairment.</p> <p>On 9/23/24 at 2:46 PM Resident 21 was interviewed and confirmed she/he fell out of the mechanical lift and went to the hospital. Resident 21 was not able to recall the specific details of her/his fall or injury, however the resident remembered the fall and stated, I fell out of the [mechanical lift] and broke my arm.</p> <p>On 9/25/24 at 10:19 AM Staff 10 (CNA) stated mechanical lift training was provided in CNA school, but no updated training was provided at the facility. She recalled when Resident 21 fell on [DATE] and broke her/his arm because of CNAs' failure to properly and safely operate the mechanical lift.</p> <p>On 9/25/24 at 2:17 PM Staff 2 (DNS) confirmed Resident 21's accident on 6/8/24 occurred because of CNAs' error in using the mechanical lift.</p> <p>From 9/23/24 through 9/27/24 Staff 43 and Staff 44 did not respond to multiple attempts to interview.</p> <p>26991</p> <p>2. Resident 36 was admitted to the facility in 4/2023 with a diagnosis of Parkinson's disease.</p> <p>An 4/19/24 annual MDS revealed Resident 36 had impaired mobility and was at risk for falls.</p> <p>A care plan initiated 4/20/23 revealed Resident 36 was at risk for falls. Interventions to prevent falls included staff were to keep her/his wheel chair within reach and to ensure brakes were locked. Staff were also to provide toileting after meals and before bed. Staff were to encourage the resident to use her/his call light and to ensure frequently used items were within reach.</p> <p>a. On 9/26/24 at 8:28 AM Resident 36 was in bed, her/his wheelchair was not within reach, and the wheelchair brakes were not locked. Resident 36 was observed to have a wrist call light.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/26/24 at 8:29 AM Staff 36 (CNA) verified Resident 36's wheelchair was not locked and not within reach.</p> <p>On 9/26/24 at 10:29 AM Staff 2 (DNS) stated Resident 36's wheel chair was to be locked and within reach.</p> <p>b. Un-witnessed Fall investigations dated 7/22/24, 7/30/24, 8/1/24, 8/2/24, 8/10/24, 8/18/24, 8/31/24, 9/24/24 and 9/26/24 revealed the following:</p> <p>-7/22/24 at 3:53 PM Resident 36 was found on the floor in front of the bathroom. The investigation did not include when Resident 36 was last visualized, when she/he was toileted, and where her/his wheelchair was located at the time of the fall. New interventions included staff were to ensure frequently used items were within reach (this was not a new intervention).</p> <p>- 7/30/24 at 5:45 AM Resident 36 was found on the floor near her/his window. Resident 36 requested to use the bathroom when staff found the resident. The investigation did not indicate when the resident was last visualized or toileted. New interventions included the resident was to use a wrist call light. The care plan was not updated to include a wrist call light.</p> <p>-8/1/24 at 8:00 PM Resident 36 was found at the side of her/his bed. Resident 36 reported she/he had to use the bathroom. New intervention to be implemented included for staff to remind Resident 36 to use her/his call light (this was not a new intervention).</p> <p>-8/2/24 at 8:00 PM Resident 36 was found on the floor near her/his bed and wheelchair. The investigation indicated Resident 36 was last checked on 10 minutes prior to the fall but did not specify if the resident was assisted with toileting. New interventions included staff were to ensure frequently used items were to be within reach (this was not a new intervention).</p> <p>-8/10/24 at 9:21 PM Resident was found on the floor. The resident was last observed and incontinent check done at 8:55 PM. New interventions to be implemented included keeping frequently used items within reach (this was not a new intervention).</p> <p>-8/18/24 at 7:10 AM Resident 36 was observed on the floor with her/his unlocked wheelchair in front of her/him. New interventions to prevent falls included to have frequently used items within reach (this was not a new intervention).</p> <p>-8/31/24 at 5:56 AM Resident 36 was observed between her/his bed and window. The investigation did not include when Resident 36 was last assisted. New interventions to prevent falls included to have frequently used items within reach (this was not a new intervention).