| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675390 | A. Building<br>B. Wing | 11/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sunflower Park Health Care | 1803 Highway 243 East<br>Kaufman, TX 75142 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006<br><br>Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 3 of 4 residents (Resident's #28, #32, #37) reviewed for dignity.<br><br>1. The facility failed to ensure Resident #32 was treated with dignity and respect when the Administrator called her big girl on 10/22/24.<br><br>2. The facility failed to ensure Resident #32 was treated with dignity and respect when CNA GG and MA HH told her washing her hair was too time consuming on 10/30/24.<br><br>3. The facility failed to ensure Resident #37 was treated with dignity and respect when CNA MM told her to shut up.<br><br>4. The facility failed to ensure Resident #28 was treated with dignity and respect when CNA MM put pressure on Resident #28 to clean herself and walked out of the room with her pants still pulled down.<br><br>These failures could place residents at an increased risk of embarrassment and a diminished quality of life.<br><br>The findings included:<br><br>1. Record review of the face sheet dated 10/31/24, reflected Resident #32 was a [AGE] year-old female who admitted to the facility with diagnoses that included major depressive disorder (persistent feeling of sadness and loss of interest), anxiety, morbid obesity (body mass index of 40 or higher which can increase the risk of many health problems and premature death) due to excess calories, and heart failure (heart muscle does not pump blood as well as it should).<br><br>Record review of the quarterly MDS assessment dated [DATE], reflected Resident #32 was able to make herself understood and was able to understand others. The MDS reflected Resident #32 had a BIMS score of 11, indicating her cognition was moderately impaired. The MDS reflected Resident #32 was dependent on staff with toileting, showers, personal hygiene, and lower body dressing. The MDS reflected no behaviors or refusal of care.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the comprehensive care plan dated 03/27/24, reflected Resident #32 had an ADL self-care performance deficit. The care plan interventions reflected: assist with personal hygiene as required: hair, shaving, oral care as needed, and bathing requires of one staff member for assistance.<br><br>Record review of the comprehensive care plan dated 10/26/24, reflected Resident #32 had a mood problem related to disease process. The care plan interventions reflected to administer medications as ordered, behavioral health consults as needed, and to educate resident/family/caregivers regarding expectations of treatment.<br><br>Record review of the comprehensive care plan dated 06/25/24, reflected Resident #32 had a potential to demonstrate verbally abusive behaviors, ineffective coping skills, and poor impulse control. The care plan interventions included to notify the charge nurse of any abusive behaviors.<br><br>Record review of the psychiatric evaluation and consultation progress note dated 10/23/24, reflected . Pt [Patient] report that she had an incident where a management staff called her a big girl and it broke her heart. She reports that she cried all day and was hurt, but most of the staff were very comforting, thus helping her overcome her emotional breakdown. She cried during the visit .Pt [Patient] denied SI [suicidal ideation], HI [homicidal ideation], AVH [auditory verbal hallucinations], lack of motivation, hopelessness, lack of appetite, lack of sleep, but endorsed sadness over what happened yesterday. Staff reports no other concerning behavioral disturbance, barriers to care or treatment, aside from the incident that occurred yesterday.<br><br>Record review of the trauma informed PRN assessment dated [DATE], completed by the Social Worker, reflected Resident #32 had a history of trauma and had a diagnosis of Post-Traumatic Stress Disorder (mental and behavioral disorder that develops from experiencing a traumatic event). The assessment reflected Resident #32 had experienced physical assault and was physically threatened. The assessment reflected Resident #32's family member physically assaulted her on numerous occasions. The trauma assessment reflected Resident #32 sometimes became angry when she felt disrespected by other people in the facility.<br><br>Record review of Resident #32's nursing progress note dated 10/30/24 signed by LVN OO reflected . After being reported to this nurse that resident refused a shower. This nurse went to speak with the resident, the resident had requested her hair to be washed and was told by the aides that washing her hair was too time consuming resident was offered a shower as an alternative to a bed bath, but the resident refused the shower and insisted on a bed bath. After speaking with resident, resident reported refusing due to aides telling her that washing her hair was too time consuming. This nurse spoke with aides [CNA NN and CNA GG], both aides reported a bed bath would take three hours to wash her hair this nurse insisted they give her a bed bath. Resident was now visibly upset to take a bed bath and stated she wanted to take care of this tomorrow in the morning. ADON and DON notified.<br><br>During an interview on 10/28/24 at 9:54 AM, the ADO stated he was the acting Administrator because the Interim Administrator was on paid-time-off and not accessible by telephone as she was on a cruise.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 10/28/24 beginning at 10:57 AM, Resident #32 stated the Administrator called her big. Resident #32 stated one of the CNAs providing care that morning had kicked her bed. Resident #32 asked the CNA why she kicked her bed, and the CNA went to get the Administrator. Resident #32 stated the Administrator came into her room and said, Hey big girl, let's get you to the dining room. Resident #32 stated she felt disrespected. Resident #32 stated she told the Administrator she was not going anywhere with her because she talked to her like that. Resident #32 stated the Administrator just walked out and did not apologize to her. Resident #32 stated she became upset and started crying. Resident #32 stated she told a staff member that her feelings were hurt, and the ADO came to talk to her. Resident #32 stated since the incident she has refused several meals. Resident #32 said she did not want people to view her as a big girl.<br><br>During an interview on 10/28/24 beginning at 4:28 PM, the DON stated Resident #32 wanted to get up for an event that started at 10 AM on 10/22/24. The DON stated the staff did not get into Resident #32's room until 10:10 AM - 10:15 AM so she was already upset because she was late. The DON stated Resident #32 started making comments like you don't want to deal with me, so the CNA went to get the Administrator. The DON stated the Administrator had a bubbly, smiley, and happy personality so she walked into the room and told Resident #32 Hey big girl, let's get you to the dining room. The DON stated the Administrator told her she immediately realized she shouldn't have said that. The DON stated the Administrator meant it more as motivation and encouragement and not her size. The DON said Resident #32 perceived it as her size, so she became sad and upset. The DON said psychiatric services and the Social Worker talked with Resident #32. The DON stated the Administrator was suspended pending investigation and was provided customer service training, which included using a better choice of words. The DON stated all other residents during the investigation had no complaints or issues with the Administrator.<br><br>During an interview on 10/31/24 beginning at 1:55 PM, LVN OO stated last night [10/30/24] two CNAs reported Resident #32 was refusing a shower. LVN OO stated the CNAs told her Resident #32 wanted a bed bath and her hair washed but it was too time-consuming. LVN OO stated she went to talk to Resident #32. LVN OO stated Resident #32 stated she wanted a bed bath with her hair washed but the CNAs told her it was too time-consuming. Resident #32 was unsure who said it. LVN OO stated she was hearing a lot of excuses from the CNAs about why the bed bath could not have been completed. LVN OO stated she did not like hearing it was too time-consuming. LVN OO stated Resident #32 finally agreed to a shower but by the time the CNAs went back into the room she was frustrated and refused her shower. LVN OO stated she documented the incident and sent a text message to the ADON and DON. LVN OO stated she felt like a text message was okay. LVN OO stated she felt like it was a dignity issue.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 10/31/24 beginning at 5:45 PM, the ADO stated from what he remembered the CNAs were going into Resident #32's room to get her up for lunch. The ADO said the CNA bumped her bed and Resident #32 became upset. The ADO stated the CNAs went to get the Administrator to help de-escalate the situation. The ADO stated the Administrator had a very bubbly and uppity personality. The ADO stated the Administrator was trying to be encouraging when she said, Hey big girl. The ADO stated however the Administrator meant it, Resident #32's feelings were hurt, and she could not understand why the Administrator would have called her fat. The ADO stated the Administrator was suspended pending the investigation. The ADO stated skin assessments were completed on non-verbal residents and interviews were completed with interviewable residents and staff. The ADO stated no other complaints were received on the Administrator. The ADO stated the Administrator was assigned a training course that had to have been completed before she started working again. The ADO stated he sat with her while she completed the course. The ADO stated it covered customer service and sensitivity. The ADO stated it was important to ensure their words came out correctly to make sure the residents felt satisfied with the customer service.<br><br>During an interview on 10/31/24 beginning at 9:11 PM, CNA GG stated the facility had notified her she was suspended pending an investigation for not meeting the needs of a resident. CNA GG stated there was an incident with Resident #32. CNA GG said Resident #32 reported the CNAs would not wash her hair. CNA GG stated they never said they would not wash her hair. CNA GG stated they did not deny Resident #32 a shower or bed bath. CNA GG stated they talked about different ideas for washing Resident #32's hair because she had so much hair. CNA GG stated she did not tell Resident #32 washing her hair was too time consuming. CNA GG stated it was very hard to wash Resident #32's hair properly in the bed. CNA GG stated MA HH was helping her with Resident #32 while CNA NN finished changing another resident. CNA GG stated Resident #32 finally agreed to a shower but when they went to get her up, she refused. CNA GG stated it was important to respect the residents wishes to promote dignity.<br><br>During an interview on 10/31/24 beginning at 9:31 PM, CNA NN stated she was suspended earlier in the day pending an investigation. CNA NN stated Resident #32 was on her hall, but she did not go into Resident #32's room during the incident. CNA NN stated MA HH was assisting CNA GG while she was providing care to another resident. CNA NN stated it took approximately 3 hours to wash Resident #32's hair in the bed. CNA NN stated staff tried to encourage Resident #32 to get in the shower when she needed her hair washed. CNA NN stated it was time consuming when she needed her hair washed.<br><br>During an interview on 10/31/24 beginning at 9:52 PM, MA HH stated there was an incident last night [10/30/24] with Resident #32. MA HH stated Resident #32 wanted a bed bath and they tried to convince her to take a shower. MA HH stated Resident #32 got mad and told the CNAs to get out of her room that she would handle the shower tomorrow. MA HH stated she did not tell Resident #32 she would not wash her hair. MA HH said she told Resident #32 washing her hair was very time consuming and it would be best if she took a shower. MA HH stated Resident #32 misunderstood what she was trying to say. MA HH stated the ADO spoke with her before she started her shift and explained that we should watch what we say around the resident because they can take it another way. MA HH stated she signed an in-service on the incident. MA HH stated it could have made Resident #32 feel bad like the staff did not have time for her. MA HH stated it was important to ensure residents were treated with dignity and respect.<br><br>During an interview on 11/01/24 beginning at 8:44 AM, Resident #32 stated MA HH telling her washing her hair was too time consuming made her feel like the staff did not want her at the facility. Resident #32 stated it made her feel bad because when her hair did not get washed; it was itchy.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. Record review of the face sheet dated 10/31/24, reflected Resident #37 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of cerebrovascular disease (disorder that affect blood flow to the brain), Alzheimer's (a disease that destroys brain cells, causing a gradual decline in memory, thinking, and behavior), major depressive disorder (persistent feeling of sadness and loss of interest), and need for assistance with personal care.<br><br>Record review of the admission MDS assessment dated [DATE], reflected Resident #37 was usually understood by other and was usually able to understand others. The MDS reflected Resident #37 had a BIMS score of 4, indicating her cognition was severely impaired. The MDS reflected Resident #37 required substantial/maximal assistance with toileting, showering, lower body dressing, and transfers. The MDS reflected Resident #37 had no behaviors or refusal of care.<br><br>Record review of the comprehensive care plan dated 03/29/24, reflected Resident #37 had a communication problem related to Alzheimer's. The care plan interventions were to anticipate and meet needs, ensure/provide a safe environment, and to encourage resident to continue verbalizing thoughts even if resident was having difficulty.<br><br>Record review of the provider investigation report dated 09/23/24, reflected on 09/18/24 it was reported by Resident #37's family member that an alert resident, who wished to remain anonymous, witnessed CNA MM being rough with Resident #37.<br><br>During an attempted interview and observation on 10/28/24 beginning at 4:49 PM, Resident #37 was wandering around the facility looking for a way home. Resident #37 was unable to answer questions appropriately as evidenced by confused conversation.<br><br>During an interview on 10/29/24 beginning at 1:59 PM, Resident #37's family member stated she was told by another resident, a CNA was mean and rude to Resident #37 and told her to shut up. The family member stated it was another resident who reported the incident, but he wished to remain anonymous. The family member stated when she arrived at the facility on 09/18/24 she went to the front desk and gave the staff members the description of the CNA. The staff members told her it was CNA MM. The family member asked the CNAs how they knew it was CNA MM and the told her several residents had similar complaints. The family member stated the DON had already left for the evening, but the Administrator was at the facility, so she reported it to him. The family member said the Administrator was shocked it had not been reported to him already. The family member stated there had been so much turn over with Administrator's that it could have been lost in communication. The family member stated the Administrator immediately acted and suspended CNA MM pending investigation. The family member stated within 30 minutes of reporting the CNA, the DON and ADON were back at the facility to investigate. The family member stated CNA MM has not been back to work since the incident occurred.<br><br>3. Record review of the face sheet dated 10/31/24, reflected Resident #28 was an [AGE] year-old female who originally admitted to the facility on [DATE] with diagnoses that included rhabdomyolysis (condition in which damaged skeletal muscle breaks down rapidly), dementia (memory loss), muscle weakness, macular degeneration (condition which may result in blurred or no vision of the visual field), and needed for assistance with personal care.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the quarterly MDS assessment dated [DATE], reflected Resident #28 was able to be make herself understood and sometimes understood others. The MDS reflected Resident #28 had a BIMS score of 10, indicating her cognition was moderately impaired. The MDS reflected Resident #28 had no behaviors or refusal of care. The MDS reflected Resident #28 required partial/moderate assistance with oral hygiene, toileting, showering, dressing and personal hygiene. The MDS reflected Resident #28 was always incontinent of urine.<br><br>Record review of the comprehensive care plan revised 12/22/21, reflected Resident #28 had an ADL self-care performance deficit related to unsteadiness with mobility and joint pain. The care plan interventions included to assist with personal hygiene as required.<br><br>Record review of the safe survey dated 09/19/24, reflected Resident #28 said she was mistreated by an employee at the facility. The explanation was aide putting pressure on me to clean myself and she pulled my pants up with wet pull-up on and stormed out of room.<br><br>Record review of CNA MM's witness statement, signed 09/19/24, reflected I, CNA MM was asked to write a statement on something I know nothing about that said happened 3 days ago. There was no issues intill I posted a question on [communication platform] after that I got a call saying I was suspended. For me to write a statement I was not told what I have done wrong to get suspended. Everything was fine till I was asked a question on [communication platform]. I will not defended myself when I have done nothing wrong only do my job.<br><br>During an interview on 10/29/24 beginning at 2:58 PM, Resident #28 was unable to recall specific dates but remembered she felt like CNA MM was trying to force her opinion on her. Resident #28 stated she felt like CNA MM was trying to encourage her independence but took it too far by putting too much pressure on her. Resident #28 stated CNA MM walked out on her with her pants down and towel to cover herself. Resident #28 said CNA MM told her she could change herself. Resident #28 stated she did not report the incident immediately but reported it when she was asked about CNA MM. Resident #28 said she was unsure if CNA MM had been back to work. Resident #28 stated she felt CNA MM was disrespectful. Resident #28 expressed she did not want to get anyone in trouble.<br><br>During an attempted phone interview on 10/30/2024 at 11:43 AM, CNA MM did not answer the phone. A brief message was left with call back number.<br><br>During an attempted phone interview on 10/30/2024 at 1:37 PM, CNA MM did not answer the phone. No return call was made upon exit of the facility.<br><br>During an interview on 10/30/24 beginning at 2:10 PM, the DON stated it was reported to Resident #32's family member that CNA MM had told her to shut up. The DON stated CNA MM was suspended pending investigation of the incident. The DON stated during the investigation it was discovered Resident #28 had similar allegations, so it was decided to terminate CNA MM's employment at the facility. The DON stated CNA MM did not work on the floor again from the time she was suspended. The DON stated Resident #37 or Resident #28 had no significant physical or behavioral changes since the incident.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 10/31/24 beginning at 5:45 PM, the ADO stated from what he remembered, it was reported by Resident #37's family member that a CNA was rude or mean to Resident #37. The ADO stated another male resident told the family member, but he wished to remain anonymous. The ADO said the Administrator performed safe surveys and the male resident and Resident #28 reported similar allegations regarding CNA MM being mean or rude. The ADO stated CNA MM was fired because of the allegations against her.<br><br>Record review of the Resident Rights policy, dated 11/28/16, reflected the resident has a right to be treated with respect and dignity, including: .the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences . |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>46892<br><br>Based on interview and record review, the facility failed to consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life and failed to demonstrate their response and rationale for such response for 16 of 16 confidential residents reviewed for resident council.<br><br>The facility failed to ensure there was documentation of the facility's efforts to resolve concerns collected at the resident council meetings on 05/22/2024, 06/26/2024, 07/25/2024, 08/29/2024, 09/26/2024, and 10/15/2024.<br><br>This failure could place residents at risk of not having their concerns and grievances followed through and a diminished quality of life.<br><br>Findings included:<br><br>Record review of the Resident Advisory Council Minutes for 05/22/2024 indicated the call lights were not being answered timely.<br><br>Record review of the Resident Advisory Council Minutes for 06/26/2024 indicated the call lights were not being answered timely.<br><br>Record review of the Resident Advisory Council Minutes for 07/25/2024 indicated the call lights were not being answered timely on the night shift.<br><br>Record review of the Resident Advisory Council Minutes for 08/29/2024 indicated the call lights were not being answered timely.<br><br>Record review of the Resident Advisory Council Minutes for 09/26/2024 indicated the call lights were not being answered timely.<br><br>Record review of the Resident Advisory Council Minutes for 10/15/2024 indicated the call lights were not being answered timely all the time.<br><br>Record review of the grievances from May 2024-October 2024 did not indicate grievances to address resident councils' concerns.<br><br>During a confidential group interview with 16 residents on 10/29/2024 starting at 11:02 AM, the resident group said the call lights were not being answered in a timely manner. The resident group said the facility staff turned off their call lights and told them they would come back, and they never did. The resident group said they had voiced their concerns to the Administrator and other facility staff and the issue has not been resolved.<br><br>(continued on next page) |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 11/01/2024 at 12:55 PM, the ADO said a grievance should have been filed in PCC, their electronic system, for the resident group's concern regarding the call lights not being answered timely. The ADO said the Administrator was responsible for the grievances and follow up, but the facility had had 4-5 different interim administrators, and the current Administrator had been at the facility he believed since 10/07/2024. The current Administrator was out on vacation on a cruise. The ADO said after the resident group a grievance should be filed so that at the next resident group meeting there could be follow up to see if the residents were better satisfied. The ADO said it was important for the residents' grievances to be resolved because they had a responsibility to the residents, so the residents felt they were heard, and they saw action and improved upon the residents' grievances.<br><br>Record review of the facility's policy titled, Grievances, revised 11/02/2016, indicated, The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have . The grievance official of this facility is the administrator or their designee. The grievance official will: Oversee the grievance process Receive and track grievances to their conclusion Lead any necessary investigations by the facility Maintain the confidentiality of all information associated with grievances Issue written grievance decisions to the resident . |

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| Sunflower Park Health Care | 1803 Highway 243 East<br>Kaufman, TX 75142 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006<br><br>Based on observation, interview and record review, the facility failed to ensure the rights of the residents to be free from abuse and neglect for 1 of 4 residents (Resident #30) reviewed for abuse.<br><br>The facility failed to keep Resident #30 free from abuse and neglect, when CNA K, CNA EE, Student NA FF, and Student NA O held her down and provided incontinent care while she was screaming and yelling stop, leave me alone on 10/05/2024.<br><br>An Immediate Jeopardy (IJ) was identified on 10/29/2024 11:10 AM. The IJ template was provided to the facility on [DATE] at 11:13 AM. While the IJ was removed on 10/30/2024 the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on abuse policies, behavior management policies, and restraint policies.<br><br>This failure could place residents at risk for serious psychosocial harm from abuse, humiliation, intimidation, fear, shame, agitation, and decreased quality of life.<br><br>The findings included:<br><br>Record review of the face sheet dated 10/29/24, reflected Resident #30 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included cerebral infarction (necrotic tissue in the brain), dementia (memory loss) with behavioral disturbances, essential hypertension (high blood pressure), and need for assistance with personal care.<br><br>Record review of the quarterly MDS assessment dated [DATE], reflected Resident #30 was understood by others and was able to understand others. The MDS reflected Resident #30 had a BIMS score of 10, indicating her cognition was moderately impaired. The MDS reflected Resident #30 had verbal behaviors and refused care daily. The MDS reflected Resident #30 was dependent on staff with toileting, showers, and personal hygiene. The MDS reflected Resident #30 was always incontinent of bowel and bladder.<br><br>Record review of the comprehensive care plan revised on 10/15/24, reflected Resident #30 was resistive to care, refused nursing/CNA care frequently such as weights, incontinent care, medications, showers, vital signs, labs, and other care. The care plan interventions included: allow the resident to make decisions about treatment regimen, to provide sense of control; if resident resists with ADLs, reassure resident, ensure safety, leave, and return 5-10 minutes later and try again; and it was her choice to be changed or not when asked/offered by CNAs/nurses.<br><br>Record review of Resident #30's comprehensive monthly note dated 10/15/24 and created by the NP indicated . When seen last week, she reported an episode of abuse to me and other staff members. DON and Administrator notified. She was seen today while lying in bed. Pt initially started off calm and pleasant, then started yelling and cursing. In the midst of her yelling, she reported physical abuse again by staff and how she has pain in her [left] arm. Offered pain meds [medications] and scans, she refused and started yelling more .<br><br>(continued on next page) |

