| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535022 | A. Building<br>B. Wing | 05/23/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Legacy Living and Rehabilitation Center | 1000 S Douglas Hwy<br>Gillette, WY 82716 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0576<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Ensure residents have reasonable access to and privacy in their use of communication methods.<br><br>35081<br><br>Based on resident and staff interview, the facility failed to ensure mail was delivered, including on Saturday. The census was 116. The findings were:<br><br>1. Interview with 7 residents during a group interview on 5/21/24 at 1:56 PM revealed the facility no longer delivered mail to residents on Saturday. The residents revealed the transportation aide was previously responsible to ensure Saturday mail delivery; however, he told residents that would no longer occur.<br><br>2. Interview with the DON on 5/23/24 at 10:27 AM confirmed the transportation aide was responsible for ensuring mail delivery occurred on the weekends.<br><br>3. Interview with the transportation aide on 5/23/24 at 10:50 AM confirmed resident mail was no longer delivered on Saturday. He revealed the post office did not deliver to the facility until after he left the facility at 11 AM. Further interview revealed the residents' mail had not been delivered on Saturday for about 4 months. |

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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>37603<br><br>Based on medical record review, and staff interview, the facility failed to ensure advance directives were formulated for 2 of 27 residents (#14, #21) reviewed. The findings were:<br><br>1. Review of the physician orders for resident #14 showed a 5/20/24 do not resuscitate (DNR) order. Further review of the resident's medical record showed a Cardiopulmonary Resuscitation Directive, dated 9/27/23, which indicated the resident requested to be a full code.<br><br>2. Review of the physician orders for resident #21 showed a DNR order dated 12/1/23. Further review of the resident's medical record showed a Cardiopulmonary Resuscitation Directive, dated 12/1/23, where the advance directive was unselected.<br><br>3. Interview with medication aide #1 on 5/22/24 at 11:35 AM revealed when determining what a resident's advance directive was, staff were to consult the resident's profile.<br><br>4. Interview with the DON on 5/22/24 at 11:44 AM revealed it was the facility's expectation staff look either at the resident's profile, the advance directive binder, or if there was a blue dot on the name plate of the resident's door. The blue dot indicated the resident was a full code. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220<br><br>Based on observation, staff and resident representative interview, and medical record review, the facility failed to ensure a safe and homelike environment in 1 of 4 units (Pine). The findings were:<br><br>1. Multiple random observations during the survey timeframe showed residents from the Cottonwood unit would wander into the Pine unit and the Pine staff would have to assist or redirect the residents. The Pine residents were not observed on the Cottonwood unit.<br><br>2. Review of the medical record for resident #98 showed the following concerns:<br><br>a. Review of a behavior note dated 3/9/24 and timed 9:36 AM showed resident intruding into Pine [male/female] residents room, removing cue entry/name signs from the door and belongings from inside room. [Male/female resident's [spouse] expressed anger that resident intrudes into [the resident's] room, stating it is an invasion of [the resident's] privacy and [s/he] requested something to be done about it immediately. This nurse and nursing staff increase rounding on resident to keep watch on [his/her] wandering throughout unit.<br><br>b. Review of CNA documentation dated 3/13/24 and timed 11:14 PM showed Resident has been going into other residents rooms continuously. Try to redirect [him/her] to [his/her] own room and then goes back into others rooms. Continue to redirect.<br><br>c. Review of CNA documentation dated 3/14/24 and timed 12:04 AM showed Resident entered another residents room while I was in the middle of changing the resident and asked [him/her] to leave numerous times before [s/he] finally left.<br><br>d. Review of a behavior note dated 3/14/24 and timed 7:30 PM showed Resident pacing and wandering unit throughout the day. [S/he] wanders into nurses/CNA stations and grabs staff belongings and tries to drink out of staff water bottles. [S/he] tries to go through papers/forms and desk items as well. Resident becomes agitated and belligerent when attempting to redirect, striking out at staff at times. Resident also observed going into other residents rooms and taking clothes and belongings. [S/he] requires constant supervision.<br><br>e. Review of a behavior note dated 3/27/24 and timed 1:42 AM showed Resident found in room [ROOM NUMBER] (Pine unit) and was eating a snack. [S/he] told resident of that room I'm gonna eat you CNA removed resident from room.<br><br>3. Interview on 5/20/24 at 3:36 PM with medication aide #1 revealed having the doors open between the Cottonwood and Pine units had its ups and downs because sometimes residents wandered into rooms and items came up missing. Interventions included submitting grievances and trying to find something else for the wandering resident to do.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 4. Review of an alert note, dated 5/12/24, showed resident #28's representative was informed of a resident-to-resident altercation and Daughter was upset, stating that since the doors have been opened a particular resident has been going over and stealing things from [resident's] room and also stated that she has seen this particular resident stealing food from other people. This nurse did not disclose who the other resident was that was involved in the altercation, but daughter was assuming that it was this particular resident that she had been speaking about. Daughter stated that she would be putting in a grievance for the doors being open.<br><br>5. Interview on 5/22/24 at 1:17 PM with resident #5's representative revealed the doors between the Cottonwood and Pine units were opened on 2/27/24. The resident's representative was concerned about the safety of resident #5 and had placed a video camera in his/her room. The resident's representative had documented 18 circumstances in which a resident had wandered into resident #5's room uninvited. Further, water had been spilled on the floor and photographs had been rearranged.<br><br>6. Interview on 5/22/24 at 4:09 PM with resident #91's representative revealed the privacy of the residents on the Pine unit had gone downhill since the doors between the Cottonwood and Pine units had been opened. The resident's representative stated he had witnessed both a female and male resident from the Cottonwood unit enter the room of the resident on separate occasions when the door had been closed. In addition, food and personal property had gone missing. The resident's representative was angry about the situation and stated it did not do any good to complain.<br><br>7. Interview with LPN #1 on 5/23/24 at 8:24 AM revealed resident #98 from the Cottonwood unit would wander into resident rooms on the Pine unit which upsets the [residents] over there. The LPN stated staff would attempt to redirect the resident back to the Cottonwood unit; however, redirecting the resident was difficult at times as s/he often refused. In addition, resident #26 had advanced Alzheimer's disease and would wander throughout both the Pine and Cottonwood units including entering resident's rooms. The LPN stated resident #26 did not have aggressive behaviors and wandered out of curiosity.<br><br>8. Interview with CNA #1 on 5/23/24 at 8:35 AM revealed resident #98 was very difficult to care for, exhibited aggressive behaviors, and wandered into other resident's rooms. The CNA stated the resident had recently been staying in the back hallway and she would check on him/her every 2 hours. In addition, the CNA stated the family members of the residents on the Pine unit were very upset about the resident's wandering.