STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675977	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Creek Nursing & Rehabilitation	3825 Village Creek Rd Fort Worth, TX 76119

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observations, interviews, and record reviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents for 3 (rooms [ROOM NUMBER]) of 10 rooms reviewed for environment. The facility failed to maintain total visual privacy by allowing the window blinds for room [ROOM NUMBER], 308, and 310 to be missing several slats. This failure placed residents at risk of a lack of privacy, feeling insecure, or uncomfortable in their rooms. Findings included: Observation on 07/09/24 from 8:12 AM-8:40 AM of the facility's Secure Unit revealed the window blinds in Rooms 302, 308 and 310 were broken and missing several blind slats. Interview and observation on 07/10/24 at 2:42 PM with CNA D revealed she had been employed for four weeks. She stated when something needed to be fixed in a resident room, she reported it to the charge nurse. CNA D observed room [ROOM NUMBER] and stated she was aware of the window blinds being broken, but she could not recall how long they had been broken. She stated she reported the broken blinds to the charge nurse. Interview and observation on 07/10/24 at 2:47 PM with LVN E stated she was the nurse assigned to the secure unit. LVN E stated she had noticed some window blinds in the residents' rooms to be broken. LVN E observed room [ROOM NUMBER] and stated the blinds needed to be replaced. She stated about two weeks ago she reported the blinds in the maintenance logbook. She stated the maintenance logbook was in the main nurse's station. She stated nothing had been done. She stated the window blinds provided privacy to the residents. Record review on 07/10/24 at 2:50 PM of the Maintenance logbook revealed broken window blinds had not been reported. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/10/24 at 2:54 PM with Maintenance Manager revealed when something needed to be fixed, he expected staff to report and document in the maintenance logbook. He stated he reviewed the logbook daily. He stated broken window blinds had not been reported, and he had not received any requests to replace any broken window blinds. He stated blinds in the secure unit were constantly changed due to residents breaking them. He stated he expected staff to report it. He stated it was his responsibility to ensure blinds were in good condition. Interview on 07/11/24 at 3:28 PM with the Administrator stated it was a constant battle where they continued to replace the window blinds in the facility's Secure Unit because residents broke them. She stated it was the responsibility of all staff to report them to the Maintenance Manager, and it was the responsibility of the Maintenance Manager to replace the window blinds. She stated having broken window blinds could lead to a dignity risk when providing care to the residents. Record review of the facility's Privacy and Dignity policy, dated June 2020, reflected the following: To ensure that care and services provided by the facility promote and/or enhance privacy, dignity and overall quality of life. The Facility promotes resident care in a manner and an environment that maintains or enhances dignity and respect, in full recognition of each resident's individuality. Record review of the facility's Resident Rooms and Environment policy, dated August 2020, reflected the following: To provide residents with a safe, clean, comfortable, and homelike environment .VI. Facility staff work to minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting including .F. Generic, mass produced bedding, drapes, and furniture.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (Residents #8) reviewed for abuse. The facility failed to ensure Hospice Aide did not abuse Resident #8. The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 05/08/24 and ended on 05/08/24. The facility had corrected the noncompliance before the survey began. This failure could affect the residents at the facility and place them at risk for physical, verbal, and/or psychosocial harm. Findings included: Review of Resident #8's annual MDS assessment dated [DATE] revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included cerebral palsy, non-Alzheimer's dementia, seizure disorder, anxiety disorder, contractures of muscles, and need for assistance with personal care. The MDS further reflected the resident was dependent of one staff member for all ADLs including bathing, dressing, and hygiene. Resident #8 had long and short-term memory impairment and speech was rarely understood and she rarely understood others. Review of Resident #8's care plan revealed she was on hospice services as of 08/22/23 for cerebral palsy. Interventions included to work cooperatively with hospice team to ensure resident's spiritual, emotional, intellectual, physical, and social needs