| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455444 | A. Building<br>B. Wing | 01/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mesa Vista Inn Health Center | 5756 N Knoll Dr<br>San Antonio, TX 78240 |

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) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075<br><br>Based on the observations, interviews, and record review the facility failed to ensure that the resident's environment remained free of accidents and hazards as was possible and each resident received adequate supervision to prevent accidents for 1 (Resident #60) of 2 residents reviewed for accidents.<br><br>The facility failed to make sure Resident #60's environment was free of sharp devices that could harm the resident such as a pair of nail clippers.<br><br>This failure could place the resident at risk of self-injury and complications with resident's diabetic condition.<br><br>Findings included:<br><br>Record review of Resident #60's Admission Record dated 01/30/25, documented a [AGE] year-old male admitted to facility's secure unit on 05/30/24. His diagnoses included unspecified dementia (impaired ability to remember, think or make decisions that interferes with doing everyday activities), senile degeneration of the brain (gradual decline in cognitive function that involves the deterioration of brain cells and connections, leading to changes in memory, thinking, and behavior), type 2 diabetes mellitus (a chronic health condition that affects how the body turns food into energy) with diabetic chronic kidney disease (kidneys are damaged and can't filter blood the way they should), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities ).<br><br>Record review of Resident #60's Care Plan with Date Initiated 6/26/24 revealed resident was on anticoagulant therapy (a blood thinner). The interventions included Resident/family/caregiver teaching to include the following: Avoid activities that could result in injury, take precautions to avoid falls, signs/symptoms of bleeding .)<br><br>Record review of Resident #60's Quarterly MDS dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment.<br><br>(continued on next page) |

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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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation and interview with Resident #60 on 01/29/25 at 4:15 pm, revealed resident was sitting in a wheelchair beside his bed with various clothes and personal items strewn about his bed, nightstand, and floor. Resident #60 stated he wanted to get his nails cut and cleaned and was holding a nail clipper and trying to figure out how to make it work. When the state surveyor suggested he wait for staff to come and assist him since he probably should be careful and not do that himself, Resident #60 replied, I know, I'm diabetic. ADON C was then informed by the state surveyor about the clippers. ADON A immediately went to Resident #60's room and secured the clippers. ADON C stated she did not know where he got the clippers and commented that Resident #60's family member often brought him items .<br><br>During an interview with the DON on 01/31/25 at 9:52 AM, the DON who has worked here about 1.5 months, was asked what could happen if a resident with diabetes has a nail clipper in their possession. The DON stated a resident could clip their fingernail and clip the skin and cause an infection. The DON stated Resident #60's family member brings him things, and they will have to monitor that closer and educate the family with a loved one in memory care that people wander, and they could pick up items and walk away. The DON stated podiatry came to do nails at the facility, and the podiatrist was at the facility recently. The DON also stated they did not have a policy on accidents and hazards. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075<br><br>Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections for 1 of 2 residents (Resident #31) reviewed for incontinent care:<br><br>The facility failed to ensure CNA A and CNA B properly cleaned Resident #31's vaginal and buttock area after an incontinent episode.<br><br>This deficient practice could place residents at-risk for infection and skin break down due to improper care practices.<br><br>The findings included:<br><br>Record review of Resident #31's face sheet dated 1/29/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a decline in cognitive abilities severe enough to interfere with daily life), diabetes (chronic condition when the body cannot produce enough insulin or effectively use the insulin the body produces leading to elevated blood sugar levels) with complications and hydronephrosis with renal and ureteral calculous obstruction (swelling of the kidney due to a blockage caused by kidney stones in the urinary tract).<br><br>Record review of Resident #31's most recent annual MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills, utilized an indwelling urinary catheter, and was always incontinent of bowel.<br><br>Record review of Resident #31's Order Summary Report dated 1/29/25 revealed the following:<br><br>- Apply TRIAD paste mixed with Nystatin powder to affected areas of diaper dermatitis: sacrum, buttocks, groin one time a day for Diaper Dermatitis with order date 1/21/25 and no stop date<br><br>- May apply barrier cream as needed every shift with order date 7/20/23 and no stop date<br><br>- Provide catheter care every shift, with order date 7/20/23 and no stop date<br><br>Record review of Resident #31's comprehensive care plan with revision date 12/27/23 revealed the resident had an indwelling urinary catheter related to obstructive uropathy and had bowel incontinence. Interventions included to apply barrier cream and provide peri care after each incontinent episode.