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | 9. Interview with CNA #2 on 5/23/24 at 8:43 AM revealed the opening of the doors between the Cottonwood and Pine units had caused a massive issue as the levels of dementia were very different between the two units, and the families of the Pine residents were upset. The CNA stated since the doors were opened the behaviors of the residents on the Cottonwood unit had caused an increase in the behaviors of the residents on the Pine unit. The CNA stated resident #98 would come into the Pine unit and urinate and defecate on the floor and wander into other resident's rooms causing resident #86 to be fearful and scared to go into his/her room; choosing to sleep in a recliner in the common room. In addition, the CNA stated staffing was a concern as the units used to be staffed with 2 CNAs on both the day and night shift; however, that had been reduced to only 1 CNA on the nightshift with one nurse available for both units. Further, Cottonwood CNAs would not follow their residents into the Pine unit so they became the Pine CNAs responsibility. The CNA added that if staffing was short on another unit in the facility a CNA from Pine would be pulled to fill the vacancy. The CNA also revealed the residents on the Pine unit were not exit seeking; however, the residents on the Cottonwood unit were exit seeking and when they came to the Pine unit, especially during the sundowning hours, the Cottonwood residents would continuously set off the door alarms. The CNA stated concerns from staff and family members went unanswered from the management team.<br><br>10. Interview with the DON and ADON on 5/23/24 at 2:26 PM revealed the doors between the Cottonwood and Pine units were opened because the facility determined having the doors locked was too restrictive for the Cottonwood residents. An evaluation risk was performed before opening the doors and it was determined the level of dementia was the same on both units; however, a reevaluation of the decision had not been completed. In addition, it was the facility's expectation the CNAs from Cottonwood would monitor their residents when they wandered into the Pine unit; however, the facility had not increased staffing in either of the secure units and responded to resident representative concerns by informing them the facility was monitoring the situation. |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220<br><br>Based on medical record review, staff interview, policy and procedure review, and review of the state licensing division incident report form, the facility failed to protect the resident's right to be free from abuse by another resident for 3 of 10 residents reviewed for abuse (#26, #63, #106). This failure resulted in harm to resident #106 who experienced sexual abuse. The findings were:<br><br>1. Review of the [DATE] admission MDS assessment for resident #106 showed s/he was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. The resident had a BIMS score of ,d+[DATE] (severe cognitive impairment), did not exhibit any behaviors, and require supervision or touching for walking up to 50 feet. The following concerns were identified:<br><br>a. Review of a [DATE] alert note showed CNA notified writer that another resident was found with [his/her] hand up this residents shirt touching [resident's upper chest]. CNA immediately separated residents and notified writer. Writer assessed receiving resident and initiating resident for skin concerns and found nothing to report. Resident accepted being moved away from initiating resident without issue.<br><br>b. Review of a [DATE] Risk Management Review Note showed a physical interaction occurred where a resident, [identified as resident #28], had [his/her] hand up a resident's shirt. The residents were immediately separated and monitored for distress. The root cause was determined to be poor impulse control of other resident [resident #28] and impaired cognition of both residents.<br><br>c. Interview with the resident's representative on [DATE] at 1:49 PM confirmed the resident had been involved in an incident where another resident had placed his/her hands up the resident's shirt. The resident's representative stated it was very upsetting and the resident would have been horrified if s/he was cognitively intact.<br><br>d. Review of a [DATE] progress note showed resident #28 had his/her hand down another resident's pants. Interview on [DATE] at 3:27 PM with medication aide #1 revealed she had observed resident #28 with his/her hands positioned in the waistband of another resident's pants. The medication aide revealed the resident's hand was not far into the waistband and away from the perineal area of the other resident. The medication aide revealed the other resident did not react to the placement of resident #28's hand and neither resident was concerned with the interaction; however, she separated the residents, placed them on increased monitoring, and assisted resident #28 to activities. Further interview revealed resident #28 had not had any previous sexual incidents prior to [DATE].<br><br>e. Interview with the DON and ADON on [DATE] at 2:16 PM revealed the facility had not followed up on the incident which occurred on [DATE] and were unable to identify the resident involved at the time of the interview.<br><br>2. Review of the [DATE] quarterly MDS assessment showed resident #63 was admitted to the facility on [DATE]. The resident had a BIMS score of ,d+[DATE] (severe cognitive impairment), did not exhibit any behaviors, and had diagnoses which included non-traumatic brain dysfunction, Alzheimer's disease, dementia, and anxiety disorder. The following concerns were identified:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | a. Review of a [DATE] physician communication note showed Resident involved in a resident to resident with the other resident being the aggressor. Other resident grabbed [resident name] left forearm and attempted to twist it. This caused bruising and broke the skin is (sic) in three areas. Wound was cleansed well and dressed per protocol. The resident causing the injury was identified as resident #62.<br><br>b. Review of the Summary of Investigation report concluded that physical abuse did occur to resident #63 as inflicted by resident #62. It was determined resident #62 had become overstimulated during the day which led to the altercation.<br><br>c. Interview with the ADON and the DON on [DATE] at 3 PM confirmed the injury to resident #63 did occur; however, documentation of the extent of the skin tears and post-event monitoring of the injuries could not be located.<br><br>3. Review of a Summary of Investigation report showed a resident-to-resident altercation took place on [DATE] at 1:40 PM which involved resident #26 and resident #114. Resident #114 pushed resident #26 which resulted in resident #26 falling and hitting his/her head on the floor. Both residents were transported by ambulance to the emergency department. Resident #26 did not require stitches and the CT scan performed was negative. Interventions included one-to-one staff supervision for resident #114 for behaviors and resident safety following return from the hospital. Interview with LPN #1 on [DATE] at 8:24 AM revealed resident #114 was very difficult as s/he refused medications and had aggressive behaviors. Resident #114 expired on [DATE].<br><br>4. Review of the [NAME] County Memorial Hospital Long Term Care Abuse Policy, last reviewed on [DATE], showed INTENT: Every resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. STANDARDS: 1. Providing a safe environment for the resident is one of the most basic and essential duties of our facility .3. This facility promotes an atmosphere of sharing with residents and staff without fear of retribution. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff of other agencies serving the residents, family members or legal guardians, friends, or other individuals .ABUSE BY OTHER RESIDENTS .If a resident experiences a behavior change resulting in aggression toward other residents, the facility conducts further assessment and arranges for appropriate psychiatric evaluation for further screening. