

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  385280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/03/2024
NAME OF PROVIDER OR SUPPLIER  Lebanon Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE  600 North 5th Street Lebanon, OR 97355	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>41455</p> <p>Based on interview and record review it was determined the facility failed to provide risk and benefits for the use of an antipsychotic medication to a resident/responsible party before administration and communicate changes in ROM services for 2 of 6 sampled residents (#s 80 and 118) reviewed for medications and positioning. This placed residents and responsible parties at risk for lack of appropriate information. Findings include:</p> <p>1. Resident 80 admitted to the facility in 2020 with diagnoses including multiple sclerosis (disease of the central nervous system) and degeneration of the spine.</p> <p>A 1/10/24 Restorative Assessment and Referral indicated to utilize a standing frame (a device which allows an impaired individual to stand) for Resident 80 three times each week for 10 minutes for improved quality of life. Precautions required two staff present for set-up and one staff present during standing.</p> <p>A 2/29/24 revised Restorative Assessment and Referral indicated Resident 80 was to direct the frequency of the use of the standing frame.</p> <p>A 3/6/24 revised Task indicated staff were to facilitate Resident 80's ability to stand in the standing frame as needed for improved quality of life. On 4/25/24 and 4/27/24 the document indicated Resident 80 refused the standing frame and the task was not offered any additional days from 4/3/24 through 5/2/24.</p> <p>A 3/12/24 Interdisciplinary Care Conference indicated assistance would be provided to Resident 80 to have access to the standing frame per her/his request. Staff 5 (Resident Care Manager) was not in attendance.</p> <p>On 4/29/24 at 11:03 AM Resident 80 stated facility staff were to provide assistance to allow her/him to be in the standing frame three days each week, but the therapy was no longer offered by staff.</p> <p>On 5/1/24 at 9:01 AM Staff 12 (CNA) stated because Resident 80's standing frame task was PRN, staff no longer provided the standing frame service unless she/he asked.</p> <p>On 5/2/24 at 12:28 PM Staff 5 stated Resident 80 was able to advocate for herself/himself and could ask to use the standing frame.</p> <p>(continued on next page)</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/2/24 at 2:53 PM Resident 80 stated she/he was not aware she/he needed to ask staff to provide the standing frame service since the service was routine in the past. Resident 80 stated she/he only refused the standing frame services when she/he was too tired.</p> <p>On 5/3/24 at 9:42 AM Staff 2 (DNS) stated she trusted Resident 80's statement if she/he indicated she/he was not notified of the changes to her/his standing frame services. Staff 2 stated Resident 80 should be informed when changes were made to her/his therapy service plan.</p> <p>35855</p> <p>2. Resident 118 admitted to the facility in 2023 with diagnoses including bipolar disorder (mental illness with extreme mood swings) and dementia.</p> <p>A 3/11/24 signed physician order instructed staff to administer 50 mg Seroquel (an antipsychotic used to treat bipolar disorder) one time a day for bipolar disorder at bedtime with a start date of 2/29/24, and discontinue date of 3/18/24. Seroquel was increased on 3/19/24 to 100 mg two times a day in the morning and evening.</p> <p>An 4/2024 MAR instructed staff to administer 100 mg Seroquel two times a day for bipolar disorder and hold if blood pressure was 90/60 or she/he was overly drowsy with a start date of 4/18/24.</p> <p>No documentation was found in clinical records that risk and benefits were provided to Resident 118's responsible party and no consent was received for use of Seroquel.</p> <p>On 5/2/24 at 10:59 AM Staff 22 (Assistant DNS) confirmed consent was not received for use of Resident 118's Seroquel.</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 notify a resident's physician of a change in condition for 1 of 3 sampled residents (#36) reviewed for UTIs. This placed residents at risk for delayed treatment. Findings include:</p> <p>Resident 36 admitted to the facility in 2021 with a diagnoses including dementia, urinary retention, and an irregular heart beat.</p> <p>A 2/2024 annual CAA indicated Resident 36 had a diagnosis of dementia, was able to communicate, transfer to the toilet, and was incontinent of urine.</p> <p>Resident 36's 3/2024 MAR revealed she/he was administered a blood thinner daily.</p> <p>Progress Notes revealed the following:</p> <p>-2/24/24 Resident 36 was observed to have small amounts of red-tinged urine during her/his incontinent care. The resident denied pain or painful urination. The not indicate the resident would be monitored. There was no indication Resident 36's physician was notified of the red-tinged urine.</p> <p>-2/25/24 Resident 36 did not have red or pink-tinged urine or discharge.</p> <p>-2/26/24 through 3/8/29 revealed Resident 36's urinary status was not assessed.</p> <p>-3/9/24 at 5:46 PM a note by Staff 23 (Agency RN) indicated the resident continuously took her/himself to the bathroom. Resident 36 reported a stomach ache at approximately 2:30 PM and was administered an antacid which was noted to be effective. The resident was also noted to have a small amount of blood on her/his incontinent brief and genitalia. Resident 36 reported she/he had to pee every time. Staff were to monitor the resident. There was no indication Resident 36's physician was notified of the blood, abdominal pain, or frequent urination.