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| | 675390 | A. Building<br>B. Wing | 11/01/2024 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of the social history assessment dated [DATE], reflected Resident #30 had a history of trauma. The assessment reflected Resident #30 had experienced a life-threatening illness, physical assault, physically threatened, sexually assaulted, and sexually threatened. The assessment reflected Resident #30 had been in and witnessed an extremely frightening situation. The assessment reflected Resident #30 reported at the age of 29 she was kidnapped from a store where she was working at. She states that two black men kidnapped, raped, and attempted to murder her. The FBI was involved, and she was found.<br><br>Record review of the Abuse/Neglect policy, revised 09/09/24, reflected the resident has the right to be free from abuse .<br><br>During an observation and interview on 10/28/24 at 11:19 AM, Resident #30 stated she remembered an incident where she was held down and changed against her will. Resident #30 was unable to remember the date of the incident. Resident #30 said she did not yell unless there was a reason. Resident #30 said she did not know the names of the staff members that held her down, but it was abuse. Resident #30 stated if anyone held another person down, that was abuse. Resident #30 said she had bruising on her arm and her left shoulder was hurting from the incident. Resident #30 showed surveyor her arm, which was free of bruising. Resident #30 had large, blue, veins that were visible. Resident #30 said during the incident the woman walked in and took her stuff, moved it to the side, grabbed her arm and twisted from the elbow to her wrist. Resident #30 stated she reported it to the staff but did not know their names. Resident #30 said the Administrator came in and told Resident #30 the girls were not fired; they just were not allowed to come back into her room.<br><br>During an interview on 10/29/24 at 4:29 AM, CNA K stated she remembered an incident with Resident #30. CNA K stated she had only assisted with Resident #30's care on two occasions. CNA K stated on 10/05/24 she had just clocked into work when Student NA O requested assistance cleaning up Resident #30. CNA K stated herself, CNA EE, Student NA O, and Student NA FF were in Resident #30's room. CNA K stated they explained to Resident #30 she needed to be cleaned because she had bowel movement all over her. CNA K stated as soon as CNA EE moved Resident #30's fridge all hell broke loose. CNA K stated Resident #30 started screaming, cussing, hitting, and kicking staff. CNA K stated they had to clean her, so they held her down and continued cleaning her. CNA K stated Resident #30 kept yelling No, stop! CNA K stated Resident #30 told her she was hurting her when she was wiping. CNA K stated she apologized but explained she had to get her cleaned and a new brief placed on her. CNA K stated Resident #30 said she understood but kept yelling No, stop, leave me alone! CNA K stated normally when residents refused care or said no, she would stop performing care and go back at a later time. CNA K said she was told by the charge nurses that Resident #30 had to be changed twice a shift no matter what. CNA K stated she wanted to stop but felt like if she did not get Resident #30 changed, she would have gotten into trouble for disobeying. CNA K said it was important to respect Resident #30's wishes because it was her right to refuse care. CNA K stated holding someone down against their will could have been considered abuse. CNA K stated she would have done the same thing if she was changed against her will.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 10/29/24 at 4:37 AM, CNA EE stated on 10/05/24 she was asked by Student NA O to assist with changing Resident #30. CNA EE stated she had only worked at the facility for one week at the time of the incident. CNA EE said from what she remembered, there was a lot of screaming and yelling from Resident #30 when she was changed. CNA EE stated the other staff members stated it was normal for Resident #30 to yell, scream, and become combative during care so they continued. CNA EE said she held her over from the left shoulder area and on her back. CNA EE stated Resident #30 was mostly yelling and screaming and not hitting much. CNA EE said Resident #30 was pushing against the railing to try and push herself away. CNA EE said if a resident refused care, started yelling no, or became combative they should have backed away and reported it to the charge nurse. CNA EE said they did not do that in Resident #30's case. CNA EE said 4 people were in the room and it was chaos. CNA EE stated it was important to respect the resident's rights. CNA EE said continuing care for someone against their will, could have been considered abuse.<br><br>During an interview on 10/29/24 at 4:38 AM, LVN LL stated Resident #30 refused to be changed most of the time. LVN LL said when Resident #30 refused care, the CNAs reported it to her, and she would have tried to talk Resident #30 into letting them help her. LVN LL said bargaining with Resident #30 worked at times, but if she adamantly refused, then she would have documented it. LVN LL stated she was recently hired, and she was working her third shift. LVN LL said if Resident #30 refused care, she expected the CNAs to stop providing care and report it to her. LVN LL said CNAs should not have continued care if the resident refused, started yelling, or became combative. LVN LL said it was important to respect the residents' rights and it could have been considered abuse to force care on someone.<br><br>During an interview on 10/29/24 at 5:00 AM, the DON stated Resident #30 had reported on 10/14/24 that she was held down and changed against her will. The DON stated 4 people were identified during the investigation, which included CNA K, CNA EE, Student NA O, and Student NA FF. The DON stated the CNAs reported they went into change Resident #30, and she became combative. The DON said the CNAs reported Resident #30 was not held down but when she became combative the CNAs blocked and protected themselves from her hitting and kicking. The DON stated the facility policy was to stop providing care if a resident was refusing or becoming combative. The DON said Resident #37 reported her arm was hurting and she had bruising to her left arm. The DON stated an assessment was completed and no bruising was observed. The DON stated an x-ray was ordered but the resident refused. The DON stated staff should have left the room and came back at a later time to provide care. The DON stated Resident #30 had a right to refuse care. The DON stated no fault was identified during the investigation because the CNAs and NAs were doing their jobs. The DON stated Resident #30 had a history of refusing incontinent care for days to the point urine was running off her bed onto the floor. The DON stated they had tried different things to convince Resident #30 to allow staff to change her, but she continued to refuse care. The DON stated she told staff Resident #30 should have been changed at least once a shift. The DON stated it was important to respect the residents right to refuse care for multiple reasons, that included resident rights, injury, and traumatization.<br><br>During an attempted interview on 10/31/24 at 8:53 AM to obtain additional information, Student NA FF did not answer the phone. A brief message was left with call back number. No return call upon exit of the facility.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 10/31/24 at 8:54 AM, Student NA O stated on 10/05/24 Resident #30 had asked for assistance with incontinent care. Student NA O stated it was only her second day on the job and she was not certified yet. Student NA O stated she was unable to find other staff members to assist her with changing Resident #30 during her shift. Student NA O stated the charge nurse told her she needed assistance. Student NA O did not remember the name of the charge nurse. Student NA O stated at the end of her shift when the night shift arrived, she asked CNA K, CNA EE, and Student NA FF for assistance with changing Resident #30. Student NA O stated Resident #30 was upset it had taken so long to find assistance. Student NA O said as they started changing Resident #30, and she became really upset. Student NA O said they just kept trying to encourage her. Student NA O said Resident #30 hit CNA K in the face a couple of times. Student NA O stated they rolled Resident #30 so they could change her brief and Resident #30 kicked her in the chest. Student NA O said she grabbed Resident #30's legs and loosely put them beside her body to block her hitting and kicking. Student NA O stated she used her body to keep Resident #30 from hitting and kicking. Student NA O said CNA EE was shielding Resident #30's hands from hitting other staff by holding her hands. Student NA O stated they were holding her hands for protection. Student NA O said Resident #30 was yelling and cussing at them. Student NA O stated Resident #30 said they did not know what the fuck they were doing, and it only took one person to change her. Student NA O said Resident #30 was mad because of all the staff members in the room. Student NA O said she talked to Resident #30 after the incident and Resident #30 explained she only liked one person in the room with her. Student NA O said changing Resident #30 against her will could have been considered abuse or a restraint.<br><br>This was determined to be an Immediate Jeopardy (IJ) on 10/29/24 at 11:10 AM. The ADO was notified. The ADO was provided the IJ template on 10/29/24 at 11:13 AM.<br><br>The following plan of removal submitted by the facility was accepted on 10/29/24 at 5:11 PM and included the following:<br><br>Interventions<br><br>1. Resident #30 was assessed for emotional distress by the DON on 10/29/24. A trauma informed care assessment was completed on 10/29/24 by the DON. No additional emotional distress was noted. On 10/29/2024, DON completed a skin assessment and pain assessment with no negative findings.<br><br>2. The DON, and ADON were in-serviced 1:1 by the Regional Compliance Nurse on following topics below. The administrator is on paid time off. The administrator will be in-serviced prior to returning to work by the Area Director of Operations. Completed with DON and ADON on 10/29/24.<br><br>a. Abuse and Neglect to include not to hold a resident down while providing care at any time. If a resident is yelling stop, the staff members will stop and notify the charge nurse, DON, or Administrator for assistance and further direction.<br><br>b. Behavioral management policy- Explain care to be provided prior to providing the care. If the resident refuses care or becomes combative with care, stop attempting to perform the care being resisted, ensure the resident's safety allow the resident to calm down. Attempt the care at a later time or with different staff. Continued combativeness with care should be reported to the Charge nurse, Administrator and/or DON immediately.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | c. Restraint Policy- holding a resident against their will to provide care is considered a restraint.<br><br>3. The 4 staff members were in-serviced 1:1 by the DON and ADON on 10/29/24 on the following topics below.<br><br>i. Addendum - On 10/29/2204 ADO, DON, and ADON attempted to communicate with the 4 staff members via text and phone call. 2 of the 4 staff members verbally self-termed, 1 staff member was a no call no show for their shift on 10/29/2024 and is being termed and the 4th staff member is PRN and has not responded to text messages or phone calls. Images of the in-services have been texted to her and if she is to return to work she will be in serviced by DON or ADON prior to the start of her shift.<br><br>a. Abuse and Neglect to include not to hold a resident down while providing care at any time. If a resident is yelling stop, the staff members will stop and notify the charge nurse, DON, or Administrator for assistance and further direction.<br><br>b. Behavioral management policy- Explain care to be provided prior to providing the care. If the resident refuses care or becomes combative with care, stop attempting to perform the care being resisted, ensure the resident's safety allow the resident to calm down. Attempt the care at a later time or with different staff. Continued combativeness with care should be reported to the Charge nurse, Administrator and/or DON immediately.<br><br>c. Restraint Policy- holding a resident against their will to provide care is considered a restraint.<br><br>4. The medical director was informed of the immediate jeopardy citation on 10/29/24 by DON.<br><br>5. An ADHOC QAPI meeting was held on 10/29/24 to include the interdisciplinary team and medical director to discuss the immediate jeopardy citation and plan of removal.<br><br>In-services:<br><br>All staff will be in-serviced on 10/29/2024 for the following topics below by the ADO and Regional Compliance Nurse, DON, and ADON. All staff not present will not be allowed to assume their duties until in-serviced. All PRN staff will be in-serviced prior to their next assignments. All new hires will be in-service on their date of hire, during facility orientation. All agency staff will be in-serviced prior to the start of their assignment.<br><br>a. Abuse and Neglect to include not to hold a resident down while providing care at any time. If a resident is yelling stop, the staff members will stop and notify the charge nurse, DON, or Administrator for assistance and further direction.<br><br>b. Behavioral management policy- Explain care to be provided prior to providing the care. If the resident refuses care or becomes combative with care, stop attempting to perform the care being resisted, ensure the resident's safety allow the resident to calm down. Attempt the care at a later time or with different staff. Continued combativeness with care should be reported to the Charge nurse, Administrator and/or DON immediately.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | c. Restraint Policy- holding a resident against their will to provide care is considered a restraint.<br><br>On 10/30/24 the survey team confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by:<br><br>1. Record review of Resident #30's electronic medical record, reflected a new trauma informed care assessment dated [DATE] was completed. The assessment reflected Resident #30 had a history of trauma, was sexually assaulted, had been in a situation that was extremely frightening, had witnessed an extremely frightening situation, and did not feel comfortable explaining any of the situations.<br><br>2. Record review of Resident #30's skin assessment dated [DATE], reflected no injuries or skin concerns.<br><br>3. Record review of Resident #30's pain assessment dated [DATE], reflected no pain concerns.<br><br>4. Record review of the ADHOC QA meeting document dated 10/29/24, reflected the immediate jeopardy concerns were discussed with the plan of removal and monitoring. The Medical Director attended verbally and a copy of the plan was provided.<br><br>5. Record review of the in-service training attendance roster dated 10/29/24, reflected education was provided on behavior management to the DON and the ADON.<br><br>6. Record review of the in-service training attendance roster dated 10/29/24, reflected education was provided on restraints policy to the DON and the ADON.<br><br>7. Record review of the in-service training attendance roster dated 10/29/24, reflected education was provided on abuse and neglect polices to the DON and the ADON.<br><br>8. Record review of the in-service attendance roster dated 10/29/24, reflected education was provided to all staff across all shifts and disciplines on the restraint policy. There were 47 staff signatures.<br><br>9. Record review of the in-service attendance roster dated 10/29/24, reflected education was provided on the restraint policy via telephone to twelve staff members across all shifts and disciplines.<br><br>10. Record review of the in-service attendance roster dated 10/29/24, reflected education was provided on abuse and neglect policies. There were 47 staff signatures from across all shifts and disciplines.<br><br>11. Record review of the in-service attendance roster dated 10/29/24, reflected education was provided on abuse and neglect policies via telephone to 11 staff members from across all shifts and disciplines.<br><br>12. Record review of the in-service attendance roster dated 10/29/24, reflected education was provided on the behavior management policy. There were 47 staff signatures from across all shifts and disciplines.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 13. Record review of the in-service attendance roster dated 10/29/24, reflected education was provided on the behavior management policy via telephone to 12 staff members from across all shifts and disciplines.<br><br>14. During a telephone interview on 10/30/24 at 9:48 AM, the Medical Director stated he was notified of the immediate jeopardy situation and attended a QAPI meeting via phone over the immediate jeopardy and subsequent plan of removal on 10/29/24.<br><br>15. During interviews on 10/30/24 between 9:16 AM and 11: 23 AM, Housekeeper M, Housekeeper CC, LA Y, the Housekeeping Supervisor, DA R, [NAME] DD, DM SS, Student NA O, Student NA Z, CNA N, CNA S, CNA V, MA BB, LVN A, LVN D, LVN L, LVN T, RN AA, PTA Q, COTA W, COTA X, OT P, OT U, the MDS Coordinator, the Human Resource Coordinator, Medical Records, the AD, the Maintenance Supervisor, the ADON, and the DON were able to verbalize they were provided in-service education on behavior management policy, restraint policy, and abuse neglect policies. The staff members were able to explain if residents were refusing care or became combative during care, they should stop providing care, ensure the resident was safe, and notify the charge nurse. The staff stated they could attempt care at a later time with a different staff member. The staff members stated holding a resident down against their will to provide care was considered a restraint. The staff members stated it could have also been considered abuse. The staff members were able to verbalize the different types of abuse, when to report abuse, and who the abuse coordinator was.<br><br>16. Record review of the personnel action form reflected CNA K was self-terminated effective 10/30/24.<br><br>17. Record review of the personnel action form reflected CNA EE was self-terminated effective 10/20/24.<br><br>The ADO was informed the IJ was removed on 10/20/24 at 11:54 AM. The facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892<br><br>Based on interview and record review the facility failed to ensure assessments accurately reflected the resident status for 1 of 23 residents (Resident # 47) reviewed for MDS assessment accuracy.<br><br>The facility failed to ensure Resident # 47's in and out self-catheterization (procedure used to empty the bladder by inserting a catheter, small tube, into the bladder to drain urine and immediately removed) was coded accurately on the Quarterly MDS Assessment with an ARD of 08/01/2024.<br><br>These failures could place residents at risk for not receiving care and services to meet their needs.<br><br>Findings included:<br><br>Record review of a face sheet dated 10/20/2024 indicated Resident #47 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included lumbar spina bifida without hydrocephalus (birth disorder involves the incomplete development of the spine), hemiplegia (one-sided paralysis or weakness), paraplegia (paralysis of the legs and lower body caused by a problem with the spinal cord or nerves), and urinary tract infection.<br><br>Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #47 was usually understood and understood others. The MDS assessment indicated Resident #47 had a BIMS of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #47 required substantial/maximal assistance with toileting and personal hygiene and partial/moderate assistance for showering/bathing and upper body dressing and was dependent for lower body dressing. Resident #47's MDS assessment indicated none of the above for indwelling catheter, external catheter, ostomy (opening created on the skin), intermittent catheterization.<br><br>Record review of Resident #47's Order Summary Report dated 10/30/2024 did not indicate an order for the Resident #47 to perform in and out catheterization.<br><br>Record review of the July 2024 Documentation Survey Report indicated Intervention/Task Catheter urine output was documented on 07/28/2024, 07/29/2024, and 07/31/2024.<br><br>Record review of Resident #47's progress note completed by the NP on 07/30/2024 indicated Resident #47 had neurogenic bladder (a condition where normal bladder function is disrupted due to nerve damage) in and out catheter daily.<br><br>During an interview and observation on 10/31/2024 starting at 10:02 AM, the DON said when she started in January of 2023 Resident #47 was doing in and out catheters. The DON said in the past, Resident #47 had a permanent suprapubic catheter, but now she completed the in and out catheterization through the opening in her belly button, incision in her belly button.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/31/2024 at 4:34 PM, the MDS Coordinator said she was responsible for completing the MDS assessment. The MDS Coordinator said she had not coded Resident #47's in and out self-catheterization on the MDS because she did not have proof Resident #47 used the catheter within the look back period. The MDS Coordinator said it was important for the MDS assessments to be coded accurately because she was painting a picture of what Resident #47 received, what her needs were, and it showed the residents baseline, consistency, and if they had declined.<br><br>During an interview on 11/01/2024 at 12:12 PM, the Regional Compliance Nurse stated they did not have a policy for MDS accuracy. They followed the RAI manual.<br><br>During an interview on 11/01/2024 at 12:44 PM, the ADO said if Resident #47 performed self-catheterization he expected for it to be accurately reflected on her MDS. The ADO said the MDS Coordinator was responsible for the MDS assessments, and he expected communication between the DON, ADON, and MDS nurse at the standards of care meeting for the MDS to be coded accurately. The ADO said it was important for the MDS to be accurate because it generated the level of care for the resident and they could be paid too much or too little, and the MDS assessment could trigger for something that was needed on the care plan.<br><br>Record review of the Resident Assessment Instrument Version 1.18.11, October 2023, indicated, .Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliance's A-D were used in the past 7 days H0100A, indwelling catheter (including suprapubic catheter and nephrostomy tube) H0100B, external catheter H0100C, ostomy (including urostomy, ileostomy, and colostomy) H0100D, intermittent catheterization H0100Z, none of the above.Self-catheterizations that are performed by the resident in the facility should be coded as intermittent catheterization (H0100D). This includes self-catheterizations using clean technique . |

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| | 675390 | A. Building<br>B. Wing | 11/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Sunflower Park Health Care | 1803 Highway 243 East<br>Kaufman, TX 75142 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892<br><br>Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan to meet resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for 4 of 23 residents (Resident #9, Resident #30, Resident #42, and Resident #47) reviewed for care plans.<br><br>1. The facility failed to ensure a care plan was developed and implemented for Resident #47's in and out self-catheterization (procedure used to empty the bladder by inserting a catheter, small tube, into the bladder to drain urine and immediately removed).<br><br>2. The facility failed to ensure Resident #30's care plan reflected her history of trauma.<br><br>3. The facility did not ensure that Resident #42's care plan included treatment for a wound on the right medial (toward the middle or center) thigh, which required wound care three times per week.<br><br>The facility did not ensure that Resident #42's care plan included treatment for wound on the right distal (away from the center of the body) medial (toward the middle or center) calf, which required daily wound care.<br><br>4. The facility did not ensure that Resident 9's care plan reflected a diagnosis of Diabetes Mellitus.<br><br>These failures could place the residents at increased risk of not having their individual needs met and a decreased quality of life.<br><br>Findings included:<br><br>1. Record review of a face sheet dated 10/20/2024 indicated Resident #47 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included lumbar spina bifida without hydrocephalus (birth disorder involves the incomplete development of the spine), hemiplegia (one-sided paralysis or weakness), paraplegia (paralysis of the legs and lower body caused by a problem with the spinal cord or nerves), and urinary tract infection.<br><br>Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #47 was usually understood and understood others. The MDS assessment indicated Resident #47 had a BIMS of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #47 required substantial/maximal assistance with toileting and personal hygiene and partial/moderate assistance for showering/bathing and upper body dressing and was dependent for lower body dressing. Resident #47's MDS assessment indicated none of the above for indwelling catheter, external catheter, ostomy (opening created on the skin), intermittent catheterization.<br><br>Record review of Resident #47's Order Summary Report dated 10/30/2024 did not indicate an order for the Resident #47 to perform in and out catheterization.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #47's care plan last reviewed 08/23/2024 did not indicate she completed in and out catheters.<br><br>During an observation and interview on 10/28/2024 at 3:23 PM, Resident #47 had 16 fr foley catheters on top of her bedside table and a urinal, no other supplies observed. Resident #47 said she performed her own in and out catheters.<br><br>During an interview and observation on 10/31/2024 starting at 10:02 AM, the DON said when she started in January of 2023 Resident #47 was doing in and out catheters. The DON said in the past, Resident #47 had a permanent suprapubic catheter, but now she completed the in and out catheterization through the opening in her belly button, incision in her belly button. The DON said she should have made sure Resident #47's care plan included she performed her own in and out catheter. The DON said Resident #47's care plan should have included the size of the catheter she used, equipment needed and the timing for it. The DON said she had not care planned it because it slipped my mind. The DON said that placed Resident #47 at risk for urinary tract infections.<br><br>During an interview on 11/01/2024 at 12:44 PM, the ADO said if Resident #47 performed self-catheterization he expected for it to be accurately reflected on her care plan. The ADO said the MDS Coordinator, or the DON were responsible for ensuring Resident #47's care plan included she performed in and out self-catheterization. The ADO said he expected for the care plan to accurately reflect the needs of the resident especially one that was high functioning enough to self-catheterize.<br><br>47006<br><br>2. Record review of the face sheet dated 10/29/24, reflected Resident #30 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included cerebral infarction (necrotic tissue in the brain), dementia (memory loss) with behavioral disturbances, essential hypertension (high blood pressure), and need for assistance with personal care.<br><br>Record review of the quarterly MDS assessment dated [DATE], reflected Resident #30 was understood by others and was able to understand others. The MDS reflected Resident #30 had a BIMS score of 10, indicating her cognition was moderately impaired. The MDS reflected Resident #30 had verbal behaviors and refused care daily. The MDS reflected Resident #30 was dependent on staff with toileting, showers, and personal hygiene. The MDS reflected Resident #30 was always incontinent of bowel and bladder.<br><br>During an interview on 10/28/24 beginning at 11:19 AM, Resident #30 reported that she had a history of trauma. Resident #30 stated she was kidnapped from her job, repeatedly sexually assaulted by multiple men, and almost murdered. Resident #30 stated she had reported her history of trauma to the facility staff.<br><br>Record review of Resident #30's comprehensive care plan reviewed 09/10/24, reflected no care plan or interventions to address her history of trauma.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 10/29/24 beginning at 4:29 AM, CNA K stated she was aware Resident #30 had a history of trauma. CNA K stated Resident #30 had told her the story of her traumatic event. CNA K stated she was unsure where to find out if residents had a history of trauma. CNA K stated she was unsure if she had access to the care plan. CNA K stated it was important to know if residents had a history of trauma to prevent re-traumatization during care.<br><br>During an interview on 10/29/24 beginning at 4:35 AM, CNA EE stated she was unsure if Resident #30 had a history of trauma because she was new to the facility. CNA EE stated she had only been employed by the facility for a few weeks. CNA EE stated she was unsure of where to find out if residents had a history of trauma. CNA EE stated she usually asked the nurses. CNA EE stated it was important to know if a resident had a history of trauma to prevent re-traumatization during care.<br><br>During an interview on 10/29/24 beginning at 4:38 AM, LVN LL stated she was not aware if Resident #30 had a history of trauma. LVN LL stated she looked in the chart at the progress notes or diagnosis or asked the ADON or DON to find out if residents had a history of trauma. LVN LL stated it was important to know if a resident had a history of trauma to prevent re-traumatization during care.<br><br>During an interview on 10/29/24 beginning at 5:00 AM, the DON stated she was unaware Resident #30 had a history of trauma until the past few weeks. The DON stated she expected a history of trauma to have been included in the care plan. The DON stated the Social Worker or MDS Coordinator was responsible for ensuring a resident's history of trauma was included in the care plan. The DON stated it was important to ensure trauma was included in care plan so staff would know the triggers to prevent re-traumatization.<br><br>During an interview on 10/30/2024 at 4:45 PM, the Social Worker said PTSD/trauma and the triggers were placed in the care plan by the MDS Coordinator. The Social Worker said it was important to include a resident's history of trauma and the triggers on the care plan so staff would understand the residents' behaviors.<br><br>43047<br><br>3. Record review of Resident #42's face sheet, dated 10/30/24, indicated Resident #42 was originally admitted to the facility on [DATE] with diagnoses which included PVD (narrowed blood vessels reduce blood flow to the limbs) and infection following a procedure, other surgical site, subsequent.<br><br>Record review of Resident #42's quarterly MDS, dated [DATE], indicated Resident #42 made himself understood and usually understood others. Resident #42's BIMS score was 10, which indicated his cognition was moderately impaired. The MDS reflected Resident #42 had surgical wounds with dressing orders.<br><br>Record review of Resident #42's comprehensive care plan, dated revised on 10/02/24 indicated Resident #42 had a post-surgical site to right medial thigh and right distal medial calf. The care plan interventions included, observe for s/s of infection, s/s of pain during treatment and medicate PRN per physician's order, and if skin become red around surgical site, alert nurse treat per facility protocol and notify MD, family. The care plan did not include the treatment to the wounds to Resident #38 right medial thigh and right distal medial calf.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the order summary report dated 10/30/24 indicated Resident #42 had an order with a start date 10/18/24 to apply collagen sheet (wound dressing), alginate calcium with silver and secure with island gauze with border to the right proximal thigh.<br><br>Record review of the order summary dated 10/30/24 indicated Resident #42 had an order with a start date 10/19/24 to cleanse area with normal saline, pat dry, apply santyl (wound ointment), cover with alginate calcium (wound dressing), and secure with island gauze with border on Saturday and Sunday to the right distal medial calf.<br><br>Record review of the order summary dated 10/30/24 indicated Resident #42 had an order with a start date 10/21/24 to cleanse area with normal saline, pat dry, apply santyl (wound ointment), cover with alginate calcium (wound dressing), and secure with island gauze with border on Monday, Tuesday, Wednesday, Thursday, and Friday to the right distal medial calf.<br><br>Record review of the WAR dated 10/01/24-10/31/24, indicated Resident #42's wound care to his post-surgical wound of the right distal, medial calf was to cleanse area with normal saline, pat dry, apply santyl (wound ointment), cover with alginate calcium (wound dressing), and secure with island gauze with border.<br><br>Record review of the WAR dated 10/01/24-10/31/24, indicated Resident #42's wound care to his post-surgical wound of the right proximal thigh was to apply collagen sheet (wound dressing), alginate calcium with silver and secure with island gauze with border.<br><br>4. Record review of Resident #9's face sheet, dated 10/30/24, indicated Resident #9 was originally admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar) with diabetic neuropathy (nerve damage that occur in people with diabetes).<br><br>Record review of Resident #9's quarterly MDS, dated [DATE], indicated Resident #9 usually made himself understood and understood others. Resident #9's BIMS score was 5, which indicated his cognition was severely impaired. Resident #9 had a diagnosis of Diabetes Mellitus that required insulin.<br><br>Record review of Resident #9's comprehensive care plan revised on 10/02/24 did not reflect Diabetes Mellitus.<br><br>Record review of the order summary dated 10/30/24 indicated Resident #9 had an order with a start date 09/16/23 to inject Novolin N Flex Pen (insulin) per sliding scale subcutaneously before meals related to Type Diabetes Mellitus.<br><br>Record review of the order summary dated 10/30/24 indicated Resident #9 had an order with a start date 07/10/24 for metformin 500 mg 1tablet by mouth two times a day related to Type 2 Diabetes Mellitus with diabetic neuropathy.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview and record review on 10/29/24 at 8:51 a.m., the MDS Coordinator stated she was responsible for ensuring the care plan reflected Resident #42's wounds. After reviewing Resident #42 care plan, the MDS Coordinator stated that was the care plan that was used to reflect Resident #42's wounds. The MDS Coordinator stated Resident #9's care plan should have reflected Diabetes Mellitus since Resident #9 was receiving insulin. The MDS Coordinator stated, It just got missed. The MDS Coordinator stated it was important to update the care plan at the time of the change in a resident's plan of care, to paint an accurate picture of the resident care and interventions on how to achieve goals.<br><br>During an interview on 11/1/24 at 12:00 p.m., the Regional Compliance Nurse stated the MDS Coordinator was responsible for ensuring the care plan reflected the resident's status. The Regional Compliance Nurse stated Resident #42's care plan should accurately reflect the current wounds to his right distal medial calf and right proximal thigh. The Regional Compliance Nurse stated Resident #9's care plan should accurately reflect his active diagnosis of Diabetes Mellitus with treatment. The Regional Compliance Nurse stated it was important to ensure the care plan was updated to ensure it accurately reflect the resident current situation.<br><br>Record review of an undated facility policy titled, Comprehensive Care Planning (Nursing Policy and Procedure Manual GP MC 03-18.0) reflected . the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The policy also reflected residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan . |

