

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675212	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER The Homestead of Denison		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 Reba McEntire LN Denison, TX 75020	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399</p> <p>Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #9) of 6 residents reviewed for ADL's.</p> <p>The facility failed to ensure Resident #9 had her fingernails trimmed and cleaned.</p> <p>These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life.</p> <p>Findings include:</p> <p>Record review of Resident #9's Quarterly MDS assessment dated [DATE] reflected Resident #9 was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of heart failure, coronary artery disease (narrowing or blockage of your coronary arteries), Alzheimer's disease (brain disorder that causes a gradual decline in memory, thinking, and reasoning skills), dementia (neurological conditions that cause a decline in mental abilities that affect daily life), cerebral infarction (result of disrupted blood flow to the brain due to problems with blood vessels that supply it) and dementia. She had a BIMS of 13 indicating she was cognitively intact. She was total dependent with personal hygiene and showering ADLs.</p> <p>Record review of Resident #9's Comprehensive Care Plan last revised 11/25/24 reflected the following:</p> <p>-[Resident #9] is primarily bedfast all or most of the time and has potential for skin breakdown . Intervention included Provide assistance with ADL care as needed.</p> <p>-[Resident #9] has a history of CVA with the potential for a recurrence. Intervention included Assist with ADL's as needed and monitor for decline in functioning.</p> <p>-Bathing/dressing with interventions to include 1 person assist dressing and 2 person assist bathing and bed bath only.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 12/10/24 at 9:18 AM revealed Resident #9 was lying in bed. She was observed with dirty long nails of approximately 0.5 cm on the right hand. Her left hand was contracted with splint in place. Surveyor attempted to interview Resident #9 but she was confused and unable to answer about her fingernails.</p> <p>Observation on 12/11/24 at 2:49 PM revealed Resident #9 was in bed. She was observed to have long fingernails of approximately 0.5 cm that were dirty.</p> <p>Interview on 12/11/24 at 2:51 PM with LVN A revealed Resident #9 did not leave the bed and was total dependent with ADLs. She stated everyone oversee cutting and cleaning fingernails as needed. LVN A stated Resident #9 left hand was hard to trim and clean because she will freak out. Observation with LVN A revealed Resident #9 had long dirty fingernails on both hands. LVN A stated Resident #9's fingernails were dirty. LVN A stated the risk to the resident of not getting her fingernails trimmed and cleaned was infection if they are dirty.</p> <p>In an interview on 12/11/24 at 3:30 PM with CNA B revealed Resident #9 had a contracted left hand. She stated Resident #9 is total dependent with ADLs and had no resistive to care behaviors when assisting her. CNA B stated CNAs were responsible to ensure resident nails cleaned or trim them unless resident is a diabetic in which nursing is responsible to trim the fingernails.</p> <p>Interview on 12/12/24 at 4:42 PM with the DON revealed CNAs were responsible to ensure fingernails are trimmed and cleaned. She stated the Charge Nurse was responsible for ensuring residents receive fingernail care. She stated the risk to the resident were infection, skin tears and potential risk of harm to resident with long fingernails.</p> <p>Review of the facility's policy titled Care of Fingernails/Toenails, revised October 2010, reflected to clean the nail bed, to keep nails trimmed, and to prevent infections . Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed .4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.</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>42971</p> <p>Based on observation, interview, and record review the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing, administering, and securing of medications for 2 medication carts (Nurses medication cart Hall 600, and Nurses medication cart 300/400 halls) of 3 medication carts reviewed for pharmacy services.</p> <p>The facility failed to ensure medications in unsecured containers were immediately removed from stock.</p> <p>These failures could place residents at risk of not having the medication available due to possible drug diversion and at risk of not receiving the intended therapeutic benefit of the medication.</p> <p>Findings Included:</p> <p>Record review and observation on 12/10/24 at 10:34 AM of the Nurses Medication Cart Hall 600, with LVN D revealed the blister pack for Resident #12's acetaminophen codeine. 300-30 mg tablet (controlled medication used for pain) had 1 blister seal broken and the pill was still inside the broken blister and tapped over.