| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555797 | A. Building<br>B. Wing | 04/12/2024 |

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|---|---|
| F 0550<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324<br><br>Based on observation, medical record review, and interview, the facility failed to promote the dignity and respect for one nonsampled resident (Resident 65).<br><br>* CNA 7 was observed standing over Resident 65 while assisting and feeding the resident with lunch. This failure posed the risk of not treating the resident with dignity and respect.<br><br>Findings:<br><br>Medical record review for Resident 65 was initiated on 4/10/24. Resident 65 was admitted to the facility on [DATE].<br><br>Review of Resident 65's H&P examination dated 3/28/24, showed Resident 65 had capacity to understand and make decisions.<br><br>On 4/9/24 at 0847 hours, a concurrent observation and interview was conducted with Resident 65 in the dining room. Resident 65 stated he needed assistance when eating during meal times.<br><br>On 4/9/24 at 1221 hours, a lunch meal observation for Resident 65 and concurrent interview was conducted with CNA 7. CNA 7 was observed standing over Resident 65 while assisting and feeding him. CNA 7 acknowledged he should not have stood over while feeding Resident 65.<br><br>On 4/10/24 at 1417 hours, an interview was conducted with RN 2. RN 2 acknowledged CNA 7 should be at eye level with Resident 65 while assisting in feeding during meal times.<br><br>On 4/12/24 at 1440 hours, an interview was conducted with the DON. The DON stated CNA 7 should have been seated and be at eye level when feeding the residents. |

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of six sampled residents (Resident 26) reviewed for psychotropic use was informed of the use of the psychotropic medication (medication affecting brain activities associated with mental processes and behavior).<br><br>* The facility failed to ensure the informed consent was obtained prior to administering the Seroquel (an antipsychotic medication that treats several kinds of mental health conditions including schizophrenia) and paroxetine (a medication used to treat depression) for Resident 26. This failure had the potential for Resident 26 to not be informed of the medication and potential effects of Seroquel and paroxetine.<br><br>Findings:<br><br>Review of the facility's P&P titled Informed Consent revised on 12/2022 showed it is the policy of this facility to uphold the rights of residents to participate in the panning and decision-making process concerning their care and treatment. When situations arise that involve complex decisions, the facility will verify the informed consent has been obtained prior to any medical intervention or treatment is initiated, including but not limited to, administration of psychotherapeutic medications.<br><br>Review of the facility's P&P titled Use of Psychotropic Medication revised on 9/2022 showed the residents and or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments or non- pharmacological interventions.<br><br>Medical record review for Resident 26 was initiated on 4/9/24. Resident 26 was admitted to the facility on [DATE].<br><br>Review of Resident 26's MDS 5-day assessment dated [DATE], showed Resident 26 was able to make self-understood and able to understand others.<br><br>Review of Resident 26's Order Summary Report as of 4/10/24, showed the following orders:<br><br>- Seroquel XR 300 mg one tablet by mouth one time a day for Schizophrenia manifested by frequent mood swings<br><br>- paroxetine hcl 40 mg one tablet by mouth one time a day for depression manifested by verbalization of feeling depressed.<br><br>Review of Resident 26's MAR for April 2024 showed Resident 26 received Seroquel XR 300 mg one tablet one time a day since 2/16/24, and paroxetine hcl 40 mg one tablet one time a day since 2/17/24.<br><br>Review of Resident 26's Physician Documentation of Informed Consent for Seroquel 300 mg, undated, failed to show a physician signature on the form.<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 | Review of Resident 26's Physician Documentation of Informed Consent for paroxetine 40 mg, undated, failed to show a physician signature on the form.<br><br>Review of the Facility Verification of Informed Consent form was incomplete and failed to show verification of informed consent was obtained from and by the facility staff for Seroquel 300 mg for Schizophrenia and paroxetine 40 mg for depression.<br><br>On 4/11/24 at 0840 hours, a concurrent interview and medical record review was conducted with LVN 3. LVN 3 verified Resident 26 was currently receiving Seroquel XR 300 mg one tablet one time a day since 2/16/24, and paroxetine hcl 40 mg one tablet one time a day since 2/17/24. LVN 3 verified the informed consents for Seroquel XR 300 mg and paroxetine hcl 40 mg were not signed by the MD and the facility verification form failed to show verification of informed consent obtained from and by the facility staff for Seroquel and paroxetine.<br><br>On 4/11/24 at 1338 hours, a concurrent interview and medical record review was conducted with the DON. The DON stated the informed consents should have been signed by the MD and the facility verification of informed consents should have been completely filled out. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853<br><br>Based on observation, interview, and P&P review, the facility failed to ensure the accomodations of needs were met for one of 19 final sampled resident (Resident 67) and two of nonsampled residents (Residents 83 and 84).<br><br>* The call lights were not within reach for Residents 83 and 84.<br><br>* The call light was not answered promptly for Resident 67.<br><br>These failures had the potential for the residents not getting their needs met timely.<br><br>Findings:<br><br>Review of the facility's P&P titled Call Lights: Accessibility and Timely Response revised 9/2/22, showed the purpose of this policy is to assure the facility is adequately equipped with a call light. Staff will ensure the call light is within reach of resident and secure as needed.<br><br>Medical Record review for Resident 83 was initiated on 4/9/24. Resident 83 was admitted to the facility on [DATE].<br><br>Review of Resident 83's 5-day Admission Assessment MDS dated [DATE], showed under Section B, the resident was able to make needs known, understood, and understand. Section C showed BIMS 9 and section GG showed no limitation in range of motion of both upper and lower extremities.<br><br>On 4/9/24 at 0815 hours, during initial tour, Resident 83 was observed laying in bed. The call light was observed behind the head board of Resident 83's bed.<br><br>On 4/9/24 at 0817 hours, an interview was conducted with CNA 3. CNA 3 stated Resident 83 was able to use the call light and make needs known. CNA 3 verified the call light was behind Resident 83's headboard and should be placed within easy reach.<br><br>2. Medical record review for Resident 84 was initiated on 4/9/24. Resident 84 was admitted to the facility on [DATE].<br><br>Review of Resident 84's 5-day Assessment MDS dated [DATE], showed under Section B, the resident was able to make needs known, understood, and understand. Section C showed BIMS 12 and section GG showed no limitation in range of motion of both upper and lower extremities.<br><br>On 4/9/24 at 0851 hours during the initial tour, Resident 84 was observed laying in bed. The call light was clipped to the call light panel on the wall.<br><br>On 4/9/24 at 0900 hours, an interview was conducted with the customer relations staff. The customer relations staff stated Resident 84 was able to use call light and able to make needs known. Customer Relations further stated the call light should be kept within Resident 84's reach.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/11/24 at 1438 hours, an interview was conducted with the DON. The DON stated the call lights were expected to be within the resident's reach. The DON was informed and acknowledged the above findings.<br><br>49324<br><br>3. Medical record review for Resident 67 was initiated on 4/12/24. Resident 67 was admitted to the facility on [DATE], and was readmitted [DATE].<br><br>Review of Resident 67's MDS Section C dated 1/27/24, showed Resident 67 had a BIMS Summary Score of 14.<br><br>Review of Resident 67's H&P examination dated 10/19/23, showed Resident 67 was oriented to date, time, and place; and able to make decisions.<br><br>On 4/11/24 at 1608 hours, an interview was conducted with Resident 67. Resident 67 stated CNA 8 came 4/10/24 at 1030 hours, and said she would periodically check throughout the course of the day but she never came back. Resident 67 further stated he pushed the call light button, but she never showed up.<br><br>On 4/12 /24 at 1440 hours, an interview was conducted with DON and Administrator. They were informed of the above finding and acknowledged the CNA and other staff should have attended to Resident 67's needs. |

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| F 0585<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346<br><br>Based on interview and medical record review, the facility failed to thoroughly investigate a grievance for one of 19 sampled residents (Resident 87). This failure posed the risk of not taking all appropriate corrective action.<br><br>Findings:<br><br>Medical record review for Resident 87 was initiated on 4/10/24. Resident 87 was admitted to the facility on [DATE].<br><br>Review of Resident 87's H&P examination dated 3/21/24, showed Resident 87 had diagnoses included post status multiple falls, episodes of delirium, anxiety, and generalized muscle weakness. Further review showed Resident 87 did not have the capacity to understand and make decisions.<br><br>Review of Resident 87's progress note dated 4/1/24, showed Resident 87's RP verbalizing that she observed many times where the staff did not answer the call lights and the residents almost falling. The RP further stated she had to go find a staff.<br><br>Further review of the medical record showed no documented evidence the resident's RP concerns was addressed.<br><br>On 4/12/24 at 1046 hours, a concurrent interview and medical record review was conducted with the DON. When asked if any investigation was completed for the reason for call lights not being answered or for the residents almost falling, the DON did not have any documented investigation follow up for the resident's RP concern.<br><br>Cross reference to F919. |

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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** 48844<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to implement the comprehensive care plan to address the individual care needs for one of one sampled resident (Resident 7) reviewed for IV antibiotic use.<br><br>* The facility failed to develop a plan of care addressing Resident 7's Vancomycin (antibiotic used to treat and prevent various bacterial infections) treatment given intravenously (giving medicines through a needle or tube inserted into a vein). This failure had the potential for not providing appropriate, consistent, and individualized care.<br><br>Findings:<br><br>According to the facility's P&P titled Comprehensive Care Plans revised 12/19/22, showed the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident comprehensive assessment.<br><br>Medical record review for Resident 7 was conducted on 4/10/24. Resident 7 was readmitted to the facility on [DATE].<br><br>Review of Resident 7's comprehensive care plan initiated on 4/10/22, and revised on 4/10/24, showed a care plan problem addressing the IV therapy of Rocephin (antibiotic used to treat many kinds of bacterial infection) related to UTI (urinary tract infection). The intervention included when on Vancomycin, to monitor the input and output and check for signs of nephrotoxicity which was initiated on 4/10/24.<br><br>Review of Resident 7's Order Summary Report for the order dates between 11/1/23 to 4/30/24, showed an initial order for Vancomycin IV solution dated 3/26/24, to use 1.25 gram intravenously one time a day for UTI/sepsis until 4/28/24. The order summary repport showed the Vancomycin trough level (to check inadequacy and an increased risk of developing bacterial resistance) on 3/30/24 at 0830 hours.<br><br>Review of Resident 7's IV Administration Report for March 2024 showed Vancomycin 1.25 grams was intravenously started on 3/28/24.<br><br>On 4/10/24 at 1439 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 reviewed Resident 7's plan of care and was not able to see a care plan for Vancomycin IV therapy. The last care plan for IV therapy was resolved on 3/1/23. Furthermore, RN 2 stated no care plan was developed.<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 4/11/24 at 1305 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 stated a care plan should be initiated as soon as the physician had new orders. RN 3 verified the daily Vancomycin IV was started on 3/27/24, until 4/28/24, and the care plan interventions for the use of Vancomycin was only initiated on 4/10/24. Furthermore, RN 3 verified Vancomycin was in the intervention and not as a focused problem.<br><br>On 4/12/24 at 1015 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified a care plan for IV Vancomycin was only initiated on 4/10/24. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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** 48853<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care was revised to reflect the resident's care needs for one of 19 final sampled residents (Resident 84).<br><br>* The facility failed to ensure Resident 84's care plan was revised to reflect the treatment for both lower extremities for maintenance of skin integrity from the cellulitis related to venous insufficiency (a condition in which the veins fail to return blood efficiently to the heart). This failure placed Resident 84 at risk for the specific care needs not being addressed.<br><br>Findings:<br><br>Review of the facility's P&P titled Comprehensive Care Plan revised 12/19/22, showed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident's rights, that includes measurable objectives and time frames to meet resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress.<br><br>Review of Resident 74's medical record was initiated on 4/9/24. Resident 74 was admitted on [DATE], and readmitted on [DATE].<br><br>Resident 74's H&P examination dated 1/17/24, showed Resident 74 had the capacity to understand and make decisions.