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| F 0680<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure the activities program is directed by a qualified professional.<br><br>46892<br><br>Based on interview and record review, the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional who completed a training course approved by the State for 1 of 1 facility reviewed for Activity Director qualifications.<br><br>The facility did not ensure the Activity Director was qualified to serve as the director of the activities program.<br><br>This failure could place residents at risk of not receiving a program of activities that meets their assessed activity needs.<br><br>Findings include:<br><br>Record review of a Personnel File Review Sheet, undated, indicated the Activity Director was hired on 10/14/2024.<br><br>During an interview on 10/29/2024 at 12:12 PM, the Activity Director said she started as the activity director on 10/17/2024, and she was not certified. The Activity Director said the Administrator had given her six months to obtain her activities certification. The Activity Director said Medical Records, the DON and ADON had been helping her schedule activities, but they were not certified either. The Activity Director said it was important for her to be certified so she had a basis to know what she needed to do, knew what needs the residents had, education on what she could and could not do for activities.<br><br>During an interview on 11/01/2024 at 1:00 PM, the ADO said the Activity Director was not monitored by anyone. The ADO said the Activity Director started a week ago or so, and she would be certified in a couple weeks. The ADO said the Activity Director should be certified because the state required it. The ADO said it was important for the Activity Director to be certified so she learned the necessary things during the certification process to do her job better.<br><br>During an interview on 11/01/2024 at 12:07 PM, a the facility's policy for activities was requested from the Regional Compliance Nurse and not received upon exit of the facility. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047<br><br>Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 2 of 23 residents (Resident #42 and Resident #51) reviewed for quality of care.<br><br>1. The facility did not ensure that LVN A and LVN OO followed physician orders for wound care on Resident #42's right distal (away from the center of the body) medial (toward the middle or center) calf.<br><br>2. The facility failed to ensure CNA N and Student NA Z reported to the charge nurse after Resident #51 had an unwitnessed fall on 10/16/24.<br><br>This failure could place residents at risk for decreased quality of care and injury.<br><br>Findings included:<br><br>1. Record review of Resident #42's face sheet, dated 10/30/24, indicated Resident #42 was originally admitted to the facility on [DATE] with diagnoses which included PVD (narrowed blood vessels reduce blood flow to the limbs) and infection following a procedure, other surgical site, subsequent.<br><br>Record review of Resident #42's quarterly MDS, dated [DATE], indicated Resident #42 made himself understood and usually understood others. Resident #42's BIMS score was 10, which indicated his cognition was moderately impaired. Resident #42 had surgical wounds with dressing orders.<br><br>Record review of Resident #42's comprehensive care plan, dated revised on 10/02/24 indicated Resident #42 had a post-surgical site to right distal medial calf. The care plan interventions included, encourage good nutrition/hydration to promote healthier skin, and if skin become red around surgical site, alert nurse treat per facility protocol and notify MD, family. The care plan did not address the wound to his right distal medial calf.<br><br>Record review of the order summary dated 10/30/24 indicated Resident #42 had an order with a start date 10/19/24 to cleanse area with normal saline, pat dry, apply santyl (wound ointment), cover with alginate calcium (wound dressing), and secure with island gauze with border on Saturday and Sunday to the right distal medial calf.<br><br>Record review of the order summary dated 10/30/24 indicated Resident #42 had an order with a start date 10/21/24 to cleanse area with normal saline, pat dry, apply santyl (wound ointment), cover with alginate calcium (wound dressing), and secure with island gauze with border on Monday, Tuesday, Wednesday, Thursday, and Friday to the right distal medial calf.<br><br>Record review of the WAR dated 10/01/24-10/31/24, indicated Resident #42's wound care to his post-surgical wound of the right distal, medial calf was to cleanse area with normal saline, pat dry, apply santyl (wound ointment), cover with alginate calcium (wound dressing), and secure with island gauze with border. The WAR was signed off by the Wound Care Nurse on 10/25/24.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the TAR dated 10/01/24-10/31/24, indicated Resident #42's wound care to his post-surgical wound of the right distal, medial calf was to cleanse area with normal saline, pat dry, apply santyl (wound ointment), cover with alginate calcium (wound dressing), and secure with island gauze with border. The WAR was signed off by LVN OO on 10/26/24 and LVN A on 10/27/24.<br><br>During an interview and observation on 10/28/24 at 11:41 a.m., reflected Resident #42 was lying in bed. Resident #42 had a dressing to his right distal, medial calf that was dated 10/25/24. Resident #42 stated his wound dressing was not changed over the weekend. Resident #42 stated he required daily wound care.<br><br>During an interview and observation on 10/28/24 at 11:46 a.m., reflected LVN B observed the dressing with the state surveyor to Resident #42's right distal, medial calf. LVN B stated the weekend charge nurses were responsible for providing care. LVN B stated the failure could potentially put Resident #42 at risk for sepsis (bloodstream infection).<br><br>During an interview on 10/28/24 at 1:15 p.m., LVN A stated she was the charge nurse for Resident #42 on 10/27/24. LVN A stated she thought she had done the wound care, but she was busy, so she guessed she forgot to do it. LVN A stated she had accidently clicked the task as completed on the TAR. LVN A stated the failure could potentially put Resident #42 at risk for an infection.<br><br>During an interview and observation on 10/28/24 at 5:00 p.m., reflected the Wound Care Nurse provided wound care to Resident #42 right distal, medial calf with the state surveyor. The wound did not have any adverse reaction. The Wound Care Nurse stated the charge nurses were responsible for ensuring wound care was done on the weekends and when the Wound Care Nurse was off. The Wound Care Nurse stated Resident #42 had a right lower extremity bypass on 06/24/24 and the surgical site became infected requiring multiple hospitalization s. The Wound Care Nurse stated the graft was removed as that was the source of reoccurring infection. The Wound Care Nurse stated the failure could potentially put Resident #42 at risk for an infection.<br><br>During an interview on 10/30/24 at 2:30 p.m., LVN OO stated she was the charge nurse for Resident #42 on 10/26/24. LVN OO stated she did notice on 10/26/24 Resident #42 had a dressing to his right calf that was dated 10/25/24. When asked why she did not perform wound care LVN OO stated, too busy passing medications. LVN OO stated she had accidently clicked the task as completed on the TAR. LVN OO stated the failure could potentially put Resident #42 at risk for an infection and a delay the healing process.<br><br>During a telephone interview on 10/31/24 at 4:00 p.m., the DON stated she expected residents wound care orders to be followed which included weekends. The DON stated the charge nurses were responsible for ensuring wound care was done on the weekends and when the Wound Care Nurse was off. The DON stated she was not aware wound care was not done on the weekends. The DON stated she expected the Wound Care Nurse to notify her when wound care was not performed. The DON stated not providing wound care could cause the wound to worsen leading to infection.<br><br>During an interview on 11/1/24 at 12:05 p.m., the Area Director of Operations stated his expectation was treatment was followed per physician's orders including the weekend. The Area Director of Operations stated the DON/ADON, and Wound Care Nurse were responsible for monitoring for compliance. The Area Director of Operations stated it was important for wound care to be performed per physician order, so the wound did not become worsens.<br><br>(continued on next page) |