</p> <p>Interview on 12/10/24 at 10:41 AM, LVN D stated she was unaware when the blister pack seal was broken. She stated she did the count in the morning with the ongoing nurse, but she did not check the blisters for damage. She stated the risk of a damaged blister would be a potential for drug diversion. At that time, the surveyor checked the medication; the count was compared to the blister pack and the count was correct.</p> <p>Record review and observation on 12/10/24 at 10:49 AM of Nurses Medication Cart Hall 300/400, with LVN I revealed the blister pack for Resident #62's hydrocodone acetaminophen 5-325 mg tablet (controlled medication used for pain) had 1 blister seal broken and the pill still inside the broken blister.</p> <p>Interview on 12/10/24 at 10:54 AM, LVN I stated the count was done at shift change and the count was correct. She stated she did not check the blister packs during the count. She stated she was unaware when the blister pack seal was broken. She stated the risk would be a potential for drug diversion. She stated the nurses and med aides were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated when a broken seal was observed, she would report it to the DON and would discard the pill with another nurse.</p> <p>Interview on 12/12/24 at 4:42 PM, the DON stated if a blister pack medication seal was broken the pill should have been discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. She stated the risk would be losing the medication because the seal was broken and potential for drug diversion. She stated nurses were responsible the check the medication packs for damaged blister during the count at the shift change. She stated the DON and the ADON were responsible to do random check of the medication carts for monitoring.</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 the facility's policy Storage of Medications, revised April 2019, reflected the following: . Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.</p>

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399</p> <p>Based on observation, interview, and record review the facility failed to ensure quality of laboratory services to meet applicable requirements for laboratories by using expired glucometer control solution for 1 medication cart (Nurses medication cart Hall 600) of 3 medication carts reviewed for pharmacy services.</p> <p>The facility failed to ensure an expired glucose control solutions (a liquid used to test the accuracy of a blood glucose meter and test strips) was removed from the nurses medication cart hall 600.</p> <p>This failure could affect diabetic residents resulting in diminished effectiveness, and not receiving the correct reading of the blood glucose level.</p> <p>The findings included:</p> <p>Record review and observation on [DATE] at 10:34 AM of the Nurses Medication Cart Hall 600, with LVN D revealed a glucose control solution with an expiration date of [DATE].</p> <p>In an interview on [DATE] at 10:41 AM, LVN D stated the glucose control solution was expired. She stated she was responsible to check the cart for expired medication and expired solution. She stated she did not check the solution in the morning. She stated the risk for using expired solution would be a potential for wrong reading of blood glucose level. She stated 4 residents were on blood sugar check in 600 hall. She stated she would use a new solution to test the glucometer and check the blood glucose level for the 4 residents.</p> <p>Interview on [DATE] at 4:42 PM, the DON stated she expected nurses to check the medication carts, daily, for expiration and labeling of medication and expired solution. She stated the risk would be a wrong result of blood sugar level. She stated the pharmacy consultant checks the medication room and the medication carts monthly.</p> <p>Review of the facility's policy Storage of Medications, revised [DATE], reflected the following: .Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50910</p> <p>Based on observations, interviews and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for the facility's only kitchen in that:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure food items in the facility refrigerator and freezer were dated or labeled. 2. The facility failed to use proper hand hygiene while handling and serving food to the residents. <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>Findings Include:</p> <p>Observation of refrigerator 1 and interview with Dietary Manager on 12/10/24 revealed:</p> <p>At 8:40am an 8oz Cool Whip container with no open date or date received.</p> <p>At 8:46am an 46oz container of Ready Care thickened sweetened tea with about 2 ounces left dated 10/31/24. The Dietary Manager stated that it was empty and needed to be thrown out. She stated that she was unsure if there was potential harm to the resident because it was just tea. She then looked at the container observed the manufacture label that stated, must refrigerate and thrown out after 7 days of opening.