</p> <p>-9/24/24 at 8:50 PM Resident 36 was observed on the floor near her/his bathroom. The investigation did not indicate when Resident 36 was last assisted.</p> <p>On 9/26/24 at 10:32 AM Staff 2 (DNS) acknowledged Resident 36's investigations did not always include information to ensure care plan interventions were followed and new interventions identified to prevent falls were already in place.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>c. Resident 36's post fall Neurological Check List forms (assessment for head injury: assessments were to be done every 15 minutes for one hour, every 30 minutes for two hours, every two hours for eight hours, every eight hours for 32 hours) revealed the following neurological checks:</p> <ul style="list-style-type: none"> <li>- For a 7/22/24 fall: on 7/22/24 at 3:50 PM, 4:05 PM, 4:35 PM, 5:05 PM and 6:00 PM, on 7/23/24 at 4:45 PM and 8:45 PM, and on 7/24/24 at 4:45 AM and 7:25 AM.</li> <li>-For a 8/18/24 fall: on 8/18/24 at 3:30 AM and 5:30 AM, on 8/19/24 at 9:30 AM and 1:30 PM, and on 8/20/24 at 1:30 PM.</li> <li>-For a 8/31/24 fall: on 8/31/24 at 11:30 PM, on 9/1/24 at 1:30 AM and 11:30 PM, and on 9/2/24 at 1:30 AM and 5:30 AM.</li> <li>-For a 9/11/24 fall: on 9/12/24 at 4:00 AM and 8:15 PM, and on 9/13/24 at 8:15 PM.</li> <li>-For a 9/24/24 fall: on 9/2/24 at 1:45 AM, and on 9/25/24 at 5:45 AM.</li> </ul> <p>On 9/27/24 at 5:08 PM Staff 2 (DNS) stated she would provide neurological assessments for the above missing dates and times. No additional information was provided.</p> <p>50930</p> <p>3. Resident 48 admitted to the facility in 2024 with diagnoses including chemical imbalance affecting the brain and repeated falls.</p> <p>An Admission MDS dated [DATE] indicated Resident 48 was cognitively intact. The MDS also revealed Resident 48 had a history of falls.</p> <p>Review of progress notes revealed Resident 48 had a falls on 7/12/24 and 8/10/24, and two falls on 9/21/24.</p> <p>Review of fall investigations and progress notes revealed staff were to place fall mats on both sides of Resident 48's bed, keep the bed in the lowest position, and keep all frequently used items within the resident's reach.</p> <p>A 9/23/24 review of the resident's care plan revealed the risk for falls area was not updated with the most recent falls, and no new interventions were created after any of her/his falls.</p> <p>On 9/27/24 at 11:36 AM Staff 2 (DNS) acknowledged Resident 48's care plan did not contain the interventions mentioned in the fall investigations and progress notes.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>50930</p> <p>Based on observation, interview and record review it was determined the facility failed to provide adequate urinary catheter care and incontinent care for 1 of 5 sampled residents (#43) reviewed for pain and incontinence. This placed residents at risk for unmet urinary catheter needs and UTI. Findings include:</p> <p>35855</p> <p>Resident 43 admitted to the facility in 4/2024 with diagnoses including retention of urine and acute kidney failure.</p> <p>A 2/7/24 care plan revealed Resident 43 had an indwelling catheter with interventions including catheter care every shift, change catheter every month and change bag PRN. Every shift was to observe and report to the physician any signs and symptoms of a UTI, pain, burning, blood tinged urine, cloudy urine, no urine output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, and change in patterns.</p> <p>A 5/10/24 Quarterly MDS indicated Resident 43's BIMS was 12 which indicated moderately impaired cognition. Resident 43 had an indwelling catheter.</p> <p>A review of Resident 43's MAR from 7/1/24 through 7/4/24 revealed instruction to staff to provide the following:</p> <p>-Change catheter and bag as needed for infection, obstruction or when the closed system was compromised. There was no documentation Resident 43 had a PRN catheter change. On 7/1/24 and 7/3/24 the MAR referred the reader to Administration notes. On 7/2/24 the MAR was documented with a check mark.</p> <p>A 7/1/24 Administration Note indicated to change the catheter and bag one time a day starting on the first and ending on the third every month. The note indicated the catheter was replaced on 6/28/24.</p> <p>A 7/3/24 Administration Note indicated to change the catheter and bag one time a day starting on the first and ending on the third every month. The note indicated was already done.