</p> <p>-3/10/24 at 7:11 AM a note revealed Resident 36 reported stomach cramping which was alleviated with PRN medication.</p> <p>-3/10/24 at 11:13 AM revealed Resident 36 had severe abdominal pain, was shaking, and crying. The note indicated the pain could be from bowel care. The resident's physician was not able to be reached and the resident was transported to the hospital.</p> <p>A 3/12/24 hospital Orders At Discharge form revealed the resident was admitted to the hospital on 3/10/24 and was diagnosed with urinary retention, UTI with hematuria (blood in urine), and sepsis (potentially life-threatening complication of an infection) with sudden onset of kidney failure without septic shock (a serious condition when the body does not respond to an infection which causes a dramatic drop in blood pressure that can damage other organs).</p> <p>(continued on next page)</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>On 5/1/24 at 12:30 PM Staff 23 stated at times when a resident had symptoms of a UTI it was difficult for staff to obtain orders from the physician for UAs. Staff 23 stated she did not recall the note she wrote on 3/9/24, would review the note, and provide additional information if able. No additional information was provided.</p> <p>On 5/2/24 at 3:00 PM Staff 32 (LPN) stated if a resident had blood in her/his urine it could be signs of a UTI. Staff should also look at the medications the resident was administered and if the resident was on a blood thinner it could be related to the medication and the physician should be notified. The physician may or may not order a UA or other labs but staff should still notify the physician.</p> <p>On 5/2/24 at 4:33 PM Staff 2 (DNS) reviewed Resident 36's clinical record and stated during 2/24/24 through 3/8/24 she was not able find information to indicate Resident 36's physician was notified of the blood on the genitalia on 2/24/24 or 3/9/24. Staff 2 acknowledged the resident's blood could have been from the blood thinner or a possible UTI. Staff 2 stated she would provide documentation if Resident 36's physician was notified. No additional information was provided.</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>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>34667</p> <p>Based on interview and record review it was determined the facility failed to provide timely Notice of Medicare Non-Coverage (NOMNC) for 1 of 1 sampled resident (#248) reviewed for notices. This placed residents at risk for lack of appeal information.</p> <p>Resident 248 was admitted to the facility in 2024 with diagnoses including heart attack and dehydration.</p> <p>A NOMNC documented the last covered day as 4/3/24.</p> <p>The NOMNC was signed by Resident 248 on 4/2/24.</p> <p>On 5/2/24 at 2:44 PM Staff 4 (Social Services Designee) confirmed the notice was not provided in the required timeframe to Resident 248.</p>

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<p>F 0585</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 voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>41455</p> <p>Based on interview and record review it was determined the facility failed to develop a sufficient grievance policy and a timely grievance response for 1 of 4 sampled resident (#128) reviewed for activities. This placed residents at risk for unaddressed concerns and grievances. Findings include:</p> <p>A 12/2023 revised facility Grievances policy indicated staff were to assist residents with the grievance process, a resolution to a grievance was as soon as possible, and the policy did not indicate a reasonable expected timeframe for the facility to complete the review of grievances. The facility policy neglected to include that a resident had the right to file a grievance orally or anonymously and obtain a written decision.</p> <p>An 4/12/24 hand-written letter from Resident 128 to Staff 6 (Recreation Director) indicated dissatisfaction with recent rule changes to a game activity because of her/his skills for the game. The letter also indicated activity staff were prejudice against Resident 128.</p> <p>On 4/29/24 at 10:00 AM Resident 128 stated she/he filed a complaint about activities and received no communication about her/his concerns since the letter was written (15 days ago).</p> <p>On 5/1/24 at 10:09 AM Staff 3 (Assistant Administrator) stated he (the Grievance Officer) did not read Resident 128's letter until 4/28/24. Staff 3 stated Staff 8 (Social Service Designee) observed Resident 128's letter on 4/12/24 when Resident 128's letter was shared by Staff 6. Staff 3 stated there was a delay in response to Resident 128 due to a team effort to determine the best way to handle information in the letter.</p> <p>On 5/1/24 at 12:43 PM Staff 8 stated he believed Resident 128's 4/12/24 letter was written to express her/his feelings and Staff 8 did not consider the letter a grievance because it was not on the grievance form.</p> <p>On 5/1/24 at 4:40 PM and 5/3/24 at 10:39 AM Staff 3 indicated a late conversation with Resident 128 regarding her/his concerns with activities was conducted on 5/1/24 and the facility Grievance policy was insufficient when updated in 12/2023.