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220<br><br>Based on medical record review, staff interview, review of the state licensing division incident database, and policy and procedure review, the facility failed to ensure allegations of abuse were reported for 1 of 9 samples residents (#62) reviewed for abuse. The findings were:<br><br>1. Review of the 3/18/24 annual MDS assessment for resident #62 showed the resident was admitted to the facility on [DATE], had a BIMS score of 5 out of 15 (indicating severe cognitive impairment), and had diagnoses which included Alzheimer's disease and depression. The resident was coded as receiving an antidepressant. The following concerns were identified:<br><br>a. Review of a 5/15/24 progress note showed resident #28 had his/her hand down another resident's pants.<br><br>b. Interview with the DON and ADON on 5/23/24 at 2:16 PM revealed the facility had not followed up on the incident which occurred on 5/15/24 and were unable to identify the resident involved at the time of the interview.<br><br>c. Interview with the DON and ADON on 5/23/24 at 3 PM revealed the resident had been identified as resident #62 and confirmed the allegation of abuse had not been reported to the state licensing division.<br><br>d. Review of the state licensing division incident database showed no evidence an allegation of sexual abuse which involved resident #62 and resident #28 had been reported.<br><br>2. Review of the [NAME] County Memorial Hospital Long Term Care abuse policy, last reviewed on 11/15/23, showed REPORTING ABUSE The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse . |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220<br><br>Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure allegations of abuse were investigated for 1 of 9 sample residents (#62) reviewed for abuse. The findings were:<br><br>1. Review of the 3/18/24 annual MDS assessment for resident #62 showed the resident was admitted to the facility on [DATE], had a BIMS score of 5 out of 15 (indicating severe cognitive impairment), and had diagnoses which included Alzheimer's disease and depression. The resident was coded as receiving an antidepressant. The following concerns were identified:<br><br>a. Review of a 5/15/24 progress note showed resident #28 had his/her hand down another resident's pants.<br><br>b. Interview with the DON and ADON on 5/23/24 at 2:16 PM revealed the facility had not followed up on the incident which occurred on 5/15/24 and were unable to identify the resident involved at the time of the interview.<br><br>c. Interview with the DON and ADON on 5/23/24 at 3 PM revealed the resident had been identified as resident #62 and confirmed the allegation of abuse had not been investigated or reported to the state licensing division.<br><br>2. Review of the [NAME] County Memorial Hospital Long Term Care abuse policy, last reviewed on 11/15/23, showed INVESTIGATION OF ABUSE, NEGLECT, OR MISAPPROPRIATION The facility will conduct an internal investigation. That investigation includes interviewing any staff members, residents, or family members who may have knowledge of the incident. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the Sate Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken . |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>35081<br><br>Based on medical record review, and staff and resident representative interview, the facility failed to ensure a discharge notice included care and services for a resident which should not or cannot be provided by the facility for 1 of 1 sample resident (#61) who was issued a 30-day discharge notice. The findings were:<br><br>1. Review of a discharge notice issued to resident #61 on 4/23/24 showed .The transfer or discharge is necessary to meet resident's welfare and the resident's welfare cannot be met in the facility, no return anticipated. Further review showed the facility was pursuing discharge based on the following:<br><br>a. On 4/3/2024, the interdisciplinary Team consisting of [staff names] met with family to discuss care decisions that violated [resident name]'s wishes as outlined in [his/her] Medical Durable Power of Attorney (MDPOA). Other topics discussed were concerns of [resident #61] receiving inappropriate wound care by [family member #1's name]. During this meeting [family member] showed pictures to the team of skin that she had debrided from [resident #61]'s wounds. [Family member #1] stated she had scrubbed' the lesions on [resident #61]'s chest with a washcloth. The IDT discussed this action as resulting in harm to the wounds and without medical direction. Further concerns were discussed regarding [resident #61]'s pain. [Resident #61] stated in [his/her] Advanced Directive her MDPOA is to consider the relief of suffering. At the time of this meeting, [Resident family member #2's name] still refused to make decisions to treat [resident #61]'s pain that was ongoing due to his perceptions on pain medicine and alleged past experience. Providers informed [family member #2] he may seek a second opinion and [physician name] provided orders to do so; however, [family member #2] did not follow through with finding a second opinion and [resident #61]'s pain continued left unmanaged until 4/14/24.<br><br>b. On 4/17/2024 it was discussed within a family meeting that a family member had made medical orders and provided prescription level wound care supplies to [family member #1] in order to treat [resident #61]. This was done without prior knowledge of wound care team and [facility name] providers.<br><br>c. On 4/19/2024 the [outside facility initials] cardiology office called [facility name] regarding [resident #61]'s digoxin [antiarrhythmic]. Family reported to Cardiology that [resident #61] was having an allergy to digoxin. This allegation was not reported to [facility name]. [Facility name] staff and [provider name] had provided education to [family member #2] and [family member #1] regarding digoxin and therapeutic labs had been drawn.<br><br>d. On 4/19/2024 Urology communicated with providers that family reported [facility name] was not treating current UTI [urinary tract infection]. [Resident #61] was currently receiving antibiotics.<br><br>e. On 4/23/2024 family scheduled appointments with Urology and Cardiology but failed to notify [facility name] of these appointments in order to schedule transportation. Family expectations of transportation within the same day is not feasible.<br><br>(continued on next page) |

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| | 535022 | A. Building<br>B. Wing | 05/23/2024 |

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| The Legacy Living and Rehabilitation Center | 1000 S Douglas Hwy<br>Gillette, WY 82716 |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | f. Family has been inconsistent in care decisions pertaining to [resident #61]'s PICC line, hospice, care meetings which impact [resident #61]'s care. Specifically saying yes to medical decisions then stating no to any further treatment.<br><br>g. As [resident #61] has had further decline in overall status over the past few weeks, the family have been resistant at times and refused to allow [resident #61] to wear incontinent products, which the IDT recommends to prevent skin breakdown while also a dignity concern for [resident #61]. Family has been resistant at times or refused at times to allow staff to assist [resident #61] in a wheelchair when [resident #61] has been unable to independently ambulate safely.<br><br>h. In the time [resident #61] resided at the [facility name], family have pursued clinical efforts outside [physician name]'s patient management and has attempted to implement their own plan of care without working cohesively with the [facility name] medical team. The MDPOA Advance Directives were not provided to the other physicians and clinics by the family and as the [facility name] provided the MDPOA to the clinics, the physicians then declined further treatment to follow the MDPOA due to advance dementia and malignancy.