</p> <p>At 8:48am a second 46oz Ready Care thickened sweetened tea almost full with a date of 10/31/24. The Dietary Manager threw that one out as well.</p> <p>Observation of Freezer 1 and interview with Dietary Manager on 12/10/24 revealed:</p> <p>At 8:48am an opened gallon sized Ziplock bag with about 1 gallon of 2-inch straw-like beige tubular items that the Dietary Manager identified as French Fries, with no label of what the item was or date opened.</p> <p>At 8:49am an unopened plastic clear bag of about 150 one-inch pink circular items with no label, that was identified by Dietary Manager as smoked sausage.</p> <p>At 8:50am a 2-gallon Ziplock bag with about a half-gallon of thin rigid 1-inch brown items without a label. The Dietary Manager was unable to identify what it was.</p> <p>Observation of Freezer 2 and interview with Dietary Manager on 12/10/24 revealed:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At 8:50am a blue plastic bag closed by a knot, with about 2 gallons worth of green pea sized frozen items with no label, no date received or date opened. The Dietary Manager stated the items were California Vegetables.</p> <p>At 8:50am a blue plastic bag closed by a knot, with about a gallon of dime size green circular items with no label, no date received or date opened. The Dietary Manager stated that it was okra.</p> <p>At 8:50am a sealed a 2-gallon Ziploc bag with 10 tan 5-inch ovals 5-inch ovals. The Dietary Manager stated they were hashbrowns.</p> <p>At 8:51am a sealed plastic bag with 5-inch tan circular disc with no label or date received. The Dietary Manager stated they were waffles.</p> <p>At 8:51am a closed clear plastic bag with 8 white and yellow with green specks 7-inch oval items with no label or date received. The Dietary manager stated they were garlic breads.</p> <p>At 8:52am an clear blue plastic bag closed with a knot on top that had about 2 gallons of white, green, and orange different sizes and shapes of frozen items no label, date received or date opened. The Dietary Manager stated it was California mixed vegetables.</p> <p>At 8:52 am a sealed plastic bag of about 2 gallons of circular wedged orange, brown 1-inch oval items with no label or date received. The Dietary Manager stated they were sweet potato fries.</p> <p>At 8:54am a clear plastic bag of 8 foot long tannish textured 1 inch straw-like items with no label or date received. The Dietary Manager stated they were churros.</p> <p>At 8:54am 4 packages of sealed tannish brown 3-inch disk stacked by 3s. The Dietary Manager stated they were pancakes.</p> <p>At 8:55am a 2nd bag of a clear plastic bag of about a gallon of circular wedged orange, brown 1-inch items with no label or date received. The Dietary Manager identified them as sweet potato fries.</p> <p>At 8:56am a sealed clear plastic bag with about 2 gallons worth of textured green leafy items with no label or date received. The Dietary Manager stated they were collard greens.</p> <p>At 8:56am an unsealed clear plastic bag with 15 white and light brown, foot long circular 1-inch items with no label date received or date opened. The Dietary Manager stated they were bread sticks.</p> <p>At 8:58am a blue plastic bag closed with a knot on top, with about a gallon of white rigid 1/2 chunky items with no label, date opened or date received. The Dietary Manager was unable to identify what it was.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview with Dietary Manager on 12/10/24 at 8:59am revealed that she did not know that items in freezer and refrigerator needed a label to identify them. She stated the expectation for dating items in the refrigerator and freezer were for all items to have a handwritten date received and if the items were opened then a date opened. She stated that she was the person who put the items in bags and took them out of their original boxes when they arrived to put them in the freezers. She stated she knew what every item was, and she could be called at any time if other staff had questions of what things were. She stated that if dietary staff didn't know what things were and they didn't have at date, then the risk to the resident would be that they may be given wrong food or bad food.</p> <p>Observation of [NAME] C on 12/10/24 at 11:35am pureeing lasagna rolls with gloves on. While pureeing her phone rang and she answered her phone and walked away to go to another room. The cook returned, threw away the gloves she had on, put new gloves on and resumed pureeing food. The cook did not wash her hands before putting new gloves on. The cook finished pureeing the lasagna rolls and walked to the dishwashing area with the food processor with her gloves on and returned to kitchen serving area and proceeded to touch the serving spoons on the heating table.</p> <p>Observation of [NAME] C on 12/10/24 at 11:50am grabbed two serving spoons with her bare hands hanging above her by the spoon instead of the handle then put the spoons in the hot food on the heating tray.