

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Dells Nursing and Rehab Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Thresher Dr Dell Rapids, SD 57022	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383</p> <p>Based on observation, interview, record review, and policy review the provider failed to ensure resident care plans had been revised to reflect their current needs for:</p> <p>*Three of three sampled residents (4, 9 and 34) who had fallen.</p> <p>*One of one sampled resident (7) who had a facility acquired pressure ulcer.</p> <p>*One of one sampled resident (10) who had a history of urinary tract infections.</p> <p>*One of one sampled resident (11) who developed a facility acquired pressure sore.</p> <p>*One of one sampled resident (29) who had attempted to leave the facility without staff knowledge.</p> <p>Findings include:</p> <p>1. Review of resident 34's electronic medical record (EMR) revealed:</p> <p>*She had fallen on 8/25/24, 10/12/24, and 12/28/24.</p> <p>*On 12/28/24 resident 34 had an injury after her she fell and required a laceration repair above her left eye in the emergency room .</p> <p>*On 8/14/24 the care plan had identified her as at risk for falls.</p> <p>Interventions on the 8/14/24 initiated care plan included a physical therapy evaluation to treat as needed and to follow the facility's fall protocol.</p> <p>Interview on 1/15/25 at 2:00 p.m. with Minimum Data Set (MDS)/director of nursing (DON) B regarding interventions for resident 34 due to her falls revealed:</p> <p>*She had an intervention for physical therapy (PT) to evaluate and treat as ordered initiated on 8/14/24.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*MDS/DON B stated that the facility's fall protocol was the same as their fall policy.</p> <p>45683</p> <p>2. Observation and interview on 1/14/25 at 8:26 a.m. of resident 10 while in her room revealed:</p> <p>*She was sitting in her recliner working with an occupational therapist.</p> <p>*Her goal was to get stronger and go to assisted living.</p> <p>*She had been in the hospital recently for an infection.</p> <p>Review of resident 10's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her diagnoses included:</p> <p>-Chronic kidney disease, stage four.</p> <p>-Type two diabetes mellitus without complications.</p> <p>-Retention of urine, unspecified.</p> <p>-History of urinary tract infection.</p> <p>*Her 1/14/25 revised care plan had an intervention to monitor for signs and symptoms of infection, UTI (urinary tract infection) initiated on 3/27/24.</p> <p>*She had orders for antibiotics to treat a UTI on 8/20/24, 8/21/24, 9/9/24, 10/21/24, 11/19/24, 12/6/24, and 12/16/24.</p> <p>*No updates to the care plan were implemented regarding resident 10's UTIs since 3/27/24.</p> <p>Interview on 1/16/25 at 10:05 a.m. with CNA G regarding resident 10's UTIs revealed:</p> <p>*She had been instructed to watch for changes in her behavior that would indicate a UTI.</p> <p>*She would report any changes to the charge nurse.</p> <p>*If a UTI was suspected they would put a hat in her toilet to collect a urine sample.</p> <p>*She did not have access to the residents' care plans.</p> <p>Interview on 1/16/25 at 1:05 p.m. with MDS/DON B regarding resident 10's care plan revealed:</p> <p>*The interdisciplinary team would review resident care plans and make changes 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 - Some</p>	<p>*Her diagnoses included chronic obstructive pulmonary disease, Parkinson's disease, and hypertension.</p> <p>*She had fallen on 10/27/24, 10/28/24, 11/3/24, 12/9/24, 12/19/24, 12/20/24, and 12/22/24.</p> <p>*There was no documentation of interventions in her care plan that addressed fall prevention since her admitted on 2/14/24.</p> <p>Interview on 1/15/25 at 1:01 p.m. with registered nurse (RN) D revealed:</p> <p>*MDS/DON B updated the residents' care plans and the pocket care plans.</p> <p>*Hired agency workers and staff referred to the pocket care plans to help care for residents' needs.</p> <p>Interview on 1/15/25 at 3:28 p.m. with MDS/DON B regarding resident care plans revealed:</p> <p>*She updated the resident's care plans and pocket care plans.</p> <p>*She stated the care plans should be updated when a new intervention was added for a resident.</p> <p>*She confirmed that residents 4 and 9 did not have new interventions documented on their care plans after their fall incidents.</p> <p>*She confirmed the care plans should be updated to provide appropriate care for the residents' needs.</p> <p>Interview on 1/16/25 at 8:32 a.m. with nurse manager C regarding resident care plans revealed:</p> <p>*DON B was responsible for updating residents care plans.</p> <p>*The interdisciplinary team (IDT) would meet daily at 10 a.m. to review resident falls that occurred during the night and discuss interventions to implement.</p> <p>*Her expectation was that DON B would update and document the interventions in the residents' care plans after the IDT meetings.</p> <p>*She was not aware that fall interventions were not documented for residents 4 and 9 in their care plans.</p> <p>*She had the capability to update the pocket care plans if it was needed.</p> <p>51472</p> <p>6. Observation and interview on 1/14/24 at 9:02 a.m. with resident 7 revealed:</p> <p>*There were two cushions in her wheelchair.</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 - Some</p>	<p>-Administer ANTIDEPRESSANT medication as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT.</p> <p>-Monitor/document/report PRN [as needed] adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL [activities of daily living] ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs [problems], movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt [weight] loss, n/v [nausea/vomiting], dry mouth, dry eyes</p> <p>7. Observation and interview on 1/14/25 at 9:20 a.m. with resident 11 revealed:</p> <p>*She was admitted to the facility after she fell and broke her hip.</p> <p>*She stated she was mixed up.</p> <p>*During the conversation resident 11 spoke with her eyes closed.</p> <p>Review of resident 11's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her 10/7/24 BIMS assessment was 10, which indicated moderate cognitive impairment.</p> <p>*Her diagnoses included: weakness, hallucinations, generalized anxiety, and dementia with psychotic disturbance.</p> <p>*She was prescribed:</p> <p>-lorazepam 0.5 mg (milligrams) every four hours as needed for anxiety or restlessness.</p> <p>-olanzapine 5 mg two times per day related to dementia with psychotic disturbance.</p> <p>Review of resident 11's care plan revealed:</p> <p>*A focus area of, I use psychotropic medications (olanzapine) with interventions to:</p> <p>-Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT.</p> <p>-Monitor/document/report PRN adverse reactions to PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person.</p> <p>*Lorazepam or interventions to monitor for adverse effects was not referenced in resident 11's care plan.</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 - Some</p>	<p>*Non-pharmalogical interventions relating to her hallucinations, anxiety, or psychotic disturbance, was not addressed in resident 11's care plan.</p> <p>Interview on 1/15/25 at 3:28 p.m. with MDS/DON B revealed:</p> <p>*She expected staff to follow the interventions on the residents' care plans.</p> <p>*She was responsible for updating resident care plans.</p> <p>*Care plan were to be updated when there were changes in resident care.</p> <p>*She agreed that resident 7's care plan was not updated to include her facility-acquired pressure ulcer.</p> <p>Interview on 1/16/25 at 8:34 a.m. with nurse manager C revealed:</p> <p>*She expected resident care plans to be updated to include pressure-reduction devices.</p> <p>*She believed that the staff knew how to access resident care plans.