| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515100 | A. Building<br>B. Wing | 07/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| White Sulphur Springs Center | 345 Pocahontas Trail<br>White Sulphur Spring, WV 24986 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give the resident's representative the ability to exercise the resident's rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650<br><br>Based on medical record review and staff interview, the facility failed to confer with the appointed resident representative regarding the physician recommendation for medical treatment (biopsy of thyroid nodules) and the recommendation of the Registered Dietitian for nutritional support. This was true for one (1) of four (4)residents whose rights were reviewed during the long-term care process. Resident identifier: #29. Census: 64.<br><br>Findings included:<br><br>a) Resident #29<br><br>ENT referral A medical record review on [DATE] at approximately 10:00 AM identified the resident had a Brief Interview for Mental Status (BIMS) of 06. It was further identified that the physician note completed on [DATE] stated the patient was alert and oriented x1 with no acute distress and that Resident #29 did not have capacity. It was further identified that the Nurse Practitioner (NP) assisted Resident #29 to complete Physician Orders for Scope of Treatment (POST) form on [DATE]. The POST form was for no cardiopulmonary resuscitation (CPR) with comfort-focused treatments and no artificial means of nutrition. Additional orders were handwritten on the Post for no intravenous infusion (IV) fluids, no weights and no labs with exceptions. The authorization was not initialed by the resident to allow changes if decision making capacities were lost. The participants noted to attend the discussion with the NP was marked for the patient with decision making capacity. It was further identified the facility failed to follow up on the hospital attending physician's referral recommendation for a biopsy for Resident #29's thyroid nodules following a hospitalization readmission to the facility on [DATE].<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 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During this medical record review there were no notes observed of the surrogate, who was appointed by the facility physician, being contacted regarding making the medical decision for the biopsy referral recommendation. On [DATE] at 11:43 PM during an interview with the Director of Nursing (DON) and NP, both DON and NP confirmed the health care surrogate had not been contacted about the referral to the (Ear Nose Throat) ENT physician. The NP stated this was because Resident#29 made it clear to her during the discussion on [DATE] that she did not want any treatment. The NP stated during the time of that discussion, the resident had issues with her gall bladder and had declined treatment for the gallbladder. Therefore, the NP did not contact the surrogate because the NP stated she firmly believed the resident would not want this done. The NP further stated the resident had a hard time with the anesthesia from her hip surgery and the NP did not feel Resident #29 would do well with a follow up with the ENT for the nodule. The DON and NP further stated they were not aware that Resident #29's grandson was the resident's appointed surrogate. The NP denied the need to contact the surrogate for follow up on the referral for the nodule biopsy because the resident had already made her wants known on [DATE].<br><br>On [DATE] at approximately 11:00 AM during an interview with the NP, she stated she was not aware of the physician note that was completed on [DATE] that identified the patient as alert and oriented x 1 with no acute distress and not having capacity. When the NP was asked why an invalid POST form was completed with Resident #29 after being deemed incapacitated on [DATE] by the facility attending physician, the NP stated that she does her own capacity determination prior to completing the post forms. She acknowledged the physician capacity form deeming the resident to be incapacitated on [DATE] made the POST form she completed on [DATE] invalid.<br><br>The NP agreed the surrogate should have been contacted for their right to exercise the resident's rights in determining the decision for the recommendation/ referral with an ENT for the thyroid nodules biopsy. b) Resident #29-nutritional support Medical record review on [DATE] at approximately 10:00 AM identified the resident had a Brief Interview for Mental Status (BIMS) of 06. It was further identified that the physician note completed on [DATE] stated that the patient was alert and oriented x 1 with no acute distress and that Resident #29 did not have capacity at this time. It was further identified that the Nurse Practitioner (NP) assisted Resident #29 to complete the Physician Orders for Scope of Treatment (POST) form on [DATE].<br><br>The POST form was for no cardiopulmonary resuscitation (CPR) with comfort-focused treatments and no artificial means of nutrition. Additional orders were handwritten on the Postform for no intravenous infusion (IV) fluids, no weights and no labs with exceptions.<br><br>(continued on next page) |

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| F 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The authorization was not initiated to allow changes if decision making capacities were lost. The participants noted to attend the discussion with the NP was marked for the patient with decision making capacity. Further review identified the facility Dietitian completed a nutritional assessment on [DATE]. The evaluation/nutritional plan stated: Readmission assessment: 80 yr.(year)/old female readmitted following fracture of left femur and UTI (urinary tract infection) with other pmh (past medical history)/dx (diagnosis) including Alzheimer's, dementia, CKD 3A (Stage 3 chronic kidney disease), Type 2 DM(diabetes mellitus) cognitive communication deficit, and history of falling. Resident DNR (Do Not Resuscitate), CMO (comfort measures only), no intravenous infusion (iv)/weights (wts)./Percutaneous Endoscopic Gastronomy (PEG) tube/labs with exception. Working with ST (speech therapy), PT (physical therapy) OT(occupational therapy). Loss of (-24.4%) -20.0 lbs. (pounds) x 14 months. CBW(current body weight) 98.2 pounds. IBW (initial body weight) 125 lbs. Regular diet order with good po (by mouth) intake since admit. Intakes ,d+[DATE]% of most meals since readmit. Medications reviewed. Registered Dietician recommendation for house shakes bid (2 times daily) for nutrition support. Further review of the medical record identified a nursing note dated [DATE] (typed as written)RD with recommendation for house shakes BID (twice a day), however NP declines this order at this time. Resident refuses them. Resident is comfort care with no weights as well. Appetite and intake sufficient at this time.<br><br>During medical record review there were no notes identified showing the surrogate appointed by the facility physician was contacted regarding the Registered Dietitians recommendation for house shakes for Resident #29's nutritional support. [DATE] 11:43 Am during an interview with Nurse Practitioner (NP) and Director of Nursing (DON),the NP stated she had declined the dietary recommendations based on the resident's comfort care. The NP stated she had not made any attempt to notify the surrogate about their choice of care for the resident. She stated she did not feel like she needed to contact the surrogate because she felt that she knew what the resident wanted since she had talked with her on [DATE].<br><br>The NP stated the resident had refused at that time to do anything with her gall bladder so the NP knew she would refuse them. She stated that because of the resident having issues with her gallbladder she felt the recommended milk product would only irritate her stomach. The NP further stated she did not consider any alternate supplement for the nutritional recommendation made by the Registered Dietician for the resident nutritional support. On [DATE] at approximately 11:00 AM during an interview with the NP, she stated she was not aware of the physician note completed on [DATE] that identified the patient as alert and oriented x 1 with no acute distress and that Resident #29 did not have capacity at this time.<br><br>When the NP was asked why an invalid POST form was completed with Resident #29 after being deemed incapacitated on [DATE] the NP stated did her own capacity determination prior to completing the post forms. The NP further acknowledged the physician capacity form deeming the resident to be incapacitated on [DATE] and that the POST form she completed on [DATE] was not valid. The NP agreed the surrogate should have been contacted for their right to exercise the resident's rights in determining the decision for the recommendation made by the Registered Dietician for house shakes twice a day for the resident's nutritional support. |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>49467<br><br>Based on record review and staff interview, the facility failed to allow Resident #28 to participate in his care and make treatment decisions, by failing to inform him of his right to participate in hospice care. The facility also failed to notify the responsible party for Resident #61 of the potential side effects of a psychotropic medication before administration. This was true for two (2) of three (3) residents reviewed for the right to make informed decisions during the survey process. Resident identifiers: #28, #61. Facility census: 64.<br><br>Findings included:<br><br>a) Resident #28<br><br>Resident #28 was admitted to the facility with the diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and Liver Cell Carcinoma. He had a Brief Interview for Mental Status (BIMS) score of 14, suggesting he was cognitively intact, and was determined to have capacity.<br><br>Upon review of the resident matrix after arrival to the facility at approximately 11:00 AM on 07/08/2024, it was noted Resident #28 was marked for end of life/palliative care/comfort measures along with 25 other residents in the facility.<br><br>At approximately 2:15 PM on 07/08/2024, Resident #28 was observed sitting on the side of his bed, bent over at the waist, with his hands almost touching the floor. Staff members then came into the room to help Resident #28 get back into his bed. At this time an interview was attempted with Resident #28, however, he was not interviewable due to him being unable to hold his eyes open, slurred speech, and his head bobbing up and down as he was unable to stay awake.<br><br>At approximately 2:30 PM on 07/09/2024, a review of Resident #28's medication orders was reviewed. The following orders were found in Resident #28's electronic health record (EHR:<br><br>Ativan Oral Tablet 1 MG- Give one tablet by mouth two times a day for anxiety r/t (related to) restlessness.<br><br>Gabapentin - Give 300 mg by mouth two times a day for neuropathy in feet.<br><br>Morphine Sulfate (Concentrate) Solution 20 MG/ML- Give 1 ml sublingually every 4 hours for pain/sob (shortness of breath).<br><br>Morphine Sulfate Oral Solution 20 MG/5ML (Morphine Sulphate) - Give 1 ml by mouth one time only for agitation and S.O.B. (shortness of breath) for 1 day.<br><br>Oxycodone HCl Oral tablet 30 MG (Oxycodone HCl) - Give 1 tablet by mouth every 4 hours for pain.<br><br>Morphine Sulphate (Concentrate) Solution 20 MG/ML - Give 0.5 ml sublingually every 2 hours as needed for pain/sob 0.5 ml = 10 mg<br><br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Morphine Sulphate (Concentrate) Solution 20 MG/ML - Give 0.5 ml sublingually every 2 hours as needed for pain/sob 0.5 ml = 10 mg<br><br>At approximately 1:00 PM on 07/10/2024, a review of progress notes for Resident #28 revealed he had passed away at the facility that morning.<br><br>At approximately 2:09 PM on 07/10/2024, an interview was conducted with the Nurse Practitioner (NP) regarding the medication orders for Resident #28 and the fact that he seemed sedated when an interview was attempted with him. During the interview the NP stated Resident #28 was end of life care and the medications were ordered for that purpose. The NP was asked if Resident #28 was referred to hospice to assist with end-of-life care to which the NP replied, No, I don't offer anyone hospice.<br><br>The NP was asked if they were aware residents had the right to participate in their care and to make informed decisions, meaning hospice should have been discussed with Resident #28 for him to make the most informed decision. The NP replied Yes, but I do not offer hospice to anyone. I don't mention hospice to anyone, I don't discuss it with anyone. I feel like we can do what they do here, without them.<br><br>The NP was asked why Resident #28 was not given the option of hospice care at the end of his life, and the NP replied, I didn't ' offer him hospice because he did not have any family or representatives. The NP was asked what that had to do with Resident #28 being offered hospice care or not being offered hospice care, to which they replied, I guess nothing. The NP was then asked if the other 25 residents in the facility were offered hospice care, due to them being on end of life/palliative care, to which the NP replied, If they've ever been seen by me then they haven't.<br><br>b) Resident #61<br><br>On 07/08/24 at approximately 09:11 PM, a review of Resident #61's medical record was performed. It revealed that on 05/19/24 at 11:15 PM the following progress note was entered into Resident #61's medical record:<br><br>Resident continues to be very restless with poor safety awareness. Attempted again to contact provider at Vis a Vis. Vis a Vis provider's microphone not working. Contacted Dr. (name) and instructed to administer 10 milligram (mg) Zyprexa intramuscularly (IM). Medication administered as ordered and resident assisted back to bed. Resting in bed at this time with 0 (zero) complaints of (c/o) pain/discomfort.<br><br>This note was revealed to be a follow up to a Change in Condition Evaluation with an effective date and time of 05/19/24 at 11:10 PM. During this review of the Change in Condition Evaluation, it was revealed that the change in condition signs and symptoms identified were documented as agitation and restlessness, with the most recent vital signs documented dated and timed for 05/19/24 at 05:16 AM. Further review of this Change in Condition evaluation revealed, under the section for Resident Representative Notification that the Department of Health and Human Resources representative was the resident representative notified, however, the section for the date and time of that notification was left blank.<br><br>A reviewof Resident #61's Medication Administration Record (MAR), revealed on 05/19/24 at 11:10 PM, documentation of administration of Zyprexa 10 mg IM, one time only for agitation.<br><br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 07/09/24 at 01:48 PM, the Policy and Procedure titled, Behaviors: Management of Symptoms was reviewed. It revealed that when administering a medication for behavioral symptoms, a consent should be obtained and that the form Psychotropic/Therapeutic Medication Use Evaluation should be completed when a patient is newly prescribed a psychotherapeutic medication.<br><br>On 07/10/24 at 2:35 PM, a further review of Resident #61's medical record was performed. It revealed that Resident #61 had 2 (two) forms titled, Psychotropic Medication Administration Disclosure. Both forms revealed that Resident #61's representative had the risks and benefits of psychotropic medication verbally explained and provided in writing. It also revealed that Resident #61's representative understood the right to refuse the administration of these medications and the right to withdraw consent of medication administration at any time.<br><br>Under the signature section of both forms, it revealed that verbal consent had been obtained and both forms were dated as the verbal consent being obtained on 05/07/24. However, when reviewing the forms, it revealed that each form was different. One of the forms listed Aricept and Ativan as the medications verbal consent had been obtained for on 05/07/24. The next form listed Aricept, Ativan and Lexapro as the medication verbal consent had been obtained for 05/07/24. Lexapro had 06/13/24 written beside it.<br><br>On 07/10/24 at 3:29 PM, an interview was conducted with the Director of Nursing (DON). At that time, the DON acknowledged that no consent was obtained before the administration of Zyprexa and that a new form titled, Psychotropic Medication Administration Disclosure should have been completed for this medication. DON further acknowledged that instead of adding Lexapro and writing the date beside it to the already existing form dated 05/07/24, a new form titled Psychotropic Medication Administration Disclosure should have been completed.<br><br>50552 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>50552<br><br>Based on record review, resident interview and staff interview, the facility failed to ensure its residents were not abused. The facility failed to provide services to residents that were necessary to avoid mental or emotional harm. In addition, the facility failed to protect residents when verbal and physical threats were made. This was true for 1 (one) of 1 (one) resident reviewed during the Long-Term Survey Process. Facility census: 64. Resident identifier #42, and #61. This created an immediate jeopardy situation.<br><br>Findings include:<br><br>a) Resident #42<br><br>On 07/08/24 at 1:30 PM an interview was conducted with Resident #42. At that time, Resident #42 stated, I don't sleep much at night due to Resident #61 coming into my room at night. I nap during the day, so I don't wake up to find him in my room. It scares me. That's why I had the staff put up the stop sign in my door.<br><br>On 07/08/24 at 9:11 PM a review of Resident #61's medical record was performed. It revealed several notes in the documentation related to physical and verbal aggression towards staff and other residents. During the review, a progress note dated 07/06/24 at 6:05 PM read as follows :<br><br>This resident was wondering [SIC] in and out of other residents rooms this morning. He was sitting on another residents bed and refused to leave. Multiple attempts to talk with resident and offer food drinks and to go to the bathroom were unsuccessful. Resident was attempting to hit at staff and the residents of the room he had entered. Resident eventually left this residents room and was shown to his own room. Around lunch this resident was very tearful and stated he wanted to go home. He walked with me to the courtyard and we sat outside for awhile. This seemed to help calm him. He has been up wondering[SIC] in the hallways since dinner was completed. No noted further behaviors. Physician is aware.<br><br>At this time, Resident #61's care plan was also reviewed, no documentation was revealed related to Resident #61's verbal or physical aggression.<br><br>On 07/09/24 at 01:48 PM, the Policy and Procedure titled, Behaviors: Management of Symptoms was reviewed. This policy stated that patients exhibiting behavioral symptoms would be individually evaluated to determine the behavior and that the Interdisciplinary Team (IDT) would identify the underlying cause of the behavior. The policy also stated that residents who display or who are diagnosed with mental or psychosocial adjustment difficulty would receive appropriate treatment and services to correct the problem or to attain the highest practicable mental and psychosocial well-being.