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| Sunflower Park Health Care | 1803 Highway 243 East<br>Kaufman, TX 75142 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 47006<br><br>2. Record review of the face sheet dated 11/01/24, reflected Resident #51 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (brain disorder caused by a chemical imbalance in the blood that affects brain function, chronic obstructive pulmonary disease (lung disease that blood airflow and make it difficult to breathe), cerebrovascular disease (affect blood flow and the blood vessels in the brain), muscle weakness, and repeated falls.<br><br>Record review of the admission MDS dated [DATE], reflected Resident #51 was usually understood by others and was usually able to understand others. The MDS reflected Resident #51 had a BIMS score of 8, indicating her cognition was moderately impaired. The MDS reflected Resident #51 required partial/moderate assistance with showers, lower body dressing, personal hygiene, and toilet/shower transfer. The MDS reflected Resident #51 had 1 fall in the last month, 1 fall in the last 2-6 months, and 1 fall with a fracture in the last 6 months.<br><br>Record review of the comprehensive care plan revised on 10/16/24, reflected Resident #51 had multiple falls. The care plan interventions included: provide education to family/resident/care giver about safety reminders and what to do if a fall occurs and review information on past falls and attempt to determine cause falls.<br><br>Record review of the fall event note dated 10/16/24 signed by the DON, reflected Resident #51 had an unwitnessed fall in her room and was discovered on the floor next to the bed. The assessment indicated Resident stated she rolled out of the bed and had no injuries or pain sustained from the fall.<br><br>Record review of the fall risk assessment dated [DATE], reflected Resident #51 had a score of 13 indicating she was a high fall risk. The assessment reflected Resident #51 had 3 or more falls in the past 3 months, was chairbound, had balance problems while standing and walking, and had decreased muscular coordination.<br><br>Record review of the provider investigation report dated 10/23/24, reflected Resident #51 had reported to staff she had fallen out of the bed and laid on the floor for several hours. It was confirmed during the investigation that on the morning of 10/16/24, Resident #51 was found on the floor during shift change (approximately 6 AM) by CNA N and Student NA Z. The provider investigation report included a witness statement from CNA N that reflected she did not report Resident #51's unwitnessed fall to the nurse because Resident #51 begged and cried for the CNAs not to tell anyone.<br><br>During an interview on 10/29/24 beginning at 3:08 PM, Resident #51 stated she remembered the incident on 10/16/24 where she had fallen. Resident #51 stated she heard knocking several times and called out to ask who was there. Resident #51 said on the last knock she rolled in her bed to get up to answer the door but rolled out of her bed onto the floor. Resident #51 stated she was unsure how long she laid on the ground but said it felt like approximately 5 hours. Resident #51 stated she was finally helped back into bed by several CNAs. Resident #51 stated she had no injuries or pain from the fall.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/30/24 beginning at 2:15 PM, the MDS Coordinator stated she was talking with Resident #51 on 10/16/24 when she reported to her that she had fallen on the ground during the night and laid freezing for hours. The MDS Coordinator stated she remembered Resident #51 said the kids had been knocking which was why she fell . The MDS Coordinator stated Resident #51 reported not being able to get to her call light for assistance, so she waited for staff. The MDS Coordinator stated she immediately reported the incident to the Administrator and DON.<br><br>During an interview on 10/30/24 beginning at 2:55 PM, CNA C stated she worked during the early morning of 10/16/24. CNA C stated she last checked on Resident #51 around 3 AM. CNA C stated Resident #51 was lying in her bed asleep. CNA C stated Resident #51 had no complaints or issues during the night.<br><br>During an interview on 10/30/24 beginning at 3:04 PM, CNA N stated Resident #51 was found on the ground around shift change on 10/16/24. CNA N stated she grabbed Student NA Z to help her get Resident #51 off the ground. CNA N stated Resident #51 was upset. CNA N stated Resident #51 begged repeatedly for them not to say anything because she believed she would get kicked out of the facility. CNA N reported Resident #51 said she wasn't hurt and just slid onto the floor. CNA N stated when they assisted Resident #51 off the ground, they pulled her pants down to make sure she had no injuries. CNA N stated Resident #51's arms were chilly. CNA N stated she made the decision not to report the fall because CNA N believed she was not hurt. CNA N stated she knew better than to not report she just felt bad for Resident #51. CNA N stated Resident #51 had reported to other staff she had fallen, so when the Administrator called her about the fall, she confirmed Resident #51 was found on the floor at shift change. CNA N stated she was provided one on one in-servicing on reporting changes immediately regardless of the situation. CNA N stated it was important to ensure unwitnessed falls were reported immediately to the charge nurse so residents could be assessed immediately for injury. CNA N stated just because Resident #51 looked unhurt from the outside, did not mean she was not hurt internally.<br><br>During an interview on 10/31/24 beginning at 5:02 PM, Student NA Z stated CNA N came up to her and said Resident #51 was on floor crying. Student NA Z said she walked into Resident #51's room and she was begging them to help her up and not tell anyone because she did not want to get kicked out of the facility. Student NA Z stated she did not remember much but she did assist CNA N getting Resident #51 up from the floor. Student NA Z said Resident #51 had no skin tears bruising when they checked. Student NA Z said she should have reported the fall to the charge nurse. Student NA Z said it was important to report falls immediately so they could be assessed for injuries by the nurse.<br><br>During an interview on 11/01/24 beginning at 11:48 AM, the Regional Compliance Nurse stated the CNAs should have reported to the nurse immediately after a fall. The Regional Compliance Nurse said it was important to ensure falls were reported immediately so the charge nurse could assess the resident for pain, injuries, needs, or treatment.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/01/24 beginning at 12:01 PM, the DON stated it was reported on 10/16/24 that Resident #51 had an unwitnessed fall during the early morning. The DON stated she spoke with the CNA on duty the morning of the 10/16/24 who reported Resident #51 was last checked on at approximately 3-4 AM and was laying in her bed. The DON stated she believed Resident #51 had heard the knocking during the last round, tried to get up, and fell . The DON stated Resident #51 was found on the ground during shift change by CNA N and Student NA Z, who assisted her into the bed. The DON stated CNA N and Student NA Z did not report the fall when it happened. The DON stated she expected CNAs to report falls immediately to the charge nurse. The DON stated a resident should be assessed immediately after a fall. The DON stated CNAs were unable to perform an assessment. The DON stated reporting a fall was something CNAs should have known to do. The DON stated it was important to ensure falls were reported immediately to ensure proper assessments were completed and for continued monitoring for possible injuries.<br><br>Record review of an undated facility policy titled Physician Orders (Medical Records Manual 2015 MR 03-2. 02 a) reflected . to monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident<br><br>Record review of the undated facility policy titled Falls/Ambulation Difficulty did not reflect or address reporting falls. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006<br><br>Based on observation, interview, and record review the facility failed to ensure that the resident environment remained as free of accident hazards as was possible to prevent accidents for 1 of 20 residents (Resident #5) reviewed for accidents and hazards related to coffee burns.<br><br>The facility failed to follow the policy and procedure for preparing and temping coffee. On 10/02/24, Resident #5 spilt coffee on herself, which caused a second-degree burn (tissue damage to the outer layer of your skin and the second layer of your skin) to Resident #5's right upper thigh and lower abdomen.<br><br>The noncompliance was identified as PNC. The Immediate Jeopardy (IJ) began on 10/02/2024 and ended on 10/02/2024. The facility had corrected the noncompliance before the survey began.<br><br>This failure could place residents at an increased risk for serious burn injuries while drinking hot liquids.<br><br>The findings included:<br><br>Record review of the face sheet dated 10/29/24, reflected Resident #5 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a chronic, progressive brain disorder that affects movement and other systems of the body), dementia (memory loss), muscle weakness, and lack of coordination.<br><br>Record review of the quarterly MDS assessment dated [DATE], reflected Resident #5 was able to make herself understood and usually understood by others. The MDS reflected Resident #5 had a BIMS score of 1, indicating her cognition was severely impaired. The MDS reflected Resident #5 had bilateral (both) upper and lower extremity limited range of motion. The MDS reflected Resident #5 required partial/moderate assistance with eating, oral hygiene, and upper body dressing. The MDS reflected Resident #5 was dependent on staff with toileting, showering and personal hygiene.<br><br>Record review of the comprehensive care plan dated 10/02/24, completed post incident, reflected Resident #5 was at risk for burns due to impaired cognition and Parkinson's. The care plan interventions included: coffee and other hot liquids should not be served if over 140 degrees, resident to use a cup with lid, resident to wear clothing/lap protector when drinking hot liquids and should be seated in upright position with table or overbed table when hot liquids are being consumed.<br><br>Record review of the event nurses note dated 10/02/24 signed by the DON, reflected Resident #5 had a burn/blister, caused by coffee, tea, or other hot liquid, to her right upper thigh that occurred in the dining room. The note reflected under details of injury; Resident #5 had a superficial layer of skin peeled measuring 2.5cm x 1.3cm. The note reflected Resident #5 had cognitive impairment. The note reflected the nursing description of the event, which indicated . Resident was drinking coffee in the dining room and dropped coffee on herself. The note reflected the resident statement of event was I spilt my coffee. The note reflected new orders to cleanse are with normal saline, Silvadene cream twice a day.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of the hot liquid assessment dated [DATE], completed post incident, reflected Resident #5 had moderate to severe cognitive impairment and Parkinson's. The assessment reflected Resident #5 could not consume hot liquids/food without special interventions. The assessment reflected the interventions needed to decrease potential burns included: lids on cups, clothing/lap barrier, and should be seated in upright position with table or overbed table.<br><br>Record review of the self-reporting protocol/ad hoc QAPI dated 10/2/24, reflected the physician was notified and treatment was initiated, hot liquids assessment and care plans were updated for residents determined at risk, in-servicing was provided to dietary and nursing staff. The ad hoc QAPI reflected monitoring was initiated by the dietary manager at least 5 days per week.<br><br>Record review of the witness statement dated 10/02/24, signed by the DON, reflected I was notified by [Student NA Z] that [Resident #5] had spilt coffee on herself in the dining room. [Student NA Z] and I took her to the bathroom to get her changed and assessed her. I noticed a 2.5 cm x 1.3 cm red area. Notified NP and hospice immediately. Received new orders for Silvadene cream twice daily. I immediately went to the dining room to confiscate any coffee that had been poured for a resident. I took the coffee pot into the kitchen to allow it to cool down. At this time only residents in the dining room had been served coffee. No other residents had any spilt coffee on them at this time.<br><br>Record review of a list of residents identified at risk for hot liquid spills dated 10/02/24, reflected 21 residents (Resident's #3, #5, #6, #8, #17, #21, #23, #24, #25, #26, #36, #39, #41, #44, #45, #46, #48, #49, #109, #259, and #260) were at risk.<br><br>Record review of Resident's #3, #5, #6, #8, #17, #21, #23, #24, #25, #26, #36, #39, #41, #44, #45, #46, #48, #49, #109, #259, and #260 comprehensive care plan, dated 10/02/24 after the incident, reflected they were at risk for hot liquid spills and interventions were put in place.<br><br>Record review of Resident's #3, #5, #6, #8, #17, #21, #23, #24, #25, #26, #36, #39, #41, #44, #45, #46, #48, #49, #109, #259, and #260 hot liquids assessments, dated 10/02/24 after the incident, were completed.<br><br>Record review of the in-service training attendance roster dated 10/02/24, reflected education was provided on residents at risk for spills. There were 47 staff signatures from across all shifts and disciplines.<br><br>Record review of the in-service training attendance roster dated 10/02/24, reflected 1:1 education was provided to Cook, DD, [NAME] UU, [NAME] VV, [NAME] WW, DA H, DA XX, and DM SS regarding the coffee preparation steps, which included cooling the coffee down prior to serving.<br><br>Record review of the in-service training attendance roster dated 10/02/24, reflected all staff were provided education on reporting burns immediately to the abuse coordinator, DON, and charge nurse. There were 76 staff signatures from across all shifts and disciplines.<br><br>Record review of the in-service training attendance roster dated 10/02/24, reflected education was provided on if residents are demanding coffee, it cannot be served if not under 140 degrees. Notify administrator and DON of resident's demand. There were 26 staff signatures from across all shifts and disciplines.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of the in-service training attendance roster dated 10/02/24, reflected education was provided on hot liquids and food spills. There were 76 staff signatures from across all shifts and disciplines.<br><br>Record review of the in-service training attendance roster dated 10/02/24, reflected education was provided on abuse and neglect. There was 76 staff signatures from across all shifts and disciplines.<br><br>During an observation and interview on 10/28/24 beginning at 11:33 AM, DA H performed a temperature check on the coffee. The coffee temperature was 136.6 degrees Fahrenheit. DA H stated she was unable to serve coffee above the temperature of 140 degrees Fahrenheit. DA H stated the kitchen had a process for preparing the coffee that had to be followed. DA H stated she was provided 1:1 in-service training on preparing the coffee and making sure the coffee was at or below 140 degrees F prior to serving.<br><br>During an observation and attempted interview on 10/28/24 beginning at 4:13 PM, Resident #5 was lying in her bed. Resident #5 was unable to answer questions appropriately as evidenced by confused conversations.<br><br>During an interview on 10/28/24 beginning at 5:02 PM, the DON stated the incident on 10/02/24 with Resident #5 happened early in the morning during breakfast time. The DON stated staff were still getting residents into the dining room. The DON said a student nurse was looking for Resident #5 and found her in the dining room fanning her pants, which were wet. The DON stated she was immediately notified by the student nurse and immediately took Resident #5 for an assessment. The DON stated she observed a burn on her leg which appeared to have the top layer of skin missing. The DON stated she notified Resident #5's family member and physician. The DON stated she thought the coffee had to have been too hot, so she into the dining room and removed all the coffee. The DON stated she temped the coffee at 158 degrees F, so she had the dietary staff remake the coffee and follow the coffee preparation process until the temperature was at or below 140 degrees F. The DON said the coffee preparation process was in place prior to the incident and should have been followed. The DON stated she identified all other residents at risk for burns from hot liquids. The DON said she performed new hot liquid assessments and updated the plan of care for each resident identified at risk. The DON stated residents were identified as being at risk for burns from hot liquids by observations such as increased shaking, ROM difficulties, or contractures. The DON stated in-servicing was provided to the staff on residents who were at risk, which included the interventions in place to prevent burns. The DON said 1:1 in-serving was provided to dietary staff on coffee preparation process, coffee temperatures, and temperature logs.<br><br>During an observation and interview on 10/29/24 beginning at 5:32 AM, DM SS prepared the coffee. DM SS brewed the coffee and then added ice until the temperature in the coffee cup was below 140 degrees F. The final temperature was at 124 degrees F. DM SS stated he did not normally prepare the coffee but was helping out this morning.<br><br>During an interview on 10/29/24 beginning at 8:05 AM, CNA E stated Resident #5 did not drink coffee routinely. CNA E stated when Resident #5 requested coffee she had to have a lid on her cup, a cover on her lap, and she must be sitting upright. CNA E stated there was a list of residents at risk for spills from hot coffee and interventions in place. CNA E stated she could also find the information in the plan of care.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During interviews on 10/30/24 between 9:16 AM and 11: 23 AM, Housekeeper M, Housekeeper CC, LA Y, the Housekeeping Supervisor, DA R, [NAME] DD, DM SS, Student NA O, Student NA Z, CNA N, CNA S, CNA V, MA BB, LVN A, LVN D, LVN L, LVN T, RN AA, PTA Q, COTA W, COTA X, OT P, OT U, the MDS Coordinator, the Human Resource Coordinator, Medical Records, the AD, the Maintenance Supervisor, the ADON, and the DON were able to verbalize they were provided in-service education on how to identified residents at risk for coffee burns. The staff members were able to verbalize who was at risk for burns from hot liquids and where to find out interventions needed. The staff said there were to report coffee burns immediately to the abuse coordinator, DON, and charge nurse. The staff verbalized coffee should not have been served over 140 degrees F. The staff said if Residents demanded hotter coffee, it should have been reported to the Administrator and DON. The staff verbalized coffee burns could have been considered neglect. DA R, [NAME] DD, DM SS were able to verbalize to correct steps for preparing the coffee.<br><br>During an interview on 11/01/2024 beginning at 8:50 AM, DM SS stated he was not in the facility for the coffee incident with Resident #5. DM SS stated the nursing department handled the situation. DM SS stated he was provided education on the coffee preparation process. DM SS stated he expected his staff to follow the coffee preparation process. DM SS stated coffee should not have been served until the temperature was at 140 degrees F or below. DM SS said coffee temperatures were documented in the coffee temperature log. DM SS stated it was important to ensure coffee was served at the correct temperature to prevent coffee burns.<br><br>During an interview on 11/01/24 beginning at 11:42 AM, the ADO stated Resident #5 had a burn from a coffee spill on 10/02/24. The ADO stated immediate action was taken to correct the noncompliance and monitoring was put into place to prevent further incidents. The ADO stated education was provided on the coffee preparation process and coffee temperatures. The ADO stated a process was in place prior to the incident and it was not followed. The ADO stated he expected the facility staff to follow the coffee preparation process and coffee should not have been served unless it was at or below 140 degrees F. The ADO stated it was important to ensure coffee was served at the appropriate temperatures to prevent burn injuries related to hot liquid spills.<br><br>Record review of the hot liquid / food spills policy, undated, reflected residents are at risk of having any hot liquid/food spilled on their person causing burns .if any staff member observes a resident spill hot liquid or food on themselves or another resident, the staff member will attempt to dissipate the heat of the item spilled with at least a liquid that is at a temperature of room temperature or below, by pouring the room temperature of cooler liquid directly on the area affected . the charge nurse is to be immediately notified so that an assessment of the resident can be completed .the charge nurse will report any injury to the attending physician and responsible party and follow any further physician orders .staff will assist with changing of clothes as needed . an incident report and investigation will then be completed and determine if the resident needs further intervention and prevent future occurrences .<br><br>Record review of the coffee preparation steps, undated, reflected coffee temperature will be obtained during the coffee preparation process, ice will be added until the temperature is at or below 140 degrees F. When the temperature is at or below 140 degrees F it may be served and recorded on the temperature log. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892<br><br>Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of the bladder and had an indwelling urinary catheter received appropriate treatment and services for 1 of 2 residents (Resident #47) reviewed for urinary catheters.<br><br>The facility failed to ensure Resident #47 was provided proper supplies to perform in and out self-catheterization (procedure used to empty the bladder by inserting a catheter, small tube, into the bladder to drain urine and immediately removed).<br><br>This failure could place residents at risk of urinary tract infections and a decreased quality of life.<br><br>Findings included:<br><br>Record review of a face sheet dated 10/20/2024 indicated Resident #47 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included lumbar spina bifida without hydrocephalus (birth disorder involves the incomplete development of the spine), hemiplegia (one-sided paralysis or weakness), paraplegia (paralysis of the legs and lower body caused by a problem with the spinal cord or nerves), and urinary tract infection.<br><br>Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #47 was usually understood and understood others. The MDS assessment indicated Resident #47 had a BIMS of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #47 required substantial/maximal assistance with toileting and personal hygiene and partial/moderate assistance for showering/bathing and upper body dressing and was dependent for lower body dressing. Resident #47's MDS assessment indicated none of the above for indwelling catheter, external catheter, ostomy, intermittent catheterization.<br><br>Record review of Resident #47's care plan last reviewed 08/23/2024 indicated she had a urinary tract infection to encourage adequate fluid intake, give antibiotic therapy as ordered and monitor/document for side effects and effectiveness, give antipyretics (medications that reduce fever), analgesics (medication for pain relief) and antispasmodics (muscle relaxers used for bladder and gut issues) as ordered/PRN and monitor/document for side effects and effectiveness, monitor intake and output, provide incontinent care as needed, and resident/family/caregiver teaching should include: good hygiene practices females to wipe and cleanse from front to back, clean peri area well after bowel movement in order to help prevent bacteria in urinary tract, void at first urge. do not hold urine for extended amount of time, wear clean underwear daily, take the full course of antibiotic therapy even if much improved after a few days of therapy. The care plan indicated Resident #47 had bladder incontinence. Resident #47's care plan indicated she had an ADL self-care deficit and required assistance of 2 staff for bathing, bed mobility and toilet use. Resident #47's care plan did not indicated she completed in and out catheters.<br><br>Record review of Resident #47's Order Summary Report dated 10/30/2024 did not indicate an order for the Resident #47 to perform in and out catheterization.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #47's progress note completed by the NP on 07/30/2024 indicated Resident #47 had neurogenic bladder (a condition where normal bladder function is disrupted due to nerve damage) in and out catheter daily.<br><br>Record review of Resident #47's urine culture dated 06/25/2024 indicated proteus mirabilis (bacteria) colony count >100,000.<br><br>Record review of Resident #47's emergency department visit arrival date 08/21/2024 indicated diagnosis of urinary tract infection.<br><br>During an observation and interview on 10/28/2024 at 3:23 PM, Resident #47 had 16 fr foley catheters on top of her bedside table and a urinal, no other supplies such as gloves, hand sanitizer, cleansing wipes or swabs were observed. Resident #47 said she performed her own in and out catheters. Resident #47 said the staff had only been giving her the foley catheters.<br><br>During an interview on 10/30/2024 at 3:53 PM, LVN L said Resident #47 completed her own in and out catheters. LVN L said Resident #47 should have a physician's order for it. LVN L checked Resident #47's electronic health record and said she could not find the physician's order, but maybe I am not looking in the right place. LVN L said she would have the DON check on it. LVN L said it was important for Resident #47 to have an order for the in and out catheters so they knew not to provide care for the resident and so they could make sure Resident #47 had the supplies she needed.<br><br>During an observation and interview on 10/30/2024 at 4:14 PM, Resident #47 said the nurses had not provided her with teaching regarding her doing her own in and out catheter. When asked how she completed the in and out catheter, Resident #47 said she just did it and motioned she grabbed the catheter inserted it, let the urine drain into a urinal she has at bedside, and removed it. Resident #47 did not indicate she performed hand hygiene or wiped the site of insertion prior to insertion. Resident #47 only had the in and out catheters and urinals at bedside.<br><br>During an interview on 10/30/2024 at 4:30 PM, the DON said Resident #47 should have an order to perform in and out catheters on herself. The DON said the nurse that received the order for the in and out catheter should have put it in Resident #47's electronic medical record. The DON said Resident #47's in and out catheterization was ordered by the urologist, and she was provided the documents and should have ensured the order was put in, but she missed it. Regarding education provided to Resident #47 for her to complete in and out catheter on herself the DON said Resident #47 was doing it at home. The DON said Resident #47 had been doing it at home, and any teaching they would have provided would have been completed when they received the order. The DON said in the past, she had observed Resident #47 perform an in and out catheter on herself and she had done it properly. The DON said it was important for Resident #47 to have an order to perform self-catheters so the nurses knew how to properly take care of the resident, and without the order they may not have the supplies she needed or be unaware that was how she was urinating. The DON said Resident #47 should have hand sanitizer, gloves, cleaning swabs within reach so she could perform her own in and out catheter.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/31/2024 at 9:26 AM, LVN A said she was not aware Resident #47 did not have gloves, hand sanitizer, and cleansing supplies for her in and out catheter. LVN A said she had not been checking Resident #47's room to ensure she had the proper supplies. LVN A said she had not provided Resident #47 teaching regarding properly performing in and out catheter because Resident #47 had been doing it on herself since before she admitted to the facility. LVN A said she was not able to provide Resident #47 education on the in and out catheter because she herself had not been educated on the type of teaching she needed to be providing Resident #47. LVN A said it was important for Resident #47 to be educated and perform in and out catheters properly to prevent urinary tract infections.<br><br>During an interview on 10/31/2024 at 9:46 AM, the Treatment Nurse said she had observed Resident #47 self-catheter and had educated her on ensuring she was using hand sanitizer and gloves. The Treatment Nurse said when she performed her weekly skin assessments on Resident #47's she reminded her to hand sanitize before she used the in and out catheter. The Treatment Nurse said she did not have documentation to show she had completed teaching with Resident #47 regarding the in and out catheter. The Treatment Nurse said it was important for Resident #47 to use proper hand hygiene and technique when she performed the in and out catheter to prevent urinary tract infections.<br><br>During an interview and observation on 10/31/2024 starting at 10:02 AM, the DON said when she started in January of 2023 Resident #47 was doing in and out catheters. The DON said in the past, Resident #47 had a permanent suprapubic catheter (catheter in incision created in the belly to drain urine from the bladder), but now she completed the in and out catheterization through the opening in her belly button, incision in her belly button. The DON said when Resident #47 performed in and out catheterization she was supposed to hand sanitize, put on gloves, clean the insertion site, change gloves, insert the catheter, let the urine run out, cleanse any residue off, and wash her hands. The DON said Resident #47 had a 3-tier clear plastic storage container in her room with the supplies she needed. The DON said the last time she had checked the supplies in Resident #47's room was in September 2024. An observation of the storage container was made with the DON. The storage container did not have catheter supplies and was out of Resident #47's reach. Resident #47's personal items were in the 3-tier storage container. The DON said the catheter supplies should have been within Resident #47's reach. The DON said ultimately, she was responsible for ensuring the staff was providing Resident #47 with the catheter supplies she needed, but it was also a team effort. The DON said the nurses should have been checking daily to ensure Resident #47 had the supplies she needed available.<br><br>During an interview on 11/01/2024 at 12:48 PM, the ADO said if Resident #47 was going to use a catheter on herself the facility needed to provide her the tools to do everything, which included the proper tools to clean and providing her help. The ADO said the nurses and CNAs were responsible for ensuring Resident #47 had the necessary supplies and proper teaching. The ADO said not providing the proper supplies, and teaching placed her at risk for urinary tract infections and infections.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the facility's policy titled, Catheter Insertion, Male/Female, indicated, Female and male catheterization is the insertion of a catheter into the urinary bladder via the urethra to drain the bladder of urine. Catheterization can be performed using straight catheter to drain urine from the bladder and then removing .Sterile technique is utilized as the bladder is a sterile cavity and infection associated with catheterization is common .Perform suprapubic catheterization: Put on gloves. Place the sterile drape over the suprapubic opening to the bladder. Hold the suprabuic [sic] opening with the nondominant hand and cleanse from the opening outward in a circular motion with antiseptic swabs or cotton balls with an antiseptic held with a forceps. Pick up the catheter four inches from the tip. Place the end in the basin to collect the urine and insert the lubricated catheter about 2 inche [sic] into the suprapubic opening. Avoid using any force during the insertion if resistance is met. Pinch catheter and collect a specimen if needed and then allow the urine to continue to flow into the basin until the bladder is empty if a single catheterization is being informed [sic] . |