</p> <p>A review of the 7/2024 Documentation Survey Report indicated on 7/3/24 evening shift there was no documentation for Resident 43's urine output.</p> <p>A 7/4/24 Alert Note indicated Resident 43 was yelling at the start of night shift. Resident 43 did not have any urine output. Resident 43's catheter was changed at the start of the shift with good results: over 1000 ccs of urine flowed freely.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A public complaint was received on 7/5/24 which indicated Resident 43 yelled out in pain for eight hours and complained of bladder pain. Staff 30 (LPN Unit Nurse) was notified and administered pain medications and instructed the resident to complete deep breathing exercises. Staff 30 was informed by Staff 12 (CNA) the last time Resident 43 complained of bladder pain her/his catheter was clogged. Staff 30 was also informed by Staff 12 Resident 43 did not have any urine output. It was unknown if the physician was notified. When Staff 13 (RN Unit Nurse) arrived for night shift Resident 43's catheter was changed and her/his pain was relieved.</p> <p>On 9/25/24 at 11:04 AM Staff 12 (CNA) stated she arrived to evening shift and was informed Resident 43 was yelling out in pain on day shift. Staff 12 stated Resident 43 informed her she/he had bladder pain. Staff 12 told Staff 30 about Resident 43's bladder pain and was told it was bladder spasms. Resident 43 yelled out in pain the entire evening shift. At midnight Staff 12 continued working on night shift. Staff 12 stated she was in the room when Staff 13 completed a catheter change on Resident 43 and over 600 ccs of urine came out of her/his bladder. Staff 12 stated she did not document anything for output for Resident 43 as she/he did not have any output on evening shift.</p> <p>On 9/25/24 at 1:43 PM Resident 43 stated she/he remembered a couple of months ago her/his bladder hurt and she/he could not urinate.</p> <p>On 9/25/24 at 2:32 PM Staff 14 (CMA) stated Resident 43 was in pain often and she/he complained of her/his catheter not draining.</p> <p>On 9/26/24 at 9:48 AM Staff 10 (CNA) stated on 7/3/24 on day shift Resident 43 was yelling out in pain stating her/his left leg was hurting. When Staff 12 arrived to the facility Staff 10 reported to Staff 12 Resident 43 was in pain during day shift.</p> <p>The following interviews occurred on 9/26/24:</p> <p>-1:00 PM Staff 2 (DNS) and Staff 29 (Regional Nurse) stated they would like to review Resident 43 and her/his catheter care for 7/3/24.</p> <p>-2:45 PM Staff 2 and Staff 29 stated Staff 30 who worked the evening shift of 7/3/24 was available to come in and discuss what occurred.</p> <p>-2:47 PM with Staff 2, Staff 29 and Staff 30 in the room Staff 30 stated in the beginning of 7/2024 Resident 43 had sediment in her/his urine and they started flushing her/his catheter. Resident 43 was in constant pain for a long time. The facility attempted to provide pain medications to help with her/his pain. Staff 30 stated her normal procedure when a CNA reported bladder pain was to make sure the catheter was flowing, and medications were in place. Staff 30 indicated she was assigned two halls, and many CNAs requested her to assess residents. She placed the residents' names on a list so she would not forget. Staff 30 stated she did not remember completing a bladder scan on Resident 43 on 7/3/24 evening shift.</p> <p>No documentation was found in clinical records Staff 30 completed an assessment on Resident 43 on 7/3/24 for concerns of bladder pain and no urine flow from her/his catheter.</p> <p>(continued on next page)</p>		

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F 0690  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	On 9/27/24 at 10:06 AM Staff 13 stated she started working on the 7/3/24 night shift. After Staff 30 left the facility Resident 43 started yelling out in pain. Staff 30 completed an assessment of Resident 43. Resident 43's bladder was distended and firm and she/he stated she/he could not urinate.		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>26991</p> <p>Based on interview and record review it was determined the facility failed to follow the nutritional care plan for 1 of 5 sampled residents (#36) reviewed for nutrition. This placed residents at risk for weight loss. Findings include:</p> <p>Resident 36 admitted to the facility admit in 4/2023 with a diagnosis of Parkinson's disease.