</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>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, it was determined the facility failed to ensure residents were free from sexual and physical abuse for 2 of 5 sampled residents (#s 38 and 108) reviewed for abuse by Resident 139 and Resident 141. This placed residents at risk for abuse. Findings include:</p> <p>1. Resident 38 admitted to the facility in 2018 with diagnoses including panic disorder, dementia, and PTSD (Post-Traumatic Stress Disorder).</p> <p>Resident 141 admitted to the facility in 2024 with a diagnosis of Alzheimer's Disease.</p> <p>An 10/11/23 Annual MDS indicated Resident 38 was rarely understood.</p> <p>An 4/4/24 Investigation revealed on 4/4/24 while Resident 38 was on a video call with Witness 1 (Family Member), Resident 141 was sitting next to Resident 38 and reached over and rubbed Resident 38's chest area. Witness 1 stated, Keep your hands to yourself. Staff moved Resident 38 into her/his wheelchair to the nurses' station to complete the video call. Resident 141 was escorted back to her/his unit. The facility substantiated sexual abuse.</p> <p>On 5/1/24 at 10:10 AM Witness 1 stated Resident 38 was seated in a recliner while engaged in a video call with her. Witness 1 stated she saw a hand and forearm reach across and touch Resident 38's chest and was rubbing the area. Witness 1 yelled at Resident 141 and Resident 141 quit.</p> <p>On 5/2/24 at 7:49 AM Staff 17 (CNA) stated she was in a resident's room and Resident 141 was sitting next to Resident 38. Staff 17 stated she heard Witness 1 state leave [her/him] alone. Resident 141 touched Resident 38's chest two times. Staff 17 stated she stood between the two recliners until Resident 38 could be removed from the area.</p> <p>On 5/3/24 at 8:57 AM Staff 21 (RCM) confirmed the facility substantiated sexual abuse by Resident 141 to Resident 38.</p> <p>2. Resident 108 admitted to the facility in 2024 with diagnoses including depression.</p> <p>Resident 139 admitted to the facility in 2023 with diagnoses including dementia, psychotic disturbance, mood disturbance, anxiety, and PTSD (Post-Traumatic Stress Disorder).</p> <p>A 2/15/24 care plan indicated Resident 108 had a history of trauma to remain safe and stable.</p> <p>A 2/22/24 Annual MDS indicated Resident 108 had a BIMS score of 11 indicating moderate cognitive impact.</p> <p>A Nurse's Note on 4/17/24 at 8:30 PM indicated Resident 108 was struck by a thrown object on the side of her/his face. No injuries were identified on Resident 108, and the staff would continue to monitor her/him for any abnormalities.</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>An 4/18/24 Investigation report revealed on 4/18/24 (incident occurred 4/17/24) around 7:30 PM Resident 139's behaviors escalated, she/he went into the kitchen and picked up a hand-held game in its packaging. Resident 139 threw the game into Resident 108's room and struck Resident 108 on the left side of her/his face.</p> <p>On 5/2/24 at 7:31 AM Staff 15 (CNA) stated around 7:30 PM on 4/17/24 she witnessed Resident 139's behaviors escalate, and she/he was upset. Resident 139 was yelling, Resident 108's door was open, and Resident 139 threw a handheld game into the room. Staff 15 went into the room and Resident 108 stated the game hit her/him in the face.</p> <p>On 5/1/24 at 12:21 PM Staff 14 (CNA) stated on 4/17/24 he observed Resident 139 pick up a hand-held game and throw it into Resident 108's room. Staff 14 stated he heard a sound of impact and Resident 108 reported to him that she/he was struck in the head by the game. Staff 14 did not get a chance to observe Resident 108's head at the time as he was attempting to keep other residents safe from 108's behaviors.</p> <p>On 5/3/24 at 8:54 AM Staff 40 (RCM) stated the facility did not substantiate abuse during the investigation. The facility determined Resident 139's PTSD was triggered, and she/he was agitated and did not believe Resident 139 was aware of her/his actions.</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 timely investigate abuse for 1 of 3 sampled residents (#38) reviewed for abuse. This placed residents at risk for abuse and neglect. Findings include:</p> <p>Resident 38 admitted to the facility in 2018 with diagnoses including panic disorder, dementia, and PTSD (Post-Traumatic Stress Disorder).</p> <p>Resident 141 admitted to the facility in 2024 with a diagnosis of Alzheimer's Disease.</p> <p>An 4/4/24 Investigation revealed an investigation timeframe 4/4/24 through 4/10/24. On 4/4/24 while Resident 38 was on a video call with Witness 1 (Family Member) Resident 141 was sitting next to Resident 38 and reached over and rubbed Resident 38's chest area. Witness 1 stated Keep your hands to yourself. The facility determined sexual abuse was substantiated.</p> <p>On 5/3/24 at 8:57 AM Staff 21 (RCM) confirmed the investigation was not completed timely.</p> <p>Refer to F600</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>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 within the required timeframe for 1 of 5 sampled residents (#118) reviewed for nutrition. This placed residents at risk for unassessed needs. Findings include:</p> <p>Resident 118 admitted to the facility in 2023 with diagnoses including diabetes, pressure ulcer and dementia.</p> <p>A 9/13/24 Admission MDS revealed Resident 118's BIMS score was 15 which indicated she/he was cognitively intact. There were no concerns with Resident 118's mood and she/he did not have any behaviors. Resident 118 was frequently incontinent of bowel and had occasional pain presence with PRN pain medications. Resident 118 had one Stage 3 (a deep wound that has broken through the top two layers of skin into the fatty tissue) pressure ulcer and moisture associated skin breakdown. Medications administered to Resident 118 included insulin and antidepressants.