

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2024
NAME OF PROVIDER OR SUPPLIER  Matlock Place Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7100 Matlock Rd Arlington, TX 76002	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227</b></p> <p>Based on interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent neglect for one (09/12/23) of one incidents reviewed for reporting.</p> <p>The facility failed to follow their policy to report to the State Survey Agency when Resident #302 tilted in her wheelchair while being transported to an appointment in the facility van.</p> <p>This failure could place the residents in the facility at risk of lacking timely reporting of incidents.</p> <p>Findings included:</p> <p>Review of the facility's Abuse, Neglect, and Exploitation policy, revised 01/01/23, reflected the following</p> <p>Policy</p> <p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures and that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>VII. Reporting/Response</p> <p>1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:</p> <p>a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or</p> <p>b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #302's MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility 08/16/23. The resident's diagnoses included hypertension (high blood pressure), diabetes, arthritis, presence of left artificial shoulder joint, and bicipital tendinitis (inflammation of the long head of the biceps tendon). Resident #302 had a BIMS of 10, cognition moderately impaired, and clear speech.</p> <p>Review of Resident #302's care plan revised on 08/24/23 reflected she had an ADL self-care performance deficit related to left shoulder arthroplasty (surgical procedure to restore the function of a joint) and right finger fracture.</p> <p>Review of a Resolution Form dated 09/14/23 signed by the Administrator reflected the following:</p> <p>Concern</p> <p>Upset [Resident #302] fell out of chair on van. Says that more falls could lead to set backs. Concerned that she will not be able to discharge to ALF</p> <p>Review of Resident #302's progress notes dated 09/12/23 documented by RN E revealed the following:</p> <p>Informed by facility driver that during transport back to facility from ortho appointment resident fell over out of wheel chair while reaching for her purse on the floor, resident assessed upon return to facility, bruise and abrasion noted to right side of face above eye, patient c/o mild pain to right side rib area, physician notified, 2-view xray ordered for right rib area, 2-view skull series ordered, due to post fall pain, resident medicated for pain.</p> <p>Further review of Resident #302's clinical record revealed she did not sustain any fractures or severe injuries as a result of the van incident.</p> <p>Interview on 03/27/24 at 1:34 PM with Resident #302 revealed she was in her wheelchair in the van, being taken to an appointment and as the van was turning, she thought they might have hit a bump and her wheelchair tilted to the side. The resident stated she felt like she was falling to the side when she was tilted in the wheelchair. Resident #302 said the Van Driver stopped right away and adjusted her wheelchair and she thought she might have hit her head but did not recall the extent of her injuries or if she was in pain.</p> <p>Interview on 03/26/24 at 11:38 AM with the Van Driver revealed the day of the incident, 09/12/23, she was turning onto a street and Resident #302 appeared to be trying to reach for something in her bag and as soon as they made the turn, she heard the resident yell, and she noticed the wheelchair tilted on its side on two wheels. The Van Driver said she stopped the van and checked on the resident and she appeared to be ok and did not notice any injuries. The resident was returned to the facility, and she was assessed by a nurse. The Van Driver said she did not know how the wheelchair tilted because she remembered strapping the resident in appropriately.</p> <p>Interview on 03/26/24 at 11:58 AM with RN E revealed the day of the incident, 09/12/23, he was told by the Van Driver that Resident #302 bent over to get something off the floor and had fallen over. RN E did not recall many details of the extent of the resident's injuries but thought Resident #302 sustained an abrasion with no bleeding.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/26/24 at 11:33 AM with the Administrator revealed after the van incident with Resident #302, she was taken back to the facility and assessed by the charge nurse. The Administrator stated he did not know how the resident's wheelchair tilted but he gave the Van Driver additional training to make sure she was securing the residents in the van appropriately. The Administrator further stated he did not think the incident rose to the level of reporting because there was no injury and after talking to Resident #302, she was happy with how the facility handled the situation.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227</b></p> <p>Based on interview and record review, the facility failed to ensure all alleged violations involving abuse and neglect were reported immediately but not later than 24 hours if the events that cause the allegation did not involve abuse and did not result in serious bodily injury to the State Survey Agency for one of one incidents reviewed for reporting.</p> <p>The facility failed to report to the State Survey Agency when Resident #302 tilted in her wheelchair while being transported to an appointment in the facility van.</p> <p>This failure could affect residents by resulting in a delay of identification of abuse or neglect and lack of timely follow-up on recommended interventions to prevent harm, or impairment.</p> <p>Findings included:</p> <p>Review of Resident #302's MDS assessment, dated 08/23/23, reflected the resident was [AGE] year-old female admitted to the facility 08/16/23. The resident's diagnoses included hypertension (high blood pressure), diabetes, arthritis, presence of left artificial shoulder joint, and bicipital tendinitis (inflammation of the long head of the biceps tendon). Resident #302 had a BIMS of 10, cognition moderately impaired, and clear speech.</p> <p>Review of Resident #302's care plan revised on 08/24/23 reflected she had an ADL self-care performance deficit related to left shoulder arthroplasty (surgical procedure to restore the function of a joint) and right finger fracture.</p> <p>Review of a Resolution Form dated 09/14/23 signed by the Administrator reflected the following:</p> <p>.Concern</p> <p>Upset [Resident #302] fell out of chair on van. Says that more falls could lead to set backs. Concerned that she will not be able to discharge to ALF</p> <p>Review of Resident #302's progress notes dated 09/12/23 documented by RN E revealed the following:</p> <p>Informed by facility driver that during transport back to facility from ortho appointment resident fell over out of wheel chair while reaching for her purse on the floor, resident assessed upon return to facility, bruise and abrasion noted to right side of face above eye, patient c/o mild pain to right side rib area, physician notified, 2-view xray ordered for right rib area, 2-view skull series ordered, due to post fall pain, resident medicated for pain.</p> <p>Further review of Resident #302's clinical record revealed she did not sustain any fractures or severe injuries as a result of the van incident.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937</b></p> <p>Based on interview and record review, the facility admitted a resident with a mental disorder before the State mental health authority had determined he was appropriately placed for 1 of 7 residents (Resident #95) reviewed for Preadmission Screening and Resident Review (PASARR) screening.</p> <p>The MDS Coordinator failed to complete the PASARR screening process accurately for Resident #95.</p> <p>This failure could place residents at risk of not receiving specialized services.</p> <p>Findings included:</p> <p>Review of Resident #95's undated face sheet revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included Unspecified Dementia (decline in cognitive abilities), severe, with psychotic disturbance (mental health disorders), cognitive communication deficit (communication impairment), and Schizophrenia (general misperception of reality).</p> <p>Review of Resident #95's quarterly MDS assessment, dated 01/12/24, revealed a BIMS score of 00, indicating the score was not able to be completed. Resident #95 required setup or clean-up assistance with eating, Supervision or touching assistance with oral hygiene and upper body dressing, Dependent with toileting and showering/baths, personal hygiene, putting on and taking off footwear. Substantial assistance required for lower body dressing. Active diagnosis included Schizophrenia.</p> <p>Review of Resident #95's care plan, reviewed 03/26/24, revealed she has impaired thought.