</p> <p>An 4/16/24 Nutrition: Assessment/Nutritional Data Collection form indicated Resident 36 was at nutritional risk due to her/his Parkinson's disease and mental health disorders. Resident 36 was also assessed to have difficulty swallowing. The RD assessment indicated Resident 36 had a gradual weight loss but was stable. The current plan of care was to be continued which included snacks BID.</p> <p>A care plan revised on 6/23/24 revealed Resident 36 was to be provided snacks BID.</p> <p>There was no documentation in Resident 36's record to indicate she/he was provided snacks BID</p> <p>On 9/26/24 at 1:08 PM Staff 2 (DNS) stated staff did not enter the task for Resident 36's snacks correctly and the CNA task only included meal intake.</p> <p>On 9/27/24 9:12 AM Staff 33 (CNA) stated if a resident was to be provided scheduled snacks it was on the CNA task list. Staff were to document if a snack was provided.</p>

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49677</b></p> <p>Based on observation, interview and record review it was determined the facility failed to ensure residents received appropriate pain management for 2 of 2 sampled residents (#s 41 and 52) reviewed for pain. Resident 41 was not administered pain medication for five days resulting in unresolved severe pain which limited her/his usual activities. Findings include:</p> <p>1. Resident 41 was admitted to the facility in 2024 with diagnoses including pressure ulcer of the sacrum and chronic pain syndrome.</p> <p>A 5/2024 MAR revealed Resident 41 took oxycodone (narcotic pain medication) twice daily from 5/1/24 through 5/23/24. From 5/24/24 through 5/28/24 Resident 41 was not administered oxycodone.</p> <p>A quarterly MDS dated [DATE] confirmed Resident 41 was assessed to be cognitively intact.</p> <p>On 9/25/24 at 2:26 PM Staff 43 (CMA) stated she was frustrated the facility failed to order medications in a timely manner for Resident 41, and stated it consistently happened to other residents twice a month. She stated there was never an excuse for running out of medications, and stated if a physician was on vacation, there was an on-call physician available, and an order could be called in by the on-call physician to the pharmacy. The pharmacy provided the facility with a code to access the locked emergency medication cart. Staff 43 confirmed there was no code given to access the emergency supply of medication for Resident 41. Staff 43 confirmed from 5/24/24 through 5/28/24 Resident 41 did not receive her/his oxycodone that was ordered to be administered one tablet by mouth every four hours as needed and prior to wound care. On average Resident 41's pain level prior to receiving oxycodone was between seven and eight on a pain scale from one to 10. This constituted unresolved severe pain that prevented Resident 41 from doing her/his usual daily activities.</p> <p>On 9/26/24 at 9:28 AM Resident 41 stated from 5/24/24 through 5/28/24 (five days) the pain was unbearable because she/he was not given her/his usual pain medication (oxycodone) twice daily. She/he described the pain as burning, stabbing pain that was constant. Resident 41 stated her/his sacral pressure ulcer was the most painful, she/he could not get comfortable in bed, and she/he refrained from usual activity because of the severe pain. Resident 41 stated she/he laid down and waited until Tuesday until they could get a code to get into the emergency supply. Resident 41 stated on 5/28/24 it took a couple of hours before the medication relieved the pain and it was two days before baseline pain level was achieved.</p> <p>On 9/27/24 at 11:10 AM Staff 2 (DNS) confirmed the emergency kit for medications was not accessed over the memorial weekend.</p> <p>26991</p> <p>2. Resident 52 admitted to the facility on [DATE] after spinal surgery.</p> <p>8/13/24 hospital admission orders revealed Resident 36 was to be administered oxycodone (narcotic pain medication) every eight hours PRN.</p> <p>(continued on next page)</p>		