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 1/30/25 at 9:02 a.m. revealed Resident #31 was observed with stool and remnants of a thick white substance on the crease of the thighs and buttocks, and stool was observed in the vaginal area around the urinary indwelling catheter and on the buttock area. CNA A took several disposable wipes to clean the vaginal area, and then placed the used disposable wipe with stool on it and tucked it between the resident's thighs. CNA A continued with care and wiped the resident's crotch area, vaginal area and between the inner thighs with disposable wipes and a wet washcloth and used a back-and-forth motion and circular motion, instead of wiping from front to back and tossing the wipe. Further observation revealed CNA A and CNA B used the same back-and-forth motion and circular motion when cleaning Resident #31's buttock area with disposable wipes or with a wet washcloth instead of wiping from front to back and tossing the wipe and the washcloth after each pass.<br><br>During an interview on 1/30/25 at 9:41 a.m., CNA A stated she realized when providing Resident #31 with incontinent care she had been wiping from back to front instead of from front to back, and in a back-and-forth motion and circular motion instead of wiping once and then tossing the disposable wipe and the washcloth. CNA A stated she should not have been wiping from back to front and should not have used a back-and-forth motion or circular motion because it was a risk for spreading infection. CNA A stated she had only worked for the facility for approximately 2 or 3 months but had worked as a CNA for over [AGE] years. CNA A stated she had not received any competency training while employed at the facility.<br><br>During an interview on 1/30/25 at 10:00 a.m., CNA B stated, I think that wiping in a circular [motion] trying to get the cream off, because there was so much, was not proper because it could irritate the resident's skin.<br><br>During an interview on 1/30/25 at 2:28 p.m. the DON revealed it was her expectation, when providing incontinent/peri care, the staff should be wiping an area from front to back and then tossing the disposable wipe or wash cloth after each pass. The DON further stated, placing a soiled wipe between the resident's thighs, and wiping in the wrong direction was considered cross contamination and could result in the resident developing an infection. The DON revealed she was newly employed by the facility and was not sure if CNA A and CNA B had completed any competency training for incontinent/peri care. The DON stated, she and the ADON's would be responsible for providing competency training.<br><br>Record review of the facility policy and procedure titled, Perineal Care Female (With or without catheter), revision date 12/8/2009 revealed in part, .Purpose: To clean the female perineum without contaminating the urethral area with germs from the rectal area .Beginning Steps .Gather needed supplies .Washcloths or Pre-moistened cleansing wipes .DO NOT WIPE MORE THAN ONCE WITH THE SAME SURFACE OF THE TISSUE OR WIPES .Gently wash perineal area, wiping from clean urethral area toward dirty rectal area to avoid contaminating urethral area with germs from the rectum .Continue to wash the rest of the perineal area, wiping from front to back, alternating from side to side and moving outward to the thighs. Change the washcloth or pre-moistened cleansing wipe surface or use a new wash cloth or pre-moistened cleansing wipe with each wipe . |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075<br><br>Based on observation, interview, and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, that are complete; and accurately documented for 1 of 8 residents (Resident #31) reviewed for medical records:<br><br>The facility failed to ensure staff obtained a written order for Resident #31's use of a left arm sling.<br><br>This failure could result in residents not having an accurate overall view of their care and services.<br><br>The findings included:<br><br>Record review of Resident #31's face sheet dated 1/29/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included ataxia following cerebrovascular disease (a neurological condition characterized by a lack of muscle coordination, including difficulty with fine motor tasks and unsteady walking).<br><br>Record review of Resident #31's most recent annual MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and had a functional limitation in range of motion to both upper and lower extremities.<br><br>Record review of Resident #31's Order Summary Report dated 1/29/25 revealed there was no written order for the use of a left arm sling.<br><br>Record review of Resident #31's Nursing Progress Note dated 1/8/25 revealed the following:<br><br>-Seen by RN from hospice with new order to keep sling on left arm until 1/14/25, then hospice to re-assess. Continue prn pain medication for comfort. RP at facility and informed. Order noted and carried out.<br><br>Record review of Resident #31's MAR dated 1/29/25 revealed the following:<br><br>Resident to wear Left Arm Sling until 1/14/25, hospice to reassess related to left clavicle fracture every shift for left arm sling until 1/14/25.