<br><br>Review of Resident 74's Order Summary Report dated 4/10/24 showed the following physician's orders:<br><br>- for the left lower leg swelling, to clean with soap and water, apply vitamin A and D ointment daily and wrap with Kerlix (roll gauze), then cohesive bandage every day shift for 14 days.<br><br>- for the right lower leg swelling, to clean with soap and water, apply vitamin A and D ointment daily and wrap with Kerlix, then cohesive bandage every day shift for 14 days.<br><br>Review of Resident 74's care plan failed to show the care plan was revised to show the interventions for the treatments to the left and right lower legs for skin maintenance.<br><br>On 4/10/24 at 0835 hours, an interview and medical record review were conducted with LVN 2. LVN 2 verified the above physician's treatment orders and care plan were not updated for the left and right lower legs.<br><br>On 4/10/24 at 1237 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>48853<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of a wound for one of three sampled residents observed for wound care (Resident 74).<br><br>* The facility failed to provide skin treatment to Resident 74's right lower leg swelling as ordered by the physician. This failure had the potential for Resident 74 to develop or worsening of skin breakdown.<br><br>Findings:<br><br>Review of the facility's P&P titled Clean Dressing Change revised on 12/19/22 showed to provide wound care in a manner to decrease potential for infection and or cross contamination. The physician's order will specify type of dressing and frequency of changes. The policy showed place a barrier cloth or pad next to the resident, under the wound to protect the linen and other body sites; and apply topical ointments or creams and dress the wound as ordered.<br><br>Review of Resident 74's Order Summary Report dated 4/10/24, showed the following physician's orders:<br><br>- for the left lower leg swelling, to clean with soap and water, apply vitamin A and D ointment daily and wrap with Kerlix (antimicrobial large roll dressing to provide an antimicrobial barrier to prevent microbial penetration and microbial growth within the dressing) then cohesive bandage every day shift for 14 days ordered on 4/9/24.<br><br>- for the right lower leg swelling, to clean with soap and water, apply vitamin A and D ointment daily and wrap with Kerlix then cohesive bandage every day shift for 14 days ordered on 4/9/24.<br><br>On 4/10/24 at 0828 hours, a wound care observation for the resident's right leg was conducted with LVN 2. LVN 2 had completed the dressing change to the left leg prior to the observation of the wound care treatment. LVN 2 was observed having the Derma Klenz (a wound cleanser with zinc that contains no detergents and facilitates the removal of wound debris) wound cleanser on Resident 74's bed, and Kerlix dressing and latex flexible cohesive bandage on a metal plate on Resident 74's bedside table. LVN 2 was observed to spray Derma Klenz on a gauze, cleanse the right leg, applied vitamin A and D ointment, and wrap with Kerlix dressing then put the cohesive bandage.<br><br>On 4/10/24 at 0835 hours, an interview and medical record review was conducted with LVN 2. LVN 2 verified the physician's order was to use soap and water. LVN 2 verified he used Derma Klenz to the right leg during the wound care observation instead of cleansing the area with soap and water. LVN 2 verified he failed to provide a cloth barrier or protective drape under Resident 74's foot during the wound care.<br><br>On 4/10/24 at 1237 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>48853<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the worsening of a pressure ulcer for one of the three sampled residents observed wound care (Resident 26).<br><br>* The facility failed to provide wound treatment to Resident 26's right hip and right lateral malleolus pressure injuries as ordered by the physician. This failure had the potential for Resident 26's worsening of existing pressure ulcer.<br><br>Findings:<br><br>Review of the facility's P&P titled Clean Dressing Change revised on 12/19/22, showed the facility to provide wound care in a manner to decrease potential for infection and or cross contamination. Physician's order will specify type of dressing and frequency of changes. Policy explanation and compliance guidelines showed place a barrier cloth or pad next to the resident, under the wound to protect the linen and other body sites. Apply topical ointments or creams and dress the wound as ordered.<br><br>Review of Resident 26's Order Summary Report dated 4/10/24, showed the following physician's orders:<br><br>- an order dated 3/22/24, for the right lateral malleolus (a bony projection on either side of the ankle) pressure injury, to cleanse with Dakin (a mixture of sodium hypochlorite and boric acid diluted in water) solution 1/4 (quarter) strength pat dry, apply Santyl (used to remove damaged tissue from chronic skin ulcers and severely burned areas) ointment daily, and cover with a dry dressing, then secure with Kerlix (antimicrobial large roll dressing to provide an antimicrobial barrier to prevent microbial penetration and microbial growth within the dressing) for 30 days.<br><br>- an order dated 4/9/24, for the right hip pressure injury, to cleanse with normal saline (a nontoxic, isotonic solution that does not damage healing tissues), pat dry, soak a dry gauze on Dakin solution 1/4 strength daily, and cover with a dry dressing for 30 days.<br><br>On 4/10/24 at 0905 hours, a wound care observation was conducted with LVN 2. LVN 2 was observed during the wound care of Resident 26's right lateral malleolus and right hip pressure injuries. LVN 2 was observed to set up a bedside table covered with the protective drape with the following supplies: Derma Klenz (a wound cleanser with zinc that contains no detergents and facilitates the removal of wound debris) spray, a bottle of 1/4 strength Dakin solution, dry gauze dressings and Kerlix dressing; and took the bedside table to Resident 26's bedside. LVN 2 washed hands, donned gloves, and removed the old dressing of the right malleolus. LVN 2 supported Resident 26's right foot on top of the pillow. LVN 2 washed hands, then proceeded to spray Derma Klenz on the gauze, and cleansed the right lateral malleolus pressure injury. LVN 2 washed hands, donned gloves then soaked the dry gauze with 1/4 strength Dakin solution, applied to the right lateral malleolus pressure injury, then wrapped with Kerlix dressing. However, LVN 2 did not apply Santyl ointment to the right lateral malleolus pressure injury as ordered.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LVN 2 proceeded to perform the right hip pressure injury wound care. LVN 2 washed hands, donned gloves, rolled up Resident 26's diaper and rolled down the resident's pants then removed the dressing of the right hip. LVN 2 washed hands, donned gloves, sprayed Derma Klenz to a gauze and cleansed the right hip pressure injury, LVN 2 washed hands, donned gloves, then soaked a dry gauze with 1/4 strength Dakin solution; and the diaper was observed to flipped back to the wound bed and the pants rolled back up to the pressure injury site. LVN 2 proceeded to put the gauze dressing soaked with Dakin solution to the right hip pressure injury and covered with a dry dressing. However, LVN 2 used Derma Klenz instead of normal saline as ordered.<br><br>On 4/10/24 at 0935 hours, a concurrent interview and medical record review were conducted with LVN 2. LVN 2 verified Derma Klenz was used to cleanse the right lateral malleolus and the dressing soaked with Dakin solution applied to the right lateral malleolus pressure injury, and covered with Kerlix dressing. LVN 2 verified Santyl ointment was not applied to the right lateral malleolus wound as ordered by the physician. LVN 2 also verified right hip pressure injury was cleansed with Derma Klenz instead of normal saline as ordered. LVN 2 verified he failed to open the diaper to prevent it from flipping back to the wound bed. LVN 2 verified he did not put any protective pads under the pressure injury sites to protect the body sites. LVN 2 further stated he did not get the wound care treatment supply this morning from the central supply and used what he had in the treatment cart.<br><br>Cross reference to F684. |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453<br><br>Based on observation, interview, and medical record review, the facility failed to provide the necessary GT care and services for one of two sampled residents reviewed for GT care.<br><br>* The facility failed to ensure Resident 53 was positioned safely at 30 to 45 degrees during the enteral feeding via GT. This failure posed the risk for developing complications related to GT.<br><br>Findings:<br><br>According to Taylor's Fundamentals of Nursing seventh edition, Nursing Considerations with Tube Feeding, to make sure the resident is as upright as possible during feeding. If the resident is in bed during feedings, elevate the head of the bed at least 30 degrees during feeding and for one hour afterward to prevent reflux (occurs when stomach acid repeatedly flows back into the esophagus or the tube connecting your mouth and stomach) and aspiration.<br><br>Medical record review for Resident 53 was initiated on 4/9/24. Resident 53 was readmitted to the facility on [DATE].<br><br>Review of Resident 53's Order Summary Report showed a physician's order dated 3/21/24, to administer Diabetisource AC 1.2 (a tube feeding formula made with a unique blend of carbohydrates that includes pureed fruits and vegetables) at 65 ml per hour for 20 hours to provide 1300 ml per day.<br><br>On 4/11/24 at 0816 hours, Resident 53 was observed slouched in bed. Resident 53's GT Diabetisource AC 1. 2 was observed infusing via a feeding pump at 65 ml per hour.<br><br>On 4/11/24 at 0820 hours, an observation for Resident 53 and concurrent interview was conducted with LVN 1. Resident 53 was observed slouched in bed with the GT feeding pump turned on. LVN 1 verified the above findings. LVN 1 stated Resident 53 usually slides down the bed, and she would ask the CNAs for assistance to pull him up, and there should be a pillow on his legs to prevent Resident 53 from sliding down.<br><br>On 4/12/24 at 1410 hours, Resident 53 was observed slouched in bed. Resident 53's GT Diabetisource AC 1. 2 was observed infusing via a feeding pump at 65 ml per hour.<br><br>On 4/12/24 at 1417 hours, an observation for Resident 53 and concurrent interview was conducted with LVN 1. Resident 53 was observed slouched in bed with the GT feeding pump turned on. LVN 1 verified the above findings. LVN 1 stated Resident 53's family members just came out of the room, and they could have repositioned the resident. LVN 1 could not provide documentation when asked if an education or a training was provided to Resident 53's family members regarding repositioning the resident while the resident was receiving a GT feeding.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/12/24 at 1426 hours, an interview and concurrent medical record review for Resident 53 was conducted with the DON. The DON stated the head of the bed of the resident receiving feeding via GT should be at least 45 degrees. The DON stated she was not aware if Resident 53 sliding down the bed. The DON stated if Resident 53's family members repositioned the resident, they should be educated to keep Resident 53's head of the bed elevated while the GT feeding was on. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of one sampled resident (Resident 74) reviewed for the use of BiPAP (Bilevel positive airway pressure, a form of noninvasive ventilation that providers use to help with breathing) was provided with the appropriate respiratory care.<br><br>* The facility failed to ensure the BiPAP mask was cleaned according to the facility's P&P. This failure had the potential to negatively impact Resident 74's medical condition.<br><br>Findings:<br><br>Review of the facility's P&P titled CPAP (continuous positive airway pressure) /BiPAP Cleaning revised on 12/19/22, showed to clean the CPAP/BiPAP equipment in accordance with the current CDC guidelines and manufacturer recommendations in order to prevent the occurrence or spread of infection. The P&P also showed clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well. Cover with plastic bag or completely enclosed in machine storage when not in use. Weekly cleaning activities: a. wash headgear/ straps in warm, soapy water and air dry; b. wash tubing with warm, soapy water and air dry.<br><br>Review of Resident 74's medical record was initiated on 4/9/24. Resident was admitted on [DATE], and readmitted on [DATE].<br><br>Resident 74's H&P examination dated 1/17/24, showed Resident 74 had the capacity to understand and make decisions.<br><br>Review of Resident 74's MDS Quarterly assessment dated [DATE], under Section C, showed BIMS of 14 (cognitively intact).<br><br>Review of the Order Summary Report for April 2024 showed an order for BiPAP as follows:<br><br>- Type of mask: Full Mask,<br><br>- Humidifier, oxygen at 2 liters/minute<br><br>- Pressure settings IPAP (inspiratory positive airway pressure, pressure delivered while the patient is inhaling): cmH18 EPAP (expiratory positive airway pressure, pressure delivered while the patient is exhaling): 5 cmH20 every evening and night shift shortness of breath monitoring of mask placement.<br><br>On 4/9/24 at 0825 hours, an interview with Resident 74 was conducted. Resident 74 stated her BiPAP mask was never cleaned since she was admitted to the facility.<br><br>On 4/9/24 at 0942 hours, an interview was conducted with LVN 3. LVN 3 verified the resident used BiPAP at night and had no treatment order for the cleaning of the BiPAP mask.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/10/24 at 1238 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON further stated a treatment order was placed yesterday to clean the BiPAP mask. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the pain management was provided to two of two sampled residents (Residents 7 and 23).<br><br>* The facility failed to notify the physician of Resident 7's pain to obtain a pain medication to manage the resident's pain.<br><br>* The facility failed to ensure Resident 23 was administed the pain medications as ordered.<br><br>These failure had the potentitial for not providing the necessary care and services and effectively managing the residents' pain.