</p> <p>Interview on 1/16/25 at 10:21 a.m. with registered nurse (RN) D revealed:</p> <p>*She had access to view resident care plans.</p> <p>*She was not able to edit the care plans.</p> <p>*Therapy [physical and occupational] was to be initiated for residents with pressure ulcers.</p> <p>*If therapy placed ROHO cushions in residents' chairs they were to inform MDS/DON B to update the care plans.</p> <p>*Nurse manager C worked with the pharmacist on the psychotropic medications.</p> <p>*The charge nurse did not chart the side effects and effectiveness of the psychotropic and antidepressant medications.</p> <p>Review of provider's 3/2024 Care Planning Process Policy revealed:</p> <p>*Using an intradisciplinary approach, each resident will have an individualized plan of care which addresses the resident's needs and severity of condition, impairment, disability, or disease and based on the universal care standards identified by the DNRC staff as the minimum standards for all residents.</p> <p>*It is the responsibility of the IDT members to access the resident, individualize the plan of care, evaluate the effectiveness and the plan of care, revise the plan of care as the resident's needs change and attend care conferences.</p> <p>Review of the provider's undated Fall Policy revealed:</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383</p> <p>Based on observation, interview, record review, and policy review the provider failed to:</p> <ul style="list-style-type: none"> * Implement and monitor care planned approaches for one of one sampled resident (25) identified on admission as having potential for pressure ulcer development prior to the development of a heel pressure ulcer. *Implement, monitor and accurately document skin injuries, and care plan approaches for two of two sampled residents (7 and 33) who acquired pressure ulcers after admission. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation and interview on 1/14/25 at 10:36 a.m. with resident 25 while she was sitting in her recliner with her legs elevated revealed she: <ul style="list-style-type: none"> *Had been admitted to the facility on [DATE] for strengthening due to urinary tract infection. *Had a black spot on her left heel that was not on her heel when she was admitted . *Had edema leggings on her right leg. *Had a wound dressing to her left leg. <p>Observation on 1/15/25 at 9:00 a.m. of resident 25's left heel revealed she had a black area to her left heel with her skin intact and no open areas.</p> <p>Interview on 1/16/25 8:00 a.m. with resident 25 revealed she had not started using the Prevalon boot (for pressure relief) until after she had the sore on her left heel.</p> <p>Interview on 1/16/25 at 8:12 a.m. with certified nursing assistant (CNA) N regarding resident 25's Prevalon boot usage revealed:</p> <ul style="list-style-type: none"> *The Prevalon boot use had started when her pressure ulcer had been identified. *Resident 25 had not used a sheepskin on her to heels. <p>Interview on 1/16/25 at 8:40 a.m. with RN D regarding resident 25's admission nursing assessment revealed she agreed that assessment did not indicate she had a pressure ulcer to her left heel on admission.</p> <p>Interview on 1/16/25 at 11:30 a.m. with nurse manager C regarding resident 25's interventions for pressure ulcer prevention revealed:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*Prevalon boots were on the standing orders for all residents to use for pressure ulcer prevention.</p> <p>*She had not been aware that staff were not using the Prevalon boots or sheepskin for pressure ulcer prevention.</p> <p>*She had been aware that staff were using the Prevalon boot since the identification of the pressure ulcer</p> <p>Review of resident 25's EMR revealed:</p> <p>*She had admitted to the facility on [DATE].</p> <p>*Her brief interview for mental status (BIMS) assessment that had been completed on 1/6/25 had a score of 15 which indicated her cognition was intact.</p> <p>*Her admission nursing assessment had identified inflammation (redness or swelling) to her lower back that was pink and intact.</p> <p>*No documentation of any skin alteration to her left heel.</p> <p>*On 1/6/25 the skin alteration had been identified.</p> <p>Review of resident's Braden Score for predicting risk of pressure sore development revealed:</p> <p>*On 12/23/24 and 12/30/24 her score was 16.0 indicating she was at risk.</p> <p>*On 1/6/25 and 1/13/25 her score was 17.0 indicating she was at risk.</p> <p>Review of resident 25's care plan initiated on 12/23/24 revealed:</p> <p>*She had been identified for having the potential for pressure ulcer development.</p> <p>*Prevalon boots as needed to prevent heel skin breakdown.</p> <p>*Sheepskin to the end of the bed and chair for skin breakdown prevention as needed.</p> <p>*Administer treatments as ordered and monitor for effectiveness.</p> <p>*Resident 25's care plan had not been revised once her skin alteration had been identified.</p> <p>51472</p> <p>2. Observation on 1/14/25 at 8:10 a.m. of resident 7's room revealed:</p> <p>*There was no cushion in her recliner.</p> <p>*She had a standard pressure reduction mattress.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Dells Nursing and Rehab Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Thresher Dr Dell Rapids, SD 57022	

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 1/14/24 at 9:02 a.m. with resident 7 revealed:</p> <ul style="list-style-type: none"> *There were two cushions in her wheelchair. *The top cushion was a waffle cushion that covered the bottom and back of the wheelchair. *The cushion under the waffle cushion was a Roho cushion (air cushion that helps distribute weight evenly to prevent pressure ulcers). *The Roho cushion was not inflated. *Resident 7 transferred herself to her recliner. *There was not a cushion in the recliner. *Resident 7 stated that her daughter brought her the waffle cushion for her comfort. *She did not remember if she had any sores or skin problems. <p>Interview on 1/15/25 at 3:28 p.m. with minimum data set (MDS)/director of nursing (DON) B revealed:</p> <ul style="list-style-type: none"> *She was responsible for updating resident care plans. *Care plan interventions were to be updated when there were changes in resident care. *She agreed that resident 7's care plan was not updated to include her facility-acquired pressure ulcer. *It was her expectation that someone was checking the ROHO cushions to ensure they did not go flat. *She stated that therapy would be providing education on the ROHO cushions. <p>Interview on 1/16/25 at 8:34 a.m. with nurse manager C revealed:</p> <ul style="list-style-type: none"> *It was her expectation that staff reposition residents every two hours, the cushions in the wheelchairs were properly placed, heel boots were on the residents per information provided in the electronic medical record (EMR). *MDS/DON B was responsible for updating resident care plans. *She expected resident care plans to be updated to include pressure-reduction devices. *She believed that the staff knew how to access resident care plans. *ROHO cushions were managed by therapy (physical and occupational) but it was everyone's responsibility to monitor the filling and maintenance of the ROHO cushions. *She did not know if staff had received training on filling and use of the ROHO cushions. <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 1/16/25 at 10:50 a.m. with certified nursing assistant (CNA) G revealed:</p> <ul style="list-style-type: none"> *She did not have access to resident care plans. *She did not know what a ROHO cushion was. *She stated that the cushions were managed by therapy. *She was unable to identify pressure reduction interventions that were being utilized for resident 7. <p>Review of resident 7's electronic medical record (EMR) revealed:</p> <ul style="list-style-type: none"> *She was admitted on [DATE]. *Her 12/7/24 brief interview for mental status (BIMS) assessment was 12, which