<br><br>Further review of Resident #31's MAR revealed the order had a stop date of 1/14/25 and nursing staff documenting the left arm sling was being utilized on 1/14/25.<br><br>Record review of Resident #31's comprehensive care plan dated 12/26/24 revealed the resident had an alteration in musculoskeletal status related to fracture of the clavicle. Interventions included to encourage/supervise/assist the resident with the use of supportive devices, sling, as recommended.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observations on 1/29/25 at 8:11 a.m., 1/30/25 at 6:56 a.m., and 1/30/25 at 1:27 p.m. revealed Resident #31 in bed wearing a black arm sling on the left arm.<br><br>During an observation and interview on 1/29/25 at 8:22 a.m., CNA A stated, Resident #31 wore the black arm sling on the left arm due to contractures and wore the sling all the time except during showers. CNA A stated the resident's hospice nurse took care of the sling.<br><br>During an interview on 1/30/25 at 1:47 p.m., LVN D revealed Resident #31 used the arm sling to the left arm related to a clavicle fracture. LVN D revealed Resident #31 had a repeat x-ray ordered by hospice and determined the resident should continue to use the left arm sling. LVN D confirmed Resident #31's Order Summary was not updated to reflect the resident needed to continue using the left arm sling per hospice recommendation. LVN D stated the communication to keep the arm sling in place should have been reflected in a physician's order. LVN D stated the order was necessary and would determine how long the arm sling needed to be in place. LVN D stated nursing staff referred to the physician's orders and communication nursing notes to determine resident care and services.<br><br>During an interview on 1/30/25 at 2:25 p.m., the DON revealed Resident #31 did not have a physician's order to continue the use of the left arm sling and further stated it was necessary as a means of instruction and monitoring it's use including if any skin issues should develop.<br><br>Record review of the facility policy and procedure titled Physician's Orders, dated 2015 revealed in part, . Purpose: To monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075<br><br>Based on observation, interview, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 2 or 4 residents (Residents #31 & #33) reviewed for infection control.<br><br>1. The facility failed to identify and implement interventions for Resident #33 on Enhanced Barrier Precaution who had a colostomy.<br><br>2. The facility failed to ensure CNA A and CNA B used appropriate infection control principles including during catheter care, incontinent/peri care, and hand hygiene/glove changes for Resident #31.<br><br>These deficient practices could affect residents who were on EBP and required assistance with incontinent/peri care and could place residents at risk for cross contamination and infections.<br><br>The findings included:<br><br>1. Review of Resident #33's electronic face sheet dated 1/31/2025 revealed she was admitted to the facility on [DATE] with diagnoses of colostomy status (surgery to create an opening in the abdomen), dementia (condition that causes a person to lose the ability to think, remember and reason), and orthostatic hypertension (a sudden drop in blood pressure).<br><br>Review of Resident #33's quarterly MDS assessment dated [DATE] revealed Resident #33 scored a 3/15 on her BIMS which indicated she severe cognitive impairment.<br><br>Review of Resident #33's comprehensive person-centered care plan revised date 1/21/2025 revealed The resident has a Colostomy.<br><br>Observation on 1/28/2025 revealed no EBP signage on or around the resident's room.<br><br>Staff interview on 1/28/2025 at 10:15 am with LVN F, she stated there was no signage of EBP on or around the Resident #33's room and that the resident did have a colostomy bag. She stated EBP signage should have been posted to identify vulnerable residents and to prevent infections for those residents.<br><br>Staff interview on 1/31/2025 at 11:00 am with the DON, stated that those residents' rooms should have EBP signage. She stated the potential for harm could be an infection.<br><br>Record review of internal facility document, undated, titled, Enhanced Barrier Precautions, showed EBP are indicated for residents with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. This document did not address the facility system for informing staff of which residents were on enhanced barrier precautions.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Record review of Resident #31's face sheet dated 1/29/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a decline in cognitive abilities severe enough to interfere with daily life), diabetes (chronic condition when the body cannot produce enough insulin or effectively use the insulin the body produces leading to elevated blood sugar levels) with complications and hydronephrosis with renal and ureteral calculous obstruction (swelling of the kidney due to a blockage caused by kidney stones in the urinary tract).<br><br>Record review of Resident #31's most recent annual MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills, utilized an indwelling urinary catheter, and was always incontinent of bowel.<br><br>Record review of Resident #31's Order Summary Report dated 1/29/25 revealed the following:<br><br>- Provide catheter care every shift, with order date 7/20/23 and no stop date<br><br>Record review of Resident #31's comprehensive care plan with revision date 12/27/23 revealed the resident had an indwelling urinary catheter related to obstructive uropathy and had bowel incontinence. Interventions included to apply barrier cream and provide peri care after each incontinent episode.