<br><br>Findings:<br><br>1. According to the facility's P&P titled Pain Management revised 12/19/22, showed the facility must ensure the pain management is provided to the residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>The P&P also showed the following:<br><br>- Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated;<br><br>- Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs.<br><br>- Manage or prevent pain, consistent with the comprehensive assessment and plan of care;<br><br>- Facility staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include but are not limited to negative vocalizations (e.g. groaning, crying, whimpering, screaming);<br><br>The pain management and treatment section in the P&P showed the following:<br><br>- Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor, and revise as necessary interventions to prevent or manage each individual resident's pain.<br><br>- The interventions for pain management will be incorporated into the components of the comprehensive care plan, addressing conditions or situations that may be associated with pain or may be included as a specific pain management need or goal.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Medical record review for Resident 7 was initiated on 4/10/24. Resident 7 was readmitted to the facility on [DATE].<br><br>Review of Resident 7's MDS dated [DATE], showed Resident 7 was moderately cognitively impaired.<br><br>Review of Resident 7's Order Summary Report showed an order dated 3/26/24, for the pain evaluation (on a pain scale of 0 to 10 with 0 = no pain, 1-4 = mild pain, 5-7 = moderate pain, 8-9 = severe pain, 10 = very severe pain) every shift<br><br>Review of Resident 7's plan of care showed a care plan problem initiated on 12/1/23, addressing the resident's pain related to diabetic neuropathy (nerve damage), medical procedure, and wound. The care plan interventions included to administer analgesia medication as ordered and give half an hour before treatments or care.<br><br>Review of the Progress Notes for skin evaluation dated 3/27 and 4/4/24, showed Resident 7 had constant pain and painful skin tissue. There was no documented evidence of the physician notification of the resident's constant pain. There was no pian medication prescribed for the resident.<br><br>On 4/11/24 at 0820 hours, an observation and concurrent interview regarding Resident 7's coccyx (a small triangular bone at the base of the spinal column) pressure ulcer was conducted with LVN 2. CNA 4 was also present to assist with repositioning Resident 7. Resident 7 was observed smiling before the start of the wound treatment. When the bandaged of the coccyx wound was removed by LVN 2, Resident 7 started to cry. Resident 7 continued to cry and stated it hurt. When LVN 2 was asked if a pain medication was given prior to wound care treatment, LVN 2 stated no. The wound treatment for Resident 7 was not completed because Resident 7 continued to cry.<br><br>Further review of the medical record showed the physician's order dated 4/11/24, to administer tramadol 50 mg one tablet every 12 hours as needed for moderate to severe pain (pain score of 5-9) for 60 days; and Tylenol 325 (over-the-counter analgesic) two tablets every six hours as needed for mild to moderate pain (pain score of 4-6) for 60 days.<br><br>On 4/11/24 at 1013 hours, an observation and concurrent interview regarding Resident 7's coccyx area pressure ulcer was conducted with LVN 2. CNA 5 was also present to assist with repositioning Resident 7. According to LVN 2, Resident 7 was administered tramadol (medication for pain) at 0920 hours. LVN 2 applied zinc oxide (used to treat or prevent minor skin irritations) around the wound area and packed the pressure ulcer with dakin solution (used to kill germs and prevent germ growth in wounds). Wound treatment for Resident 7 was completed. LVN 2 stated Resident 7's physician was not notified regarding the resident's increased pain, and did not request for an order for pain medication.<br><br>On 4/11/24 at 1243 hours, an interview was conducted with CNA 6. CNA 6 stated Resident 7 was always complaining of pain. Resident 7 was crying and complaining of pain at the legs and back. CNA 6 stated the CNA reported to the nurse if Resident 7 was in pain.<br><br>On 4/11/24 at 1305 hours, an interview and concurrent medical review was conducted with RN 3. RN 3 verified a pain medication was not initiated on admission and the care plan for pain was not followed for Resident 7.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/12/24 at 0826 hours, an interview and concurrent medical review was conducted with LVN 4. LVN 4 stated the orders for Tylenol and Tramadol were recently renewed on 4/11/24, for Resident 7. LVN 4 confirmed no pain medication was given to Resident 7 during the medication administration.<br><br>On 4/12/24 at 1032 hours, an interview and concurrent medical review was conducted with the DON. The DON did not see any pain medication ordered before 4/11/24, for Resident 7. The DON verified the care plan for Resident 7 showed to medicate the resident 30 minutes prior to wound care.<br><br>On 4/12/24 at 1244 hours, an interview was conducted with LVN 2. LVN 2 described Resident 7's moaning came and went when the wound treatment was provided. Resident 7 would moan when the bandaged was removed and when the wound was cleaned and packed. When asked if the physician was notified of Resident 7's pain during the wound treatment, LVN 2 stated no.<br><br>39453<br><br>2. On 4/9/24 at 0912 hours, during the initial facility tour, Resident 23 was observed sitting in the wheelchair in the room. Resident 23 stated she was on her wheelchair so she can get the nurse to give her pain medication for her back pain.<br><br>Medical record review for Resident 23 was initiated on 4/9/24. Resident 23 was readmitted to the facility on [DATE].<br><br>Review of Resident 23's MDS (Minimum Data Set, a standardized assessment tool) dated 3/22/24, showed Resident 23 was cognitively intact.<br><br>Review of Resident 23's Order Summary Report showed the following physician's orders:<br><br>- On 3/28/24, for the pain evaluation (on the pain scale of 0 to 10 with 0 = no pain, 1-4 = mild pain, 5-7 = moderate pain, 8-9 = severe pain, and 10 = very severe pain) every shift;<br><br>- On 3/22/24, methadone (opioid analgesic) 15 mg by mouth two times a day for moderate to severe pain;<br><br>- On 3/28/24, Tylenol 325 mg two tablets by mouth every six hours as needed for mild pain; and<br><br>-On 3/28/24, to administer hydromorphone (opioid analgesic) 4 mg one tablet by mouth every four hours as needed for moderate pain for 60 days;<br><br>Review of Resident 23's MAR for March and April 2024 showed Resident 23 was given pain medication not corresponding to the pain level as per the physician's orders. For example:<br><br>- Resident 23 had a mild pain level of 3-4 and was given the methadone medication on 3/24/24 at 0900 hours, and 4/1, 4/2, 4/4, 4/5, 4/8, 4/9, and 4/10/24 at 1700 hours; and<br><br>- Resident 23 had a severe pain level of 8 and was given the hydromorphone medication on 3/28/24 at 1902 hours, 3/30/24 at 1000 hours, 4/5/24 at 1400 hours, 4/6/24 at 0620 and 2100 hours, and 4/9/24 at 0230 hours.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Further review of Resident 23's medical record did not show Resident 23's severe pain level was addressed.<br><br>On 4/12/24 at 1250 hours, an interview and concurrent medical record review for Resident 23 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated Resident 23 was always complaining of pain, and the resident would come to the nursing station to ask for pain medication. RN 1 verified the pain medications were not administered to Resident 23 per the physician's orders. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346<br><br>Based on interview and medical record review, the facility failed to ensure two of two sampled residents (Residents 59 and 61) reviewed for dialysis services were monitored for fluid restriction as ordered. This failure posed the risk of the residents' not receiving appropriate care.<br><br>Findings:<br><br>1. On 4/10/24, medical record review was initiated for Resident 59. Resident 59 was readmitted to the facility on [DATE], and discharged to the acute care hospital on 4/11/24.<br><br>Review of Resident 59's physician's progress note dated 12/8/23, showed Resident 59's diagnoses included end stage renal disease with dialysis.<br><br>Review of Resident 59's nutritional assessment dated [DATE], showed Resident 59's albumin level was trending downward.<br><br>Review of Resident 59's April 2024 Order Summary Report showed an order dated 12/22/23, for Novasource 275 ml (nutritional supplement) three times daily; and an order dated 12/5/23, for a breakdown of Resident 59's daily fluid restrictions provided by nursing: a daily total of 780 ml.<br><br>Review of Resident 59's April 2024 intake and output record completed by the nursing staff showed Resident 59's total daily fluid intake was ranging between 920 to 1260 ml, exceeding the 780 ml daily fluid restriction provided by the nursing.<br><br>On 4/11/24 at 1552 hours, a concurrent interview and medical record review of Resident 59's Intake and Output Record for April 2024 was conducted with LVN 5. When asked about documenting the specific amount consumed by Resident 59 for his Novasource, LVN 5 stated the amounts documented on Resident 59's Intake and Output Record were just the total fluids intake, and LVN 5 was not sure of any specific fluid total amount or how much of the documented amounts were water or the resident's Novasource, or other liquid. LVN 5 stated the nursing staff gave the resident the nutritional supplement and documented as given, but not how much of the supplement was consumed by the resident. LVN 5 stated the daily total tallied on the document could be from the dietary or nursing.<br><br>On 4/12/24 at 1033 hours, a concurrent interview and medical record review was conducted with the RD. When asked about the order of the daily fluid intake for Resident 59's (780 ml daily fluid restriction provided by nursing and 720 ml daily fluid restriction provided by the dietary) and the amounts documented on Resident 59's April Intake and Output Record, the RD stated she did not audit the total of fluid intake provided by the nursing staff. According to the RD, the nursing staff was in charge of tallying the amounts of liquids consumed by Resident 59. When asked about Resident 59's Novasource, the RD stated the nursing staff would verbally inform her if Resident 59 drank his Novasource or not.<br><br>2. On 4/10/24, medical record review was initiated for Resident 61. Resident 61 was admitted to the facility on [DATE], with diagnoses including end stage renal disease with dialysis.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 61's nutritional assessment dated [DATE] showed Resident 61 was on fluid restriction per the dialysis center.<br><br>Review of Resident 61's April 2024 Order Summary Report showed an order dated 4/9/24, for Boost 275 ml (nutritional supplement) twice daily, and an order dated 4/10/24, for a breakdown of Resident 61's daily fluid restrictions provided by the nursing staff: a daily total of 600 ml.<br><br>Review of Resident 61's April 2024 Intake and Output Record completed by the nursing staff showed Resident 61's total daily fluid intake was more than 600 ml daily fluid restriction on 4/1, 4/2, 4/4, 4/5, 4/6, 4/7, 4/8, 4/9, and 4/10/24.<br><br>On 4/11/24 at 1552 hours, an interview was conducted with LVN 5. When asked about Resident 61's intake and output record, LVN 5 stated he could not locate it. When asked about documenting the specific amount consumed by Resident 61 for her Boost, LVN 5 stated the amounts documented on Resident 61's Intake and Output Record were just the documentation of the total fluids. LVN 5 was not sure of any specific fluid total amount or how much of the documented amounts were water or the resident's Boost, or other liquid. LVN 5 stated the nursing staff gave the resident the nutritional supplement and documented as given, but not how much of the supplement was consumed by the resident. LVN 5 stated the daily total tallied on the document could be from the dietary or nursing.<br><br>On 04/12/24 at 1033 hours, a concurrent interview and medical record review was conducted with the RD. When asked about the order for daily fluid intake for Resident 61 (600 ml nursing daily fluid restriction and 600 ml dietary daily fluid restriction) and the amounts documented on Resident 61's April Intake & Output Record, the RD stated she did not audit the total fluid intake provided by the nursing. Per the RD, the nursing staff was in charge of tallying amounts of liquids consumed by Resident 61. When asked about Resident 61's Boost, the RD stated the nursing staff would verbally inform her if Resident 61 drank her Boost or not. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346<br><br>Based on observation, interview, and facility document review, the facility failed to ensure the nursing services were provided by the appropriate staff (four of four CNAs) as evidenced by:<br><br>* Two CNAs (CNAs 9 and 10) applied the oxygen tubing and set the residents' oxygen rate.<br><br>* The facility failed to ensure CNAs 1 and 2 were provided training on the implementation of the enhanced barrier precautions. CNAs 1 and 2 were observed not wearing a gown while transferring Resident 35 on enhanced barrier precautions.<br><br>These failures posed the risk of the residents not receiving appropriate care.<br><br>Findings:<br><br>1. On 4/9/24 at 1220 hours, CNA 9 was observed grabbing Resident 61's oxygen tubing and placing it into Resident 61's nostrils. CNA 9 was observed asking Resident 61's sitter whether Resident 61 was on two liters of oxygen. CNA 9 was then observed setting the dial on Resident 61's oxygen tank.<br><br>On 4/9/24 at 1227 hours, an interview was conducted with CNA 9. When asked about setting the dial on Resident 61's oxygen tank, CNA 9 verified he set Resident 61's oxygen to two liters per minute. CNA 9 verbalized he was taught by a nurse as to how to set the number on the resident's oxygen tank and cylinder.<br><br>Review of Resident 61's April 2024 Order Summary Report showed Resident 61 was admitted to the facility on [DATE], with diagnoses, including acute respiratory failure with hypoxia, asthma, and anxiety disorder. Further review the orders showed Resident 61 had an order dated 3/9/24, for oxygen via nasal cannula at two liters per minute, may titrate oxygen to maintain oxygen saturation level greater or equal to 92%.