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In addition, at this time, the Policy and Procedure titled, Abuse Prohibition was reviewed. This policy stated that verbal abuse was the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to patients or their families, within their hearing distance, regardless of their age, ability to comprehend or disability. This policy and procedure further stated that examples of abuse include but were not limited to threats of harm and saying things to frighten a patient. The Policy and Procedure titled; Abuse Prohibition also stated that if the suspected abuse if patient to patient the Center will do the following:<br><br>* The patient who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed.<br><br>* The Center will provide adequate supervision when the risk of patient to patient altercation is suspected.<br><br>* The Center will be responsible for identifying patients who have a history of disruptive or intrusive interactions or who exhibit behaviors that make them more likely to be involved in an altercation.<br><br>* The patient representative and physician will be notified and any follow up recommended will be completed (e.g., psychiatric evaluation).<br><br>* The Center should seek alternative placement for the patient exhibiting the abusive behavior, if warranted.<br><br>* Immediately upon receiving information concerning a report of suspected or alleged abuse the allegation will be entered into the PCC Risk Management Portal.<br><br>* Allegations involving abuse will be reported not later than 2 (two) hours after the allegation is made.<br><br>* The Center will protect other patients from further harm.<br><br>* The Center will provide the patient with a safe environment.<br><br>* The Center will assign a representative from Social Services or designee to monitor the patients feelings concerning the incident, as well as the patients involvement in the investigation.<br><br>On 07/09/24 at 2:13 PM, an interview was conducted with the Director of Nursing (DON). During the interview, the DON acknowledged the following:<br><br>- Knowledge of Resident #61's wandering behaviors.<br><br>- Knowledge of Resident #61's verbal and aggressive behaviors.<br><br>- No knowledge of any incident occurring between Resident #42 and Resident #61.<br><br>- The residents in the room Resident #61 had entered on 07/06/24 and verbally and physically threatened had not been identified.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - No assessment had been performed on the unidentified residents.<br><br>- No follow up related to potential adverse outcomes from Resident #61's verbal and<br><br>aggressive behavior had been completed for any resident this occurred with.<br><br>- No follow-up was made by Social Services for any of the incidents.<br><br>- The incident from 07/06/24 had not been reported and should have been.<br><br>- Resident #61 was not placed on one-on-one observation following the incident occurring on 07/06/24 and was not.<br><br>- Nothing had been done at this time to ensure other residents residing in the facility felt safe.<br><br>- The IDT (interdisciplinary team) had not assessed Resident #61 for underlying causes which could contribute to Resident #61's verbal and aggressive behavior.<br><br>- Resident #61's verbal and aggressive behavior have not been discussed in the IDT meetings.<br><br>- Resident #61's verbal and aggressive behavior had not been taken to or reviewed in Quality Assurance and Performance Improvement (QAPI) committee meetings.<br><br>On 07/09/24 at 3:35 PM, an additional interview was conducted with Resident #42 who stated, I don't remember who I told about the fact that Resident #61 scared me when Resident #61 comes into my room at night, it was a staff member and that staff member placed the stop sign on my door, but it doesn't stop Resident #61, Resident #61 just ducks under it. I hate to close my eyes.<br><br>On 07/09/24 at 3:40 PM, an additional interview was conducted with the DON. At that time, the Social Worker (SW) and Assistant Director of Nursing (ADON) were present. When this Surveyor asked the DON if a psychological appointment had been made for Resident #61, and if not, why not, the DON responded, I don't have an answer for that. We can certainly try it, it can't hurt.<br><br>The facility was notified of the Immediate Jeopardy (IJ) on 07/09/24 at 4:38 PM. The abatement plan of correction (POC) was submitted and accepted by the state agency on 07/09/24 at 6:11 PM. The POC read as follows:<br><br>The Director of Nursing (DON) initiated one to one supervision for Resident #61 on 7/9/24 at 5pm. The Registered Nurse conducted a change in condition assessment with medical provider notification for Resident #42 on 7/9/24.<br><br>All residents of the facility have the potential to be affected.<br><br>The Director of Nursing (DON)/designee interviewed all residents with BIMS scores of 8 and above for potential emotional and mental distress on 7/9/24 with any corrective action immediately upon discovery.<br><br>(continued on next page) |

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| | 515100 | A. Building<br>B. Wing | 07/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| White Sulphur Springs Center | 345 Pocahontas Trail<br>White Sulphur Spring, WV 24986 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Re-education was provided by the Director of Nursing (DON)/designee to all employees on 7/9/24 to ensure that allegations of emotional and mental distress are identified, immediate intervention put in place to prevent reoccurrence, immediately reported to the appropriate state agencies, and thoroughly investigated. A Post-test to validate understanding. Any employee not available during this time frame will be provided re-education, including post-test upon the beginning of next shift to work. New employees will be provided education, including post-test during orientation by the DON/designee.<br><br>Re-education was provided by the DON to the Unit Managers on 7/9/24 regarding reviewing progress notes of assigned units to ensure allegations of emotional, mental distress, and any resident behaviors that may have negative effects on other resident have been correctly identified, reported in a timely manner, and appropriate intervention put in place to prevent reoccurrence daily. A posttest to validate understanding. New Unit Managers will be povided education, including post-test during orientation by the DON/designee.<br><br>The Unit Mangers of assigned units will monitor progress notes starting on 7/9/24 to ensure that allegations of emotional, mental distress, and any resident behaviors that may have negative effects on other resident have been correctly identified, reported in a timely manner, and appropriate intervention put in place to prevent reoccurrence daily.<br><br>The Director of Nursing (DON) will monitor progress notes starting on 7/9/24 to ensure that allegations of emotional, mental distress, and any resident behaviors that may have negative effects on other resident have been correctly identified, reported in a timely manner, and appropriate intervention put in place to prevent reoccurrence daily across all shifts for 2 weeks including weekends and holidays, then 3 times a week for 2 weeks then randomly thereafter.<br><br>Results of monitors will be reported by the Director of Nursing (DON)/designee monthly to the Quality Improvement Committee (QIC) for any additional follow up and or in-servicing until the issue is resolved, then randomly thereafter as determined by the QIC committee.<br><br>On 07/11/24 at 03:05 PM, after staff interviews of the implementation of the POC, the IJ was abated.<br><br>The IJ began on 07/09/24 and ended on 07/11/24. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>50801<br><br>Based on observation, staff interviews and record reviews, the facility failed to implement two (2) of 19 resident's care plans. Resident #7's care plan was not implemented in the area of nutritional assistance. Resident #7 was not monitored or assisted with her meal for over one (1) hour after her meal was delivered. Resident #61 had no nutritional care plan developed despite having experienced weight loss. Resident identifiers: #7, #61. Facility census: 64.<br><br>Findings include:<br><br>a) Resident #7<br><br>07/08/2024 based on record review the flow chart revealed Resident #7's lunch was delivered to her room at 12:00 PM. Before surveyor entered resident's room at 1:05 PM.<br><br>07/08/24 at 1:05 PM the surveyor observed resident's tray was not eaten. Her hands appeared constricted, and she was holding her tea between her knuckles and could not place it back on her tray.<br><br>The resident's roommate stated Resident #7 needed help and could not feed herself. This surveyor asked Resident #7 if she needed help with her food and drink and she said yes. This surveyor went into the hall and found Registered Nurse (RN) #43 for assistance. She stated the resident had been feeding herself last week but thought this could be due to med issues. She stated staff should have checked on her, but that she would get help.<br><br>During observation at or around 1:15 PM Certified Nurse Aide (CAN) #38 Certified entered the resident's room and asked Resident #7 if she wanted to eat and if she needed help. Resident #7 stated, yes. CNA #38 picked up the fork and started to feed her from the same food tray that had been sitting there since approximately 12:00 PM. This surveyor asked CNA #38 if the food was warm and she stated, It is kind of cold and said she would reorder the resident another tray.<br><br>Observation on 07/08/24 at 1:35PM revealed a new tray was brought in by CNA #20 and assisted Resident #7 with eating her meal.<br><br>A review of the resident's care plan as of 07/09/2024 revealed the following interventions:<br><br>Monitor for signs/symptoms of aspiration i.e. coughing, watery eyes, choking, moist sounding voice. If coughing occurs, no food/liquids until coughing resolves.<br><br>Provide assistance as needed.<br><br>b) Resident #61<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 07/08/24 at 9:33 PM, a review of Resident #61's medical record was performed. It revealed that Resident #61 had a physician's order for weekly weights for four (4) weeks then every month entered on 05/17/24, along with a diet order for Regular/Liberalized diet, Regular Texture entered on 05/17/24 also. Further review of Resident #61's medical record revealed the following weights entered Point Click Care (PCC):<br><br>7/8/2024 124.0 Lbs.<br><br>5/31/2024 125.8 Lbs.<br><br>5/17/2024 129.6 Lbs.<br><br>At that time, a review of Resident #61's care plan was performed revealing no dietary care plan present.<br><br>On 07/10/24 at 2:54 PM, an interview was conducted with the Director of Nursing. At that time the DON acknowledged no dietary care plan had been developed for Resident #61. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552<br><br>Based on record review and staff interview the facility failed to review and revise the care plan for Resident #61's psychotropic medication, dementia, and behaviors. In addition the facility failed to revise the care plan to reflect weights no longer be obtained for Resident #59 and the care plan to reflect the surrogate for Resident #29. This was true for 3 (three) of 19 residents reviewed for the Long Term Care Survey process. Facility census: 64. Resident identifiers: #61,#59 and #29.<br><br>Findings include:<br><br>a) Resident #61 Psychotropic Medication<br><br>On 07/08/24 at 9:11 PM a review of Resident #61's medical record was performed. It revealed there were several notes in the documentation related to, refusal of care, physical and verbal aggression towards staff and other residents. During the review, a progress note dated 07/06/24 at 6:05 PM read as follows :<br><br>This resident was wondering [SIC] in and out of other residents rooms this morning. He was sitting on another residents bed and refused to leave. Multiple attempts to talk with resident and offer food drinks and to go to the bathroom were unsuccessful. Resident was attempting to hit at staff and the residents of the room he had entered. Resident eventually left this residents room and was shown to his own room. Around lunch this resident was very tearful and stated he wanted to go home. He walked with me to the courtyard and we sat outside for awhile. This seemed to help calm him. He has been up wondering[SIC] in the hallways since dinner was completed. No noted further behaviors. Physician is aware.<br><br>In addition, review of Resident #61's medical record revealed on 05/19/24 at 11:15 PM the following progress note was entered into Resident #61's medical record:<br><br>Resident continues to be very restless with poor safety awareness. Attempted again to contact provider at Vis a Vis. Vis a Vis provider's microphone not working. Contacted Dr. [NAME] and instructed to administer 10 milligram (mg) Zyprexa intramuscularly (IM). Medication administered as ordered and resident assisted back to bed. Resting in bed at this time with 0 (zero) complaints of (c/o) pain/discomfort.<br><br>This note was revealed to be a follow up to a Change in Condition Evaluation with an effective date and time of 05/19/24 at 11:10 PM. During this review of the Change in Condition Evaluation, it revealed the change in condition signs and symptoms identified was documented as agitation and restlessness, with the most recent vitals signs documented dated and timed 05/19/24 at 05:16 AM. Further review of this Change in Condition evaluation revealed, under the section for Resident Representative Notification that the Department of Health and Human Resources representative was the name of the resident representative notified, however, the section for the date and time of that notification was left blank.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review was performed of Resident #61's Medication Administration Record (MAR), it revealed on 05/19/24 at 11:10 PM, documentation of administration of Zyprexa 10 mg IM, one time only for agitation.<br><br>On 07/08/24 at 09:33 PM, Resident #61's physician's orders was reviewed. Resident #61 was noted to be prescribed the following medications:<br><br>* Ativan oral tablet 0.5 milligrams (mg). Give 1 (one) tablet by mouth two times a day for anxiety related to restlessness.<br><br>* Lexapro oral tablet 10 mg. Give 1 (one) tablet by mouth one time a day for depression.<br><br>On 07/09/24 at 01:48 PM, the Policy and Procedure titled, Behaviors: Management of Symptoms was reviewed. It revealed that when administering a medication for behavioral symptoms, a consent should be obtained and that the form Psychotropic/Therapeutic Medication Use Evaluation should be completed when a patient is newly prescribed a psychotherapeutic medication. In addition, Resident #61's care plan was reviewed. It revealed a care plan with the focus of Resident is at risk for complications related to the use of psychotropic drugs: Ativan. No further care plan related to the use of psychotherapeutic drugs was found at that time.<br><br>On 07/10/24 at 02:35 PM, a further review of Resident #61's medical record was performed. It revealed that Resident #61 had 2 (two) forms titled, Psychotropic Medication Administration Disclosure. Both of these forms revealed that Resident #61's representative had the risks and benefits of psychotropic medication verbally explained and provided in writing. It also revealed that the Resident #61's representative understood the right to refuse the administration of these medications and the right to withdraw consent of medication administration at any time. Under the signature section of both forms, it revealed that verbal consent had been obtained and both forms were dated as the verbal consent being obtained on 05/07/24. However, when reviewing the forms, it revealed that each form was different. One of the forms listed Aricept and Ativan as the medications verbal consent had been obtained for on 05/07/24. The next form listed Aricept, Ativan and Lexapro as the medication verbal consent had been obtained for 05/07/24. Lexapro had 06/13/24 written beside it.<br><br>On 07/10/24 at 03:29 PM, an interview was conducted with the Director of Nursing (DON). At that time, the DON acknowledged that Resident #61's psychotherapeutic medication care plan had not been revised to reflect the use of Lexapro and the one time administration of Zyprexa. The DON further acknowledged that Resident #61 had not been monitored for adverse reactions following the one time dose of Zyprexa IM.<br><br>b) Resident # 61 Dementia Care<br><br>On 07/08/24 at 9:11 PM a review of Resident #61's medical record was performed. It revealed there were several notes in the documentation related to, refusal of care, physical and verbal aggression towards staff and other residents. During the review, a progress note dated 07/06/24 at 6:05 PM read as follows :<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | This resident was wondering [SIC] in and out of other residents rooms this morning. He was sitting on another residents bed and refused to leave. Multiple attempts to talk with resident and offer food drinks and to go to the bathroom were unsuccessful. Resident was attempting to hit at staff and the residents of the room he had entered. Resident eventually left this residents room and was shown to his own room. Around lunch this resident was very tearful and stated he wanted to go home. He walked with me to the courtyard and we sat outside for awhile. This seemed to help calm him. He has been up wondering[SIC] in the hallways since dinner was completed. No noted further behaviors. Physician is aware.<br><br>In addition, review of Resident #61's medical recorder revealed that on 05/19/24 at 11:15 PM the following progress note was entered into Resident #61's medical record:<br><br>Resident continues to be very restless with poor safety awareness. Attempted again to contact provider at Vis a Vis. Vis a Vis provider's microphone not working. Contacted Dr. [NAME] and instructed to administer 10 milligram (mg) Zyprexa intramuscularly (IM). Medication administered as ordered and resident assisted back to bed. Resting in bed at this time with 0 (zero) complaints of (c/o) pain/discomfort.<br><br>This note was revealed to be a follow up to a Change in Condition Evaluation with an effective date and time of 05/19/24 at 11:10 PM. During this review of the Change in Condition Evaluation, it revealed the change in condition signs and symptoms identified was documented as agitation and restlessness, with the most recent vitals signs documented dated and timed 05/19/24 at 05:16 AM. Further review of this Change in Condition evaluation revealed, under the section for Resident Representative Notification that the Department of Health and Human Resources representative was the name of the resident representative notified, however, the section for the date and time of that notification was left blank.<br><br>On 07/09/24 at 09:33 AM, a review of Resident #61's diagnosis list was reviewed. Resident #61's diagnosis list revealed that Resident #61 had been diagnosed with Unspecified Dementia, unspecified severity, with other behavioral disturbance onset 05/21/24. Also at this time, Resident #61's care plan was reviewed, which revealed a care plan for Psychiatric Disorder Dementia and Parkinson's was noted. The care plan read as follows:<br><br>Focus:<br><br>* Resident #61 exhibit or is at risk for distressed/fluctuating mood symptoms related to : Psychiatric Disorder Dementia and Parkinson's.<br><br>Goal:<br><br>* Resident #61 will demonstrate improved mood state as evidenced by calmer appearance, happier demeanor by the next review date.<br><br>Interventions:<br><br>* Observe for signs of delirium, including delusions/hallucinations; notify physician/advance practice practitioner as needed.