<br><br>2. Review of a progress note, dated 4/23/24 and timed 11:48 AM, showed DON contacted [family member #2] via phone call to follow-up on resident's status. Phone call was witnessed by [staff member name], ADON. Discussed medication availability with [family member #2] regarding antibiotics from yesterday and thanked him for picking up the antibiotics that we experienced a delay in getting from our pharmacy. [Family member #2] consented verbally to following Urology recommendations for a maintenance/prophylactic regimen of antibiotic for UTI. [Family member #2] requested a camera in [resident #61]'s room. DON advised that this is obtainable, we have to review a contract to ensure that we are meeting privacy and HIPAA of other residents. [Family member #2] agreed. DON discussed care transition for [resident #61]. Advised that we are not able to meet the needs for [resident #61] at this time and are issuing a 30-day discharge as of today. [Family member #2] will get a certified letter in the mail. Explained that [family member #2] can contest the discharge and file a grievance if desired. [Family member #2] educated to contact the State ombudsman and/or licensing agency for Wyoming and explained contact information will also be in the letter. DON explained [facility name] will support and offer assistance with locating a new facility for [resident #61]. [Family member #2] was not ready to make a decision on where he would like to have referrals sent and will follow-up with facility later. [Family member #2] then declined the request for a camera, stating it would be a waste of money if we are discharging [him/her] anyways.<br><br>3. Review of a progress note, dated 4/26/24 and timed 4:25 PM, showed Referral for LTC faxed to [nursing facility name], [NAME] Wy, [skilled nursing facility name], [NAME] WY, and [skilled nursing facility name].<br><br>4. Interview with family member #1 on 5/23/24 at 9:47 AM revealed she felt the facility issued the discharge notice in retaliation of her filing a grievance, related to neglect, the day before the notice was issued.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | 5. Interview with the DON on 5/23/24 at 2:54 PM revealed the resident's family did not feel the providers were providing appropriate care; however, she felt the facility was not meeting the family's requests for care as they were against the resident's wishes. The DON revealed the facility was able to meet the resident's care needs; however, the resident's family requests for care could not be met. Further interview confirmed the care and services provided at the nursing facilities and skilled nursing facilities where referrals had been sent were the same level of care and services the facility was able to provide. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>37220<br><br>Based on staff interview, medical record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure MDS assessment information was an accurate reflection of resident status for 1 of 7 residents reviewed for antibiotics (#26). The findings were:<br><br>1. Review of the 2/8/24 annual MDS assessment showed resident #26 was coded as taking an antibiotic with the indication noted box also checked. Review of the resident's physician orders and the 2024 January and February medication administration record showed no evidence the resident had been prescribed an antibiotic.<br><br>2. Interview on 5/23/24 at 9:58 AM with the MDS coordinator confirmed the resident had not been prescribed an antibiotic and the MDS assessment was coded incorrectly.<br><br>3. According to the MDS 3.0 RAI Manual version 1.18.11 page 483 N0415F1. Antibiotic: Check if an antibiotic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). N0415F2. Antibiotic: Check if there is an indication noted for all antibiotic medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days). |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081<br><br>Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure a pre-admission screen and resident review (PASARR or PASRR) was performed for 1 of 1 sample residents (#83) who had a PASARR level II indicated. The findings were:<br><br>1. Review of the medical record for resident #83 showed the resident was admitted to the facility on [DATE] and the PASARR level 1 completed at the time of admission indicated the need for a PASARR level II. Further review showed no evidence a PASARR level II was completed at that time.<br><br>2. Review of an Authorization Request Summary, dated 5/17/24 and timed 2:25 PM, showed a review type as PASRR Level 2. Further review showed the resident had diagnoses which included post-traumatic stress disorder and major depressive disorder and the Letter Rationale showed .Mental Health rehabilitation services may be recommended.<br><br>3. Interview with the DON on 5/22/24 at 4:05 PM confirmed the PASARR level II was not requested when the PASSAR I was completed. Further interview revealed she was unsure why it was not requested until 5/17/24.<br><br>4. Review of the policy titled PASRR dated 9/26/23 showed .All residents are required to have a PASRR Level I screen completed prior to nursing facility admission. PASRR Level I and II (when applicable) will be kept on filed in the resident's medical record and kept accurate according to OBRA and state regulations . |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220<br><br>Based on medical record review and staff interview, the facility failed to develop a comprehensive person-centered care plan for 3 of 27 sample residents (#62, #63, #98) reviewed. The findings were:<br><br>1. Review of the 3/18/24 annual MDS assessment for resident #62 showed the resident was admitted to the facility on [DATE], had a BIMS score of 5 out of 15 (indicating severe cognitive impairment), and had diagnoses which included Alzheimer's disease and depression. The resident was coded as receiving an antidepressant. The following concerns were identified:<br><br>a. Review of the resident's care plan, last revised on 4/1/24, showed the resident used an antidepressant medication related to depression and hypersexuality. Review of the current physician orders showed the facility was to monitor target behaviors of tearfulness, sadness, and withdrawal.<br><br>b. Interview with the DON and ADON on 5/23/24 at 2:26 PM revealed the resident liked residents of the opposite gender; however, confirmed the care plan did not address what hypersexual behaviors were exhibited by the resident.<br><br>2. Review of the 4/23/24 quarterly MDS assessment for resident #63 showed the resident was admitted to the facility on [DATE], had a BIMS score of 4 out of 15 (indicating severe cognitive impairment), and had diagnoses which included Alzheimer's disease, unspecified dementia, and anxiety. Further, the resident was coded as receiving an antianxiety medication. Review of the physician orders showed the resident was prescribed 10 milligrams of buspirone (antianxiety medication) at bedtime for anxiety. The following concerns were identified:<br><br>a. Review of the resident's care plan, last revised on 4/17/24, showed the resident used an antidepressant medication related to depression. Further review of the care plan showed no evidence a care plan had been developed for the use of the antianxiety medication.<br><br>b. Interview with the ADON on 5/23/24 at 10:21 AM revealed she thought buspirone was an antidepressant.<br><br>3. Review of the 2/9/24 significant change MDS assessment showed resident #98 was admitted to the facility on [DATE], discharged to the hospital on 1/8/24, and was readmitted to the facility on [DATE] with a new diagnosis of a traumatic brain injury. Additional diagnoses included Alzheimer's disease, unspecified dementia, and depression. A staff assessment showed the resident had severe cognitive impairment and was not administered any high-risk medications. The following concerns were identified:<br><br>a. Review of the care plan, initiated on 4/18/24, showed the resident had the potential to be physically aggressive related to dementia, poor impulse control, and neurological deficits. The interventions included a directive to Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. There was no evidence the facility had completed the analysis and developed a resident-centered comprehensive care plan.<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 | b. Interview with the DON and ADON on 5/23/24 at 2:26 PM confirmed the analysis had not been completed. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>37603<br><br>Based on medical record review, staff interview, review of emergency medicine inventory documents, policy and procedure review, and a pharmaceutical reference, the facility failed to ensure residents received medications as ordered by the physician for 1 of 7 sample residents (#61) reviewed for medication administration. The findings were:<br><br>1. Review of the 3/19/24 quarterly MDS assessment for resident #61 showed the resident was coded as being severe cognitive impairment and had diagnoses which included cancer, malignant neoplasm of unspecified site of left breast, anemia, malnutrition, Alzheimer's disease, dementia, and mastitis. Review of the care plan, initiated on 4/7/24, showed to monitor and document for signs and symptoms of a urinary tract infection (UTI): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and a change in eating patterns. The resident will verbalize burning and will have weakness as signs of a UTI. In addition, the care plan showed the resident was on extended antibiotics for recurrent UTI. The interventions, revised on 5/23/24, included to give antibiotic therapy as ordered. Monitor and document for side effects and effectiveness. The following concerns were identified:<br><br>a. Review of the physician orders showed an order for 500 milligrams (mg) of ampicillin was to be administered by mouth four times a day for UTI starting on 4/22/24 at 11:07 AM until 4/23/2024 at 11:59 PM. The order was to finish the 7 days of antibiotics due to the intravenous antibiotic access being removed by the resident on 4/21/24.<br><br>b. Review of the April 2024 medication administration record showed the facility failed to administer the medication 4 times between the order date and the time of the next administered dose.<br><br>c. Review of a 4/22/24 and timed 4:11 AM progress note showed family requested an oral (and possibly liquid) antibiotic be given to finish the resident's course of antibiotics for treatment of the UTI. The family wanted to discuss, with the provider, setting up maintenance antibiotics to prevent further UTIs. Further review of the progress notes showed on 4/22/24 at 8:24 PM Orders - Administration Note Text: Ampicillin Oral Capsule 500 MG not available.<br><br>d. Review of the 4/24/24 and timed 7:02 AM IDT Risk Management review note showed the date of the incident was 4/22/24 and the type of incident was a delay in care for antibiotic regimen. The root cause was determined to be because the resident was unable to maintain his/her IV and the family requested to change to PO (by mouth) antibiotic to minimize invasive IV starts. An order was placed with the pharmacy and then requested from the backup pharmacy; however, the backup pharmacy did not deliver the medication. The delay in care was due to availability/supply concerns with the pharmacy. The provider contacted the backup pharmacy and the prescription was filled and picked up by a family member and the night dose was administered. Interventions put into place included the pharmacist at the facility's primary pharmacy was working with the backup pharmacy to establish a process and troubleshoot delivery concerns.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | e. Interview with LPN #2 on 5/23/24 at 9:57 AM revealed when the physician placed an order for a medication, the nurses would acknowledge, save, and confirm it before the order was sent to the pharmacy. The LPN stated antibiotics may take a couple of days to arrive; however, the nurses could obtain the medication from the Omnicell (pysix) until the medication arrived.<br><br>f. Interview with LPN #1 on 5/23/24 at 10:14 AM revealed when the physician placed an order for a new medication the nurses confirmed the order and would then send the order to the pharmacy. The LPN stated not all medications came right away, especially antibiotics; however, a pyxis was available upstairs that medication could be obtained from until the facility received the medication from the pharmacy.<br><br>g. Interview with the DON on 5/23/24 at 10:19 AM revealed the medications were ordered from the primary pharmacy, and the resident would have to wait for them to come the next day if they were ordered after 2 PM. The nursing staff could obtain the medication out of the pyxis, if it was available, and administer it on time. The DON confirmed the resident had missed 4 doses of the antibiotic.<br><br>h. Review of the pyxis emergency inventory sheet showed ten 250 mg amoxicillin capsules were available. Review of the progress notes failed to show if the nursing staff had asked the physician if amoxicillin could be substituted until the ampicillin arrived.<br><br>2. Review of the Medicine Net.com on 5/31/24 showed Amoxicillin is a penicillin-type antibiotic. Other members of this class include ampicillin .<br><br>3. Review of the Medication Administration policy, dated 2/29/24 showed .New Medication Starts - Begin new medication orders timely. Begin routine orders on the same day ordered, unless the next dose would be normally given the next day. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | 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** 37220<br><br>Based on observation, medical record review and staff interview, the facility failed to ensure a safe environment for 2 of 12 residents (#26,#98) reviewed for supervision/accident hazards. The findings were:<br><br>1. Review of the 2/8/24 annual MDS assessment for resident #26 showed the resident was admitted to the facility on [DATE] and had a diagnosis of Alzheimer's disease. The resident had a BIMS score of 1 out of 15 which indicated severe cognitive impairment. Review of the resident's care plan, initiated on 10/3/23, showed the resident was an elopement wanderer related to dementia and staff were to intervene as appropriate. In addition, the care plan stated the resident was at risk for harm from residents due to cognition of self and others on his/her neighborhood and staff were to be aware of the resident's surrounding to ensure [the resident] is not placing [him/herself] into a dangerous situation. Staff to provide distracting techniques and redirection to encourage this resident away from those situations. The following concerns were identified:<br><br>a. Multiple observations during the survey timeframe showed the resident wandered between the Pine unit and the Cottonwood unit frequently picking up items and food.<br><br>b. Review of a Summary of Investigation report showed an unwitnessed resident-to-resident altercation took place on 4/15/24 at 1:40 PM which involved resident #26 and resident #114. Resident #114 pushed resident #26 which resulted in resident #26 falling and hitting his/her head on the floor. Both residents were transported by ambulance to the emergency department.<br><br>c. Review of an Alert note, dated 5/22/24 and timed 4:50 PM, showed Resident was found coming out of a resident's room with Remedy zinc oxide paste skin protectant. The resident had the zinc oxide in his/her mouth, tongue and lips.<br><br>2. Review of the 2/9/24 significant change assessment for resident #98 showed the resident was admitted to the facility on [DATE] and had diagnoses which included Alzheimer's disease, traumatic brain injury, and depression. The resident had a staff assessment which determined the resident to have severe cognitive impairment. Review of the resident's care plan, initiated on 10/20/23, showed the resident was at risk for elopement and wandering related to dementia. The staff were to intervene as appropriate. The following concerns were identified:<br><br>a. Review of a 5/12/24 incident report showed resident #98 was involved in an unwitnessed resident-to-resident altercation involving resident #28. Resident #98 resided in the Cottonwood unit and walked over to the Pine unit on 5/12/24 when at 6 PM CNAs heard yelling and responded to find resident #98 with a scratched earlobe. Resident #98 stated s/he had been hit by resident #28. Resident #28 responded with damn straight I did, [s/he] stole from me. The facility finalized the incident as inconclusive because it was not witnessed.<br><br>b. Review of a progress note, dated 5/19/24 and timed 5:06 AM, showed Resident had a large liquid bowel movement in addition to one episode of emesis. Resident had been going through both kitchens when staff was busy with other residents and eating several different things .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | c. Review of a behavior note dated 5/17/24 and timed 6:09 AM showed the Cottonwood CNA found the resident at approximately 4:30 AM drinking a bottle of hand sanitizer. The amount the resident drank was unknown; however, the bottle was 3/4 full when the CNA found the resident.<br><br>d. Review of a behavior note, dated 3/14/24 and timed 7:30 PM, showed Resident pacing and wandering unit throughout the day. [S/he] wanders into nurses/CNA stations and grabs staff belongings and tries to drink out of staff water bottles. [S/he] tries to go through papers/forms and desk items as well. Resident becomes agitated and belligerent when attempting to redirect, striking out at staff at times. Resident also observed going into other residents rooms and taking clothes and belongings. [S/he] requires constant supervision.<br><br>3. Interview with the DON and ADON on 5/23/24 at 2:26 PM revealed the resident's behaviors were monitored; however, interventions to ensure residents' safety had not been developed. In addition, zinc oxide was stored in resident rooms and used for residents that required incontinence care. |