</p> <p>Observation of [NAME] C on 12/10/24 at 12:01pm revealed removing the hot tray of lasagna roll out of the oven and placing it on the shelf, one of the pot mittens fell on the floor and the [NAME] picked it up and put it next to the stove.</p> <p>Interview with [NAME] C on 12/10/24 at 12:45am revealed that she should wash her hands before putting gloves and gloves should be worn anytime handling food like cooking and serving. She stated she should have washed her hands after coming from the back room after her phone call and then should have put gloves on. She stated that you need to wash your hands whenever you leave the serving area and go to another part of the kitchen. [NAME] C stated she should have not touched the part of the serving utensil that would go in the food and stated she should have been wearing gloves. She stated that she put the cooking mitten that fell on the floor on the cart on the side of the stove to put in in the laundry basket later. She stated that if she forgot to put it in the laundry basket it would potentially cause harm to the residents by exposing them to bacteria and cross contamination which could make them sick.</p> <p>Interview with Dietary Manager on 12/10/24 at 12:56pm revealed the expectation for kitchen staff was to wash their hands any time they go into a different part of the kitchen or changed tasks. She stated that [NAME] C should have washed her hands after she put the food processor in the dishwashing area. She stated that all kitchen staff should have worn gloves any time they are serving food or managing serving utensils. Dietary Manager clarified when they received food deliveries, she was responsible for labeling the food and putting it away. She stated that everything should have had a date received and a date opened once it was opened.</p> <p>Record review of Food Receiving and Storage revised July 2014 reflected, Policy Interpretation and Implementation . 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date) 10. The freezer must keep frozen foods frozen solid. Wrappers of frozen foods must stay intact until thawing</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices revised October 2008 reflected, .6. Employees must wash their hands: .c. Whenever entering or re-entering the kitchen; d. Before coming in contact with any food surfaces; .f. After handling soiled equipment or utensils; g. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/or h. After engaging in other activities that contaminate the hands . 10. Gloves are considered single-use items and must be discarded after completing the task for which they are used. The use of disposable gloves does not substitute for proper handwashing .</p> <p>Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety</p> <p>Review of the Food and Drug Administration Food Code, dated 2022, reflected .2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301. 12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and: . (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; . (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands .</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971</p> <p>Based on interview and record review the facility failed to maintain medical records in accordance with accepted professional standards and practices for one of twenty-four residents (Resident #165) reviewed for medical records.</p> <p>LVN F and RT G failed to document physician notification about the Resident #165's trach dislodgement and change of condition on [DATE].</p> <p>The noncompliance was identified as PNC from [DATE] to [DATE]. The facility had corrected the noncompliance before the survey began on [DATE].</p> <p>This failure placed residents at risk for inaccurate medical records.</p> <p>Findings include:</p> <p>Record review of Resident #165's Comprehensive MDS assessment, dated [DATE], reflected a [AGE] year-old female admitted to the facility on [DATE] and a re-admission on [DATE]. Resident #165 had a BIMS of 15 which indicated her cognition was intact. Resident #165 required partial assistance with ADLs. Her diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing breathing problems), respiratory failure (not enough oxygen in the blood). In Section O-Special Treatments, Procedures, and Programs it reflected she required tracheostomy (surgical procedure which consists of making an incision on the anterior aspect of the neck and opening a direct airway through an incision in the trachea) care and oxygen therapy.