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | * Observe for signs/symptoms of worsening sadness/depression/anxiety/fear/anger/agitation.<br><br>* Observe for worsening signs/symptoms of existing psychiatric disorder (e.g., mania, hypomania, frequent mood changes, etc.). Notify physician/advanced Practice Practitioner as needed.<br><br>* Observe for signs/symptoms of new psychiatric disorder (e.g., mania, hypomania, frequent mood changes, etc.). Notify physician/advanced Practice Practitioner as needed.<br><br>On 07/09/24 at 01:48 PM, the Policy and Procedure titled, Behaviors: Management of Symptoms was reviewed. This policy stated that patients exhibiting behavioral symptoms would be individually evaluated to determine the behavior and that the Interdisciplinary Team (IDT) would identify the underlying cause of the behavior. The policy also stated that residents who display or who are diagnosed with mental or psychosocial adjustment difficulty that the Center would implement individualized, person centered, non-pharmacological interventions as the initial behavior mitigation strategy and update the care plan accordingly.<br><br>On 07/10/24 at 03:29 PM, an interview was conducted with the Director of Nursing (DON). At that time, the DON stated that the best thing for Resident #61 when he is exhibiting behaviors is to take him outside. That seems to work the best. When asked if Resident #61's behaviors had been taken to the IDT committee to review for a root cause with new behavioral interventions to be added to Resident #61's care plan, the DON acknowledged Resident #61's behaviors had not been reviewed by the IDT committee and that the care plan had not been revised.<br><br>On 07/09/24 at 3:40 PM, an additional interview was conducted with the DON. At that time, the Social Worker (SW) and Assistant Director Of Nursing (ADON) were present. When this Surveyor asked the DON if a psychological appointment had been made for Resident #61, and if not, why not, the DON responded, I don't have an answer for that. We can certainly try it, it can't hurt.<br><br>c) Resident #61 Behavior Care<br><br>On 07/08/24 at 9:11 PM a review of Resident #61's medical record was performed. It revealed there were several notes in the documentation related to, refusal of care, physical and verbal aggression towards staff and other residents. During the review, a progress note dated 07/06/24 at 6:05 PM read as follows :<br><br>This resident was wondering [SIC] in and out of other residents rooms this morning. He was sitting on another residents bed and refused to leave. Multiple attempts to talk with resident and offer food drinks and to go to the bathroom were unsuccessful. Resident was attempting to hit at staff and the residents of the room he had entered. Resident eventually left this residents room and was shown to his own room. Around lunch this resident was very tearful and stated he wanted to go home. He walked with me to the courtyard and we sat outside for awhile. This seemed to help calm him. He has been up wondering[SIC] in the hallways since dinner was completed. No noted further behaviors. Physician is aware.<br><br>In addition, review of Resident #61's medical recorder revealed that on 05/19/24 at 11:15 PM the following progress note was entered into Resident #61's medical record:<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident continues to be very restless with poor safety awareness. Attempted again to contact provider at Vis a Vis. Vis a Vis provider's microphone not working. Contacted Dr. [NAME] and instructed to administer 10 milligram (mg) Zyprexa intramuscularly (IM). Medication administered as ordered and resident assisted back to bed. Resting in bed at this time with 0 (zero) complaints of (c/o) pain/discomfort.<br><br>This note was revealed to be a follow up to a Change in Condition Evaluation with an effective date and time of 05/19/24 at 11:10 PM. During this review of the Change in Condition Evaluation, it revealed the change in condition signs and symptoms identified was documented as agitation and restlessness, with the most recent vitals signs documented dated and timed 05/19/24 at 05:16 AM. Further review of this Change in Condition evaluation revealed, under the section for Resident Representative Notification that the Department of Health and Human Resources representative was the name of the resident representative notified, however, the section for the date and time of that notification was left blank.<br><br>Further review of Resident #61's documentation revealsed the following Medication Administration Record (MAR) Progress Notes (PN):<br><br>6/15/2024 21:21 eMAR PN<br><br>Note Text: Ativan Oral Tablet 1 MG<br><br>Give 1 tablet by mouth two times a day for anxiety r/t restlessness<br><br>Resident refused medication. Spit medication into floor. Provider aware.<br><br>6/15/2024 06:04 eMAR PN<br><br>Note Text: Sepsis Vitals<br><br>three times a day<br><br>Resident refused to allow vital signs to be obtained this AM. Provider aware<br><br>On 07/09/24 at 09:33 AM, a review of Resident #61's diagnosis list was reviewed. Resident #61's diagnosis list revealed that Resident #61 had been diagnosed with the following conditions<br><br>*Unspecified Dementia, unspecified severity, with other behavioral disturbance onset 05/21/24.<br><br>* Altered Mental Status, unspecified, onset 05/17/24.<br><br>* Generalized Anxiety Disorder, onset 06/25/24.<br><br>* Major Depressive Disorder, Recurrent, Moderate, onset 06/13/24.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | At this time, Resident #61's care plan was also reviewed, which revealed that Resident #61 had a care plan entered with a focus of Resident/Patient is at risk for or exhibits symptoms of delirium related to dementia was present. In this care plan, that each intervention listed had a creation date of 06/05/24 with no revisions noted. In addition, no care plan addressing Resident #61's anxiety or depression diagnosis. Further review did not reveal a care plan related to Resident #61's behaviors such as wandering at night, tearfulness, refusal of care and physical and verbal aggression towards staff and other residents.<br><br>On 07/10/24 at 03:29 PM, an interview was conducted with the Director of Nursing (DON). At that time, the DON stated that the best thing for Resident #61 when he is exhibiting behaviors is to take him outside. That seems to work the best. When asked if Resident #61's behaviors had been taken to the IDT committee to review for a root cause with new behavioral interventions to be added to Resident #61's care plan with each occurrence of behaviors, the DON acknowledged Resident #61's behaviors had not been reviewed by the IDT committee and that the care plan had not been revised.<br><br>On 07/09/24 at 3:40 PM, an additional interview was conducted with the DON. At that time, the Social Worker (SW) and Assistant Director Of Nursing (ADON) were present. When this Surveyor asked the DON if a psychological appointment had been made for Resident #61, and if not, why not, the DON responded, I don't have an answer for that. We can certainly try it, it can't hurt.<br><br>d) Resident #29<br><br>During a medical record review for Resident #29 on 07/08/24 at approximately 07:45 PM it is identified in the residents care plan that the resident has an established advanced directive, Health Care Surrogate appointing her sister. This focus was created and intiated on 04/20/22 and revised on 10/11/22.<br><br>A further record review identified a State of [NAME] Virginia Checklist for Surrogate Selection completed that states that the sister was the previous Health Care Surrogate (HCS) but is no longer able to be reached or returns calls. This State of [NAME] Virginia Checklist for Surrogate Selection further identifies that the resident was notified on 06/06/24 that the residents grandson was now the appointed surrogate.<br><br>During an interview with the Director of Nursing (DON) on 07/10/24 at approximately 02:46 PM, the DON agreed that the care plan had not been revised to reflect the change in the Surrogate.<br><br>e) Resident #59<br><br>During a medical record review on 07/08/24 at approximately 08:22 PM, Resident #59 physician determination of capacity identified resident to be incapciated on 04/47/24. The attending physician completed the surrogate selection appointing Resident #59's sister as the health care surrogate.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A further review of the medical record the physicians note dated 04/26/24 stated the Residents sister wantes Resident # 59 to be DNR/Comfort care, No Peg tube or weights. A review of the physicians orders Resident #59 identified a verbal order for no weights ordered on 06/06/24. A further review of the residents care plan identified the resident to be care planned for the risk of oral health and dental care problems as evidenced by dentures. An intervention created on and initiated on 05/10/24 is to monitor for changes in nutritional/hydration status (changes in intake, ability to feed self, unplanned weight loss or gain). No other care plan was identified regarding Resident #59 weight orders.<br><br>During an interview with the Director of Nursing (DON) on 07/10/24 at approximately 02:46 PM, the DON agreed that the care had not been revised to reflect the Surrogate request and physicians orders for no weights.<br><br>49650<br><br>d) Resident #29<br><br>During a medical record review for Resident #29 on 07/08/24 at approximately 07:45 PM it is identified in the residents care plan that the resident has an established advanced directive, Health Care Surrogate appointing her sister. This focus was created and intiated on 04/20/22 and revised on 10/11/22.<br><br>A further record review identified a State of [NAME] Virginia Checklist for Surrogate Selection completed that states that the sister was the previous Health Care Surrogate (HCS) but is no longer able to be reached or returns calls. This State of [NAME] Virginia Checklist for Surrogate Selection further identifies that the resident was notified on 06/06/24 that the residents grandson was now the appointed surrogate.<br><br>During an interview with the Director of Nursing (DON) on 07/10/24 at approximately 02:46 PM, the DON agreed that the care plan had not been revised to reflect the change in the Surrogate.<br><br>e) Resident #59<br><br>During a medical record review on 07/08/24 at approximately 08:22 PM, Resident #59 physician determination of capacity identified resident to be incapciated on 04/47/24. The attending physician completed the surrogate selection appointing Resident #59's sister as the health care surrogate.<br><br>A further review of the medical record the physicians note dated 04/26/24 stated the Residents sister wantes Resident # 59 to be DNR/Comfort care, No Peg tube or weights. A review of the physicians orders Resident #59 identified a verbal order for no weights ordered on 06/06/24. A further review of the residents care plan identified the resident to be care planned for the risk of oral health and dental care problems as evidenced by dentures. An intervention created on and initiated on 05/10/24 is to monitor for changes in nutritional/hydration status (changes in intake, ability to feed self, unplanned weight loss or gain). No other care plan was identified regarding Resident #59 weight orders.<br><br>(continued on next page) |

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| | 515100 | A. Building<br>B. Wing | 07/11/2024 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview with the Director of Nursing (DON) on 07/10/24 at approximately 02:46 PM, the DON agreed that the care had not been revised to reflect the Surrogate request and physicians orders for no weights. |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650<br><br>]Based on medical record review, and staff interview, the facility failed to follow up on physician's recommendations for a biopsy of Resident #29 thyroid nodules upon readmission to the facility on [DATE]. This was true for one (1) of nineteen (19) residents care reviewed during the long-term care survey process. This created a situation of immediate jeopardy.<br><br>Resident identifier: Resident #29. Census: 64.<br><br>Finding included:<br><br>a) Resident #29<br><br>No documentation in the chart of surrogate being notified of the hospitals recommendations to refer to and ENT (Ear Nose and Throat) for a possible biopsy of thyroid nodules.<br><br>On [DATE] at 11:43 PM during an interview with the DON and NP confirmed the health care surrogate had not been contacted about the referral to the ENT because the resident made it clear upon her admission in 2022 that she did not want treatments. Therefore, they did not contact the surrogate. The NP further stated she believed that the resident would not want this done because she didn't want her gallbladder removed. The NP further stated that the resident had a hard time with the anesthesia from her hip surgery and she did not feel she would do well with a follow up with the ENT for the nodule. The DON and LPN further stated they were not aware that Resident #29's grandson was the residents appointed surrogate and they had not made effort to contact him to follow up on the referral for the nodule biopsy.<br><br>On [DATE] at 10:30 AM a review of the capacity for Resident #29 identified three (capacity forms completed.<br><br>The capacity form completed by the attending physician dated [DATE] was identified to give the resident capacity. This capacity form was signed by the physician but not dated to identify the date of completion.<br><br>A further review of the physician notes identified the physician note was completed on [DATE] and stated the patient was alert and oriented x1 with no acute distress and that Resident #29 does not have capacity at this time.<br><br>The capacity form completed by the attending physician on [DATE] identified Resident #29 to be incapacitated. This capacity form was signed by the physician but not dated to identify the date of completion.<br><br>A further review of the physician's notes did not identify a note for the physician's visit.<br><br>The capacity form completed by the attending physician on [DATE] identified Resident #29 to be incapacitated and Resident #29 sister was appointed to be her surrogate. This capacity form was signed by the physician but not dated to identify the date of completion.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A further review of the physician's notes did not identify a note for the physician's visit.<br><br>A review of Resident #29's Physician Orders for Scope of Treatment (POST) identified 3 POST forms on file.<br><br>Post form is dated [DATE] with the Licensed Practical Nurse (LPN) #03 identified to have assisted Resident #29 to complete the form. Resident #29 had identified yes to cardiopulmonary resuscitation (CPR) with full treatments with additional orders for IV fluids for six (6) weeks.<br><br>Authorization was initiated to allow changes if decision making capacities, is loss. Resident #29's grandson was marked to be her emergency contact. The primary care provider name and phone number are not listed. No participants are marked to have participated in the discussion. This form was signed by the Nurse Practitioner and dated [DATE].<br><br>b) Post form is dated [DATE] with the Nurse Practitioner identified to have assisted<br><br>Resident #29 to complete the form. Resident #29 had identified at this time to no<br><br>cardiopulmonary resuscitation (CPR) with comfort-focused treatments and not artificial means of nutrition. Additional orders for no IV fluids, no weights and no labs with exceptions.<br><br>Authorization was not initiated to allow changes if decision making capacities, is loss. The participants noted to attend the discussion is marked the patient with decision making capacity. This form did not identify the Residents social security number, the residents address/zip code or the residents preferred name. This form identifies Resident #29s grandson as the Residents emergency contact. This form was signed by the Nurse Practitioner and dated [DATE]. The Nurse Practitioner phone number and license/certification number is not identified on this form.<br><br>c) Post form was dated [DATE] with the Nurse Practitioner identified to have assisted<br><br>Resident #29 to complete the form. Resident #29 had identified at this time to no<br><br>cardiopulmonary resuscitation (CPR) with comfort-focused treatments and not artificial means of nutrition. Additional orders for no IV fluids, no weights and no labs with exceptions. Authorization was not initiated to allow changes if decision making capacities, is loss. The participants noted to attend the discussion is marked the patient with decision making capacity.<br><br>This form does identify the Residents social security number, the residents address/zip code. This form identifies that the Resident #29s grandson name is marked off and the Residents sisters' information is written over top of the grandson's emergency contact information. Resident #29's sister is marked to be the MPOA Representative/surrogate. This form was signed by the Nurse Practitioner and dated [DATE]. The Nurse Practitioner phone number and license/certification number is identified on this form.<br><br>Post form was dated [DATE] with the Nurse Practitioner identified to have assisted<br><br>Resident #29 to complete the form. Resident #29 had identified at this time to no<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | cardiopulmonary resuscitation (CPR) with comfort-focused treatments and not artificial means of nutrition. Additional orders for no IV fluids, no weights and no labs with exceptions. Authorization was not initialed to allow changes if decision making capacities, were loss. The participants noted to attend the discussion is marked the patient with decision making capacity.<br><br>This form does identify the Residents social security number, the residents address/zip code. This form identifies that the Resident #29s grandson name is marked off and the Residents sister's information is written over top of the grandson's emergency contact information. Resident #29's sister is marked to be the MPOA Representative/surrogate. This form was signed by the Nurse Practitioner and dated [DATE]. The Nurse Practitioner phone number and license/certification number is identified on this form.<br><br>During an interview with the NP on [DATE] at 10:38 AM the NP stated that she does her own capacity determination prior to completing the post forms. She further stated she had contacted the grandson on [DATE] and that the grandson is considering treatment for his grandmother.<br><br>The facility was notified of the Immediate Jeopardy (IJ) on [DATE] at 01:30 PM. The abatement plan of correction (POC) was submitted and accepted by the state agency on [DATE] at 05:15 PM. The POC read as follows:<br><br>The Nurse Practitioner (NP) called resident #29 health care surrogate (HCS) on [DATE] at 12: 35 pm regarding thyroid mass on Computed Tomography (CT) scan and the HCS stated he wanted to talk with a friend of his who is a doctor and let us know in ,d+[DATE] days how to proceed. The Director of Nursing contacted the HCS on [DATE] to follow up.<br><br>All residents of the facility have the potential to be affected.<br><br>The Director of Nursing (DON)/designee conducted an audit on [DATE] for all current residents admissions/readmissions since [DATE] discharge summary/orders to ensure physician recommendations are followed up with the resident/ responsible party with any corrective action immediately upon discovery.