</p> <p>(continued on next page)</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>processes related to Sepsis (body's response to infection causing injury to its own tissues and organs), Goal: she will be able to communicate basic needs on a daily basis, Intervention: ask yes/no questions in order to determine the residents needs. Cue, reorient and supervise as needed. Monitor/document/report as needed any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Resident #95 has a communication problem however noted to usually being understood and usually understand. Goal: The resident will be able to make basic needs known on a daily basis. Interventions: Anticipate and meet needs. Be conscious of resident position when in groups, activities, dining room to promote proper communication with others. COMMUNICATION: Allow adequate time to respond, Repeat as necessary, Do not rush, Request clarification from the resident to ensure understanding, Face when speaking, make eye contact, Turn off TV/radio to reduce environmental noise, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed. Monitor/document/report as needed any changes in: Ability to communicate, Potential contributing factors for communication problems, Potential for improvement. Resident #95 uses Antipsychotic Medication related to schizophrenia. Goal: Resident #95 will be/remain free of antipsychotic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment. Interventions: Administer antipsychotic medications as ordered by physician. Monitor for side effects and effectiveness every shift. Discuss with MD, family regarding ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of clozapine (a type of antipsychotic medication that treats mental health conditions like schizophrenia).</p> <p>Review of Resident #95's physician orders revealed Clozapine Oral Tablet 50 MG. Give 1 tablet by mouth at bedtime for Schizophrenia. Dated 02/04/24.</p> <p>Review of Resident #95's PASRR I screening, completed by transferring facility, dated 01/08/24 revealed the resident had evidence of a mental illness.</p> <p>Review of Resident #95's PASRR I screening, completed on 01/08/24 by facility, revealed the resident no evidence of mental illness.</p> <p>Interview on 03/24/24 at 1:10 PM Resident #95 was not able to have conversation with clear communication, only able to answer yes or no questions.</p> <p>Interview on 03/24/24 at 1:30 PM with CNA M revealed Resident #95 was newly admitted to the facility, required supervision when eating. Resident #95 can feed herself but required some encouragement when eating. Resident #95 was able to express her wants and needs, for example when she was ready to get in and out of wheelchair and bed. Resident #95 wore a catheter that was emptied every shift. CNA M stated Resident #95 was still getting familiar with staff and her stay at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/26/24 at 11:25 AM with the ADON revealed Resident #95 was new to the facility. ADON stated Resident #95 was diagnosed with Schizophrenia. The ADON said family stated she was well until she had children and she had a change in condition from that time and never bounced back to her normal life. ADON stated currently Resident #95 was not receiving PASARR services. ADON stated MDS Coordinators were responsible for completing the PASARR screenings for new resident admissions. ADON stated if a resident were positive for PASARR services and they were not receiving services that would place them at risk of not meeting goals that were care planned and prevents residents from having a better quality of life.</p> <p>Interview on 03/25/24 at 4:35 PM with MDS Coordinator revealed Resident #95's PASARR Level 1 screening was completed at the facility on 01/08/24. After reviewing the facility screening which indicated no mental illness, MDS Coordinator reviewed transferring facility's screening and noted there was indication of mental illness. According to MDS Coordinator, Resident #95's PASARR evaluation was not triggered due to an error of indicating she had no evidence of a mental illness (a box was not checked). MDS Coordinator stated she was responsible for ensuring PASARR evaluations were updated and completed correctly. MDS Coordinator stated not doing so placed Resident #95 at risk of not receiving PASARR services.</p> <p>Review of the facility's Resident Assessment-Coordination with PASARR Program, revised 10/01/23, reflected:</p> <p>This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs.</p> <p>1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening.</p> <p>A. PASARR Level 1 - initial pre-screening that is completed prior to admission.</p> <p>i. negative Level I Screen- permits admission to proceed and end the PASARR process unless a possible serious mental disorder or intellectual disability arises later.</p> <p>ii. Positive Level I Screen - necessitates a PASARR Level II evaluation prior to admission.</p> <p>B. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has Mental Disorder, Intellectual Disability, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140</b></p> <p>Based on observations, interviews, and record reviews the facility failed to develop a comprehensive care plan for 1 (Resident #54) of 5 residents reviewed for comprehensive care plans.</p> <p>The facility failed to update Resident #54's care plan to address the use of his hinged knee brace.</p> <p>This failure could result in the resident not receiving appropriate care for his fracture.</p> <p>Findings included:</p> <p>Review of Resident #54's face sheet dated 03/26/24 indicated Resident #54 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #54 had a diagnosis of hyperkalemia (high potassium), end stage renal disease (renal failure), type 2 diabetes mellitus, unspecified fracture of shaft (middle bone) of left tibia (shinbone), subsequent encounter for closed fracture with routine healing and other reduced mobility.</p> <p>Review of Resident #54's quarterly MDS assessment dated [DATE] revealed Resident #54 had a BIMS score of 14 which indicated cognition was intact. MDS Assessment further revealed section J - Health Condition - Resident #54 had a major injury- bone fractures, joint dislocation, closed head injuries with altered consciousness, subdural hematoma (bleeding near the brain).</p> <p>Review of Resident #54's care plan, revised date 2/27/24 revealed: Focus: Resident has had a fall with/without injury. His fall risk assessment score is 17, indicating resident is at high risk for falls d/t Poor Balance 2/2/22 slid off bed - no injury 2/26/24 Fall with fx with immobilizer. Goal: [Resident #54] will resume usual activities without further incident through the review date. Interventions: 2/26/24 Psych service contact for intervention due to anxiety post dialysis, Monitor/document /report PRN x 72h to MD for s/sx: Pain, bruises, change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Refer resident to therapy for evaluation and treatment. Care Plan did not address the use of hinged knee brace.</p> <p>Review of Resident #54's orthopedic order, dated 03/05/24, revealed f/u in 3 months with xr of the L knee on arrival. Nondisplaced bicondylar fracture of left tibia, initial encounter for closed fracture. Knee Brace, Hinged - Use as directed.</p> <p>Interview on 03/25/24 at 3:10 PM with Resident #54 revealed he had a recent fall unknown of the exact date. He stated he had returned from dialysis and he was sitting on his bed when he became dizzy and fell forward. Resident #54 stated he sustained a fracture to his left leg. Observed Resident #54 to have a hinged knee brace to his left leg. Resident #54 stated staff and he does not remove it. He stated he always wears the brace. Resident #54 denied any skin breakdowns.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 3/26/24 at 9:50 AM with LVN C revealed Resident #54 had a fall last month February 2024. She stated Resident #54 was found on the floor and he was able to state what happened. LVN C stated Resident #54 was transferred to the hospital and returned in less than 24 hours. She stated Resident #54 was provided with a left knee brace. LVN C stated they do not remove the brace, she stated she was unaware of how long the brace was needed for. She stated Resident #54's falls were care planned but was not sure if the knee brace was care planed. LVN C reviewed Resident #54's care plan and stated it was not care planned. She stated ADON D was responsible for reviewing orders, updating, and completing the care plans.</p> <p>Interview on 3/26/24 at 2:12 PM with ADON D revealed he was responsible for updating care plans. ADON D stated Resident #54's falls were care planned but not his knee brace. He stated the risk of not care planning the knee brace would be staff not knowing how to care for and monitor the use of the knee brace.</p> <p>Interview on 03/26/24 at 4:23 PM with the DON revealed her expectations regarding care plans are for her staff to follow physician orders, complete skin checks, and interventions are in place. The DON stated ADON D notified her about Resident #54's use of a knee brace. She stated ADON D was responsible for completing residents' care plans and it was her responsibility to oversee. She stated she was unaware Resident #54's knee brace was not care planned. DON stated not having an updated care plan placed the resident at risk of not knowing th,e interventions on how to care and monitor.</p> <p>Review of the facility's Comprehensive Care Plans policy, revised 01/01/24 reflected the following: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessments.</p>