are met. Review of the facility's Provider Investigation Report dated 05/08/24 reflected the following: On 5/8/24 around 6:30 am [CNA A] was working 200 hall and heard Resident #8 screaming/crying louder than normal. [Resident #8] has a scream/cry when she needs changed or something, but this was heard from clear down the hall by the shower room and [Resident #8's] door was closed. When [CNA A] heard [Resident #8] screaming/yelling in a louder way than normal she went to check on her. [CNA A] opened the door to [Resident #8's] room and saw Hospice CNA performing a bed bath on [Resident #8]. She had [Resident #8] naked turned on her side facing the wall, the hospice aide had one hand on her thigh and the other hand by her waist. [Resident #8] was screaming and the hospice aide was standing facing the wall. The hospice CNA struck [Resident #8] on her side, between her ribs and buttock twice and said, Be Quiet! When [CNA A] saw this she audibly gasped. The hospice CNA turned around and saw [CNA A] and yelled HEY! [CNA A] left the door to the room open and immediately called for the nurse to come. Nurse was exiting a room across the hall and came immediately to intervene. Hospice aide claimed that she moved her hand quickly to keep resident from rolling back into BM. Observation on 07/09/24 at 10:00 AM revealed Resident #8 was in her bed connected to a feeding tube and her body appeared to be contracted. The resident was non-verbal and would only make a few auditory noises from time to time. The resident could not be interviewed due to her severely impaired cognition and would not even make eye contact when she was being spoken to. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/10/24 at 9:48 AM with CNA A revealed she was working on 05/08/24 on the 200 Hall around 6:15 AM. CNA A said Resident #8 would normally make a crying out sound when she needed to be changed but that morning, Resident #8 was heard to be yelling louder than normal behind the resident's closed door. CNA A went to Resident #8's room and as she opened the door, she noticed the Hospice Aide was giving Resident #8 a bed bath and the resident was facing towards the window with her back to CNA A. At that time, when she opened the door CNA A saw the Hospice Aide pop Resident #8 on her side and told her to Be Quiet and CNA A yelled out HEY as the Hospice Aide gasped . CNA A said she went to the door and yelled for LVN B, who went to the room right away, and she told her what she had just witnessed. At that same time CNA A said she was on the phone with DON. CNA A said LVN B immediately asked the panicked Hospice Aide to leave. The Hospice Aide kept repeating she had not done anything and said she loved the resident. The Hospice Aide gathered her belongings and CNA A and LVN B finished caring for the resident. CNA A said the Hospice Aide was not her normal aide that worked with her, and when her normal aide was there, Resident #8 had never been heard yelling like she was that day of the incident. CNA A further stated there was some redness around where Resident #8 had been popped but that could have been from the abdominal binder she normally wore for her G-tube. Interview on 07/10/24 at 10:13 AM with Medical Records Coordinator revealed she was working the day of the incident (05/08/24) when she heard CNA A yelling for help in a panicked voice at the same time, she had heard Resident #8 yelling out at the top of her lungs, which was not normal for the resident. As the Medical Records went to the resident's room, CNA A and LVN B were already there and the Hospice Aide was gathering her stuff. CNA A told Medical Records what she had seen and the Hospice Aide was gathering her stuff and she was walked out of the building. Medical Records stated she had not seen that Hospice Aide and was later told she had been filling in for Resident #8's regular hospice aide. Interview on 07/11/24 at 1:57 PM with LVN B revealed she was across Resident #8's room the day of the incident (05/08/24) when she heard CNA A yell out for her and say [LVN B] come quick. LVN B thought Resident #8 had fallen because of how panicked CNA A had yelled out for her so when she went to Resident #8's room, CNA A told her she had walked in on the Hospice Aide as she had popped Resident #8. At that time LVN B said she told the Hospice Aide she needed to leave and the Hospice Aide appeared to be very nervous saying she was just giving the resident a bath. LVN B told the Hospice Aide again, she needed to leave so she gathered her belongings and she and CNA A finished caring for Resident #8. LVN B said she assessed Resident #8 from head to toe because the resident was already nude from her bed bath, and she did not see any marks or redness on the resident. Resident #8 continued to scream and cry and appeared to be in distress as she tried to calm the resident down. LVN B stated the way Resident #8 was crying was not normal. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 07/11/24 at 11:14 AM with the Hospice Aide revealed she was at the facility on 05/08/24, to give Resident #8 a bed bath. As she was giving her a bath the resident had a large bowel movement so she rolled her on her right side. As she was trying to get some wipes Resident #8 started to roll back to her back. The Hospice Aide said she put her left hand on resident side to stabilize the resident and at that time CNA A walked in and said she had hit Resident #8. The Hospice Aide denied hitting the resident and telling her to be quiet and as far as she knew, that was the resident's normal cry and she had only worked with Resident #8 for a week. At that time, she said she walked out to get a wash rag and upon returning to the room she was confronted by a different staff member asking her if things were ok. The Hospice Aide was told there had been an abuse allegation against her and she needed to leave and she was escorted out of the building as CNA A yelled you hit her you need to leave. The Hospice Aide further stated Resident #8 was never combative when she would care for her and at no time did she pop the resident or tell her to be quiet. Interview on 07/11/24 at 12:32 PM with the DON revealed she got a call from CNA A to tell her she had walked in on the Hospice Aide as she popped Resident #8. The DON said she remained on the phone with CNA A while they escorted the Hospice Aide and she could hear the Hospice Aide asking if she could finish what she was doing and the staff told her no. The DON said Resident #8 was assessed by the nursing staff and she was told there was some redness noted but did not know if it was caused by the pop. The Hospice Agency was notified of the incident immediately and the Hospice Aide was not allowed to return again. All staff were re-inserviced on abuse and neglect and what to do if they see abuse. After the incident they called the police and reported the incident to the State Survey Agency. Interview on 07/11/24 at 12:43 PM with the Administrator revealed she was called and told about the incident with the Hospice Aide and Resident #8. She was told CNA A had heard Resident #8 crying abnormally and when she entered the resident's room, CNA A saw the Hospice Aide hit the resident on her side and told her to be quiet. The Hospice Aide was asked to leave immediately and the nursing staff did a head-to-toe assessment on Resident #8 and there were no marks or injuries noted. The Hospice Agency also assessed the resident and the Hospice Aide was not allowed to return to the facility. The Administrator further stated they had re-inserviced staff on abuse and neglect and prevention. Review of the facility inservices dated 05/08/24 revealed all staff had received in- service training on abuse, prevention, and reporting. Review of the facility's policy titled Abuse, Prevention, and Prohibition Program revised October 2022 reflected the following: .Policy I. Each resident had the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. The facility has zero tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. II. The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, consultants, volunteers, staff from other agencies serving resident

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on interview and record review, the facility to ensure a new resident was not admitted with a mental disorder, unless the state mental health authority determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority prior to admission, that the individual requires the level of services provided by a nursing facility and if the resident requires such level of services, whether the resident requires specialized services for one of six residents (Resident #10) reviewed for PASRR screening. The MDS Coordinator failed to ensure Resident #10's PL1 was accurate with the proper mental illness diagnoses when he was admitted . This failure could place residents at risk of not receiving specialized services. Findings included: Record review of Resident #10's Face sheet, dated 07/11/24, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Record review of Resident #10's quarterly MDS assessment, dated 05/15/24, reflected his diagnoses included paranoid schizophrenia, bipolar disorder, post traumatic stress disorder. Resident #10 had a BIMS score of 11, which indicated hiss cognition was moderately impaired. Record review of Resident #10's care plan, revised on 05/22/24, reflected: Focus: [Resident #10] has impaired cognitive function/dementia or impaired thought processes r/t schizophrenia, bipolar disorder. Goal: The resident will maintain current level of cognitive function through the review date. Interventions: Administer meds as ordered. Engage the resident in simple, structured activities that avoid overly demanding tasks. Keep the resident's, routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Record review of Resident #10's PASRR Level 1 Screening, dated 05/03/24, reflected NO had