indicated moderate cognitive impairment. *Her diagnoses included dementia, repeated falls, and weakness. *She had had a stage II pressure ulcer (a shallow open ulcer that resulted due to pressure) on her left hip identified on 11/16/24. -The stage II pressure was documented as healed on 12/6/24. *The record lacked ongoing documentation of assessment, measurements and size of the pressure ulcer as it progressed to being healed. *Skin observation tool documentation reflected: <ul style="list-style-type: none"> -Bruising to left elbow. -Red coccyx area noted, 2-3 small open areas noted. Fax MD [medical doctor] for tx [treatment]. Barrier cream applied. Small area noted on outer left elbow bruised with scab noted over the bony area. Area intact. <p>Review of resident 7's 1/14/25 care plan revealed:</p> <ul style="list-style-type: none"> *A focus area of I have the potential to have impairment to skin integrity which was initiated on 5/30/24 and updated on 6/3/24. *The use of the ROHO cushion or the waffle cushion was not included in the care plan. *A focus area of I have a potential nutritional problem r/t [related to] hx [history] of CHF [congestive heart failure]; COPD [chronic obstructive pulmonary disease] and recent hip fracture with repair initiated on 7/8/24 included an intervention of Resident with stage II wound to left hip. Dislikes supplements. Will offer extra 1 oz [ounce] of protein with meals to aid in wound healing initiated on 12/6/24. <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>3. Observation on 1/15/25 at 9:35 a.m. of resident 33's while in the shower room with certified nursing assistant (CNA) I revealed:</p> <p>*Resident 33 reported that his butt hurt.</p> <p>*CNA I radioed for registered nurse (RN) D to come to the shower room for a skin check.</p> <p>*When RN D came into the shower room, CNA I reported that resident 33 had sores on his butt.</p> <p>*A scabbed area was present on his left middle buttock and two open areas were present on his right middle buttock.</p> <p>*RN D stated that resident 33's buttocks had open areas on them and instructed CNA I to apply a barrier cream.</p> <p>*RN D indicated she would fax the doctor for orders.</p> <p>*CNA I applied barrier cream to resident 33's buttocks.</p> <p>Observation on 1/16/25 at 10:25 a.m. of resident 33 in the common area by the nurses' stations revealed:</p> <p>*He walked with a walker.</p> <p>Observation on 1/16/25 at 12:08 p.m. of resident 33's room revealed:</p> <p>*There was no pressure reduction cushion on his recliner.</p> <p>*His mattress was a standard pressure reduction mattress.</p> <p>Interview on 1/16/25 at 10:21 a.m. with registered nurse (RN) D revealed:</p> <p>*She had access to view resident care plans.</p> <p>*She was not able to edit the care plans.</p> <p>*She indicated ways to implement pressure reduction included:</p> <p>-Repositioning the resident every two hours.</p> <p>-Application of heel boots.</p> <p>-An air mattress placed on the bed.</p> <p>-Cushions in the residents' chairs</p> <p>*Therapy was to be initiated for residents with pressure ulcers.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>*The therapists were not employed by the provider.</p> <p>*Therapy placed the ROHO cushions in resident chairs and then notified MDS/DON B to update the care plan.</p> <p>*She did not know who was responsible for monitoring and filling the ROHO cushions.</p> <p>*She had not received training on the care and maintenance of the ROHO cushions.</p> <p>*Wounds were monitored by the charge nurse within the treatment administration record (TAR).</p> <p>*Wounds were not measured by the charge nurse.</p> <p>*Wounds were measured by MDS/DON B if the resident was referred to the wound clinic.</p> <p>*She did not believe that resident 33 had a cushion in his recliner in his room.</p> <p>*She stated that she knew he did not have a cushion in the chair he frequently sat in in the common area by the nurses' station.</p> <p>Review of resident 33's EMR revealed:</p> <p>*He was admitted on [DATE].</p> <p>*His 12/19/24 BIMS assessment was 5, which indicated severe cognitive impairment.</p> <p>*His diagnoses included: diabetes, dementia with behavioral disturbance, and muscle weakness.</p> <p>*He had an order for calmoseptine ointment to be applied twice daily to open areas on his buttocks that was ordered on 1/15/25.</p> <p>*The 1/15/25 Skin Observation Tool documented a site of Coccyx, type as Pressure and stage as II. There was no documentation of size, number of open areas, specific locations, drainage, appearance of wound bed, or interventions.</p> <p>*Per standard of practice there was no weekly documentation of the pressure ulcer.</p> <p>Review of resident 33's 1/16/25 care plan revealed:</p> <p>*A focus area of I have potential to have impairment to skin integrity which was initiated on 6/10/24 and revised on 6/17/24.</p> <p>*The interventions for that focus area included:</p> <p>-Encourage good nutrition and hydration to promote healthier skin.</p> <p>-I have a pressure reduction mattress on my bed and in my wheelchair.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>--This intervention was initiated on 6/10/24 and revised on 6/17/24.</p> <p>-Identify/document potential causative factors and eliminate/resolve where possible.</p> <p>Review of the provider's 8/2024 PRESSURE ULCER (PREVENTION) policy revealed:</p> <ul style="list-style-type: none"> *Resident care plans reflect any specific skin care needs. *Protect boney prominences with cushions and pads. *Document all wounds weekly and the pressure ulcer skin flow sheet.

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51472</p> <p>Based on observation, interview, and policy review the provider failed to ensure chemicals had not been stored under sinks in four of four rooms and were secured per their written instructions.</p> <p>Findings include:</p> <p>1. Observation on 1/14/25 at 8:36 a.m. of the Garden Terrace hopper room revealed:</p> <p>*The Garden Terrace hopper room was not locked.</p> <p>*Under the sink was a brown wood cabinet with a lock present on the door.</p> <p>*The door was not locked.</p> <p>*This cabinet contained:</p> <p>-A spray bottle with a broken top labeled 75% Ethyl Alcohol.</p> <p>-A spray bottle labeled C-Diff Solution Tablets.</p> <p>-A bottle of Betco Kling toilet bowl cleaner.</p> <p>*On the wall above the sink was a sign that said, Keep all chemicals in LOCKED Cupboard and securely locked when not in use.</p> <p>2. Observation on 1/14/25 at 9:29 a.m. of the Happy Trails hopper room revealed:</p> <p>*The Happy Trails hopper room was not locked.</p> <p>*The cupboard and under the sink was:</p> <p>-An aerosol spray can of Spectracide wasp and hornet killer.</p> <p>-An empty spray bottle with a handwritten label PH7Q Dual disinfectant Do not throw away.</p> <p>-An empty bottle labeled Isopropyl Rubbing Alcohol 70% that was outdated on 6/17.</p> <p>*In a cupboard between the sink and the hopper was:</p> <p>-A partially full bottle of Dermal Wound Cleanser that did not have a resident name or date of opening on the bottle.</p> <p>-An aerosol bottle of [NAME]-Mist furniture polish.