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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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140</b></p> <p>Based on observation, interview, and record review, the facility failed to provide residents who were unable to carry out activities of daily living the necessary services to maintain grooming and personal hygiene for two (Residents #35 and #83) of eight residents reviewed for facial hair.</p> <p>The facility failed to remove Resident #35 and Resident #83's facial hair.</p> <p>These failures could place residents at risk for poor hygiene, dignity issues, and decreased quality of life.</p> <p>Findings included:</p> <p>Review of Resident #35's face sheet revealed Resident #35 was admitted to the facility on [DATE] with diagnoses of reduce mobility, dysphagia (difficulty swallowing), major depressive disorder, essential hypertension (high blood pressure), unsteadiness of feet, and muscle weakness.</p> <p>Review of Resident #35's quarterly MDS assessment, dated 03/04/24, revealed Resident #35 had a BIMS score of 06, which indicated severe cognitive impairment. Section GG - Functional Abilities and Goals, Question GG0130. Self-Care revealed Resident #35 required maximal assistance with ADLs of bathing, dressing, toileting and required supervision or touching assistance with the ADL personal hygiene.</p> <p>Record review of Resident #35's care plan, revised on 03/11/24, indicated the following: Focus: [Resident #35] has an ADL self-care performance deficit r/t weakness. Goal: will maintain current level of function in through the review date. Interventions/Tasks: Bed Mobility: The resident requires extensive (physical help) by staff to turn and reposition in bed and as necessary. Dressing: The resident requires extensive (physical help) by staff to dress. Eating: The resident requires set up by staff to eat. Personal Hygiene: The resident requires (extensive assistance) by staff with personal hygiene and oral care. Toilet use: The resident requires (Total dependence assistance) by staff for toileting. Transfer: The resident requires (extensive assistance) by staff to move between surfaces and as necessary. Encourage the resident to participate to the fullest extent possible with each interaction.</p> <p>Review of Resident #83's face sheet indicated Resident #83 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, major depressive disorder, type 2 diabetes, essential hypertension (high blood pressure), muscle weakness, chronic kidney disease, other reduce mobility.</p> <p>Review of Resident #83's quarterly MDS assessment, dated 01/15/24, revealed Resident #83 had a BIMS of 10, which indicated moderate cognitive impairment. Section GG - Functional Abilities and Goals, Question GG0130. Self-Care revealed Resident #83 required maximal assistance with ADLs of bathing, dressing, toileting and required supervision or touching assistance with the ADL personal hygiene.</p> <p>Review of Resident #83's Care plan, revised dated 3/13/24, did not address ADLs.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and observation on 03/24/24 at 10:44 AM, Resident #35 stated she was well and facility staff treated her well. Resident #35 was observed lying in bed in her room with several white/gray hairs on her chin, roughly .25 inches in length. Resident #35 stated she would like to have her facial hair shaved. Resident #35 stated she could not recall the last time someone asked if she would like to be shaved. Observed Resident #35 touch her chin and stated, Oh yeah, I need to cut it. It is long.</p> <p>Interview and observation on 03/24/24 at 10:57 AM, Resident #83 stated she was well. Resident #83 was observed eating a yogurt and lying in bed in her room with several white/gray hairs on her chin, roughly .25 inches in length. Resident #83 stated she would like to have her facial hair shaved. She stated she could not recall the last time someone asked if she would like to be shaved. Resident #83 stated she has asked staff to shave it off; however, they do not. Resident #83 stated she does not like her facial hair.</p> <p>Interview on 03/26/24 at 11:11 AM with CNA M revealed he was the assigned CNA for Resident #35 and Resident #83. CNA M stated the CNAs provide showers to residents. He stated Resident #35 received showers/bed baths during the 6AM-2PM shift and Resident #83 received showers/bed baths during the 2PM-10PM shift. He stated Resident #35 does refuse bed baths at times. He stated Resident #35 does have facial hair; however, it was the responsibility of the beautician to remove residents' facial hair. He stated he had not mentioned to anyone of Resident #35 facial hair. He stated the potential risk of not removing facial hair would be built up of bacteria.</p> <p>Interview on 3/26/24 at 11:20 AM with LVN C revealed she was the nurse assigned to Resident #35 and Resident #83. She stated the assigned CNAs were responsible to provide residents with showers. LVN C stated CNAs should remove residents' facial hair unless they refuse. LVN C stated Resident #35 was known to refuse care; however, she was unsure when was the last time she was asked regarding her facial hair. She stated Resident #35 facial hair was long. LVN C stated there was no risk to resident if they have facial hair.</p> <p>Interview on 03/26/24 at 2:56 PM with CNA N revealed she was the assigned CNA for Resident #35 and Resident #83. She stated she provide bed baths to Resident #83. She stated she is not known to refuse bed baths. CNA N stated Resident #83 does have long facial hair; however, she does not know if she was able to remove it. She stated she had not been told to remove Resident #83's facial hair.</p> <p>Interview on 03/26/24 at 3:13 PM with LVN I revealed she was the nurse assigned to Resident #83. She stated Resident #83 was not known to refuse ADL care. She stated CNAs were responsible to remove facial hair unless the resident refused. She stated Resident #83 was able to state if she would like her facial hair removed but had not.</p> <p>Interview on 03/26/24 at 4:30 PM with the DON revealed her expectations are for residents' facial hair to be removed if the resident desires. She stated staff who provide showers/bed baths should be asking the residents if they desire to remove their facial hair. The DON stated female residents should not have facial hair unless told otherwise. She stated it was the responsibility of the CNAs, Nurses, ADON and herself to ensure ADLs are being completed. She stated the potential risk would be affecting resident dignity.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility Activities of Daily Living (ADLs) policy, revised 01/01/23, reflected the following: .Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming and oral care .</p> <p>A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32227 43791</p> <p>Based on interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 2 (Residents #21 and #54) of 5 residents reviewed for quality of care.</p> <ol style="list-style-type: none"> <li>The facility failed to follow physician orders for weekly weights on Resident #21 resulting in a weight gain.</li> <li>The facility failed to obtain physician orders for Resident #54 use of hinged knee brace.</li> </ol> <p>This failure could place the resident at risk of not receiving the care intended by the physician.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Review of Resident #21's undated Admission Record reflected the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia, depression, heart disease, and diabetes.</li> </ol> <p>Review of Resident #21's quarterly MDS assessment, dated 01/26/24, revealed a BIMS score of 7, indicating severe cognitive impairment. Her Functional Status assessment revealed she required minimal assistance with her ADLs.</p> <p>Review of Resident #21's care plan, dated 11/21/23, reflected she had a focus of impaired physical mobility, impaired cognition and memory loss related to dementia, and required a therapeutic diabetic diet.</p> <p>Review of Resident #21's physician orders revealed an active order on 06/20/23 for weekly weights.</p> <p>Review of Resident #21's weight record from 06/15/23 to 03/05/24 revealed the resident was weighed weekly until 08/07/23, she was weighed three times in September 2023, and then monthly thereafter. Resident #21's weight decreased by 30 pounds from 06/15/23 to 09/11/23; and from 09/11/23 to 03/05/24 she gained 30 pounds.</p> <p>Interview on 03/25/24 at 4:11 PM the DON stated CNAs were responsible for weighing residents per physician orders. The DON stated residents are weighed monthly, unless ordered differently by the physician. The DON stated the risk of not weighing residents as directed could be failure to catch a resident with malnutrition, or a cardiac resident being fluid overloaded. The DON stated she did not know why Resident #21 was not being weighed weekly, or the order had not been modified to monthly.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of Resident #54's face sheet dated 03/26/24 indicated Resident #54 was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #54 had a diagnosis of hyperkalemia (high potassium), end stage renal disease (renal failure), Type 2 diabetes mellitus, unspecified fracture of shaft (middle bone) of left tibia (shinbone), subsequent encounter for closed fracture with routine healing and other reduced mobility.