</p> <p>Record review of Resident #165's care plan, dated [DATE], reflected, [Resident #165] has a tracheostomy (related to respiratory failure .Goal .The resident will have no signs or symptoms of infection through the review date .Interventions .Ensure that trach ties are secured at all times . Monitor/document for restlessness, agitation, confusion, increased heart rate, and bradycardia (decreased heart rate)</p> <p>Record review of the Order Summary Report dated ,d+[DATE] for Resident #165 indicated orders:</p> <ul style="list-style-type: none"> - change inner cannula daily and as needed, start date of [DATE]. - Change trach collar setup as needed, start date of [DATE]. - Change trach tube every 3 month on dayshift and as needed, start date of [DATE]. - Cleanse trach site and change dressing every shift and as needed, start date [DATE]. - Code status: full code, start date of [DATE]. <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the nursing progress note dated [DATE] for Resident #165 and completed by LVN F indicated: At 6:30 PM , RT G was in resident's room, resident's tracheostomy tube was not all the way in, it would not advance, RT G removed the tube to reinsert it properly, the trach tube would not advance, Residents O2 was 96%. resident was following commands and looking at nurse. at 6:38 PM resident saturations were decreasing, at 6:40 PM resident became unconscious and pulse was at 50, Pulse declined, and CPR was initiated at 6:40 PM, 911 was called at 6:40 PM. At 6:50 PM EMS has not arrived, recalled 911, Operator said EMT was on the way. 911 dispatched another [NAME] EMS, at 7:00 PM EMS arrived, CPR remained in progress, EMT continued CPR. At 7:13 PM EMS ceased CPR and stated resident was deceased . EMS left facility not removing the body. At 7:17 PM DON was notified, at 7:19 PM family member was notified, at 10:00 family arrived at facility.</p> <p>Record review of the nursing progress note dated [DATE] for Resident #165 and completed by RT G indicated: Around 6:30 PM pt called me in and asked if I could suction her. I tried to pass the suction tube but it would not pass. I checked her trach and found it part way out. I notified the nurse. I also notified RT director. He advised to take trach all the way out and add some lubricant and try to replace trach. Attempted to replace trach twice but could not get to go in. Nurse was holding trach collar trying to get her O2 up higher to try and insert trach again but pt started desatting (a drop I a person's oxygen saturation levels) quickly. I took out her ambu bag and hooked it up to e-tank and started bagging. we bagged pt for 10 minutes trying to get sats up. pt lost consciousness around 6:40 PM so the nurse called 911. CPR was started and we continued to bag pt and administer CPR until EMS arrived. PT lost pulse just as EMS arrived. EMS arrived around 7:00 PM. they took over CPR and placed AED leads on pt. they performed CPR for a few minutes and pronounced her deceased .</p> <p>In an interview with the RT Director on [DATE] at 3:24 PM he stated RT G called him and told him about Resident #165's trach partial dislodgement, he told her to pull the trach all the way-out and to reinsert it properly. He stated the insertion of the trach is part of the school education for respiratory therapists. He stated the RT G tried twice to reinsert the trach and she called 911. That was the expectation.</p> <p>In an interview with the physician on [DATE] at 4:10 PM he stated in general if a trach dislodged, respiratory therapist supposed to reinsert it that is why an extra trach by the bed side. He stated respiratory therapists were trained to replace the trach, if the trach was partially dislodged, they had to pull it to reestablish the air way. He stated the respiratory therapists were capable to replace the trach, it is not common to fail to replace it, but it happens because sometimes the opening of the stoma is not straight. It is unfortunate. He stated if a trach came out, first thing to do was to try to put it back in. It was the respiratory therapist scope of practice to replace the trach. He stated They did what I expected them to do. I am not expecting them to call me during a code. the protocol of the emergency is to call 911. I know from experience the RT change the trach. Is in their scope of practice. If not able to get it back - call 911.</p> <p>In an interview with LVN F on [DATE] at 1:45 PM she stated everything was very fast, when Resident #165 lost consciousness, she started CPR and told another staff to call 911. LVN F stated she called the physician after the code. She stated she forgot to document that she called the physician.</p> <p>Attempted to reach RT G on [DATE] at 1:50 PM by phone. No answer.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LVN E on [DATE] at 1:35 PM she stated that Resident #165 had history of trach dislodgment. She stated on [DATE] Resident #165's trach was dislodged; RT H tried to reinsert it twice unsuccessfully. They called 911, they arrived to the facility and transferred the resident to the hospital. LVN E stated the difference between the two incidents was 911 arrived to the facility in less than 10 min on [DATE] instead of 20 min on [DATE].</p> <p>Attempted to reach RT H on [DATE] at 1:42 PM by phone. No answer.</p> <p>Interview with the DON on [DATE] at 4:42 PM she stated she started working in the facility on [DATE], she stated LVN F called her after the code. She stated she did not expect staff to call her or call the physician during an emergency. She stated per protocol they called 911. The DON stated she expected LVN F to document that she called the physician.