</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 - Some</p>	<p>3. Observation on 1/14/25 at 1:36 p.m. of the beauty shop revealed:</p> <ul style="list-style-type: none"> *The beauty shop door was open. *There was a wooden cabinet beside the stationary hair dryer with a lock on it. *The cabinet was not locked. *In the cabinet was: <ul style="list-style-type: none"> -A spray bottle with a white label that did not have a chemical name on it. --The label was identified as a Drug Facts Label with the main ingredient on the label identified as Ethyl Alcohol 75%. --The label also included Uses: Hand sanitizer to help reduce bacteria that potentially can cause disease. --The label was dated 4/17/20. -A bottle of Brush Delite. --The label indicated Use rubber or plastic gloves. NEVER bare hands. -Nail polish remover that was outdated on 4/19. -A partial bottle of BETCO odor eliminator. *On the counter was a blue-green bottle with a clear liquid in the bottle that was one-third full. This bottle did not contain an identifier of what was in the bottle. <p>4. Observation on 1/15/25 at 8:43 a.m. of the shower room revealed:</p> <ul style="list-style-type: none"> *The door to the shower room was not locked. *There was no staff present in the shower room. *On an over-the-bed table near the window was a spray bottle with a clear liquid that was almost empty. <ul style="list-style-type: none"> -Handwritten on the spray bottle was, For reusable items combs tweezers razor parts. Use new label for each bottle of alcohol label w/ [with] exp [expiration]. The adhesive label attached to the bottle reads Alcohol Spray 05/25. *A tall white cabinet had a padlock with a key hanging from the padlock and the door was open. *On the bottom shelf of the white cabinet was a spray bottle that contained a blue liquid. <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 - Some</p>	<p>-Virex II 256 Disinfectant cleaner was handwritten on the spray bottle.</p> <p>*Between the toilet and the wall was a white basin that held a toilet plunger, two toilet brushes, and a white bottle of blue liquid.</p> <p>-The bottle was labeled Kling Toilet Cleaner on a manufacturer's label.</p> <p>5. Interview on 1/15/25 at 9:35 a.m. with certified nursing assistant (CNA) I revealed:</p> <p>*The shower room door was not locked.</p> <p>*The white cabinet was supposed to be locked when staff were not present.</p> <p>*The key for the cabinet was stored on the top of the cabinet.</p> <p>6. Interview on 1/15/25 at 11:08 a.m. with housekeeping L revealed:</p> <p>*Chemicals were to be stored in a closet or storage room.</p> <p>*All chemicals were to be in a locked area.</p> <p>*Chemicals were to be stored away from residents.</p> <p>7. Interview on 1/15/25 at 4:30 p.m. with minimum data set (MDS)/director of nursing (DON) B revealed:</p> <p>*She was unaware that the cabinet in the beauty shop was unlocked.</p> <p>*It was her expectation that the beauty shop cabinet was locked.</p> <p>*She had been told that items could not be stored under the sinks.</p> <p>*She confirmed there were items stored under the sinks in the hopper rooms and some were chemicals.</p> <p>*She was unaware that chemicals needed to be labeled with manufacturer's labels.</p> <p>*She expected the toilet bowl cleaner to be in a locked cabinet and not accessible to the residents.</p> <p>8. Interview on 1/16/25 at 8:34 a.m. with nurse manager C about chemical storage revealed:</p> <p>*It was her expectation that chemicals were not stored under the sink.</p> <p>*The provider was previously told that products could not be stored under the sink.</p> <p>*She believed that the cupboards under the sink had been cleaned out.</p> <p>*Chemicals were to be kept out of access from the residents.</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 - Some</p>	<p>*Chemicals were to be stored in locked cabinets and not left unattended.</p> <p>*Indicated that the toilet bowl cleaner stored in the shower room beside the toilet was accessible to residents due to the door not being locked.</p> <p>9. Interview on 1/16/25 at 10:50 a.m. with CNA G revealed:</p> <p>*She did not handle chemicals.</p> <p>*She stated it was the responsibility of housekeeping and maintenance.</p> <p>10. Review of the provider's 2/24 Chemical Safety policy revealed:</p> <p>*Promote safe use and storage of chemicals.</p> <p>*Toxic items such as detergents and polishes will be properly stored, labeled, and used in a way that will not contaminate food.</p> <p>*This policy, presented by the provider as the chemical storage policy, referred to dietary staff and chemical use and storage related to food contamination.</p>

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51370</p> <p>Based on observation, interview, and record review the provider failed to ensure one of one sampled resident (24) had been monitored for consistent weight loss.</p> <p>Findings include:</p> <p>1. Observation on 1/15/24 from 12:00 p.m. through 12:35 p.m. of the lunch meal service revealed:</p> <ul style="list-style-type: none"> *Resident 24 was seated in her wheelchair at a table. *An empty chair was between her and another resident. *Certified Nursing Assistant (CNA) G sat in the chair and assisted to resident to her left. *At 12:02 p.m. CNA Q brought her meal, and cut her burger in half, told the resident she had a cheeseburger and fries. *Resident 24 did not respond to the CNA. *At 12:06 p.m. CNA G reminded the resident that she had a burger and fries. *She made several attempts to pick up her burger and was able to take a small bite. *CNA G assisted her in eating several bites of fruit fluff. *At 12:25 p.m. CNA G left the table and began helping other residents leave the dining room. *At 12:33 p.m. CNA H walked up to the table and said [resident's name], are you awake? <p>-CNA H did not encourage her to eat or assist her with eating.</p> <p>*At 12:35 p.m. the resident pushed herself away from the table.</p> <p>-She consumed approximately one-quarter of the cheeseburger, no fries, approximately 3 oz. of fruit fluff, and 2 oz. of the red liquid which was identified by CNA G as Boost. [supplement]</p> <p>-No documentation of her consumption was made in the EMR.</p> <p>2. Interview on 1/16/25 at 10:30 a.m. with CNA G revealed that resident 24 had refused breakfast.</p> <p>*Interview on 1/16/25 at 10:50 a.m. with Nurse Manager C revealed:</p> <ul style="list-style-type: none"> *She agreed that nutrition was addressed in multiple places in the resident's care plan. <p>-She would expect all meal consumption for resident 24 to be documented.</p> <p>(continued on next page)</p>		

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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>-She was unaware that there was no documentation for many meals.</p> <p>_She was unaware that there was no documentation for any evening meals this month.</p> <p>-The residents' meal percentage consumed should be recorded by dietary staff if the resident eats in the dining room and by CNA if the resident eats in their room.</p> <p>-The resident had been sleeping a lot in the last few months and missing a lot of meals in the dining room.</p> <p>*She was unaware that meal consumption was not being regularly recorded for resident 24.</p> <p>*The management team would meet every morning at 10:00 a.m. and discusses resident information including weight.</p> <p>-Weights were to be obtained weekly on bath day.</p> <p>-Weight loss should have been brought to the attention of the charge nurse.</p> <p>-She was unaware that resident 24 had flagged for weight loss on her past seven of the past weekly weights.</p> <p>-She stated that they had a hard time with CNAs obtaining accurate weights.</p> <p>3. Review of resident 24's electronic medical record (EMR) revealed:</p> <p>*She was admitted to the facility on [DATE].</p> <p>-She has an indwelling catheter that was present on her admission.</p> <p>*She had a Brief Interview for Mental Status (BIMS) assessment score of 7 on 11/13/24, indicating severe cognitive impairment.</p> <p>*Was to receive a regular diet.</p> <p>*Her current care plan included:</p> <p>-She needed supervision or touching assistance by 1 staff member when eating.</p> <p>-A 5/8/24 initiated and 1/14/25 revised focus area that indicated she had a functional abilities performance deficit.</p> <p>-EATING: I need supervision or touching assistance by 1 staff member for eating.</p> <p>*An initiated 5/8/24 focus area of congestive heart failure, Encourage adequate nutrition. Offer small frequent feedings.</p> <p>(continued on next page)</p>