</p> <p>Review of Resident #54's quarterly MDS assessment dated [DATE] revealed Resident #54 had a BIMS score of 14 which indicated cognition was intact. MDS Assessment further revealed section J - Health Condition - Resident #54 had a major injury- bone fractures, joint dislocation, closed head injuries with altered consciousness, subdural hematoma (bleeding near the brain).</p> <p>Review of Resident #54's care plan, revised date 02/27/24 revealed: Focus: Resident has had a fall with/without injury. His fall risk assessment score is 17, indicating resident is at high risk for falls d/t Poor Balance 02/02/22 slid off bed - no injury 02/26/24 Fall with fx with immobilizer. Goal: [Resident #54] will resume usual activities without further incident through the review date. Interventions: 02/26/24 Psychiatric service contact for intervention due to anxiety post dialysis, Monitor/document /report PRN x 72h to MD for s/sx: Pain, bruises, change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Refer resident to therapy for evaluation and treatment. Care Plan did not address the use of hinged knee brace.</p> <p>Review of Resident #54's EHR revealed no orders to monitor for the use of hinged knee brace. No orders pertaining to care related to knee brace.</p> <p>Interview on 03/25/24 at 3:10 PM with Resident #54 revealed he had a recent fall unknown of the exact date. He stated he had returned from dialysis and he was sitting on his bed when he became dizzy and fell forward. Resident #54 stated he sustained a fracture to his left leg. Observed Resident #54 to have a hinged knee brace to his left leg. Resident #54 stated staff and he does not remove it, he stated he always wears the brace. Resident #54 denied any skin breakdowns.</p> <p>Interview on 03/26/24 at 9:50 AM with LVN C revealed Resident #54 had a fall last month February 2024. She stated Resident #54 was found on the floor and he was able to state what happened. LVN C stated Resident #54 was transferred to the hospital and returned in less than 24 hours. She stated Resident #54 was provided with a left knee brace. LVN C stated they do not remove the brace. She stated she was unaware of how long the brace was needed for. She stated Resident #54 was seen by therapy and she believed therapy removed the knee brace. LVN C reviewed Resident #54's orders and stated they did not have orders for the knee brace or to monitor. She stated ADON D was responsible for reviewing physician orders. LVN C stated there was no risk to the resident due to them monitoring resident skin daily .</p> <p>Interview with on 03/26/24 at 9:57 AM with Therapy Director revealed Resident #54 was seen 3 times a week. She stated Resident #54 had a fall and sustained a fracture. She stated Resident #54 had an orthopedic appointment and he was ordered to use a Hinged knee brace. She stated when Resident #54 comes to therapy they remove it and they monitor his skin, she stated Resident #54 does not have any skin issues. Therapy Director reviewed Resident #54's orders and stated Resident #54 did not have an order for the Hinged knee brace. She stated he should have one and to monitor. Therapy Director provided Resident #54's paper orthopedic order. She stated ADON C provide her with the orders.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #54's orthopedic order, dated 03/05/24, revealed f/u in 3 months with xr of the L knee on arrival. Nondisplaced bicondylar fracture of left tibia, initial encounter for closed fracture. Knee Brace, Hinged - Use as directed.</p> <p>Observation on 03/26/24 at 10:02 AM of Resident #54's left leg with Therapy Director revealed no skin breakdown.</p> <p>Interview on 03/26/24 at 2:12 PM with ADON D revealed he had not noticed Resident #54 did not have orders for the use of his knee brace. ADON D stated no one had noticed they did not have orders. He stated Resident #54 had the orthopedic order but it was not updated in the resident's chart. He stated they also did not have orders to monitor. He stated he had contacted the doctor and the doctor ordered to always keep the knee brace on unless to remove for showers. He stated it was the responsibility of the DON, MDS, and himself to review orders. He stated the potential risk would be skin breakdown.</p> <p>Interview on 03/26/24 at 4:23 PM with the DON revealed her expectations are for her staff to follow physician orders, and to monitor for skin breakdowns. The DON stated ADON D notified her about Resident #54's use of a knee brace. She stated ADON D was responsible for updating physician orders. She stated she was unaware Resident #54 did not have an order for his knee brace. DON stated physician orders are needed because it provides the care and staff should follow them.</p> <p>Review of the facility's Physician Orders policy, dated 01/01/23, reflected:</p> <p>A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide written and/or verbal orders for the resident's immediate care needs.</p> <p>The orders should allow facility staff to provide essential care to the resident consistent with the resident's mental and physical status.</p> <p>44140</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227</b></p> <p>Based observation, interview, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for two (Resident #40 and #302) of six residents reviewed for accidents.</p> <ol style="list-style-type: none"> <li>1. The Van Driver failed to properly restrain Resident #302's wheelchair in the facility transportation van to prevent the wheelchair from tipping over on its side on the way to dialysis on 09/12/23.</li> <li>2. The facility failed to provide adequate supervision for Resident #40 when she was stuck outside in the courtyard and she was not able to call the facility because their phone lines were down.</li> </ol> <p>This failure could place residents at risk for serious injury or harm, decline in health, and decreased quality of life.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Review of Resident #302's MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility 08/16/23. The resident's diagnoses included hypertension (high blood pressure), diabetes, arthritis, presence of left artificial shoulder joint, and bicipital tendinitis (inflammation of the long head of the biceps tendon). Resident #302 had a BIMS of 10, cognition moderately impaired, and clear speech.</li> </ol> <p>Review of Resident #302's care plan revised on 08/24/23 reflected she had an ADL self-care performance deficit related to left shoulder arthroplasty (surgical procedure to restore the function of a joint) and right finger fracture.</p> <p>Review of a Resolution Form dated 09/14/23 signed by the Administrator reflected the following:</p> <p>.Concern</p> <p>Upset [Resident #302] fell out of chair on van. Says that more falls could lead to set backs. Concerned that she will not be able to discharge to ALF</p> <p>Review of Resident #302's progress notes dated 09/12/23 documented by RN E revealed the following:</p> <p>Informed by facility driver that during transport back to facility from ortho appointment resident fell over out of wheel chair while reaching for her purse on the floor, resident assessed upon return to facility, bruise and abrasion noted to right side of face above eye, patient c/o mild pain to right side rib area, physician notified, 2-view xray ordered for right rib area, 2-view skull series ordered, due to post fall pain, resident medicated for pain.</p> <p>Further review of Resident #302's clinical record revealed she did not sustain any fractures or severe injuries as a result of the van incident.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/27/24 at 1:34 PM with Resident #302 revealed she was in her wheelchair in the van, being taken to an appointment and as the van was turning, she thought they might have hit a bump and her wheelchair tilted to the side. The resident stated she felt like she was falling to the side when she was tilted in the wheelchair. Resident #302 said the Van Driver stopped right away and adjusted her wheelchair and she thought she might have hit her head but did not recall the extent of her injuries or if she was in pain.</p> <p>Interview on 03/26/24 at 11:38 AM with the Van Driver revealed the day of the incident, 09/12/23, she was turning onto a street and Resident #302 appeared to be trying to reach for something in her bag and as soon as they made the turn, she heard the resident yell, and she noticed the wheelchair tilted on its side on two wheels. The Van Driver said she stopped the van and checked on the resident and she appeared to be ok and did not notice any injuries. The resident was returned to the facility, and she was assessed by a nurse. The Van Driver said she did not know how the wheelchair tilted because she remembered strapping the resident in appropriately.</p> <p>Interview on 03/26/24 at 11:58 AM with RN E revealed the day of the incident, 09/12/23, he was told by the Van Driver that Resident #302 bent over to get something off the floor and had fallen over. RN E did not recall many details of the extent of the resident's injuries but thought Resident #302 sustained an abrasion with no bleeding.</p> <p>Interview on 03/26/24 at 11:33 AM with the Administrator revealed after the van incident with Resident #302, she was taken back to the facility and assessed by the charge nurse. The Administrator stated he did not know how the resident's wheelchair tilted but he gave the Van Driver additional training to make sure she was securing the residents in the van appropriately.