</p> <p>A 3/13/24 Quarterly MDS revealed Resident 118's BIMS was nine which indicated moderate cognitive impairment. Resident 118 felt down, depressed or hopeless two to six days during the look back period. Behaviors included physical symptoms towards others such as hitting or kicking, verbal behaviors such as threatening others, and behavioral symptoms not directed toward others such as pacing. Resident 118 also rejected care one to three days. Resident 118 was always incontinent of bowel. Pain levels were frequent pain with scheduled and PRN pain medications with a pain presence of eight on a one to 10 scale. Resident 118 had one Stage 4 (a deep wound that impacts muscle, tendons, ligaments, and bone) pressure ulcer and moisture associated skin breakdown. Medications administered to Resident 118 included insulin, antipsychotic, antianxiety, anticoagulant, and opioid medications.</p> <p>There was no documentation found in Resident 118's clinical records to indicate a significant change assessment was considered or ruled out.</p> <p>On 5/3/24 at 7:35 AM Staff 21 (RCM) stated she did not know why a significant change assessment was not completed for Resident 118.</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> 35855</p> <p>Based on observation, interview, and record review it was determined the facility failed to revise care plan interventions for 3 of 8 sampled residents (#s 38, 101 and 121) reviewed for accidents, pressure ulcers and position and mobility. This placed residents at risk for unmet needs. Findings include:</p> <p>1. Resident 38 admitted to the facility in 2018 with diagnoses including Parkinson's disease.</p> <p>A current care plan dated 2/14/22 indicated Resident 108 had a problematic manner of ineffective coping with interventions including taking Resident 108 on walks.</p> <p>An 4/10/24 Quarterly MDS indicated walking 10 feet was not attempted due to medical conditions or safety concerns.</p> <p>An 4/30/24 Abnormal Involuntary Movement Scale indicated Resident 38 could not sit in a chair without leaning back. Resident 38 could only stand with two persons with maximum assistance for balance and she/he twisted her/his feet.</p> <p>On 5/3/24 at 8:57 AM Staff 21 (RCM) stated Resident 38 declined in her/his abilities, no longer walked, and the care plan did not reflect their current abilities.</p> <p>2. Resident 121 admitted to the facility in 2024 with diagnoses including cramp and spasm disorder, and anxiety.</p> <p>A 3/2/24 Admission MDS indicated Resident 121 had a BIMS score of 11 indicating moderate cognitive impairment. Resident 121 had a history of falls.</p> <p>A current care plan dated 3/18/24 indicated Resident 121 was at risk for falls with interventions including a fall mat at the bedside and in the bathroom. Resident 121 was to have commonly used items within reach. Physical therapy was to evaluate and treat for gait and proper assistive equipment. Staff were to remind Resident 121 to use the call light for assistance and place a sign to remind Resident 121 to use the call light near her/his clock in the bedroom, and near the call light in the bathroom.</p> <p>An 4/15/24 Post Fall Assessment revealed Resident 121 was found on the floor. Resident 121 had a history of falls with interventions that were effective were she/he was switched from using double canes for walking to using a walker and to have room and bed sensors.</p> <p>No documentation was found in Resident 121's care plan to include the use of room and bed sensors for fall interventions.</p> <p>47001</p> <p>3. Resident 101 admitted to the facility in 2021 with a diagnosis of dementia.</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 5/2023 annual MDS indicated Resident 101 was assessed to identify activities which were very important which included being with people and being in fresh air.</p> <p>A Care Plan updated 6/8/23 revealed the resident enjoyed bird watching out her/his window.</p> <p>Resident 101's clinical record revealed she/he moved to her/his current room [ROOM NUMBER]/28/23.</p> <p>On 5/1/24 at 12:03 PM Resident 101 was observed in her/his recliner next to the window. The window blinds were shut.</p> <p>On 5/1/24 at 3:00 PM Staff 41 (CNA) stated Resident 101 loved to go to outside and to the casino. Staff 41 stated Resident 101 did not like her/his window blinds open. Staff 41 also stated if the blinds were opened the resident told staff to shut the blinds. Staff 101 stated when Resident 101 lived in a different part of the facility the resident used to bird watch from her/his window. Staff 41 stated since the resident moved to her/his current room the resident did not like to watch the birds from her/his window.</p> <p>On 5/2/24 at 11:20 AM Staff 6 (Recreational Director) indicated the care plan may not have been updated to reflect the resident's current preferences.</p> <p>26991</p>

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NAME OF PROVIDER OR SUPPLIER  Lebanon Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE  600 North 5th Street Lebanon, OR 97355	
