

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/11/2024
NAME OF PROVIDER OR SUPPLIER  McKinney Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 253 Enterprise Dr McKinney, TX 75069	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028</b></p> <p>Based on, interview and record review, the facility failed to have evidence that all alleged violations were thoroughly investigated for one (Resident # 138) of six residents reviewed for misappropriation of property.</p> <p>The Administrator failed to start thoroughly investigating a misappropriation of property on 01/11/2024, after the facility filed a report to the state regarding Resident # 138's [NAME] Of Attorney misappropriating her property.</p> <p>Failure to timely investigate misappropriation of property placed residents at risk for unidentified misappropriation of property.</p> <p>Findings included:</p> <p>Review of Resident #138's face sheet reflected she was a [AGE] year-old female with an original admitted [DATE] and she was discharged to an assisted living facility on 02/15/2024. Resident was diagnosed with dementia (loss of cognitive functioning), schizophrenia (a chronic brain disorder), cognitive communication deficit (difficulty with thinking and use of language), end stage renal disease ( kidney failure). MDS assessment dated [DATE] reflected Resident had a BIMS score of 09 which indicated resident's cognition was moderately impaired. Resident required moderate assistance with toilet/shower transfers, and she was occasionally incontinent of bowel and urine.</p> <p>Review of the Adult Protective Services report dated 01/09/2024 and facility self-reported incident dated 01/11/2024 reflected the facility staff had concerns of misappropriation of property by resident # 138's friend who obtained a [NAME] Of Attorney that included financial access. Further review revealed the facility failed to investigate this allegation of misappropriation of property to ensure her finances were safe.</p> <p>Record review of progress note dated 01/09/2024 reflected the Social Services Staff made and Adult Protective Services report of suspicious activity against Resident 138's friend who was enquiring about finances and document being signed.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the facility Social Services staff on 04/10/2024 at 9:41 AM revealed resident's friend started asking Social Services staff about reimbursement for his visits to the facility and the Resident #138 had recently signed a Power Of Attorney over to the friend Social Services staff stated Resident's friend's had a sudden interest in resident's finances and his (Power Of Attorney-friend) access to her (Resident #138) finances made her suspicious of Power Of Attorney friend and she filed an Adult Protective Services report to investigate and find out what exactly was going on. Social Services Staff stated the facility received a copy of the Power Of Attorney document, she stated she did not read the Power Of Attorney document prior to making the Adult Protective Services report.</p> <p>An attempted call to Resident #138 at her cell phone listed in the admission record was not answered on 04/10/24 at 9: 50 AM.</p> <p>Interview with Business Office Manager on 04/10/24 at 10:52 AM revealed she was familiar with Resident #138 and resident's friend was the only point of contact at the time of her admission. She stated the friend was listed as the Resident #138's Medical Power Of Attorney and that document (Medical Power Of Attorney) was signed on 05/21/2022. She stated at the time of Resident #138's admission, the Power Of Attorney did not want to be involved in her financial matters, but he started showing interest in her finances by the end of December 2023. She stated the facility wanted to apply for Medicaid for the Resident # 138 and the friend was contacted for Resident's financial documents. The friend informed the Business Office Manager that resident received a lump sum amount from her brother who passed away and the friend obtained a guardianship of the resident. Business Office Manager stated the Power Of Attorney friend brought a guardianship document to her on 01/09/2024, he started showing interest in Resident #138's finances and asked about her social security income and status of resident's trust fund account. Business Office Manager stated the friend wanted reimbursement for his expenses towards the visit such as gas, food purchases for the resident, she reimbursed him from the resident's trust fund for food. Business Office Manager stated his sudden interest in resident's finances made her suspicious of his intentions. Business Office Manager stated she discussed her concerns about Resident #138's finances with the social services staff and the administrator. Business Office Manager stated the social services staff made an Adult Protective Services report against resident's friend/Power Of Attorney for financial exploitation, Business Office Manager stated she did not know the outcome of the Adult Protective Services report. Business Office Manager stated the resident was discharged on [DATE]. Business Office Manager stated she was able to identify misappropriation of property, the recent in-service training she received on misappropriation of property was 2 weeks ago. Business Office Manager stated if she came to know about a misappropriation of property, she would immediately report it to Adult Protective Services, also notify the social worker and the administrator, and the facility would investigate the allegation. Business Office Manager stated not investigating an allegation of misappropriation of property would place a resident at the risk of the continuation of misappropriation. Business Office Manager stated whoever made the report was responsible to follow up and ensure an investigation was completed and resident's assets were safe.</p> <p>A second attempted telephone call on 04/10/2024 at 10:26 AM to Resident #138 was not answered.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A follow up interview with the Social Services staff on 04/10/2024 at 11:02 AM revealed she had received in services on misappropriation of property and the last in service she received was a year ago. She stated she would report to Adult Protective Services and administrator whenever she learned that an individual was taking advantage of a resident financially. She stated she made the report to make sure the Resident 138's finances were safe, and she was not taken advantage of by his friend/Power Of Attorney. She stated the risk for the resident for not investigating misappropriation of property was her safety, her stay at the facility and her finances. She stated in this case she was responsible to ensure an investigation was completed. She stated she was not aware of any other state agency report regarding exploitation other than the one she made to Adult Protective Services.</p> <p>Interview with the administrator on 04/10/2024 at 12:55 PM revealed he was familiar with Resident #138 and her friend/Power Of Attorney. He stated the friend's sudden interest in her finances made the facility Business Office Manager and Social Services staff suspicious of his intention and the Inter Disciplinary Team meeting discussed and determined the issue was more appropriate for Adult Protective Services to investigate. Administrator stated he was not aware if the Adult Protective Services completed the investigation, the staff who reported was responsible to follow up and ensure an investigation was completed. Administrator stated the staff were provided training on misappropriation of property at least once a month and he expect his staff to immediately notify him and report to the state if there was a concern of misappropriation of property. He stated he was the only one who has access to Tulip to file a state report and he did not report it because he did not fell this case was appropriate for misappropriation. He stated not investigating a misappropriation of property could affect the finances of a resident.</p> <p>An interview with DON on 04/11/2024 at 10:38 AM revealed she was familiar with Resident #138 and his friend. DON stated resident's friend did not have any responsibility at the time of her admission. DON stated his sudden interest in resident's finances and his demand for reimbursement for any visits and purchases towards resident made the facility staff suspicious of his intention. The friend brought a Power Of Attorney document on the resident and the facility staff made an Adult Protective Services report to investigate financial exploitation. DON stated she did not know the outcome of the investigation. DON stated she was not aware of the incident reported to any other state agency than Adult Protective Services. DON stated the business office was responsible to do the due diligence, she stated she could not say who was responsible to ensure an investigation was completed. DON sated she did not know the risk for the resident if a misappropriation of property report was not investigated.</p> <p>Review of the hospital document from dated 05/21/2022 reflected Resident #138 appointed her friend as her Medical Power Of Attorney.</p> <p>Review of the Probate Court document reflected Resident #138 did not need a guardian and Resident #138's friend was appointed as her durable Power Of Attorney on 12/14/2023 based on the Power Of Attorney Resident signed on 08/03/2023.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy dated 10/1/2022 reflected It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment . Residents must not be subjected to abuse by anyone, including, but not limited to, Facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, resident representatives, families, friends, or other individuals. Misappropriation of resident property - means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.</p> <p>PROCEDURES:</p> <p>In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility will:</p> <ul style="list-style-type: none"> <li>o Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but:</li> <li>o Not later than two (2) hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury</li> <li>o Not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury</li> <li>o Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to:</li> <li>o The Administrator of the Facility</li> <li>o The State Survey Agency</li> <li>o Adult Protective Services (as appropriate)</li> <li>o Ensure that, after receipt of a report of possible abuse, neglect, mistreatment, exploitation, or misappropriation of resident property, steps are immediately taken to protect the identified resident(s).