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| F 0699<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006<br><br>Based on observations, interviews, and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 3 of 4 residents' (Resident's #2, #4, and #30) reviewed for trauma-informed care.<br><br>1. The facility failed to ensure Resident #30 was not held down and provided incontinent care while she was screaming and yelling stop, leave me alone on [DATE] by CNA K, CNA EE, Student NA FF, and Student NA O.<br><br>2. The facility failed to ensure Resident #30's history of being kidnapped, raped, and almost murdered was included on the care plan.<br><br>3. The facility failed to ensure Resident #30's potential triggers for re-traumatization were assessed and documented in the care plan.<br><br>4. The facility failed to ensure Resident #4's history of trauma and diagnosis of PTSD was reflected on her trauma screening.<br><br>5. The facility failed to ensure Resident #4's history of trauma and diagnosis of PTSD was included on the care plan, with her potential triggers for re-traumatization identified.<br><br>6. The facility failed to ensure Resident #2's trauma screening reflected her diagnosis of PTSD.<br><br>An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 11:13 AM. While the IJ was removed on [DATE] the facility remained out of compliance at a scope of patterned and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on abuse policies, behavior management policies, and restraint policies.<br><br>These failures could put residents at an increased risk for severe psychological distress due to re-traumatization.<br><br>The findings included:<br><br>1. Record review of the face sheet dated [DATE], reflected Resident #30 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included cerebral infarction (necrotic tissue in the brain), dementia (memory loss) with behavioral disturbances, essential hypertension (high blood pressure), and need for assistance with personal care.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of the quarterly MDS assessment dated [DATE], reflected Resident #30 was understood by others and was able to understand others. The MDS reflected Resident #30 had a BIMS score of 10, indicating her cognition was moderately impaired. The MDS reflected Resident #30 had verbal behaviors and refused care daily. The MDS reflected Resident #30 was dependent on staff with toileting, showers, and personal hygiene. The MDS reflected Resident #30 was always incontinent of bowel and bladder.<br><br>Record review of the comprehensive care plan revised on [DATE], reflected Resident #30 was resistive to care, refused nursing/CNA care frequently such as weights, incontinent care, medications, showers, vital signs, labs, and other care. The care plan interventions included: allow the resident to make decisions about treatment regimen, to provide sense of control; if resident resists with ADLs, reassure resident, ensure safety, leave, and return ,d+[DATE] minutes later and try again; and it was her choice to be changed or not when asked/offered by CNAs/nurses. The comprehensive care plan did not address Resident #30's history of trauma to include potential triggers for re-traumatization.<br><br>Record review of the social history assessment dated [DATE], reflected Resident #30 had a history of trauma. The assessment reflected Resident #30 had experienced a life-threatening illness, physical assault, physically threatened, sexually assaulted, and sexually threatened. The assessment reflected Resident #30 had been in and witnessed an extremely frightening situation. The assessment reflected Resident #30 reported at the age of 29 she was kidnapped from a store where she was working at. She states that two black men kidnapped, raped, and attempted to murder her. The FBI was involved, and she was found.<br><br>Record review of Resident #30's comprehensive monthly note dated [DATE] and created by the NP indicated . When seen last week, she reported an episode of abuse to me and other staff members. DON and Administrator notified. She was seen today while lying in bed. Pt initially started off calm and pleasant, then started yelling and cursing. In the midst of her yelling, she reported physical abuse again by staff and how she has pain in her [left] arm. Offered pain meds [medications] and scans, she refused and started yelling more .<br><br>Record review of Resident #30's progress note dated [DATE], reflected . Pt [patient] gets anxious and combative with nursing care. She has a history of being sexually assaulted by several males. She denies symptoms of PTSD (a mental and behavioral disorder that develops from experiencing a traumatic event). I cannot rule out post-traumatic stress disorder at this time .<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on [DATE] at 11:19 AM, Resident #30 stated she remembered an incident where she was held down and changed against her will. Resident #30 said she did not yell unless there was a reason. Resident #30 said she did not know the names of the staff members that held her down, but it was abuse. Resident #30 stated if anyone held you down, that was abuse. Resident #30 said she had bruising on her arm and her left shoulder was hurting. Resident #30 said the woman walked in and took her stuff, moved it to the side, grabbed her arm and twisted from the elbow to her wrist. Resident #30 stated the girls were not fired; they just were not allowed to come back into her room. Resident #30 stated she was kidnapped by two men, sexually assaulted, and almost murdered. Resident #30 said the two men came into the store and asked for some liquor. Resident #30 stated they followed her into the back and grabbed her. Resident #30 stated they placed a gun to her head and made her take off her clothing. Resident #30 stated she was raped for hours. Resident #30 said her brain shut off, but she remembered being by some water. Resident #30 said after they were done, they tried to make her get out of the car. Resident #30 said a short time later the FBI rescued her. Resident #30 said she knew if she got out of the car she would have been killed. Resident #30 said for the longest time she was unable to talk about the incident because her brain was trying to protect itself.<br><br>During an interview on [DATE] at 4:29 AM, CNA K stated she remembered an incident with Resident #30. CNA K stated she had only assisted with Resident #30's care on two occasions. CNA K stated on [DATE] she had just clocked into work when Student NA O requested assistance cleaning up Resident #30. CNA K stated herself, CNA EE, Student NA O, and Student NA FF were in Resident #30's room. CNA K stated they explained to Resident #30 she needed to be cleaned because she had bowel movement all over her. CNA K stated as soon as CNA EE moved Resident #30's fridge all hell broke loose. CNA K stated Resident #30 started screaming, cussing, hitting, and kicking staff. CNA K stated they had to clean her, so they held her down and continued cleaning her. CNA K stated Resident #30 kept yelling no, stop. CNA K stated Resident #30 told her she was hurting her when she was wiping. CNA K stated she apologized but explained she had to get her cleaned and a new brief placed on her. CNA K stated Resident #30 said she understood but kept yelling no, stop, leave me alone. CNA K stated normally when residents refused care or said no, she would stop performing care and come back at a later time. CNA K said she was told by the charge nurses that Resident #30 had to be changed twice a shift no matter what. CNA K stated she wanted to stop but felt like if she did not get Resident #30 changed, she would have gotten into trouble for disobeying. CNA K stated she was aware of Resident #30's history of trauma. CNA K stated Resident #30 told her the story of being kidnapped, raped, and almost murdered. CNA K stated changing someone against their will could have triggered re-traumatization, but she was told by the DON Resident #30 had to be changed. CNA K stated she would have done the same thing if she was changed against her will.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on [DATE] at 4:37 AM, CNA EE stated on [DATE] she was asked by Student NA O to assist with changing Resident #30. CNA EE stated she had only worked at the facility for one week at the time of the incident. CNA EE said from what she remembered, there was a lot of screaming and yelling from Resident #30 when she was changed. CNA EE stated the other staff members stated it was normal for Resident #30 to yell, scream, and become combative during care so they continued. CNA EE said she held her over from the left shoulder area and on her back. CNA EE stated Resident #30 was mostly yelling and screaming and not hitting much. CNA EE said Resident #30 was pushing against the railing to try and push herself away. CNA EE said if a resident refused care, started yelling no, or became combative they should have backed away and reported it to the charge nurse. CNA EE said they did not do that in Resident #30's case. CNA EE said 4 people were in the room and it was chaos. CNA EE stated she was unsure if Resident #30 had a history of trauma. Resident #30 said it was important to know if a resident had a history of trauma, but she was unsure where to find out if a resident had a history of trauma. CNA EE said she usually asked the nurse. CNA EE said continuing care for someone against their will, could have traumatized the resident.<br><br>During an interview on [DATE] at 4:38 AM, LVN LL stated Resident #30 refused to be changed most of the time. LVN LL said when Resident #30 refused care, the CNAs reported it to her, and she would have tried to talk Resident #30 into letting them help her. LVN LL said bargaining with Resident #30 works at times, but if she adamantly refused, then she would have documented it. LVN LL stated she was recently hired, and she was working her third shift. LVN LL said if Resident #30 refused care, she expected the CNAs to stop providing care and report it to her. LVN LL said CNAs should not have continued care if the resident refused, started yelling, or became combative. LVN LL said she was not aware if Resident #30 had a history of trauma. LVN LL said she found out if residents had a history of trauma by looking in the chart or asking staff. LVN LL said if Resident #30 had a history of trauma and was changed against her will, it could have caused re-traumatization.<br><br>During an interview on [DATE] at 5:00 AM, the DON stated Resident #30 had reported that she was held down and changed against her will. The DON stated 4 people were identified during the investigation, CNA K, CNA EE, Student NA O, and Student NA FF. The DON stated the CNAs reported they went into change Resident #30, and she became combative. The DON said the CNAs reported Resident #30 was not held down but when she became combative the CNAs blocked and protected themselves from her hitting and kicking. The DON said Resident #30 reported the Administrator she was assaulted in her 30's. The DON stated she was unaware of Resident #30's history of trauma until the incident occurred. The DON said Resident #30 being held down and changed against her will could have triggered her and caused re-traumatization. The DON stated the facility policy was to stop providing care if a resident was refusing or becoming combative. The DON stated staff should have left the room and came back at a later time to provide care. The DON stated no fault was identified during the investigation because the CNAs and NAs were doing their jobs. The DON stated Resident #30 went days refusing incontinent care to the point urine was running off her bed onto the floor. The DON stated they had tried different things to convince Resident #30 to allow staff to change her, but she continued to refuse care. The DON stated she told staff Resident #30 should have been changed at least once a shift. The DON stated it was important to respect the residents right to refuse care for multiple reasons, that included resident rights, injury, and traumatization.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on [DATE] at 8:10 AM, the psychiatric NP stated he was familiar with Resident #30. The psychiatric NP stated Resident #30 was on his services. The psychiatric NP said the staff reported Resident #30 was irritable and refused care. The psychiatric NP said when he visited with Resident #30, she was pleasant and in a good mood. The psychiatric NP stated Resident #30 reported no issues. The psychiatric NP stated Resident #30 did not want help or medications. The psychiatric NP stated Resident #30 reported a history of trauma, that included sexual assault on her initial evaluation but denied any PTSD symptoms. The psychiatric NP stated Resident #30 had depressive symptoms that included irritable mood and lack of motivation to care for herself. The psychiatric NP stated he had tried several antidepressant medications in the past and Resident #30 recently started sertraline (antidepressant). The psychiatric NP said Resident #30 recently reported an incident were staff held her down to change her. The psychiatric NP said that incident had the potential to cause PTSD symptoms related to her history of trauma. The psychiatric NP said that she was assessed for trauma and trauma triggers on initial evaluation but since Resident #30 denied symptoms of PTSD, they did not assess further. The psychiatric NP stated counseling and medications were the only interventions attempted at this time.<br><br>2. Record review of the face sheet dated [DATE], reflected Resident #4 was a [AGE] year-old female who originally admitted to the facility on [DATE] with diagnoses that included cerebral palsy (group of neurological disorders that affect a person's ability to move, balance, and maintain posture), intellectual disabilities (below average intelligence and set of life skills present before age 18), essential hypertension (high blood pressure), and post-traumatic stress disorder (disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event).<br><br>Record review of the quarterly MDS assessment dated [DATE], reflected Resident #4 was able to make herself understood and usually understood others. The MDS reflected Resident #4's had a BIMS score of 13, indicating her cognition was intact. The MDS reflected Resident #4 had no behaviors or refusal of care. The MDS reflected Resident #4 had an active diagnosis of PTSD.<br><br>Record review of Resident #4's comprehensive care plan, last reviewed on [DATE], reflected no care plan in place for her diagnosis of PTSD or history of trauma. The care plan did not address potential triggers for re-traumatization.<br><br>Record review of the social history dated [DATE], reflected Resident #4 had no diagnosis of PTSD or history of trauma.<br><br>Record review of the most recent psychiatric note dated [DATE], reflected Resident #4's diagnosis of PTSD was not addressed.<br><br>During an interview on [DATE] at 10:15 AM, Resident #4 said she had trauma related to being born with drugs in her system. Resident #4 said her family member molested her and poured drugs and alcohol down her. Resident #4 stated she was made to take care of her younger family members at the age of 10. Resident #4 said the facility staff were aware of her history of trauma.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 3. Record review of Resident #2's face sheet dated [DATE], indicated a [AGE] year old female who admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Cerebral palsy (also known as CP, a group of neurological disorders that affect a person's ability to move, balance, and maintain posture), diabetes mellitus type 2 (also known as diabetes, a chronic disease that occurs when the body has high blood sugar levels), Post-traumatic stress disorder (also known as PTSD, a mental health condition that can develop after someone experiences or witnesses a traumatic event),Depression (a mental health condition that can affect anyone, causing a persistent low mood and loss of interest in activities), and Anxiety( a feeling of fear, dread, and uneasiness that can be a normal reaction to stress).<br><br>Record review of Resident #2's annual MDS assessment dated [DATE], indicated Resident #2 was usually able to make herself understood and understood others. The MDS assessment indicated Resident #2 had a BIMS score of 06, indicating her cognition was severely impaired. The MDS assessment indicated Resident #2 had received insulin 7 days out of the 7-day look back period. The MDS assessment indicated Resident #2 had received a hypoglycemic medication within the last 7 days of the look back period.<br><br>Record review of Resident #2's comprehensive care plan dated [DATE] indicated Resident #2 had PTSD or other similar diagnoses related to memories from her childhood. The interventions were for staff to identify situation/event/images that trigger recollections of the traumatic event and limit the resident's exposure to these as much as possible, If the resident has escalated, if possible do not touch the resident unless absolutely necessary for resident's or others safety. Monitor for escalating anxiety, depression or suicidal thought and report immediately to the nurse.<br><br>Record review of Resident #2's physician order dated [DATE] revealed an order for [name] Psychiatric Services.<br><br>Record review of Resident #2's social history dated [DATE] completed by the social worker did not indicate any history of PTSD.<br><br>During an interview on [DATE] at 9:14 AM, Resident #2 said she had PTSD related to being verbally and mentally abused by her family member from the age of nine months old until she was [AGE] years old when her family member died . Resident #2 said she told one of the social workers at the facility when she was admitted , and she had also told some of the other staff about having PTSD.<br><br>During an interview on [DATE] at 4:45 PM, the Social Worker said he screened residents for a history of trauma on admission when he completed the social history. The Social Worker said if a resident had trauma or PTSD the DON asked him to complete a trauma assessment as needed. The Social Worker said he was responsible for checking the residents for trauma. The Social Worker said he also assessed for the triggers, and sometimes he put them in the notes because there was no column on the social history to add the triggers. The Social Worker said PTSD/trauma and the triggers were placed in the care plan by the MDS Coordinator. The Social Worker said it was important to assess for trauma and the triggers to understand the residents' behaviors. The Social Worker said Resident #2 had not reported her mother abusing her to him. The Social Worker was aware Resident #4 and Resident #30 had a history of trauma.<br><br>(continued on next page) |

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| | 675390 | A. Building<br>B. Wing | 11/01/2024 |