</p> <p>Review of the facility's policy titled Operating Company Vehicle revised on 01/01/23 reflected the following:</p> <p>Policy</p> <p>It is the policy of this facility to ensure residents are transported in accordance to the Department of Public Safety</p> <p>5. All unforeseen situations will be reported immediately to the facility Administrator.</p> <p>2. Review of Resident #40's MDS assessment dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included coronary artery disease, hypertension, end-stage renal disease, and diabetes. Resident #40 had a BIMS of 13, cognition intact, and she used a wheelchair for mobility.</p> <p>Review of Resident #40's care plan revised on 03/08/21 reflected the resident had an ADL self-care performance deficit related to pain due to radiculopathy (pinching of a nerve root in the spinal column).</p> <p>Review of the facility's Provider Investigation Report dated 03/03/24 reflected the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administrator was made aware of a [social media] video containing allegations of neglect against the facility. In the video, the [family] says that [Resident #40] called her saying she was stuck outside in the courtyard and couldn't get the facility to answer. The video then shows the [family] running into the facility, confronting staff, finding [Resident #40] in the courtyard, then cursing at staff accusing them of neglect before going with staff to retrieve [Resident #40] Facility phones were down at the time due to internet being down which was the reason the [family] was unable to call facility. Video footage at the facility showed [Resident #40] going into the courtyard on her own at 10a, then shows her getting her right wheel stuck in the fountain area. She is there for 1 hour and 20 minutes before the [family] is seen coming outside with staff. Staff checked resident and did assessment, MD was notified, resident was not harmed.</p> <p>Review of Resident #40's progress notes dated 03/03/24 documented by the Weekend Supervisor reflected the following:</p> <p>Resident [family] in the facility to speak to nurse stated to the nurse '[Resident #40] called me at 10:09 and said she was outside in the courtyard and could not get back in the building, I called the facility and could not get through so I came up here, she was out there until I came to get her out at 11:30'. Nurse went to resident room to assess her, no injuries noted, denied pain sitting in room. Resident propels self around in wheelchair independently, AAOX4 and able to voice needs. Resident stated she was pushed outside by an employee because she wanted to sit for a while. Resident stated 'I don't know who it was who open [sic] the courtyard door and took me out'. No one confirmed at this at this time. Nurse informed [family] that we will monitor her closely and let her know if she has a status change, vital signs stable at this time.</p> <p>Social media post was reviewed on 03/24/24 and it showed Resident #40's right wheel had come off the paved walkway in the courtyard and was stuck in the landscape area around the water fountain that contained dirt and wood chips.</p> <p>Review of the weather history revealed the temperature was 67 degrees at 10:00 AM on 03/03/24.</p> <p>Observation and interview on 03/24/24 at 9:32 AM with Resident #40 revealed she went outside to the courtyard and as she was wheeling herself one of her wheels got stuck by the water fountain, and she was not able to get herself out. The resident stated she was yelling for help and told another resident, not able to recall who, who was outside to go inside for help, but that resident never did. Resident #40 said she had her cell phone with her, and she was trying to call the facility, but was later told the facility phones were down so she called her family member who arrived at the facility to help her. The resident did not recall how long she was outside but said it was starting to feel warm.</p> <p>Phone call attempts to Resident #40's family member on 03/24/24 were unsuccessful.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/25/24 at 2:47 PM with LVN F revealed Resident #40's family member approached her very aggressively saying the resident had been left outside. Once they went outside, they noticed Resident #40's wheel had gotten stuck around the water fountain. Once the resident was taken back into the facility, she was assessed and there were no injuries or concerns noted and stated she felt fine. LVN F said Resident #40 had been seen after breakfast where she was going to work on a puzzle with another resident. LVN F further stated the resident did not require any assistance getting around the facility in her wheelchair. The LVN also stated the internet was down causing the phones lines not to work.</p> <p>Interview on 03/25/24 at 3:02 PM with CNA G revealed he cared for Resident #40 on 03/03/24 and assisted her into her wheelchair that morning. He stated he did not see Resident #40 go outside but she was alert and oriented and independent in her wheelchair and did not require a lot of supervision.</p> <p>Interview on 03/26/24 at 4:16 PM with the Weekend Supervisor revealed Resident #40's family member had told her the resident had been outside in the courtyard since 10:00 AM for an hour and no one at the facility would answer the phone. The Weekend Supervisor said she went to assess Resident #40, and there were no injuries noted and her vital signs were good. The Weekend Supervisor also said the phones were not working that day because the internet had gone down.</p> <p>Interview on 03/26/24 at 12:50 PM with the DON revealed she had been made aware by the Weekend Supervisor that Resident #40's family was upset because the resident was stuck outside in the courtyard. The resident and family had been trying to call the facility but due to a car accident off the property, the internet was down causing the phone lines not work. They reviewed the facility cameras, and it showed the resident wheeling herself to the courtyard and was out there for about an hour. The DON also said Resident #40 was independent in her wheelchair and was safe to go outside to the courtyard and residents that had cognitive impairments were monitored more closely and accompanied by staff if they wished to go outside. The DON further stated risks of being outside for a prolonged length of time could be dangerous if the temperatures were too cold or too hot.</p> <p>Interview on 03/24/24 at 12:56 PM with the Administrator revealed he had been made aware the following day, 03/04/24, about the social media post where Resident #40 had been stuck outside in the courtyard. He then watched the camera footage within the facility and it showed the resident going outside on her own and by the time she was taken back inside the facility, it had been an hour and twenty minutes. The Administrator was told Resident #40 and the family had been trying to call the facility when the resident was stuck but because there had been a car accident that knocked down the internet the phones were not working. The Administrator said they began 30 minute checks of the courtyard after the incident and all staff were inserviced to check the courtyard as they are walking by to make sure there were no residents that appeared to be in distress. He also stated they have a remote system they used to send out COVID-19 alerts to families, they will use going forward when their phones are not working, giving them an alternate phone number to call in case of an emergency.</p> <p>Review of the facility's Resident Rights policy, dated 01/01/23, reflected the following:</p> <p>Resident Rights</p> <p>The resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227</b></p> <p>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 #46) of four residents reviewed for feeding tubes.</p> <p>The nursing staff failed to ensure Resident #46's water flushes were correct on the feeding pump per the physician orders.</p> <p>The failure placed residents, who received nutrition via g-tube, at risk for decreased nutritional intake and weight loss complications.</p> <p>Findings included:</p> <p>Review of Resident #46's MDS assessment dated [DATE] revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. The resident's diagnoses included hypertension (high blood pressure), Cerebrovascular Accident (stroke), non-Alzheimer's dementia, hemiplegia (Muscle weakness or partial paralysis on one side of the body). The MDS further reflected Resident #46 did not have a BIMS due to having severely impaired cognition and he had a feeding tube.</p> <p>Review of Resident #46's care plan revised on 02/27/24 reflected he required a tube feeding due to swallowing problems. Interventions included to follow MD orders for tube feeding and water flushes.</p> <p>Review of Resident #46's order summary report for March 2024 reflected the following:</p> <p>Jevity 1.5 Cal running at 65 ml/hr X22 hours with water auto-flushes of 200 ml every 6 hours continuously every shift</p> <p>Observation on 03/24/24 at 1:58 PM of Resident #46 revealed he was in bed with his eyes open and he was not able to respond when he was spoken to. The resident's tube feeding was running, and the water flushes were set at 150ml every 4 hours.</p> <p>Further observation on 03/25/24 at 1:05 PM revealed Resident #46's tube feeding water flushes were still set at 150ml every 4 hours.