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F 0697  Level of Harm - Actual harm  Residents Affected - Few	<p>An 8/2024 MAR revealed on 8/14/24 (day of admission) staff did not administer oxycodone to Resident 52. On 8/14/24 Resident 52 reported severe pain.</p> <p>Progress Notes revealed no documentation related to resident 52's pain medication.</p> <p>An 8/16/24 admission MDS indicated Resident 52 was cognitively intact.</p> <p>On 9/25/24 at 3:10 PM Resident 52 stated she/he was always in pain related to her/his surgery.</p> <p>On 9/25/24 at 3:19 PM Witness 9 (Pharmacy Technician) stated on 8/14/24 the pharmacy authorized facility staff to remove three doses of oxycodone from the emergency supply.</p> <p>On 9/25/24 at 3:35 PM and 9/26/24 at 10:36 AM Staff 2 (DNS) stated the staff had authorization to pull the oxycodone from the emergency kit but did not. Staff 2 stated Resident 52 was sent to the emergency room for pain medication and returned. Staff 2 acknowledged there was no documentation in Resident 52's record related to Resident 52's transfer to the hospital and the rationale for not administering the pain medication.</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>50930</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure the staffing information was posted in a location easily accessible to residents and visitors. The facility also failed to post accurate and complete staffing information for 4 of 46 days reviewed for staffing. This placed residents and visitors at risk for incomplete, inaccessible, and inaccurate information. Findings include:</p> <p>On 9/23/24 at 11:00 AM the Direct Care Staff Daily Report was observed to be posted above standing eye level on a wall behind the nurse's station counter.</p> <p>On 9/24/24 at 3:12 PM the Direct Care Staff Daily Report was not filled out for the evening (2:00 PM to 10:00 PM) shift.</p> <p>On 9/26/2024 at 8:40 AM the Direct Care Staff Daily Report was posted without any data.</p> <p>Review of the Direct Care Staff Daily Reports for 8/12/24 through 9/26/24 revealed missing census data for 8/31/24 evening shift and missing nursing hours for the night shift on 9/16/24.</p> <p>On 9/26/24 at 12:25 PM Staff 34 (Staffing Coordinator/Admissions Coordinator) stated the staffing sheet was always posted in the observed location, and acknowledged it was hard to see from outside the nurse's station. She also acknowledged the missing data for the identified dates.</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>26991</p> <p>Based on interview and record review it was determined the facility failed to ensure non-pharmacological interventions were provided prior medication administration and document a rationale for no gradual dose reduction for 1 of 5 sampled residents (#43) reviewed for medications. This placed residents at risk for adverse medication reactions. Findings include:</p> <p>Resident 43 admitted to the facility in 2/2024 with a diagnosis of dementia.</p> <p>a. A 7/10/24 Pharmacy Consultation Report revealed Resident 43 was administered venlafaxine (antidepressant) daily, amitriptyline (antidepressant) every evening, citalopram (antidepressant) daily and mirtazapine (antidepressant; can be used to stimulate appetite) every evening for malnutrition. A recommendation was to decrease the citalopram. A physician response revealed the recommendations were accepted. Citalopram was to be tapered and discontinued. The response also indicated in approximately two months a gradual dose reduction was to start for Resident 43's venlafaxine.</p> <p>A 9/4/24 Pharmacy Consultation Report revealed venlafaxine was to be assessed to see if the medication was at the lowest dose. A physician response indicated the recommendations were declined because Resident 43 had a difficult time adjusting to her/his medical condition.</p> <p>7/2024, 8/2024 and 9/2024 TARs revealed Resident 43 was documented to have behaviors on 7/20/24 (type of behavior was not identified), 8/23/24 and 8/24/24 (type of behavior not identified), and on 9/1/24 (behavior not identified).</p> <p>Resident 43's record revealed no rationale to support the declination of venlafaxine dose reduction.</p> <p>A request was made on 9/25/24 at 11:13 AM to Staff 2 (DNS) to provide a rationale to alter the plan in 7/2024 to decrease Resident 43's venlafaxine dose when she/he did not exhibit frequent behaviors. No additional information was provided.</p> <p>b. A 9/2024 MAR revealed Resident 43 was to be administered Ativan (antianxiety medication) PRN for anxiety. Ativan was administered on 9/9/24, 9/11/24, 9/14/24, 9/17/24 and 9/24/24.</p> <p>A 9/2024 TAR revealed no documented behaviors on 9/9/24, 9/11/24, 9/14/24, 9/17/24 and 9/24/24.</p> <p>On 9/25/24 at 11:13 AM Staff 2 (DNS) stated non-pharmacological interventions were to be provided prior to PRN Ativan administration. A request was made to provide documentation non-pharmacological interventions were provided on the above dates. No additional information was provided.</p>		