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| F 0699<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an attempted interview on [DATE] at 8:53 AM to obtain additional information, Student NA FF did not answer the phone. A brief message was left with call back number. No return call upon exit of the facility.<br><br>During an interview on [DATE] at 8:54 AM, Student NA O stated on [DATE] Resident #30 had asked for assistance with incontinent care. Student NA O stated it was only her second day on the job and she was not certified yet. Student NA O stated she was unable to find other staff members to assist her with changing Resident #30 during her shift. Student NA O stated the charge nurse told her she needed assistance. Student NA O stated at the end of her shift when the night shift arrived, she asked CNA K, CNA EE, and Student NA FF for assistance with changing Resident #30. Student NA O stated Resident #30 was upset it had taken so long to find assistance. Student NA O said as they started changing Resident #30, she became really upset. Student NA O said they just kept trying to encourage her. Student NA O said Resident #30 hit CNA K in the face a couple of times. Student NA O stated the rolled Resident #30 so they could change her brief and Resident #30 kicked her in the chest. Student NA O said she grabbed Resident #30's legs and loosely put them beside her body to block her hitting and kicking. Student NA O stated she used her body to keep Resident #30 from hitting and kicking. Student NA O said CNA EE was shielding Resident #30's hands from hitting other staff. Student NA O stated they were holding her hands for protection. Student NA O said Resident #30 was yelling and cussing at them. Student NA O stated Resident #30 said they did not know what the fuck they were doing, and it only took one person to change her. Student NA O said Resident #30 was mad because of all the staff members in the room. Student NA O said she talked to Resident #30 after the incident and Resident #30 explained she only liked one person in the room with her. Student NA O said Resident #30 had a history of trauma. Student NA O said changing Resident #30 against her will could have caused her to re-live her traumatic event.<br><br>During an interview on [DATE] at 4:37 PM, the MDS nurse said she did the comprehensive care plans. She said the social worker usually does the trauma care plans and they reviewed them during the care plan meetings. She said she did not realize Resident #2 and Resident #4's care plan was not specific to their trauma.<br><br>During an interview on [DATE] at 11:45 AM, the ADON said she was aware Resident#2 had trauma but did not know in full detail what the trauma was until this week ([DATE] until [DATE]) when she asked her what happened. She said she was not aware of who was supposed to do the care plan for trauma but said it needed to be on the care plan. She said it was important for the staff to know how to meet her needs.<br><br>Record review of the Trauma Informed Care policy, dated ,d+[DATE], reflected the intent of this requirement is to ensure that facilities deliver care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally- competent and account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization .facilities should use a multi-pronged approach to identifying a resident's history of trauma as well as his or her cultural preferences .include asking resident about triggers that may be stressors or may prompt recall of a previous traumatic event .facilities must identify triggers which may re-traumatize residents with a history of trauma The facility should collaborate with resident trauma survivors to develop and implement individualized interventions .trigger specific interventions should be identified .<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 11:10 AM. The ADO was notified. The ADO was provided the IJ template on [DATE] at 11:13 AM.<br><br>The following plan of removal submitted by the facility was accepted on [DATE] at 5:11 PM and included the following:<br><br>Interventions<br><br>1.Resident numbers #2, #4, and #30 were assessed for emotional distress by the DON on [DATE]. A trauma informed care assessment was completed for each resident on [DATE] by the DON. No additional emotional distress was noted for each resident. DON updated care plans for resident #2, #4 and #30 on [DATE]. DON documented trauma informed care interventions with identified triggers and assistance with avoidance on Care Plan and Kardex as of [DATE]. Residents #2, #4, and #30 are all receiving psych services. Residents #2, #4, and #30 were involved in setting interventions to reduce re-traumatization.<br><br>2. The DON, and ADON were in-serviced 1:1 by the Regional Compliance Nurse on following topics below. The administrator is on paid time off. The administrator will be in-serviced prior to returning to work by the Area Director of Operations. Completed with the DON and ADON [DATE].<br><br>a. Trauma Informed Care Policy- all residents with a history of trauma or a diagnosis of PTSD will be assessed for potential triggers and have their plan of care modified accordingly.<br><br>b. Abuse and Neglect to include not to hold a resident down while providing care at any time. If a resident is yelling stop, the staff members will stop and notify the charge nurse, DON, or Administrator for assistance and further direction.<br><br>c. Behavioral management policy- Explain care to be provided prior to providing the care. If the resident refuses care or becomes combative with care, stop attempting to perform the care being resisted, ensure the resident's safety allow the resident to calm down. Attempt the care at a later time or with different staff. Continued combativeness with care should be reported to the Charge nurse, Administrator and/or DON immediately.<br><br>d. Restraint Policy- holding a resident against their will to provide care is considered a restraint.<br><br>3. The 4 staff members were in-serviced 1:1 by the DON and ADON on [DATE] on the following topics below.<br><br>i. Addendum - On [DATE] ADO, DON, and ADON attempted to communicate with the 4 staff members via text and phone call. 2 of the 4 staff members verbally self-termed, 1 staff member was a no call no show for their shift on [DATE] and is being termed and the 4th staff member is PRN and has not responded to text messages or phone calls. Images of the in-services have been texted to her and if she is to return to work, she will be in-serviced by DON or ADON prior to the start of her shift.<br><br>a. Abuse and Neglect to include not to hold a resident down while providing care at any time. If a resident is yelling stop, the staff members will stop and notify the charge nurse, DON, or Administrator for assistance and further direction.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | b. Behavioral management policy- Explain care to be provided prior to providing the care. If the resident refuses care or becomes combative with care, stop attempting to perform the care being resisted, ensure the resident's safety allow the resident to calm down. Attempt the care later or with different staff. Continued combativeness with care should be reported to the Charge nurse, Administrator and/or DON immediately.<br><br>c. Restraint Policy- holding a resident against their will to provide care is considered a restraint.<br><br>4. The medical director was informed of the immediate jeopardy citation on [DATE] by DON.<br><br>5. An ADHOC QAPI meeting was held on [DATE] to include the interdisciplinary team and medical director to discuss the immediate jeopardy citation and plan of removal.<br><br>In-services:<br><br>All staff will be in-serviced on [DATE] regarding the following topics below by the ADO and Regional Compliance Nurse, DON, and ADON. All staff not present will not be allowed to assume their duties until in-serviced. All PRN staff will be in-serviced prior to their next assignments. All new hires will be in-service on their date of hire, during facility orientation. All agency staff will be in-serviced prior to the start of their assignment.<br><br>a. Abuse and Neglect to include not to hold a resident down while providing care at any time. If a resident is yelling stop, the staff members will stop and notify the charge nurse, DON, or Administrator for assistance and further direction.<br><br>b. Behavioral management policy- Explain care to be provided prior to providing the care. If the resident refuses care or becomes combative with care, stop attempting to perform the care being resisted, ensure the resident's safety allow the resident to calm down. Attempt the care at a later time or with different staff. Continued combativeness with care should be reported to the Charge nurse, Administrator and/or DON immediately.<br><br>c. Restraint Policy- holding a resident against their will to provide care is considered a restraint.<br><br>All clinical staff will be in-serviced on [DATE] regarding the following topic below by the ADO and Regional Compliance Nurse, DON, and ADON. All staff not present will not be allowed to assume their duties until in-serviced. All PRN staff will be in-serviced prior to their next assignments. All new hires will be in-service on their date of hire, during facility orientation. All agency staff will be in-serviced prior to the start of their assignment.<br><br>a. Trauma Informed Care - Definition of and locating triggers/interventions on Care Plan or Kardex.<br><br>On [DATE] the survey team confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by:<br><br>1. Record review of Resident #2, Resident #4, and Resident #30's electronic medial record, reflected a new trauma informed care assessment dated [DATE] was completed.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 2. Record review of Resident #2, Resident #4, and Resident #30's comprehensive care plan, reflected an updated plan of care to include potential triggers for re-traumatization was dated [DATE].<br><br>3. Record review of Resident #2, Resident #4, and Resident #30's Kardex, reflected the history of trauma and interventions in place to prevent re-traumatization.<br><br>4. Record review of Resident #2, Resident #4, and Resident #30's progress notes, reflected they were being seen by psychiatric services.<br><br>5. Record review of the ADHOC QA meeting document dated [DATE], reflected the immediate jeopardy concerns were discussed with the plan of removal and monitoring. The Medical Director attended verbally and copy of the plan was provided.<br><br>6. Record review of the in-service training attendance roster dated [DATE], reflected education was provided on trauma informed care to the DON, the ADON, and the Social Worker.<br><br>7. Record review of the in-service training attendance roster dated [DATE], reflected education was provided on behavior management to the DON and the ADON.<br><br>8. Record review of the in-service training attendance roster dated [DATE], reflected education was provided on restraints policy to the DON and the ADON.<br><br>9. Record review of the in-service training attendance roster dated [DATE], reflected education was provided on abuse and neglect polices to the DON and the ADON.<br><br>10. Record review of the in-service attendance roster dated [DATE], reflected education was provided to all staff on the restraint policy. There were 47 staff signatures.<br><br>11. Record review of the in-service attendance roster dated [DATE], reflected education was provided on the restraint policy via telephone to twelve staff members.<br><br>12. Record review of the in-service attendance roster dated [DATE], reflected education was provided to clinical staff on trauma informed care. There were 27 staff signatures.<br><br>13. Record review of the in-service attendance roster dated [DATE], reflected education was provided to clinical staff on trauma informed care via telephone to 5 staff members.<br><br>14. Record review of the in-service attendance roster dated [DATE], reflected education was provided on abuse and neglect policies. There were 47 staff signatures.<br><br>15. Record review of the in-service attendance roster dated [DATE], reflected education was provided on abuse and neglect policies via telephone to 11 staff members.<br><br>16. Record review of the in-service attendance roster dated [DATE], reflected education was provided on the behavior management policy. There were 47 staff signatures.<br><br>17. Record review of the in-service attendance roster dated [DATE], reflected education was provided on the behavior management policy via telephone to 12 staff members.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 18. During a telephone interview on [DATE] at 9:48 AM, the Medical Director stated he was notified of the immediate jeopardy situation and attended a QAPI meeting via phone over the immediate jeopardy and subsequent plan of removal on [DATE].<br><br>19. During interviews on [DATE] between 9:16 AM and 11: 23 AM, Housekeeper M, Housekeeper CC, LA Y, the Housekeeping Supervisor, DA R, [NAME] DD, DM SS, Student NA O, Student NA Z, CNA N, CNA S, CNA V, MA BB, LVN A, LVN D, LVN L, LVN T, RN AA, PTA Q, COTA W, COTA X, OT P, OT U, the MDS Coordinator, the Human Res[TRUNCATED] |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892<br><br>Based on observation, interview, and record review, the facility failed to ensure that licensed staff were able to demonstrate the specific competencies and skill sets necessary to care for resident's needs for 1 of 5 staff (CNA K) reviewed for competencies.<br><br>The facility failed to ensure CNA K was competent in infection control and providing incontinent care on 10/29/2024.<br><br>This failure could potentially affect residents by placing them at an increased and unnecessary risk of exposure to staff who lack the appropriate skills and competencies to provide safe care and minimize infections.<br><br>Findings included:<br><br>Record review of a face sheet dated 10/30/2024 indicated Resident #209 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of unspecified ovary (ovarian cancer) and chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system).<br><br>Record review of Resident #209's electronic medical record on 10/30/2024 indicated her MDS assessment had not been completed.<br><br>Record review of Resident #209's care plan with date initiated 10/26/2024 indicated she had bladder and bowel incontinence to check every two hours and assist with toileting as need and to provide peri care after each incontinent episode.<br><br>During an observation of incontinent care on 10/29/2024 starting at 4:37 AM, CNA K donned gloves, unfastened Resident #209's brief, placed a packet of wipes on top of Resident #209's bed, and pulled out wipes. CNA K cleaned Resident #209's front peri area and turned Resident #209 onto her side. CNA K touched the wipes packet with her dirty gloves and wiped Resident #209's back peri area. CNA K said she had finished wiping Resident #209. The Surveyor intervened due to residue of stool observed, and asked CNA K to wipe Resident #209 one more time. CNA K wiped Resident #209 again and residue of stool was noted on the wipe. CNA K said she had not completely cleaned Resident #209's back peri area and cleaned her again. CNA K finished cleaning Resident #209 and using her dirty gloves applied the clean brief and sheet. CNA K with her dirty gloves put on Resident #209's pants on, removed her dirty gloves, and repositioned Resident #209 and then performed hand hygiene. CNA K left Resident #209's room, disposed of the trash, and handed the packet of wipes to a different CNA who took the packet of wipes into another resident's room to provide care.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/29/2024 at 6:14 AM, CNA K said hand hygiene should be performed before they started and then after. CNA K said she only changed her gloves if they were visibly soiled with bowel movement. CNA K said that was the way she was taught by other staff at the facility. CNA K said nurse management had not watched her perform incontinent care or done any teaching with her on providing incontinent care since she started at the facility. CNA K said when performing incontinent care she used as many wipes as she could, and she thought she had wiped Resident #209 until she was clean. CNA K said she did not see any residual from the bowel movement on Resident #209. CNA K said she tried to look at the wipes after wiping to ensure there was no bowel movement left. CNA K said it was important to ensure the residents were cleaned properly because they could get any type of infection and urinary tract infections. CNA K said she was not sure how she was supposed to use the wipes. CNA K said most of the residents had their own packet of wipes in their rooms. CNA K said when she did orientation with the other CNAs, she watched them take the whole packet of wipes into the residents' rooms. Then they returned the packet of wipes to the clean linen cart to use it on other residents, so that's what she did. CNA K said taking the packet of wipes in the residents' rooms, touching it with dirty gloves, placing it on the residents' beds or bedside tables could cause infection because bacteria would be transferred. CNA K said a competency check was left at the facility for her to sign. CNA K said nurse management left it for her to sign, and nobody observed her providing the care listed on the competency check. CNA K said it was important for her competency check to be adequately completed so she knew how to correctly provide care to the residents.<br><br>During an interview on 11/01/2024 at 11:27 AM, the DON said she was responsible for monitoring the CNAs to ensure they were performing proper incontinent care. The DON said she performed random audits and competencies were completed upon hire and annually. The DON said the ADON was responsible for completing CNA K's competency. The DON said it was important for the staff competencies to be completed to ensure the CNAs provided proper care.<br><br>During an interview on 11/01/2024 at 12:12 PM, the ADON said the competencies were completed between the DON and herself. The ADON said she completed the competency checks by observing the staff first. The ADON said she had observed CNA K perform skills to complete her competency check. The ADON did not specify when she observed CNA K perform the skills to have a competency check completed. The ADON said she guessed she got too busy, and that was why she had not dated CNA K's competency check. The ADON said it would be ideal to date the competency checks when they were completed. The ADON said it was important to make observations of the staff performing skills and complete the competency checks to ensure they were doing things correctly.<br><br>During an interview on 11/01/2024 at 12:52 PM, the ADO said the staff competencies should be completed per protocol. He thought they should be completed upon hire, annually, and then as need to follow the policy. The ADO said the ADON and DON were responsible for completing the staff competencies. The ADO said it was important to complete the competencies to ensure they were hiring people that were sufficient to do the job they did. The ADO said it was important to observe the staff complete skills to ensure they were doing it correctly, and not making the observations of the skills placed residents at risk for inaccurate care and incorrect care performed.<br><br>Record review of an undated CNA Proficiency Audit for CNA K signed by the ADON indicated she had performed all skills satisfactory, which included female perineal care, handwashing, and infection control awareness.<br><br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/01/2024 at 12:07 PM, the facility's policy for staff competencies was requested from the Regional Compliance Nurse and not received upon exit of the facility. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879<br><br>Based on observation, interview, and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records are in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 1 storage area reviewed for expired and discontinued medications.<br><br>The facility failed to keep a record of the receipt of controlled medications awaiting disposition to allow accurate and periodic reconciliation.<br><br>This failure could place residents at risk for loss of prescribed medications and drug diversion.<br><br>Findings included:<br><br>During an observation and interview on [DATE] at 3:47 p.m., the following unlogged medications were observed in the controlled medications storage area waiting to be disposed of:<br><br>*Morphine/Diazepam supp 10mg/10mls-12 Supp,<br><br>*Diazepam 5mg/0.5ml - 30 tablets,<br><br>*Diazepam gel 10mg/1ml - 10 syringes,<br><br>*Diazepam 5mg/0.5ml - 7 syringes,<br><br>*Hydrocodone/APAP 7XXX,d+[DATE]mg -23 tabs,<br><br>* Morphine/Diazepam supp 10mg/10mls-12 Supp,<br><br>*Morphine 50mg/0.5mls- 18 syringes, and<br><br>*Diazepam 5mg/0.5ml - 20 syringes<br><br>The DON said her process when she reconciled medications that needed to be disposed of was as follows: the nurse that brought her the medications and herself signed off on the narcotic sheet indicating how much medication was left, the narcotic sheet was placed with the medication, and the medication and narcotic sheet was placed in the locked cabinet until the medication destruction was completed with the pharmacist. The DON said the medication log was not up to date. The DON said she had been busy and did not follow the policy of logging medications. The DON said she was responsible for logging the medication when it was brought to her. The DON said by not logging the medications there was a risk for medications to come up missing.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a phone interview on [DATE] at 3:00 p.m., the facility's Pharmacist said the DON was responsible for overseeing the expired or discontinued medications. She said when a nurse brought the DON either the discontinued or expired medication both nurses were to sign the narcotic sheet verifying the medication was correct. She said then the DON was responsible for logging it on the destruction sheet and keeping it under double lock until she came to destroy it.<br><br>During an interview on [DATE] at 12:52 p.m., the Regional Director of Operations said he expected the expired or discontinued narcotics to be given to the DON with the narcotic count sheet. The Regional Director of Operations said he expected the DON to log the narcotic medications as soon as possible and it was the DON's responsibility to ensure that was completed. The Regional Director of Operations said by not logging the medications there was a risk for medications to be taken, lost, or not destroyed properly.<br><br>Record review of the facility policy titled, Storage of Medication, from the Pharmacy Policy & Procedure Manual 2003, indicated Medications and biologicals are stored safely, securely, and properly following manufacturers recommendations or those of the supplier.<br><br>Record review of the facility policy titled, Ordering Scheduled II Controlled Medication by Pharmacy [NAME] 2003, indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt, and record keeping requirements in the facility, in accordance with federal and state laws and regulations. 6. Medications listed in Schedules II, III, IV, and V are stored under double lock in a locked cabinet or safe designated for that purpose, separate from all other medications. Alternatively, in a unit dose system, Schedule III, IV, and V medications may be kept with other medications in the cart however this is at the discretion of the consultant pharmacist and Director of Nursing, due to the possibility of abuse for any of the controlled drug categories. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879<br><br>Based on observation, interview, and record review, the facility failed to ensure that it was free from a medication error rate of 5 percent or greater. The facility had a medication error rate of 5.26 %, based on 2 errors out of 38 opportunities, which involved 2 of 4 residents (Resident #12 and #2) reviewed for medication administration.<br><br>1. The facility failed to ensure LVN B administered insulin correctly for Resident #12.<br><br>2. The facility failed to ensure LVN A administered insulin correctly for Resident #2.<br><br>These failures could place residents at risk for not receiving the intended therapeutic benefit of their medications or receiving them as prescribed, per physician orders.<br><br>Findings included:<br><br>Record review of Resident #12's face sheet dated 10/31/24, indicated a [AGE] year old female who admitted to the facility on [DATE] with diagnoses which included congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs), diabetes mellitus type 2 (also known as diabetes, a chronic disease that occurs when the body has high blood sugar levels), schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors), and chronic obstructive pulmonary disease (also known as COPD, a common lung disease that makes it difficult to breathe).<br><br>Record review of Resident #12's annual MDS assessment dated [DATE], indicated Resident #12 was usually able to make herself understood and understood others. The MDS assessment indicated Resident #12 had a BIMS score of 13, indicating her cognition was intact. The MDS assessment indicated Resident #12 had received insulin 7 days out of the 7-day look back period. The MDS assessment indicated Resident #13 had received a hypoglycemic medication within the last 7 days of the look back period.<br><br>Record review of Resident #12's comprehensive care plan revised on 09/25/23, indicated Resident #12 had Diabetes Mellitus. The care plan interventions included to give diabetes medication as ordered by the doctor.<br><br>Record review of Resident #12's order summary report dated 10/31/24, indicated Resident #12 had an order for the following:<br><br>*Insulin glargine 100unit/ml inject 34 units subcutaneously one time a day at bedtime for diabetes with a start dated of 10/30/24.<br><br>*Insulin lispro (Humalog)pen injector 100unit/ml inject per sliding scale: if 0 - 150 = 0 units if FSBS below 70 give OJ and sugar and recheck in 15 minutes, if not effective call NP/MD; 151 - 200 = 6 units; 201 - 250 = 8 units; 251 - 300 = 10 units; 301 - 350 = 12 units; 351 - 400 = 14 units If FSBS was over 400 Notify MD/NP, subcutaneously before meals and at bedtime with a start date of 12/20/23.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 10/29/24 at 6:23 a.m., LVN B checked Resident #12's blood sugar which revealed it was 168. LVN B came back to the cart, checked the order, and said she needed to administer 6 units of Humalog. LVN B dialed the Humalog insulin pen to 6 units and administered the 6 units to Resident #12. LVN B did not prime the insulin Humalog pen for Resident #12.<br><br>During an interview on 10/29/24 at 6:30 a.m., LVN B said she dialed Resident #12's Humalog pen to 6 to prime the pen and then to 6 again to give the insulin. This surveyor did not see LVN B prime the Humalog insulin pen and LVN B could not tell the surveyor when she primed the insulin pen. LVN B said she had to go and walked away.<br><br>2.Record review of Resident #2's face sheet dated 10/31/24, indicated a [AGE] year old female who admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Cerebral palsy (also known as CP, a group of neurological disorders that affect a person's ability to move, balance, and maintain posture), diabetes mellitus type 2 (also known as diabetes, a chronic disease that occurs when the body has high blood sugar levels), Post-traumatic stress disorder (also known as PTSD, a mental health condition that can develop after someone experiences or witnesses a traumatic event),Depression (a mental health condition that can affect anyone, causing a persistent low mood and loss of interest in activities), and Anxiety( a feeling of fear, dread, and uneasiness that can be a normal reaction to stress).<br><br>Record review of Resident #2's annual MDS assessment dated [DATE], indicated Resident #2 was usually able to make herself understood and understood others. The MDS assessment indicated Resident #2 had a BIMS score of 06, indicating her cognition was severely impaired. The MDS assessment indicated Resident #2 had received insulin 7 days out of the 7-day look back period. The MDS assessment indicated Resident #2 had received a hypoglycemic medication within the last 7 days of the look back period.<br><br>Record review of Resident #2's comprehensive care plan revised on 11/28/19, indicated Resident #2 had Diabetes Mellitus. The care plan interventions included to give diabetes medication as ordered by the doctor.<br><br>Record review of Resident #2's order summary report dated 08/01/23, indicated Resident #2 had an order for the following:<br><br>*Novolog (Insulin aspart's) pen injector 100 units/ml. Inject as per sliding scale: if 0 - 149 = 2 UNITS; 150 - 199 = 4 units; 200 -249 = 6 units; 250 - 299 = 8 units; 300 - 349 = 10 units; 350 - 449 = 12 units IF Blood Sugar over 450 notify the doctor or nurse practitioner, subcutaneously before meals for diabetes.<br><br>Record review of Resident #2's order summary report dated 10/15/24, indicated Resident #2 had an order for the following:<br><br>*Insulin glargine (Lantus)100unit/ml inject 20 units subcutaneously twice a day for diabetes.<br><br>During an observation on 10/29/24 at 7:12 a.m., LVN A checked Resident #2's blood sugar which revealed it was 92. LVN A came back to the cart, checked the order, and said she needed to give 2 units of Novolog. LVN A dialed the Novolog pen to 2 units and administered it. LVN A did not prime the insulin Novolog pen for Resident #2.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/29/24 at 7:30 a.m., LVN A said she did not prime the Novolog insulin pen before administering it to Resident #2. She said she was not aware she needed to prime the insulin pen first. She said she could see why it would be important to prime the insulin pen ensuring it was functional properly. She said she would prime the insulin pens going forward because she wanted to ensure the residents were receiving the correct dose of insulin.<br><br>During an interview on 11/01/24 at 11:45 a.m., the ADON said she was not aware that the insulin pens needed to be primed before given insulin. She said they had done training on insulin for the nurses, but they had not been educated on priming the insulin pens before use. The ADON reviewed the facility policy and said she would have to re-educate staff on priming the insulin pen. She said if the insulin pen were not working correctly the resident may not receive the correct dose which could cause their blood sugar levels to go up.<br><br>During an interview on 11/01/24 at 12:16 p.m., the DON said she expected nurses to give insulin correctly. The DON read the facility's policy on insulin pens and said she thought they only needed to be primed with the first dose. She said she would do an in-service about priming the insulin pens before each use. She said if the pen were malfunctioning then a resident might not receive the correct dose of insulin which could make their blood sugar level rise.<br><br>During an interview on 11/01/24 at 1:01 p.m., the Regional Director of Operations said if it was required for the nurses to prime the insulin pens, then he expected for the nurses to do it. He said they should follow the policy and nurse management was to ensure they were administrating insulin correctly. He said failure to give insulin as ordered could cause a resident insulin to increase.<br><br>Record review of the facility's policy titled, Physician Orders revised 2015, indicated The purpose was to monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident.<br><br>Written Orders by the Physician or Nurse Practitioner. 1. The Nurse will review the order and if needed contact the prescriber for any clarifications.<br><br>Record review of facility's policy titled, Insulin Pen Use by Pharmacy Policy & Procedure Manual 2003 revised 04/01/15, indicated Important information for the use of an insulin pen:<br><br>o Always attach a new needle before each use.<br><br>o Always perform the safety test before each injection.<br><br>o Do not select a dose or press the injection button without a needle attached.<br><br>o This pen is only for one resident's use<br><br>Step 1. Check the insulin.<br><br>A. Check the label on the pen to make sure you have the correct insulin.<br><br>Step 2. Attach the needle.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Step 3. Perform a Safety test A. Select a dose of 2 units by turning the dosage selector. B. Hold the pen with the needle pointing upwards. C. Tap the insulin reservoir so that any air bubbles rise towards the needle. D. Press the injection button in. Check if insulin comes out of the needle tip. Step 4. Select the dose. A. Check that the dose window shows 0 following the safety test. Step 5. Inject the dose. A. Insert the needle into the skin at a 90-degree angle. B. Deliver the dose by pressing the injection button all the way. The number in the dose window will return to 0 as you inject. C. Keep the injection button pressed all the way in and slowly count to 10 before you withdraw the needle from the skin. This ensures that the full dose will be delivered. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>46892<br><br>Based on observations, interviews, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 2 of 5 medication carts (Treatment Cart and Hall C Nurse Cart) and 1 of 1 medication room refrigerator reviewed for drugs and biologicals.<br><br>1. The facility failed to ensure the Treatment Nurse secured the facilities only treatment cart.<br><br>2. The facility failed to ensure Resident #12's Humalog (fast-acting insulin to control high blood sugar) insulin was dated when opened on Hall C's nurse cart.<br><br>3. The facility failed to ensure Resident #4's Lantus (Long-acting insulin that regulates blood sugar levels at a stable rate throughout the day) was dated when opened on Hall C's nurse cart.<br><br>4. The facility failed to ensure Resident # 14's Combivent Respimat inhaler (which is used to prevent bronchospasm (tightening and narrowing of the airways) in people with chronic obstructive pulmonary, was dated when opened on Hall C's nurse cart.<br><br>5. The facility failed to ensure Resident # 9's Albuterol solution (medication used to prevent and decrease symptoms of wheezing and trouble breathing), was dated when opened on Hall C's nurse cart.<br><br>6. The facility failed to ensure Resident # 42's Stiolto Respimat (an inhaler used to treat chronic obstructive pulmonary disease (COPD)medication), and Lispro (fast-acting insulin to control high blood sugar) were dated when opened on Hall C's nurse cart.<br><br>7. The facility failed to ensure Resident #24's Diazepam suppositories were removed from the medication room when it had expired on 09/2024.<br><br>These failures could place residents at risk of not receiving drugs and biologicals as needed, not receiving the therapeutic benefit of medications, adverse reactions to medications, or expired medications, medication misuse, and drug diversion.<br><br>Findings included:<br><br>1. During an observation and interview on 10/28/2024 starting at 12:32 PM, an unlocked treatment cart was observed at the nurse's station. Several residents were observed around the unlocked treatment cart. The Treatment Nurse was observed down the hallway and came to the treatment cart. The Treatment Nurse said she should have locked the treatment cart when she walked away from it, but she had rushed off and left it unlocked. The Treatment Nurse said with the treatment cart unlocked residents could get into things and get hurt.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 11/01/2024 at 11:43 AM, the DON said the facility had only one treatment cart. The DON said when they stepped away from the medication carts, they should lock them. The DON said the nurses were responsible for making sure they locked the carts. The DON said it was her job to in-service, educate, and remind them to lock their carts. The DON said on her daily rounds of the facility she spot check to ensure the carts were locked. The DON said if medications carts were unlocked the residents, or anybody could go into the cart and get whatever they wanted.<br><br>During an interview on 11/01/2024 at 12:43 PM, the ADO said he expected the nurses to lock their medication carts when they were not in use that way the residents did not snoop or take anything that could possibly injure or harm them. The ADO said nurse management was responsible for ensuring medication carts were locked. The ADO said anybody that walked by a cart should know it was not supposed to be unlocked. The ADO said if he saw it he would lock it and tell the nurse they need to make sure they locked it if it was not in use.<br><br>45879<br><br>2. During an observation on 10/29/24 at 8:29 a.m., Hall C's nurse's cart revealed Resident #12's Humalog insulin, Resident #4's Lantus insulin, Resident # 14's Combivent Respimat inhaler, Resident # 9's Albuterol solution, and Resident # 42's Stiolto Respimat and Lispro were all open and not dated.<br><br>During an observation of the medication room on 10/29/24 at 8:40 a.m., Resident #24's Diazepam suppositories was in the refrigerator and expired on 09/24.<br><br>During an interview on 10/29/24 at 8:45 a.m., LVN B said all medications should be dated when opened. She said the nurse who opened these medications should have put a date on each of them. LVN B said all nurses should be held accountable for ensuring medications were dated; she said including herself. She said if medications were given past the manufacturer or expiration date, then they may not be as effective.<br><br>During an interview on 11/01/24 at 11:42 a.m., the ADON said she expected the nurses to check their carts daily. She said the insulin. Albuterol solutions and inhalers should be dated when opened and discarded when expired. The ADON said the medication aide or nurse who opened the insulin and inhaler was responsible for dating it. The ADON said by not dating the inhalers when opened the staff would be unaware of when the inhalers expired. She said since these medications had a certain number of days before they would expire and if not given during those time frames, it could cause the medications not to be as effective.<br><br>During an interview on 11/01/24 at 12:16 p.m., the DON said she expected the nurses and medication aides to audit their carts at least weekly to check for expired medications. She said it was her responsibility to oversee that the carts were being audited. The DON said she expected the insulin and the inhaler to be dated when opened. She said whoever opened the insulin and the inhaler should have been responsible for dating them. She said expired medications should be removed from the cart. The DON said the residents were at risk for medications to be ineffective.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 01/11/24 at 5:44 p.m., the Regional Director of Operations said he did not expect any undated or expired medications on the medication carts or in the refrigerator. He said he expected the insulin pens, albuterol packages, and inhalers to be dated when opened and discarded after expiration days. The Regional Director of Operations said the resident was at risk of receiving expired medication that could be ineffective.<br><br>Record review of the facility's policy titled, Insulin Pen Use by Pharmacy Policy & Procedure Manual 2003 revised 04/01/15, indicated, To take the insulin pen out of cool storage you can use it for up to 28 days. Ensure that the pen was dated when placed into use. During this time, it can be safely kept at room temperature. Do not use it after this time.<br><br>Record review of the facility's policy titled, Recommended Medication Storage, revised 07/12, indicated, Medications that require an open date as directed by the manufacturer should be dated when opened in a manner that it was clear when the medication was opened.<br><br>Record review of the Storage of Medication policy from the facility's Pharmacy Policy & Procedure Manual 2003, indicated, .The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . Medication rooms, carts, and medication supplies are locked and attended by persons with authorized access . |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely, quality laboratory services/tests to meet the needs of residents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047<br><br>Based on interview and record review, the facility failed to ensure laboratory services were obtained to meet the needs of 2 of 8 residents (Resident #9 and Resident #49) reviewed for laboratory services.<br><br>1. The facility did not obtain a physician's ordered A1C (used to measure average blood sugar over the past three months) for Resident #9.<br><br>2. The facility failed to ensure Resident #49's potassium level (Potassium is a mineral and electrolyte that helps maintain the body's water and electrolyte balance. It is also important for nerve and muscle function) was drawn on 07/23/24.<br><br>These failures could place residents at risk of not receiving lab services as ordered and not managing medications at a therapeutic level.<br><br>Findings included:<br><br>1. Record review of Resident #9's face sheet, dated 10/30/24, indicated Resident #9 was originally admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar) with diabetic neuropathy (nerve damage that occur in people with diabetes).<br><br>Record review of Resident #9's quarterly MDS, dated [DATE], indicated Resident #9 usually made himself understood and understood others. Resident #9's BIMS score was 5, which indicated his cognition was severely impaired. Resident #9 had a diagnosis of Diabetes Mellitus that required insulin.<br><br>Record review of Resident #9's comprehensive care plan revised on 10/02/24 did not address Diabetes Mellitus.<br><br>Record review of the order summary report dated 10/30/24 indicated Resident #9 had an order, which was ordered on 06/03/24 for A1C every 3 months.<br><br>Record review of the order summary report dated 10/30/24 indicated Resident #9 had an order with a start date 09/16/23 to inject Novolin N Flex Pen (insulin) per sliding scale subcutaneously before meals related to Type Diabetes Mellitus.<br><br>Record review of the order summary report dated 10/30/24 indicated Resident #9 had an order with a start date 07/10/24 for metformin 500 mg 1tablet by mouth two times a day related to Type 2 Diabetes Mellitus with diabetic neuropathy.<br><br>Record review of Resident #9's electronic medical record indicated his last A1c was drawn on 07/09/24.<br><br>(continued on next page) |

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| Sunflower Park Health Care | 1803 Highway 243 East<br>Kaufman, TX 75142 |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a telephone interview on 10/31/24 at 4:00 p.m., the DON stated she unaware until state surveyor intervention Resident #9 was missing his October A1C. The DON stated Resident #9 was hospitalized back in October and she should have reviewed his discharge paperwork to ensure an A1C was drawn. The DON stated if she had of reviewed the paperwork and realized the A1C was not drawn she would have ordered the lab. The DON stated she monitored labs by reviewing the labs in the lab system to ensure a standing order for future lab draws was there and if not, the lab company was contacted. The DON stated it was important to ensure labs were drawn per the physician order to ensure continuity of care.<br><br>45879<br><br>2. Record review of Resident #49' face sheet dated 10/31/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Angelman syndrome (a genetic disorder that mainly affects the nervous system), protein-calorie malnutrition (protein calorie deficiency), severe intellectual disabilities (neurodevelopmental condition that affects cognitive and adaptive functioning, and begins before age 18), eating disorder, intermittent explosive disorder (impulse-control disorder characterized by sudden episodes of unwarranted anger).<br><br>Record review of Resident #49's quarterly MDS assessment dated [DATE], indicated Resident #49 was rarely understood and rarely understood others. The MDS assessment indicated Resident #49 had short term/long term memory problems and her cognition was severely impaired. The MDS assessment required substantial/maximal assistance with eating and upper body dressing. Resident #49 was dependent on staff with oral hygiene, toileting, showering, lower body dressing, and personal hygiene. The MDS assessment indicated Resident #49 was always incontinent of urine and bowel.<br><br>Record review of Resident #49's lab drawn on 07/15/24, indicated the physician requested a re-draw of potassium on 07/23/24. The lab result was 5.3 (normal range 3.5-5.1).<br><br>Record review of the care plan last reviewed 12/23/23 indicated Resident #49 had Seizure Disorder and on 01/04/24 indicated Resident #49 had a potential for fluid deficit. The interventions were to obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated.<br><br>Record review of Resident #49's electronic health record did not indicate a potassium level was drawn as ordered on 07/23/24.<br><br>During an interview on 10/31/24 at 3:25 p.m., the DON said she did not have any potassium lab results for Resident #49 from 07/23/24 until 10/31/24. She said they had a breakdown in the lab system and made a change as of August 2024. She said previously the doctor gave all his orders to the medical records person and she was scanning the orders into the electronic medical records without herself or the nurses reviewing them. She said since August 2024 all orders and labs come to her, and she checks and verifies that they have been done or completed. She said Resident #49's potassium lab was missed. She said she would get a potassium level drawn tomorrow (11/01/24). She said failure to have this lab drawn could cause circulation problems which could lead to cramps in your limbs and shortness of breath.<br><br>(continued on next page) |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/01/24 at 11:42 a.m., the ADON said she was not aware of Resident #49's potassium order. She said they usually looked at labs in the morning meetings and did not know how Resident #49's lab was missed. She said usually the doctor wrote the orders and either she or the DON would oversee them. She said labs should be drawn when ordered.<br><br>During an interview on 01/11/2024 at 5:10 p.m., the Regional Director of Operations said the labs were overseen by the nursing administration. He said he expected the labs to be drawn as ordered. The Regional Director of Operations said it was important to draw labs as ordered for the health of the resident.<br><br>During an interview on 11/01/24 at 12:16 p.m., the DON said they did not have a policy on labs, but they followed the physician order policy. She said lab was unable to draw Resident #49's lab this morning (11/01/24) and would try again at an unknown date.<br><br>Record review of the facility's policy titled, Physician's Orders, dated 2015 indicated, the purpose: To monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident.1. Nurse will receive the order and read the order back to the prescriber to ensure it is correct 3. The nurse will enter the order into PCC for the resident and select either verbal or telephone, depending on how the nurse received the order. 4. If the order requires documentation, it will be directed to the proper electronic administration record once the order is completed. 5. The receiving nurse will contact any other department or external facilities as required, i.e., dietary department, pharmacy, lab provider, x-ray provider, etc. 6. If the order requires documentation, it will be directed to the proper electronic administration record once the order is completed. 7. If the physician signs with wet ink, a telephone or verbal order will be generated by PCC and this order will be sent to the physician for signature. When returned, the order will be placed in the resident's clinical record. 8. If the physician signs electronically, no paper copy is required for signature. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>43047<br><br>Based on observations, and interviews the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 16 of 16 confidential residents reviewed for food and nutrition services.<br><br>The facility failed to ensure dietary staff provided food that was palatable and had an appetizing temperature on 10/29/24.<br><br>This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss.<br><br>Findings included:<br><br>During a confidential resident group meeting 16 residents stated the food was bland and always cold.<br><br>During an observation and interview on 10/29/24 at 11:59 a.m., the lunch tray was sampled by Dietary Manager SS and four surveyors. The sampled tray consisted of buttered noodles, which were lukewarm, carrots which were cool, and pork shank which tasted lukewarm. Dietary Manager SS stated the buttered noodles and pork shank tasted lukewarm and the carrots were cool. Dietary Manager SS puckered his lip when he tasted the honey roll, he stated the roll had a vinegary taste.<br><br>During an interview on 10/31/24 at 2:55 p.m., Dietary Manager SS stated he had not had any complaints regarding food being cold or food tasting different. Dietary Manager SS stated food complaints are usually brought to him by grievances. Dietary Manager SS stated he randomly go around and asked residents about the food and randomly sampled the food during one of the meals. Dietary Manager SS stated there had been complaints in the past, but he thought the issue was resolved. Dietary Manager SS stated it was important to ensure food was palatable and had an appetizing temperature to prevent weight loss.<br><br>During an interview on 10/31/24 at 5:06 p.m., the Regional Compliance Nurse stated there was not a policy regarding palatability of meals.<br><br>During an interview on 11/1/24 at 12:05 p.m., the Area Director of Operations stated he expected the meals to be palatable regarding temperature and taste. The Area Director of Operations stated the dietary department was responsible for ensuring meals were palatable. The Area Director of Operations stated a resident could potentially lose weight the foods were not appetizing.<br><br>47006 |