</li> <li>o Ensure that the results of all investigations are reported within five (5) working days of the incident to:</li> <li>o The Administrator</li> <li>o The State Survey Agency</li> <li>o Ensure that, if the alleged violation is verified, appropriate corrective action is taken.</li> </ul> <p>GUIDELINES FOR FACILITY COMPLIANCE</p> <p>In order to comply with the Facility's obligations as set forth in 42 CFR Section 483.12, it will:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>o Make all staff aware of the applicable reporting requirements.</li> <li>o Educate all staff on the definitions of abuse, neglect, mistreatment, exploitation, and misappropriation of resident property.</li> </ul> <p>Policy / Procedure - Nursing Administration</p> <p>Revised 10/1/2022 Page 4</p> <ul style="list-style-type: none"> <li>o Educate all staff on the types of conduct which might meet the definition of abuse, neglect, mistreatment, exploitation, or misappropriation of resident property.</li> <li>o Support an environment in which staff and others freely and without hesitation report situations which may be or are consistent with abuse, neglect, mistreatment, exploitation, or misappropriation of resident property.</li> <li>o Conduct a prompt, thorough and complete investigation in response to reportable allegations of abuse, neglect, mistreatment, exploitation, or misappropriation of resident property.</li> <li>o Maintain evidence that all allegations of abuse, neglect, mistreatment, exploitation, or misappropriation of resident property are thoroughly investigated.</li> <li>o Depending on the nature of the allegation, immediately put effective measures in place to ensure that further potential abuse, neglect, mistreatment, exploitation, or misappropriation of resident property does not occur while the investigation is in process.</li> <li>o Take corrective action as appropriate given the results of the investigation.</li> <li>o Assess the corrective action taken, if any, in response to the results of the investigation to determine its effectiveness.</li> </ul>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34918</p> <p>Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for four of 18 (Residents #6, #16, #49 and #287) reviewed for comprehensive care plans.</p> <ol style="list-style-type: none"> <li>The facility failed to include in the care plan on 01/16/24 Resident #6's contractures to her right hand with interventions required to prevent further decline.</li> <li>The facility failed to include in the care plan dated 03/28/24 Resident #16's contractures to her hands with interventions required to prevent further decline.</li> <li>The facility failed to create a care plan on 03/26/24 for Resident #49's scoop mattress.</li> <li>The facility failed to ensure Resident #287's care plan dated 02/21/2024 was revised to reflect discontinued use of BiPAP (bilevel positive airway pressure: normalizes breathing by delivering pressurized air into the upper airway leading into the lungs)</li> </ol> <p>These failures could place residents at risk for possible adverse side effects, adverse consequences, and decreased quality of life and care and did not represent a person-centered coordination of care.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Record review of Resident #6's annual MDS assessment dated [DATE] reflected a [AGE] year-old female with a BIMS of 0 which indicated she was severely cognitively impaired but could sometimes make herself understood and could sometimes understand others. She had functional limitation in range of motion both upper and lower to one side and had received occupation therapy services until the end date of 03/08/24. She required extensive assistance with ADL care and had current diagnoses of aphasia (language disorder that affects ability to communicate), cerebral vascular accident (stroke), dementia, and seizure disorder.</li> </ol> <p>Record review of Resident #6's care plan revised on 01/19/24 did not address the residents' contractures or any interventions to help prevent further decline.</p> <p>Record review of Resident #6's physician orders summary report for April 2024, reflected, Occupational Therapy Clarification: Skilled Occupational therapy services 5x/week for 4 weeks with emphasis on Self-care management, Therapeutic activities, UE (upper extremity) therapeutic excises, Neuromuscular reeducation and Patient/Caregiver education . with a start date of 01/07/23. There were no recent orders indicating Occupation therapy was currently active.</p> <p>An observation on 04/09/24 at 9:15 AM revealed Resident #6 up in wheelchair with mechanical lift sling under her. Resident had a contracted right hand. No hand rolls or splints were in use. Resident self-propelling her wheelchair in the hallways with the use of her feet and left hand.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 04/09/24 at 2:15 p.m. revealed CNAs E and D perform mechanical lift transfer on Resident #6. Hand splint was observed on the resident's bedside table.</p> <p>In an interview with CNA E on 4/10/24 at 12:40 a.m. she stated she does not place any splint on Resident #6' hand. She stated therapy placed the splints on the residents.</p> <p>In an interview with the DOR on 04/10/24 at 12:50 p.m. she stated they had Resident #6 on case load as of 04/04/24. She stated it was a mixture of nursing and therapy when it comes to splint placement. She stated therapy will do the splints until they train the nursing staff that will be managing the splints. She stated there should be a current order for Occupational therapy services and would see why there was not an order. She stated they review the residents they have on case load at stand morning meetings with clinical team. She stated they have a contracture management book on all residents with contractures and those residents are re-evaluated every quarter and would be placed back on case load if they saw a decline.</p> <p>2. Record review of Resident #16's Quarterly MDS assessment dated [DATE], reflected a [AGE] year-old female with an admitted [DATE]. Resident #16 was severely cognitively impaired and unable to complete the interview for mental status. Resident #16 had functional limitation in Range of Motion on both sides in his upper and lower extremities. She was totally dependent of one-to-two-person assistance with all ADLs and was always incontinent of bowel and bladder. She had received occupation therapy services with a start date 04/17/23. Her diagnoses included aphasia (disorder that affects communication), cerebral vascular accident (stroke), and contractures to bilateral elbows and hands.</p> <p>Record review of Resident #16's care plan revised on 03/28/24 did not address the residents' contractures to her hands or elbows or any interventions that had been put into place to help prevent further decline.</p> <p>Record review of Resident #16's physician order summary for April 2024 reflected, Patient to wear bilateral c-splint as determined by OT staff or as patient tolerates in order to manage wrist, finger contractures. Skin assessment to be completed prior to and after don/doff splint. Therapist to document were time/skin condition in daily notes . with a start date of 03/07/23.</p> <p>In an observation on 04/10/24 at 11:15 a.m. Resident #16 observed in bed with no hand splints in use.</p> <p>In an interview with LVN B on 04/10/24 at 11:20 a.m. she stated Resident #16 had splints for both her hands that she puts on at 7 am and takes off at 11 am. She stated therapy had determined this was about length of time the resident could tolerate the splints for now.</p> <p>In an interview with MDS D on 04/11/24 at 10:30.m., she stated she was responsible for updating the comprehensive care plan. She stated the contracture on Resident #6 and Resident #16 should have been care planned and they should document what prevention had been put into place. She stated the care plan should reflect when a resident's intervention were no longer effective or if they had refused. She stated the care plan was supposed to be a comprehensive approach to what the needs of the resident were or what their wishes were.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the DON on 04/11/23 at 12:00 p.m. revealed the MDS Coordinator was responsible for updating the care plan. She stated all contractures should have been care planned with interventions in place. She stated if a resident had splinting ordered, it should be placed on the physician's orders. The DON stated if a resident refused the required splint, then it should be documented on the care plan. She stated failing to have interventions in place, put residents at risk of further decline and decreased range of motion and by not updating the care plan, they had no evidence of what attempts had been made to prevent a resident's decline.</p> <p>3. Review of Resident #49's quarterly MDS, dated [DATE], reflected she was a [AGE] year-old female admitted on [DATE]. The resident's cognition was severely impaired. Her diagnoses included non-Alzheimer's dementia.</p> <p>Review of Resident #49's Order Summary Report, dated April 2024, reflected there was not an order for a scoop mattress.</p> <p>Review of Resident #49's Comprehensive Care Plans, not dated, reflected she did not have a care plan for a scoop mattress.</p> <p>Review of Resident #49's Hospice Order, dated 03/26/24, reflected she had an order for a scoop mattress.</p> <p>An observation and interview on 04/09/24 at 1:20 PM revealed the resident was sitting in a wheelchair. Her family was at the bedside. The resident had a scoop mattress on her bed. The family member said the resident had a scoop mattress because she had a history of falls.</p> <p>An interview on 04/10/24 at 1:48 PM with CNA N revealed the resident had a history of falls but did not know why Resident #49 had a scoop mattress. She said maybe Hospice had placed the mattress.</p> <p>An interview on 04/10/24 at 3:33 PM with the DON for Resident #49 revealed the resident did not have falls very often. She said the resident had a scoop mattress because Hospice provided it. She said she did not know if there was an order for the scoop mattress. She said she did not know if there was a care plan for the scoop mattress.</p> <p>An observation and record review on 04/11/24 at 9:46 AM with RN M revealed there was not an order for Resident #49's scoop mattress in her Hospice binder. RN N walked to the resident's room and saw the scoop mattress. She said she did not know the resident had a scoop mattress.