<br><br>The Director of Nursing (DON)/designee conducted an audit on [DATE] for all current residents to ensure that the most recent physician visit matches the capacity form completed by the physician with any corrective action immediately upon discovery.<br><br>The Director of Nursing (DON)/designee conducted an audit on [DATE] for all current residents to ensure that the correct responsible party has signed the Physician Order Scope of Treatment (POST) form with any corrective action immediately upon discovery.<br><br>Re-education was provided by the Director of Nursing(DON)/Designee on [DATE] to all licensed nurses regarding new admissions/readmissions to ensure discharge summary/orders with physician recommendations are followed up with the responsible party. A Post-test to validate understanding. Any licensed nurses not available during this time frame will be provided re-education, including post-test upon the beginning of the next shift to work. New licensed nurses will be provided education, including post-test during orientation by the DON/designee.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Re-education was provided by the Director of Nursing(DON)/Designee on [DATE] to the Nurse Practitioner and Medical Director regarding documentation that the capacity of the resident matches the capacity form and when completing a POST form with the responsible party ensure the form is signed by the correct responsible party. A Post-test to validate understanding. Any Nurse Practitioner (NP) and Medical Director not available during this time frame will be provided re-education, including post-test upon the beginning of the next shift to work.<br><br>The Unit Managers (UM)/designee will monitor starting on or before [DATE] new admissions and readmissions to ensure discharge summary/orders with physician recommendations are followed up with the responsible party daily for 2 weeks including weekends and holidays, then 5 times a week for 4 weeks, then 3 times a week for 4 weeks then randomly thereafter.<br><br>The Unit Managers (UM)/designee will monitor medical provider notes starting on or before [DATE] to ensure the resident capacity matches the resident capacity form daily for 2 weeks including weekends and holidays, then 5 times a week for 4 weeks, then 3 times a week for 4 weeks then randomly thereafter.<br><br>The Unit Managers (UM)/designee will monitor new admissions/readmissions and residents with a change in advance directives starting on or before [DATE] to ensure the POST form is signed by the correct responsible party daily for 2 weeks including weekends and holidays, then 5 times a week for 4 weeks, then 3 times a week for 4 weeks then randomly thereafter.<br><br>Results of monitors will be reported by the Director of Nursing (DON) /designee monthly to the Quality Improvement Committee (QIC) for any additional follow-up and or in-servicing until the issue is resolved, then randomly thereafter as determined by the QIC committee.<br><br>On [DATE] at 08:25 PM, after staff interviews of the implementation of the POC, the IJ was abated.<br><br>The IJ began on [DATE] and ended on [DATE]. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<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** 49467<br><br>Based on Record review and family and staff interview, the facility failed to ensure residents were provided with a safe environment to prevent elopement, resulting in Resident #120 leaving the facility and being found outside the facility, deceased . The facility ' s failure to ensure residents did not exit the facility unattended on [DATE] placed all at risk residents who could have exited the facility in an Immediate Jeopardy (IJ) situation. This will be cited at past noncompliance because the facility corrected the failure as of [DATE], prior to this survey. This was true for one (1) of six (6) residents reviewed for accidents and one (1) of three (3) reviewed for elopement during the survey process.Resident Identifier: 120. Facility census: 64<br><br>Findings include:<br><br>A) Facility report/investigation<br><br>According to the facility ' s report:<br><br>At approximately 12:35 PM on [DATE], Resident #120 was found outside the facility, face down, unresponsive. Preliminary investigation by the facility revealed a nurse had checked Resident #120's vital signs at approximately 12:00 PM. the patient allegedly exited on foot through the 400 hall door located adjacent to the hallway containing her room. At approximately 12:35 PM a staff member returning to the facility from lunch witnessed the resident face down in a grassy area adjacent to the sidewalk located to the rear of the center. The initial staff member entered the center alerting others of the patient's location. Licensed nursing staff exited the center, arrived on scene, assessed the resident, and determined her decision maker had selected a do not resuscitate (DNR) status.<br><br>Law enforcement and EMS were notified at approximately 12:35 PM. Foul play was ruled out at this time.<br><br>Initial investigation revealed the staff were not aware of Resident #120 exiting the facility. There was an elopement assessment completed for Resident #120 on [DATE], which revealed she was not an elopement risk.<br><br>B) Family interview<br><br>At approximately 1:13 PM on [DATE], an interview was conducted with a family member of Resident #120. During the interview, the family member stated Resident #120 came to the facility for therapy, due to losing strength, following gallbladder surgery. The family member stated they were notified by the facility on [DATE] that Resident #120 was found outside the facility and had passed away. The family member states the family was told in a meeting with administrative staff the facility was unaware of how Resident #120 exited the facility. The family member states Resident #120 was not a wanderer and did not leave her room unless family was there or she was attending therapy. The family member states the facility was in possession of video footage of the incident.<br><br>C) Staff interview<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | At approximately 10:50 AM on [DATE], an interview was conducted with the Administrator and Director of Nursing (DON) concerning the incident involving Resident #120. During the interview, the DON stated the morning of the incident was very uncharacteristic for Resident #120, as she was up and dressed before 5:30 AM. The DON states Resident #120 usually slept in, stayed in her bed to eat breakfast, and would get up and get dressed much later in the morning. The DON states Resident #120 had complained of feeling nauseated and being extremely fatigued throughout the day. The administrator stated no one heard alarms going off that morning, and when they arrived at the facility, the alarms were checked, and all functioned. When asked about the video footage, the administrator stated the facility was not in possession of it, but the senior administrator, who oversees multiple facilities in the region, and assisted with the investigation, would be able to obtain the footage. The administrator and DON states, to their knowledge, no alarms were disabled in the facility.<br><br>At approximately 11:30 AM on [DATE], an interview was conducted with the Senior Administrator (SA) regarding the incident. During the interview, the SA stated the facility did not know exactly how Resident #120 was able to leave the facility. The SA stated, to their knowledge, no one turned off any alarms in the facility and, upon their arrival to the facility to assist with the investigation, all doors and alarms functioned. The SA states they are not in possession of video footage, but could obtain it. The SA then informed this surveyor they would arrive at the facility on [DATE] with the video footage of the incident.<br><br>At approximately 12:09 PM on [DATE], an interview was conducted with Unit Manager (UM) #36 regarding this incident. During the interview, UM #36 stated they were in the facility that day to cover a call in and was working on the 400 hall. UM #36 stated Resident #120 got up early that morning, which was uncharacteristic for her. UM #36 states Resident #120 complained of being tired throughout the day but they did not think anything of it because she had gotten up so early. UM#36 states they did not hear any alarms throughout the day and did not know anything was wrong until they heard someone saying they needed help outside, at which point, they walked outside and realized it was Resident #120.<br><br>At approximately 12:20 PM on [DATE] an interview was conducted with the Assistant Director of Nursing (ADON). The ADON states they were in the facility that day to split a shift with UM #36. The ADON states they arrived at the facility around 12:30 and never heard an alarm going off. The ADON states they went to their office and was there for about five (5) minutes and heard a housekeeper yelling for help. At this time, the ADON states they went outside and saw a nurse attending to Resident #120. The ADON states they returned to the facility to obtain the code status for the resident and the crash cart, if needed.<br><br>At approximately 12:30 PM on [DATE], an interview was conducted with Licensed Practical Nurse (LPN) #34 concerning the incident for Resident #120. LPN #34 states they work on the 100 and 300 units and was not familiar with Resident #120 due to her residing on the 400 hall. LPN #34 states they heard someone screaming they needed help at the back laundry door. When LPN #34 walked out the door, they saw Resident #120 lying face down in the grass. LPN #120 states I immediately got down and rolled her over. She was blue in the face and had blood on her where she had fallen. I didn't know who she was because I had never worked with her before, I don't work on that unit. LPN #34 stated they did not hear any alarms going off at that time.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A copy of the work order for the facility's alarm system revealed the alarms were checked on the doors upon their arrival on [DATE] and that upon their inspection, all doors and alarms were operational.<br><br>D) Video Footage<br><br>At approximately 9:30 AM on [DATE], the SA arrived at the facility and the video footage was viewed. The video footage viewed was from cameras from another building, with cameras facing the back of the facility. The footage was grainy and unclear. A figure, wearing clothes matching the description of Resident #120's, was observed exiting the facility and walking towards the location where Resident #120 was found. The figure in the video walked out of the frame of view before falling.<br><br>E) Education<br><br>UM #36, the ADON, LPN #34, Nurse Aide (NA) #20, and Registered Nurse (RN) #35 all acknowledged understanding for education on elopement, door alarms, and elopement drills.<br><br>The Immediate Jeopardy Template was presented to the facility administration on [DATE] at 2:26 PM.<br><br>F) Plan of Correction<br><br>Staff interviews were immediately taken by everyone present and working at the time of the incident by the Administrator and Senior Administrator on [DATE]. Interviews were then conducted with all other staff over the phone or in person.<br><br>All doors and door alarms were assessed for proper functionality by the Senior Maintenance Director on [DATE].<br><br>All windows were assessed to have stop gaps and screens in them by the Senior Maintenance Director<br><br>Secondary door alarms were placed on all exit doors by the Senior Maintenance Director on [DATE].<br><br>Fifteen minute checks were started on [DATE] to ensure functionality of all doors and door alarms.<br><br>Staff educations with post tests were initiated on [DATE] related to elopement process and door alarms by the Unit Manager. Staff educations continue to occur until all staff have been educated by the Director of Nursing/Designee.<br><br>NewTech Systems assessed all exit doors and door alarms for functionality with the Senior Maintenance Director on [DATE].<br><br>All residents were re-assessed for elopement by the Unit Manager on [DATE].<br><br>An elopement/fire alarm drill was completed by the facility on [DATE] that included all staff on all shifts. Mock elopement/fire drills will continue weekly across all shift x 4 weeks and monthly across all shifts x 2 months, then as determined by the QAPI committee.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] while performing checks on all doors, the 400 hall door in the egress was noted not to alarm or release the mag lock. Door was addressed with readjustment of the mag lock by the Maintenance Director and is in working order. (Surveyors verified the functionality of the door during survey process.)<br><br>All doors are audited twice daily to ensure alarms are functioning and that they open after 15 seconds.<br><br>All alarm batteries are dated and will be monitored and changed every 30 days.<br><br>Pulled Risk Management System for past 90 days for elopements.<br><br>On [DATE] while checking alarms on evening shift, it was noted the perimeter alarm did not sound on the 300 hall door. Both the mag lock and the secondary alarm functioned properly.<br><br>Doors and alarms without concerns, monitoring will change from every 15 minutes to every hour. Doors will be checked to ensure the alarm sounds and that it opens after 15 seconds every hour beginning on [DATE]. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650<br><br>The facility failed to address the needs of residents at risk or already experiencing impaired nutrition and hydration. The facility declined the Registered Dietician dietary recommendations without notifying the surrogate and failed to obtain weights. This was true for two (2) of four (4) residents reviewed for nutritional needs during the long term care survey process. Resident identifiers: Resident #29 and Resident #61. Census. 64.<br><br>a) Resident #29- nutritional support<br><br>During a medical record review on [DATE] at approximately 10:00 AM of Resident #29's medical record, it is identified that the resident has a Brief Interview for Mental Status (BIMS) of 06. It is further identified that the physician note completed on [DATE] stated that the patient was alert and oriented x 1 with no acute distress and that Resident #29 does not have capacity at this time.<br><br>It is further identified that the Nurse Practitioner (NP) assisted Resident #29 to complete the Physician Orders for Scope of Treatment (POST) form on [DATE]. The POST form was for no cardiopulmonary resuscitation (CPR) with comfort-focused treatments and no artificial means of nutrition. Additional orders were hand written on the Post form for no intravenous infusion (IV) fluids, no weights and no labs with exceptions. The authorization was not initialed to allow changes if decision making capacities lost. The participants noted to attend the discussion with the NP was marked for the patient with decision making capacity.<br><br>With further review it is identified that the facility Dietitian completed a nutritional assessment on [DATE]. The evaluation/nutritional plan is as written: Readmission assessment: 80 yr (year)/old female readmitted following fracture of left femur and UTI (urinary tract infection) with other pmh (past medical history)/dx (diagnosis) including Alzheimer's, dementia, CKD 3A (Stage 3 chronic kidney disease), Type 2 DM (diabetes mellitus) cognitive communication deficit, and history of falling. Resident DNR (Do Not Resuscitate), CMO (comfort measures only), no intravenous infusion (iv)/weights (wts)./Percutaneous Endoscopic Gastronomy (PEG) tube/labs with exception. Working with ST (speech therapy), PT (physical therapy) OT (occupational therapy). Loss of (-24.4%) -20.0 lbs (pounds) x 14 months. CBW (current body weight) 98.2 pounds. IBW (initial body weight) 125 lbs. Regular diet order with good po (by mouth) intake since admit. Intakes , d+[DATE]% of most meals since readmit. Medications reviewed. Registered Dietician recommendation for house shakes bid (2 times daily) for nutrition support.<br><br>Further review of the medical record identified a nursing note dated [DATE] identified that the (typed as written) RD with recommendation for house shakes BID, however NP declines this order at thist time. Resident refuses them. Resident is comfort care with no weights as well. Appetite and inake sufficient at this time.<br><br>During this medical record review there were no notes identified of the surrogate who was appointed by the facility physician to have been contacted in regards to the Registered Dietitians recommendation for house shakes for Resident #29's nutritional support.<br><br>(continued on next page) |

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| | 515100 | A. Building<br>B. Wing | 07/11/2024 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | [DATE] 11:43 AM during an interview with Nurse Practitioner (NP) and Director of Nursing (DON), She further stated that she had declined the dietary recommendations based on the residents comfort care. The NP stated that she had not made any attempt to notify the surrogate for their choice of care for the resident. She stated that she didn't feel like she needed to contact the surrogate because she felt that she knew what the resident wanted since she had talked with her on [DATE]. The NP stated that the resident had refused at that time do do anything with her gall bladder so the NP knew she would refuse them. She stated that because of the resident having issues with her gallbladder the NP felt that the recommended milk product would only irritate her stomach. The NP further stated she did not consider any alternate supplement for the nutritional recommendation made by the Registered Dietician for the resident nutritional support.<br><br>On [DATE] at approximately 11:00 AM during an interview with the NP, she stated she was not aware of the physician note that was completed on [DATE] that identified the patient as alert and oriented x 1 with no acute distress and that Resident #29 does not have capacity at this time. When the NP was asked why an invalid POST form was completed with Resident #29 after being deemed incapacitated on [DATE] by the facility attending physician, the NP stated that she does her own capacity determination prior to completing the post forms. She further acknowledged that with the physician capacity form deeming the resident to be incapacitated on [DATE] that the POST form she completed on [DATE] was not valid.<br><br>The NP further agreed that the surrogate should have been contacted for their right to exercise the resident's rights in determining the decision for the recommendation made by the Registered Dietician for house shakes bid for the resident nutrtional support.<br><br>50552<br><br>b) Resident #61<br><br>On [DATE] at 09:33 PM, a review of Resident #61's medical record was performed. It revealed that Resident #61 had a physician's order for weekly weights for 4 weeks then every month entered on [DATE], along with a diet order for Regular/Liberalized diet, Regular Texture entered on [DATE] also. Further review of Resident #61's medical record revealed the following weights entered into Point Click Care (PCC):<br><br>[DATE] 07:37 124.0 Lbs Standing LLEE44 (Manual)<br><br>[DATE] 11:59 125.8 Lbs Standing LLEE44 (Manual)<br><br>[DATE] 16:19 129.6 Lbs Standing ksurface (Manual)<br><br>On [DATE] at 02:54 PM, an interview was conducted with the Director of Nursing. At that time the DON acknowledged the physician's order for weekly weights had not been followed and that Resident #61 had weights missing. |

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|---|---|
| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>50552<br><br>Based on record review, staff interview and observation, the facility failed to follow physician's order related to volume of feeding to be administered to Resident #52. This was true for 1 (one) of 1 (one) resident reviewed for the Long-Term Care Survey Process. Facility census: 64. Resident identifier: #52.<br><br>Findings include:<br><br>a) Resident #52<br><br>On 07/10/24 at approximately 12:30 PM, a review of Resident #52's medical record was completed which revealed that in the physician's orders, the following order was present:<br><br>Order: five times a day for Nutrition Jevity 1.5 CAL Administer bolus via gravity 320 ML 5 times per day FLUSH tube with 30 ML of water prior to feeding, and a final 30 ML flush of water at the end of each feeding. Total volume of flush = 300 ML/24 hrs (excluding medication flushes). Total volume of nutrient + this flush = 380 ml (1900 ML/24 hrs.)<br><br>On 07/10/24 at 12:53 PM, a tube feeding administration observation was completed for Resident #52 with LPN #46. When LPN #46 was preparing the feeding at the cart to take into the room, LPN #46 poured feeding from a 1000 milliliter (ml) ready to hang bottle that was stored in the 3rd drawer of LPN #46's medication cart. The bottle was labeled with Resident #52's name and dated as being opened 07/10/24. LPN #46 poured the Jevity 1.5 into 2 (two) 7 (seven) ounce non-graduated plastic cups.<br><br>At this time, this Surveyor asked LPN #46 how much Jevity 1.5 the order stated to be administered. LPN #46 responded, 320 ml's. This Surveyor then asked how LPN #46 knew how much feeding was in the 2 (two) 7 (seven) ounce cups. LPN #46 responded, Me and my manager measured it yesterday, there is 207 ml's in each 7 (seven) ounce cup, which is 414 ml' This Surveyor then asked LPN #46 how he was able to determine if he had the correct amount because both cups had varying amounts close to the top (lip) of the cup. LPN #46 stated that he would pinch the Percutaneous Endoscopic Tube (PEG) of Resident #52 and measure the amount using the graduated syringe. LPN #46 also stated I have asked for graduated cups/cylinder to measure the feeding, but we haven't gotten any. I can see how you are questioning this. At that time, LPN #46 and this Surveyor went into Resident #52's room to administer the feeding. LPN #46 was observed pouring the feeding into the graduated syringe without pinching the tube to use the graduated syringe as a measuring device. LPN #46 was then noted to completely administer both 7 (seven) ounce cups of feeding. After administrating, LPN #46 acknowledged that he did not use the graduated syringe to measure the feeding and administered both cups of feeding which was more feeding than the physician's order called for. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>49650<br><br>Based on facility record review and staff interview, the facility failed to complete the Nurse staffing information accurately. Some of the data required was not completed, the direct care staff and the total actual hours worked by the direct care staff was inaccurate. This was true for nine (9) of ten (10) Nurse Staffing forms reviewed during the long term care survey process. Census: 24.<br><br>Findings included:<br><br>a) 03/19/23<br><br>During a review of the Daily Staffing form on 07/09/24 at approximately 7:30 PM, the total direct care staffing hours identified was 148 hours with a hours per patient day (hppd) for a census of 65 at 2.28. During a review of the Genstar daily staffing sheet and the Genstar daily time detail, the actual total direct care staffing hours were 164.65 with an HPPD of 2.53.<br><br>07/10/24 at 08:58 AM during an interview with the Administrator, the Administrator agreed that the total direct care staffing hours identified was not correct for 03/19/23.<br><br>b) 05/14/23<br><br>During a review of the Daily Staffing form on 07/09/24 at approximately 07:30 PM, the total direct care staffing hours identified was 160 with a hours per patient day for a census of 63 at 2.53. During a review of the Genstar daily staffing sheet and the Genstar daily time detail, the actual total direct care staffing hours were 167.20 with an HPPD of 2.65.<br><br>07/10/24 at 08:58 AM during an interview with the Administrator, the Administrator agreed that the total direct care staffing hours identified was not correct for 05/14/23.<br><br>c) 07/02/23<br><br>During a review of the Daily Staffing form on 07/09/24 at approximately 07:30 PM, the total direct care staffing hours identified was 159.50 with a hours per patient day for a census of 61 at 2.61. During a review of the Genstar daily staffing sheet and the Genstar daily time detail, the actual total direct care staffing hours were 163.80 with an HPPD of 2.68.<br><br>During a further review of the Daily Staffing form the total hours for the evening shift direct care staffing was not completed.<br><br>07/10/24 at 08:58 AM during an interview with the Administrator, the Administrator agreed that the total direct care staffing hours identified was not correct for 07/02/23 and the evening shift direct care staffing hours total was not completed.<br><br>d) 11/23/23<br><br>(continued on next page) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the Daily Staffing form on 07/09/24 at approximately 07:30 PM, the total direct care staffing hours identified was 163 with a hours per patient day for a census of 65 at 2.50. During a review of the Genstar daily staffing sheet and the Genstar daily time detail, the actual total direct care staffing hours were 157.92 with an HPPD of 2.43.<br><br>07/10/24 at 08:58 AM during an interview with the Administrator, the Administrator agreed that the total direct care staffing hours identified was not correct for 11/23/23.<br><br>e) 05/07/24<br><br>During a review of the Daily Staffing form on 07/09/24 at approximately 07:30 PM, the total direct care staffing hours identified was 158.5 with a hours per patient day for a census of 63 at 2.501 During a review of the Genstar daily staffing sheet and the Genstar daily time detail, the actual total direct care staffing hours were 140.85 with an HPPD of 2.235.<br><br>During a review of the CNA's on 07/09/24 at approximately 07:30 PM it is identified that the day shift CNA total hours and the total direct care staffing hours for the day shift staff (RN, LPN, CNA) was not completed.<br><br>During a review of the direct care staffing on 07/09/24 at approximately 07:30 PM, it is identified that the Registered Nurse (RN) direct care total staff for the day to be 8 RN Staff members, this included but was not limited to the RN Administrative Clinical Reimbursement Staff, RN Administrative Nurse Practice Educator, RN Unit Manager, RN Assistant Director of Nursing and the Director of Nursing.<br><br>07/10/24 at 08:58 AM during an interview with the Administrator, the Administrator agreed that the total direct care hours identified was not correct and the data was not completed for 05/07/24. A further review was completed with the Administrator of The Labor Classification/ Job Title section of the Centers for Medicare & Medicaid Services- Electronic Staffing Data Submission- Payroll-Based Journal- Long-Term Care Facility- Policy Manual Version 2.6. This section defines that the Labor Classification/Job Title Reporting shall be based on the employee' s primary role and their official categorical title. It is understood that most roles have a variety of non-primary duties that are conducted throughout the day (e.g., helping out others when needed). Facilities shall still report just the total hours of that employee based on their primary role. CMS recognizes that staff may completely shift primary roles in a given day. For example, a nurse who spends the first four hours of a shift as the unit manager, and the last four hours of a shift as a floor nurse. In these cases, facilities can change the designated job title and report four hours as a nurse with administrative duties, and four hours as a nurse (without administrative duties). The Administrator agreed that based on the job descriptions being RN with administrative roles and the inability to identify how the RN with nursing administrative roles completed their individual eight (8) hours shifts of direct care for this shift, they should not be identified on the daily staffing form as total direct care staff for 05/07/24.<br><br>f) 05/08/24<br><br>(continued on next page) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the Daily Staffing form on 07/09/24 at approximately 07:30 PM, the total hours identified was 168 with a hours per patient day for a census of 64 at 2.62. During a review of the Genstar daily staffing sheet and the Genstar daily time detail, the actual total hours were 143.58 with an HPPD of 2.24.<br><br>During a review of the direct care staffing on 07/09/24 at approximately 07:30 PM, it is identified that the Registered Nurse (RN) direct care total staff for the day to be 9 RN Staff members, this included but was not limited to the RN Administrative Clinical Reimbursement Staff, RN Administrative Nurse Practice Educator, RN Unit Manager, RN Assistant Director of Nursing and the Director of Nursing.<br><br>07/10/24 at 08:58 AM during an interview with the Administrator, the Administrator agreed that the total direct care hours identified was not correct, the data was not completed for 05/08/24. A further review was completed with the Administrator of The Labor Classification/ Job Title section of the Centers for Medicare & Medicaid Services- Electronic Staffing Data Submission- Payroll-Based Journal- Long-Term Care Facility- Policy Manual Version 2.6. This section defines that the Labor Classification/Job Title Reporting shall be based on the employee' s primary role and their official categorical title. It is understood that most roles have a variety of non-primary duties that are conducted throughout the day (e.g., helping out others when needed). Facilities shall still report just the total hours of that employee based on their primary role. CMS recognizes that staff may completely shift primary roles in a given day. For example, a nurse who spends the first four hours of a shift as the unit manager, and the last four hours of a shift as a floor nurse. In these cases, facilities can change the designated job title and report four hours as a nurse with administrative duties, and four hours as a nurse (without administrative duties). The Administrator agreed that based on the job descriptions being RN with administrative roles and the inability to identify how the RN with nursing administrative roles completed their individual eight (8) hours shifts of direct care for this shift, they should not be identified on the daily staffing form as total direct care staff for 05/08/24.<br><br>g) 05/09/24<br><br>During a review of the Daily Staffing form on 07/09/24 at approximately 07:30 PM, the total hours identified was 192.5 with a hours per patient day for a census of 6 at 2.96. During a review of the Genstar daily staffing sheet and the Genstar daily time detail, the actual total hours were 183.56 with an HPPD of 2.86.<br><br>During a review of the direct care staffing on 07/09/24 at approximately 07:30 PM, it is identified that the Registered Nurse (RN) direct care total staff for the day to be 8 RN Staff members, this included but was not limited to the RN Administrative Clinical Reimbursement Staff, RN Administrative Nurse Practice Educator, RN Unit Manager, RN Assistant Director of Nursing and the Director of Nursing.<br><br>(continued on next page) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 07/10/24 at 08:58 AM during an interview with the Administrator, the Administrator agreed that the total direct care hours identified was not correct, the data was not completed for 05/09/24. A further review was completed with the Administrator of The Labor Classification/ Job Title section of the Centers for Medicare & Medicaid Services- Electronic Staffing Data Submission- Payroll-Based Journal- Long-Term Care Facility- Policy Manual Version 2.6. This section defines that the Labor Classification/Job Title Reporting shall be based on the employee' s primary role and their official categorical title. It is understood that most roles have a variety of non-primary duties that are conducted throughout the day (e.g., helping out others when needed). Facilities shall still report just the total hours of that employee based on their primary role. CMS recognizes that staff may completely shift primary roles in a given day. For example, a nurse who spends the first four hours of a shift as the unit manager, and the last four hours of a shift as a floor nurse. In these cases, facilities can change the designated job title and report four hours as a nurse with administrative duties, and four hours as a nurse (without administrative duties). The Administrator agreed that based on the job descriptions being RN with administrative roles and the inability to identify how the RN with nursing administrative roles completed their individual eight (8) hours shifts of direct care for this shift, they should not be identified on the daily staffing form as total direct care staff for 05/09/24.<br><br>h) 06/08/24<br><br>During a review of the Daily Staffing form on 07/09/24 at approximately 07:30 PM, the total direct care staffing hours identified was 162.5 with a hours per patient day for a census of 62 at 2.62. During a review of the Genstar daily staffing sheet and the Genstar daily time detail, the actual total hours were 168.12 with an HPPD of 2.71.<br><br>07/10/24 at 08:58 AM during an interview with the Administrator, the Administrator agreed that the total direct care staffing hours identified was not correct for 06/08/24. |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552<br><br>Based on record review and staff interview, the facility failed to provide the necessary behavioral health care and psychiatric services to Resident #61. This was true for 1 (one) of 3 (three) residents reviewed for the Long Term Survey Process. Facility census: 64. Resident identifier: Resident #61.<br><br>Findings include:<br><br>a) Resident #61<br><br>On 07/08/24 at 9:11 PM a review of Resident #61's medical record was performed. It revealed there were several notes in the documentation related to, refusal of care, physical and verbal aggression towards staff and other residents. During the review, a progress note dated 07/06/24 at 6:05 PM read as follows :<br><br>This resident was wondering [SIC] in and out of other residents rooms this morning. He was sitting on another residents bed and refused to leave. Multiple attempts to talk with resident and offer food drinks and to go to the bathroom were unsuccessful. Resident was attempting to hit at staff and the residents of the room he had entered. Resident eventually left this residents room and was shown to his own room. Around lunch this resident was very tearful and stated he wanted to go home. He walked with me to the courtyard and we sat outside for awhile. This seemed to help calm him. He has been up wondering[SIC] in the hallways since dinner was completed. No noted further behaviors. Physician is aware.<br><br>In addition, review of Resident #61's medical recorder revealed that on 05/19/24 at 11:15 PM the following progress note was entered into Resident #61's medical record:<br><br>Resident continues to be very restless with poor safety awareness. Attempted again to contact provider at Vis a Vis. Vis a Vis provider's microphone not working. Contacted Dr. [NAME] and instructed to administer 10 milligram (mg) Zyprexa intramuscularly (IM). Medication administered as ordered and resident assisted back to bed. Resting in bed at this time with 0 (zero) complaints of (c/o) pain/discomfort.<br><br>This note was revealed to be a follow up to a Change in Condition Evaluation with an effective date and time of 05/19/24 at 11:10 PM. During this review of the Change in Condition Evaluation, it revealed the change in condition signs and symptoms identified was documented as agitation and restlessness, with the most recent vitals signs documented dated and timed 05/19/24 at 05:16 AM. Further review of this Change in Condition evaluation revealed, under the section for Resident Representative Notification that the Department of Health and Human Resources representative was the name of the resident representative notified, however, the section for the date and time of that notification was left blank.<br><br>On 07/09/24 at 09:33 AM, a review of Resident #61's diagnosis list was reviewed. Resident #61's diagnosis list revealed that Resident #61 had been diagnosed with the following conditions<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | *Unspecified Dementia, unspecified severity, with other behavioral disturbance onset 05/21/24.<br><br>* Altered Mental Status, unspecified, onset 05/17/24.<br><br>* Generalized Anxiety Disorder, onset 06/25/24.<br><br>* Major Depressive Disorder, Recurrent, Moderate, onset 06/13/24.<br><br>At this time, Resident #61's care plan was also reviewed, which revealed that Resident #61 had a care plan entered with a focus of Resident/Patient is at risk for or exhibits symptoms of delirium related to dementia was present. In this care plan each intervention listed had a creation date of 06/05/24 with no revisions noted. In addition, no care plan addressing Resident #61's anxiety or depression diagnosis. Further review did not reveal a care plan related to Resident #61's behaviors such as wandering at night, refusal of care and physical and verbal aggression towards staff and other residents.<br><br>On 07/10/24 at 03:29 PM, an interview was conducted with the Director of Nursing (DON). At that time, the DON stated that the best thing for Resident #61 when he is exhibiting behaviors is to take him outside. That seems to work the best. When asked if Resident #61's behaviors had been taken to the IDT committee to review for a root cause with new behavioral interventions to be added to Resident #61's care plan with each occurrence of behaviors, the DON acknowledged Resident #61's behaviors had not been reviewed by the IDT committee and that the care plan had not been revised.<br><br>On 07/09/24 at 3:40 PM, an additional interview was conducted with the DON. At that time, the Social Worker (SW) and Assistant Director Of Nursing (ADON) were present. When this Surveyor asked the DON if a psychological appointment had been made for Resident #61, and if not, why not, the DON responded, I don't have an answer for that. We can certainly try it, it can't hurt. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.<br><br>50552<br><br>Based on record review and staff interview, the facility failed to provide necessary appropriate person-centerd care and individualized treatment and services to meet Resident #61's behavioral and psychosocial needs. This was true for 1 (one) of 3 (three) residents reviewed for the Long Term Survey Process. Facility census: 64. Resident identifiers: Resident #61.<br><br>Findings include:<br><br>a) Resident #61<br><br>On 07/08/24 at 9:11 PM a review of Resident #61's medical record was performed. It revealed there were several notes in the documentation related to physical and verbal aggression towards staff and other residents. During the review, the following documentation was revealed to be entered into Resident #61's medical record:<br><br>On 07/06/24 at 6:05 PM a progress note read as follows :<br><br>This resident was wondering [SIC] in and out of other residents rooms this morning. He was sitting on another residents bed and refused to leave. Multiple attempts to talk with resident and offer food drinks and to go to the bathroom were unsuccessful. Resident was attempting to hit at staff and the residents of the room he had entered. Resident eventually left this residents room and was shown to his own room. Around lunch this resident was very tearful and stated he wanted to go home. He walked with me to the courtyard and we sat outside for awhile. This seemed to help calm him. He has been up wondering[SIC] in the hallways since dinner was completed. No noted further behaviors. Physician is aware.