</p> <p>Record review of the facility's in-service initiated on [DATE] by the DON reflected 23 of nursing staff were in-serviced on change of condition, notifications, and documentation.</p> <p>Individual interviews with LVNs, RNs from all shifts (LVN D, LVN E, LVN I, LVN J, LVN K, LVN L, and RN M) on [DATE] and [DATE] revealed they had received in-service training on change of condition, notifications, and documentation.</p> <p>Record review of the facility's policy Emergency Trach Care Procedures, not dated, reflected the following: .If you are unable to re-inset either the same size trach tube or a smaller size, call 911 and have the resident shipped to the ER.</p> <p>Review of the facility's policy Change in a Resident's Condition or Status, revised [DATE], reflected the following: .The nurse will notify the resident's Attending Physician, Nurse Practitioner or physician on call when there has been . significant change in the resident's physical/emotional/mental condition . Need to transfer the resident to a hospital/treatment center .</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399</p> <p>Based on interview and record review, the facility failed to ensure the QAA committee developed and implemented appropriate plans of action to correct identified quality deficiencies for change of condition concerns.</p> <p>The QAA committee failed to discuss and review Resident #165's change of condition after Resident #165 expired at the facility on [DATE] to determine any quality deficiencies at QAPI meeting in [DATE].</p> <p>This failure could place residents at risk of quality of care concerns.</p> <p>Findings included:</p> <p>Record review of the nursing progress note dated [DATE] for Resident #165 and completed by RT G indicated: Around 1830 (6:30 PM) pt called me in and asked if I could suction her. I tried to pass the suction tube but it would not pass. I checked her trach and found it part way out. I notified the nurse. I also notified RT director. He advised to take trach all the way out and add some lubricant and try to replace trach. Attempted to replace trach twice but could not get to go in. Nurse was holding trach collar trying to get her O2 up higher to try and insert trach again but pt started desatting (decreasing oxygen saturation levels) quickly. I took out her ambu bag (device used to provide respiratory support to patients in an emergency situation) and hooked it up to e-tank and started bagging. we bagged pt for 10 minutes trying to get sats up. pt lost consciousness around 1840 (6:40 PM) so the nurse called 911. CPR was started and we continued to bag pt and administer CPR until EMS arrived. PT lost pulse just as EMS arrived. EMS arrived around 1900 (7:00 PM). they took over CPR and placed AED leads on pt. they performed CPR for a few minutes and pronounced her deceased .</p> <p>Interview on [DATE] with DON at 4:42 PM revealed she could not recall Resident #165's change of condition and death on [DATE] being discussed at an Interdisciplinary Meeting or at a QAPI meeting. Surveyor requested any documentation of discussion of Resident #165's death. She stated she was hired in [DATE]. She stated she could not recall the incident of Resident #165's change of condition and death. She stated in the QAPI meetings the facility discussed any clinical issues like incident/accidents and change of conditions. She stated the importance of having QAPI meetings were to discuss and review any clinical concerns to see if any changes need to be implemented.</p> <p>Interview on [DATE] at 2:38 PM revealed the Administrator stated he was not able to find any documentation of QAPI meeting for [DATE] and was unable to review documentation to see what was discussed. He stated they had a change of ownership in [DATE] and he took over as Administrator in [DATE].</p> <p>(continued on next page)</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] at 10:01 AM with the Administrator and Regional VP revealed the facility had a monthly QAPI meeting. Administrator stated in QAPI meetings they discuss resident weight loss, falls, change of conditions, hospitalization and tracking/trends. The Administrator stated if they identify concerns, discuss in in QAPI meetings and can come up with a plan for any identified concerns. He stated all department heads were invited to the QAPI meetings but the Medical Director, DON and wound care nurse participated in them. He stated the potential risk of not discussing resident change of conditions could place the facility at risk of not getting the opportunity to educate the employees in the event staff education needs were identified.</p> <p>Interview on [DATE] at 10:47 AM with MDS Coordinator revealed they meet monthly for QAPI meetings even in previous ownership and usually discuss about new admissions, discharge residents and deaths. The MDS Coordinator stated she cannot recall any discussion on QAPI meetings about Resident #165's death. She stated it was important to have QAPI meetings so they can collaborate together for patient safety and care concerns. She stated it can help us in things we can improve on and do better for resident quality of care.