<br><br>2. On 4/10/24, medical record review for Resident 49 was initiated. Resident 49 was readmitted to the facility on [DATE], with diagnoses including COPD exacerbation and acute hypoxic respiratory failure.<br><br>Review of Resident 49's physician's orders showed an order dated 3/21/24, for oxygen via nasal cannula three liters per minute, may titrate to keep oxygen saturation level at 92% or higher.<br><br>On 4/10/24 at 1512 hours, an interview was conducted with CNA 10. When asked about caring for the residents on oxygen, CNA 10 verbalized he would put the resident's oxygen tubing on, would sometimes put on the oxygen humidifier on the resident's oxygen concentrator, and would set the oxygen levels. When asked about setting the resident's oxygen rate, CNA 10 verbalized most residents were on two to three liters of oxygen. When asked how he knew what number to set the oxygen setting for Resident 61, CNA 10 stated he would check with the nurse.<br><br>On 04/10/24 at 1606 hours, the DSD verified the CNAs were not to touch the residents' oxygen.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 39453<br><br>3. Review of the CMS QSO-24-08-NH dated 3/20/24, for Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of MDROs, showed MDRO transmission is common in long-term care facilities such as nursing homes, contributing to substantial resident morbidity and mortality and increased healthcare costs. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of MDROs that employs targeted gown and glove use during high-contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.<br><br>On 4/10/24 at 0927 hours, an Enhanced Barrier Precautions sign was observed posted outside Resident 35's room alerting anyone to perform hand hygiene before entering and when leaving the room. The sign also alerted the providers and staff to wear gloves and a gown for high-contact resident care activities. A number 6 was observed beside Resident 35's name by the door. A cart containing gowns was observed inside the room. CNAs 1 and 2 were observed assisting Resident 35 transfer from bed to wheelchair. CNAs 1 and 2 were wearing gloves but not wearing gowns.<br><br>On 4/10/24 at 0941 hours, an observation for Resident 35 and concurrent interview was conducted with CNA 1. CNA 1 verified the above findings. CNA 1 verified the Enhanced Barrier Precaution sign placed outside Resident 35's room, with a number 6 besides Resident 35's name by the door. CNA 1 verified she transferred Resident 35 from bed to wheelchair, with CNA 2. CNA 1 verified they were only wearing gloves, and not gown while transferring Resident 35. When asked if they had received any inservice training on EBP, CNA 1 answered yes, but did not remember when the last training was.<br><br>On 4/11/24 at 1539 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated when an Enhanced Barrier Precaution sign was placed by the door and the resident's name was marked with a number 6, the staff who provided the high-contact care activities should wear gloves and a gown, in addition to hand hygiene. The IP stated high-contact resident care activities included transferring, or mobility assistance and preparing the resident to leave the room. When asked if she had provided inservice training to the facility staff regarding EBP, the IP stated she had provided an inservice training to all the staff, including the CNAs, licensed nurses, therapists, and students, to which she showed the inservice training records.<br><br>Review of the Inservice Training Report dated 4/1/24, for the Implementation of ESP (Enhanced Standard Precaution)/ EBP for all staff did not show CNAs 1 and 2 were provided an inservice training on ESP/ EBP.<br><br>The IP verified the above findings.<br><br>Cross reference to F880, example #6. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>50127<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to meet the needs of the residents when:<br><br>* The facility failed to ensure all controlled medications were accurately documented for one of 19 final sampled residents (Resident 61) and one nonsampled resident (Resident 46).<br><br>* The facility failed to ensure the oral and IV E-Kit(s) for Nursing Station A were refilled/replaced by pharmacy within 72 hours of opening the E-Kit(s).<br><br>These failures posed the risk for diversion of the controlled medications and medication administration errors; and timely replacement of medication for emergency use.<br><br>Findings:<br><br>Review of the facility's P&P titled Controlled Substance Administration and Accountability revised 6/5/23, showed it is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. All controlled substances (Schedule II, III, IV, V) are accounted for in one of the following ways: All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided.<br><br>Review of the facility's P&P titled Preparation and General Guidelines IIA7: Controlled Substance revised 10/2019, showed when a controlled substance is administered, the license nurse administering the medication immediately enters the following on the accountability record and/or medication administration records (MAR):<br><br>- Date and time of administration (MAR, Accountability record)<br><br>- Amount administered (Accountability record)<br><br>- Remaining quantity (Accountability record)<br><br>- Signature of the nurse administering the dose on the accountability record at the time the medication is removed<br><br>from supply.<br><br>- Initials of the nurse administering the dose.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1. On 4/11/24 at 1230 hours, an interview and concurrent medication cart inspection of Medication Cart C was conducted with LVN 3. During the inspection of Medication Cart C, the Controlled Medication Count sheets were reviewed with LVN 3. The form titled Antibiotic Or Controlled Drug Record showed a count of eight tablets remaining for lorazepam (medication to relieve anxiety) 0.5 mg for Resident 61. The form showed the last written entry for Count #9 with the month of 4 (April), untimed, and with staff signature. However, review of Resident 61's medication bubble pack/card containing lorazepam 0.5 mg tablet showed nine tablets remaining. LVN 3 verified the controlled count sheet and the medication supply on hand did not match. LVN 3 stated he popped the medication out of the bubble pack; however, the lorazepam was not due; and he signed it but left it in the bubble pack. LVN 3 further stated Resident 61 were to receive the lorazepam every Monday, Wednesday, and Friday; and he had signed it by mistake. When asked for the facility's process when an error occurred pertaining to controlled medications, LVN 3 stated he should have crossed out the entry right away in the Controlled Drug Record to correct the error he made.<br><br>2. On 4/11/24 at 1232 hours, an interview and concurrent medication cart inspection of Medication Cart C was conducted with LVN 3. During the inspection of Medication Cart C, the Controlled Medication Count sheets were reviewed with LVN 3. The form titled Antibiotic Or Controlled Drug Record showed a count of six tablets for clonazepam (medication to relieve anxiety or control seizures) 2 mg for Resident 46. The form showed a last written entry for Count #7 on 4/11/24 at 0900 hours, with staff signature. However, review of Resident 46's medication bubble pack/card containing clonazepam 2 mg showed seven tablets remaining. LVN 3 verified the Controlled Medication Count sheet and the medication supply on hand did not match. When LVN 3 was asked if he performed a count today with the previous shift for the controlled medications, LVN 3 stated yes. LVN 3 further verified he signed the clonazepam out for 4/11/24 at 0900 hours; however, he did not take the medication out of the bubble pack and did not administer the medication to Resident 46 because the resident had been sleeping since 0900 hours.<br><br>3. Review of the facility's P&P titled Medication Ordering and Receiving from Pharmacy IC5: Emergency Pharmacy Service and Emergency Kits dated 8/2014, showed if exchanging kits, the used sealed kits are replaced with the new sealed kits within 72 hours of opening.<br><br>On 4/9/24 at 1023 hours, an inspection of Medication Room A and concurrent interview was conducted with the DSD. The oral E-kit showed a fill date of 4/4/24, and the IV E-kit showed a pack date of 4/8/24. The DSD verified the fill date/pack date for the oral and IV E-Kit(s).<br><br>Review of the oral E-kit log showed showed oxycodone (controlled pain medication) 5 mg was taken out on 3/27/24 at 1130 hours.<br><br>Review of the IV E-Kit Pharmacy Log showed Flagyl (an antibiotic to treat infection) 500 mg was taken out of the E-kit on 3/31/24.<br><br>On 4/10/24 1156 hours, an interview and concurrent facility document review was conducted with the DON. When asked about the process of removing a medication from the E kit, the DON stated the facility must first obtain authorization from the pharmacy to open the E-kit before opening the E-Kit and the nurses were supposed to log each time a medication was pulled from the E-Kit. The DON verified the oral and IV E-Kit(s) were not replaced within 72 hours. The DON further stated either the medications removed from the E-Kit(s) were not being logged accordingly on the E-Kit log or the E-Kit replacement was not ordered on time. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the Pharmacy Consultant's recommendations were acted upon for one of five unnecessary medication sampled residents (Resident 23).<br><br>* The facility failed to follow-up on the Pharmacy Consultant recommendation to monitor for CNS (central nervous system) and respiratory depression for Resident 23 who was taking routine gabapentin (nerve pain medication), methadone (opioid narcotic analgesic), and Dilaudid (opioid narcotic analgesic) medications. In addition, the facility failed to follow-up on the Pharmacy Consultant recommendation to place hold parameters for gabapentin medication for Resident 23.<br><br>These failures had the potential to put the resident at risk for adverse consequences related to the medications.<br><br>Findings:<br><br>Review of the facility's P&P titled Medication Regimen Review revised date 12/19/22, showed medication regimen review (MRR) or drug regimen review, is a thorough evaluation of the mediation regimen of a resident, with a goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with the medication. The facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.<br><br>Medical record review for Resident 23 was initiated on 4/9/24. Resident 23 was readmitted to the facility on [DATE].<br><br>Review of Resident 23's Order Summary Report showed the following physician's orders dated:<br><br>- On 3/22/24, to administer methadone 15 mg by mouth two times a day for moderate to severe pain;<br><br>- On 3/28/24, to administer gabapentin 800 mg one tablet by mouth three times a day neuropathy (a condition that affects the nerves outside the brain or spinal cord); and<br><br>- On 3/28/24, to administer hydromorphone (Dilaudid) four mg one tablet by mouth as needed for moderate pain for 60 days.<br><br>Review of the Consultant Pharmacist's Medication Regimen Review for Resident 19 dated 3/26/24, showed to monitor for CNS and respiratory depression, and to clarify order for the gabapentin medication to hold if the respiratory rate less than 10 breaths per minute. Resident 23 was receiving routine gabapentin, methadone, and Dilaudid. This combination can potentiate the effects of the opiate on respiration, CNS depression, sedation, and hypotension. Under the Follow-Through section showed a handwritten note showing as per resident, she was taking before, doesn't want to change.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/8/24 at 1001 hours, an interview and concurrent medical record review for Resident 23 was conducted with RN 2. RN 2 verified the above findings. RN 2 stated she was responsible for following up on the pharmacy consultant's recommendations. When asked about the pharmacy consultant's recommendations for Resident 23, RN 2 stated she wrote on the follow-through section that Resident 23 did not want any changes to her medications. When asked to elaborate, RN 2 stated Resident 23 did not want the gabapentin, Dilaudid, and methadone medications combined. When asked about the pharmacy consultant's recommendation to monitor Resident 23 for CNS and respiratory depression, RN 2 could not provide documented evidence to show Resident 23 was being monitored for CNS and respiratory depression. When asked about the pharmacy consultant's recommendation to place the hold parameters for the gabapentin medication, RN 2 could not provide documented evidence she clarified the order for the hold parameter with the attending physician. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>50127<br><br>Based on observation, interview, and medical record review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 24%. Two licensed nurses (LVNs 1 and 4) who were observed during the medication administration were found to have made errors.<br><br>* LVN 1 failed to check Resident 53's heart rate prior to administering metoprolol (blood pressure medication) per the physician's orders. In addition, Resident 53 received partial dose for one medicaiton when residual of the medication was left in the medication cup.<br><br>* Resident 72 received partial doses for three medications when residual of the medications were left in the medication cups.<br><br>These failures had the potential to negatively impact the residents' health status and well-being.<br><br>Findings:<br><br>Review of the facility's P&P titled Medication Administration- General Guidelines dated October 2017 showed the medications are administered as prescribed in accordance with good nursing principles and practices.<br><br>1.a. On 4/10/24 at 0915 hours, a medication administration observation for Resident 53 was conducted with LVN 1. LVN 1 prepared and administered Resident 53's medications which included the following:<br><br>- one tablet of apixaban 5 mg (medication to treat and prevent blood clots)<br><br>- one tablet of aspirin 81 mg (medication use to treat pain, headache, inflammation and reduce the risk of a heart attack)<br><br>- 35 units of Basaglar insulin (medication use to treat diabetes)<br><br>- one tablet of metoprolol tartate 100 mg (medication use to treat high blood pressure)<br><br>- five ml of multivitamin with mineral (supplement)<br><br>- one tablet of vitamin C (supplement).