<br><br>On 6/15/2024 at 21:21 PM a Medication Administration Record progess note read as follows:<br><br>Note Text: Ativan Oral Tablet 1 MG<br><br>Give 1 tablet by mouth two times a day for anxiety r/t restlessness<br><br>Resident refused medication. Spit medication into floor. Provider aware.<br><br>On 06/13/24 at 21:44 PM a nursing skilled evaluation read as follows:<br><br>Level of cognitive impairment: Severe impairment (affecting all areas of judgement). Resident is incoherent. Speech is clear. Language barrier: No. Resident usually makes self understood. Resident sometimes understands others. Mental Status Note: Poor safety awareness d/t Dementia. Hx: falls.<br><br>Mood and Behavior: Resident is agitated. Resident is anxious. Anxious - No recent change in mood. Agitated - No recent change in mood.<br><br>(continued on next page) |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident is awake at night. Resident wanders at night.<br><br>Resident verbalizes expressions of fear / depression.<br><br>Resident is currently experiencing unwanted behavior(s).<br><br>Delusions: Chronic.<br><br>Hallucinations: Chronic.<br><br>Refuses care: Chronic.<br><br>Resident is refusing to wear denture(s).Resident is refusing to allow dressing to be changed. Resident is refusing to receive a bath.<br><br>Wandering: Chronic.<br><br>Withdrawn: Chronic.<br><br>Mood & Behavior Note: Increased anxiety, anger, agitation, and depression. When awake at night, does not understand not to go into other resident's rooms. Wanders. Wander guard to right ankle.<br><br>Nutrition:<br><br>Change in appetite noted. Decrease in fluid intake noted.<br><br>Complaints of thirst: No.<br><br>Nutrition note: Decreased fluid intake. Decreased appetite.<br><br>Safety Note: Wander guard to right ankle. Poor safety awareness d/t dementia.<br><br>Functional: Able to move all extremities. Upper extremity ROM: No impairment. Lower extremity ROM: No impairment.<br><br>Gait is unsteady.<br><br>Balance is poor.<br><br>At this time, Resident #61's care plan was also reviewed, no documentation was revealed related to Resident #61's tearfulness over wanting to go home, his refusal of care or verbal or physical aggression.<br><br>On 07/09/24 at 09:33 AM, a review of Resident #61's diagnosis list was reviewed. Resident #61's diagnosis list revealed that Resident #61 had been diagnosed with the following conditions<br><br>*Unspecified Dementia, unspecified severity, with other behavioral disturbance onset 05/21/24.<br><br>(continued on next page) |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | * Altered Mental Status, unspecified, onset 05/17/24.<br><br>* Generalized Anxiety Disorder, onset 06/25/24.<br><br>* Major Depressive Disorder, Recurrent, Moderate, onset 06/13/24.<br><br>At this time, a further review of Resident #61's care plan was performed, which revealed that Resident #61 had a care plan entered with a focus of Resident/Patient is at risk for or exhibits symptoms of delirium related to dementia was present. In this care plan, each intervention listed had a creation date of 06/05/24 with no revisions noted. In addition, no care plan addressing Resident #61's anxiety or depression diagnosis was present. Further review did not reveal a care plan related to Resident #61's behaviors such as tearfulness, hallucinations, delusions, wandering at night, refusal of care and physical and verbal aggression towards staff and other residents.<br><br>On 07/09/24 at 01:48 PM, the Policy and Procedure titled, Behaviors: Management of Symptoms was reviewed. This policy stated that patients exhibiting behavioral symptoms would be individually evaluated to determine the behavior and that the Interdisciplinary Team (IDT) would identify the underlying cause of the behavior. The policy also stated that residents who display or who are diagnosed with mental or psychosocial adjustment difficulty would receive appropriate treatment and services to correct the problem or to attain the highest practicable mental and psychosocial well being.<br><br>On 07/10/24 at 03:29 PM, an interview was conducted with the Director of Nursing (DON). At that time, the DON stated that the best thing for Resident #61 when he is exhibiting behaviors is to take him outside. That seems to work the best. When asked if Resident #61's behaviors had been taken to the IDT committee to review for a root cause with new behavioral interventions to be added to Resident #61's care plan with each occurrence of behaviors, the DON acknowledged Resident #61's behaviors had not been reviewed by the IDT committee and that the care plan had not been revised.<br><br>On 07/09/24 at 3:40 PM, an addition interview was conducted with the DON. At that time, the Social Worker (SW) and Assistant Director Of Nursing (ADON) were present. When this Surveyor asked the DON if a psychological appointment had been made for Resident #61, and if not, why not, the DON responded, I don't have an answer for that. We can certainly try it, it can't hurt. |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552<br><br>Based on record review and staff interview, the facility failed to provide an interdisciplinary approach to address Resident #61's needs and to provide the necessary services related to the diagnosis of dementia. This was true for 1 (one) of 3 (three) residents reviewed during the Long Term Care Survey Process. Facility census: 64. Resident identifier: Resident #61.<br><br>Findings include:<br><br>a) Resident #61<br><br>On 07/08/24 at 9:11 PM a review of Resident #61's medical record was performed. It revealed there were several notes in the documentation related to, refusal of care, physical and verbal aggression towards staff and other residents. During the review, a progress note dated 07/06/24 at 6:05 PM read as follows :<br><br>This resident was wondering [SIC] in and out of other residents rooms this morning. He was sitting on another residents bed and refused to leave. Multiple attempts to talk with resident and offer food drinks and to go to the bathroom were unsuccessful. Resident was attempting to hit at staff and the residents of the room he had entered. Resident eventually left this residents room and was shown to his own room. Around lunch this resident was very tearful and stated he wanted to go home. He walked with me to the courtyard and we sat outside for awhile. This seemed to help calm him. He has been up wondering[SIC] in the hallways since dinner was completed. No noted further behaviors. Physician is aware.<br><br>In addition, review of Resident #61's medical recorder revealed that on 05/19/24 at 11:15 PM the following progress note was entered into Resident #61's medical record:<br><br>Resident continues to be very restless with poor safety awareness. Attempted again to contact provider at (name of provider) provider's microphone not working. Contacted Dr. [NAME] and instructed to administer 10 milligram (mg) Zyprexa intramuscularly (IM). Medication administered as ordered and resident assisted back to bed. Resting in bed at this time with 0 (zero) complaints of (c/o) pain/discomfort.<br><br>This note was revealed to be a follow up to a Change in Condition Evaluation with an effective date and time of 05/19/24 at 11:10 PM. During this review of the Change in Condition Evaluation, it revealed the change in condition signs and symptoms identified was documented as agitation and restlessness, with the most recent vitals signs documented dated and timed 05/19/24 at 05:16 AM. Further review of this Change in Condition evaluation revealed, under the section for Resident Representative Notification that the Department of Health and Human Resources representative was the name of the resident representative notified, however, the section for the date and time of that notification was left blank.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 07/09/24 at 09:33 AM, a review of Resident #61's diagnosis list was reviewed. Resident #61's diagnosis list revealed that Resident #61 had been diagnosed with Unspecified Dementia, unspecified severity, with other behavioral disturbance onset 05/21/24. Also at this time, Resident #61's care plan was reviewed, which revealed a care plan for Psychiatric Disorder Dementia and Parkinson's was noted. The care plan read as follows:<br><br>Focus:<br><br>* Resident #61 exhibit or is at risk for distressed/fluctuating mood symptoms related to : Psychiatric Disorder Dementia and Parkinson's.<br><br>Goal:<br><br>* Resident #61 will demonstrate improved mood state as evidenced by calmer appearance, happier demeanor by the next review date.<br><br>Interventions:<br><br>* Observe for signs of delirium, including delusions/hallucinations; notify physician/advance practice practitioner as needed.<br><br>* Observe for signs/symptoms of worsening sadness/depression/anxiety/fear/anger/agitation.<br><br>* Observe for worsening signs/symptoms of existing psychiatric disorder (e.g., mania, hypomania, frequent mood changes, etc.). Notify physician/advanced Practice Practitioner as needed.<br><br>* Observe for signs/symptoms of new psychiatric disorder (e.g., mania, hypomania, frequent mood changes, etc.). Notify physician/advanced Practice Practitioner as needed.<br><br>On 07/09/24 at 01:48 PM, the Policy and Procedure titled, Behaviors: Management of Symptoms was reviewed. This policy stated that patients exhibiting behavioral symptoms would be individually evaluated to determine the behavior and that the Interdisciplinary Team (IDT) would identify the underlying cause of the behavior. The policy also stated that residents who display or who are diagnosed with mental or psychosocial adjustment difficulty that the Center would implement individualized, person centered, non-pharmacological interventions as the initial behavior mitigation strategy and update the care plan accordingly.<br><br>On 07/10/24 at 03:29 PM, an interview was conducted with the Director of Nursing (DON). At that time, the DON stated that the best thing for Resident #61 when he is exhibiting behaviors is to take him outside. That seems to work the best. When asked if Resident #61's behaviors had been taken to the IDT committee to review for a root cause with new behavioral interventions to be added to Resident #61's care plan, the DON acknowledged Resident #61's behaviors had not been reviewed by the IDT committee and that the care plan had not been revised.<br><br>On 07/09/24 at 3:40 PM, an additional interview was conducted with the DON. At that time, the Social Worker (SW) and Assistant Director Of Nursing (ADON) were present. When this Surveyor asked the DON if a psychological appointment had been made for Resident #61, and if not, why not, the DON responded, I don't have an answer for that. We can certainly try it, it can't hurt. |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>50552<br><br>Based on record review, staff interview and resident interview, the facility failed to provide medically related social services for Resident #61 or residents that suffered abuse from Resident #61. This was true for 1 (one) of 3 (three) residents reviewed during the Long-Term Survey Process. Facility census: 64. Resident identifiers: Resident #61 and Resident #42.<br><br>Findings include:<br><br>a) Resident #61<br><br>On 07/08/24 at 1:30 PM an interview was conducted with Resident #42. At that time, Resident #42 stated, I don't sleep much at night due to Resident #61 coming into my room at night. I nap during the day so I don't wake up to find him in my room. It scares me. That's why I had the staff put up the stop sign in my door.<br><br>On 07/08/24 at 9:11 PM a review of Resident #61's medical record was performed. It revealed there were several notes in the documentation related to physical and verbal aggression towards staff and other residents. During the review, a progress note dated 07/06/24 at 6:05 PM read as follows :<br><br>This resident was wondering [SIC] in and out of other residents rooms this morning. He was sitting on another residents bed and refused to leave. Multiple attempts to talk with resident and offer food drinks and to go to the bathroom were unsuccessful. Resident was attempting to hit at staff and the residents of the room he had entered. Resident eventually left this residents room and was shown to his own room. Around lunch this resident was very tearful and stated he wanted to go home. He walked with me to the courtyard and we sat outside for awhile. This seemed to help calm him. He has been up wondering[SIC] in the hallways since dinner was completed. No noted further behaviors. Physician is aware.<br><br>At this time, Resident #61's care plan was also reviewed, no documentation was revealed related to Resident #61's verbal or physical aggression.<br><br>On 07/09/24 at 01:48 PM, the Policy and Procedure titled, Behaviors: Management of Symptoms was reviewed.<br><br>This policy stated that patients exhibiting behavioral symptoms would be individually evaluated to determine the behavior and that the Interdisciplinary Team (IDT) would identify the underlying cause of the behavior.<br><br>The policy also stated that residents who display or who are diagnosed with mental or psychosocial adjustment difficulty would receive appropriate treatment and services to correct the problem or to attain the highest practicable mental and psychosocial well-being.<br><br>(continued on next page) |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In addition, at this time, the Policy and Procedure titled, Abuse Prohibition was reviewed. This policy stated that verbal abuse was the use of oral, written or gestured language that willfully included disparaging and derogatory terms to patients or their families, within their hearing distance, regardless of their age, ability to comprehend or disability.<br><br>This policy and procedure further stated that examples of abuse include but are not limited to threats of harm and saying things to frighten a patient. The Policy and Procedure titled; Abuse Prohibition also stated that if the suspected abuse if patient to patient the Center will do the following:<br><br>* The patient who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed.<br><br>* The Center will provide adequate supervision when the risk of patient to patient altercation is suspected.<br><br>* The Center will be responsible for identifying patients who have a history of disruptive or intrusive interactions or who exhibit behaviors that make them more likely to be involved in an altercation.<br><br>* The patient representative and physician will be notified and any follow up recommended will be completed (e.g., psychiatric evaluation).<br><br>* The Center should seek alternative placement for the patient exhibiting the abusive behavior, if warranted.<br><br>* Immediately upon receiving information concerning a report of suspected or alleged abuse the allegation will be entered into the PCC Risk Management Portal.<br><br>* Allegations involving abuse will be reported not later than 2 (two) hours after the allegation is made.<br><br>* The Center will protect other patients from further harm.<br><br>* The Center will provide the patient with a safe environment.<br><br>* The Center will assign a representative from Social Services or designee to monitor the patients feelings concerning the incident, as well as the patients involvement in the investigation.<br><br>On 07/09/24 at 2:13 PM, an interview was conducted with the Director of Nursing (DON). During the interview, the DON acknowledged the following:<br><br>* Knowledge of Resident #61's wandering behaviors.<br><br>* Knowledge of Resident #61's verbal and aggressive behaviors.<br><br>* No knowledge of any incident occurring between Resident #42 and Resident #61.<br><br>(continued on next page) |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | * The residents in room Resident #61 had entered on 07/06/24 and verbally and physically threatened had not been identified.<br><br>* No assessment has been carried out on the unidentified residents.<br><br>* No follow up related to potential adverse outcomes from Resident #61's verbal and aggressive behavior had been completed for any resident this occurred with.<br><br>* No follow-up was made by Social Services for any of the incidents.<br><br>* The incident from 07/06/24 had not been reported and should have been.<br><br>* Resident #61 should have been placed on one-on-one observation following the incident occurring on 07/06/24 and was not.<br><br>* Nothing had been done at this time to ensure other residents residing in the facility feel safe.<br><br>* The IDT had not assessed Resident #61 for underlying causes which could contribute to Resident #61's verbal and aggressive behavior.<br><br>* Resident #61's verbal and aggressive behavior have not been discussed in the IDT meetings.<br><br>* Resident #61's verbal and aggressive behavior had not been taken to or reviewed in Quality Assurance and Performance Improvement (QAPI) committee meetings.<br><br>On 07/09/24 at 3:35 PM, an additional interview was conducted with Resident #42 who stated, I don't remember who I told about the fact that Resident #61 scares me when Resident #61 comes into my room at night, it was a staff member and that staff member placed the stop sign on my door, but it doesn't stop Resident #61, Resident #61 just ducks under it. I hate to close my eyes.<br><br>On 07/09/24 at 3:40 PM, an additional interview was conducted with the DON. At that time, the Social Worker (SW) and Assistant Director of Nursing (ADON) were present. When this Surveyor asked the DON if a psychological appointment had been made for Resident #61, and if not, why not, the DON responded, I don't have an answer for that. We can certainly try it, it can't hurt. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552<br><br>Based on record review and staff interview, the facility failed to monitor Resident #61 for side effects of psychotropic medication after administration of Zyprexa 10mg Intramuscularly (IM). This was true for 1(one) of 5 (five) residents reviewed for the Long Term Care Survey Process. Facility census: 64. Resident identifier: Resident #61.<br><br>Findings include:<br><br>a) Resident #61<br><br>On 07/08/24 at approximately 9:11 PM, a review of Resident #61's medical record was performed. It revealed that on 05/19/24 at 11:15 PM the following progress note was entered into Resident #61's medical record:<br><br>Resident continues to be very restless with poor safety awareness. Attempted again to contact provider at Vis a Vis. Vis a Vis provider's microphone not working. Contacted Dr. [NAME] and instructed to administer 10 milligram (mg) Zyprexa IM. Medication administered as ordered and resident assisted back to bed. Resting in bed at this time with 0 (zero) complaints of (c/o) pain/discomfort.<br><br>This note was revealed to be a follow up to a Change in Condition Evaluation with an effective date and time of 05/19/24 at 11:10 PM. During this review of the Change in Condition Evaluation, it revealed the change in condition signs and symptoms identified was documented as agitation and restlessness, with the most recent vital signs documented dated and timed 05/19/24 at 5:16 AM. Further review of this Change in Condition evaluation revealed, under the section for Resident Representative Notification that the Department of Health and Human Resources representative was the name of the resident representative notified, however, the section for the date and time of that notification was left blank.