| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676315 | A. Building<br>B. Wing | 08/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Hillcrest of North Dallas | 18648 Hillcrest Rd<br>Dallas, TX 75252 |

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) |
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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786<br><br>Based on interview and record review, the facility failed to ensure residents who were unable or required assistance to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene, for 1 of 2 residents (Resident #1 and Resident #2) reviewed for ADLs.<br><br>The facility failed to provide bed baths for Resident #1 on a Monday, Wednesday, and Friday schedule.<br><br>The facility failed to wash the hair of Resident #1 on a Monday, Wednesday, or Friday schedule.<br><br>This failure could place residents who required assistance with showering and maintaining good personal hygiene at risk for not receiving care and services to meet their needs and avoid ADL decline.<br><br>Findings include:<br><br>Record review of Resident #1's face sheet, dated 08/29/24, reflected a [AGE] year-old female, with an initial admitted [DATE]. Resident #1 had a diagnosis of Acute Respiratory Failure (shortness of breath), Cellulitis of lower left limb (bacterial infection in the skin and underlying tissue), Type 2 Diabetes (high blood sugar), Neuromuscular Dysfunction of Bladder (nerves that control the bladder do not work properly), Morbid Obesity (body mass index of 40 or higher), Muscle Weakness, Hemiplegia and Hemiparesis following Cerebral Infarction (paralysis and weakness on one side of the body), and Need for Assistance with Personal Care.<br><br>Record review of Resident #1's MDS, dated [DATE], reflected a BIMS score of 15 which indicated she was cognitively intact.<br><br>Record review of Resident #1's Care Plan, dated 03/18/24 reflected Resident #1 was at risk of skin breakdown and has an ADL self-care performance deficit. Resident #1's care plan noted a two staff requirement for assistance with bathing.<br><br>Record review of a shower schedule dated 08/17/24, reflected Resident #1 was scheduled to get baths on Monday, Wednesday, and Friday during the 6:00 AM to 2:00 PM shift.<br><br>Record review of the shower sheets for Resident #1 reflected the following:<br><br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676315 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/30/2024 |
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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 07/24/24- Bed bath given, hair washed was not circled<br><br>07/26/24- Shower and<br><br>7/29/24- noted shower Fridays<br><br>7/31/24- Bed bath given, hair washed was not circled<br><br>08/02/24- Bed bath given, hair washed was circled<br><br>08/05/24- Bed bath given, hair washed was not circled<br><br>08/07/24- Shower given, hair washed was circled<br><br>08/12/24- Shower given, hair washed was circled<br><br>08/14/24- Shower given, hair washed was circled<br><br>08/16/24- Refused<br><br>08/18/24- Bed bath given, hair washed was not circled<br><br>08/19/24- Refused<br><br>08/22/24- Refused<br><br>08/26/24- Noted resident would take later in the week<br><br>08/28/24- Bed bath given, hair washed was not circled<br><br>Record review of Resident #1's Progress Notes reflected the following late entries for shower/bed bath refusals documented by LVN C:<br><br>All refusals were documented on 08/29/24 after the start of the investigation:<br><br>Progress notes created on 08/29/24 noted:<br><br>Resident #1 refused a bed bath on 08/05/24<br><br>Resident #1 refused a bed bath on 08/07/24<br><br>Resident #1 refused a bed bath on 08/12/24<br><br>Resident #1 refused a bed bath on 08/16/24<br><br>Resident #1 refused a bed bath on 08/19/24<br><br>Resident #1 refused a bed bath on 08/21/24<br><br>(continued on next page) |

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Resident #1 refused a bed bath on 08/26/24

In an interview on 08/29/24 at 10:35 AM, Resident #1 stated her brief had not been changed since 3:00 AM. She stated her brief needed to be changed. She stated she had not had a bed bath in three weeks. She stated the staff stated it was easier to give her a bed bath instead of a shower. Resident #1 stated she preferred a bed bath too. She stated she could not remember the last time her hair was washed. She stated it had been a long time. Resident #1 stated she had not received a bed bath or hair wash this week. She stated she had not refused any showers or bed baths this week. She stated she has never refused a shower or bed bath. She stated she may have said come back later or that she would like a bed bath later if she had visitors or if she was eating or about to eat a meal. Resident #1 stated usually staff would not return to give her the bed bath.

In an interview on 08/29/24 at 3:04 PM, Caregiver A stated she provided care to Resident #1 and last gave her a bed bath about two weeks ago. She stated since then she was not sure if any other staff members provided bed baths or showers to Resident #1. Caregiver A stated Resident #1 was a larger woman and required a two person assist. Caregiver A stated she recalled Resident #1 refused a bed bath last week, and due to the short staff recently, Resident #1 might not have received the care she requested. Caregiver A stated a bed bath was washing a resident from head to toe with soap and water. She stated she could not remember if she washed Resident #1's hair the last time she gave her a bed bath.