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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>41455</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on interview and record review it was determined the facility failed to ensure dependent residents received required assistance with ADLs for 1 of 4 sampled residents (#80) reviewed for ADLs. This placed resident at risk for inadequate personal hygiene. Findings include:</p> <p>Resident 80 admitted to the facility in 2020 with diagnoses including multiple sclerosis (disease of the central nervous system) and degeneration of the spine.</p> <p>An 10/23/23 revised care plan indicated Resident 80 required one staff to assist with bathing.</p> <p>3/2024 and 4/2024 shower calendars for Resident 80 indicated the resident received one shower during the week on 3/6/24, 4/18/24, 4/25/24, and 4/29/24. No showers were provided on any Sundays and Resident 80 was to receive her/his showers at night.</p> <p>The 3/12/24 Quarterly MDS indicated Resident 80 required substantial to maximum assistance for bathing.</p> <p>On 4/29/24 at 10:57 AM and 5/1/24 at 11:33 AM Resident 80 stated she/he received no Sunday shower as expected and only one shower during the week for the last 30 days due to lack of staff. Resident 80 indicated she/he filed a grievance related to lack of showers but concerns related to her/his showers continued.</p> <p>On 5/1/24 at 9:01 AM Staff 12 (CNA) indicated Resident 80 was the only resident who requested showers at night to help relax her/his muscles and it was difficult to get her/his shower task completed. Staff 12 stated Staff 11 (CNA) was often left to work alone at night over the last two months due to lack of staffing.</p> <p>On 5/2/24 at 2:33 PM Staff 27 (CNA) stated Resident 80 often informed her no shower was provided earlier in the week and nurses were aware. Staff 27 stated because Resident 80's shower required staff assistance for one hour, she sometimes was not able to complete Resident 80's make-up shower.</p> <p>On 5/2/24 at 4:48 PM Staff 3 (Assistant Administrator) confirmed he spoke with Resident 80 about her/his shower concern in 1/2024 and expected Resident 80 to be provided a follow-up shower if weekend showers were missed.</p> <p>On 5/3/24 at 9:42 AM Staff 2 (DNS) and Staff 22 (Assistant DNS) acknowledged Staff 7 (Staffing Coordinator) received direction that the same resident unit should not always be required to work short-handed when the expectations for the facility staffing model were not met. Staff 2 acknowledged teamwork was necessary for Resident 80 to receive two showers weekly and it did not occur.</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 interview and record review it was determined the facility failed to monitor a resident for a change of condition, make a urology appointment, and follow physician orders for 2 of 8 sampled residents (#s 36 and 118) reviewed for UTIs and medications. This placed residents at risk for delayed care and unmet needs. Findings include:</p> <p>1. Resident 36 admitted to the facility in 2021 with a diagnosis of dementia.</p> <p>a. A 2/2024 annual CAA indicated Resident 36 had a diagnoses of dementia, was able to communicate, was able to transfer to the toilet, and was incontinent of urine.</p> <p>Resident 36's 3/2024 MAR revealed she/he was administered a blood thinner daily.</p> <p>Progress Notes revealed the following:</p> <p>-2/24/24 Resident 36 was observed to have small amounts of red-tinged urine during her/his incontinent care. The resident denied pain or painful urination. The not indicate the resident would be monitored.</p> <p>-2/25/24 Resident 36 did not have red or pink-tinged urine or discharge.</p> <p>-2/26/24 through 3/8/29 revealed Resident 36's urinary status was not assessed.</p> <p>-3/9/24 at 5:46 PM a note by Staff 23 (Agency RN) indicated the resident continuously took her/himself to the bathroom. Resident 36 reported a stomach ache at approximately 2:30 PM and was administered an antacid which was noted to be effective. The resident was also noted to have a small amount of blood on her/his incontinent brief and genitalia. Resident 36 reported she/he had to pee every time. Staff were to monitor the resident.</p> <p>-3/10/24 at 7:11 AM a note revealed Resident 36 reported stomach cramping which was alleviated with PRN medication.</p> <p>-3/10/24 at 11:13 AM revealed Resident 36 had severe abdominal pain, was shaking, and crying. The note indicated the pain could be from bowel care. The resident's physician was not able to be reached and the resident was transported to the hospital.</p> <p>A 3/12/24 hospital Orders At Discharge revealed the resident was admitted to the hospital on 3/10/24 and was diagnosed with urinary retention, UTI with hematuria (blood in urine), and sepsis (potentially life-threatening complication of infection) with sudden onset of kidney failure without septic shock (a serious condition when the body does not respond to an infection which causes a dramatic drop in blood pressure that can damage other organs).</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 5/2/24 at 4:33 PM Staff 2 (DNS) reviewed Resident 36's clinical record and stated during 2/24/24 through 3/8/24 she did not see Resident 36's physician was notified of the blood on the genitalia on 2/24/24 or 3/9/24. Staff 2 acknowledged the resident's blood could have been from the blood thinner or a possible UTI. Staff 2 also stated she expected staff to monitor the resident each shift for at least 72 hours to ensure the resident did not have continued bleeding or additional symptoms of a UTI.</p> <p>b. Resident 36's After visit Summary revealed the resident was hospitalized from 3/10/24 through 3/12/24 and orders included the resident was to be seen by urology (Physician who specializes in conditions related to the urinary system).