</p> <p>Interview on 03/25/24 at 1:53 PM with LVN C revealed the last time she worked was on Friday, 03/22/24, and she recalled the feeding pump water flush settings were correctly set 200ml every 6 hours. LVN C stated she did not know who or why it was changed to 150ml every 4 hours. LVN C said when she turned the feeding pump on, it asked her if the settings were correct and she pushed the yes button but today she did not look to verify if all the settings were correct because they usually were. LVN C further stated it was important to look and verify with the orders to make sure the tube settings were correct because the resident could run the risk of dehydration if they are not getting enough water or getting too much water.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/26/24 at 12:19 PM with ADON D revealed he was made aware by LVN C that Resident #46's water flushes were not correct. ADON D stated he did not know what happened but said nurses should be checking the physician orders before connecting the residents to the tube feeding to ensure it was correct. ADON D further stated it was important to follow the orders to ensure residents were getting the correct nourishment and resident also ran the risk of getting too much fluids or not enough water.</p> <p>Interview on 03/26/24 at 12:44 PM with DON revealed she had been made aware of Resident #46's incorrect water flushes. She stated nurses should have been checking settings on the feeding pump to ensure the orders were being followed. The DON further stated residents were at risk of not getting the correct nourishment, getting dehydrated, or getting more fluids than they need.</p> <p>Review of the facility's Care and Treatment of Feeding Tubes policy, revised 01/01/23 reflected the following:</p> <p>.1. Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>44140</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the daily nurse staffing was posted as required each day for three (03/24/24, 03/25/24 and 03/26/34) of three days reviewed for nursing services and postings.</p> <p>The facility failed to update the daily staffing information posting on 03/24/24, 03/25/24 and 03/26/24.</p> <p>This failure could affect residents, their families, and facility visitors by placing them at risk of not having access to information regarding staffing data and facility census.</p> <p>Findings included:</p> <p>Observation on 03/24/24 at 10:35 AM of the building revealed the daily nursing staff posting was posted on the wall by the entrance with a date of 03/22/24.</p> <p>Observation on 03/25/24 at 10:40 AM of the building revealed the daily nursing staff posting was posted on the wall by the entrance with a date of 03/22/24.</p> <p>Observation on 03/26/24 at 9:45 AM of the building revealed the daily nursing staff posting was posted on the wall by the entrance with a date of 03/22/24.</p> <p>Interview on 03/26/24 at 3:49 PM with the ADON D revealed it was his responsibility for completing and posting the daily nursing staffing posting. He stated it was part of his morning routing to complete and post the daily nursing staffing posting. He stated with everything going on these past few days he forgot to complete the daily nursing staffing post. He stated the daily nursing staffing post was needed to give residents and visitors accurate information on facility's census and staffing ratio.</p> <p>Interview on 03/26/24 at 3:54 PM with the Administrator revealed ADON D was responsible for posting the daily nursing staff information each day. He stated it might had slipped the ADON D's mind to post the daily nursing staffing posting. He stated the daily nursing staffing post was needed to give visitors and staff accurate information on facility's census and staffing ratio.</p> <p>Review of the facility's Nurse Staffing Posting Information policy, dated 01/01/23, reflected the following:</p> <p>It is the policy of this facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time.</p> <p>1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information:</p> <p>a. Facility name</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>b. The current date</p> <p>c. Facility's current resident census</p> <p>d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <ul style="list-style-type: none"> <li>i. Registered Nurses</li> <li>ii. Licensed Practical Nurses/Licensed Vocational Nurses</li> <li>iii. Certified Nurse Aides</li> <li>iv. Certified Medication Aides</li> </ul>

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43791</p> <p>Based on record review and interviews the facility failed to provide or obtain laboratory services to meet the needs of its residents in a timely manor for 1 (Resident #77) of 5 residents reviewed for laboratory services in that</p> <p>The facility failed to follow physician orders for routine lab work for Resident #77, resulting in the lab not being performed.</p> <p>This failure could result in missing resident's medical conditions getting worse.</p> <p>Findings included:</p> <p>Review of Resident # 77's undated Admission Record revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia, diabetes, vitamin deficiency, high cholesterol, and bipolar disorder.</p> <p>Review of Resident #77's annual MDS assessment, dated 2/02/24, revealed a BIMS score not calculated due to the resident's dementia. Her Functional Status assessment indicated she required substantial assistance with her ADLs.</p> <p>Review of Resident #77's care plan, dated 2/23/24, revealed she had a self-care deficit, limited activity involvement, and behavioral problems.</p> <p>Review of Resident #77's physician orders revealed an order on 12/23/23 and one on 3/14/24 for routine lab work. Review of her EHR revealed no results of the lab work, no nursing notes indicating results were received, and no documentation of the resident refusing labs.</p> <p>Review of Resident #77's nursing notes indicated on 3/4/24 urine was collected for a urinalysis and urine culture. There was no indication why the urine was collected or why the lab work was ordered. On 03/20/24 there is a note indicating the resident was started on antibiotics for her urine infection as well as placing the resident in contact isolation. There were no other notes between 03/04/24 and 03/20/24.</p> <p>Review of the urine lab results indicated the urine was collected on 03/04/24, the lab was run on 03/05/24, and the culture was resulted on 03/08/24. The results indicated Resident #77's urine was positive for klebsiella oxytoca (a type of gram-negative bacteria that can cause various healthcare-associated infections).</p> <p>Interview on 03/26/24 at 10:00 AM LVN-A stated she was told Resident #77 had her urine tested because she had blood in her urine, and she had started being incontinent frequently. LVN A stated Resident #77 had been started on antibiotics on 03/20/24 and placed in isolation the same day.</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/26/24 at 11:15 AM the Nurse Practitioner stated he did not recall when he was notified of Resident #77's urine results, but stated it must have been on 03/20/24 when he started the antibiotics. He stated if he remember right he was not notified of the results, but he had discovered the results when he was reviewing the lab results. He did not know why he was not notified on 03/08/24 when the culture results were reported. The Nurse Practitioner stated the risk of not starting antibiotics right away included the resident developing an overwhelming infection and possibly dying, and infecting other residents.</p> <p>Interview on 03/26/24 at 12:40 PM the DON stated there was no reason staff should not have reported the urine results to the physician on 03/08/24. Lab results are sent to the facility by fax, located at the nurse's station, and they are also sent directly to the EHR under the Results tab. The DON stated the nursing staff should have been anticipating the lab results since they had requested the test and collected the urine. The DON stated there was a lack of follow through on the part of the nurses. The DON stated the risk of delay in starting antibiotics and placing the resident in isolation included prolonging the infection and spreading the infection to other residents.</p> <p>Interview on 03/25/24 at 2:45 PM the DON stated the nurses were responsible for carrying out all physician orders. She stated the lab work should have been completed. The DON stated she would research the resident's EHR to ensure the lab results had not been recorded somewhere not found.</p> <p>Follow up interview on 03/25/24 at 3:05 PM the DON stated she could not find any evidence of the lab work being done. The DON stated the risk of not following the physician orders included the physician not receiving a complete picture of the resident's health status, the resident not receiving the appropriate care., and not being able to track changes in the resident's condition.</p> <p>Review of the facility's Physician Orders policy, dated 01/01/23, reflected:</p> <p>A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide written and/or verbal orders for the resident's immediate care needs.</p> <p>The orders should allow facility staff to provide essential care to the resident consistent with the resident's mental and physical status.