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| | 535022 | A. Building<br>B. Wing | 05/23/2024 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>37603<br><br>Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure urinary Foley catheter bags were handled in a manner to prevent urinary tract infections for 1 of 4 (#38) residents with urinary catheters. The findings were:<br><br>1. Review of the 3/4/24 significant change MDS assessment for resident #38 showed the resident had a BIMS score of 15 out of 15 (cognitively intact), was coded as having an indwelling catheter, and had diagnoses which included neurogenic bladder and urinary tract infection. The following concerns were identified:<br><br>a. Observation on 5/20/24 at 2:22 PM of resident care showed CNA #3 lifted the urinary catheter bag above the resident's waist while untangling the tubing. The cloudy urine in the tubing was observed returning toward the resident's bladder. Further observation showed the CNA lifted the urinary bag and held it above the bladder when transferring the resident to a wheelchair via the ceiling lift.<br><br>b. Interview with the CNA on 5/21/24 at 11:57 AM revealed she was educated to keep the urinary catheter bag below the bladder.<br><br>2. Interview with the ADON and infection preventionist on 5/22/24 at 10:21 AM revealed it was the facility's expectation of staff to keep the urinary catheter bag below the bladder.<br><br>3. Review of the policy and procedure Urinary Catheter Care showed . Maintaining Unobstructed Urine Flow: .3. The drainage bag must be held/positioned lower than the bladder at all time to prevent the urine in the tubing and drainage bag from flowing back into the bladder. |

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| F 0744<br><br>Level of Harm - 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** 37220<br><br>Based on observation, medical record review, and staff interview, the facility failed to ensure residents with dementia received the appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being for 1 of 3 residents (#98) reviewed for dementia care. This failure resulted in actual harm to resident #98. The findings were:<br><br>1. Review of the 2/9/24 significant change MDS assessment for resident #98 showed the resident was admitted to the facility on [DATE] and had diagnoses which included Alzheimer's disease, traumatic brain injury, and depression. The resident had a staff assessment which determined the resident to have severe cognitive impairment. Further review showed the resident had not been prescribed any high-risk medications. Review of the resident's care plan, initiated on 10/20/23, showed the resident was at risk for elopement and wandering related to dementia. The staff were to intervene as appropriate. The following concerns were identified:<br><br>a. Review of the resident's pain care plan, last revised 5/10/24, showed Administer pain medications per order, if non-medication interventions are ineffective. The care plan failed to include what the non-medication interventions were.<br><br>b. Review of the care plan, initiated on 4/18/24, showed the resident had the potential to be physically aggressive related to dementia, poor impulse control, and neurological deficits. The interventions included a directive to Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. There was no evidence the facility had completed the analysis and developed a resident-centered comprehensive care plan.<br><br>c. Review of the care plan for fall prevention, dated 12/26/23, showed Resident frequently chooses to urinate on the floor, [in his/her] room and also in other residents restroom. Monitory (sic) for wet floors often.<br><br>d. Review of the neurological care plan, initiated on 1/19/24, showed the resident had an alteration in neurological status related to a head injury. The interventions included cueing, reorientation as needed, reposition or ambulation as tolerated. There was no evidence the facility had developed or implemented interventions to address the resident's neurological deficits.<br><br>e. Review of the 2/9/24 significant change MDS assessment showed the resident did not exhibit physical or verbal behaviors towards self or towards others, did not wander, and rejected care 4 to 6 days of the look-back period. The resident was coded as having improved behavior since the prior assessment.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | f. Review of the 5/21/24 Regulatory Progress Note showed the resident was resistant to participate in review of systems. [S/he] does not allow for assessment and dismisses this provider .[s/he] does have behavioral disturbances of pushing, cursing or name-calling, grabbing, yelling and screaming, kicking and hitting toward staff. [S/he] does not have any behaviors directed at other residents. [S/he] does have an occasion of refusing care as well as self-neglect and throwing or smearing bodily waste .Staff report resident is compliant with medications but generally does not allow for cares or assessment. There are otherwise no additional concerns per staff. Further review of the progress note showed no assessment or behavioral care plan had been developed.<br><br>g. Review of the 5/22/24 Multidisciplinary Care Conference note showed the resident was incontinent of bowel and bladder; resistive to cares being physical and verbally abuse towards staff. The resident was able to ambulate independently and can be found walking amongst the neighborhood and checking in on other residents. Currently, there is a barrier with having incontinent episodes and the behaviors that come when [s/he] offered to be cleaned. The most recent provider visit was unsuccessful, as resident denied participation. Further review of the care conference note showed no indication of an assessment to address the resident's behaviors and wandering. The care plan summary showed it had been reviewed with the patient and family; however, it had not been updated.<br><br>h. Review of a behavior note, dated 3/9/24 and timed 9:36 AM, showed resident intruding into Pine [male/female] residents room, removing cue entry/name signs from the door and belongings from inside room. [Male/female] resident's [spouse] expressed anger that resident intrudes into [the resident's] room, stating it is an invasion of [the resident's] privacy and [s/he] requested something to be done about it immediately. This nurse and nursing staff increase rounding on resident to keep watch on [his/her] wandering throughout unit.<br><br>i. Review of CNA documentation, dated 3/13/24 and timed 11:14 PM, showed Resident has been going into other residents rooms continuously. Try to redirect [him/her] to [his/her] own room and then goes back into others rooms. Continue to redirect.<br><br>j. Review of CNA documentation, dated 3/14/24 and timed 12:04 AM, showed Resident entered another residents room while I was in the middle of changing the resident and asked [him/her] to leave numerous times before [s/he] finally left.<br><br>k. Review of CNA documentation, dated 3/14/24 and timed 4:01 AM, showed Resident used call button in bathroom, went in to help [him/her] get out of feces brief and resident started pushing me away while trying to clean [his/her] bottom resident was hitting and punching me and almost fell due to [his/her] behaviors got resident stable in [his/her] step and let [him/her] walk to [his/her] bed.