been marked for the question if there was evidence or an indicator the individual had a mental illness. Interview on 07/11/24 at 11:02 AM with the MDS Coordinator revealed she was responsible for looking at the PASRR Level 1 Screenings before residents were admitted . She stated the hospital where Resident #10 admitted from provided the negative PASRR Level 1. She stated when she entered the information in the system, she entered it without noticing the diagnosis. The MDS Coordinator stated based on Resident #10's diagnosis resident should had been referred for another PASRR Level 1 evaluation. She stated she had submitted Form 1012 (Mental Illness/Dementia Resident Review) today (07/11/24) and was waiting on the doctors' signature. The MDS Coordinator stated once it was signed then a PASRR Level 1 will be entered and she will contact Local Authorities. She stated not ensuring the PASRR had the correct mental illness diagnoses could lead to residents not receiving further services. Interview on 07/11/24 at 2:38 PM with the DON revealed the MDS Coordinator was responsible for reviewing PASRR Level 1 Screenings. She stated the Regional MDS Nurse was responsible for overseeing the PASRRs. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/11/24 at 3:41 PM with Regional MDS Nurse revealed she was responsible for overseeing the MDS Coordinator's work. She stated she completed forms 1012 quarterly on every resident, and she stated she last completed them end of April 2024. Record review of Resident #10's Form 1012 Mental Illness/Dementia Resident Review revealed it was submitted on 07/11/24. Record review of the facility's Pre-Admission Screening Resident Review (PASRR), policy, revised June 2020, reflected the following: .Policy: A negative Level 1 screen permits admission to proceed and ends the PASRR process, unless a possible serious mental disorder or intellectual disability arises later . The facility must notify the state-designated mental health or intellectual disability authority promptly when a resident with MD or ID experiences a significant change in mental or physical status.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review, the facility failed to ensure a resident who was fed by enteral means received appropriate treatment and services to prevent complications for one (Resident #48) of three residents reviewed for feeding tubes. LVN C failed to flush Resident #48's g-tube with 60cc of water before her bolus feeding (feeding method using a syringe to deliver formula through feeding tube) as ordered by the physician. This failure could place residents at risk for a decline in health or adverse effects due to inappropriate management of G-tube care. Findings included: Record review of Resident #48's quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included cerebral palsy, quadriplegia, seizure disorder, and dysphagia (trouble swallowing) and required a feeding tube. The MDS further reflected the resident was dependent of one staff member for all ADLs including bathing, dressing, and hygiene. Resident #8 had long and short term memory impairment and speech was rarely understood and she rarely understood others. Record review of Resident #48's care plan last reviewed on 06/03/24 revealed she required a tube feeding and was NPO. Interventions included the resident was dependent with tube feeding and water flushes; see MD for orders for current feeding orders. Record review of Resident #48's Order Summary Report for July 2024 reflected the following: Enteral Feed Order every 4 hours every 4 hours flush g-tube with 60cc of water before and after each bolus feeding. Observation on 07/10/24 at 4:29 PM of Resident #48's tube feeding revealed the resident was in bed with her head elevated. LVN C washed her hands and donned some gloves, and the water, formula, and medications were set up at the bedside table. LVN C checked the feeding tube for residual and there were no concerns, then poured the formula up to gravity and there were no concerns with the flow. LVN C then flushed the feeding tube with 60cc of water and continued to give the medications per physician orders. After LVN C finished with the medications, she flushed the feeding tube with 60cc of water. Interview on 07/10/24 at 5:24 PM with LVN C revealed after administering the feeding to Resident #48 she thought about it and realized she forgot to flush the feeding tube before the formula. LVN C said it was important to flush the feeding tube to make sure it was clear for the formula, and she was just nervous because she was being watched. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/11/24 at 12:40 PM with the DON revealed LVN C should have flushed the feeding tube with water before adding the formula. The DON said it was important to ensure the tube had patency (unobstructed) and did not have a clog. Record review of the facility's Tube Feeding policy, revised December 2020, reflected the following: Purpose To ensure that the Facility meets the nutritional guidelines and resident's nutritional requirements per physician orders