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>44937</p> <p>Based on observation, interview, and record review, the facility failed to provide food prepared by methods, which conserved nutritive value, flavor, and appearance for one of one pureed meal observed for nutrition.</p> <p>The Dietary Manager failed to ensure the pureed lunch meal on 03/24/24 was prepared according to the recipe to conserved nutritive value and flavor.</p> <p>The failure could place residents, who were on a pureed diet, at risk for a decrease in nutritive status, loss of appetite, decreased intake and unwanted weight loss.</p> <p>Findings included:</p> <p>Observation on 03/24/24 at 10:55 AM of the Dietary Manager preparing the pureed lunches revealed she put shredded turkey pieces, hot water, and thickener into a blender. She then blended the mixture. The pureed meat appeared to have a pudding consistency. The Dietary Manager then mixed stuffing which included the stuffing, thickener, and hot water.</p> <p>Interview on 03/24/24 at 11:11 AM with the Dietary Manager revealed she was notified by her morning cook that surveyors were in the building, and she was nervous. She stated she came in to assist. The Dietary Manager stated she was preparing pureed lunch for seven residents. She stated she mixed the food item, thickener, and hot water until they were a pudding texture. She stated there was no need to add additional seasonings because the food was cooked with seasonings and adding more would over season the taste. She stated she used hot water so the thickener would not clump because if she used broth instead of hot water it would over season the food. The Dietary Manager stated she and the cooks were responsible for following the recipe for all meals and not doing so would alter the nutrients in the recipe.</p> <p>Observation and interview on 03/26/24 at 12:20 PM of lunch trays, both pureed and regular texture, revealed cranberry glazed pork loin with gravy, blackeyed peas, and green beans. During the taste of the pureed tray, it appeared each item on the tray to include pork loin, blackeye peas, green beans were without seasoning or flavor. The pork loin had gravy on top and it appeared full of flavor. The Dietary Manager stated the pureed food items should have had more flavor. She stated having the gravy on the pork loin helped with the taste and flavor. The Dietary Manager stated Cook P perhaps did not cook with seasonings because she recently was written up for over seasoning the food. The Dietary Manager stated it was important to provide residents with nutritious foods they could enjoy eating. She stated she and the cooks were responsible for preparing foods according to the recipe. She stated not doing so placed residents at risk for weight loss and malnutrition.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/26/24 at 12:30 PM with Cook P revealed she prepared the pureed lunch meal to include pork loin, blackeye peas, green beans, and gravy. Cook P stated she cooked the meal with seasonings. She stated when it was time to puree the foods, she added chicken broth to the pork loin, green beans, and blackeye peas. Cook P stated she was careful when seasoning and preparing foods for residents because she recently got in trouble for over seasoning food. According to Cook P she did taste the pureed food and thought it was without flavor, but with the gravy, it should have given balance without over flavoring the food. Cook P stated she was responsible for ensuring the food looked and tasted good. Cook P stated without doing so placed residents at risk of not eating and leading to weight loss and not getting proper nutrition.</p> <p>Record review of the facility's recipe on 03/24/24 for pureed meals reflected:</p> <p>*Note: Any liquid specified in the recipe is a suggested amount of liquid (if needed). Some recipe items will require no liquid added to achieve the desired consistency.</p> <ol style="list-style-type: none"> <li>1. If product needs thinning, gradually add an appropriate amount of liquid (NOT WATER) to achieve a smooth, pudding or soft mashed potato consistency.</li> <li>2. If the product needs thickening, gradually add a commercial or natural food thickener (ex, potato flakes or baby rice cereal) to achieve a smooth, pudding or soft mashed potato consistency.</li> <li>3. Follow any facility policies/procedures, such as the puree volume method procedure, to ensure a correct portion is served.</li> </ol> <p>Top pureed foods with appropriate sauces or gravies, as needed, to ensure adequate moisture for safe consumption and enhanced flavor.</p> <p>Review of the facility's Puree Food Preparation policy, dated 01/01/23, reflected the following:</p> <p>It is the policy of this facility to provide puree food that has been prepared in a manner to conserve nutritive value, palatable flavor, and attractive appearance.</p> <p>Each resident must receive, and the facility must provide food that is prepared by methods that conserve nutritive value, flavor, and appearance Do not use water as an additive to prepare puree foods.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44937</p> <p>Based on observation, interview, and record review, the facility failed to ensure food, subject to spoilage and removed from its original container, was kept sealed, labeled, and dated in the facility's only kitchen.</p> <p>1. The facility failed to ensure food items stored in the freezer were properly labeled with the contents after being removed from the original packages and not dated to reflect when the food items were opened.</p> <p>2. The facility failed to ensure the freezer was maintained in a sanitary manner free from dark substances.</p> <p>This failure could place all residents at risk for food contamination and food borne illness.</p> <p>Findings included:</p> <p>Observation of the freezer and interview on 03/24/24 beginning at 9:00 AM revealed the following:</p> <ul style="list-style-type: none"> <li>- a grey tub in the bottom of the freezer,</li> <li>- 6 clear plastic bags with frozen chicken parts, undated and unlabeled,</li> <li>- 1 clear bag with breaded patties, undated and unlabeled.</li> </ul> <p>At the bottom of the freezer underneath the grey tub and to the left of the tub appeared to be a dark substance that was spilled and frozen. According to Cook Q, the spillage was from a tray of tea that had spilled, and no one cleaned from the night before. Cook Q stated the grey tub contained bags of chicken breast that the facility stored in this freezer to have easy access.</p> <p>Observation of the walk-in freezer and interview on 03/24/24 at 9:10 AM revealed a clear bag of 2-3 pork chops, 1 bag of tater tots, an unknown frozen meat approximately 3-pounds, and 1 bag of meatballs was not labeled or dated. Interview with Cook Q revealed the pork chops, tater tots, and meatballs were food items that were left over from preparing previous meals. Cook Q stated the process when storing foods included cooks to place left over food items in a storage bag to conceal properly, label the food item, and include the opened date. Cook Q stated it was the responsibility of the cooks to do walk thru daily to remove anything 2 weeks out from dates written on the stored food items. Cook Q was not able to identify the frozen 3-pound meat without a label or date. Cook Q stated Dietary Manager also completed walk thru when she ordered foods and when the truck delivered every Tuesday and Friday.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 03/24/24 at 10:30 AM with the Dietary Manager revealed the tub in the bottom of the freezer was a tub the facility used for leftover chicken to be used another day. She stated Cook Q expressed to her the spillage in the freezer was tea the night shift did not clean up and Cook Q had not had a chance to clean prior to surveyor entering the kitchen. According to the Dietary Manager, herself and the Cooks are required to ensure any leftover foods are stored properly by sealing, dating, and labeling prior to being stored. The Dietary Manager stated it was her expectation that anything that spilled in the freezer, or the refrigerator was to be cleaned immediately. She stated she expected cooks to remove anything placed in the freezers or refrigerators that were without a label or date immediately because you would not know the contents or how long it had been stored. She stated without knowing how long the food had been stored it could lead to serving residents food that was not appropriate for cooking or serving causing food borne illness.</p> <p>Review of the facility's Food Storage policy, dated 2023, reflected:</p> <p>Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored in a manner that is clean, dry and free from contaminants. Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination.</p> <p>Frozen Foods:</p> <p>All freezer units are kept clean and in good working condition at all times All foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2024