<br><br>LVN 1 was observed pouring water into the medication cup containing the crushed metoprolol tablet. LVN 1 was then observed reaching for the GT syringe, however, LVN 1 was immediately instructed to stop and step away from the resident. When LVN 1 was asked if she knew why she was instructed to stop the medication administration, LVN 1 stated she did not know. LVN 1 stated she needed to check Resident 53's pulse rate first prior to administering the metoprolol medication but forgot. LVN 1 was then observed checking Resident 53's pulse rate and administering the metoprolol via GT.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 53's Order Summary Report dated 4/11/24 showed a physician's order to administer metoprolol tartate 100 mg one tablet via GT two times a day for HTN (hypertension), hold if SBP (systolic blood pressure) less than 110 mmHg or HR (heart rate) less than 60 beats per minute.<br><br>b. LVN 1 was observed crushing the vitamin C, mixing it with water in a separate medication cup. After administering the medication, the medication cup was observed with medication residue.<br><br>On 4/10/24 at 0933 hours, an interview was conducted with LVN 1. LVN 1 verified there was medication residue in the medication cup for vitamin C. LVN 1 stated she should have added more water into the medication cup to fully dissolve the medication.<br><br>2. On 4/11/24 at 0850 hours, a medication administration observation for Resident 72 was conducted with LVN 4. LVN 4 prepared and administered Resident 72's medications which included the following:<br><br>- one tablet of famotidine 20 mg (medication use to prevent and treat heartburn)<br><br>- one tablet of finasteride 5 mg (medication use to shrink enlarged prostates in men)<br><br>- one tablet of quetiapine 25 mg (medication use to treat schizophrenia and bipolar disorder)<br><br>- one tablet of metoprolol 50 mg (medication use to treat high blood pressure)<br><br>- five ml of levetiracetam (medication use to treat seizures)<br><br>- one table of multivitamin with mineral (supplement)<br><br>- 10 units of Lantus Solostar insulin (medication use to treat diabetes).<br><br>LVN 4 was observed crushing the multivitamin with mineral, metoprolol and famotidine and mixing it with water in three separate medication cups. After administering the medications, the three medication cups were each observed with medication residue.<br><br>On 4/11/24 at 0915 hours, an interview was conducted with LVN 4. LVN 4 verified there were medication residue in the medication cups for multivitamin with mineral, metoprolol and famotidine. LVN 4 verified Resident 72 did not receive the complete dose for the multivitamin with mineral, metoprolol and famotidine.<br><br>On 4/11/24 at 1445 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. |

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| | 555797 | A. Building<br>B. Wing | 04/12/2024 |

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| Gordon Lane Care Center | 1821 E Chapman Ave<br>Fullerton, CA 92831 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>50127<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of two LVNs observed for medication administration administered the medications without significant medication errors.<br><br>* LVN 1 failed to check Resident 53's heart rate prior to administering metoprolol per the physician's orders. This failure placed Resident 53 at risk for medical complications.<br><br>Findings:<br><br>Review of the facility's P&P titled Medication Administration- General Guidelines dated October 2017 showed the medications are administered as prescribed in accordance with good nursing principles and practices.<br><br>On 4/10/24 at 0915 hours, a medication administration observation for Resident 53 was conducted with LVN 1. LVN 1 prepared and administered Resident 53's medications which included the following:<br><br>- one tablet of apixaban 5 mg<br><br>- one tablet of aspirin 81 mg<br><br>- 35 units of Basaglar insulin<br><br>- one tablet of metoprolol tartate 100 mg<br><br>- five ml of multivitamin with mineral<br><br>- one tablet of vitamin C.<br><br>LVN 1 was observed pouring water into the medication cup containing the crushed metoprolol tablet. LVN 1 was then observed reaching for the GT syringe, however, LVN 1 was immediately instructed to stop and step away from the resident. When LVN 1 was asked if she knew why she was instructed to stop the medication administration, LVN 1 stated she did not know. LVN 1 then stated she needed to check Resident 53's pulse rate first prior to administering the metoprolol medication but forgot. LVN 1 was then observed checking Resident 53's pulse rate and administering the metoprolol via GT.<br><br>Review of Resident 53's Order Summary Report dated 4/11/24, showed a physician's order to administer metoprolol tartate 100 mg one tablet via GT two times a day for HTN, hold if SBP (systolic blood pressure) less than 110 mmHg or HR (heart rate) less than 60 beat per minute.<br><br>On at 04/11/24 at 952 hours, a medical record review and concurrent interview was conducted with the DON and LVN 1. The DON and LVN 1 verified Resident 53's physician's order for the metoprolol included the parameter when to hold the medication based on the resident's blood pressure or heart rate. The DON was informed and acknowledged the above finding. The DON stated she made sure to teach the license nurses when she observed them during medication administration.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Cross reference to F759, example #1. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50127<br><br>Based on observation, interview, and facility P&P review, the facility failed to ensure the medications were stored and labeled properly and failed to ensure the drugs and biologicals were stored in a safe manner when:<br><br>* One of two medication rooms (Medication Room A) had one opened, unsealed package of IV Statlock PICC Plus (a device to secure an IV catheter from kinking which could lead to blockage of fluids going through the vein).<br><br>* The facility's Central Supply Room was observed to contain artificial tears, earwax softener drops, dry eye relief, muscle rub cream, and enema bottles stored on the same shelf next to the oral medications such as calcium, omeprazole, sodium chloride, and fish oil.<br><br>* The facility's treatment cart was observed to contain the expired dressings, topical creams with labels not readable; and the treatment supplies and cart were not maintained in a sanitary condition.<br><br>* Two of three medication carts (Medication Carts A and C) contained the medication bottles with sticky residue, and Medication Cart A had an expired medication inside the medication cart.<br><br>* The facility failed to ensure zinc oxide ointment medication was safely stored in the Treatment Cart. The zinc oxide was observed on top of the Treatment Cart unattended by a licensed staff.<br><br>These failures had the potential to negatively impact the residents' well-being and unauthorized persons having access to the medications.<br><br>Findings:<br><br>Review of the facility's P&P titled Medication Storage in the Facility ID1: Storage of Medications dated , d+[DATE], under the section Procedures, showed the following:<br><br>- Orally administered medications are kept separate from the externally used medications such as suppositories, liquids, and lotions.<br><br>- Eye medications are kept separately from ear medications.<br><br>- Orally administered medications are kept seprate from externally used medications, such as suppositories, liquids, and lotions.<br><br>- Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from the stock, disposed of acccording to the procedures for medication disposal, and reordered from the pharmacy if a current order exists.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures.<br><br>- Medication storage conditions are monitored on a routine basis and corrective action taken if problems are identified.<br><br>1. On [DATE] at 1101 hours, an inspection of Medication Room A and concurrent interview was conducted with the DSD. During the inspection, an unseald tray of Statloc PICC Plus was observed inside Medication Room A, stored with the rest of the IV supplies in a plastic container. The DSD acknowledged and verified the findings.<br><br>2. On [DATE] at 1131 hours, an inspection of the facility's Central Supply Room and concurrent interview was conducted with CNA 3. CNA 3 verified she was in charge of stocking the Central Supply Room. During the Central Supply Room inspection, several over the counter medications (non-prescription medications) such as bottles of artificial tears, dry eye relief, earwax softener drops, enema (helps to relieve constipation) bottles and containers of muscle pain relief rub cream were stored alongside with multiple bottles of oral over the counter medications such as calcium (supplement to prevent weak or brittle bones), sodium chloride (essential nutrient to help prevent residents from becoming dehydrated), fish oil (supplement to reduce pain, improve morning stiffness and relieve joint tenderness) capsules , and omeprazole (medication to relieve heartburn, difficulty swallowing, and cough) tablets on the same shelf. When asked if she should have stored the medications such as enema, muscle rub, artificial tears next to oral medications, CNA 3 stated no, and would not have done how the medications were stores together; however, the medications were already stored that way and just followed what was already there. CNA 3 verified the findings and stated the identified medications should not have been stored together.<br><br>3. On [DATE] at 1435 hours, a Treatment Cart inspection and concurrent interview was conducted with LVN 1. During the Treatment Cart inspection, the following was identified:<br><br>- A 4 x 4 gauze was observed laid directly on the surface of the inside of the treatment cart<br><br>- A tube of Traimicinolone Acetonide Cream 0.1% (topical medication to treat skin conditions resulting from allergies or immune system disorders) label was not clear and readable<br><br>- A tube of Fluocinonide Cream 0.1% (topical medication to treat skin conditions resulting from allergies) label was not clear and readable<br><br>- Procure Hydrocortisone Acetate 1% Cream (topical medication to relieve itching associated with minor skin irritation or inflammation) was stored inside a box of bandaids<br><br>- 10 packets of Medifill Collagen Particles (collagen which promotes wound healing and formation of new tissues), 1 g, had an expiration date of ,d+[DATE]<br><br>- DermaFilm X-Thin Clear Hydrocolloid Wound Dressing (a dressing which helps maintain a moist wound environment to support moist wound healing; also provides insulation and protection) with Grid, 6 x 6, box was wet.<br><br>-The bottom drawer of the treatment cart was observed with reddish, yellowish stain<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -A bottle of Nystatin (treats fungal or yeast infection) topic powder had no cover, and no open date.<br><br>-A bottle of Providone Iodine Prep Solution (a solution to disinfecting skin, cleans abrasions, cuts, or lacerations) was observed with brown, dried solution on the outside of the container.<br><br>-A Derma Klenz Wound cleaner container was observed with brown stain on the outside of the container<br><br>LVN 1 acknowledged and verified all the findings.<br><br>4. On [DATE] at 0852 hours, a medication pass observation was conducted with LVN 1. During the observation, Medication Cart A was observed with a bottle of ProStat liquid (liquid protein) with an expiration date of [DATE]. Furthermore, the bottle of ProStat liquid was noted with sticky residue on the outside of the bottle. LVN 1 acknowledged and verified the findings.<br><br>On [DATE] at 1317 hours, an inspection of Medication Cart C and concurrent interview was conducted with LVN 3. During the inspection, a bottle of Milk of Magnesia (laxative) was observed with white dried dripping residue from the top to bottom of the bottle. In addition, a bottle of Geri Tussin (cough medicine) was observed with dried red dripping residue from the top to bottom of the bottle. LVN 3 acknowledged and verified the findings.<br><br>49324<br><br>5. Review of the facility's P&P titled Medication Storage in the Facility dated ,d+[DATE] showed to ensure medications are stored safely, securely and properly, only licensed nurses, pharmacy personnel and those lawfully authorized are allowed to access to medications.<br><br>On [DATE] at 0848 hours, during an observation in the hallway near Station 2, a zinc oxide ointment was placed on top of the Treatment Cart, unattended by the licensed nurse.<br><br>On [DATE] at 0849 hours, an interview was conducted with RN 3. RN 3 stated the zinc oxide ointment medication should be stored inside the Treatment Cart and not left unattended.<br><br>On [DATE] at 1307 hours, an interview was with LVN 2. LVN 2 stated it was his honest mistake. The licensed nurses should not leave any medication on top of treatment cart and that some residents may be confused , might take it and use it in different way.<br><br>On [DATE] at 1440 hours, an interview was conducted with the DON. The DON stated the zinc oxide ointment should not be left unattended on top of the Treatment Cart and should be stored properly in the Treatment Cart. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>48844<br><br>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menus were followed as evidenced by:<br><br>* The facility failed to ensure the spreadsheet was followed for the liberal house renal diet and renal diet. The facility failed to provide 10 pieces of cheese ravioli for Residents 13 and 34 as per the menu.<br><br>*The facility failed to ensure the menu for the pureed breadstick and butter was followed when the wrong scoop size was used to serve the pureed bread for Residents 16 and 78.<br><br>* The facility failed to provide butter or margarine, and milk to Resident 78 as per the menu. In addition, the facility failed to provide coffee to Resident 78 as per the resident's lunch tray ticket.<br><br>* The facility failed to provide the appropriate dessert portion to one nonsampled resident (Resident 4). Two desserts instead of one dessert were given to Resident 4 during lunch.<br><br>These failures had the potential for the residents to not receive adequate nutrition and appropriate servings to meet their individual needs.