<br><br>A review was performed of Resident #61's Medication Administration Record (MAR), it revealed on 05/19/24 at 11:10 PM, documentation of administration of Zyprexa 10 mg IM, one time only for agitation.<br><br>On 07/09/24 at 01:48 PM, the Policy and Procedure titled, Behaviors: Management of Symptoms was reviewed. It revealed that when administering a medication for behavioral symptoms, a consent should be obtained and that the form Psychotropic/Therapeutic Medication Use Evaluation should be completed when a patient is newly prescribed a psychotherapeutic medication.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 07/10/24 at 02:35 PM, a further review of Resident #61's medical record revealed that Resident #61 had 2 (two) forms titled, Psychotropic Medication Administration Disclosure. Both forms revealed that Resident #61's representative had the risks and benefits of psychotropic medication verbally explained and provided in writing. It also revealed that Resident #61's representative understood the right to refuse the administration of these medications and the right to withdraw consent of medication administration at any time. Under the signature section of both forms, it revealed that verbal consent had been obtained and both forms were dated as the verbal consent being obtained on 05/07/24. However, when reviewing the forms, it revealed that each form was different. One of the forms listed Aricept and Ativan as the medications verbal consent had been obtained for on 05/07/24. The next form listed Aricept, Ativan and Lexapro as the medication verbal consent had been obtained for 05/07/24. Lexapro had 06/13/24 written beside it.<br><br>On 07/10/24 at 03:29 PM, an interview was conducted with the Director of Nursing (DON). At that time, the DON acknowledged that no consent was obtained before the administration of Zyprexa and that a new form titled, Psychotropic Medication Administration Disclosure should have been completed for this medication. DON further acknowledged that instead of adding Lexapro and writing the date beside it to the already existing form dated 05/07/24, a new form titled Psychotropic Medication Administration Disclosure should have been completed. In addition, the DON acknowledged that no monitoring occurred on Resident #61 after the administration of Zyprexa IM. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552<br><br>Based on record review and staff interview the facility failed to administer a as needed (PRN) psychotropic for a specifically diagnosed condition for Resident #61. This was true for 1 (one) of 5 (five) residents reviewed for the Long-Term Care Survey Process. Facility census: 64. Resident identifier: #61.<br><br>Findings include:<br><br>a) Resident #61<br><br>On 07/08/24 at approximately 9:11 PM, a review of Resident #61's medical record was performed. It revealed that on 05/19/24 at 11:15 PM the following progress note was entered into Resident #61's medical record:<br><br>Resident continues to be very restless with poor safety awareness. Attempted again to contact provider at Vis a Vis. Vis a Vis provider's microphone not working. Contacted Dr. [NAME] and instructed to administer 10 milligram (mg) Zyprexa IM. Medication administered as ordered and resident assisted back to bed. Resting in bed at this time with 0 (zero) complaints of (c/o) pain/discomfort.<br><br>This note was revealed to be a follow up to a Change in Condition Evaluation with an effective date and time of 05/19/24 at 11:10 PM. During this review of the Change in Condition Evaluation, it was revealed that the change in condition signs and symptoms were identified and documented as agitation and restlessness, with the most recent vital signs documented dated and timed 05/19/24 at 5:16 AM. Further review of this Change in Condition evaluation revealed, under the section for Resident Representative Notification that the Department of Health and Human Resources representative was the name of the resident representative notified, however, the section for the date and time of that notification was left blank.<br><br>A review was performed of Resident #61's Medication Administration Record (MAR). This MAR review revealed on 05/19/24 at 11:10 PM, documentation of administration of Zyprexa 10 mg IM (intramuscular), one time only for agitation. The order contained no specific condition as diagnosed and documented in the clinical record.<br><br>On 07/09/24 at 01:48 PM, the Policy and Procedure titled, Behaviors: Management of Symptoms was reviewed. The Policy and Procedure review revealed that when administering a medication for behavioral symptoms, a consent should be obtained and that the form Psychotropic/Therapeutic Medication Use Evaluation should be completed when a patient is newly prescribed a psychotherapeutic medication.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 07/10/24 at 02:35 PM, a further review of Resident #61's medical record was performed. It revealed that Resident #61 had 2 (two) forms titled, Psychotropic Medication Administration Disclosure. Both forms revealed that Resident #61's representative had the risks and benefits of psychotropic medication verbally explained and provided in writing. It also revealed that Resident #61's representative understood the right to refuse the administration of these medications and the right to withdraw consent of medication administration at any time. Under the signature section of both forms, it revealed that verbal consent had been obtained and both forms were dated as the verbal consent being obtained on 05/07/24. However, when reviewing the forms, it revealed that each form was different. One of the forms listed Aricept and Ativan as the medications verbal consent had been obtained for on 05/07/24. The next form listed Aricept, Ativan and Lexapro as the medication verbal consent had been obtained for 05/07/24. Lexapro had 06/13/24 written beside it.<br><br>On 07/10/24 at 03:29 PM, an interview was conducted with the Director of Nursing (DON). At that time, the DON acknowledged that no consent was obtained before the administration of Zyprexa and that a new form titled, Psychotropic Medication Administration Disclosure should have been completed for this medication. When the DON as was asked if agitation was a specific condition that was diagnosed and documented in the clinical record, the DON stated, I can't say. I am a nurse and not able to diagnose. DON further acknowledged that instead of adding Lexapro and writing the date beside it to the already existing form dated 05/07/24, a new form titled Psychotropic Medication Administration Disclosure should have been completed. In addition, DON acknowledged that no monitoring occurred on Resident #61 after the administration of Zyprexa IM. |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>49467<br><br>Based on record review and staff interview, the facility failed to employ qualified dietary staff, due to letting employees work in the dietary department before obtaining food handler permits. This had the potential to affect all residents residing in the facility. Facility census: 64.<br><br>Findings include:<br><br>a) At approximately 10:00 AM on 07/09/2024, food handler permits were requested from the Dining Services Account Manager (DSAM). The DSAM made copies of the ones on file in the dietary office and stated, I'll have to find the others.<br><br>At approximately 1:30 PM the DSAM stated they were still waiting on a couple food handlers cards.<br><br>On 07/10/2024, the DSAM supplied a copy of a food handler permit for [NAME] #59, with an issue date of 07/10/2024. Upon review of the employee list provided by the facility, [NAME] #59 has been employed at the facility and working without a food handler permit since 10/17/2023.<br><br>On 07/11/2024, the DSAM supplied copies of food handler permits for Dietary Aide/Cook #64 and Dietary Aide/Cook #58, both with an issued date of 07/11/2024. Upon review of the employee list proved by the facility, it was determined Dietary Aide/Cook #64 had been employed at the facility and working without a food handler permit since 04/30/2024. It was determined Dietary Aide/Cook #58 had been employed at the facility and working with a food handler permit since 05/30/2024<br><br>All three instances were acknowledged by the DSAM and Dining Services District Manager. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467<br><br>Based on observation and staff interview, the facility failed to store and prepare food in a sanitary manner, due to having items that were out of date and not dated in the refrigerators, items exposed to the elements, having dirty equipment, and failing to monitor refrigerator temperatures of personal refrigerators in resident rooms. This has the potential to affect all residents receiving food from the kitchen and all residents with personal refrigerators in their rooms. Facility census: 64.<br><br>Findings include:<br><br>A) Outdated, undated, and exposed items<br><br>At approximately 11:20 AM on 07/08/2024 a tour of the kitchen in the facility was conducted. During the tour, the following were found in the walk-in refrigerator:<br><br>Three (3) trays of cake with no date.<br><br>A plastic container of beef based with no lid on it.<br><br>A plastic container of strawberries with no date on it.<br><br>A cardboard box containing squash with a discard date of 07/01/2024.<br><br>Twenty (20) individual cookies placed in plastic sleeves were in the dry stock room with no date. Dietary Aide/Cook #59 stated Those were made yesterday (Sunday) for today.<br><br>The following items were found in the walk-in freezer:<br><br>Chicken breasts with no date.<br><br>A box containing a bag of frozen corn. The bag was open, exposing the corn to the elements.<br><br>A box containing a plastic bag of frozen biscuits. The bag was open, exposing the biscuits to the elements.<br><br>The following items were found in the reach in refrigerator:<br><br>Barbeque Sauce with manufacturers discard date of 05/28/2024.<br><br>A pitcher of pink lemonade without a date on it.<br><br>A large container of tea without a date on it.<br><br>A box of peeled hard cooked eggs with a discard date of 07/03/2024.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Dietary Aide/Cook #59 confirmed the items found during the tour were out of date, not dated, or exposed to the elements in the freezer. Dietary Aide/Cook #59 stated, You will probably find all kinds of stuff in there that doesn't have dates because we have people coming to work here from other centers and they don't care, they will throw stuff in there without dates on it and everything else.<br><br>B) Oven<br><br>At approximately 11:30 AM on 07/08/2024, during a tour of the kitchen, [NAME] #66 opened the oven to take the temperature of French fries that were being prepared for lunch. When the oven was opened, burnt food was found lying at the bottom along with four (4) large globs of black debris. What appeared to be pieces of burned shredded cheese were observed scattered throughout the oven. [NAME] #66 was asked how often the oven was cleaned, to which they replied, We should have already cleaned it, it needs cleaned, but we haven't had a chance to clean it because we haven't had staff here to do it.<br><br>C) Nourishment room microwaves<br><br>At approximately 3:00 PM on 07/08/2024, a tour of the nourishment rooms was conducted with the Dining Services Account Manager (DSAM). Upon entering the nourishment room for the 100 and 300 units of the facility, the microwave was noted to have rust throughout the inside. The DSAM stated We have been trying to get new ones for a while because we can't get these cleaned. The DSAM was asked if the facility prepared food for residents in the microwave, to which they stated, Yes.<br><br>Upon entering the nourishment room for the 200 and 400 units of the facility, the microwave was noted to have rust through the inside and was missing the turntable. The DSAM stated We have been trying to get a new one here also. We can't get either of them clean, and this one is missing the turntable on the inside. The DSAM confirmed resident food was prepared and heated in the microwave.<br><br>49650<br><br>d) Resident refrigerator temperatures<br><br>The following was identified during a review of the facility Policy and Procedure OPS192 refrigerators:.<br><br>Patient In-Room that states the PROCESS (documented as written) Maintenance will provide calibrated refrigerator thermometers and placed within each unit for both refrigerator and freezer, if applicable.<br><br>4.1 A refrigerator/freezer temperature log will be maintained for every patient refrigerator.<br><br>.2 Nursing will observe and record temperatures of the refrigerator on a daily basis using the refrigerator/freezer temperature log.<br><br>4.3 If temperature falls outside of the acceptable range, notify the Maintenance Department immediately.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a tour of the facility on 07/08/24 at approximately 3:23 PM it was identified that the residents with their personal refrigerators in their rooms did not have a visible temperature log being maintained. During an interview with Registered Nurse Skin Health Team Lead (RN TLSH) #36, she identified Unit Clerk (UC) #08 to be the one who completed the temperature logs for each resident refrigerator daily. A request of the temperatures logs was made at this time.<br><br>During an interview with the UC #08 on 07/08/24 at approximately 04:00 PM, UC #08 apologized for taking so long to get the documents that she was still completing the form for a newly admitted resident. She further stated if she was not in the facility, someone else would obtain the temperatures for her and she would document them when she returned to the facility. A review of the refrigerator temperatures UC #08 provided identified a distinct pattern for each refrigerator with the same exact times and/or the same exact temperatures noted for each day for the refrigerator and the freezer.<br><br>During a review with the Administrator of the June 2024 and July 2024 resident refrigerator temperature logs on 07/08/24 at 4:10 PM the Administrator completed a random observation of three (3) of the 19 resident temperature logs provided. The log completed for each resident identifies the acceptable temperature ranges for the refrigerator to be 32-40 degrees Fahrenheit and the freezer to be 0-10 degrees Fahrenheit.<br><br>The following discrepancies were identified:<br><br>room [ROOM NUMBER]B<br><br>The refrigerator temperature logs for the entire month of June was documented to be checked at exactly 9:05 AM every day and each day the refrigerator was documented to be at 35 degrees Fahrenheit and the freezer was documented to be at 10 degrees Fahrenheit.<br><br>The July temperatures were documented to be checked at exactly 09:05 AM every day from 07/01/24 through 07/04/24 and then exactly at 9:00 AM each day from 07/05/24 through 07/08/24.<br><br>The July temperatures were also documented to be at 35 degrees Fahrenheit for the refrigerator every day and 10 degrees Fahrenheit for the freezer consistently each day.<br><br>During the random observation of 108 B refrigerator temperatures the Administrator made at 4:13 PM on 07/08/24 the refrigerator did not have a thermometer inside to obtain a temperature with. The freezer temperature was 10 degrees Fahrenheit. The Administrator agreed with the identified concern of the distinct pattern and the accuracy of the documentation when there was not a thermostat located in the refrigerator to obtain the temperature with.<br><br>room [ROOM NUMBER]<br><br>The refrigerator temperature logs for the entire month of June was documented to be checked at exactly 9:10 AM every day and each day the refrigerator was documented to be at 32 degrees Fahrenheit and the freezer was documented to be at 10 degrees Fahrenheit.<br><br>The July temperatures were checked at exactly 9:10 AM every day from 07/01/24 through 07/04/24 and at exactly 9:05 AM every day from 07/05/24 through 07/08/24.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The July temperatures were also documented to be at 32 degrees Fahrenheit every day for the refrigerator and 10 degrees Fahrenheit for the freezer consistently each day.<br><br>During the random observation of 109 A refrigerator temperatures the Administrator made at 4:15 PM on 07/08/24 the refrigerator temperature was 35 degrees Fahrenheit and the freezer temperature was -5 degrees Fahrenheit.<br><br>The Administrator agreed that the temperatures were not consistent with the monthly documentation being completed and that the freezer temperature was outside the acceptable temperature range.<br><br>room [ROOM NUMBER] B<br><br>The refrigerator temperature logs for the entire month of June was documented to be checked at exactly 9:15 AM every day and each day the refrigerator was documented to be at 35 degrees Fahrenheit and the freezer were documented to be at 10 degrees Fahrenheit.<br><br>The July temperatures were checked at exactly 9:15 AM every day from 07/01/24 through 07/04/24 and exactly at 09:10 AM from 07/05/24 through 07/08/24.<br><br>The July temperatures were also documented to be at 35 degrees Fahrenheit every day for the refrigerator and 10 degrees Fahrenheit for the freezer consistently each day.<br><br>During the random observation of room [ROOM NUMBER] B refrigerator temperatures the Administrator made at 4:15 PM on 07/08/24 the refrigerator temperature was 38/40 degrees Fahrenheit and the freezer temperature was 10 degrees Fahrenheit.<br><br>The Administrator agreed that the temperatures were not consistent with the monthly documentation being completed. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Dispose of garbage and refuse properly.<br><br>49467<br><br>Based on observation and staff interview, the facility failed to dispose of refuse in a manner to prevent attracting vermin. This has the potential to affect all residents residing in the facility. Facility census: 64.<br><br>Findings include:<br><br>a) At approximately 2:00 PM on 07/10/2024, a tour was conducted of the rear of the facility where the facility kept their dumpsters. Upon arriving at the dumpsters, an empty potato chip bag, multiple clear gloves, pieces of food, and clear plastic garbage bags were scattered around and underneath the dumpsters. Three (3) of the four (4) dumpsters had the lids opened, with one missing a lead entirely. One dumpster was leaking a white substance out of the bottom, onto the pavement.<br><br>At approximately 2:09 PM on 07/10/2024, the Dining Services District Manager acknowledged the trash on the ground and the state of the dumpsters. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>49467<br><br>Based on record review and staff interview, the facility failed to accurately document medication administration times on the Medication Administration Record (MAR) and medication sign out and administration times on the narcotic count sheet for Resident #28 ' s Morphine Sulphate. This was a random opportunity for discovery. Facility census: 64.<br><br>Findings include:<br><br>A) Resident #28<br><br>Resident #28 was admitted to the facility with the diagnoses of Chronic Obstructive Pulmonary Disease (COPD) and Liver Cell Carcinoma. He had a Brief Interview for Mental Status (BIMS) score of 14, suggesting he was cognitively intact, and was determined to have capacity.<br><br>Upon review of the resident matrix after arrival to the facility at approximately 11:00 AM on 07/08/2024, it was noted Resident #28 was marked for end of life/palliative care/comfort measures along with 25 other residents in the facility.