</p> <p>A follow-up interview on 04/11/24 at 12:38 PM with the DON revealed she received the Hospice order for Resident #49's scoop mattress on 04/11/24. She said without the order, a care plan could not be generated. She said if the facility did not know about Hospice orders, then there could be a safety risk to the resident.</p> <p>An interview on 04/11/24 at 1:28 PM with the Hospice Nurse revealed she received the order for Resident #49's scoop mattress and faxed it to the facility. She said she did not know if she talked to the facility staff, but usually she did.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of Resident #287's Face Sheet dated 04/09/2024 reflected that resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included unspecified chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and iron deficiency anemia (deficiency of healthy red blood cells that carry oxygen to all parts of the body).</p> <p>Review of Resident #287's Comprehensive MDS assessment dated [DATE] reflected resident had a moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment also indicated one of the primary medical issues was chronic obstructive pulmonary disease. The Comprehensive MDS Assessment did not indicate resident was on BiPAP.</p> <p>Review of Resident #287's Comprehensive Care Plan dated 02/21/2024 reflected Resident #287 used BiPAP at bedtime.</p> <p>Review of Resident #287's Physician Order on 04/09/2024 reflected no order for BiPAP.</p> <p>Review of resident #287's Order Summary Report on 04/09/2024 reflected BiPAP was discontinued on 03/05/2024.</p> <p>Observation and interview with Resident #287 on 04/09/2024 at 11:05 AM revealed Resident #287 was in her wheelchair awake. It was noted that resident still had a BiPAP machine on the side table. According to Resident #287, she used BiPAP before but had stopped using it because she does not need it anymore.</p> <p>Observation and interview with LVN K on 04/09/2024 at 1:32 PM, LVN K confirmed that Resident #287 does not use the BiPAP anymore. LVN K checked the system and verified that the resident did not have any order for BiPAP. She then checked the care plan and saw that the resident was still care planned for BiPAP. LVN K said the care plan should had been revised because it did not reflect the current need of the resident. LVN K added the care plan should be updated or revised to show the present health condition of the resident. She said if the care plan were not updated, it would be a suggestion that the staff were not assessing the health status of the resident in order to see if the planned care was still applicable and appropriate. She added if the care plan was not updated, there could be a confusion on the care of the residents and the residents might not receive the treatment needed.</p> <p>Observation and interview with the DON on 04/10/2024 at 10:52 AM, the DON stated the Resident #287 did not use a BiPAP when she came back from the hospital. The DON said the BiPAP was discontinued because the resident was not using it anymore. The DON checked the resident's profile and confirmed that there was no order for the BiPAP and it was discontinued on 03/05/2024. The DON then checked the resident's care plan and verified she was still care planned for BiPAP. The DON further added if the resident's BiPAP was discontinued, the care plan should be revised. The DON said the care plan should reflect the current status of the resident to be able to provide appropriate interventions. She said if the care plan was not revised, there could be confusion on the resident's care and the resident might not be able to receive the required care. The DON said there was an oversight on her part because the care plan was not reviewed and revised. The DON said she was not concluded that the expectation was the care plans should be checked to see if the plan needed revisions. The DON concluded she would revise Resident #287's care plan to prevent confusion about his care.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the Administrator on 04/11/2024 at 8:23 PM, the Administrator stated residents care plans should be accurate in reflecting the needs of the residents. The Administrator said without the care plan, the needs of the residents won't be met. The Administrator added the care plan should be evaluated and revised if needed to prevent confusion among the staff about the care needed by the residents. The Administrator said the expectation was the staff to do their due diligence, have a conscious effort to make sure that the residents' care plans were revised, updated, and reflect the current need of the residents.</p> <p>In an interview with the MDS Coordinator on 04/11/2024 at 10:42 AM, the MDS Coordinator stated she was responsible in doing the care plan but everybody that was involved in her care should communicate and contribute to make a person-centered care plan. She said if the BiPAP was used by the resident or the use of the BiPAP had been resolved, then the resident's care plan should had been revised. The MDS Coordinator said the care plan should reflect the plan of care needed by a resident. She further explained the main purpose of the care plan was to address the current needs of the residents and for the staff to have a guide on how to care for the resident. If the care was not applicable to the resident, the care plan must be revised to indicate the accurate and personal care of the resident. She further said that the care plan should also reflect if the resident was refusing the BiPAP. The MDS Coordinator said she would check Resident 287's care plan and do the necessary revisions so that the resident could have the treatment needed.</p> <p>Review of the facility policy, Comprehensive Person-Centered Care Planning, revised December 2023, reflected, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment .</p> <p>37028</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34918</p> <p>Based on observation, interview and record review, the facility failed to provide the necessary services to maintain good personal hygiene to a resident who was unable to carry out activities of daily living for one of six residents (Resident #8) reviewed for ADL care.</p> <p>The facility failed to provide Resident #8, who required extensive assistance, with timely incontinence care on 04/09/24 from 9:30 a.m. to 3:00 p.m.</p> <p>This failure could place residents at risk of skin breakdown, urinary tract infections and loss of dignity.</p> <p>Findings included:</p> <p>Record review of Resident #8's quarterly MDS assessment, dated 01/22/24, reflected a [AGE] year-old female with an admitted d of 03/25/17. She had a BIMS of 14, indicating she was cognitively intact. She had no behaviors documented and not resisted care. Resident #8 required extensive assistance with toileting and personal hygiene and was always incontinent of urinary bladder and bowel. Resident #8 was at risk of pressure ulcers with no current skin issues. Her active diagnoses included atrial fibrillation (fast irregular heart rate), depression, and bipolar disorder (mental disorder that cause extreme mood swings).</p> <p>Record review of Resident #8's Comprehensive Care Plan initiated on 09/06/22, reflected, . Has bowel/bladder incontinence r/t dementia, decrease/impaired mobility Interventions .Change as required for incontinence. Wash, rinse and dry perineum .Monitor/document for s/sx of UTI: pain, burning .urinary frequency .foul smelling urine .</p> <p>In an interview with Resident #8 on 04/09/24 at 2:30 p.m. she stated she was not getting changed throughout the day. She stated she was gotten up around 9:30 a.m. so she can make the first smoke break. She stated she was not laid back down and changed until after the last smoke break which was at 6:30 p.m. She stated it may be close to 7:30 p.m. before she gets changed. She stated she cannot make staff understand that she wants to be gotten back up so she can have her smoke breaks, so they just leave her up the whole time. She stated by the time they laid her down at night she was soaked in urine. She stated she was wet right now and would like to be changed, but stated she wanted to make sure they knew she wanted to get back up.</p> <p>On 04/09/24 at 2:35 p.m. LVN B was notified Resident #8 was wet and had requested to be changed. She stated she would let the CNAs know and they would be in to change her.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 04/09/24 at 2:40 p.m. reveled LVN B and CNA D entered Resident #8's room with a stand assist lift. Resident stated, after I get changed, I want to be gotten back up, LVN B attached the lift sling around the resident's waist and slowly lift her to a standing position which revealed the resident was soaked in urine with the front and back of her pants wet. Resident was transferred to the bed and both staff removed the residents' wet pants and opened the wet brief. LVN B wiped from front to back and down the middle and with assistance from CNA D rolled the resident onto her side, revealing she had also had a bowel movement. Resident #6 stated her butt was burning. Residents' buttocks was slightly red but no skin breakdown. LVN B removed the soiled brief and placed a clean brief under the resident before completion of incontinence care. LVN B wiped the resident's anal area and buttocks from front to back until all bowel movement had been removed. LVN B then opened a packet of barrier cream without removing her soiled gloves or performing hand hygiene and was about to apply to the resident buttocks, when the resident stated she needed to turn on her other side. LVN B handed the barrier cream to CNA D, and they assisted the resident onto her other side. CNA C applied the barrier cream to the resident's buttocks and the staff rolled the resident back onto her back and fastened the brief. LVN B and CNA D then removed their gloves and performed hand hygiene and redressed the resident, transferred her back into her wheelchair.</p> <p>In an interview with LVN B on 04/09/24 at 3:15 p.m. she stated incontinent residents were supposed to be checked and changed every two hours. She stated she was not sure if the resident had been changed earlier in the shift or not. She stated she knew the resident wanted to be up before the first smoke break which was at 10:00 a.m.