<br><br>l. Review of a behavior note, dated 3/14/24 and timed 7:30 PM, showed Resident pacing and wandering unit throughout the day. [S/he] wanders into nurses/CNA stations and grabs staff belongings and tries to drink out of staff water bottles. [S/he] tries to go through papers/forms and desk items as well. Resident becomes agitated and belligerent when attempting to redirect, striking out at staff at times. Resident also observed going into other residents rooms and taking clothes and belongings. [S/he] requires constant supervision.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | m. Review of a behavior note, dated 3/17/24, showed Resident has had an incontinent episode of bowel. Took resident to room to be changed. Resident combative with staff, stepping on staff's feet and kicking at them while staff is trying to clean resident. Was not able to get resident cleaned up all the way D/T (due to) the resident kept being combative. Gave resident [his/her] clothes to get dressed and left the room.<br><br>n. Review of a 3/18/24 behavior note showed While trying to shower [resident name] due to have BM (bowel movement) all over [his/her] legs and hands, [resident name] became very combative with CNAs by trying to hit and scratch them. CNA tried talking to [resident name] and explaining what they are doing and the reason for [his/her] shower but were unable to redirect [his/her] behavior during [his/her] shower.<br><br>o. Review of an alert note, dated 3/26/24, showed Resident observed sitting on the floor in hallway; Unable to recall what happened; Was incontinent of BM and had BM all over [him/her] Resident is combative, kicking and hitting at staff the whole time we are trying to assist up and to the shower. Stayed combative the whole time while showering. Noted a small abrasion to right knee, and bruising to right great toe; Unsure if resident hit [his/her] head so neuro's where (sic) were initiated.<br><br>p. Review of a behavior note, dated 3/27/24 and timed 1:42 AM, showed Resident found in room [ROOM NUMBER] (Pine unit) and was eating a snack. [S/he] told resident of that room I'm gonna eat you CNA removed resident from room.<br><br>q. Review of an alert note, dated 4/8/24 and timed 5:25 AM, showed Resident paced the hallways for the entirety of the shift. [Resident] spent long periods of time at the end of the hallway. [Resident] found to have urinated all over the floor. Floors cleaned. [Resident] also spent the shift switching shoes back and forth with another resident .<br><br>r. Review of a 5/12/24 incident report showed resident #98 was involved in an unwitnessed resident-to-resident altercation involving resident #28. Resident #98 resided in the Cottonwood unit and walked over to the Pine unit on 5/12/24 when at 6 PM CNAs heard yelling and responded to find resident #98 with a scratched earlobe. Resident #98 stated s/he had been hit by resident #28. Resident #28 responded with damn straight I did, [s/he] stole from me. The facility finalized the incident as inconclusive because it was not witnessed.<br><br>s. Review of a behavior note, dated 5/15/24, showed Resident is at the end of the hall, going to the corner and peeing on the floors. Is trying to take [his/her] brief off and digging feces out of [his/her] brief and throwing it all over the end of the hallway, on the walls, furniture and floor; is not directable, will not follow commands; Assisted x4 assist to the shower and was combative with staff the whole time getting a shower.<br><br>t. Review of a behavior note, dated 5/19/24 and timed 6:06 AM, showed at approximately 4:30 AM the cottonwood CNA found [resident name] drinking a bottle of hand sanitizer. The amount the resident drank was unknown; however, the bottle was 3/4 full when the CNA found the resident.<br><br>u. Review of a 5/19/24 behavior note showed Resident has been changed two times this shift thus far d/t (due to) diarrhea and each time is combative toward staff hitting and kicking at staff. Try to redirect but continues to be combative.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | v. Review of a progress note, dated 5/19/24 and timed 5:06 AM, showed Resident had a large liquid bowel movement in addition to one episode of emesis. Resident had been going through both kitchens when staff were busy with other residents and eating several different things .<br><br>2. Interview with LPN #1 on 5/23/24 at 8:24 AM revealed resident #98 from the Cottonwood unit would wander into resident rooms on the Pine unit which upsets the [residents] over there. The LPN stated staff would attempt to redirect the resident back to the Cottonwood unit; however, redirecting the resident was difficult at times as s/he often refused.<br><br>3. Interview with CNA #1 on 5/23/24 at 8:35 AM revealed the resident was very difficult to care for, exhibited aggressive behaviors, and wandered into other resident's rooms. The CNA stated the resident had recently been staying in the back hallway and she would check on him/her every 2 hours; however, the resident often refused incontinence care.<br><br>4. Interview with CNA #2 on 5/23/24 at 8:43 AM revealed the resident would come into the Pine unit and urinate and defecate on the floor and wander into other resident's rooms.<br><br>5. Interview with the DON and ADON on 5/23/24 at 2:26 PM revealed the facility monitored the resident's behaviors and relied on evaluations and assessments from providers to assist with managing a resident that exhibited behaviors. The DON confirmed a thorough analysis of what triggered the resident's behaviors and interventions and a professional evaluation of the resident had not been completed. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>37220<br><br>50485<br><br>Based on observation, staff and resident interview, review of policy and procedure, and review of the 2022 FDA Food Code, the facility failed to provide food service in a manner that ensured a safe and appetizing meal for 1 of 1 food service observation of the Pine, Cottonwood and Birch units. The findings were:<br><br>1. Observation on 5/22/24 at 11:55 AM showed the steam table food cart was transported from the kitchen to the Pine unit. Dietary aide #1 took the temperature of the food prior to the beginning of meal service at 12:03 PM. The temperature of the turkey casserole was 180 degrees Fahrenheit (F). The following concerns were identified.<br><br>a. At 12:13 PM the dietary aide washed her hands and began to serve the noon meal. At that time, she noted she had not arrived with the correct sized serving scoops and had to call the kitchen.<br><br>b. At 12:18 PM service was paused when a resident from the Cottonwood unit wandered into the serving area and the dietary aide had to redirect the resident to the common room. The dietary aide then noted she did not have enough food to serve the residents who required a minced and moist meal as well as enough food for the regular diets and had to call the kitchen a second time.<br><br>c. At 12:30 PM the nutrition supervisor arrived on the Pine unit and began assisting dietary aide #1. Food service ended at 12:40 PM.<br><br>d. Interview with the nutrition supervisor at 12:45 PM revealed the noon meal service should begin at 12 PM on the Pine unit and be completed within 20 minutes; service on the Cottonwood unit should start at 12:30 PM.<br><br>2. Observation of the noon meal service on the Cottonwood unit began at 12:47 PM with dietary aide #1 and the nutrition supervisor providing the service. The last plate for Cottonwood unit was served at 1:06 PM and a test plate was requested. The following concerns were identified:<br><br>a. At 1:10 PM dietary aide #1 determined the temperature of the turkey noodle casserole was 128 degrees F.<br><br>b. The turkey noodle casserole was tasted by the surveyor and found to be lukewarm.<br><br>3. Interview with resident #28's representative on 5/21/24 at 9:43 AM revealed the food was constantly served cold.<br><br>4. Interview with 7 residents during a group interview on 5/21/24 at 1:56 PM revealed residents complained of food being dry, cold or burnt, and with inconsistent portion size during meals. Residents also complained of being served warm drinks with no ice.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 5. Interview with the dietitian on 5/23/24 at 11:40 AM confirmed the need for education to dietary aides was necessary to increase speed and to balance efficiency when serving meals. She stated the servers only plated one plate at a time to ensure the food was kept warm, and her expectation was for food to be held at 140 degrees F.<br><br>6. Review of the Food Preparation Practices policy dated 8/2023, provided by the Infection Control nurse on 5/22/24 showed .4. All hot food shall be served immediately after preparation. Once prepared, hot food must be held at a temperature of 135 degrees F and above. Highly hazardous foods must never be held at temperatures from 41 degrees F-135 degrees F for longer than 4 hours.<br><br>7. Review of the 2022 FDA Food Code showed 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained:(1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above . |