<br><br>Findings:<br><br>Review of the facility's P&P titled Menu Planning Criteria revised 5/20/20, showed the food and nutritional needs of the residents shall be planned to meet the U.S. Dietary Guidelines and Dietary Reference Intakes, in order to provide menus that include safe and adequate intake of essential nutrients.<br><br>1. Review of the facility's Daily Spreadsheet for Wednesday dated 4/10/24, for lunch showed to serve 10 each cheese ravioli (no sauce) for liberal house renal and renal diets.<br><br>On 4/10/24 at 1130 hours, during the tray line observation, Resident 13 was noted to have been served with nine cheese raviolis and Resident 34 was served with seven cheese raviolis, instead of the 10 cheese raviolis per the day's menu spreadsheet.<br><br>On 4/10/24 at 1410 hours, an interview was conducted with the DSS, with the RD and DSS in Training present. According to the DSS, the facility was using the jumbo ravioli five pounds 80 ounces bag. The menu indicated cheese ravioli, frozen .57 ounces with portion size of ten each. The RD, DSS and DSS in Training all confirmed the number of raviolis to be served using the five pounds 80 ounces bag had not been changed in the menu.<br><br>2. Review of the facility's Daily Spreadsheet Wednesday dated 4/10/24, for lunch, showed puree#12/1 each for the breadstick and butter.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/10/24 at 1130 hours, during the trayline observation, the Cook was noted to be using #16 scoop (colored royal blue = 1/4 cup) to serve pureed breadstick and butter instead of the #12 scoop (colored green = 1/3 cup) as per the facility's menu spreadsheet.<br><br>On 4/10/24 at 1130 hours, an observation, interview, and concurrent trayline inspection was conducted with the DSS and Cook. When asked about the scoop used for the pureed breadstick and butter, the Cook showed the royal blue scooper. The tray cart was stopped prior to tray distribution to the residents. The DSS was asked to show the items to be served for the residents on pureed diet. The DSS showed Residents 16 and 78 were on a regular pureed diet and both were served with pureed breadstick and butter. The DSS verified the findings.<br><br>39453<br><br>3. Review of the facility's menu titled Week at a Glance, Spring 2024 for Regular diet showed the lunch menu for 4/9/24, was roast beef au jus, oven roasted potatoes, savory peas, dinner roll and butter or margarine, fudge brownie with coconut topping, and whole mil<br><br>On 4/9/24 at 1212 hours, during the dining observation, Resident 78 was observed being assisted with her meals by Resident 78's Family Member. Resident 78 was served with beef, dinner roll, peas, potatoes, a slice of fudge brownie, and juice. Resident 78's Family Member stated Resident 78 was not served with butter or margarine, which was needed since the dinner roll was dry. Resident 78's Family Member also stated Resident 78 was not served with milk per the weekly menu, nor served with coffee per the tray ticket.<br><br>Review of Resident 78's lunch tray ticket dated 4/9/24, showed coffee and juice were to be served for Resident 78.<br><br>On 4/9/24 at 1231 hours, an observation for Resident 78 and concurrent interview as conducted with the DSS, with Resident 78's Family Member present. The DSS verified Resident 78 was not served with butter or margarine with the dinner roll. In addition, the DSS verified Resident 78 was not served with whole milk as per the weekly menu. The DSS also verified Resident 78 was also not served with coffee as per the tray ticket.<br><br>50127<br><br>4. Review of Resident 4's physician's order dated 2/12/22, showed an order for the regular diet, regular texture, thin consistency, add fortified foods with all meals.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/9/24 at 1200 hours, during the dining observation, Resident 4 stated, I don't know why I received two desserts, I didn't ask for it. Resident 4 was observed seated at a dining table with another male resident. Next to Resident 4's lunch plate entree were two small bowls of fudge brownie with coconut topping desserts covered with plastic wrap. When asked if Resident 4 asked for two desserts, Resident 4 stated, I didn't ask for that. I can't eat all that. I don't eat sweets and I don't know why I got two desserts. The DSD and LVN 6 verified Resident 4 received two desserts. LVN 6 stated she checked Resident 4's lunch meal tray today and stated, I checked the meal tray, I checked it against the diet slip, the list. Resident 4's meal ticket on her lunch tray showed regular, regular portion, independent with feed ability; devices - none; allergies- none; beverages - whole milk; dislikes - none; prefers - no preferences; regular TID (three times a day) (Fortified Food, fortified cream soup).<br><br>When asked what the purpose of the diet slip and list were, LVN 6 stated to make sure the resident was served the right meal. LVN 6 stated, I gave her, Resident 4, two desserts because she wanted two. LVN 6 was observed approaching and asking Resident 4 if Resident 4 wanted two desserts and Resident 4 stated, no, I did not. I don't even eat one. I didn't ask for that. LVN 6 verified Resident 4 should not have received two desserts. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>39453<br><br>Based on observation, interview, and facility document review, the facility failed to ensure the food served was palatable.<br><br>* The facility failed to ensure the roast beef served to Residents 78, 27, and 392 was not tough and not hard to cut or chew. This failure had the potential for the residents to not eat the food served and could affect their nutritional status.<br><br>Findings:<br><br>Review of the facility's menu titled Week at a Glance, Spring 2024 for regular diet showed the lunch menu for 4/9/24, including roast beef au jus, oven roasted potatoes, savory peas, dinner roll and butter or margarine, fudgy brownie with coconut topping, and whole milk.<br><br>1. On 4/9/24 at 1212 hours, during the dining observation, Resident 78 was observed being assisted with her meals by Resident 78's Family Member. Resident 78's Family Member stated the roast beef served to Resident 78 was very hard to cut and chew. Resident 78's Family Member was observed trying to cut the roast beef several times with a knife but could not cut the roast beef.<br><br>Review of Resident 78's tray ticket dated 4/9/24, showed Resident 78 was on NAS (no added salt) - regular diet.<br><br>2. On 4/9/24 at 1220 hours, during the dining observation, Resident 392 was observed sitting in the wheelchair inside her room. A lunch tray was observed in front of her. When asked about the roast beef, Resident 392 stated, very hard. Resident 392 was observed trying to cut the roast beef several times with a knife and could not cut the roast beef.<br><br>Review of Resident 392's tray ticket dated 4/9/24, showed Resident 392 was on a regular diet.<br><br>3. On 4/9/24 at 1222 hours, during the dining observation, Resident 27 was observed sitting in bed. A lunch tray was observed in front of him. When asked about the roast beef, Resident 27 stated the roast beef was not edible. Resident 27 was observed trying to cut the roast beef several times with a knife and could not cut the roast beef.<br><br>Review of Resident 27's tray ticket dated 4/9/24, showed Resident 27 was on a regular diet.<br><br>On 4/9/24 at 1231 hours, an observation for Residents 27, 78, and 392, and concurrent interview was conducted with the DSS. The DSS verified the above findings. The DSS verified the roast beef served to Residents 27, 78 and 392 was tough and hard to cut. |

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|---|---|
| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>48844<br><br>Based on observation, interview, facility document review, and facility P&P, the facility failed to ensure the residents on pureed diet were provided with food prepared in a form to meet the residents' individual needs. This failure risk posed the risk for residents on pureed diet to develop complications like aspiration (accidental breathing in food or fluid into the lungs) and choking.<br><br>Findings:<br><br>Review of the facility's titled Texture-Modified and Thickened Liquids revised 9/27/21, showed texture-modified diets are prepared and served as prescribed by the physician or appropriate personnel at the community when a resident has difficulty chewing and/or swallowing. For pureed: designed for people who have severe chewing and/or swallowing problems. Properly pureed foods eliminate the chewing phase. Smooth with no lumps.<br><br>Review of the Diet Type Report completed by the facility on 4/12/24, showed 10 residents on pureed diet texture.<br><br>On 4/10/24 at 1030 hours, a pureed food preparation was observed with the Dietary Cook. The DSS and RD were present during the observation. A food processor was used to puree the vegetable lasagna. The pureed vegetable lasagna showed tiny carrot bits after preparation. This was verified by the DSS.<br><br>The RD verified the above findings and stated the tiny carrot bits from the pureed vegetable lasagna could cause choking. |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844<br><br>Based on observation, interview, medical record review, and facility document review, the facility failed to ensure the food preferences was honored for one nonsampled resident (Resident 543).<br><br>* Resident 543's tray card showed puree regular with dislikes all dairy products; however, he was served pureed breadstick and butter with milk. This failure had the potential to negatively impact the resident's well-being.<br><br>Findings:<br><br>Medical record review for Resident 543 was initiated on 4/10/24. Resident 543 was admitted to the facility on [DATE].<br><br>Review of the Diet Type Report for pureed diet completed by the facility on 4/12/24, did not show any additional directions for Resident 543.<br><br>Review of Resident 543's lunch tray ticket showed dislikes all dairy products.<br><br>On 4/10/24 at 1030 hours, a pureed food preparation was observed with the Cook. The DSS and RD were present during the observation. During the pureed food preparation observation for the breadstick and butter, the Dietary Cook was observed to add milk to softened the breadstick and butter. When asked what was added to the breadstick and butter, the Dietary Cook stated milk.<br><br>On 4/10/24 at 1130 hours, during trayline observation, the Dietary Cook was observed to serve pureed breadstick and butter for the residents with pureed diet. The tray cart was stopped prior to tray distribution to the residents. The DSS was asked to show the items to be served for the residents on pureed diet. The DSS showed Resident 543's lunch tray ticket showed dislike all dairy products and was served with pureed breadstick and butter added with milk. The RD had interviewed Resident 543's family member, Resident 543 did not have allergies to dairy products. The facility could serve yogurt and cottage cheese, however, Resident 543's family member did not want milk or milk products on Resident 543's meal. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** 48844<br><br>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food preparation, storage, and sanitary requirements were met in the kitchen.<br><br>* The facility failed to ensure the proper disposal, labeling and dating of foods in the kitchen.<br><br>* The facility failed to ensure the cutting board was in sanitary condition.<br><br>* The facility failed to ensure the countertop can opener was free from brownish, whitish, and grayish discoloration.<br><br>* The facility failed to ensure the stainless mixing bowls, knives, and water pitchers were rinsed prior to use.<br><br>* The facility failed to ensure one knife and blender were air dried prior to use.<br><br>* The facility failed to ensure a clean spatula was placed on top of an unsanitized preparation area.<br><br>These failures had the potential to cause foodborne illnesses to a medically vulnerable resident population who consumed food prepared in the kitchen.<br><br>Findings:<br><br>Review of the Dietary Order Listing Report completed by the facility on [DATE], showed 84 of 88 residents in the facility received food prepared in the kitchen.<br><br>1. Review of the facility's P&P titled Food Storage revised [DATE] showed the food items should be stored, thawed, and prepared in accordance with good sanitary practice. Any expired or outdated food products should be discarded.<br><br>Review of the facility's POL 154b - Refrigerated Storage Chart with revised date [DATE], recommended storage time at ,d+[DATE] degrees Fahrenheit or less for unopened beets, carrots, radishes, turnips were one to two weeks.<br><br>During the initial kitchen tour with the DSS on [DATE] at 0745 hours, the following items were observed:<br><br>- one pack of opened hamburger buns with received date of [DATE], and used by [DATE];<br><br>- Several pieces of carrots in a plastic bin with received date of [DATE], and used by [DATE]. Carrots were not in the original plastic bag;<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 - Some | - Grape jelly in plastic container measuring more than two liters with no received and used by date;<br><br>- Few pieces of ham with incorrect label, with the prepared date of [DATE], and used by [DATE].<br><br>The DSS verified the findings.<br><br>2. According to the USDA Food Code 2022 ,d+[DATE].12 Cutting Surfaces, cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These may be transferred to foods that are prepared on such surfaces.<br><br>During the initial kitchen tour on [DATE] at 0745 hours, with the DSS, one brown chopping board was observed heavily marred and scratched. The DSS verified the finding and stated the bacteria could get into the cracks.<br><br>3. According to USDA Food Code 2022 ,d+[DATE].15 Can Openers, once the can openers become pitted or the surface in any way becomes uncleanable, they must be replaced because they can no longer be adequately cleaned and sanitized. Can openers must be designed to facilitate replacement.<br><br>During an initial kitchen tour on [DATE] at 0745 hours, with the DSS, a brownish, whitish, and grayish discoloration were observed on the countertop can opener. The DSS confirmed the findings.<br><br>4. According to USDA Food Code 2022 ,d+[DATE].11, Inability to effectively wash, rinse and sanitize the surfaces of food equipment may lead to the buildup of pathogenic organisms transmissible through food.<br><br>During an initial kitchen tour on [DATE] at 0745 hours, with the DSS, the following items were observed:<br><br>- One stainless steel mixing bowl with hard water marks<br><br>- Four knives with hard water marks on the tip<br><br>The DSS verified the findings.