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 4 residents (Resident #18) reviewed for dialysis. The facility failed to ensure post-dialysis assessments were completed for Resident #18 after return from dialysis treatment. This failure could place residents at risk of inadequate post dialysis care. Findings included: Interview on 07/10/24 at 6:46 AM with Resident #18 revealed she went for dialysis Tuesday, Thursday and Saturday. She stated she got a form that she took to dialysis and brought back to facility. Record review of Resident #18's EHR reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #18 had diagnoses which included acute kidney failure (when kidneys suddenly become unable to filter waste products from blood) and chronic kidney disease stage 4 (severe damage to kidneys, and they are less able to filter waste and fluid out of the blood). Record review of Resident #18's quarterly MDS assessment, dated 06/03/24, reflected a BIMS score of 8, which indicated her cognition was moderately impaired. The MDS section O related to special treatments, procedures and programs reflected Resident #18 received dialysis. Record review of Resident #18's care plan, dated 06/08/24, reflected Resident #18 needed dialysis to rule out renal failure. Resident #18 will have no signs of complication from dialysis through next review. The access site will function and be maintained without signs and symptoms of infection. Monitor/document for peripheral edema(swelling on the lower legs or hands). Obtain vital signs and weight per protocol. Report significant changes in pulse respiration weight gain over 2 pounds a day and blood pressure immediately. Monitor/record/report to the physician as needed signs and symptoms of renal insufficiency (poor function of the kidneys that may be due to a reduction in blood-flow to the kidneys caused by renal artery disease), changes in level of consciousness, changes in skin turgor (the skin's elasticity), oral mucosa(the mucous membrane lining or skin inside of the mouth, including cheeks and lips), changes in heart and lung sounds. Record review of Resident #18's July 2024 physician's order reflected there were no orders for post dialysis monitoring; check site for clotting, bleeding, drainage and dressing intact. Monitor vital signs in the morning every Tuesday, Thursday, and Saturday for dialysis and in the afternoon every Tuesday, Thursday, and Saturday for dialysis. Record review of Resident #18's EHR reflected no nursing documentation regarding Resident #18's post-dialysis vital signs. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #18's dialysis communication forms reflected dialysis communication forms with no information on the resident assessment and observation post-dialysis section on 06/06/24, 06/11/24, 06/13/24, 06/18/24, 06/20/24, 06/25/24, 06/27/24, 07/02/24 and 07/04/24. Interview on 07/11/24 at 01:04 PM with LVN G revealed she was aware she was supposed to send Resident #18 with the dialysis communication form when she left for dialysis and then collect the form when the resident returned from dialysis. LVN G stated she knew she was supposed to monitor the dialysis access site for the bruit thrill (a vibration caused by blood flowing through the fistula and can be felt by placing your fingers just above incision line), dressing for bleeding and vital signs when Resident #18 was back from dialysis, but she was not consistent. She stated it was all nurse's responsibility to update the dialysis communication form when Resident#18 came back. LVN G stated failure to monitor and assess Resident #18 post dialysis put her at risk of low blood pressure, infection, and bleeding. She stated she had done trainings, on dialysis communication form. Interview on 07/11/24 at 02:47 PM with the DON revealed her expectation was for the nurses to perform post-dialysis assessments when residents returned from dialysis, and document on dialysis communication forms on dialysis days. She stated nursing management were responsible of following up with nurses and ensuring the post dialysis monitoring was being done and documented, on the dialysis communication form. She stated the ADON was supposed to check and follow up with nurses. The DON stated failure to monitor the vital signs after dialysis would lead change of condition, bleeding, and unstable vital signs . She stated she had done training with staff and the last in-service was in April 2024. Interview on 07/11/24 at 03:21 PM with the ADON revealed it was her responsibility to ensure the staff completed post dialysis communication forms when Resident #18 returned to the facility. ADON stated she goes through the dialysis communication forms every day after dialysis and she had noticed there were some that were missing documentation and she had told the nurses responsible to fill in the