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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>37220<br><br>50485<br><br>Based on observation, staff interview, review of policy and procedures, and review of the 2022 FDA Food Code, the facility failed to ensure temperatures were monitored for 6 of 6 refrigerator/freezers which stored food for resident use outside of the kitchen (Cottonwood, Pine, Birch, Rehab, Spruce, first floor servery and second floor servery). In addition, the facility failed to ensure a sanitary environment in 1 of 1 food preparation area. The census was 116. The findings were:<br><br>1. Observation on 5/23/24 of the refrigerator/freezers outside of the kitchen showed the following concerns:<br><br>a. The Frigidaire Gallery refrigerator located in the Cottonwood unit had milk, cheese, cottage cheese, and juices available for resident use. The thermometer located on the outside of the refrigerator showed a temperature of 35 degrees Fahrenheit (F) and the thermometer inside the refrigerator showed a temperature of 42 degrees F.<br><br>b. The Frigidaire Gallery refrigerator located in the Pine unit had milk, yogurt, juice, and sandwiches available for resident use. The thermometer located on the outside of the refrigerator showed a temperature of 35 degrees F and the thermometer inside the refrigerator showed a temperature of 42 degrees F.<br><br>c. The Delfield refrigerator located in the Cottonwood and Pine servery had thickened liquids, fortified drinks, pop, juice and sandwiches available for resident use. The thermometer located on the outside of the refrigerator showed a temperature of 38 degrees F. There was no thermometer inside of the refrigerator.<br><br>d. The Delfield refrigerator located in the Birch servery had thickened liquids and fortified drinks available for resident use. The thermometer located on the outside of the refrigerator showed a temperature reading of def and inside thermometer reading of 38 degrees F.<br><br>e. The Frigidaire Gallery refrigerator located in the Spruce unit had drinks, fruit, and sandwiches available for resident use. The thermometer located on the outside of the refrigerator showed a temperature of 38 degrees F and the thermometer inside the refrigerator showed a temperature of 42 degrees F.<br><br>f. Interview with the dietitian on 5/23/24 at 11:40 AM revealed monitoring of the refrigerators and freezers on the units was not being done.<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 | 2. Observation on 5/22/24 at 11:20 AM showed cook #1 used gloved hands to place raw hamburger patties on a paper-lined baking sheet. After completing the task, the cook discarded his gloves and without performing hand hygiene donned new gloves and proceeded to pick up seasoning containers. Interview with the dietitian on 5/22/23 at 11:25 AM confirmed the dietary aide should have performed hand hygiene after taking off his gloves. The dietitian educated the dietary aide at that time. In addition, the dietitian revealed she required the kitchen staff to complete the Serve Safe certification within 3 months of hire. In an additional interview with the dietitian on 5/23/24 at 3 PM revealed the cook was to complete his Serve Safe certification by 4/30/24; however, as of 5/23/24 it had not been completed.<br><br>3. Review of the Food Storage/Inventory policy dated 8/2023, provided by the Infection Control nurse on 5/22/24, showed .7. All perishable items are stored in either refrigerators maintained at a temperature of 40 degrees F or below or freezers maintained between temperatures of 10 degrees F or below .10. A reliable thermometer is provided for each reach-in or walk-in refrigerator and freezer in an easily readable location. Refrigerator/freezer temperatures are documented daily using approve [sic] temperature logs. Any corrective actions are reported to supervisors immediately.<br><br>4. According to the 2022 FDA Food Code 2-103.11 Person in Charge. The PERSON IN CHARGE shall ensure that . (I) EMPLOYEES are properly maintaining the temperatures of<br><br>TIME/TEMPERATURE CONTROL FOR SAFETY FOODS during hot and cold holding through daily oversight of the EMPLOYEES' routine monitoring of FOOD temperatures .<br><br>5. According to the 2022 FDA Food Code showed 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the<br><br>toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403. 11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and<br><br>contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands. |

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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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>37603<br><br>Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure enhanced barrier precautions were followed for 1 of 4 (#38) resident reviewed for transmission-based precautions. The findings were:<br><br>1. Review of the 3/4/24 significant change MDS assessment for resident #38 showed the resident had a BIMS score of 15 out of 15 (cognitively intact), had an indwelling catheter and a urinary tract infection. Review of the resident's care plan, initiated on 5/4/24, showed the resident had precautions in place to prevent the spread of multidrug resistant organisms (MDROs) secondary to the indwelling catheter and wounds. Staff were to use enhanced barrier precautions (EBP) which included the utilization of gowns and gloves for high-contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (eg, central line, urinary catheter, feeding tube, tracheostomy/ventilator), and wound care/skin care (eg, any skin opening requiring a dressing). Outside of resident rooms, EBPs to be followed when performing transfers, assisting during bathing in a shared/common shower room, and working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. Hand hygiene was recommended before and after resident contact. The following concerns were identified:<br><br>a. Observation on 5/20/24 at 2:22 PM showed CNA #4 and CNA #3 were only wearing gloves when they placed a brief, shirt, and pants on the resident. The CNAs lifted the urinary catheter up above resident while untangling the urinary tubing. The cloudy urine in the tubing was seen returning toward the resident. The CNA lifted the urinary bag up and held it over the resident's bladder during a transfer to his/her wheelchair, via the ceiling lift, and hooked it on the lift strap above the resident's bladder. The cloudy urine was observed flowing back towards the bladder. Further, no signage was posted on the door or wall for the EBP required.<br><br>b. Interview with the ADON and infection preventionist on 5/22/24 at 10:21 AM revealed the EBP list included urinary catheter, wounds, and tracheostomies. The EBP sign was tucked inside the PPE (personal protective equipment) hanging storage unit on the resident's door. All staff were trained last April and May on EBP. The facility's expectation for providing care of a resident with a catheter and /or wound would be for nursing staff to be gowned and gloved.<br><br>2. Review of the policy and procedure Enhanced Barrier Precautions, dated 1/6/23, showed . 2. EBPs employ targeted gown and glove use during high-contact resident care activities when contact precaution do not otherwise apply. A. Gloves and gown are applied prior to performing high-contact resident care activities . 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: . c. transferring, d. providing hygiene; e. changing linens; f. changing briefs or assisting with toileting; g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); . 10. Signs are posted on the door or wall outside the resident room indicating the type of precaution and PPE required. |