NAME OF PROVIDER OR SUPPLIER  Matlock Place Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7100 Matlock Rd Arlington, TX 76002	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43791</p> <p>Based on observation, interview, and record review, the facility failed to ensure the system for identifying and reporting infections and communicable diseases for all resident was followed for 1 (Resident #63) of 2 residents reviewed for infection control.</p> <p>The staff failed to notify the physician of Resident #63's urine culture being positive for an infectious agent, resulting in a delay in starting antibiotics and contact isolation.</p> <p>This failure could place residents at risk of being exposed to an infectious agent.</p> <p>Findings included:</p> <p>Review of Resident #63's undated Admission Record revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included difficulty swallowing, dementia, muscle weakness and diabetes.</p> <p>Review of Resident #63's quarterly MDS assessment, dated 03/21/24, revealed a BIMS score of 13, indicating intact cognition.</p> <p>Review of Resident #63's care plan, dated 01/26/24, indicated she had impaired nutrition, impaired decision making, and she had bowel and bladder incontinence.</p> <p>Observation on 03/25/24 at 10:10 AM revealed Resident #63 had signage on her door indicating she was in contact isolation and PPE was located outside her room.</p> <p>Interview on 03/25/24 at 10:14 AM CNA B stated Resident #63 was on isolation because her urine was infected, and staff were required to wear a gown and gloves for any direct contact with the resident.</p> <p>Review of Resident #63's nursing notes indicated on 03/04/24 urine was collected for a urinalysis and urine culture. There was no indication why the urine was collected or why the lab work was ordered. On 03/20/24 there is a note indicating the resident was started on antibiotics for her urine infection as well as placing the resident in contact isolation. There were no other notes between 03/04/24 and 03/20/24.</p> <p>Review of the urine lab results indicated the urine was collected on 03/04/24, the lab was run on 03/05/24, and the culture was resulted on 03/08/24. The results indicated Resident #63's urine was positive for klebsiella oxytoca (a type of gram-negative bacteria that can cause various healthcare-associated infections).</p> <p>Interview on 03/26/24 at 10:00 AM LVN A stated she was told Resident #63 had her urine tested because she had blood in her urine, and she had started being incontinent frequently. LVN A stated Resident #63 had been started on antibiotics on 03/20/24 and placed in isolation the same day.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 03/26/24 at 11:15 AM the Nurse Practitioner stated he did not recall when he was notified of Resident #63's urine results, but stated it must have been on 03/20/24 when he started the antibiotics. He stated if he remember right he was not notified of the results, but he had discovered the results when he was reviewing the lab results. He did not know why he was not notified on 03/08/24 when the culture results were reported. The Nurse Practitioner stated the risk of not starting antibiotics right away included the resident developing an overwhelming infection and possibly dying, and infecting other residents.</p> <p>Interview on 03/26/24 at 12:40 PM the DON stated there was no reason staff should not have reported the urine results to the physician on 03/8/24. Lab results were sent to the facility by fax, located at the nurse's station, and they are also sent directly to the EHR under the Results tab. The DON stated the nursing staff should have been anticipating the lab results since they had requested the test and collected the urine. The DON stated there was a lack of follow through on the part of the nurses. The DON stated the risk of delay in starting antibiotics and placing the resident in isolation included prolonging the infection and spreading the infection to other residents.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>44140</p> <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure the facility was free of pests for 3 (100, 200 and 400 Hall) of 6 Halls, and 1 of 1 conference room reviewed for pests.</p> <p>The facility failed to ensure an effective pest control program was implemented to prevent the presence of gnats throughout the facility.</p> <p>This failure could place residents at risk for the potential spread of infection, cross-contamination, and decreased quality of life.</p> <p>Findings included:</p> <p>Observations between 03/24/24 at 9:30 AM through 03/26/24 at 5:00PM revealed 2-3 gnats in the facility Conference room.</p> <p>Observations between 03/24/24 at 10:30 AM through 03/26/24 at 5:00 PM revealed gnats flying in 100, 200, and 400 Hall.</p> <p>Observation and interview on 03/24/24 at 10:44 AM revealed Resident #35 lying in her bed. Resident #35 room was in the 100 Hall. Resident #35 stated she was doing well. She stated her room was cleaned every day; however, she had been having issues with gnats in her room. Observed about 4-5 gnats in Resident #35's room. Gnats were around Resident #35 bed side table, wall and privacy curtain and linen. She stated she had told the staff but could not recall how long ago.</p> <p>Observation and interview on 03/24/24 at 10:57 AM revealed Resident #83 lying in her bed. Resident #83 room was in the 100 Hall. Resident #83 stated she was doing well. Resident #83 stated her room does get cleaned. Observed about 2 gnats in Resident #83's room. Gnats were on the privacy curtain. She stated she had noticed them but does not recall if she had mentioned it to the staff. She stated she did not like them.</p> <p>Observation and interview on 03/24/24 at 11:00 AM revealed Resident #51 lying in her bed. Resident #51 room was in the 100 Hall. Resident #51 stated she was doing well. Resident #51 stated her room does get cleaned. Observed about 2-3 gnats in Resident #51's room. Gnats were on the privacy curtain and wall. She stated she had not noticed the gnats in her room, until now.</p> <p>Observation and interview on 03/24/24 at 11:30 AM revealed Resident #54 lying in her bed. Resident #54 stated he was doing well. Resident #54 room was in the 100 Hall. Resident #54 stated his room does get cleaned. Observed about 2 gnats in Resident #54's room. Gnats were observed on the wall next to Resident #54 bedside table. Resident #54 stated from time-to-time gnats would appear. He stated he had observed facility staff spray something to get rid of the gnats. He stated he could not recall the last time they had sprayed anything. He stated they had less gnats than before.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 03/24/24 at 11:40 AM revealed Resident #53 sitting in her wheelchair. Resident #53 had a family member in her room. Resident #53 room was in the 100 Hall. Observed about 4-5 gnats in Resident #53 room. Gnats were around the resident wheelchair and privacy curtain. Resident #53 Family Member stated last week unknown of the exact date, it was observed staff spraying something to get rid of the gnats. He stated it was a lot worse than now.</p> <p>Interview on 03/26/24 at 11:11 AM with CNA M revealed he had not had any residents complain about gnats; however, he had witnessed them on the 100 Hall . CNA M stated he had observed pest control be in the building and maintenance staff spray once a week. When asked if he had reported the gnats, CNA M stated, I cannot monitor and report everything at the same time when assisting residents. He stated it was maintenance staffs' responsibility to ensure there were no pests.</p> <p>Interview on 03/26/24 at 11:11 AM with LVN C stated she was the nurse assigned to 100 Hall. She stated they had issues with gnats but nothing recently. She stated if they had any concerns, they would notify the Maintenance Supervisor and Administrator verbally. She stated she had observed maintenance staff spray a chemical to treat for pest control.</p> <p>Interview on 03/26/24 at 11:27 AM with Housekeeping O revealed she was assigned to clean 100, 200 and 300 Hall. She stated she cleaned the rooms once a day. She stated she had observed gnats in the 100 Hall. She stated when she observed the gnats she reports to her supervisor. She stated she tried her best to clean and disinfect the areas; however, they reappear.</p> <p>Interview on 03/26/24 at 12:57 PM with the Maintenance Supervisor revealed the facility has had issues with fruit flies/gnats. He stated the gnats were mostly by station 1 and the kitchen. He stated Pest Control had been to the facility more frequent to treat the gnats. He stated once a week he had been spraying bug spray. The Maintenance Supervisor stated since it had been raining, pest control had been an issue due to the standing water outside. He stated there was no risk to the residents since they were just fruit flies.</p> <p>Interview on 03/26/24 at 3:50 PM with Housekeeper Supervisor revealed he had been notified of the gnats in the 100 Hall. He stated he reports to the Maintenance Supervisor and he would treat the area. He stated Pest Control had been to the facility more frequently to treat the gnats.</p> <p>Interview on 03/26/24 at 3:54 PM with the Administrator revealed gnats had been a concern. He stated they had been addressing the gnats. He stated they have had Pest Control come to the facility more frequently. He stated he had not had any recent complaints regarding pest control.</p> <p>Review of the facility Pest Control binder for the months of January 2024 through March 2024 revealed pest control visited on 01/11/24 for roaches, 01/18/24 for gnats, 02/26/24 for gnats, 03/06/24 for spiders, 03/18/24 for monthly service.</p> <p>Record review of facility's Pest Control Program policy, dated 04/01/23, reflected the following: It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents.</p>		