information that was missing, but she does not know why they are still showing missing. ADON stated the assessments were important to ensure the vital signs were stable and check for bleeding. She stated the risk for not assessing the vitals was Resident #18's vital signs could be unstable leading to change of condition. Record review of the facility trainings reflected the facility had done training on the Dialysis communication form on 4/10/24. Record review of the facility's Dialysis Care policy, dated June 2020, reflected the following: .III .The nursing staff, dialysis provider staff, and the attending physician will collaborate on a regular basis concerning the resident's care as follows : I. Nursing staff will communicate pertinent information in writing to the dialysis staff which may include: a. Any medication changes b. Any recent changes in condition c. The resident's tolerance of dialysis procedures. (continued on next page)

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	675977	A. Building B. Wing	07/11/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii. The dialysis provider will communicate in writing to the facility. a. The resident's current vital signs b. Pre and post dialysis weight. III. Nursing staffs will keep the attending physician, the resident and the resident's family informed of any changes in condition. V. Documentation concerning dialysis services and care of the dialysis resident will be maintained in the resident's medical record.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on interview and record review, the facility failed to maintain clinical records that were complete and accurate for two (Resident #18 and Resident #28) of six residents reviewed for clinical records. 1. The facility failed to obtain physician orders for Resident #18 dialysis port site monitoring, vital signs, and documentation of the pre and post dialysis Vitals on the communication form. 2. The facility failed to document when the physician was notified when Resident #28's blood sugar exceeded 250. This failure could place residents at risk for incomplete and inaccurately documented medical record that included their progress treatment, services, and interventions. Findings include: 1. Record review of Resident #18's electronic record reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #18 had diagnoses which included acute kidney failure (when kidneys suddenly become unable to filter waste products from blood) and chronic kidney disease stage 4 (severe damage to kidneys, and they are less able to filter waste and fluid out of the blood). Record review of Resident #18's quarterly MDS assessment, dated 06/03/24, reflected a BIMS score of 8, which indicated her cognition was moderately impaired. The MDS section O related to special treatments, procedures and programs reflected Resident #18 received dialysis. Record review of Resident #18's care plan, dated 06/08/24, reflected Resident #18 needed dialysis rule out renal failure. Resident #18 will have no signs of complication from dialysis through next review. The access site will function and be maintained without signs and symptoms of infection. Monitor/document for peripheral edema (swelling on the lower legs or hands). Obtain vital signs and weight per protocol. Report significant changes in pulse respiration weight gain over 2 pounds a day and blood pressure immediately. Monitor/record/report to the physician as needed signs and symptoms of renal insufficiency (poor function of the kidneys that may be due to a reduction in blood-flow to the kidneys caused by renal artery disease), changes in level of consciousness, changes in skin turgor (the skin's elasticity), oral mucosa (the mucous membrane lining or skin inside of the mouth, including cheeks and lips), changes in heart and lung sounds. Record review of Resident #18's July physician's order reflected there were no orders for post dialysis monitoring; check site for clotting, bleeding, drainage and dressing intact. Monitor vital signs in the morning every Tuesday, Thursday, and Saturday for dialysis and in the afternoon every Tuesday, Thursday, and Saturday for dialysis. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/11/24 at 01:04 PM with LVN G revealed she was not aware that Resident # 18 did not have dialysis orders to monitor pre and post dialysis, the site, vitals and for documentation on the dialysis communication form. LVN G stated she was aware they were supposed to have the orders to document and monitor Resident #18 pre and post dialysis, but she did not check because she knew what she was supposed to do. Interview on 07/11/24 at 02:47 PM with the DON revealed her expectation was Resident #18 to have orders to monitor pre and post dialysis and document on the dialysis communication form before leaving for dialysis and when residents#18 was back from dialysis. She stated nursing management were responsible of following up to ensure orders for pre and