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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>-Monitor/document for s/sx [signs/symptoms] of malnutrition. Do not force me to eat. Offer small frequent feedings. Monitor/document food preferences.</p> <p>-An initiated 5/8/24, revised 5/17/24, focus area of I have peripheral vascular disease, Encourage good nutrition and hydration.</p> <p>-An initiated 5/10/24, revised 8/7/24, focus area of I have a potential nutritional problem r/t hx (related to history) of dementia and CHF [congestive heart failure].</p> <p>-Initiated 5/8/24, revised 5/17/24, focus area of I have potential to have impairment of skin integrity, Encourage good nutrition and hydration in order to promote healthier skin.</p> <p>*On 1/6/25, Registered Dietician Licensed Nutritionist (RDLN) S entered a nutrition note in the EMR that indicated:</p> <p>-Weight down 5# x 1 mo. (4%).</p> <p>-down 13# x 3 mo. (10.8%).</p> <p>-down 10# x 6 mo. (8.3%).</p> <p>-Indicates a significant weight loss over past 3 months.</p> <p>-Resident is assisted with meals.</p> <p>-Consider need for appetite stimulant.</p> <p>-Encourage meal intake.</p> <p>*Resident 24's meal documentation was incomplete in the EMR (electronic medical record):</p> <p>-From 1/3/25 to 1/15/25, there were 39 meals served.</p> <p>-A total of 25 meals showed documentation.</p> <p>-There was no documentation of any evening meal consumed.</p> <p>-7 of 25 meals were marked as 0-25% of meal eaten.</p> <p>-Her meal consumption recorded on 1/15/2025 at 10:05 a.m. was 51-75%.</p> <p>-According to the task list report in the EMR, the schedule for nutrition recording was every day at 09:00 a.m. , 13:00 p.m., and 18:00 p.m.</p> <p>-The CNAs and Dietary Aides were responsible for the nutrition recording.</p> <p>*No hydration documentation was recorded in the EMR.</p> <p>(continued on next page)</p>		

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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>-A task to record supplemental fluids was added to the EMR on 1/15/24, to be completed three times a day by a dietary aide or a CNA.</p> <p>*No update to the care plan had been made addressing resident's weight loss of greater that 10%.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383</p> <p>Based on record review and interview the provider failed to ensure four sampled residents (11, 29, 33, and 34) had received the wrong medication administered by four of four of staff, registered nurse (RN) (D and F) and certified medication aide (CMA) (O and P).</p> <p>Findings include:</p> <p>1. Record review of resident 33's electronic medical record (EMR) revealed:</p> <p>*On 12/8/2024 at 1:09 a.m. a nursing progress note had been entered that resident 33 had been given another resident's medications by CMA O.</p> <p>*Resident 33 was given the following medications:</p> <ul style="list-style-type: none"> -Tylenol 1000 milligrams (mg) (pain reliever), -Olanzapine 5mg (antipsychotic), -Celecoxib 100mg (pain reliever). -Tamsulosin 4mg (to treat an enlarged prostate). <p>2. Record review of resident 34's EMR revealed:</p> <p>*On 9/14/24 at 5:00 p.m. resident 34 had been administered:</p> <ul style="list-style-type: none"> -Carbidopa/Levodopa 25/100 mg (treat symptoms for Parkinson's disease) by CMA P. -This medication had not been ordered based on review of the physician orders. <p>*Poison control had been notified and guided to monitor for adverse reactions including agitation and stomach pain.</p> <p>51472</p> <p>3. Review of resident 11's EMR revealed:</p> <p>*She was not a diabetic.</p> <p>*On 12/13/24 at 2:30 p.m. a progress note that stated, Resident 11 was mistaken for a different resident. At 1200 [12:00 p.m.], her blood sugar was taken and found to be 172. 7 units NovoLog insulin (a fast acting insulin) given by mistake at that time, and resident ate a good lunch. Primary MD [medical doctor] and resident's daughter were both notified. Will continue to monitor for hypoglycemia. Re-check BS [blood sugar] 1400 [2:00 p.m.] =145.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*There were no further blood glucose checks documented in resident 11's EMR.</p> <p>*On the 12/13/24 at 1:54 p.m. fax that was sent to the provider that notified him of the medication error, the provider replied, OK: Noted- Continue to monitor for signs of hypoglycemia [low blood sugar] for 8-12 hrs [hours] from injection.</p> <p>Review of the provider's 12/13/24 Medication Error Incident Audit Report for resident 11 revealed:</p> <p>*The Medication Error Incident Audit Report was completed by registered nurse (RN) F on 12/13/24 at 5:20 p.m.</p> <p>*Resident 11 was mistaken for a different resident. Her blood sugar was taken and found to be 172. 7 units of NovoLog insulin given by mistake. Resident ate a good lunch.</p> <p>*Resident 11's description was documented as Oh, okay.</p> <p>*The Description of Action Taken was, Primary MD and resident's daughter were notified. Will Continue to monitor for hypoglycemia over the next 6-8 hours. Will recheck BS at 1400.</p> <p>Interview on 1/15/25 at 2:16 p.m. with nurse manager C regarding resident 11's medication error revealed:</p> <p>*She was not sure if education was provided or if a review of the medication error had been completed.</p> <p>*She stated she would have to look if there was anything completed because she was not available at the facility at the time of the medication error.</p> <p>Interview on 1/16/25 at 8:34 a.m. with nurse manager C about medication errors revealed:</p> <p>*An agency staff member made resident 11's medication error.</p> <p>*The company that the agency staff work for is responsible for the education and competencies of all agency staff.</p> <p>*Agency staff was not provided training by the provider.</p> <p>*When she reached out to the travel agency to request agency staff receive education on something she expected the travel agency to complete the education.</p> <p>*She did not follow up with the travel agency to be sure the education was completed.</p> <p>*She expected agency staff to work on the floor on the first day of hire after being given a facility tour.</p> <p>4. Review of resident 29's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*Her 7/26/24 BIMS was 12, which indicated moderate cognitive impairment.</p> <p>*On 12/29/24 at 2:36 p.m. an incident/fall progress note indicated, This writer had just counted controlled medications with med aide today and counted Lorazepam [Ativan] for resident. Reviewed paper order in the Narcotic book and gave 1 tablet of 5mg [milligram] Lorazepam. When this nurse went to chart in the EMR, realized medication had been discontinued but not removed from the narcotic drawer of the medication cart. Contacted Nurse Manager C. Contacted resident 29's next of kin regarding medication given with no [current] order.</p> <p>Review of the provider's 12/30/24 Medication Error Report Sheet for resident 29 revealed:</p> <p>*On 12/29/24 at 1:31 p.m. RN D administered Ativan (an anti-anxiety medication) 5mg by mouth to resident 29.</p> <p>*The order for Ativan for resident 29 was discontinued on 11/11/24.</p> <p>*Steps taken to correct the error were, Medication was removed from cart. Education provided on 5 rights of med administration. PCP [primary care provider] faxed, vitals taken.</p> <p>*The cause of the error was identified as Medication was not verified in the EMAR [electronic medication administration record] prior to administration.</p> <p>*The action taken to prevent the error from reoccurring was, Always use 5 rights of med administration, when medications are discontinued pull medications @that time.</p> <p>Review of the provider's Medication Error policy revealed:</p> <p>*The policy was Guidelines designed to prevent, identify, report and address errors related to administration of medications.</p> <p>*The policy outlines responsibilities, steps of reporting errors, and corrective actions to be taken.</p> <p>*To ensure patient safety by minimizing the risks associated with medication administration.</p> <p>*The procedure included: Obtain Vital Signs, Fax Provider. If after clinic hours or during weekend call the on-call provider., Create Incident in Risk Management., and Notify Nurse Manager/DON to initiate Medication Error Report Sheet.</p> <p>*The Medication Error Report Sheet included details about the medication error as well as, Type of Medication Error, Steps taken to correct error, Was Physician notified, Describe exactly what caused error to occur, and Actions taken to prevent error from reoccurring.</p>