</p> <p>Resident 36's 4/15/24 facility NP visit note revealed the resident was sent to the hospital and was identified to have UTI and a Referral to urology was sent for urinary retention (bladder does not empty completely after urinating).</p> <p>Review of Resident 36's record revealed no documentation a referral to urology was completed.</p> <p>On 5/2/24 at 3:30 PM a request was made to Staff 40 (RNCM) to provide documentation a referral was made. No additional information was provided.</p> <p>35855</p> <p>2. Resident 118 admitted to the facility in 2023 with diagnoses including pressure ulcer and diabetes.</p> <p>A 4/2024 MAR instructed staff to administer one fourth a cup of Kefir (fermented milk with probiotic effects on blood sugar, cholesterol, and digestion) two times a day for 14 days with a start date of 4/12/24, and a discontinue of 4/25/24. Eighteen times the MAR referred the reader to administration notes, and six times it was documented as administered.</p> <p>The 4/12/24, 4/13/24, 4/18/24, and 4/19/24 Medication Administration Notes indicated Kefir was not available.</p> <p>On 5/3/24 at 7:35 AM Staff 21 (RCM) stated staff should notify the physician when Kefir was unavailable.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>47001</p> <p>Based on observation, interview, and record review it was determined the facility failed to accurately assess pressure ulcers for 2 of 5 sampled residents (#s 59 and 118) reviewed for pressure ulcers. This placed residents at risk for worsening wounds. Findings include:</p> <p>1. Resident 59 admitted to the facility in 3/2017 with diagnoses including paraplegia (the inability to voluntarily move the lower parts of the body).</p> <p>A review of Resident 59's care plan revealed a 1/21/24 care plan for a moisture associated wound (inflammation of the skin caused by moisture) to her/his sacrum.</p> <p>A review of a 1/22/24 Wound Evaluation revealed Resident 59 had moisture associated damage to her/his sacrum. The Wound Evaluation stated the wound was 12 cm X 8.14 cm with 90% dead tissue on the wound bed.</p> <p>A review of a 1/29/24 Wound Evaluation revealed Resident 59 had an unstageable pressure wound (wound caused by pressure with full thickness tissue loss with exposed bone, tendon, or muscle; dead tissue may be present on some parts of the wound bed; often includes tissue damage beneath the skin) on her/his sacrum. The Wound Evaluation stated the wound was 12.88 cm X 9.56 cm with a 1.4 cm depth and 80% dead tissue on the wound bed.</p> <p>A review of a 2/4/24 Wound Evaluation revealed Resident 59 had moisture associated damage to her/his sacrum. The Wound Evaluation stated the wound was 16.1 cm X 9.04 cm with a 2.4 cm depth and 3.2 cm tunneling under the skin and 80% dead tissue on the wound bed.</p> <p>A review of a 4/29/24 Wound Evaluation revealed Resident 59 had a Stage 4 pressure wound (wound caused by pressure with full thickness tissue loss with exposed bone, tendon, or muscle; dead tissue may be present on some parts of the wound bed; often includes tissue damage beneath the skin) on her/his sacrum. The Wound Evaluation stated the wound was 12.76 cm X 16.57 cm with 10% dead tissue.</p> <p>On 5/1/24 at 10:47 AM Staff 38 (LPN) stated Resident 59 had the sacrum pressure ulcer since 1/2024.</p> <p>On 5/1/24 at 10:47 AM a wound was observed on Resident 59's sacrum with Staff 38. The wound was observed to have full thickness tissue loss with a mixture of pale pink and red tissue through much of the wound with scattered dead tissue and undermining (erosion underneath the outwardly visible wound margins resulting in more extensive damage beneath the skin surface). Resident 59's wound met the definition of a Stage 4 pressure ulcer.</p> <p>On 5/1/24 at 2:56 PM Staff 9 (RCM) stated Resident 59's wound to her/his sacrum started on 1/14/24 as an unstageable pressure wound. Staff 9 stated the wound worsened and on 2/4/24 Resident 59 was admitted to the hospital for wound debridement (surgical removal of dead tissue).</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/2/24 at 9:44 AM Staff 9 and Staff 13 (RCM) stated Resident 59 had a stage 4 pressure wound to her/his sacrum. Staff 9 and 13 acknowledged Resident 59's sacrum wound was incorrectly assessed as moisture associated damage and Resident 59's stage 4 pressure wound to her/his sacrum was not on the care plan.</p> <p>35855</p> <p>2. Resident 118 admitted to the facility in 2023 with diagnoses including a sacral (lies between the two hip bones behind the pubic bone) pressure ulcer.</p> <p>A 9/13/23 Admission MDS indicated Resident 118 had a Stage 3 pressure ulcer (deep wound broken through the top to layers of the skin into fatty tissue) to the sacrum. Resident 118 was at risk for skin breakdown and had a history of slow healing.</p> <p>A 11/7/23 care plan revealed Resident 118 had a chronic Stage 4 pressure ulcer (deep wound which impacts muscle, tendons, ligaments, and bone) with interventions including providing weekly wound assessments and documentation.</p> <p>A review of Resident 118's Skin and Wound Evaluations from 1/29/24 through 4/30/24 revealed the following.</p> <p>-On 2/16/24 and 3/15/24 the evaluation did not include a description of the wound bed or if there was any drainage from the wound. There was no description of the surrounding tissue, edges, temperature, or swelling. Resident 118's pain level and treatment were not included in the evaluation.