post dialysis were on the electronic health records. The DON stated failure to have orders could lead to staffs not monitoring of the site for bleeding, infection, and failure to assess the site could result to infection or a failed shunt that could lead to residents going to theatre for unnecessary procedure to replace the failed shunt. Interview on 07/11/24 at 03:21 PM with the ADON revealed it was her responsibility and the DON's to ensure the staff are putting orders to completed pre and post dialysis communication forms when Resident #18 went and returned to the facility. ADON stated she goes through the orders, and she was not aware she did not have orders. ADON stated the importance of having orders were to ensure the pre and the post assessment were being done. She stated the risk for not having orders could lead to missed assessment that could lead to change of condition. Interview attempt on 07/11/24 at 03:08PM with Resident#18 Doctor by phone was not successful; a voicemail was left. 2. Record review of Resident 28's Face sheet, dated 07/11/24, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #28's quarterly MDS assessment, dated 04/12/24, reflected he had a BIMS score of 12, which indicated moderate cognitive impairment. MDS indicated his diagnoses included Type 2 Diabetes mellitus (high level of sugar in the blood), hyperlipidemia (high cholesterol), unspecified dementia and essential hypertension (high blood pressure). Record review of Resident #28's care plan, revised on 05/29/24, reflected: Focus: [Resident #28] has Diabetes Mellitus. Goal: The resident will be free from any s/sx of hyperglycemia (high blood sugar) through the review date. [Resident #28] will have no complications related to diabetes through the review date. Interventions: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Monitor/document/report to MD PRN s/sx of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor (skin paleness), Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait. Record review of Resident #28's Order Summary Report for June 2024 reflected the following: Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 50 unit subcutaneously every morning and at bedtime for DM related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS PLEASE, CALL DOCTOR FOR BLOOD SUGAR LESS THAN 60 MG/DL OR GREATER THAN 250 MG/DL. Record review of Resident #28's blood sugar readings reflected the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/11/2024 - 280.0 mg/dL 7/10/2024 - 272.0 mg/dL 7/10/2024 - 286.0 mg/dL 7/9/2024 - 266.0 mg/dL 7/8/2024 - 300.0 mg/dL 7/8/2024 - 331.0 mg/dL 7/6/2024 - 267.0 mg/dL 7/2/2024 - 280.0 mg/dL 6/29/2024 - 263.0 mg/dL 6/28/2024 - 297.0 mg/dL 6/19/2024 - 322.0 mg/dL 6/18/2024 - 297.0 mg/dL 6/17/2024 - 311.0 mg/dL 6/13/2024 - 302.0 mg/dL 6/12/2024 - 299.0 mg/dL 6/11/2024 - 278.0 mg/dL 6/10/2024 - 281.0 mg/dL Record review of Resident #28 progress notes for the month of June and July 2024 revealed physician was only notified on 06/07/24 when blood sugar reading of 398mg/dl. There was no other documentation where the physician was notified of blood sugar exceeding 250. Interview on 07/09/24 at 11:04 AM of Resident #28 stated he was doing well. Resident #28 was not a good historian and could not recall if he received insulin. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/11/24 at 1:47 PM with LVN F stated he was the nurse assigned to Resident #28. He stated resident had an order for insulin. He stated nurses should notify the doctor when Resident #28's blood sugar levels were out of range. LVN F reviewed Resident #28's physician orders and resident had an order to call the doctor when Resident #28's blood sugars are more than 250. LVN F stated when they notify the doctor, nurses should document in the progress notes that the doctor had been notified. LVN F stated he does contact the doctor when Resident #28's blood sugars are more than 250; however, he forgot to document. LVN F reviewed Resident #28's progress notes and stated there was no documentation and stated it was bad nursing practice. He stated if it was not documented it did not happen. He stated the risk of not documenting would be incoming staff not knowing if the doctor was made aware. Interview on 07/11/24 at 2:07 PM by phone with the Doctor revealed the facility nurses were good at notifying him when Resident #28's blood sugar levels were out of range. He stated that was one thing the nurses at the facility were good at doing was to notify him. He stated his expectations were for nurses to notify him when resident blood sugar levels were out of range and to document in the resident's clinical records that he had been notified. Doctor stated documentation was a big issue and it should be worked on. Interview on 07/11/24 at 2:31 PM with the DON revealed her expectations were for the nurses to follow physician orders. The DON stated Resident #28's orders were recently changed last month (June 2024). She