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<p>F 0772</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided.</p> <p>26991</p> <p>Based on interview and record review it was determined the facility failed to ensure a blood sample was obtained for 1 of 1 sampled resident (#21) reviewed for laboratory tests. This placed residents at risk for delayed treatment. Findings include:</p> <p>Resident 21 was admitted to the facility in 4/2023 with a diagnosis of a stroke.</p> <p>A 7/2024 TAR revealed on 7/10/24 staff were to obtain a blood sample for blood chemistry.</p> <p>Resident 33's record did not have blood chemistry results.</p> <p>On 9/25/24 at 1:58 PM a request was made to Staff 2 (DNS) and Staff 24 (LPN IP) to provide laboratory results. No additional information was provided.</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>26991</p> <p>Based on interview and record review it was determined the facility failed to ensure a resident was offered a dental appointment for 1 of 2 sampled residents (#3) reviewed for dental services. This placed residents at risk for oral pain. Findings include:</p> <p>Resident 3 admitted to the facility in 7/2024 with a diagnosis of rib fractures.</p> <p>A 7/13/24 Nutrition: Assessment/Nutritional Data Collection form revealed Resident 3 had Missing/broken/decaying teeth.</p> <p>A 7/9/24 admission MDS revealed Resident 3 was cognitively intact and had no dental issues including cavities.</p> <p>On 9/23/24 at 10:00 AM and 11:57 AM Resident 3 was observed with missing bottom front teeth and Resident 3 reported she/he had cavities. Resident 3 stated the facility did not inquire if she/he wanted assistance scheduling a dental appointment</p> <p>On 9/25/24 at 10:23 AM Staff 4 (Social Service Director) stated if a resident was assessed to have dental issues she/he was notified and followed up with a resident for dental care. Staff 4 stated he was not notified Resident 3 had dental concerns.</p> <p>On 9/25/24 at 11:17 AM Staff 2 (DNS) acknowledged staff identified Resident 3 to have dental concerns, but there was no follow-up with the resident.</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>26991</p> <p>Based on observation, interview and record review it was determined the facility failed to implement enhanced barrier precautions (EBP; requires staff to wear gown and gloves with resident contact) and transmission based precautions for 2 of 3 sampled residents (#s 3 and 9) reviewed for pressure and non-pressure ulcers. This placed residents at risk for cross-contamination. Findings include:</p> <p>1. Resident 3 admitted to the facility in 7/2024 with a diagnosis of rib fractures.</p> <p>On 9/23/24 at 12:02 PM Resident 3 was observed to have scabs and a wound dressing on her/his right shin. Resident 3's room was not identified to require EBP.</p> <p>On 9/24/24 at 7:50 AM Staff 25 (LPN) stated each day staff were provided a list of residents who required EBP. Staff stated Resident 3 was not on the list.</p> <p>On 9/24/24 at 8:15 AM Staff 2 (DNS) stated residents who had wound care should be on EBP.</p> <p>2. Resident 9 admitted to the facility in 7/2024 with a diagnosis of a leg fracture.</p> <p>On 9/25/24 at 8:32 AM Resident 9 was observed to have a sign on the door indicating EBP and droplet precautions (mask required) when staff entered the resident's room. Staff 27 (PT) was observed standing by Resident 9 with gloves on but no mask or gown.</p> <p>On 9/25/24 at 9:04 AM Staff 2 (DNS) stated staff were to wear a mask when they entered Resident 9's room, and if they had contact with her/him they were to don gloves and a gown.</p> <p>On 9/25/24 at 9:04 AM Staff 27 stated he was not notified Resident 9 was on droplet precautions and he did not see the new sign posted by Resident 9's door for droplet precautions.