</p> <p>-On 4/12/24 the evaluation did not include a description of the wound bed. There was no description of the surrounding tissue, edges, temperature, or swelling. There was no documentation about the progress of the wound, or if there was an infection.</p> <p>-On 4/19/24 no skin and wound evaluation was completed.</p> <p>-On 4/30/24 (reviewed on 5/3/24) the evaluation was still in progress and was not completed. The skin and wound evaluation did not include a description of the wound bed, or if the wound had any drainage. There was no description of the surrounding tissue, edges, temperature, or swelling. The evaluation did not include if Resident 118 had pain with the wound and what type of treatment or if there was an infection.</p> <p>On 5/3/24 at 7:43 AM Staff 21 (DNS) confirmed the skin and wound evaluations should be fully comprehensive.</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>26991</p> <p>Based on observation, interview and record review it was determined the facility failed to assess and care plan a resident's ability to transfer from a reclining chair and timely investigate a fall for 2 of 8 sampled residents (#s 121 and 142) reviewed for dementia care and accidents. This placed residents at risk for falls. Findings include</p> <ol style="list-style-type: none"> <li>1. Resident 142 admitted to the facility with a diagnosis of dementia.</li> </ol> <p>A 3/25/24 admission MDS indicated Resident 142 walked without assistive devices. The assessment indicated she/he and had a fall prior to and one fall after admission to the facility. Resident 142's risk factors for falls included medication side effects which could cause confusion and dizziness. The resident also had insomnia and was often awake for many hours at a time placing the resident at risk for falls.</p> <p>A care plan initiated 3/18/24 revealed Resident 142 was at risk for falls and the resident was to wear non-skid socks and call staff for assistance.</p> <p>On 4/30/24 at 12:52 PM Resident 142 was observed in a recliner with her/his eyes shut, she/he was covered with blankets, and her/his legs were elevated on the recliner leg rests. Resident 142 was not observed to attempt to get out of the recliner.</p> <p>On 5/2/24 at 12:08 PM Staff 21 (RNCM) stated the recliners had remote controls to elevate the leg rests, there should always be one staff in the common area, and if a resident needed assistance to stand staff should be able to intervene. Staff 21 acknowledged many residents in the memory care unit were not able to use the remote control to adjust the recliner leg rests. Staff 21 stated Resident 142 was not assessed to determine if she/he was able to use the remote, and acknowledged if the resident attempted to transfer out of the chair with the leg rests elevated it would increase the resident's risk for falls. Staff 21 stated the care plan did not direct staff to ensure leg rests were down if staff were not in the common area and the resident was asleep.</p> <p>On 5/2/24 at 1:25 PM Resident 142 was observed in a recliner with her/his legs elevated on the recliner leg rests. Resident 142 was covered with blankets and her/his eyes were shut. Resident 142 was then observed to attempt to transfer out of the recliner but was not able to lower the leg rests. Resident 142 swung her/his legs over the leg rests and attempted to get out of the chair. Staff 18 (CNA) was then observed to assist the resident with the recliner remote to lower the leg rests and assisted the resident to stand. Resident 142 was observed to be unsteady when she/he initially stood and then was able to walk to the dining room table. Staff 18 stated in general they always tried to have one staff member in the common area, but there were times when all the staff were assisting other residents and may not be available. Staff 18 stated Resident 142 was not able to use the remote to lower the recliner leg rests without staff providing verbal assistance and directions, but was able to stand if the leg rests were down.</p> <p>41455</p> <p>(continued on next page)</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>2. Resident 121 admitted to the facility in 2024 with diagnoses including anxiety, and cramp and spasm disorder.</p> <p>An 4/15/24 Post Fall Assessment revealed Resident 121 was found on the floor. The investigation was completed on 4/22/24.</p> <p>An 4/23/24 Post Fall Assessment revealed Resident 121 reported a fall in the bathroom. The investigation was completed on 5/1/24.</p> <p>On 5/3/24 at 9:09 AM Staff 40 (RCM) confirmed the 4/15/24 and 4/23/24 fall investigations were not completed timely.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>47001</p> <p>Based on observation, interview, and record review it was determined the facility failed to obtain orders for oxygen for 1 of 1 sampled resident (#86) reviewed for respiratory care. This placed residents at risk for impaired respiratory status. Findings include:</p> <p>Resident 86 admitted to the facility in 12/2022 with diagnoses including chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems).</p> <p>A review of Resident 86's care plan revealed a 3/3/23 care plan for as-needed oxygen.</p> <p>An 4/8/24 Progress Note revealed Resident 86 received oxygen due to respiratory difficulties and shortness of breath.</p> <p>On 4/29/24 at 10:42 AM an oxygen concentrator was observed by Resident 86's bed. Resident 86 stated she/he used oxygen a couple of times a week, usually in the evenings.</p> <p>A 5/1/24 review of Resident 86's medical record revealed no evidence of oxygen orders.