</p> <p>In an interview with CNA D on 04/09/24 at 3:50 p.m. she stated she works the 2 p.m. to 10 p.m. shift. She stated they do not check Resident #8 for incontinences until after she goes to bed after the last smoke break. She stated the resident can let them know if she wants to be changed. She stated she was not sure if day shift changed her after she was gotten up in the morning.</p> <p>In an interview with CNA E on 04/10/24 at 12:40 a.m. she stated she was not assigned to Resident #8 on 04/09/24 but does assist with getting her up and incontinent care when asked. She stated she does not recall getting asked on 04/09/24 to assist with providing any incontinence care to Resident #8. She stated she knows she likes to be up before 10:00 a.m. so she can go for the first smoke break. She stated Resident #8 was always incontinent.</p> <p>In an interview with the DON on 04/10/24 at 2:00 p.m. she stated incontinent residents were to be checked and changed every two hours. She stated failing to do this could cause skin breakdown and puts them at risk of urinary tract infections.</p> <p>Review of the facility's policy titled, Incontinent Care, dated May 2007, reflected, It is the policy of this facility to remove urine or feces from skin, cleanse and lubricate skin, provide dry, odor free perineal care system . Check for wetness at least every two hours.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34918</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of six residents (Resident #47) reviewed for incontinence care.</p> <p>The facility failed to ensure NA C provided appropriate perineal care for Resident # 47 after an incontinent episode when he failed to clean the resident's scrotum, and penis on 04/09/24.</p> <p>This failure could place residents at risk for the development and/or worsening of urinary tract infections and skin breakdown.</p> <p>Findings included:</p> <p>Record review of resident #47's quarterly MDS assessment, dated 02/25/24, reflected a [AGE] year-old male with an admitted [DATE]. Staff assessed residents' cognition as severely impaired. He required extensive assistance with personal hygiene and toileting and was frequently incontinent of urine and always incontinent of bowel. Active diagnoses included diabetes, cerebral vascular accident (stroke) and dementia.</p> <p>Review of Resident #47's care plan, initiated on 10/03/23, reflected .Has bowel/bladder incontinence r/t impaired mobility, post CVA, hemiplegia .Interventions .use disposable briefs. Change as needed .</p> <p>An observation on 04/09/24 at 1:30 p.m. revealed NA C with assistance from therapy staff transferring Resident #47 from his wheelchair to the bed so he could provide incontinence care. Resident #47 was observed to have wet pants from front to back. NA C performed hand hygiene and put on gloves and removed the resident wet pants and unfasted the wet brief and took a peri wipe and wiped up and down residents' groin without changing the surface of the wipe with each stroke. NA C did not clean the resident's penis or scrotum or pull back the foreskin to clean the tip of the penis. NA C rolled the resident over onto his side and wiped the back of the resident's thighs and wiped the anal area from front to back with a clean peri-wipe. NA C placed a clean brief under the resident without changing his gloves and performing hand hygiene. NA C fastened the brief and repositioned the resident and then removed his gloves and gathered the trash and dirty linens and left the room without performing hand hygiene and walked across the hall and entered the soiled linen closet to deposit the trash and linens, and then performed hand hygiene.</p> <p>In an interview with NA C on 04/09/24 at 01:55 p.m. he was unsure about the proper steps of peri-care for a male resident and was not sure what steps he had missed. After a few minutes he stated he should have cleaned the penis and scrotum. He stated the foreskin needed to be pulled back to clean the tip of the penis. He stated failing to do this could cause skin breakdown and infections.</p> <p>Review of NA C's skill check off for Male Perineal care dated 03/09/24 reflected he was competent in providing this care.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/10/24 at 02:00 p.m., the DON stated when providing incontinent care staff were to clean the peri area including penis and scrotum for male residents then moving toward the buttocks. She stated by not providing accurate incontinent care it placed residents at risk for urinary tract infections, skin breakdown and overall poor hygiene. She stated NA C was very nervous and stated she knew he knew how to provide proper care.</p> <p>Record review of the facility's procedure check off titled, Male Perineal Care, dated 2019, reflected, .Wash hands .Put on disposable gloves .Use a different section of the washcloth or disposable wipe for each stroke . Hold penis upright .pull back the foreskin of the uncircumcised penis. Wash the urinary meatus (tip of penis) in a circular motion .Return the foreskin to the natural position .wet and sop a new washcloth. With downward strokes(away from the urinary meatus), wash down the shaft of the penis, then scrotum, perineum, and thigh creases .Wash the perineum and the anal area .Wash from front to back .Change gloves and perform hand hygiene if apply peri cream .Apply incontinent brief .Remove gloves and wash hands .Tie up bags of soiled linen and trash .Wash hands .</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</b></p> <p>Based observation, interview, and record review, the facility failed to ensure that five (Resident #289, Resident #290, Resident #61, Resident # 79, and Resident #16) of ten residents were provided medications and/or biologicals and pharmaceutical services to meet the needs of the residents.</p> <ol style="list-style-type: none"> <li>1.The facility failed to ensure MA L re-ordered medications in a timely manner for Residents #289 (Lasix ), Resident #290 (Lasix), and Resident #61 (Entresto).</li> <li>2.The facility failed to ensure MA J re-ordered medications in a timely manner for Residents #79 (Metoprolol).</li> <li>3.The facility failed to ensure LVN B re-ordered medications in a timely manner for Resident #16 (Famotidine).</li> </ol> <p>This failure placed the residents at risk of not receiving medications as ordered by the physician.</p> <p>Findings included:</p> <p>1.Review of Resident #289's Face Sheet dated 04/10/2024 reflected resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included pleural effusion (accumulation of excessive fluid on the space that surrounds each lung), acute systolic congestive heart failure (condition in which the heart cannot pump blood well enough to meet the body's needs), and fluid overload (too much fluid in the body).</p> <p>Review of Resident #289's Quarterly MDS assessment dated [DATE] reflected Resident#289 had congestive heart failure and was taking diuretics (medications that help reduce fluid buildup in the body).</p> <p>Review of Resident #289's Comprehensive Care Plan dated 04/08/2024 reflected resident was on diuretic and one of the interventions was to administer medication as ordered.</p> <p>Review of Resident #289's Physician's Order for Lasix dated 03/28/2024 reflected, Lasix Oral Tablet 20 MG (Furosemide). Give 1 tablet by mouth one time a day for CHF (congestive heart failure).</p> <p>Review of Resident #290's Face Sheet dated 04/10/2024 reflected that resident was a [AGE] year-old male admitted on [DATE]. One of the diagnoses was acute kidney failure.</p> <p>Review of Resident #290's Quarterly MDS assessment dated [DATE] reflected Resident #290 was cognitively intact. The Quarterly MDS Assessment also indicated that the resident had renal failure (kidney stopped working).</p> <p>Review of Resident #290's Comprehensive Care Plan dated 04/09/2024 reflected resident was on diuretic and one of the interventions was to administer medication as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #290's Physician Order for Lasix dated 03/29/2024 reflected Lasix Oral Tablet (Furosemide). Give 10 mg by mouth one time a day for Diuretic.</p> <p>Review of Resident #61's Face Sheet dated 04/10/2024 reflected resident was a [AGE] year-old male admitted on [DATE]. One of the relevant diagnoses was biventricular heart failure (combination of symptoms associated with both left heart failure and right-side failure).</p> <p>Review of Resident #61's Comprehensive MDS assessment dated [DATE] reflected Resident #61 had a moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment also indicated resident had heart failure.</p> <p>Review of Resident #61's Comprehensive Care Plan on 04/09/2024 reflected resident had congestive heart failure and one of the interventions was give cardiac medications as ordered.</p> <p>Review of Resident #61's Physician Order for Entresto dated 03/13/2024 reflected Sacubitril-Valsartan Oral Tablet 24-26 MG (Sacubitril-Valsartan). Give 1 tablet by mouth two times a day for CHF.</p> <p>Observation and interview with MA L on 04/10/2024 at 11:26 AM revealed MA L opened her cart for inspection. Three blister packs were noted running low. Residents #289's Lasix 20 mg (milligrams) only had one tablet, Resident #290's Lasix 10 mg only had two tablets, and Resident #61's Entresto 24-26 mg only had three tablets. MA L confirmed both Lasix were to be administered once daily and Entresto was to be administered twice daily. When asked if the medications were already re-ordered, MA L checked the cart and said there were no other blister packs for Residents #289's Lasix 20 mg, Resident #290's Lasix 10 mg, and Resident #61's Entresto 24-26 mg. MA L checked the system, and the system showed the three medications where not re-order yet. MA L said she was not able to re-order the medications. MA L then clicked the re-order button on the system for the three medications. She said the medications should have been re-ordered when the medication reach the light blue portion of the blister pack. MA L said medication should be re-ordered four to five days before the medications were consumed. MA L stated whichever nurse saw that the tablets were running low should re-order the medications. MA L added if the medications were not re-ordered, the residents would not have any medications to take. She stated skipping Lasix could result to fluid retention and skipping Entresto could result to exacerbation of the symptoms of the heart failure.</p> <p>2. Review of Resident #79's Face Sheet dated 04/10/2024 reflected resident was an [AGE] year-old female admitted on [DATE]. One of the relevant diagnoses was hypertension.