stated the blood sugar parameters were lowered to 250. The DON stated nurses should document in the resident progress notes every time they notify the doctor. She stated if they do not document in the progress notes it would appear the doctor was never notified. She stated it was her responsibility to review progress notes. The DON stated she reviewed the progress notes every day; however, she had not noticed that her nurses were not documenting correctly. Record review of facility policy Physician Orders, dated June 2020, reflected the following: This will ensure that all physician orders are complete and accurate. I. A Licensed Nurse will transcribe telephone orders with date, time and signature of the person receiving the order. II. Orders will include a description complete enough to ensure clarity of the physician's plan of care. IV. Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. V. Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other health care disciplines will be transcribed onto the appropriate communication system for that discipline. VI. Documentation pertaining to physician orders will be maintained in the resident's medical record. 44140

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview, and record review the facility failed to ensure resident bedrooms were designed or equipped to assure full visual privacy by having ceiling suspended curtains designed to give privacy for one (306 A bed and B Bed) of 4 triple occupied rooms reviewed for privacy. The facility failed to ensure room [ROOM NUMBER] had a privacy curtain between A bed and B bed. This failure placed residents at risk of loss of privacy and dignity and decreased quality of life. Findings included: Observation on 07/09/24 at 8:16 AM of room [ROOM NUMBER] revealed the room had three beds and only two privacy curtains. The room was occupied by three residents. There was no privacy curtain between A bed and B bed. Observation and interview on 07/09/24 at 8:26 AM of Resident #39 in the Day Room sitting watching TV. Resident #39 stated she was doing well. Resident #39 stated she shared a room and her bed was in the middle. Resident #39 was not a good historian and was not able to answer further questions. Observation and interview on 07/09/24 at 11:13 AM of Resident #1 in the Day Room sitting watching TV. Resident #1 stated she was doing well. Resident #1 stated she was unaware if she had a privacy curtain in her room. Resident #1 was not a good historian and was not able to answer further questions. Interview and observation on 07/10/24 at 2:42 PM with CNA D revealed she had been employed for 4 weeks. She stated in rooms that were occupied by three residents, there should be three privacy curtains. CNA D observed room [ROOM NUMBER] and stated she had noticed that the privacy curtain between A bed and B bed was missing. She stated she had noticed it a couple of days ago and forgot to report it to the charge nurse. She stated privacy curtains are needed to provide residents privacy. Interview and observation on 07/10/24 at 2:47 PM with LVN E stated she was the nurse assigned to the secure unit. She stated rooms that were occupied by three residents required three privacy curtains. She stated there should be a privacy curtain in between each bed. LVN E stated room [ROOM NUMBER] was occupied by three residents. LVN E observed room [ROOM NUMBER] and stated she had not noticed there was no privacy curtain between A bed and B bed. She stated privacy curtains are needed for residents' privacy and dignity. Interview on 07/10/24 at 2:54 PM with Maintenance Manager revealed rooms occupied by three residents should have three privacy curtains. He stated privacy curtains are removed and cleaned monthly; however, no one had reported any missing privacy curtains. He stated on 07/08/24 he had removed a privacy curtain from one of the rooms in 400 Hall but had not removed any from 300 Hall. He stated it was his responsibility to ensure each room had privacy curtains. The Maintenance Manager stated each resident should have privacy curtains to provide total privacy during care. (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/11/24 at 3:28 PM with the Administrator stated each resident should have a privacy curtain. She stated for rooms that are occupied by three residents there should be a privacy curtain in between the beds. She stated it was the responsibility of all staff to ensure each resident had a privacy curtain. She stated privacy curtains are needed for residents' privacy and dignity. Record review of facility policy Privacy and Dignity, dated June 2020, reflected the following: To ensure that care and services provided by the facility promote and/or enhance privacy, dignity and overall quality of life. The Facility promotes resident care in a manner and an environment that maintains or enhances dignity and respect, in full recognition of each resident's individuality. Policy did not address privacy curtains.