</p> <p>On 5/2/24 at 8:45 AM Staff 30 (CNA) stated Resident 86 used oxygen as needed or requested.</p> <p>On 5/2/24 at 9:41 AM Staff 13 (RCM) acknowledged Resident 86 used oxygen as needed but had no orders for oxygen.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>35855</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were free from significant medication errors for 1 of 5 sampled residents (#118) reviewed for medications. This placed residents at risk of jeopardized health status. Findings include:</p> <p>Resident 118 admitted to the facility in 2023 with diagnoses including partial intestinal obstruction.</p> <p>A signed 3/11/24 physician's order instructed staff to administer Loperamide (to treat diarrhea) by mouth in the morning for diarrhea with a start date of 12/14/23. The physician order also instructed staff to administer Senna (to treat constipation) by mouth in the morning for constipation with a start date of 2/14/23.</p> <p>2/2024, 3/2024 and 4/2024 MARs instructed staff to administer Loperamide by mouth in the morning for diarrhea with a start date of 12/14/23. The physician order also instructed staff to administer Senna by mouth in the morning for constipation with a start date of 2/14/23. Resident 118 was administered both medications daily as follows:</p> <p>-2/14/24 through 2/23/24, and 2/25/24 through 2/29/24;</p> <p>-3/1/24 through 3/5/24, 3/7/24 through 3/13/24, 3/15/24, and 3/17/24 through 3/31/24.</p> <p>-4/1/24 through 4/12/24, 4/14/24 through 4/17/24 and 4/21/24 through 4/24/24.</p> <p>An 4/2024 Documentation Survey Report revealed from 4/8/24 through 4/12/24 Resident 118 did not have a bowel movement (five days).</p> <p>An 4/13/24 Nurses Note indicated Resident 118 was on alert since she/he did not have a bowel movement for five days. Resident 118 was provided a suppository.</p> <p>An 4/14/24 Medication Administration Note indicated Resident 118 was administered Miralax for bowel care as she/he did not have a bowel movement for three days.</p> <p>On 4/15/24 a Medication Administration Note indicated Resident 118 was administered Miralax for bowel care which was effective.</p> <p>On 5/3/24 at 7:40 AM Staff 21 (RCM) stated Resident 118 should not have both Loperamide and Senna administered at the same time and the Loperamide should be a PRN administration. Staff 21 stated the order was put in clinical records incorrectly and was considered a medication error.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>35855</p> <p>Based on interview and record review it was determined the facility failed to ensure resident records were complete and accurate for 1 of 5 sampled residents (#118) reviewed for medications. This placed residents at risk for unmet needs Findings include:</p> <p>Resident 118 admitted to the facility in 2023 with a diagnosis of diabetes.</p> <p>A 3/11/24 signed physician order instructed staff to administer insulin (regulates level of blood sugar) injection three times a day for diabetes with a start date of 10/22/23.</p> <p>An 4/2024 Diabetic Orders report instructed staff to administer insulin injection three times a day for diabetes. The following dates and times were documented Resident 118 was sleeping and was not administered her/his insulin 4/1/24 5:00 PM, 4/13/24 7:00 AM, 4/14/24 7:00 AM, 4/16/24 12:00 PM, 4/21/24 12:00 PM, and 4/23/24 12:00 PM.</p> <p>On 5/3/24 at 7:35 AM Staff 21 (RCM) stated the dates listed above were marked in error and Resident 118 was administered her/his medication as physician ordered.</p>

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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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47001</p> <p>Based on observation, interview, and record review it was determined the facility failed to practice proper infection control procedures for 1 of 5 sampled residents (#59) reviewed for pressure ulcers and sanitize resident care equipment for 1 of 3 halls. This placed residents at risk for infection. Findings include:</p> <p>1. Resident 59 admitted to the facility in 3/2017 with diagnoses including paraplegia (the inability to voluntarily move the lower parts of the body).</p> <p>A review of an 4/29/24 Wound Evaluation revealed Resident 59 had a Stage 4 pressure ulcer (wound caused by pressure with full thickness tissue loss with exposed bone, tendon, or muscle; dead tissue may be present on some parts of the wound bed; often includes damage underneath the skin) on her/his sacrum.</p> <p>On 5/1/24 at 10:47 AM Staff 38 (LPN) was observed performing Resident 59's wound care with Staff 37 (CNA). Staff 38 was observed emptying Resident 59's catheter bag, he removed his gloves, and put on new clean gloves. Staff 38 was not observed performing hand hygiene and stated he was not aware he had to perform hand hygiene after removing gloves and before applying clean gloves. Staff 36 stated she was not aware of the need to perform hand hygiene after gloves were removed.</p> <p>On 5/1/24 at 2:56 PM Staff 9 (RCM) stated staff were expected to perform hand hygiene after taking off gloves, prior to applying new gloves.</p> <p>34703</p> <p>2. On 4/29/24 at 11:33 AM Staff 36 (CNA) was completing blood pressure and oxygenation checks in rooms 201, 205, 209 and 210. Staff 29 was stopped before entering another room due to not sanitizing the equipment after each use.</p> <p>On 4/20/24 at 11:40 AM Staff 36 acknowledged she did not sanitize the blood pressure cuff or oxygen saturation monitor after each resident in the above rooms.</p>		