</p> <p>Review of Resident #79's Comprehensive MDS assessment dated [DATE] reflected Resident #79 had a moderate impairment in cognition. The Comprehensive MDS Assessment also indicated resident had hypertension.</p> <p>Review of Resident #79's Physician Order for metoprolol reflected Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate). Give 1 tablet by mouth two times a day for hypertension Hold SBP (systolic blood pressure) less than 110, DBP (diastolic blood pressure) less than 60 and HR (heart rate) less than 60.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview with MA J on 04/10/2024 at 1:04 PM revealed MA J opened her medication cart for inspection. It was noted that the blister pack for Resident #61's metoprolol was running low with only one tablet. MA J checked the cart and confirmed there were no other blister pack for Resident #61's metoprolol. She also confirmed that the resident was to take the anti-hypertensive tablet twice a day. MA J checked the system and the system showed Resident #61's metoprolol was not yet re-ordered. MA J proceeded to re-order the medication. MA J added if the residents do not have their medications, their medical concerns could get worse. MA J said she would audit her cart to check if there were medications that needed to be re-ordered.</p> <p>3. Review of Resident #16's Face Sheet dated 04/10/2024 reflected resident was a [AGE] year-old female admitted on [DATE]. One of the relevant diagnoses was gastro-esophageal reflux disease.</p> <p>Review of Resident #16's Comprehensive MDS assessment dated [DATE] reflected Resident #16 had a severe impairment in cognition. The Comprehensive MDS Assessment also indicated resident had heart failure.</p> <p>Review of Resident #16's Comprehensive Care Plan on 04/12/2024 reflected resident had GERD (gastro-esophageal reflux disease: stomach acid repeatedly flows back into the tube connecting the mouth and stomach) without esophagitis (inflammation of the esophagus).</p> <p>Review of Resident #16's Physician Order for Famotidine reflected Famotidine Tablet 20 MG Give 1 tablet . two times a day related to GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS.</p> <p>Observation and interview with LVN B on 04/11/2024 at 7:06 AM revealed LVN B was preparing Resident #16's medication. She said she would prepare first the resident's famotidine that she took from the e-kit. LVN B said she gave the last one yesterday. LVN B said the medication was re-ordered the night before, but the pharmacy was not able to deliver because of the weather. She added medications should be re-ordered as soon as the medications reached the part of the blister pack that says refill to ensure enough supply. She said it should not be re-ordered last minute because the residents would not have adequate supply of medication in circumstances that the delivery was late or was not able to come. LVN B said they had an e-kit (emergency kit) but it was supposed to be for new admissions and STAT (urgent) medications. She said it was not proper for a medication to be taken from the e-kit just because the medication was not re-ordered timely.</p> <p>In an interview with the DON on 04/11/2024 at 8:07 AM, the DON stated medications should be re-ordered 3 to 4 days before the pills were consumed. The DON said it could be done through the system or by calling the pharmacy. The DON added if the medications were not re-ordered in a timely manner, the resident would run out of medications, and they would not have any medications to take especially if the order was to take the medications routinely. The DON stated the medication aide, and the nurses were responsible for re-ordering the medications. The DON further added if the resident will not have their medications, their condition could get worse. The DON said the expectation was to re-order the medications in a timely manner. She said she would remind the medication aides and the nurses to re-order timely to ensure there was enough supply of medications and to always audit the carts for the needed medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the Administrator on 04/11/2024 at 8:23 PM, the Administrator stated the staff must make sure that the medications were re-ordered on a timely manner to make sure that the residents have the medications they need. He said that moving forward, he and the clinical managers would educate and monitor if the staff were following the policy and procedures.</p> <p>Record review of facility policy, Medication Ordering and Receiving from Pharmacy Provider revealed Procedures . 2. Repeat medications (refill) are written on a medication order . a. Reorder medication (seven) days in advance of need to assure an adequate supply is on hand.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</b></p> <p>Based on observations, interviews, and record review, the facility failed to ensure medication was labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions for one (Resident #81) of two residents reviewed for labelling of drugs and biologicals.</p> <p>The facility failed to ensure MA L placed a change of instruction label for Resident #81's Sertraline blister pack (a type of packaging in which a product is sealed in plastic, often with a cardboard backing) after the order was changed.</p> <p>This failure could place residents at risk for wrong medication administration, mismanagement of care, adverse effects, and physical harm.</p> <p>Findings included:</p> <p>Review of Resident #81's Face Sheet dated 04/10/2024 reflected the resident was an [AGE] year-old female admitted on [DATE]. One of the relevant diagnoses was depression.</p> <p>Review of Resident #81's Quarterly MDS assessment dated [DATE] reflected resident had a moderately impaired cognition with a BIMS score of 07. The Quarterly MDS Assessment indicated the resident had depression.</p> <p>Review of Resident #81's Comprehensive Care Plan dated 04/09/2023 reflected resident was taking antidepressant medication and one of the interventions was to administer antidepressant medications ordered by physician.</p> <p>Review of Resident #81's Physician's order for Sertraline dated 04/09/2024 reflected Zoloft Oral Tablet 100 MG (Sertraline HCl). Give 1 tablet by mouth one time a day related to DEPRESSION, UNSPECIFIED.</p> <p>Review of Resident #81's discontinued Physician's order for Sertraline on 04/09/2024 reflected Zoloft Oral Tablet 50 MG (Sertraline HCl). Give 1 tablet by mouth one time a day related to DEPRESSION, UNSPECIFIED.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 04/10/2024 at 11:26 AM revealed MA L was checking Resident #81's blister pack for sertraline. It was noted that the blister pack's instruction was to give 50 mg (milligrams) once a day while the instruction in the eMAR (electronic medication administration record) was to give 100 mg once a day. MA L acknowledged that the instruction on the blister pack was different from the instruction in the system. MA L stated the dose for the sertraline was increased from 50 mg to 100 mg. MA L said the staff use a sticker that says change in instruction, check the eMAR or the staff could write a note on the blister pack to denote the change in order. MA L said since there was a change in instruction, she should had placed a change in instruction note or sticker on the sertraline 50 mg blister pack while waiting for the sertraline 100 mg blister pack. MA L opened her medication cart and looked for the sticker. She said she had no change of direction sticker so she would just write a note on the blister pack to ensure the right dosage of medication was administered and avoid medication error.</p> <p>In an interview with MA J on 04/10/2024 at 1:04 PM, MA J stated the staff giving the medications should make sure they were reading the order and comparing the blister pack with the order in the system. She said the MAs and nurses were responsible in placing a change of direction sticker on blister pack if there was a change in direction. MA J said if there was change in order, the blister pack should have a note of change of direction to avoid medication error, undermedication, overmedication, or confusion among the staff.</p> <p>In an interview with the DON on 04/10/2024 at 10:52 AM, the DON stated whoever staff that received the new order should have placed a change in order instruction on the blister pack to avoid confusion. The DON said the risk were overmedication or undermedication which could have an adverse effect for the residents. The DON said the expectation was to provide the right dosage of medication as per order and make sure the medications correlate with the eMAR and the order in the package.</p> <p>In an interview with the Administrator on 04/11/2024 at 8:23 PM, the Administrator stated whatever the procedure was in giving the medications, it should have been followed to prevent any errors.</p> <p>Record review of facility's policy Medication Orders revealed Procedures . g. orders . 2. The following steps are initiated . d). Transcribe newly prescribed medications on the MAR . When a new order changes the dosage of a previously prescribed medication, discontinue the previous entry by (writing DC'd [discontinued] . ).</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34918</p> <p>Based on interview and record review, the facility failed to ensure physician orders were obtained for lab services and failed to promptly notify the physician of laboratory results that fall outside of clinical reference ranges in accordance with facility policy and procedures for notification of a practitioner or per the ordering physician orders for one of two (Resident #6) reviewed for labs.</p> <p>1. The Facility failed to transcribe the physician orders for a lab draw to obtain a Dilantin (medication used for seizure control) level on 02/13/24 and 03/28/24 into Resident #6's clinical record.</p> <p>2. The Facility failed to provide timely notification to the physician or nurse practitioner of laboratory results that fell outside of clinical reference ranges of the Dilantin level drawn on 02/13/24 for Resident #6 and failed to document notification of results obtained on 03/29/24 for the repeat Dilantin level request for Resident #6.</p> <p>This failure could affect residents by placing them at risk for ineffective treatment of seizure control or side effects from toxicity.</p> <p>Findings included:</p> <p>Record review of Resident #6's annual MDS assessment dated [DATE] reflected a [AGE] year-old female with a BIMS of 0 which indicated she was severely cognitively impaired but could sometimes make herself understood and could sometimes understand others. She required extensive assistance with ADL care and had current diagnoses of aphasia (language disorder that affects ability to communicate), cerebral vascular accident (stroke), dementia, and seizure disorder.