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 1/30/25 at 9:02 a.m. revealed CNA A and CNA B each put on a gown and gloves to prepare to provide Resident #31 with catheter and incontinent/peri care. CNA B took Resident #31's bed remote and raised the bed. CNA A removed Resident #31's sheet and placed a clean sheet over the resident's bottom torso, and then removed a pillow that was used to offload the resident's lower extremities. CNA A and CNA B then pulled up the resident's gown to expose her vaginal and peri area. Resident #31 was observed with stool and remnants of a thick white substance on the crease of the thighs and buttocks, and stool was observed in the vaginal area around the urinary indwelling catheter and on the buttock area. CNA A then, without changing her gloves, took clean disposable wipes and began catheter care and incontinent/peri care. CNA A continued with catheter care and incontinent/peri care and after using several disposable wipes to clean the area of stool, took a clean washcloth and placed it in a gray bin filled with water. CNA A then used both soiled gloved hands, retrieved the washcloth from the gray bin and wrung the washcloth over the gray bin. CNA A continued using the same soiled gloves and continued with incontinent/peri care and retrieved several washcloths following the same process of putting her gloved hands in the gray bin with water, retrieving the washcloth, and wringing the washcloth of water over the bin. CNA A and CNA B then took the drawer sheet Resident #31 was laying on and with the same soiled gloves, assisted the resident onto her left side. While CNA B ensured Resident #31 was positioned to her left, CNA A continued to use the same soiled gloves and resumed cleaning the resident's anal and buttock area of stool. CNA A, using the same soiled gloves, then took a clean disposable pad and placed it on the resident's bed. CNA A then took a clean washcloth and placed it in the gray bin filled with water. CNA A then used both soiled gloved hands, retrieved the washcloth from the gray bin and wrung the washcloth over the gray bin. CNA A continued using the same soiled gloves and continued with incontinent/peri care and retrieved several washcloths following the same process of putting her gloved hands in the gray bin with water, retrieving the washcloth, and wringing the washcloth of water over the bin. CNA A, having completed cleaning the resident's right buttock area, moved to the other side of the bed and instructed CNA B to leave the bedside to retrieve more disposable wipes. CNA B removed her gown and gloves, did not sanitize her hands, and left the resident's room. CNA A, removed her gloves, did not wash or sanitize her hands and took the clean sheet on the resident's bed and covered the resident. CNA B then returned to the bedside, took a pair of gloves and a gown that were stored on the resident's door and put on a new pair of gloves without washing or sanitizing her hands. CNA B returned to the left side of the bed, and CNA A opened Resident #31's bedroom door, took a pair of gloves that were stored on the door and put on the new pair of gloves without washing or sanitizing her hands. CNA A returned to the bedside and continued with incontinent/peri care. CNA A and CNA B then assisted Resident #31 onto her right side and CNA B then continued to clean the resident's left buttock of stool while CNA A continued to assist the resident onto the right side until care was completed. CNA A stayed with the resident, and CNA B left the bedside, removed her gloves and gown, and summoned the Treatment Nurse.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 1/30/25 at 9:41 a.m., CNA A stated, I feel like I skipped a couple of steps as far as rinsing and drying off the area (to Resident #31). CNA A revealed she had washed her hands prior to care, and stated, I washed me hands in the sink, then I washed the resident's bin that is used for a bed bath and then filled with water and placed on the bedside table. CNA A stated she should have changed her gloves after cleaning the stool, but insisted her gloves never got stool on them. CNA A revealed she had been moving from a dirty area to a clean area and should not have done that because it could spread infection. CNA A stated, we didn't have any sanitizer in there, I ain't gonna lie, we should have had sanitizer. You need to sanitize before putting on gloves and after you take them off to prevent infection. So, if I go to another resident then I run the risk of spreading something to the next person. CNA A revealed she should not have placed her gloves in the bin with water while she had wrung the washcloths because she dirtied the water and that was a break in infection control.<br><br>During an interview on 1/30/25 at 10:00 a.m., CNA B stated she had sanitized her hands with the wall mounted hand sanitizer outside of Resident #31's room. CNA B revealed she had not sanitized or washed her hands between glove changes and realized she had moved from a dirty area to a clean area when providing care. CNA B stated it was considered cross contamination and could result in the resident getting sick. CNA B further stated, we didn't have sanitizer, maybe there was some in the resident's nightstand drawer but since it wasn't visible, I guess it was out of site out of mind.