</p> <p>Review of QAPI Attendance Record for [DATE] meeting included Medical Director reflected MDS Coordinator was present at this meeting. The Infection Preventionist was not present during the meeting.</p> <p>Review of facility's policy Quality Assurance and Performance Improvement Program revised [DATE] reflected this facility shall develop, implement, and maintain and ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) program that builds on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals. The primary purpose of the Quality Assurance and Performance Improvement Program is to establish data-driven, facility-wide processes that improve the quality of care, quality of life and clinical outcomes of our residents.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971</p> <p>Based on 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 1 of 8 residents (Resident #54) reviewed for infection control.</p> <p>The facility failed to ensure LVN D used the required PPE for Resident #54, who was on enhanced barrier precautions due to his tube feeding and foley catheter, while administering resident medication through tube feeding on 12/10/24.</p> <p>This failure could place the resident at risk of cross-contamination and development of infection.</p> <p>Findings included:</p> <p>Record review of Resident #54's Comprehensive MDS assessment dated [DATE] reflected a [AGE] year-old male admitted to the facility on [DATE] 3. Resident had a BIMS score of 9 which indicated he was moderately cognitively impaired. Diagnoses included pressure ulcer of sacral region, and local infection of the skin. Review of section K: Swallowing/Nutritional Status resident had feeding tube.</p> <p>Record Review of Resident #54's Physician Orders Report on 12/13/24 reflected:</p> <ul style="list-style-type: none"> - Implement and maintain enhanced barrier precautions (EBP) when performing high contact care activities related to peg tube (tube feeding), foley catheter, with a start date of 10/04/24. - Alprazolam 0.25 mg, Give 1 tablet via PEG-Tube one time a day, with a start date of 10/16/24. - Hydrocodone-Acetaminophen 10-325 mg, Give 1 tablet via PEG-Tube every 6 hours, with a start date of 9/12/24. - Methocarbamol 750 mg, Give 1 tablet via PEG-Tube every 6 hours, with a start date of 9/12/24. <p>Record review of Resident #54's comprehensive care plan initiated on 6/26/24, reflected, Resident is on Enhanced Barrier Precautions related to peg tube .Goal: Resident will remain in EBP until no longer meet criteria . Interventions .Enhanced barrier precautions until no longer required . Post appropriate enhanced barrier precautions signs.</p> <p>An observation of the medication pass on 12/10/24 at 1:41 PM revealed LVN D at the medication cart preparing Resident #54's medication and gathering supplies needed to administer medication through tube feeding. LVN D entered Resident #54's room, performed hand hygiene and put on gloves, but did not put on a gown. LVN D checked the placement of the tube feeding by checking the residual, she flushed the tube feeding with 60 ml of water. LVN D then administered medication (Alprazolam 0.25 mg, Hydrocodone-Acetaminophen 10-325 mg, Methocarbamol 750 mg). LVN D returned to the medication cart and removed her gloves and performed hand hygiene.</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 - Few</p>	<p>In an interview with LVN D on 12/10/24 at 2:04 PM she stated Resident #54 was on Enhanced Barrier Precautions because of his tube feeding, foley catheter and his sacrum wound. She stated she was supposed to wear a gown and gloves while providing care or medication administration to his tube feeding and failed to do so. She stated she just forgot. She stated she had been in serviced on the use of Enhanced Barrier Precautions and what PPE was required. She stated the risk to the resident would be potential spread of infections.</p> <p>In an interview with the DON on 12/12/24 at 04:42 PM, she stated they had in serviced the staff that for anyone with a catheter or tube feeding they were required to wear a gown when performing direct care . She stated the risk was potential spread of multi-drug resistant organism (MDRO) from resident to resident. She stated the DON and the ADON were responsible to do routine rounds to monitor staff.</p> <p>Record review of the facility's policy, Enhanced Barrier Precautions, dated 3/2024, reflected, Enhanced Barrier Precautions - expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDRO to staff hands and clothing. MDROs may be indirectly transferred from resident to resident during these high contact care activities . Examples of EBP residents: Wounds . Indwelling medical devices: include central lines, urinary catheters, feeding tubes.</p>		