</p> <p>Record review of Resident #6 's care plan imitated on 09/14/22 reflected, Has seizure disorder (unspecified) . Interventions .Give Medications as ordered .Obtain and monitor lab/diagnostic work as ordered. Report results to ME and follow up as indicated .</p> <p>Record review of Resident #6's Order Summary Report for February 2024 through April 2024 did not reflect orders for Dilantin Level lab request.</p> <p>Record review of Laboratory results for Resident #6 reflected:</p> <p>1. Therapeutic Phenytoin (Dilantin), Total Serum- Results 22.4 (H) Reference Ranges- 10.0-20.0 - note Patient drug level exceeds published reference range. Evaluate clinically for signs of potential toxicity. - Lab was drawn on 02/13/24 and was reported to the facility on [DATE] at 05:13 a.m.</p> <p>2. Therapeutic Phenytoin (Dilantin), Total Serum- Results 20.8 (H) Reference Ranges- 10.0-20.0 - note Patient drug level exceeds published reference range. Evaluate clinically for signs of potential toxicity. - Lab was drawn on 03/28/24 and was reported to the facility on [DATE] at 06:13 a.m.</p> <p>Record review of Resident #6's Nurse's Progress notes for February 2024 did not reflect physician notification of the laboratory results received on 02/14/24.</p> <p>(continued on next page)</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #6 Nurse Progress note written by ADON A on 03/27/24 at 12:58 p.m. reflected, New orders to repeat Dilantin level d/t previous high levels .</p> <p>Record review of Resident #6's Nurse Progress notes from 03/29/24 through 04/11/24 did not reflect notification to the physician or nurse practitioner of the lab results received on 03/29/24.</p> <p>In an interview with the DON on 04/10/24 at 1:55 p.m. she stated the nurses were responsible for checking the lab portal each day for any lab updates and were responsible for notifying the physician at that time. She stated most of the laboratory results are received on the morning shift. She stated there should be an order for the laboratory test requested and would check to see if the orders had not been scanned into the electronic record.</p> <p>In an interview with LVN B on 04/10/24 at 2:15 p.m. she stated she had received the laboratory results on 03/29/24 and had notified the NP for Resident #6 but stated she had not documented the notification. She stated she was the primary day shift charge nurse for Resident #6. She stated she was aware there was delay in the notification of the lab results for the Dilantin level drawn on 02/13/24, which was why a new request to repeat the lab draw was ordered on 03/28/24. She stated when they get an order for a lab, they placed it into the laboratory portal. She stated only recently had they had the system connect with the resident's electronic record which allowed the physician to be able to view the lab results as soon as the lab posted them into the portal. She stated she did not realize the orders did not transcribe over into the resident clinical record, and assumed when they put the order request into the lab portal it created the physician's order. She stated they also used a secured communication portal on a separate electronic device where they updated the physicians on lab results or changes in the resident's condition. She stated those notifications do not show up in the electronic record. She stated she realized now she needed to update the progress notes on any notifications to the physician and needed to place the order into the electronic record. She stated these failures could result in delays of notifications of lab results and any necessary follow up for the oncoming shifts.</p> <p>In an interview with the NP for Resident #6 on 04/10/24 at 4:33 p.m. she stated she had requested some Dilantin levels but could not recall when she had requested them. She stated if she had been contacted about a Dilantin level that was outside of the reference range, she would have requested a re-draw of the lab to ensure it was a correct range before making any changes to the residents' medications. She stated since there was no request for a re-draw in February, she most likely was not made aware of the laboratory results. She stated she does not get excited when the lab is outside of the reference range, until it gets into the 30's or if the resident is having seizures. She stated Resident #6 had been stable and was not showing any signs or symptoms of toxicity and had not had any reported seizures.</p> <p>In an interview with the DON on 04/11/24 at 8:55 a.m. she stated she was not able to locate an order for the labs that were requested on 02/13/24 and 03/28/24. She stated she was also unable to locate any documentation that the physician or NP had been notified of the lab results. She stated failure to notify the physician regarding lab results could result in a delay in treatment or the need to adjust a medication depending on which labs were drawn. She stated all lab requests had to have a physician order.</p> <p>(continued on next page)</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with ADON A on 04/11/24 at 9:32 a.m. stated she was the one who had spoken to the NP for Resident #6 on 03/27/24. She stated the resident had been starting to pocket her food when eating, so she had reviewed the labs the resident had done and discovered the lab drawn on 02/13/24 did not indicate the physician had not been notified. She stated she spoke with the NP who was in the building that day and informed her about the previous lab results and she stated the NP requested the lab to be re-drawn. She stated she had informed the charge nurse but did not write an order for the lab. She stated she should have written the order for the request. She stated it was the nurse's responsibility to check the labs every day. She stated the lab will contact the facility by phone if there was a critical lab level and will document who they gave those critical levels to.</p> <p>Review of the facility's policy titled, Diagnostic Test Results Notification, dated January 2022, reflected, It is the policy of this facility to obtain laboratory and radiology services when ordered by a Physician, Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) and to promptly notify the ordering provider of test results. Results of laboratory, radiological, and diagnostic test outside the clinical reference ranges shall be reported to the resident's attending physician, PA, NP or CNS promptly or as specified in the order. Notification of test results will be documented in the resident's clinical record. Results of lab, radiology, &amp; diagnostic services shall be made a part of the resident's medical record.</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49459</p> <p>Based on observation, interview and record review, the facility failed to provide each resident with a nourishable, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences for 1 (Resident # 31) of 24 residents reviewed for needs and preferences.</p> <p>The facility failed to ensure Resident # 31 was offered alternative meal options.</p> <p>This failure placed residents at risk of not having their needs and preferences honored.</p> <p>Findings included:</p> <p>A record review of Resident #31's face sheet dated 04/12/2024 reflected she was an [AGE] year-old female and admitted to the facility on [DATE]. Her diagnoses included Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety.</p> <p>During an interview on 4/09/24 at 11:30 am., Resident #31 stated the food was not appetizing. Resident #1 stated she was unaware of available options, so she does not ask for any. Resident #1 stated she does not eat much.</p> <p>The confidential group meeting on 4/10/24 at 10:00 am., revealed, if a food item is not on the menu, it's not an option. The residents stated they were unaware of alternative food options.</p> <p>During an observation and interview on 4/10/24 at 11:45 am., Resident #1 was observed sitting in the dining room with her lunch plate sitting on the table. Resident #1 stated, I like the okra but not the seasoned beans and potatoes. Resident #1 stated she requested and was provided a chef salad instead.</p> <p>Observation on 04/10/24 at 9:44am revealed the facility meal times and menu were posted on the wall near the dining room and the facility meals times were posted. Observation revealed there was no posting of the alternative meal option, snacks, or the availability of snacks between mealtimes.</p> <p>Interview with the Dietary Manager on 04/11/24 at 9:45 am revealed the Fall/Winter menu cycle contained alternative meal options but the Spring menu does not have alternative meal options. The Dietary Manager stated the Spring menu recently started.</p> <p>A record review of the facility's policy titled Policy/Procedure-Section: Dietary Services, Subject: Menus and Food dated June 2017 revealed the policy did not reflect alternative meal options for residents.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>49459</p> <p>Based on observation, interview, and record review, the facility failed to ensure there were no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack was served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span for 1 of 3 residents (Resident #1) reviewed for timely meals, in that:</p> <p>The facility failed to ensure residents were offered snacks at bedtimes as required due to meal times being more than 14 hours apart.</p> <p>This failure could affect all 70 residents who received meals served from the facility's only kitchen by placing residents at risk for decreased meal satisfaction, decreased intake, loss of appetite, unplanned weight loss, and side effects from medication given without food, and diminished quality of life.</p> <p>Findings included:</p> <p>Observation on 04/09/2024 at 9:15 AM, of the posted Meal Service Times in the dining room revealed the following:</p> <p>Breakfast - 7:30 -9:30 AM</p> <p>Lunch - 11:45-1:45 PM</p> <p>Evening meal - 5:00 -7:00 PM</p> <p>Observation on 04/10/2024 at 9:32 AM, of the posted Meal Service Times in the dining room revealed the same as the previous date. There is no posting to advise any resident a snack or availability of type of snack after specified times. During interviewing residents, it has been brought to the attention of the state surveyors that they have not been made aware of options of snack which are available to residents.