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>51472</p> <p>Based on Payroll Based Journal (PBJ) record review, employee timecard review, staffing schedules, and electronic medical record (EMR) review, the provider failed to submit PBJ data accurately for one of one federal fiscal quarter (Quarter 4, 2024). Findings include:</p> <p>1. Review of PBJ records submitted to the Center for Medicaid and Medicare Service (CMS) revealed the provider submitted no licensed nursing coverage 24 hours per day for quarter 4, 2024: 9/15/24, 9/17/24, 9/19/24, and 9/21/24.</p> <p>Review of the provider's employee timecards, staffing schedules, and residents' EMR records documentation revealed the provider had licensed nursing coverage 24 hours per day for the period referenced above.</p> <p>Interview on 1/15/25 at 3:03 p.m. with administrator A and nurse manager C revealed:</p> <ul style="list-style-type: none"> *Nurse manager C made the nursing schedule. *She did not participate in PBJ submission. *Administrator A submitted the records to PBJ. *The information was automatically obtained from the individual staff timecards by their electronic payroll system. *She entered the agency staff manually. *She was not aware the PBJ reports indicated the provider did not have licensed nursing coverage 24 hours per day in quarter 4, 2024. *She did not know where to find the PBJ reports. *She thought the missed information could have been due to her manually entering agency staff hours. *She reviewed the September 2024 nurse schedule and indicated that some of the days of missing coverage in the report were not staffed by agency staff. *She did not know how the hours were incorrectly reported to PBJ.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51472</p> <p>Based on observation, interview, record review, and policy review the provider failed to:</p> <p>*Accurately identify and implement enhanced barrier precautions (EBP) for three of three sampled residents (4, 20, and 24) who had care concerns requiring personal protective equipment (PPE).</p> <p>*Utilize appropriate hand hygiene and gloves during cares by one of one staff (certified nursing assistant (CNA) I with one of one resident (33).</p> <p>*Appropriately maintain and dispose of resident care items in two of two hopper rooms, one of one shower room, and one of one beauty shop.</p> <p>Findings include:</p> <p>1. Observation on 1/14/25 at 8:15 a.m. of the Garden Terrace hallway revealed there was no PPE in the hallway or residents' rooms.</p> <p>Observation on 1/14/25 at 9:09 a.m. of resident 4 in the dining room revealed:</p> <p>*She was seated in her wheelchair.</p> <p>*She had her right lower extremity (RLE) wrapped in a dressing.</p> <p>*She was touching what appeared to be a wound on her RLE that was not covered and was open and red.</p> <p>2. Observation on 1/14/25 at 9:36 a.m. of resident 4's room revealed:</p> <p>*There was no sign indicating a need for EBP.</p> <p>*There was no personal protective equipment (PPE) outside or inside her room.</p> <p>*She shared a room with resident 9.</p> <p>*The room and an adjoining bathroom with the room next door.</p> <p>Review of resident 4's electronic medical record (EMR) revealed:</p> <p>*She was admitted on [DATE]</p> <p>*She had a Brief Interview of Mental Status (BIMS) assessment score of 8, which indicated she was moderately cognitively impaired.</p> <p>*Her diagnoses included cellulitis, dementia, and bulbous pemphigoid (autoimmune disease that causes skin blisters)</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*She had an order for wound care to her RLE.</p> <p>*She was not on enhanced barrier precautions.</p> <p>Interview on 1/15/25 at 9:22 a.m. with registered nurse (RN) D regarding how she performed resident 4's RLE dressing change revealed:</p> <p>*She performed hand hygiene before putting on gloves.</p> <p>*She removed the dirty wound dressing and threw it away in the garbage can.</p> <p>*She performed hand hygiene before putting on a clean pair of gloves.</p> <p>*She applied clean dressings to the wound.</p> <p>*She confirmed she would only wear gloves for PPE for resident 4's dressing change of her wound.</p> <p>Interview on 1/15/25 at 12:09 p.m. with minimum data set (MDS)/ director of nursing (DON) regarding their enhanced barrier precautions (EBP) protocol revealed:</p> <p>*She believed the statement in the policy that read, CMS [Center for Medicare and Medicaid Services] notes facilities have some discretion when implementing EBP and balancing the need to maintain a homelike environment for residents came from the CDC (Center for Disease Control) website.</p> <p>*She did not produce where that portion of the policy was referenced from as requested.</p> <p>Interview on 1/16/25 at 10:21 a.m. with RN D about EBP revealed:</p> <p>*Anyone with a urinary catheter was on EBP.</p> <p>-She listed three residents who had a urinary catheter.</p> <p>*She indicated that residents who had MRSA (methicillin-resistant Staphylococcus aureus) or VRE (Vancomycin resistant enterococcus) would also be on EBP.</p> <p>-There were no residents in the facility that currently had either of these.</p> <p>3. Observation on 1/14/25 at 8:15 a.m. of Garden Terrace hallway revealed:</p> <p>*There was one wall hanging alcohol-based hand sanitizer (ABHS) in the hallway.</p> <p>-It was in the middle of the hallway.</p> <p>*Each resident room had a wall hanging ABHS near the bathroom door.</p> <p>4. Observation on 1/14/25 at 8:36 a.m. of the Garden Terrace hopper room revealed:</p> <p>*The cabinet under the sink contained:</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-A spray bottle labeled 75% Ethyl Alcohol with a broken spray top.</p> <p>-A spray bottle labeled C-Diff [clostridium difficile] solution tablets.</p> <p>-Multiple glass containers.</p> <p>-A plastic basin.</p> <p>-Empty plastic ice cream buckets.</p> <p>-A short white extension cord.</p> <p>-A bottle of toilet bowl clearer with a brush in a plastic white bucket. The bottom of the bucket had multiple black flecks of an unknown substance and a yellow crusty unknown substance.</p> <p>*There was no ABHS available in or outside the door of the hopper room.</p> <p>*Soap and water were available at the sink.</p> <p>*Two unidentified staff opened the door, threw trash in the garbage and exited the room without washing their hands.</p> <p>5. Observation on 1/14/25 at 8:56 a.m. in Garden Terrace hallway revealed:</p> <p>*A covered cart was parked in the hallway.</p> <p>*On top of the cart were two fabric soaker pads and a bed sheet.</p> <p>*The linen was not covered.</p> <p>*There were two full body mechanical lifts parked in the hallway.</p> <p>*Neither lift had a container of disinfectant wipes.</p> <p>6. Observation on 1/14/25 at 9:29 a.m. of the Happy Trails hopper room revealed:</p> <p>*There was no ABHS available in or outside the door of the hopper room.</p> <p>*Soap and water were available at the sink.</p> <p>*The cabinet under the sink contained:</p> <p>-One teal plastic bedpan and two gray plastic bed pans.</p> <p>-A can of Spectracide wasp and hornet killer.</p> <p>-A white basin.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Two plastic buckets.</p> <p>-A clear Sterlite four-quart plastic container with brown paper towels. On top of the paper towels was a rectangular silver metal cover with green corrosion on it. Inside the clear container along the paper towels was cobwebs and brown flakes of an unknown substance.