<br><br>During an interview on 1/30/25 at 2:28 p.m., the DON revealed cross contamination and a break in infection control occurred when CNA A and CNA B moved from a dirty area to a clean area, and when they did not wash or sanitize their hands between glove changes which could result in the resident developing an infection.<br><br>Record review of the facility policy and procedure titled, Hand Hygiene/PPE, undated, revealed in part, .How to practice proper hand washing and hand hygiene .Wet hands with clean warm water .Apply appropriate amount of soap to your hands .Rub hands together vigorously for 20 seconds covering all surfaces of the hands, wrists and fingers, then rinse allowing water to drop from fingertips .When using hand sanitizer .Apply product to palm of one hand .Rub hands together covering all surfaces of hands, wrists, and fingers .Rub until hands are dry .Hand hygiene must be performed before touching a patient, after providing care, after removing gloves and PPE .and anytime you touch a contaminated surface .PPE works as a barrier to help protect you from potentially infectious agents that you may come in contact with while working with residents .<br><br>47611 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455444 | A. Building<br>B. Wing | 01/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mesa Vista Inn Health Center | 5756 N Knoll Dr<br>San Antonio, TX 78240 |

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) |
|---|---|
| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075<br><br>Based on observations, interviews, and record reviews the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relayed the call directly to a staff member or to a centralized staff work area from each resident's bedside, toilet, and bathing facilities, for 1 of 2 residents (Resident #41) reviewed for call light accessibility and functionality.<br><br>On 01/28/25 at 10:05 am, Resident #41 was observed to have utilized his call light which did not illuminate the nurse call light directly outside and above his room door.<br><br>This failure could place residents at risk for harm by not receiving care and attention when their nurse call light system malfunctioned and/or was out of reach.<br><br>The findings included:<br><br>Record review of Resident #41's Admission Record dated 01/30/25 documented an [AGE] year-old male admitted to the facility 04/15/24. His diagnoses included unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities); atherosclerotic heart disease of native coronary artery without angina pectoris (a condition where the arteries that supply blood to the heart called coronary arteries, become narrowed and hardened due to the buildup of plaque but the patient does not experience chest pain or other typical symptoms of angina, a type of chest pain); and chronic obstructive pulmonary disease (diseases that cause airflow blockage and breathing-related problems).<br><br>Record review of Resident #41's Care Plan with date initiated 04/15/24, documented he was at risk for falls due to debility and weakness. One of the interventions was to be sure resident's call light is within reach and encourage the resident to use it for assistance as needed.<br><br>During an observation and interview with Resident #41 on 01/28/25 at 10:05 am, the resident was observed to be in his room and was holding his call light. When asked how long it took staff to answer the call light, Resident #41 stated It takes a long time - like 2 hours. The call light was observed lit up at the call light pull station on the wall, but the light was not on outside his door.<br><br>During an interview with CNA D on 01/28/25 at 10:15 am, CNA D was asked if the call light was sounding at the nurse's station, and he verified it was not working. CNA D then immediately reported to ADON C that the light was not working .<br><br>During an interview with ADON C on 01/28/25 at 10:17 am, she verified that she had checked the light and it was not working. ADON C stated she would call maintenance to come and fix it.<br><br>During an interview on 01/31/25 at 9:38 am with the Maintenance Director, he reported that he had fixed the call light for Resident #41. The Maintenance Director stated when someone pulls the call light without resetting it, you ground the system. He also stated the Administrator had conducted an in-service with staff to show them how to reset the call light. He stated that the Maintenance Assistant checked the call lights daily .<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455444 | A. Building<br>B. Wing | 01/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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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.

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with the Administrator on 01/31/25 at 10:52 am, Administrator stated the call light in Resident #41's room was not reset and did not light up but will give an audible. The Administrator stated they spoke with everyone one on one and had them do a repeat demonstration to reset the call light. The Administrator also stated the Assistant Maintenance Director checked the call lights daily on his walking rounds.<br><br>Record review of Maintenance Policy, undated, titled Preventive Maintenance/Work Order Request:<br><br>1. The facility will repair/replace damaged/broken equipment or building amenities as needed.<br><br>2. The facility will educate all staff members on the procedures for requesting repairs or damages to the building or equipment. |