</p> <p>Interview on 04/10/2024 at 9:45 AM, with DM Z. revealed staff could request a snack for resident, but options were not provided to residents.</p> <p>On 04/10/2024 10:00 AM, during a confidential Resident Council meeting 6 of 6 residents said they were not offered any HS snacks.</p> <p>Observation on 04/11/2024 at 09:30 AM, in main dining area, observed in addition to the daily menu for posted for Breakfast, lunch and dinner. An additional posting advising residents with a suggested option to the daily menu and alternatives. It clearly shows a choice for one (1) Entree for resident, with the option of other items.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/11/2024 at 9:45 AM, DM Z advised that in the past the staff would ask the resident if they would like a snack or alternative meal. This has been what they have done in the past. It was asked do you think this should be a normal routine on providing residents an option that being both a snack and a meal. It was also addressed that residents had no knowledge of the ability to request an alternative menu item.</p> <p>Fall winter menus had the options presented on the slip and they were able to</p> <p>Spring menu does not have the options she emphasized that they had just started the spring calendar menu.</p> <p>Record Review of Facility Policies and Procedures dated 06/2017, reflects serve meals at the times specified/posted. AD advised the following in addition to what is included in the policy, we follow the guidelines of the Texas Food Establishment Rules. We do not have a policy for snacks. We follow the reg and offer 8 pm (HS) snacks and the recommended best practice of 10a/2pm snacks.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49459</b></p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that:</p> <p>1. There was an expired, large, sealable, plastic bag of graham cracker crust. Which expired on [DATE]. Dietary staff failed to dispose of expired food items in freezer.</p> <p>These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness if consumed, and food contamination.</p> <p>The findings were included:</p> <p>During observation(s) on [DATE] between 9:15 AM and 10:25 AM in the facility kitchen revealed the following:</p> <p>1. There was a large plastic bag container of graham cracker crust. Which expired on [DATE].</p> <p>Dietary staff failed to dispose of expired food items in freezer.</p> <p>During an interview with the DM Z on [DATE] between 9:00 AM and [DATE]:45 AM, a walk-through of the facility kitchen was performed, and the confirmed the Surveyor observations and stated the listed items would be corrected. The DM Z confirmed she was responsible for kitchen proper storage of food products and that the deficient practice was an oversight. She also reported that she would throw out the bag of graham cracker mix immediately since it was past the best by date. She also stated that the risk to residents of serving food that is past best by date was possible risk of food borne illness.</p> <p>Record review of the facility policy. Food Receiving and Storage, revised [DATE], revealed Food purchased, stored, and served in this facility is labeled and dated according to all applicable food service regulations.</p> <p>Food prepared for consumption by our residents is prepared according to all applicable food service regulations.</p> <p>The U.S. Public Health Service, Food Code, dated 2022, reflected the following, XXX, [DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include .(2) Marking the date or day of preparation, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under (B) of this section.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34918</p> <p>Based observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for five of sixteen residents (Resident #50, Resident #77, Resident #6, Resident #8, and Resident #47) observed for infection control.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure that LVN K capped Resident #50's PICC (peripherally inserted central catheters) line while not in use on 04/09/24.</li> <li>The facility failed to ensure that CNA I changed her gloves and perform hand hygiene while providing incontinence care to Resident #77 on 04/09/24</li> <li>The facility failed to ensure that CNA E changed her gloves and perform hand hygiene while providing incontinence care to Resident #6 on 04/11/24</li> <li>The facility failed to ensure LVN B changed her gloves and perform hand hygiene while providing incontinence care to Resident #8 on 04/09/24</li> <li>The facility failed to ensure NA C changed his gloves and perform hand hygiene while providing incontinence care to Resident #47 04/09/24.</li> </ol> <p>These failures could place the residents at risk of cross-contamination and development of infection.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Review of Resident #50's Face Sheet dated 04/10/2024 reflected resident was a [AGE] year-old male admitted on [DATE]. One of the relevant diagnoses was acute hematogenous osteomyelitis (a bone infection that spreads through the bloodstream from a distant source) of the left ankle and foot.</li> </ol> <p>Review of Resident #50's Comprehensive MDS assessment dated [DATE] reflected Resident #50 had a moderate impairment in cognition. The Comprehensive MDS Assessment also indicated Resident #50 was on IV (intravenous) medications while a resident of the facility.</p> <p>Review of Resident #50's Care Plan dated 04/09/2024 reflected resident had an infection of the skin/bone related to osteomyelitis (bone infection) and one of the interventions was to maintain standard precautions when providing care.</p> <p>Review of Resident #50's Physician Order dated 03/26/2024 reflected Daptomycin Intravenous Solution Reconstituted (Daptomycin). Use 550 mg (milligrams) intravenously in the morning for Osteomyelitis until 04/11/2024 23:59.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #50's Physician Order dated 03/26/2024 reflected PICC line flushing to RUE (right upper extremity): Flush with 10 cc (cubic centimeter) 0.9 % NS (normal saline) IV Solution every shift.</p> <p>Observation and interview with Resident #50 on 04/09/2024 at 9:14 AM revealed Resident #50 was on his bed awake. It was noted that resident had a single lumen (with only one port) PICC line connected to an IV bag with approximately 10 milliliters of fluid, infusing well. The IV bag with label, time and initial. The IV insertion site to right upper extremity clean, dry, and intact. The dressing IV site was covered with dressing dated 04/09/2024. Resident #50 stated he was on antibiotics because of his foot. He said he would be on antibiotics for a couple of days more.</p> <p>Observation and interview with Resident #50 on 04/09/2024 at 1:19 PM revealed resident was sitting in the activity room. Resident #50 said he just finished lunch. He said LVN K already disconnected him to the IV bag because it was already done. He added he will have another one in the afternoon. Resident #50 then rolled his sleeve on his right arm and showed his PICC line. The end of the PICC line was not capped.</p> <p>Interview with LVN K on 04/09/2024 at 1:31 PM, LVN K stated she already disconnected Resident #50's IV and flushed it afterwards. She said she did not put a cap on the PICC line. She said she would find one and put it at the port of the PICC line. She said the PICC line should be capped when not in use to reduce the risk of contamination and infection. She said the resident was already in antibiotics because of infection on his foot and she had to make sure that there would be no complication.</p> <p>Record review of facility's policy, Peripherally Inserted Central Catheters revealed 1. Purpose: To safely care for . PICC lines . Guidelines . m. maintain a closed system</p> <p>2. Review of Resident #77's Face Sheet dated 04/10/2024 reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included severe sepsis (infection of the blood stream) with septic shock (extreme reaction to an infection) and retention of urine.</p> <p>Review of Resident #77's Comprehensive MDS assessment dated [DATE] reflected Resident #77 had a moderate impairment in cognition with a BIMS score of 10. The Comprehensive MDS Assessment also indicated Resident #77 needed assistance with personal care. Resident #77 was dependent for toileting hygiene and was always incontinent for urinary and bowel.</p> <p>Review of Resident #77's Care Plan dated 01/08/2024 reflected resident had a bowel/bladder incontinence related to history of history of foley for urinary retention and one of the interventions was to check for incontinence.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 04/09/2024 at 10:35 AM revealed ADON H and CNA I were about to do incontinent care for Resident #77. ADON H and CNA I washed their hands and put on clean gloves. CNA I prepared the things needed for incontinent care and positioned herself on the left side of the bed and ADON H on the right side of the bed. ADON H unfastened the tape on both sides of the soiled brief, rolled the front portion and pushed it downward in between the resident's legs. ADON H removed her gloves, performed hand hygiene, and put on a new pair of gloves. ADON H then cleaned Resident #77's front part. ADON H instructed and assisted Resident #77 to roll towards CNA I. ADON H proceeded to clean the resident's buttocks. ADON H then pulled the soiled brief and threw it on the trash can. ADON H removed her gloves, performed hand hygiene, and donned new gloves. ADON H went ahead and took the clean brief and placed it on the resident's buttocks and instructed the resident to roll towards her. After the resident rolled towards ADON H, CNA I noticed the resident still had some feces on the left buttock. CNA I pulled some wipes and cleaned Resident #77's left buttock. CNA I then fixed the new brief without changing her gloves and performing hand hygiene. Resident #77 was instructed to roll back. CNA I then fastened the tape on both sides. ADON H and CNA I then pulled the resident up, pulled the blanket to Resident #77's chest. ADON H and CNA I removed their gloves, threw the soiled gloves to the trash can, and washed their hands.</p> <p>Interview with CNA I on 04/09/2024 at 11:00 AM, CNA I stated she did not change her gloves after she cleaned the other side of the buttocks. She said she noticed the resident still had feces when he was turned towards ADON H that was why she took some wipes and wiped it. She added did not change nor washed her hands after doing it and eventually touched the new brief. CNA I said it was important to wash hands and change gloves before touching the clean brief because the dirty gloves could contaminate the clean brief and this could result to infection.