</p> <p>-An empty spray bottle labeled PH7Q Dual disinfectant.</p> <p>-A partial bottle of tearless Shampoo & Body Wash.</p> <p>-An open container of Super Sani-Cloths.</p> <p>- Two round pink basins.</p> <p>-Two bundles of brown paper towels and two rolls of toilet paper.</p> <p>-An empty bottle labeled Isopropyl Rubbing Alcohol 70% that had outdated on 6/17.</p> <p>*The cabinet between the hopper and the sink contained:</p> <p>-A partial bottle of Dermal Wound Cleanser that was outdated on 4/22.</p> <p>-A partial bottle of hand sanitizer that was outdated on 8/22.</p> <p>-A cardboard box that contained red bags with moisture damage present to the box.</p> <p>*Two unidentified individuals opened the door, threw garbage into the hamper and did not wash their hands.</p> <p>7. Observation on 1/14/25 at 1:36 p.m. of the beauty shop revealed:</p> <p>*A wooden cabinet around the stationary hair dryer.</p> <p>*The wooden cabinet contained:</p> <p>-A partial bottle of hand sanitizer that was expired on 7/22.</p> <p>-Nail polish remover that was expired on 4/19.</p> <p>-A bottle of Tresemme conditioner that had a name on it that was not a current resident.</p> <p>-A partial container of disinfectant wipes that was expired on 2/21.</p> <p>*The counter beside the hair washing sink contained:</p> <p>-A dry container of disinfectant wipes.</p> <p>-A bottle of ABHS that was outdated on 9/23.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-A bottle of Biolage Antidandruff shampoo that was outdated on 10/24.</p> <p>-A white bucket that contained hair curlers with no resident identifier on the bucket.</p> <p>-The curlers contained strands of gray and white hair.</p> <p>-A clear container of pins to secure the curlers with no resident identifier.</p> <p>*The filter on the back of the stationary hair dryer had a thick coating of dust and gray and tan particles.</p> <p>Interview on 1/14/25 at 1:56 p.m. with RN D revealed:</p> <p>*Staff use the beauty shop for the residents.</p> <p>*Bath aides use the curlers to set residents' hair.</p> <p>*Local beauticians use the beauty shop to cut residents' hair.</p> <p>8. Observation on 1/15/25 at 8:43 a.m. of the shower room revealed:</p> <p>*There were tiles missing on the shower floor.</p> <p>*In a plastic three-drawer cabinet were:</p> <p>-Two electric razors that were filled with white and gray hair.</p> <p>-Two different sized curling irons with an unknown crusted white substance and long white hairs on the barrels.</p> <p>*On the floor near the sink were two blue squares of non-stick rubber-like material that had hairs and other unknown white particles on them.</p> <p>*On the wooden shelves between the cabinet and the sink there were:</p> <p>-Multiple bags of open incontinent products without any resident identifiers.</p> <p>-An open container of disposable skin wipes with an unknown brown substance on the container.</p> <p>--There was no resident identifier on the container.</p> <p>-Twelve uncovered towels.</p> <p>-A gray basin with black garbage bags and two unrolled gait belts with a brown substance on one of the gait belts.</p> <p>*On the outside of the white cabinet was a piece of paper titled Bath Aide.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-A list of the bath aide duties was on the piece of paper.</p> <p>-Under the duties there was a portion labeled Infection Control.</p> <p>--Use 1/3 cup or less Virex Cleaner in spray bottle fill with water. Spray down shower chair/bath in between resident use.</p> <p>--Use alcohol spray for all other reusable items between uses. Combs Nail clippers Tweezers Shave Parts.</p> <p>*A towel was covering an over-the-bed table by the window.</p> <p>*On the towel was a plastic gray basin that contained two black electric razors filled with gray hair, a temporal thermometer (thermometer that takes temperature on the forehead), a wrist blood pressure cuff, and a white coffee cup.</p> <p>*The coffee cup contained:</p> <p>-Eight pens, two black combs, one purple pick, one silver scissors, one black handles scissors, two nail clippers, a spray bottle with a handwritten label For reusable items combs tweezers, razor parts. Alcohol Spray 05/25, and a bottle of alcohol-based hand sanitizer (ABHS).</p> <p>*A towel was covering an over-the-bed table near the shower.</p> <p>*On the towel was five wash cloths and two pump bottles labeled conditioner and shampoo and body wash.</p> <p>9. Observation and interview on 1/15/25 at 9:09 a.m. of CNA I as she removed hair rollers from a resident in the beauty shop revealed:</p> <p>*She removed the rollers from the resident's hair and placed them in a white bucket with other rollers.</p> <p>*She did not clean the rollers, or the pins used to hold the rollers in place.</p> <p>*She stated that this was the only resident she set hair for.</p> <p>*She had not been trained on the use of rollers or how to clean them.</p> <p>*She reused the rollers and pins without them being cleaned.</p> <p>10. Observation and interview on 1/15/25 at 9:35 a.m. of CNA I during a resident shower revealed:</p> <p>*Applied gloves without prior hand hygiene.</p> <p>*She undressed the resident.</p> <p>*Took the resident's blood pressure and temperature and did not cleanse the equipment after use.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*It would have been the facility's discretion if PPE was required with enhanced barrier precautions.</p> <p>Interview on 1/15/25 at 2:00 p.m. with medical director U regarding residents placed on enhanced barrier precautions and urinalysis collection revealed:</p> <p>*He had not been aware of enhanced barrier precautions and the criteria for residents to place on precautions.</p> <p>*He would not want residents to be isolated if there were on precautions.</p> <p>*If a resident has had multiple urinary tract infection, he would prefer a catheter urinalysis to be collected.</p> <p>*He would prefer more infection symptoms to be exhibited by the resident before a u/a is collected.</p> <p>*He does participate in the antibiotic stewardship and other providers have access to the facilities program.</p> <p>51370</p> <p>17. Observation on 1/14/25 at 1:40 p.m. revealed a 1.5 x 3 inch magnet with EBP written on it stuck to the top of the door frame to resident 24's room.</p> <p>-No personal protective equipment (PPE) was present in the hall or in resident 24's room.</p> <p>Interview on 1/14/25 at 1:57 p.m. with certified nursing aide (CNA) Q revealed:</p> <p>-She wasn't sure what the EBP tag meant.</p> <p>-She thought it had something to do with the floor mat.</p> <p>-She stated I should know since I get her up.</p> <p>-She went to the nurse's station and returned, saying that the EBP had to do with blood sugars.</p> <p>-She did not know what enhanced barrier precautions meant.</p> <p>-She did not wear any PPE when working with resident 24.</p> <p>Record review on 1/14/25 revealed resident 24 had an indwelling catheter since prior to admission on 5/8/24.</p> <p>-The care plan had no guidance for enhanced barrier precautions.</p> <p>Review of the provider's 6/23/23 Cleaning of Durable Medical and Therapy Equipment policy revealed:</p> <p>*To provide residents with clean, sanitary equipment and prevent the spread of infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*The policy did not address items such as thermometers or blood pressure cuffs.</p> <p>Review of the provider's Hand Hygiene policy revealed:</p> <p>*Cleaning hands promptly and thoroughly between resident contact and after contact with blood, body fluids, secretions, excretions, equipment and potentially contaminated surfaces is an important strategy for preventing healthcare associated infections.</p> <p>Hand hygiene should be performed:</p> <p>After removing gloves, After handling equipment supplies, or linen contaminated with body substances, and When moving from contaminated to clean body sites.