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| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879<br><br>Based on observation, interview, and record review, the facility failed to provide liquids consistent with the resident's needs, for 2 of 3 (Resident #49 and Resident #44) residents reviewed for liquid inconsistency, in that:<br><br>1. The facility failed to ensure staff served Resident #49 nectar-thickened tea during her lunch meal on 10/28/24.<br><br>2. The facility failed to ensure LVN D checked the lunch tray appropriately for Resident #44 who required nectar thick liquids.<br><br>This failure could place residents who have dysphagia at risk for aspiration.<br><br>Findings included:<br><br>1.Record review of Resident #49' face sheet dated 10/31/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Angelman syndrome (a genetic disorder that mainly affects the nervous system), protein-calorie malnutrition (protein calorie deficiency), severe intellectual disabilities (neurodevelopmental condition that affects cognitive and adaptive functioning, and begins before age 18), eating disorder, intermittent explosive disorder (impulse-control disorder characterized by sudden episodes of unwarranted anger).<br><br>Record review of Resident #49's quarterly MDS assessment dated [DATE], indicated Resident #49 was rarely understood and rarely understood others. The MDS assessment indicated Resident #49 had short term/long term memory problems and her cognition was severely impaired. The MDS assessment required substantial/maximal assistance with eating and upper body dressing. Resident #49 was dependent on staff with oral hygiene, toileting, showering, lower body dressing, and personal hygiene. The MDS assessment indicated Resident #49 was always incontinent of urine and bowel. The MDS assessment indicated Resident #49 had a mechanically altered diet.<br><br>Record review of Resident #49's comprehensive care plan revised on 01/04/24, indicated Resident #49 had a potential fluid deficit. The care plan interventions included to encourage the resident to drink fluids of choice, ensure the resident had fluids within reach, and ensure all beverages complied with the diet/fluid restrictions and consistency requirements.<br><br>Record review of Resident #49's comprehensive care plan dated 12/08/23, indicated Resident #49 had an order for thickened fluids. The care plan intervention indicated all resident fluids should be thickened to nectar consistency.<br><br>Record review of Resident #49's order summary report dated 10/29/24, indicated Resident #49 had the following orders:<br><br>*Regular diet pureed texture, nectar consistency, double portion with an order start date of 12/07/23.<br><br>(continued on next page) |

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| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 10/28/24 at 12:05 p.m., revealed Resident #49's meal ticket for lunch had a diet order for puree and nectar diet.<br><br>During an interview on 10/28/24 at 12:41 p.m., CNA E said she did not notice Resident #49's tea was not nectar consistency. She said she would have given it to Resident #49 if the surveyor did not intervene. She said she was not sure who checked the trays but assumed it was correct.<br><br>During an observation and interview on 10/28/24 at 12:42 p.m., the ADON looked at the tea and said it was not nectar consistent. The ADON took the tea back to the kitchen and asked for nectar thick tea. She said Resident #49 had an order for nectar thick liquids and should receive them to prevent choking.<br><br>During an interview on 10/28/24 at 12:44 p.m., DA H said she did not have the correct nectar thick liquid so he just eyeballed what the nectar consistency should look like. She said the container she had was one liter and she put 17 pumps into the tea. She said she was trained to follow the directions on the bottle but said she had been at the facility for a long time and felt she could just eyeball the thicket liquids. She said not serving the right consistency could choke a resident.<br><br>2. Record review of a face sheet dated 10/31/2024 indicated Resident #44 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's Disease (progressive disorder that affects the nervous system and the parts of the body controlled by the nerves causes unintended or uncontrollable movements) and dementia (deterioration of memory, language, and other thinking abilities).<br><br>Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #44 was rarely/never understood by others and was rarely/never able to understand others. The MDS assessment indicated Resident #44 had a short-term and long-term memory problem. The MDS assessment indicated Resident #44 was dependent on staff for all her ADLs. The MDS assessment indicated Resident #44 had a swallowing disorder which included loss of liquids/solids from mouth when eating or drinking and holding food in mouth/cheeks or residual food in mouth after meals. The MDS assessment indicated Resident #44 required a mechanically altered diet (change in texture of food or liquids such as pureed food or thickened liquids).<br><br>Record review of Resident #44's care plan revised 10/02/2024 indicated she required a pureed diet with nectar thick liquids with interventions for nectar thick liquids and to serve diet and snacks as ordered.<br><br>Record review of the Order Summary Report dated 10/31/2024 indicated Resident #44 had an order for a regular diet with a pureed texture, nectar consistency and to use a divided plate with a start date of 08/23/2024.<br><br>During an observation and interview on 10/29/24 at 12:40 p.m., LVN D was checking the hall cart trays when she told an unknown CNA the cart was ready. This surveyor asked LVN D to recheck Resident #44's tray and this time she said the tea and water were thin consistency and not nectar. She had the aide take both drinks back to the kitchen for the right consistency. She said when she first checked the trays, she did not see the nectar thick consistency on Resident #44 's tray card. She said it was important to serve the right consistency to prevent choking.<br><br>(continued on next page) |

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| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/30/24 at 3:17 p.m., the Dietary Manager said he was the overseer of the kitchen. He said on 10/28/24 the kitchen was out of pre-made nectar thick tea. He said he was not aware they were out of pre-made thickeners until the surveyors questioned his staff on 10/28/24 about the consistency of the nectar thick liquids. He said they had some thickener solution in a bottle where the staff could make some nectar tea. He said the dietary aide was aware of how to use the solution to make the nectar tea. He said he did not know why the dietary aide said she eyeballed it and did not follow the directions on how to make the nectar thick tea. He said he was not aware of why the dietary aide did not place the correct liquids on Resident #44's tray. He said failure to follow the directions or serve the correct consistency order could cause a resident to choke.<br><br>During a phone interview on 10/31/24 at 3:21 p.m., the dietitian said she expected staff to serve and prepare nectar thick liquid as directed and not to deviate because it could cause aspiration.<br><br>During an interview on 11/01/24 at 11:42 a.m., the ADON said Residents #49 and #44 should only receive nectar-thickened liquids and were at risk for aspiration and choking if not provided thickened liquids.<br><br>During an interview on 11/01/24 at 12:16 p.m., the DON said she saw that the drinks were not nectar consistency as she was in the dining room when the drinks were being served. She said the DM was the overseer of the kitchen staff. She said the kitchen should be making the drink related to the resident's diet orders. She said failure to serve nectar-thickened liquids could place residents at risk for aspiration and choking.<br><br>During an interview on 11/01/24 at 1:01 p.m., the Regional Director of Operations said he expected the kitchen to prepare and serve the correct consistency of drinks for residents who required thickened liquids. He said if we do not serve the correct drink, we could place the residents at risk of choking.<br><br>Review of the facility's policy titled, Thickened Liquids, revised February 2007, indicated, Residents that have been diagnosed with swallowing difficulties may require thickened liquid as an intervention to avoid aspiration. The facility will ensure that the resident on thickened liquids can consume them in a safe and comfortable manner. Policy: thickened liquids will be prepared as ordered by the physician. Procedure: the dietary service manager will specify the thickness of the liquid as per the physician's order on the diet card and prepare it accordingly. #5 thickened liquids will not be served until they reach the appropriate consistency. #6 prior to serving the tray to the resident the nurse aide will verify the diet's order and the desired consistency of thickened liquids if the liquid is not the correct consistency the dietary department would prepare another appropriate thickened liquid. No liquid will be served to the resident until the liquid is the ordered consistency. |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879<br><br>Based on observation, interview, and record review, the facility failed to ensure residents received therapeutic diets that were prescribed by the attending physician for 1 of 3 residents (Resident #49) reviewed for therapeutic diets.<br><br>The facility did not ensure Resident #49 was given fortified food as ordered by the physician.<br><br>This failure could place residents at risk for poor intake, weight loss, unmet nutritional needs, and a loss of dignity.<br><br>Findings Included:<br><br>Record review of Resident #49' face sheet dated 10/31/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Angelman syndrome (a genetic disorder that mainly affects the nervous system), protein-calorie malnutrition (protein calorie deficiency), severe intellectual disabilities (neurodevelopmental condition that affects cognitive and adaptive functioning, and begins before age 18), eating disorder, intermittent explosive disorder (impulse-control disorder characterized by sudden episodes of unwarranted anger).<br><br>Record review of Resident #49's quarterly MDS assessment dated [DATE], indicated Resident #49 was rarely understood and rarely understood others. The MDS assessment indicated Resident #49 had short term/long term memory problems and her cognition was severely impaired. The MDS assessment required substantial/maximal assistance with eating and upper body dressing. Resident #49 was dependent on staff with oral hygiene, toileting, showering, lower body dressing, and personal hygiene. The MDS assessment indicated Resident #49 was always incontinent of urine and bowel. The MDS assessment indicated Resident #49 had a mechanically altered diet.<br><br>Record review of Resident #49's comprehensive care plan revised on 01/09/24, indicated Resident #49 had potential risk for malnutrition. The care plan interventions were to offer diet as ordered by the physician.<br><br>Record review of Resident #49's order summary report dated 10/29/24, indicated Resident #49 had the following orders:<br><br>*Regular diet pureed texture, nectar consistency, double portion with an order start date of 12/07/23.<br><br>*Fortified Pudding one time a day for nutrition with an order start date of 12/07/23.<br><br>During an observation on 10/28/24 at 12:43 p.m., Resident #49's lunch meal ticket dated 10/28/24, indicated under meal note fortified pudding. Resident #49 had some yellow substance in a bowl on her tray.<br><br>(continued on next page) |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/28/24 at 12:44 p.m., LVN B was assisting Resident #49 with her lunch tray. LVN B said she saw Resident #49 should be receiving fortified pudding, but she did not know if the pudding she had was fortified. She said when she saw the tray, she assumed it was fortified pudding.<br><br>During an interview on 10/28/24 at 12:46 p.m., DA H said she did not make the pudding fortified today. She said she was supposed to put peanut butter and whipped cream in the pudding. She said she did not make the fortified pudding for Resident #49 because she did not think she needed it. She said residents who usually had fortified food was at risk for weight loss and she did not feel she was at risk of weight loss.<br><br>During an interview on 10/30/24 at 1:46 p.m., the Dietary Manager stated he was not sure how to make fortified pudding, but they have a recipe to follow. He said he was the overseer of the kitchen. He said he was not aware the dietary aide did not make the pudding until after he heard the surveyor interviewing her. He said it was important to follow the recipe on fortified foods. He said not receiving fortified food as ordered by the physician can cause a resident to lose weight.<br><br>During an interview on 11/01/24 at 11:46 a.m., the ADON said she expected the dietary department to follow the recipe for fortified pudding. She said it was important to make the pudding correctly because it helped with the resident's overall weight.<br><br>During an interview on 11/01/24 at 12:16 p.m., the DON said the trays were supposed to be checked by the nurses in the dining room and then the aides when they pass the trays on the halls. She said it was important for the staff to read the tickets and ensure the residents were receiving the correct diets. She said Resident #49 had been gaining weight since admission and needed her fortified pudding as she was still under 100 lbs.<br><br>During an interview on 07/10/2024 at 1:01 p.m., the Regional Director of Operations said he expected food trays to be checked and residents to receive the correct diet. The Regional Director of Operations said the dietary manager was responsible for monitoring and overseeing the kitchen. He said it was important for residents to receive the correct diet order to prevent weight loss.<br><br>Record review of the enhanced pudding recipe called for 1/4 cup of instant nonfat milk, 4 3/4 ounce of vanilla ice cream, 1/4 cup of powered nonfat instant milk, 1 1/8 ounce of vanilla pudding and 1/2 cup of milk.<br><br>Record review of the facility's policy titled Red glass and Fortified food program, by the Dietary Service Policy and procedure [NAME] 2012, indicated this program was a way for residents with unintended weight loss to receive increase nutritional needs and to provide encouragement to complete their meals and supplement. Procedure: the food and nutrition program department have a variety of fortified recipes that can be used to add additional calories and/or protein to the resident's meal tray without requiring a large volume. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047<br><br>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen.<br><br>The facility did not ensure:<br><br>1. Food items were labeled and dated.<br><br>2. Hair restraints were worn correctly.<br><br>3. The juice machine spigot was free from a red/orange gooey substance where the juice was dispersed.<br><br>4. Ice scoops were stored in a container.<br><br>5. Can opener blade was free from debris.<br><br>5. Dietary Manager TT washed her hands after touching her nose.<br><br>These failures could place residents at risk for foodborne illness.<br><br>Findings included:<br><br>During the initial tour observation and interview with Dietary Manager SS on 10/28/24 beginning at 10:26 a.m. , the following was revealed:<br><br>1. 2 ice scoops was stored on top of the ice machine uncovered.<br><br>2. The juice machine spigot with a thick gooey red/orange substance.<br><br>3. [NAME] UU and Aide H hairnets were not covering their entire head. There was loose hair sticking out for all 3 of them.<br><br>4. A bag of opened tortilla chips unlabeled and undated in the dry storage room.<br><br>5. The end of the can opener blade had a thick black substance.<br><br>During an observation on 10/29/24 at 11:47 a.m., Dietary Aide R hairnet was covering her entire head. There was loose hair sticking out. Dietary Aide R stated the hairnet should cover the entire head while in the kitchen. Dietary Aide R stated this failure could put residents at risk for food borne illness and cross contamination.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an observation on 10/29/24 at 11:59 a.m., Dietary Manager TT squeezed her nose and placed the mechanical chicken back in the oven without washing her hands. Dietary Manager TT stated she should have washed her hands prior to touching the mechanical chicken. Dietary Manager TT stated this failure could cause cross contamination.<br><br>During an interview on 10/30/24 at 3:20 p.m., Dietary Aide H stated the aides were responsible for ensuring the ice scoops were placed in a bag when not in use. Dietary Aide H stated all staff were responsible for labeling/dating. Dietary Aide stated the aides were responsible for cleaning the juice spigot after every use. Dietary Aide H stated the can opener blade should be cleaned after every use. Dietary Aide H stated hairnets should cover the entire head while in the kitchen. Dietary Aide H stated these failures could potentially put residents at risk for cross contamination and food borne illness.<br><br>An attempted phone interview on 10/30/24 at 3:24 p.m. with [NAME] UU, was unsuccessful.<br><br>During an interview on 10/30/24 at 3:49 p.m., [NAME] VV stated all staff were responsible for ensuring the ice scoops were stored correctly. [NAME] VV stated the aides were responsible for cleaning the juice spigot after every use. [NAME] VV stated all staff were responsible for labeling/dating and ensuring the packet was sealed. [NAME] VV stated all staff were responsible for cleaning the can opener after every use. [NAME] VV stated hairnets should cover the entire head while in the kitchen. [NAME] VV stated these failures could potentially put residents at risk for cross contamination and food borne illness.<br><br>During an interview on 10/31/24 at 2:55 p.m., Dietary Manager SS stated cleanliness was important in the kitchen, so her staff are not spreading germs or contaminating anything. Dietary Manager SS stated she was responsible for making sure the kitchen was cleaned appropriately. Dietary Manager SS stated all food should be labeled with date received and the date it was opened and ensure the packet is sealed. Dietary Manager SS stated hairnets should completely cover the hair. Dietary Manager SS stated the staff that was working that shift was responsible for cleaning the can opener. Dietary Manager SS stated he expected the ice scoops to be in a container when not in use. Dietary Manager SS stated the juice spigot should be cleaned daily and as needed by the dietary aides. Dietary Manager SS stated he stated was responsible for monitoring and overseeing by daily walk throughs and when there was an issue staff were verbally in serviced immediately. The Dietary Manager stated these failures could potentially put residents at risk for cross contamination, and food borne illness.<br><br>During an interview on 10/31/24 at 3:10 p.m., the Dietician stated she had been over the building for the past 3 months. The Dietician stated she expected ice scoops to be in a container when not in use, juice spigot, can opener clean after every use, food secured, labeled, and dated. The Dietitian stated hairnets should be worn and covering the entire head while in the kitchen. The Dietician stated she expected hands to be washed after touching their face. The Dietician stated she had not noticed any issues. The Dietician stated her rounds were done monthly around lunch and dinner services. The Dietitian stated these failures could potentially put residents at risk for cross contamination, and food borne illness.<br><br>(continued on next page) |