<br><br>5. According to the USDA Food Code 2022, Section ,d+[DATE].11, Equipment and Utensils, Air-Drying Required, after cleaning and sanitizing, equipment and utensils shall be air-dried or used after adequate draining. Wet equipment may allow an environment where microorganism can begin to grow.<br><br>During the initial kitchen tour on [DATE] at 0745 hours, with the DSS, one knife observed with remaining water residue. The DSS verified this finding.<br><br>On [DATE] at 1030 hours, an observation and concurrent interview was conducted during the pureed food preparation. The Dietary Cook was handed a blender still with remaining drops of water inside. The DSS verified the blender still had water inside and had it air dried. Furthermore, the DSS stated water remnants could contain bacteria. Utensils prior to use should be completely dry.<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 - Some | 6. According to the USDA Food Code 2022, Section ,d+[DATE].11, Equipment Food-Contact Surfaces and Utensils, equipment food-contact surfaces and utensils shall be cleaned at any time during the operation when contamination may have occurred.<br><br>On [DATE] hours, an observation was conducted during the pureed food preparation. The Assistance Dietary Cook placed a clean spatula on top of an unsanitized preparation area. The observation was verified by the DSS.<br><br>50127<br><br>7. On [DATE] at 1310 hours, an inspection of Medication Cart C was conducted with LVN 3, the following was observed:<br><br>- One container of chocolate pudding with a printed sticker date of [DATE], on the lid and a printed sticker date of [DATE], on the outside of the container.<br><br>- One container of apple sauce with a printed sticker date of [DATE], on the lid and a printed sticker date of [DATE], on the outside of the container.<br><br>LVN 3 verified the above finding.<br><br>On [DATE] at 1313 hours, an interview was conducted with the DSS and DSS in Training. The DSS and DSS in Training verified the dates printed on the lids and the containers of the above items did not match. The DSS in Training stated the dietary staff were responsible to check these containers for the proper preparation dates. In addition, The DSS and DSS in Training stated both dates on the lid and on the container should match. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49324<br><br>Based on interview, medical record review, and facility P&P review, the facility failed to maintain the complete and accurate medical records for two of 19 final sampled residents (Residents 23 and 31).<br><br>* The facility failed to ensure the complete documentation for Resident 31's ADL- Bed Mobility Intervention/Task.<br><br>* The facility failed to ensure the informed consents obtained from Resident 23 were signed by the physician.<br><br>These failures had the potential for the resident care needs not being met as the medical information was incomplete and inaccurate.<br><br>Findings:<br><br>1. Review of the facility's P&P titled Documentation in Medical Record revised 12/19/22, showed documentation should be timely, accurate, relevant and complete, containing sufficient details about resident's care and responses to care for.<br><br>Medical record review for Resident 31 was initiated on 4/10/24. Resident 31 was admitted to the facility on [DATE].<br><br>Review of Resident 31's Care Plan dated 2/3/24, showed the resident had an ADL self-care performance deficit related to Disease Process Diagnosis: Generalized body weakness, post status fall, Urinary Tract Infection, C-Diff, Cerebrovascular Accident with Right side Weakness, Diabetes Mellitus, hypokalemia, dysphagia, Hypertension, Hyperlipidemia, Acute Kidney Failure. The interventions included requires extensive assistance by (1) one staff to turn and reposition in bed.<br><br>Review of the ADL- Bed Mobility Intervention/Task Documentation Survey Report for the months of March and April 2024 showed missing documentation for the ADL Bed Mobility on the following dates:<br><br>- 3/2, 3/8, 3/9, 3/10, 3/11, 3/15, 3/16, 3/17, 3/20, 3/21, 3/22, 3/27, 3/29, 4/1, and 4/4/24, for the night shift; and<br><br>- 3/16, 3/21, and 3/24/24, for the day shift<br><br>On 4/12/24 at 1335 hours, an interview was conducted with the Medical Records Director. The Medical Records Director verified the missing documentations on the mentioned dates and stated the assigned staff should have documented care they had provided.<br><br>On 4/12/24 at 1440 hours, an interview was conducted with the DON. The DON acknowledged the missing documentation.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 39453<br><br>2. Medical record review for Resident 23 was initiated on 4/9/24. Resident 23 was readmitted to the facility on [DATE].<br><br>Review of Resident 23's MDS dated [DATE], showed Resident 23 was cognitively intact.<br><br>Review of Resident 23's Order Summary Report showed the following physician's orders dated 3/18/24:<br><br>- To administer buspirone (antidepressant medication) 10 mg one table by mouth two times a day for anxiety manifested by verbalization of feeling anxious; and<br><br>- To administer citalopram (antidepressant medication) 20 mg one tablet by mouth at bedtime for depression manifested by verbalization of feeling of sadness.<br><br>Review of Resident 23's MAR for March and April 2024 showed Resident 23 received the buspirone medication from 3/19 to 4/10/24 at 0900 and 1700 hours, and on 4/11/24 at 0900 hours; and received the citalopram medication from 3/19 to 4/10/24 at 2100 hours.<br><br>Review of the Physician Documentation of Informed Consent (undated) for buspirone medication did not show the consent was signed by the physician who obtained the informed consent.<br><br>Review of the Physician Documentation of Informed Consent (undated) for citalopram medication did not show the consent was signed by the physician who obtained the informed consent.<br><br>On 4/11/24 at 1359 hours, a concurrent interview and record review was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the charge nurses or the social services department usually asked the physician who obtained the informed consents from Resident 23 to sign the informed consents for the citalopram and buspirone medications.<br><br>On 4/12/24 at 1419 hours, a concurrent interview and record review was conducted with the DON. The DON verified the above findings. The DON stated she would ask the medical records to ask the physician who obtained the informed consents from Resident 23 to sign the informed consents for the citalopram and buspirone medications. |

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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** 50127<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the infection control practices designed to provide a safe and sanitary environment were followed.<br><br>* LVN 1 used Sanicloth disinfectant wipes with an unreadable expiration date.<br><br>* LVN 1 placed the spoons directly on the bedside table and used the spoons to stir the medications prior to administering medications.<br><br>* LVN 1 placed the piston syringe and plunger used for G-tube medication administration directly on the bedside table surface without a barrier.<br><br>* LVN 4 failed to follow the Enhanced Barrier Precautions when she did not wear a gown during medication administration via G-tube for Resident 72.<br><br>* LVN 4 did not perform hand hygiene and did not change gloves prior to administering oral, enteral, and subcutaneous medications. LVN 4 wore the same pair of gloves during the entire medication pass. In addition, LVN 4 used the bottom of the spoons to stir the medications and placed directly on the bedside table. LVN 4 also placed the piston syringe plunger directly on the bedside table for Resident 72<br><br>* The facility failed to ensure Derma Klenz (is a superior wound cleanser with zinc that contains no detergents and facilitates the removal of wound debris) spray was sanitized after used with two of 3 sampled residents (Residents 26 and 74) observed with wound care prior returning to treatment cart.<br><br>* CNA 8 failed to perform hand hygiene prior to getting clean towels from storage room, entering Room F, getting personal item from bedside drawer of Resident 3, before donning new set of gloves, and before repositioning Resident 3 to clean up soiled diaper.<br><br>* CNA 8 failed to label basin found on top of toilet tank in the Room E's restroom. Room E occupied with three residents (Resident 24, 38, and 77).<br><br>*CNA 1 failed to follow the Enhanced Standard Precautions when caring for Resident 35.<br><br>These failures placed the residents and staff at increased risk for infections.<br><br>Findings:<br><br>Review of the facility's P&P titled Infection Prevention and Control Program, revised 9/2/22, showed the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmissions of the communicable diseases and infections as per accepted national standards and guidelines.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility's document titled Enhanced Standard Precautions (undated) showed everyone must perform hand hygiene before entering the room. The document also showed anyone who participate in any of the six moments must also don gown, and gloves. The six moments included morning and evening care, toileting and changing incontinence briefs, caring for devices and giving medical treatment, cleaning the environment, wound care, and mobility assistance and preparing to leave the room.<br><br>1. On 4/10/24 at 0837 hours, a medication pass observation was conducted with LVN 1 for Resident 53. Prior to medication administration, LVN 1 cleaned the bedside table, sanitized the bulb of the sphygmomanometer, wiped the top of the medication cart, and sanitized the stethoscope using the Sanicloth wipes. The Sanicloth wipes container showed a non-readable expiration date.<br><br>On 4/10/24 at 0949 hours, a medication pass observation was conducted with LVN 1 for Resident 54. LVN 1 wiped Resident 54's bedside table, blood pressure cuff, stethoscope, and top of the medication cart with Sanicloth wipes. The Sanicloth wipes that LVN 1 used for Resident 54 was obtained from the same container of Sanicloth wipes with non-readable expiration date.<br><br>On 4/10/24 at 1045 hours, an interview and concurrent review of the expiration date of Sanicloth wipes was conducted with LVN 1. LVN 1 was asked to verify the expiration date on the container of the Sanicloth wipes that she had used for Residents 53 and 54. LVN 1 verified she could not read it and it was not legible.<br><br>2. On 4/10/24 at 0837 hours, a medication pass observation was conducted with LVN 1 for Resident 53. Prior to the medication administration, LVN 1 wiped the bedside table with Sanicloth wipes, with unknown expiration date due to the expiration date was not readable.<br><br>On 4/10/24 at 0904 hours, LVN 1 placed 6 spoons directly on Resident 53's bedside table.<br><br>On 4/10/24 at 0911 hours, LVN 1 placed the piston syringe directly on Resident 53's bedside table which LVN 3 used to check for residual, flush the G-tube with water, and administer the medications via G-tube.<br><br>On 4/10/24 at 1045 hours, an interview was conducted with LVN 1. When asked why she placed the spoons directly on Resident 53's bedside table, LVN 1 acknowledged and reasoned she wiped the bedside table first. LVN 1 verified the Sanicloth wipes did not have a readable label for expiration date. LVN 1 further stated she should have brought out a tray to use during the medication pass.<br><br>3. On 04/11/24 at 820 hours, during observation of medication administration with LVN 4, LVN 4 did not don a gown prior to administering medications via G-tube for Resident 72. LVN 4<br><br>read out loud the signage/posting outside of ENHANCED BARRIER PRECAUTION to prevent the spread of infections for specific care activities such as: Morning and Evening care, Toileting and Changing Incontinence briefs, Caring for devices and giving Medical treatments, Wound care, Mobility Assistance and preparing to leave the Room and Cleaning and Disinfecting the Environment.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | When asked if LVN 4 should have worn a gown prior to administering Resident 72's medications she stated yes, for the G-tube, for infection control. LVN 4 read out loud the Enhanced Barrier Precaution posted outside of Resident 72's room. When asked why LVN 4 did not put a gown on prior to medication administration, perform hand hygiene, change gloves during the entire medication pass, LVN 4 stated I forgot.<br><br>LVN 4 was observed using the bottom end of each spoon to stir each of Resident 72's medications in separate medication cups. LVN 4 was also observed placing these 6 used spoons and a piston syringe plunger used for G-tube medication administration, directly on to the surface of a tray table without a barrier.<br><br>On 4/11/24 at 916 hours, LVN 4 verified the 6 used spoons and piston syringe were directly on the surface of the tray table and LVN 4 stated, I should have put these (spoons and piston syringe) in a separate cup for infection control.<br><br>Reviewed signage/posting outside of Resident 72's room which showed ENHANCED BARRIER PRECAUTION to prevent the spread of infections for specific care activities such as: Morning and Evening care, Toileting and Changing Incontinence briefs, Caring for devices and giving Medical treatments, Wound care, Mobility Assistance and preparing to leave the Room and Cleaning and Disinfecting the Environment.<br><br>48853<br><br>2. On 4/10/24 at 0828 hours, a wound care observation for Resident 74 was conducted with LVN 2. LVN 2 was observed having the Derma Klenz wound cleanser on Resident 74's bed. LVN 2 used Derma Klenz spray to cleanse the resident's right leg. The Derma Klenz spray was not labeled with the resident's name. After the wound care was completed, LVN 2 was observed returning the Derma Klenz to the treatment cart.<br><br>On 4/10/24 at 0835 hours, a concurrent interview and medical record review were conducted with LVN 2. LVN 2 verified he did not clean the Derma Klenz spray prior to retuning to the treatment cart. LVN 2 further stated the Derma Klenz spray was being used as community supply.<br><br>On 4/12/24 at 1029 hours, an interview with the IP was conducted. The IP stated LVN 2 should have cleaned the Derma Klenz spray prior to returning to the cart to prevent the spread of infection.