<br><br>At approximately 2:15 PM on 07/08/2024, Resident #28 was observed sitting on the side of his bed, bent over at the waist, with his hands almost touching the floor. Staff members then came into the room to help Resident #28 back into his bed. At this time an interview was attempted with Resident #28, however, he was not interviewable due to him being unable to hold his eyes open, slurred speech, and his head bobbing up and down as he was unable to stay awake.<br><br>At approximately 2:30 PM on 07/09/2024, a review of Resident #28 ' s medication orders were reviewed. The following orders were found in Resident #28 ' s electronic health record (EHR:<br><br>Ativan Oral Tablet 1 MG- Give one tablet by mouth two times a day for anxiety r/t (related to) restlessness.<br><br>Gabapentin - Give 300 mg by mouth two times a day for neuropathy in feet.<br><br>Morphine Sulfate (Concentrate) Solution 20 MG/ML- GIve 1 ml sublingually every 4 hours for pain/sob (shortness of breath).<br><br>Morphine Sulfate Oral Solution 20 MG/5ML (Morphine Sulphate) - Give 1 ml by mouth one time only for agitation and S.O.B. (shortness of breath) for 1 day.<br><br>Oxycodone HCl Oral tablet 30 MG (Oxycodone HCl) - Give 1 tablet by mouth every 4 hours for pain.<br><br>Morphine Sulphate (Concentrate) Solution 20 MG/ML - Give 0.5 ml sublingually every 2 hours as needed for pain/sob 0.5 ml = 10 mg<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 - Some | Morphine Sulphate (Concentrate) Solution 20 MG/ML - Give 0.5 ml sublingually every 2 hours as needed for pain/sob 0.5 ml = 10 mg<br><br>At approximately 1:00 PM on 07/10/2024, a review of progress notes for Resident #28 revealed he had passed away at the facility that morning.<br><br>At approximately 2:30 PM on 07/10/2024, a review of the narcotic count sheet and the MAR was completed for Resident #28. During the review of the narcotic sheet for Resident #28 ' s morphine sulphate 100 mg/5 ml concentrate solution, the following eight (8) discrepancies were noted:<br><br>Registered Nurse (RN) #30 signed out 0.5 ml at 7:30 PM on 07/06/2024 but no documentation was found on the MAR to indicate the medication had been administered.<br><br>RN #30 signed out 0.5 ml at 9:00 PM on 07/07/2024 but no documentation was found on the MAR to indicate the medication had been administered.<br><br>The next sign out time on the narcotic medication count sheet was 0.5 ml by RN #30 at 1:00 AM on 07/07/2024. No documentation was found on the MAR to indicate the medication had been administered.<br><br>The next sign out time on the narcotic medication count sheet was 0.5 ml by RN #30 at 5:00 AM on 07/07/2024. No documentation was found on the MAR to indicate the medication had been administered.<br><br>RN #30 signed out 0.5 ml at 10:00 PM on 07/08/2024 and there was documentation found on the MAR to indicate the medication was administered<br><br>RN #30 signed out 0.5 ml at 2:00 AM on 07/09/2024 and there was no documentation found on the MAR to indicate the medication was given.<br><br>Two one (1) ml doses were signed out on the narcotic medication count sheet at 7:00 PM and 11:00 PM on 07/09/2024, without signatures.No documentation was found on the MAR to indicate the medications were given. RN #30 later confirmed via interview they logged the medications out and forgot to sign the sheet.<br><br>The narcotic medication count sheet noted there was 7.5 ml of morphine remaining in the bottle.<br><br>Licensed Practical Nurse (LPN) #46 counted the medication and stated there was between 7.5 and eight (8) ml remaining in the bottle. Two surveyors witnessed the count of the medication and confirmed the amount remaining.<br><br>At approximately 3:45 PM on 07/10/2024, an interview was conducted with the Director of Nursing (DON) and the Unit Managers at the facility regarding the discrepancies in the narcotic count sheet and the MAR.<br><br>LPN #6 stated RN #30 was having a lot of trouble with documentation and the facility had provided prior training and was continuing to work with RN #30. LPN #6 then provided documentation from the progress notes for Resident #28, showing RN #30 administered the medications at 10:00 PM on 07/08/2024 and 2:00 AM on 07/09/2024, however, had forgotten to log them in the MAR and entered the administration into the progress notes as a MAR error.<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 - Some | Further review of the MAR for Resident #28 indicated RN #30 had documented the logged out medications from 7:00 PM and 11:00 PM on 07/09/2024 were given at 9:00 PM on 07/09/2024 and 1:00 AM on 07/10/2024.<br><br>At approximately 5:00 PM on 07/10/2024 a phone interview was conducted with RN #30 concerning the discrepancies in the MAR and the narcotic count sheet. RN #30 stated they struggle with military time and the computer system the facility uses to document times for medication. RN #30 states education has been provided on a couple occasions and the staff at the facility are continuing to assist with documentation problems. RN #30 states the two logged medications that had no signature belonged to them. RN #30 stated I logged the medication out and had a resident that got sick and had to go assist with them. I just forgot to go back and sign. I struggle with military time and thought the times I wrote down were the correct times. I gave the medications at 9:00 PM on the 9th and 1:00 AM on the 10th. LPN #6 helped me with the missed times on the MAR from 10:00 PM on the 8th and 2:00 AM on the 9th.<br><br>The following medication sign out times were still unaccounted for on the MAR:<br><br>0.5 ml at 7:30 PM on 07/06/2024<br><br>0.5 ml at 9:00 PM on 07/07/2024<br><br>0.5 ml at 1:00 AM on 07/07/2024<br><br>0.5 ml at 5:00 AM on 07/07/2024<br><br>RN #30 confirmed during the phone interview they had forgotten to log the times in the MAR.<br><br>At approximately 9:30 AM on 07/11/2024, an interview was conducted with the DON. The DON stated RN #30 had been suspended pending investigation. |

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|---|---|---|---|
| | 515100 | A. Building<br>B. Wing | 07/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| White Sulphur Springs Center | 345 Pocahontas Trail<br>White Sulphur Spring, WV 24986 |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>49650<br><br>The facility failed to make good faith attempts to identify deficiencies of which they had or should have had knowledge of. The Quality Assurance and Performance Improvement (QAPI) program implemented to correct the [NAME] Virginia Portable Order for Scope of Treatment (POST) form completions was not being modified correctly. This has the potential to affect all the residents residing in the facility that completes a POST form. This was identified during the long term care survey process. Identifier: POST forms. Census: 64<br><br>a) Post forms<br><br>During a POST form document review of on 07/12/24 at approximately 04:00 PM it was identified that a post form cannot be modified. It is stated on the form that if changes are needed you are to void the form and complete a new POST form. It is further noted that to void a POST form the following must be completed;<br><br>If a patient or MPOA representative/surrogate (for patients lacking capacity) wants to void the form: destroy paper form and contact patients health care provider and the WV e-Directive Registry to void orders in patient's medical record and the Registry.<br><br>For healthcare provider: destroy copy (if possible), note in patient record from is voided and notify the WV 3-Directive Registry<br><br>If no new form is completed, note that full treatment and resuscitation may be provided.<br><br>During an interview with the Administrator on 07/11/24 06:05 PM the Administrator identified the POST forms as an ongoing QAPI program that was implemented to correct the WV POST forms. She stated this was an ongoing program that began with an audit because they were getting witnessed verbal signatures but not receiving back the original POST form back from mailing it to the surrogates/medical power of attorneys. The Administrator stated it had been ongoing since April of 2024. The Administrator stated that they had also began auditing the POST forms to make sure the POST forms were completed with no blanks such as missing social security numbers, addresses, physicians information, the question box on the back of the form and etc. The Administrator stated that the corrections were being completed on the original POST form but she stated she was unable provide any data in regards to the QAPI program because the Administrators computer was not operable and the data is on it.<br><br>During this review of the facilities QAPI process to correct the POST forms and the POST form itself with the referenced Instructions, the Administrator stated that she nor the Quality Assurance Committee (QAC) was aware that the forms could not be modified. She further stated they QAC was not aware of the process in which a post form is to be destroyed if modifications had to be made. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>49650<br><br>Based on medical records, facility records and staff interview the facility Quality Assurance and Performance Improvement committee failed to develop corrective actions to effectively change systems level to prevent quality of care and or quality of life problems. The POST forms were not being accurately completed and or modified based on the physician's determination of capacity. All residents had the potential to be affected by this practice. This was discovered during the facilities long term care survey process. Census: 64.<br><br>a) Post forms<br><br>During a POST form document review of on 07/12/24 at approximately 4:00 PM it was identified that a post form cannot be modified. It is stated on the form that if changes are needed you are to void the form and complete a new POST form. It is further noted that to void a POST form the following must be completed;<br><br>If a patient or MPOA representative/surrogate (for patients lacking capacity) wants to void the form: destroy paper form and contact patients' health care provider and the WV e-Directive Registry to void orders in patient's medical record and the Registry.<br><br>For healthcare provider: destroy copy (if possible), note in patient record from is voided and notify the WV 3-Directive Registry<br><br>If no new form is completed, note that full treatment and resuscitation may be provided.<br><br>During an interview with the Administrator on 07/11/24 6:05 PM the Administrator identified the POST forms as an ongoing QAPI program that was implemented to correct the WV POST forms. She stated this was an ongoing program that began with an audit because they were getting witnessed verbal signatures but not receiving back the original POST form back from mailing it to the surrogates/medical power of attorneys.<br><br>The Administrator stated it had been ongoing since April of 2024. The Administrator stated they had also began auditing the POST forms to make sure the POST forms were completed with no blanks such as missing social security numbers, addresses, physicians' information, the question box on the back of the form etc.<br><br>The Administrator stated that the corrections were being completed on the original POST form, but she stated she was unable provide any data in regard to the QAPI program because the Administrators computer was not operable, and the data is on it.<br><br>During this review with the Administrator a further review was completed of the POST form itself with the above referenced Instructions;<br><br>(continued on next page) |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | If a patient or MPOA representative/surrogate (for patients lacking capacity) wants to void the form: destroy paper form and contact patients health care provider and the WV e-Directive Registry to void orders in patient's medical record and the Registry.<br><br>For healthcare provider: destroy copy (if possible), note in patient record from is voided and notify the WV 3-Directive Registry<br><br>If no new form is completed, note that full treatment and resuscitation may be provided.<br><br>The Administrator stated that she nor the Quality Assurance Committee (QAC) was aware that the forms could not be modified. She further stated the QAC was not aware of the process in which a post form is to be destroyed if modifications had to be made. The Administrator further stated that she nor the QAC was aware the Nurse Practitioner was completing her own capacity process without the guidance of the attending physician capacity determination for the residents.<br><br>She further acknowledged that she nor the QAC were aware that the NP was completing residents POST forms without the attending physician's determination of capacity. The Administrator stated that she does feel like she has missed pertinent details in the QAPI process and audits of the POST form completions and corrections. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467<br><br>Based on observation and staff interview, the facility failed to practice proper infection control to prevent the spread of communicable diseases during lunch service. This was a random opportunity for discovery. This has the potential to affect all residents residing in the facility. Facility census: 64.<br><br>Findings included:<br><br>At approximately 12:12 PM on 07/08/2024, an observation was made during lunch service in the 400 hallway of the facility. Nurse Aide (NA) #10 took a tray off the delivery cart, took it to room [ROOM NUMBER] and brought it back to the cart upon realizing the resident was out of the facility. Upon returning to the delivery cart, NA #10 placed the tray back onto the cart with the clean, undelivered trays.<br><br>NA #10 acknowledged they should not have placed the tray back onto the cart and stated I ' m not sure why I did. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650<br><br>Based on observation and staff interview the facility failed to provide a safe, comfortable, homelike environment for residents, staff and the public. Issues were found with dead flowers and items being stored over on top of the over bed light fixture. In addition the facility did not have record of fire drills being completed as required. These were random opportunities for discovery during the long term care survey and has the potential to affect all of the residents. Room identifiers: #304, #307. Census: 64.<br><br>Findings included:<br><br>a) Exit door window pane across of dining room<br><br>On 07/08/24 at approximately 2:30 PM during a tour of the facility, the exit door to the court yard located across the hallway from the dining room was observed. This door has a glass insert that would provide a full view of the court yard outside. The glass appeared to have the seal broken with moisture trapped between the panes. The window glass that covered approximately 75% was extremely cloudy, making it impossible to enjoy the view outside in the courtyard area.<br><br>On 07/08/24 at approximately 2:44 PM during an interview with the Administrator, the Administrator agreed that the glass did not allow unobstructed visibility for the residents and visitors to enjoy the view outside in the courtyard area.<br><br>b) Exit door window pane inside the 100 hall lounge<br><br>On 07/08/24 at approximately 2:35 PM during a tour of the facility, the exit door to the court yard located inside the 100 hall lounge was observed. The door has a glass insert that would provide a full view of the court yard outside. The glass however appeared to have the seal broken with moisture trapped between the panes. The window glass that covered approximately 65% appeared cloudy, making it impossible to enjoy the view outside in the courtyard area.<br><br>On 07/08/24 at approximately 2:44 PM during an interview with the Administrator, the Administrator agreed that the glass did not allow unobstructed visibility for the residents and visitors to enjoy the view outside in the courtyard area.<br><br>c) Window pane at the entrance of the front entry door.<br><br>On 07/08/24 at approximately 2:37 PM during a tour of the facility, the window pane at the entrance of the front facility entry door was observed. This window allows the view of the front entrance area to the facility's main entrance. The glass appeared to have the seal broken with moisture trapped between the panes. This window appeared to be foggy throughout the entire surface preventing a clear visibility when looking outside to the front area of the facility.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 07/08/24 at approximately 2:44 PM during an interview with the Administrator, the Administrator agreed that the glass did not allow unobstructed visibility for the residents and visitors to enjoy the view outside in the courtyard area and the visibility outside the main entrance.<br><br>d) Over the bed table room [ROOM NUMBER] A<br><br>On 07/08/24 at approximately 01:25 PM during a tour of the facility 300 hall, the bedside table top for bed 305 A was observed to have large cracks that covered 3/4 of the top laminate surface. The molding around the edge of the table was falling off leaving the sharp edges of the inner board exposed.<br><br>During an interview with Registered Nurse (RN) #14 on 07/08/24 at approximately 1:27 PM, RN #14 acknowledged the table presented a skin tear hazard for the resident and replaced it with a different bedside table.<br><br>e) Dead flowers<br><br>During a tour of the facility on 07/08/24 at approximately 3:25 PM room [ROOM NUMBER] and #307 was identified to have containers of dead flowers in the room. The flowers were wilted and the water was cloudy and had an unpleasant odor.<br><br>During an interview with Skin Health Team Lead (SHTL) #36 on 07/08/24 at approximately 1:30 PM. SHTL #36 stated the flowers were dead and should have been removed from the room before now.<br><br>f) Storage on top of over the bed light fixture<br><br>On 07/12/24 at approximately 03:00 PM during a facility tour, room [ROOM NUMBER]B over the bed wall light was observed to have a small glass oil lamp, a corded telephone, a medium sized clock, a corded [NAME] and a corded walkie-talkie stored on top of it. These items covered approximately 75% of the top surface of the over the bed wall light fixture. The bed was positioned with the left side of the bed against the wall directly underneath the over the bed wall light.<br><br>On 07/12/24 at 03:15 PM during an interview with the DON she stated the light fixture is not designed to be a shelf and the items being stored there presents a hazard for the resident.<br><br>g) As referenced during the annual Life Safety / Emergency Preparedness Recertification Survey conducted on 07/08/24 through 07/09/24, record review on 07/08/24 at approximately 4:08 p.m., revealed no documentation during survey was available for review of a fire drill being conducted on the 3rd Shift of the 2nd Quarter of 2024. This deficiency was reiterated to the Administrator during the complaint survey on 07/10/24 at approximately 1:20 p.m.<br><br>h) As referenced during the annual Life Safety/Emergency Preparedness Recertification Survey conducted on 07/08/234 through 07/09/24, record review on 07/08/24 at approximately 4:21 p.m., revealed no documentation during survey was available for review for review of a fire drill being conducted on the 2nd Shift of the 3rd Quarter of 2023. This deficiency was reiterated to the Administrator during the complaint survey on 07/10/24 at approximately 1:22 p.m.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | i) Interview on 07/10/24 at approximately 1:23 p.m. with the Administrator verified these findings. These findings were also acknowledged by the Administrator at the exit interview on 07/10/24 at approximately 1:41 p.m. |