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| | 675390 | A. Building<br>B. Wing | 11/01/2024 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 11/1/24 at 12:05 p.m., the Area Director of Operations stated he expected hairnets to be worn to cover the entire head, ice scoops should be in a designated space so it will stay sanitary, items should be secured, labeled/dated, juice spigot/can opener cleaned after every service and hands to be washed when face was touched. The Area Director of Operations stated the Dietary Manager was responsible for monitoring. The Area Director of Operations stated these failures could potentially put residents at risk for cross contamination, and food borne illness.<br><br>Record review of the facility's policy titled, Equipment Sanitation We will provide clean and sanitized equipment for food preparation. The facility will clean all food service equipment in a sanitary manner .<br><br>Record review of the facility's policy titled, Infection Control (Dietary Services Policy and Procedures Manual 2012) . Personal cleanliness is required in sanitary food preparation. Employees should follow general sanitation guidelines from the Center of Disease Control (CDC) and the state food code when working in the Food and Nutrition Department. b. Clean hair is required. It is to be covered with an effective hair restraint. Facial hair is to be closely trimmed and is to be covered with a hair restraint 2. Careful hand washing by personnel will be done in the following situations: e. After each instance of coughing, sneezing, touching face and/or hair .<br><br>Record review of the facility's policy titled, Food Storage and Supplies (Dietary Services Policy and Procedures Manual 2012) . All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, and insects . 4. Open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened .<br><br>Review of web address:<br><br>https://www.dshs.texas.gov/sites/default/files/foodestablishements/pdf/GuidanceDoc/TFER-2021_August-2021.pdf: accessed on 9/30/2024 indicated:<br><br>TITLE 25 HEALTH SERVICES<br><br>PART 1 DEPARTMENT OF STATE HEALTH SERVICES<br><br>CHAPTER 228 RETAIL FOOD ESTABLISHMENTS<br><br>SUBCHAPTER A GENERAL PROVISIONS<br><br>S228.1. Purpose and Regulations.<br><br>(a) The purpose of this chapter is to implement Texas Health and Safety Code, Chapter 437, Regulation of Food Service Establishments, Retail Food Stores, Mobile Food Units, and Roadside Food Vendors.<br><br>(b) The department adopts by reference the U.S. Food and Drug Administration (FDA) Food Code 2017 (Food Code) and the Supplement to the 2017 Food Code.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | TFER S228.43 states that food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. It does not apply to food employees such as counter staff who only serve TEXAS DEPARTMENT OF STATE HEALTH SERVICES DIVISION FOR REGULATORY SERVICES ENVIRONMENTAL AND CONSUMER SAFETY SECTION POLICY, STANDARDS, AND QUALITY ASSURANCE UNIT PUBLIC SANITATION AND RETAIL FOOD SAFETY GROUP PSRFSGRC - No.19 Hair Restraints April 1, 2016 (Revised February 21, 2017) Page 2 Public Sanitation and Retail Food Safety Group ? PO Box 149347, Mail Code 1987 ? [NAME], Texas 78714-9347 (512) [PHONE NUMBER] ? Facsimile: (512) [PHONE NUMBER] ?<br><br>Review of web address https://www.fda.gov/media/164194/download?attachment accessed on 9/30/2024 indicated:<br><br>2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from FDA Food Code 2022 Chapter 2. Management and Personnel Chapter 2 - 22 contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.<br><br>(L) EMPLOYEES are properly SANITIZING cleaned multiuse EQUIPMENT and UTENSILS before they are reused, through routine monitoring of solution temperature and exposure time for hot water SANITIZING, and chemical concentration, pH, temperature, and exposure time for chemical SANITIZING;<br><br>Preventing contamination from the premises 3-305.11 Food Storage. 3-305.12 Food Storage, Prohibited Areas. Pathogens can contaminate and/or grow in food that is not stored properly. Drips of condensate and drafts of unfiltered air can be sources of microbial contamination for stored food. Shoes carry contamination onto the floors of food preparation and storage areas. Even trace amounts of refuse or wastes in rooms used as toilets or for dressing, storing garbage or implements, or housing machinery can become sources of food contamination. Moist conditions in storage areas promote microbial growth. Refer also to the public health reasons for S 2-501.11 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879<br><br>Based on observation, interview, and record review the facility failed to effectively 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 5 of 7 (Resident's #49, #1, #2, #209 and Resident #42) residents and 1 of 1 linen carts reviewed for infection control.<br><br>1.The facility failed to ensure CNA C provided proper incontinent care to Resident #49.<br><br>2.The facility failed to ensure CNA C wore PPE prior to entering Resident #1's room.<br><br>3. The facility failed to ensure LVN A performed hand hygiene after checking blood sugar on Resident #2.<br><br>4. The facility failed to ensure CNA K provided proper incontinent care to Resident #209.<br><br>5. The facility did not ensure the DON and NA QQ don (on) their PPE prior to entering Resident #42's room.<br><br>6. The facility did not ensure Laundry Aide RR covered the clean personal cart while passing out the resident's clothing on 10/31/24.<br><br>These deficient practices could place residents at risk for infection due to improper care practices.<br><br>Findings included:<br><br>1.Record review of Resident #49' face sheet dated 10/31/24, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included Angelman syndrome (a genetic disorder that mainly affects the nervous system), protein-calorie malnutrition (protein calorie deficiency), severe intellectual disabilities (neurodevelopmental condition that affects cognitive and adaptive functioning, and begins before age 18), eating disorder, intermittent explosive disorder (impulse-control disorder characterized by sudden episodes of unwarranted anger).<br><br>Record review of Resident #49's quarterly MDS assessment dated [DATE], indicated Resident #49 was rarely understood and rarely understood others. The MDS assessment indicated Resident #49 had short-term/long-term memory problems and her cognition was severely impaired. The MDS assessment required substantial/maximal assistance with eating and upper body dressing. Resident #49 was dependent on staff for oral hygiene, toileting, showering, lower body dressing, and personal hygiene. The MDS assessment indicated Resident #49 was always incontinent of bladder and bowel.<br><br>Record review of Resident #49's comprehensive care plan dated 12/08/23, indicated Resident #49 had an ADL self-care performance deficit with interventions to assist with toileting, and personal hygiene as required: hair, shaving, oral care as needed.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an observation on 10/29/24 at 5:00 a.m., CNA C was performing incontinent care on Resident #49 who had a bowel movement. CNA C explained what she was going to do. She applied her gloves, wiped her buttock, got some bowel on her gloves, and changed them. She then applied new gloves without hand hygiene. She then wiped her buttock again, got a clean brief and applied it without hand hygiene. CNA C never cleaned Resident #49's peri area. CNA C then pulled up her covers and lowered the bed all while using the same dirty glove.<br><br>2.Record review of Resident #1's face sheet, dated 10/31/24 indicated Resident #1 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included seizures, Basal Cell Carcinoma (the most common form of skin cancer), Contractures of the left hand, and Dementia (memory loss).<br><br>Record review of Resident #1's annual MDS assessment, dated 09/20/24, indicated that she was rarely understood and rarely understood by others. Resident #1 had short and long-term memory problems, which indicated she was cognitively impaired. Resident #1 required total assistance with toileting, personal hygiene, transfer, and bathing. The MDS indicated she was incontinent of bowel and bladder.<br><br>Record review of Resident #1's Comprehensive Care Plan dated 06/16/24 reflected Resident #1 was on enhanced barrier precautions. The intervention was for staff to perform hand sanitation before entering the room and before leaving the room and posting at the resident's room entrance indicating the resident was on enhanced barrier precautions.<br><br>During an observation on 10/29/24 at 4:15 a.m., Resident #1 had a sign outside her door that read enhanced barrier precautions.<br><br>During an observation on 10/29/24 at 4:31 a.m., CNA C checked on Resident #1 to see if she was incontinent. She walked into the room with no PPE on lifted the covers and opened her brief to see if she needed incontinence care. She then closed the brief, pulled up her covers, said she did not require any care at this time, and walked out of the room.<br><br>During an interview on 10/29/24 at 5:17 a.m., CNA C said she did not wash her hands when changing her gloves after she obtained some bowel on them for Resident #49. She said she should have washed her hands before applying the brief, touching her linen and each time she changed her gloves. She said she had been checked off on incontinent care when she was hired. She said she should have washed her hands to prevent the spread of infection. CNA C said she did not wear any PPE when she went to check on Resident #1 to see if she had an incontinent episode. She said she should have worn PPE which consisted of gloves and a gown when entering Resident #1's room because of her wounds. She said she forgot. CNA C said she did not wear any PPE earlier on her shift when she had changed Resident #1. She said she had been educated on EBP and the DON re-educated her yesterday (10/28/24) but she still forgot.<br><br>During an on 10/29/24 at 5:28 a.m., LVN LL said she was the 10-6 shift charge nurse. She said she expected her CNAs to provide incontinent care the correct way. She said she expected them to change their gloves anytime they become visible soiled and for them to perform hand hygiene when they changed their gloves to prevent cross-contamination. She said she expected staff to wear gloves and gowns when they were intended to provide incontinence to residents on EBP. She said she ensured staff was wearing PPE by making rounds, asking residents, and seeing if supplies were missing out of the cart.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 3.Record review of Resident #2's face sheet dated 10/31/24, indicated an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Cerebral palsy (also known as CP, a group of neurological disorders that affect a person's ability to move, balance, and maintain posture), diabetes mellitus type 2 (also known as diabetes, a chronic disease that occurs when the body has high blood sugar levels), Post-traumatic stress disorder (also known as PTSD, a mental health condition that can develop after someone experiences or witnesses a traumatic event), Depression (a mental health condition that can affect anyone, causing a persistent low mood and loss of interest in activities), and Anxiety( a feeling of fear, dread, and uneasiness that can be a normal reaction to stress).<br><br>Record review of Resident #2's annual MDS assessment dated [DATE], indicated Resident #2 was usually able to make herself understood and understood others. The MDS assessment indicated Resident #2 had a BIMS score of 06, indicating her cognition was severely impaired. The MDS assessment indicated Resident #2 had received insulin 7 days out of the 7-day look-back period. The MDS assessment indicated Resident #2 had received a hypoglycemic medication within the last 7 days of the look-back period.<br><br>Record review of Resident #2's comprehensive care plan revised on 11/28/19, indicated Resident #2 had Diabetes Mellitus. The care plan interventions included to give diabetes medication as ordered by the doctor.<br><br>Record review of Resident #2's order summary report dated 08/01/23, indicated Resident #2 had an order for the following:<br><br>*Novolog (Insulin aspart's) pen injector 100 units/ml. Inject as per sliding scale: if 0 - 149 = 2 UNITS; 150 - 199 = 4 units; 200 -249 = 6 units; 250 - 299 = 8 units; 300 - 349 = 10 units; 350 - 449 = 12 units IF Blood Sugar over 450 notify the doctor or nurse practitioner, subcutaneously before meals for diabetes.<br><br>Record review of Resident #2's order summary report dated 10/15/24, indicated Resident #2 had an order for the following:<br><br>*Insulin glargine (Lantus) 100 units/ml inject 20 units subcutaneously twice a day for diabetes.<br><br>During an observation on 10/29/24 at 7:12 a.m., LVN A checked Resident #2's blood sugar which revealed it was 92. LVN A came back to the cart, removed her gloves, and applied new gloves without hand hygiene. LVN A checked the order, and said she needed to give 2 units of Novolog. LVN A dialed the Novolog pen to 2 units and administered it.<br><br>During an interview on 10/29/24 at 7:30 a.m., LVN A said she did not hand hygiene her hands after she took the blood sugar and gave the insulin. She said she forgot but knew without hand hygiene she could cause an infection.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 11/01/24 at 11:45 a.m., the ADON said she expected nurses to change gloves and perform hand hygiene after they took a resident's blood sugar. She said she expected staff to wipe the entire peri area when they provide incontinence care and to change their gloves between dirty to clean. She said she had done check-offs with the CNAs. She said failure to provide incontinence care correctly or hand hygiene could lead to infection control issues. She said she expected staff to wear their PPE when going in resident rooms who were on EBP to protect the residents as well as staff.<br><br>During an interview on 11/01/24 at 12:16 p.m., the DON said she expected staff to wash both the peri area and the buttock when providing incontinence care. She said if the gloves were soiled then staff should remove them, perform hand hygiene, and apply new gloves. She said these things should be done to prevent infections. The DON said they have done incontinence care check-offs. She said they were done on hire, yearly, and as needed. She said if staff were going to be in close contact such as changing linen or providing incontinence care then they should have on PPE (gown/glove) to prevent the spread of infection or cross-contamination.<br><br>46892<br><br>4. Record review of a face sheet dated 10/30/2024 indicated Resident #209 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of unspecified ovary (ovarian cancer) and chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system).<br><br>Record review of Resident #209's electronic medical record on 10/30/2024 indicated her MDS assessment had not been completed.<br><br>Record review of Resident #209's care plan with date initiated 10/26/2024 indicated she had bladder and bowel incontinence to check every two hours and assist with toileting as need and to provide peri care after each incontinent episode.<br><br>During an observation of incontinent care on 10/29/2024 starting at 4:37 AM, CNA K donned gloves, unfastened Resident #209's brief, placed a packet of wipes on top of Resident #209's bed, and pulled out wipes. CNA K cleaned Resident #209's front peri area and turned Resident #209 onto her side. CNA K touched the wipes packet with her dirty gloves and wiped Resident #209's back peri area. CNA K said she had finished wiping Resident #209. Surveyor intervened and asked CNA K to wipe Resident #209 one more time. CNA K wiped Resident #209 again and residue of stool was noted on the wipe. CNA K said she had not completely cleaned Resident #209's back peri area and cleaned her again. CNA K finished cleaning Resident #209 and using her dirty gloves applied the clean brief and sheet. CNA K with her dirty gloves put on Resident #209's pants on, removed her dirty gloves, and repositioned Resident #209 and then performed hand hygiene. CNA K left Resident #209's room, disposed of the trash, and handed the packet of wipes to a different CNA who took the packet of wipes into another resident's room to provide care.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 10/29/2024 at 6:14 AM, CNA K said hand hygiene should be performed before you start and then after. CNA K said she only changed her gloves if they were visibly soiled with bowel movement. CNA K said that was the way she was taught. CNA K said nurse management had not watched her perform incontinent care or done any teaching with her on providing incontinent care. CNA K said when performing incontinent care, she used as many wipes as she could, and she thought she had wiped Resident #209 until she was clean. CNA K said she did not see any residual from the bowel movement on Resident #209. CNA K said she tried to look at the wipes after wiping to ensure there was no bowel movement left. CNA K said it was important to ensure the residents were cleaned properly because they could get any type of infection and urinary tract infections. CNA K said she was not sure how she was supposed to use the wipes. CNA K said most of the residents had their own packet of wipes in their rooms. CNA K said when she did orientation with the other CNAs, she watched them take the whole packet of wipes into the residents' rooms. Then they returned the packet of wipes to the clean linen cart to use it on other residents, so that's what she did. CNA K said taking the packet of wipes in the residents' rooms, touching it with dirty gloves, placing it on the residents' beds or bedside tables could cause infection because bacteria would be transferred. CNA K said a competency check was left at the facility for her to sign. CNA K said nurse management left it for her to sign, and nobody observed her providing the care listed on the competency check. CNA K said it was important for her competency check to be adequately completed so she knew how to correctly provide care to the residents.<br><br>During an interview on 11/01/2024 at 11:27 AM, the DON said during incontinent care the CNAs should be changing their gloves when moving from dirty to clean and perform hand hygiene in between glove changes. The DON said the wipes containers were not supposed to be taken in and out of the room. The DON said prior to entering the resident's room to perform incontinent care the CNAs were supposed to remove the amount of wipes needed from the wipes container, place them in a bag, and take the bag into the resident's room. The DON said if the wipes container was taken into the resident's room it should be left in the room. The DON said she was responsible for monitoring the CNAs to ensure they were performing proper incontinent care. The DON said she performed random audits and competencies were completed upon hire and annually. The DON said when performing incontinent care, the CNAs were supposed to wipe and then look at the wipe and wipe until there was no residue left on the wipes. The DON said she randomly went to the facility at night and watched the CNAs perform incontinent care and showers. The DON said not performing proper incontinent care and carrying the wipes from room to room could result in spread of infection, increased contamination, cross contamination, and placed the residents at risk for infection and sickness.<br><br>During an interview on 11/01/2024 at 12:41 PM, the ADO said he expected the CNAs to follow the policy and training that they received. He expected for them to change gloves and use the wipes appropriately. The ADO said when performing incontinent care, the CNAs needed to be sanitary because they did not want to cross contaminate anything. The ADO said the ADON and DON were nurse management, and they should be completing competency checks according to the policy and as needed. The ADO said not performing proper incontinent care placed the residents at risk for skin breakdown, possible infections, and urinary tract infections.<br><br>43047<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an observation and interview on 10/28/24 at 11:41 a.m., NA QQ was asked by the state surveyor to see Resident #42's wound dressing to his right leg. NA QQ went into Resident #42's room with only wearing gloves. NA QQ stated she was unaware that Resident #42 was on EBH, she thought only his roommate but after thinking about it due to his wounds he would be on EBH. NA QQ stated the risk associated with not wearing the correct PPE was a spread of infection.<br><br>During an observation and interview on 10/29/24 at 12:47 p.m., the DON removed Resident #42's dirty linen off his bed and placed in them in the dirty hamper only wearing gloves. The DON stated she did not have to wear a gown when removing the dirty linen only when putting clean linen on the bed. The DON stated the risk associated with not wearing the correct PPE was a spread of infection.<br><br>During an observation and interview on 10/31/24 at 3:46 p.m., Laundry Aide RR was passing out clothing from her clean personal cart on Hall C. The clothing was hanging on the rack with the cart curtain pulled back, which exposed the clean clothing. Laundry Aide RR stated she kept the curtain up while transporting linen. Laundry Aide RR stated she only kept the curtain down when leaving the laundry room so the wind would not blow the clothes away. Laundry Aide RR stated it was important to ensure clean linen cart covers were used to prevent cross contamination.<br><br>During a telephone interview on 10/31/24 at 5:01 p.m., the ADON stated she was the Infection Control Preventionist for the facility. The ADON stated she expected NA QQ and the DON to wear a gown while providing care to Resident #42. The ADON stated close contact with someone with EBP you are supposed to wear gown/gloves to protect the residents from staff and prevent spread of infection. The ADON stated Laundry Aide RR should have kept the linen cart covered unless she was getting something from the cart. The ADON stated she monitored by random rounds and in-services. The ADON stated there has not been any issues in the past.<br><br>During an interview on 10/31/24 at 5:45 p.m., the Regional Compliance Nurse stated there was no competency check off list for infection control for the DON.<br><br>During an interview on 11/1/24 at 12:05 p.m., the Area Director of Operations stated he expected NA QQ and the DON to follow the EBP by donning a gown. The Area Director of Operations stated the ADON was responsible for monitoring. The Area Director of Operations stated it was important to ensure clean linen carts were covered properly for infection control. The Area Director of Operations stated these issues could cause spread of infection.<br><br>Record review of a Texas Nurse Aide Performance Record indicated NA QQ had completed her trainings for infection control on 07/19/24.<br><br>Record review of the undated facility's policy titled, Enhanced Barrier Precautions, indicated, .EBP is used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . EBP are indicated for residents with any of the following: wounds .<br><br>Record review of the facility's policy titled, Linens (Infection Control Policy and Procedures Manual 2018 LN 03-1.0) reflected . 12. All clean linen will be stored in a secured area. The linen cart will be covered .<br><br>(continued on next page) |

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|---|---|---|---|
| | 675390 | A. Building<br>B. Wing | 11/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sunflower Park Health Care | 1803 Highway 243 East<br>Kaufman, TX 75142 |

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Record review of facility's policy titled, Hand Washing, dated 2012, indicated . We will ensure proper hand washing procedures are utilized<br><br>Record review of the facility's Infection Control Plan: Overview updated 03/2024, indicated, .Linens Personnel will handle, store, process and transport linens so as to prevent the spread of infection .<br><br>Record review of the facility's Fundamental of Infection Control Precautions, updated 03/2024, indicated. Hand Hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene . before and after direct resident contact .before and after assisting a resident with personal care .after removing gloves |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879<br><br>Based on observations, interviews, and record reviews the facility failed to ensure residents could call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside for 1 of 8 residents (Resident #1) reviewed for the ability to call for staff assistance.<br><br>The facility failed to ensure Resident #1 had a call button.<br><br>This failure could place resident at risk for a delay in assistance and decreased quality of life, self-worth, and dignity.<br><br>Findings included:<br><br>Record review of Resident #1's face sheet, dated 10/31/24 indicated Resident #1 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included seizures, Basal Cell Carcinoma (the most common form of skin cancer), Contractures of the left hand, and Dementia (memory loss).<br><br>Record review of Resident #1's annual MDS assessment, dated 09/20/24, indicated that she was rarely understood and rarely understood by others. Resident #1 had short and long-term memory problems, which indicated she was cognitively impaired. Resident #1 required total assistance with toileting, personal hygiene, transfer, and bathing.<br><br>Record review of Resident #1's Comprehensive Care Plan dated 06/20/23 reflected Resident #1 had an alteration in musculoskeletal status related to contracture in her left hand. The intervention was for staff to anticipate and meet her needs. Be sure the call light was within reach and respond promptly to all requests for assistance.<br><br>During an observation on 10/28/24 at 11:10 a.m., revealed Resident #1 was in bed with her eyes closed. No call light was noted on her side of the room in the switch.<br><br>During an observation on 10/28/24 at 3:53 p.m., revealed Resident #1 was in bed with her eyes closed. No call light was noted on her side of the room.<br><br>During an observation and interview on 10/28/24 at 4:25 p.m., LVN B said she was the charge nurse for Resident #1. She looked and said resident #1 does not have a call light. She said she did not know why Resident #1 did not have a call light. LVN B said Resident #1 could move her right hand and could benefit from the pushpad call light. She said the risk of not having a call light could be Resident #1 would not get the help she needed in a timely manner. She said she would get her a push pad call light system.<br><br>During an interview on 11/01/24 at 11:42 a.m., the ADON said all residents should have a call light and it should be always within reach. She said failure to not have a call light could lead to resident falls or not getting the help they need.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/01/24 at 12:16 p.m., the DON said all staff should be checking on the residents and ensuring they had a call light within reach. She said she was not aware Resident #1 did not have a call light. She said she expected call lights to always be within reach of residents. The DON said failure to have or keep call lights within reach could cause a resident to fall, receive a bump, bruise, or even a fracture.<br><br>During an interview on 11/01/24 at 1:01 p.m., the Regional Director of Operations said if call lights were not in reach residents' needs would not be met and it could place them at a greater risk of falling. He said all staff were responsible for ensuring residents had call lights.<br><br>During an interview on 11/01/24 at 1:20 p.m., the facility's policy on call lights was requested from the DON, but one was not provided. |

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| F 0926<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have policies on smoking.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006<br><br>Based on observation, interview, and record review the facility failed to follow their own established smoking policy for the facility's only smoking area and 1 of 7 residents (Resident #37) reviewed for smoking policies.<br><br>1. The facility failed to ensure Resident #37 wore a smoking apron during a supervised smoking break on 10/28/24.<br><br>2. The facility failed to ensure the smoking area was free of combustible materials on 10/28/24.<br><br>These failures could place residents at risk of an unsafe smoking environment.<br><br>The findings included:<br><br>1. Record review of the face sheet dated 10/31/24, reflected Resident #37 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of cerebrovascular disease (disorder that affect blood flow to the brain), Alzheimer's (a disease that destroys brain cells, causing a gradual decline in memory, thinking, and behavior), major depressive disorder (persistent feeling of sadness and loss of interest), and need for assistance with personal care.<br><br>Record review of the admission MDS assessment dated [DATE], reflected Resident #37 was usually understood by other and was usually able to understand others. The MDS reflected Resident #37 had a BIMS score of 4, indicating her cognition was severely impaired. The MDS reflected Resident #37 required substantial/maximal assistance with toileting, showering, lower body dressing, and transfers. The MDS reflected Resident #37 had no behaviors or refusal of care.<br><br>Record review of the comprehensive care plan dated 06/17/24, reflected Resident #37 smoked. The care plan interventions were to perform smoking assessments according to the facility policy, monitor when smoking to assure resident safety, and keep all smoking material at the nurses' station.<br><br>Record review of the safe smoking assessment dated [DATE], reflected Resident #37 required direct supervision and a fire-resistant smoking apron while smoking.<br><br>During an observation on 10/28/2024 beginning at 3:28 PM, Resident #37 was in the smoking area during a supervised smoking break with staff. Resident #37 did not have on a smoking apron. There was a propane grill in the smoking area with an attached propane tank. The red trashcan for cigarette butts was touching the propane grill.<br><br>(continued on next page) |

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| F 0926<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/01/2024 beginning at 9:45 AM, Student NA KK stated she was the staff member in the smoking area on 10/28/2024 during the smoking break. Student NA KK stated she was unaware Resident #37 required a smoking apron. Student NA KK stated she did not know where to find out if the residents required a smoking apron. Student NA KK stated she assumed the nurses would have told her if a resident needed a smoking apron. Student NA KK stated Resident #37 has dropped her lit cigarettes in the past but did not injury herself. Student NA KK stated she did not notify anyone after the incident happened because she was not hurt. Student NA KK stated a propane tank grill should not have been in the smoking area. Student NA KK stated she did not notice the propane tank grill in the smoking area, so it was not reported. Student NA KK was unsure how long the propane tank grill had been in the smoking area. Student NA KK stated it was important to ensure smoking interventions were implemented and combustible materials were not in the smoking area to protect the resident's and staff from getting burned or blowing up.<br><br>During an interview on 11/01/2024 beginning at 11:42 AM, the ADO stated he expected the facility staff to ensure combustible materials were not in the smoking area. The ADO stated he expected the nursing staff to ensure smoking assessments were completed quarterly and for any change of condition. The ADO stated he expected interventions from the smoking assessments, such as a smoking apron, to have been communicated to staff who assist the residents during the smoking breaks. The ADO stated the staff who were assisting residents during smoking breaks were responsible for monitoring to ensure smoking aprons were used during smoking breaks. The ADO stated it was important to ensure smoking aprons were used as appropriate so that residents did not burn themselves or catch their clothing on fire. The ADO stated keeping combustible materials in the smoking area could have caused an explosion.<br><br>During an interview on 11/01/2024 beginning at 12:01 PM, the DON stated she expected Resident #37 to have worn a smoking apron if it was on her smoking assessment. The DON stated she was unaware of any smoking residents who required a smoking apron. The DON stated she was unaware of any incidents were Resident #37 had dropped her cigarette. The DON stated if a smoking assessment was updated or changed it should have been communicated to the nursing management so the care plan could have been updated. The DON stated it was important to communicate changes in the smoking assessment so everyone would have known what to do. The DON stated it was important to ensure smoking interventions were in place and communicated to staff to maintain the safety of the resident.<br><br>Record review of the smoking policy, revised 11/01/2017, reflected .Smoking by residents classified as unsafe will be prohibited except when the resident will be directly supervised by facility personnel or visitors who are aware of the resident's limitations with smoking .if the facility identifies that the resident needs assistance/supervision and/or additional protective devices for smoking, the facility includes this information in the residents care plan, and reviews and revises the plan periodically as needed . The policy further reflected Smoking or using an e-cigarette/vape is prohibited in any area where flammable liquids, combustible gas, or oxygen are used or stored and in any other hazardous location . |