<br><br>3. On 4/10/24 at 0905 hours, a wound care observation for Resident 26 was conducted with LVN 2. LVN 2 was observed provided treatment to the resident's right lateral malleolus and right hip pressure injuries. LVN 2 was observed using the Derma Klenz spray to Resident 26's pressure injuries. The Derma Klenz spray was not labeled with the resident's name. After wound care was completed, LVN 2 was observed returning the Derma Klenz spray to the treatment cart.<br><br>On 4/10/24 at 0935 hours, a concurrent interview and medical record review were conducted with LVN 2. LVN 2 verified Resident 26 was on enhanced based precaution. LVN 2 verified the Derma Klenz was used to cleanse the right lateral malleolus and right hip pressure injuries, and LVN 2 stated he did not clean the Derma Klenz spray prior to retuning to the treatment cart. LVN 2 further stated the Derma Klenz spray was being used as community supply.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/12/24 at 1029 hours, an interview with the IP was conducted. The IP stated LVN 2 should have cleaned the Derma Klenz spray prior to returning to the cart to prevent the spread of infection.<br><br>49324<br><br>4. Review of the facility's P&P titled Hand Hygiene revised 9/2/22, showed all staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors, the use of gloves does not replace hand hygiene, if task requires gloves, perform hand hygiene prior donning gloves. Hand Hygiene Table showed hand hygiene should be performed before and after handling clean or soiled dressings, linens etc, before performing resident care procedures.<br><br>On 4/9/24 at 0950 hours, during the initial tour, CNA 8 was observed in Station 1 hallway, went directly to the storage room, took clean towels without performing hand hygiene. CNA 8 proceeded to enter Room F, without observing proper hand hygiene, laid clean towels on Resident 3's bed then opened the bedside table drawer, and took the personal item of Resident 3. CNA 8 was observed to not perform hand hygiene as she wore a new set of gloves, then repositioned Resident 3 to clean up the soiled diaper.<br><br>On 4/9/24 at 1045 hours, an interview was conducted with CNA 8. CNA 8 verified she should have performed hand hygiene before getting clean towels, before entering room [ROOM NUMBER], before getting personal items from the bedside drawer of Resident 3, before donning new set of gloves, and before repositioning Resident 3.<br><br>On 4/10/24 at 1417 hours, an interview was conducted with RN 2. RN 2 verified CNA 8 should have always performed hand hygiene before getting towels, before entering residents' room, before touching residents' items in their drawers, before donning gloves and before providing direct contact with the residents.<br><br>On 4/12/24 at 1440 hours, an interview was conducted with the DON. The DON acknowledged the above findings.<br><br>5. Review of the facility's P&P titled Resident Personal Belongings revised 12/19/22, showed the facility will ensure the resident's belongings are kept in a neat and orderly fashion and maintained in resident's room.<br><br>On 4/9/24 at 0825 hours, during the initial tour, an unlabeled basin was observed on top of the toilet tank in Room E's restroom occupied by three residents (Residents 24, 38, and 77).<br><br>On 4/10/24 at 0912 hours, an observation and concurrent interview with CNA 2 in Room E was conducted. The unlabeled basin remained on top of the toilet tank. CNA 2 stated it was used for the bed bath for Resident 38. CNA 2 further stated she should have labeled the basin to prevent cross contamination and should have not left it on top of the toilet tank.<br><br>On 4/10/24 at 1208 hours, an interview was conducted with the MDS LVN. The MDS LVN acknowledged CNA 2 should have labeled the basin to prevent cross contamination, properly and neatly stored the resident's basin.<br><br>(continued on next page) |

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| | 555797 | A. Building<br>B. Wing | 04/12/2024 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/12/24 at 1440 hours, an interview was conducted with the DON. The DON acknowledged the resident's basin should have been labeled, ensured that it was kept clean, and neatly maintained.<br><br>39453<br><br>6. Review of the facility's document titled Enhanced Standard Precautions (undated) showed everyone must perform hand hygiene before entering the room. The document also showed anyone who participate in any of the six moments must also don gown, and gloves. The six moments included morning and evening care, toileting and changing incontinence briefs, caring for devices and giving medical treatment, cleaning the environment, wound care, and mobility assistance and preparing to leave the room.<br><br>Review of the CMS QSO-24-08-NH dated 3/20/24, for Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of MDROs, showed MDRO transmission is common in long-term care facilities such as nursing homes, contributing to substantial resident morbidity and mortality and increased healthcare costs. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of MDROs that employs targeted gown and glove use during high-contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.<br><br>On 4/10/24 at 0927 hours, an Enhanced Barrier Precautions sign was observed posted outside Resident 35's room alerting anyone to perform hand hygiene before entering and when leaving the room. The sign also alerted the providers and staff to wear gloves and a gown for high-contact resident care activities. A number 6 was observed beside Resident 35's name by the door. A cart containing gowns was observed inside the room. CNAs 1 and 2 were observed assisting Resident 35 transfer from bed to wheelchair. CNAs 1 and 2 were wearing gloves but were not observed wearing gowns.<br><br>On 4/10/24 at 0941 hours, an observation for Resident 35 and concurrent interview was conducted with CNA 1. CNA 1 verified the above findings. CNA 1 verified the Enhanced Barrier Precaution sign placed outside Resident 35's room, with a number 6 besides Resident 35's name by the door. CNA 1 verified she transferred Resident 35 from the bed to wheelchair with CNA 2. CNA 1 verified they were only wearing gloves, and not gown while transferring Resident 35.<br><br>Medical record review for Resident 35 was initiated on 4/9/24. Resident 35 was readmitted to the facility 11/12/19.<br><br>Review of Resident 35's Order Summary Report showed a physician's order dated 4/3/24, for enhanced barrier precaution to prevent the spread of infections for specific care activities such as morning and evening care, toileting and changing incontinent briefs, caring for devices and giving medical treatments, wound care, mobility assistance and preparing to leave the room, and cleaning and disinfecting the environment every shift for indwelling medical device.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/11/24 at 1539 hours, an interview and concurrent medical record review for Resident 35 was conducted with the IP. The IP verified the above findings. The IP stated when an Enhanced Barrier Precaution sign was placed by the door and the resident's name was marked with a number 6, the staff who provided the high-contact care activities should wear gloves and a gown, in addition to hand hygiene. The IP stated high-contact resident care activities included transferring, or mobility assistance and preparing the resident to leave the room.<br><br>Cross reference to F726, example #2. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>29461<br><br>Based on observation, interview, and facility document review, the facility failed to ensure one glucometer (Glucometer C) from one of five medication carts (Medication Cart C) was maintained in safe operating condition. This failure had the potential for residents requiring glucose checks to have inaccurate readings.<br><br>Findings:<br><br>Review of the Assure Platinum Blood Glucose Monitoring System Instruction Manual, under Quality Checks, showed to use Assure Dose Control Solutions to check if the meter and test strips are working correctly as a system, and if the test is correct. A control solution test is performed when a new bottle of test strips is opened.<br><br>On 4/11/24 at 1245 hours, Medication Cart C inspection was conducted with LVN 3. One glucometer (Glucometer C) was observed inside the top drawer of Medication Cart C. The bottle of Assure Platinum Blood Glucose Test Strips was observed with an open date of 4/11/24, and Lot No. 012523B. A bottle of control solution was observed with the control solution range for Level 1 was 84-105 mg/dl, and the control solution range for Level 2 was 203-253 mg/dl.<br><br>On 4/11/24 at 1246 hours, an interview and concurrent review of the Assure 3 Blood Glucose Monitoring System: Daily Quality Control Record for Glucometer C was conducted with LVN 3. The Daily Quality Control Record for April 2024 showed the quality control checks for the glucometer was checked every day. However, the information on the log for Glucometer C with the date of 4/11/24, did not match the test strips Lot No. and the control solution ranges on the control solution bottle. The log for Glucometer C dated 4/11/24, showed the test strips Lot No. was 120623A, Level 1 control range was 84-104 mg/dl, and Level 2 control range was 201-251 mg/dl. LVN 3 verified the findings and also verified there was no other bottle of the glucose test strips inside Medication Cart C to match the documentation dated 4/11/24, in the Assure 3 Blood Glucose Monitoring System: Daily Quality Control Record for Glucometer C. LVN 3 stated the glucometer quality control was done by the night shift (2300-0700 hours) licensed nurse. LVN 3 verified and acknowledged the findings. LVN 3 further stated the quality control checks must be done whenever a new bottle of test strips was opened. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35346<br><br>Based on observation, interview, and facility P&P review, the facility failed to ensure the residents' call light system was fully functional as evidenced by:<br><br>* The call light system for two of two nursing stations were not audible.<br><br>* Resident 67's call light was not answered promptly.<br><br>These failures posed the risk of staff not responding promptly to residents in need of immediate assistance.<br><br>Findings:<br><br>Review of the facility's P&P titled Call Lights: Accessibility and Timely Response revised 9/2/22, showed the staff members who see or hear an activated call light were responsible for responding. If the staff member could not provide what the resident desired, the appropriate personnel should be notified.<br><br>1. On 4/9/24 at 1408 hours, Resident 61's call light was observed on but not audible.<br><br>On 4/10/24 at 1041 hours, Resident 61's call light was observed on but not audible.<br><br>On 4/10/24, medical record review for Resident 61 was initiated. Resident 61 was admitted to the facility on [DATE]. Resident 61 was observed to have a sitter inside her room due to being at risk for and having a history of falls.<br><br>On 4/11/24 at 1525 hours, the call lights for Resident Rooms C and D were observed on but not audible. Concurrent observation and interview of Resident Rooms A and B (rooms not visible and located the farthest away from the nurses station) was conducted with the Maintenance Director. The Maintenance Director verified the call lights for Resident Rooms A and B were not audible. When asked about the call lights system, the Maintenance Director verbalized the facility received recommendations from the technicians to replace the entire facility's call light system due to the problem with the facility's call lights system not being fully functional.<br><br>On 4/11/24 at 1646 hours, the survey team and facility staff checked the call light system of the whole facility, and the call lights were observed turned on showing the lights at the door and the panel but there was no audible sounds for Nursing Stations 1, 2, and 3.<br><br>On 4/11/24 at 1629 hours, the survey team had a meeting with the Administrator, AIT and DON. They were informed of the call light system concerns. The Administrator stated the call light system stopped working last week, either Thursday or Friday. The Administrator stated the call lights turned on in the call light panel, but there was no audible sound in Nursing Station A; and the call light panel completely stopped working in Nursing Station B. The Administrator stated they called the vendor on 4/5/24 (Friday), and the technician came to check the call light system on 4/9/24.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the emailed report sent by the vendor dated 4/11/24, showed the vendor would send quote for a new system for a facility with 22 rooms with three beds, and 15 rooms with two beds. When asked for the actual quote and work order, the Administrator stated it was verbal conversation with the vendor and would ask the vendor for documentation.<br><br>Per the Administrator, the interventions for the call light system not being fully functional included providing residents with manual bells. However, the staff were observed providing bells to the residents after the meeting with the facility's management team.<br><br>Review of the Guardian Angel Daily Inspections for 4/12/24, for Resident Rooms A and B showed some of the residents inside these rooms verbalized their call light response time was 30 minutes.<br><br>On 4/12/24 at 1700 hours, the survey team conducted an inspection of the facility's call lights. There was audible sounds heard from the call light panel but some were still not working. Rooms 8, 5, 36, 19, 21, 23, 24, 31, and 27's call lights were still not working, operate in the room but did not annunciate at the nursing station<br><br>2. On 4/11/24 at 1608 hours, an interview was conducted with Resident 67. Resident 67 stated CNA 8 came to the resident's room on 4/10/24 at 1030 hours, but the CNA never came back. Resident 67 further stated he pushed the call light button but the CNA never showed up.<br><br>Medical record review for Resident 67 was initiated on 4/12/24. Resident 67 was admitted to the facility on [DATE], and was readmitted [DATE].<br><br>Review of Resident 67's H&P examination dated 10/19/23, showed Resident 67 was able to make decisions.<br><br>On 4/11/24 at 1440 hours, during an interview with the DON and Administrator, they were made aware of the above findings. The DON and Administrator acknowledged that CNA and other staff should have attended to Resident 67's needs. |