</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50930</p> <p>Based on interview and record review it was determined the facility failed to ensure antibiotics were not used unless indicated and failed to monitor antibiotic usage for 1 of 5 sampled residents (#48) reviewed for urinary catheters or UTIs. This placed residents at risk for unnecessary antibiotic usage and drug resistant infections. Findings include:</p> <p>Resident 48 admitted to the facility in 2024 with diagnoses including chemical imbalance affecting the brain and repeated falls.</p> <p>An Admission MDS dated [DATE] indicated Resident 48 was cognitively intact. The MDS also revealed Resident 48 had a history of falls.</p> <p>Review of progress notes revealed Resident 48 had two falls on 9/21/24, was sent to the hospital for evaluation and treatment, and returned with a diagnosis of UTI.</p> <p>Review of a 9/21/24 UA showed Resident 48's urine was cloudy and contained bacteria. No urine culture (test for type of antibiotic capable of killing the bacteria) was present.</p> <p>A 9/22/24 provider order revealed staff were to administer Cephalexin 500mg (an antibiotic) three times a day for 7 days for an infection.</p> <p>A 9/24/24 progress note revealed staff contacted the provider about concerns related to Resident 48's increasing confusion.</p> <p>Review of urine culture results dated 9/24/24 revealed the bacteria were not affected by Cephalexin and Meropenem (an antibiotic) was the only antibiotic capable of killing the bacteria.</p> <p>A 9/26/24 progress note revealed the provider would reevaluate the appropriateness of the Cephalexin.</p> <p>A 9/26/24 provider order revealed staff were to administer Meropenem 1 gram through a PICC line (a thin, flexible tube inserted into a vein in the upper arm and ending in a larger vein in the heart; used to administer medication directly into the bloodstream) every eight hours for seven days for a UTI.</p> <p>A 9/26/24 progress note revealed staff placed an IV (a flexible tube inserted into a vein to deliver fluids and medication directly into the bloodstream) in Resident 48's left arm to administer the Meropenem while an appointment was made for the PICC line insertion.</p> <p>Review of 9/26/24 and 9/27/24 MARs revealed Meropenem was administered, and Cephalexin was not administered on 9/26/24. The MARs also revealed both antibiotics were administered on 9/27/24.</p> <p>On 9/27/24 at 11:36 AM Staff 2 (DNS) acknowledged the Cephalexin was administered without a proper indication, and the Cephalexin was not discontinued when the Meropenem was started. She also acknowledged both antibiotics were administered on 9/27/24.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/27/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Coos Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 2890 Ocean Blvd Coos Bay, OR 97420	

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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>50930</p> <p>Based on interview and record review it was determined the facility failed to ensure CNA staff received 12 hours of in-service training annually for 5 of 6 staff members (#s 11, 18, 38, 39 and 40) reviewed for in-service training. This placed residents at risk for lack of competent staff. Findings include:</p> <p>A review of the facility's staff training records revealed the following:</p> <ul style="list-style-type: none"> <li>-Staff 11 (CNA), hired 5/25/18, had 10 hours and 46 minutes of documented training from 9/26/23 through 9/26/24</li> <li>-Staff 18 (CNA), hired 5/18/22, had five hours and 36 minutes of documented training from 9/26/23 through 9/26/24</li> <li>-Staff 38 (CNA), hired 8/2/23, had no documented training from 9/26/23 through 9/26/24</li> <li>-Staff 39 (CNA), hired 3/29/18, had five hours and 52 minutes of documented training from 9/26/23 through 9/26/24</li> <li>-Staff 40 (CNA), hired 4/13/22, had four hours and 41 minutes of documented training from 9/26/23 through 9/26/24</li> </ul> <p>On 9/26/24 at 4:58 PM Staff 2 (DNS) stated all CNA staff were given competency evaluations upon hire and annually in March of each year. She stated in-service training was completed for CNA staff during staff meetings and via internet-based services.</p> <p>On 9/27/24 at 11:36 AM Staff 2 (DNS) acknowledged the identified CNA staff records did not show 12 hours of annual in-service training.</p>