</p> <p>Review of the provider's Infection Control and Prevention policy revealed:</p> <p>*Using Standard and Transmission based Precautions appropriately and correctly, you will keep yourself and your residents safe from acquiring infection while in the healthcare setting.</p> <p>*Standard Precautions include Hand washing single most effective way to prevent the transmission of disease.</p> <p>Review of the provider's April 2024 Enhanced Barrier Precautions policy revealed:</p> <p>*It is a policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms (MDRO).</p> <p>*Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDROs) in nursing homes. Enhanced barrier precautions involve gown and glove use during high contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisitions (e.g ,residents with wounds or indwelling medical devices).</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51472</p> <p>Based on observation, record review, interview, and policy review the provider failed to adequately implement and monitor an effective antibiotic stewardship program.</p> <p>Findings include:</p> <p>1. Observation and interview on 1/14/25 at 8:26 a.m. of resident 10 in room [ROOM NUMBER] revealed:</p> <p>*She was sitting in her recliner working with an occupational therapist.</p> <p>*Her goal was to get stronger and go to assisted living.</p> <p>*She had been in the hospital recently for an infection.</p> <p>Review of resident 10's EMR revealed:</p> <p>*She was admitted on [DATE].</p> <p>*Her diagnoses were:</p> <ul style="list-style-type: none"> -Chronic kidney disease, stage four. -Type two diabetes mellitus without complications. -Retention of urine, unspecified. -History of urinary tract infection. <p>*Her 1/14/25 revised care plan had an intervention to monitor for signs and symptoms of infection, UTI (urinary tract infection) initiated on 3/27/24.</p> <p>*She had orders for antibiotics to treat a UTI on 8/20/24, 8/21/24, 9/9/24, 10/21/24, 11/19/24, 12/6/24, and 12/16/24.</p> <p>Interview on 1/15/25 at 3:29 p.m. with minimum data set (MDS)/director of nursing (DON) B revealed:</p> <p>*She is the infection preventionist.</p> <p>*She presented a spreadsheet of the infections in the facility as her antibiotic stewardship tracking.</p> <p>*She stated that the infections each month are discussed at QAPI (quality assurance and performance improvement).</p> <p>(continued on next page)</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>*A PIP (performance improvement plan) has been developed related to urinary tract infections in the facility.</p> <p>*Management was auditing resident fluid intake, staff rounding on residents every two hours, and wiping from front to back when staff was performing genital hygiene.</p> <p>*Management had done hand hygiene audits in the past.</p> <p>*Staff was not obtaining an order each time a urine dip was completed.</p> <p>*It was her expectation that staff document the reason for completing a urine dip or getting a UA.</p> <p>*She expected a nurse's note to be entered into the resident's EMR that indicated what the staff was doing and why.</p> <p>*She did not believe that staff were using a form, such as a SBAR (situation, background, assessment, recommendation) to determine if a urine dip or UA is indicated.</p> <p>*She believed that there was an SBAR form available on the computer.</p> <p>-The SBAR form she located was for Skin/Soft Tissue.</p> <p>*She indicated she believed a form such as an SBAR form would be helpful in the decision-making process for the nurses.</p> <p>*She is responsible for follow-up of UA and urine culture (UC) results.</p> <p>*After the urine culture is resulted, she waits for the provider to either write an order to continue the antibiotic or stop the antibiotic.</p> <p>*Lab sends the results of the UA and UC to the facility and the results are scanned into the resident EMR.</p> <p>*She was unable to locate a UC result in resident 11's EMR for a UTI diagnosis and treatment on 1/16/24.</p> <p>*The provider does not get results of chest x-rays when residents go to the clinic and are diagnosed with pneumonia.</p> <p>Interview on 1/16/25 at 10:05 a.m. with CNA G regarding resident 10's chronic UTIs revealed:</p> <p>*She had been instructed to watch for changes in her behavior that would indicate a UTI.</p> <p>*She would report any changes to the charge nurse.</p> <p>*If a UTI was suspected they would put a hat in her toilet to collect a urine sample.</p> <p>Interview on 1/16/25 at 10:21 a.m. with registered nurse (RN) D revealed:</p> <p>(continued on next page)</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>*If the nurse suspected a resident had a urinary tract infection (UTI) the nurse would complete a urine dip test.</p> <p>*If the urine dip was positive the primary care provider would be faxed with the resident's signs and symptoms and a request to collect a urine sample for a urinalysis.</p> <p>*The urine would then be sent to lab for evaluation.</p> <p>*The lab would send the results of the urinalysis to the facility and the primary care provider would decide if treatment was necessary.</p> <p>*An order for the urine dip was not obtained prior to completing the urine dip test.</p> <p>*She was under the understanding since she was hired that there was an understanding with medical director U that a urine dip test could be performed with any signs and symptoms of a UTI.</p> <p>*Symptoms she would consider to be signs of a UTI included: urine with a strong odor, frequency of urination, pain, burning with urination, and with certain residents behavior changes.</p> <p>*She did not enter a progress note in a resident's chart if she completed a urine dip test or the reasoning the urine dip test was completed.</p> <p>*She would enter a progress note in the resident's chart when she faxed for the UA, the results are returned, and when the family was notified of the treatment.</p> <p>*When asked about documentation of the urinalysis completed on resident 11 in January 2025. RN D stated she was asked by resident 11's family to contact hospice to obtain a UA order. She agreed there was no documentation in the resident's chart that indicated the family requested the UA and any communication with hospice or the reason the UA was requested by family.</p> <p>Review of resident 11's hospice note revealed a UA was being obtained by SNF (skilled nursing facility) for symptoms if a UTI.</p> <p>Review of the Infection Prevention spread sheets revealed:</p> <p>*There were five UTIs (four residents) and two cellulitis (skin infection) (one resident) treated in August 2024.</p> <p>*There were seven UTIs (five residents) treated in September 2024.</p> <p>*There were six UTIs (four residents) and two cellulitis treated in October 2024.</p> <p>*There were two UTIs, two cellulitis, and two respiratory infections treated in November 2024.</p> <p>*There were three UTIs, and four pneumonias (three residents) treated in December 2024.</p> <p>*From August through December there were six residents that were prescribed antibiotics more than one time.</p> <p>(continued on next page)</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>Review of the provider's 2024 Infection Control and Prevention policy revealed:</p> <p>*The infection preventionist is responsible for Systemic data collection to identify, trend and track infection in residents.</p> <p>*The facility will work to optimize the treatment of infections while reducing the adverse events associated with antibiotic use.</p> <p>*Antibiotic use will be tracked and reported monthly.</p> <p>-Number of resident prescribed antibiotics.</p> <p>-Number and type of infections---trends and outbreak control if applicable.</p> <p>-Number of lab proof of infections versus those without.</p> <p>-Number of residents with C. [Clostridium] Difficile, antibiotic resistant organisms or adverse drug events.</p>