</p> <p>Interview with ADON H on 04/09/2024 at 11:12 AM, ADON H stated she did not notice CNA I did not change her gloves after cleaning the bottom of Resident #77. ADON H said she should had prompted CNA I to take off her gloves and wash her hands after cleaning the resident. ADON H said she should had known better. She said it was important to change gloves after cleaning the bottom of the resident and touching the new brief to prevent cross contamination and development of infection.</p> <p>3. Review of Resident #6's Face Sheet dated 04/11/2024 reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included spastic hemiplegia (paralysis on one side of the body) affecting right dominant side and hemiplegia and hemiparesis (weakness on one side of the body) following unspecified cerebrovascular (relating to the brain and its blood vessels) disease.</p> <p>Review of Resident #6's Comprehensive MDS assessment dated [DATE] reflected Resident #6 had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment also indicated Resident #6's needed maximal assistance with toileting hygiene. personal care. Resident #6 was also always incontinent for urinary and bowel.</p> <p>Review of Resident #6's Care Plan dated 03/01/2024 reflected resident had a bowel/bladder incontinence related to impaired mobility and the interventions were to check for incontinence, wash, rinse, and dry perineum.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview with CNA E on 04/11/2024 at 7:22 AM revealed Resident #6 was on her bed awake. CNA E then told Resident #6 that she would prepare her for breakfast. CNA E said she would clean her first before transferring her to her wheelchair. CNA E prepared the things needed for incontinent care. CNA E washed her hands and put on clean gloves and then proceeded with incontinent care. CNA E unfastened the tape on both sides of the soiled brief, rolled the front portion and pushed it downward on the center. CNA E cleaned Resident #6's front part. CNA E then instructed and assisted Resident #6 to roll towards the wall. CNA E continued to clean the resident's buttocks. CNA E pulled the soiled brief and threw it on the trash can. CNA E then went ahead and took the clean brief without changing her gloves or performing hand hygiene. CNA E placed the new brief on resident's buttocks and instructed the resident to roll back. CNA E fastened the tape on both sides. CNA E then put on clean pants and t-shirt. Resident #6 was then transferred to her wheelchair.</p> <p>CNA E removed her gloves, threw them on the trash can. CNA E acknowledged she did not wash her hands and change her gloves after she pulled the soiled brief, before she touched the new brief, before she put on the pants and t-shirt, and before transferring the resident to her wheelchair. CNA E said it was important to wash hands and change gloves before touching the clean brief because the dirty gloves could contaminate the clean brief, and this could result to infection.</p> <p>4. Record review of Resident #8's quarterly MDS assessment, dated 01/22/24, reflected a [AGE] year-old female with an admitted d of 03/25/17. She had a BIMS of 14, indicating she was cognitively intact. She had no behaviors documented and not resisted care. Resident #8 required extensive assistance with toileting and personal hygiene and was always incontinent of urinary bladder and bowel. Resident #8 was at risk of pressure ulcers with no current skin issues. Her active diagnoses included atrial fibrillation (fast irregular heart rate), depression, and bipolar disorder (mental disorder that cause extreme mood swings).</p> <p>Record review of Resident #8's Comprehensive Care Plan initiated on 09/06/22, reflected, . Has bowel/bladder incontinence r/t dementia, decrease/impaired mobility Interventions .Change as required for incontinence. Wash, rinse, and dry perineum .Monitor/document for s/sx of UTI: pain, burning .urinary frequency .foul smelling urine .</p> <p>An observation on 04/09/24 at 2:40 PM reveled LVN B and CNA D entered Resident #8's room with a stand assist lift. LVN B attached the lift sling around the resident's waist and slowly lifted her to a standing position which revealed the resident was soaked in urine with the front and back of her pants wet. Resident was transferred to the bed and both staff removed the residents' wet pants and opened the wet brief. LVN B wiped from front to back and down the middle and with assistance from CNA D rolled the resident onto her side, revealing she had also had a bowel movement. Resident #6 stated her butt was burning. Residents' buttocks was slightly red but no skin breakdown. LVN B removed the soiled brief and placed a clean brief under the resident before completion of incontinence care. LVN B wiped the resident's anal area and buttocks from front to back until all bowel movement had been removed. LVN B then opened a packet of barrier cream without removing her soiled gloves or performing hand hygiene and was about to apply to the resident buttocks, when the resident stated she needed to turn on her other side. LVN B handed the barrier cream to CNA D, and they assisted the resident onto her other side. CNA C applied the barrier cream to the resident's buttocks and the staff rolled the resident back onto her back and fastened the brief. LVN B and CNA D then removed their gloves and performed hand hygiene and redressed the resident transferred her back into her wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with LVN B on 04/09/24 at 3:05 PM she stated she was supposed to change her gloves when they were visibly soiled. She stated she placed the clean brief under the resident in case she had more bowel movement. She stated she should have changed her gloves and performed hand hygiene before moving to the clean aspect of care, the clean brief, and the residents clothing. She stated the risk was infection and spread of germs.</p> <p>5. Record review of resident #47's quarterly MDS assessment, dated 02/25/24, reflected a [AGE] year-old male with an admitted [DATE]. Staff assessed residents' cognition as severely impaired. He required extensive assistance with personal hygiene and toileting and was frequently incontinent of urine and always incontinent of bowel. Active diagnoses included diabetes, cerebral vascular accident (stroke) and dementia.</p> <p>Review of Resident #47's care plan, initiated on 10/03/23, reflected .Has bowel/bladder incontinence r/t impaired mobility, post CVA, hemiplegia .Interventions .use disposable briefs. Change as needed .</p> <p>An observation on 04/09/24 at 1:30 PM revealed NA C with assistance from therapy staff transferring Resident #47 from his wheelchair to the bed so he could provide incontinence care. Resident #47 was observed to have wet pants from front to back. NA C performed hand hygiene and put on gloves and removed the resident wet pants and unfastened the wet brief and took a peri wipe and wiped up and down residents' groin without changing the surface of the wipe with each stroke. NA C did not clean the resident's penis or scrotum or pull back the foreskin to clean the tip of the penis. NA C rolled the resident over onto his side and wiped the back of the resident's thighs and wiped the anal area from front to back with a clean peri-wipe. NA C placed a clean brief under the resident without changing his gloves and performing hand hygiene. NA C fastened the brief and repositioned the resident and then removed his gloves and gathered the trash and dirty linens and left the room without performing hand hygiene and walked across the hall and entered the soiled linen closet to deposit the trash and linens, and then performed hand hygiene.</p> <p>In an interview with NA C on 04/09/24 at 01:55 PM he was unsure about the proper steps of peri-care for a male resident and was not sure what steps he had missed. After a few minutes he stated he should have cleaned the penis and scrotum. He stated the foreskin needed to be pulled back to clean the tip of the penis. He stated failing to do this could cause skin breakdown and infections. He stated he should have changed gloves and performed hand hygiene before he left the room and during care after he finished cleaning the resident.</p> <p>In interview with the DON on 04/10/2024 at 10:52 AM, the DON stated the staff should change the gloves after cleaning the resident's bottom. She added the staff should also wash their hands or sanitize them before, during, and after incontinent care. She said she expected the staff to perform hand hygiene properly and change their gloves after cleaning the bottom of the resident and before touching the clean brief. She added she would do an in-service about hand hygiene and changing of gloves. She also said the end of the PICC line should be capped when not in use. She added it could contaminate the PICC line and could result to additional infections. She said she would try to find out what happened. She concluded that the expectation was the staff would change their gloves and wash their hands before, during, and after incontinent care.</p> <p>Interview with the DON on 04/11/2024 at 8:07 AM, she stated they do not have a policy about the PICC line being capped but agreed it should be capped to prevent further infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In interview with the Administrator on 04/11/2024 at 8:23 PM, the Administrator stated the expectation was the staff to perform hand hygiene and change their gloves when needed. He said when the hands were not washed and the gloves were not changed, there could be a possibility of contamination and infection. He said they do not have a policy that says the end of the PICC line should be capped.</p> <p>Review of the facility's policy titled, Hand Hygiene, dated October 2022, reflected, It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accept standards .Wash hands with soap and water for the following situations . When hands are visibly soiled .Use an alcohol-based hand rub .for the following situations .Before and after direct contact with residents .Before moving from a contaminated body site to a clean body site during resident care .After contact with blood or bodily fluids .After removing gloves .After removing and disposing of personal protective equipment .</p>