In an interview on 08/29/24 at 3:35 PM, Corporate Nurse B stated the facility documents showers/bed baths on paper shower sheets. She stated the refusals were documented on the shower sheets and in the resident's electronic file.

In a follow up interview on 08/30/24 at 11:55 AM, Resident #1 stated she received a bed bath and hair wash this morning. She stated during the last 2-3 weeks she did not receive a bed bath. She stated within the last two weeks staff only changed her bed sheets and cleaned her perineum area. She stated she had only been wiped down with wipes and not sure if staff considered that a bed bath. She stated she did not consider that a bed bath. Resident #1 stated what she received today, a cleaning from head to toe with soap and water, was a proper bed bath. Resident #1 stated she had not had a bed bath like she had today in a very long time, and that included her entire body being wet. She stated she did not refuse a bed bath on 08/26/24. She stated that was a Monday and usually the caregivers on the Monday shift did a great job. Resident #1 stated she did not tell the caregiver she would take one later that week. Resident #1 stated she did not refuse a bed bath on 08/22/24. She stated when they mentioned a bed bath on 08/22/24, she told the staff Thursdays were not her shower day, and she did not want to take a shower day away from another resident. Resident #1 stated on 08/19/24, the staff asked her about a bed bath right at lunch time, and she told them she would like to eat lunch and would like a bed bath later. She stated the staff never returned to give her a bed bath. Resident #1 stated she did not receive a bed bath on 08/18/24, because that was a Sunday, and the facility did not give bed baths or showers on Sundays. Resident #1 stated at one time she told the staff she was okay with getting bed baths twice a week instead of three times a week, because it seemed three times a week was hard on the facility staff. She stated she told them Mondays and Fridays would be fine, but the staff were not offering bed baths on all Mondays and all Fridays either. Resident #1 stated not getting bed baths and staff saying she refused pisses her off. Resident #1 stated there were days she could smell herself and when her son would visit every two weeks, he would have to help clean and groom her. As resident was observed crying, Resident #1 stated she told staff to at least wipe her down, because she was stinky.

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 08/30/24 at 2:45 PM, LVN C stated he had helped Resident #1, and she did not complain about not getting bed baths. LVN C stated he tried to document on a resident immediately, but at the worst at the end of each shift. LVN C stated he did not know how he missed documenting the bed bath refusals from Resident #1. He stated he noticed this week, he did not document the refusals, so he started going back yesterday to document her refusals. LVN C stated the risk of late documentation was a resident not getting the appropriate care. He stated the next shift might not have been aware that a resident still needed a bed bath or shower.<br><br>In an interview on 08/30/24 at 2:56 PM, the ADON stated Resident #1 never complained to him about not getting showers or bed baths. She stated she told them she would do two bed baths a week. He stated she would get bed baths whenever she needed one. The ADON stated he is very hands on with his residents, and he personally showed staff how to do bed baths and how to wash a resident's hair during a bed bath. He stated with a bed bath, he would ask a resident what they want first. He stated he would see if a resident wanted their hair washed or their teeth brushed. The ADON stated during a bed bath, the resident's entire body should be washed including the back of the neck, up and down their body, ensuring the water was warm and changed as much as needed. He stated he always cleaned their feet and in between the resident's toes. The ADON stated he trained his staff to ask questions to see why a resident refused and to see if they could come back later to give the bed bath or shower. The ADON stated the shower and bed bath refusals were documented on paper and staff would tell a nurse about the refusal. He stated the nurse would then go speak with the resident about the refusal and to try to get a better time. He stated the nurse would be responsible for documenting on the resident's electronic record and notifying a family member. The ADON stated the nurse should document during that shift or within 24 hours at the latest.<br><br>In an interview on 08/30/24 at 3:20 PM, the DON stated the staff were expected to document before their shift ended. He stated late documentation could intervene with a resident's care. He stated the facility had meetings every morning to review charts and to follow-up with any concerns. He stated he was not sure how the late documentation for Resident #1's refusals were missed. The DON stated the refusals should be documented immediately or by the end of the shift. He stated Resident #1 told them she did not need three baths a week but told his staff to still offer the bed baths three times a week. The DON stated Resident #1 never complained to him about missed showers or bed baths. He stated if a resident refused a bath or shower, the expectation was for staff to return to offer the shower or bed bath again that same day. He stated the refusals should have been documented in the progress notes and the family should be notified.<br><br>In an interview on 08/30/24 at 3:37 PM, the Administrator stated the facility started in-services to ensure staff know the importance of documenting timely. He stated the expectation is for staff to document during their shift or within 24 hours at the latest. He stated all refusals should be documented on the resident's electronic record. The Administrator stated if a resident refused a shower or bed bath, staff should return that same day to try to give the resident a shower or bed bath. He stated refusals could not be followed-up on if the refusal was not documented on time. He stated the DON is responsible for verification of the completion of ADLs. The Administrator stated the risks of missed bed baths or showers was infection or the resident's overall mental health.<br><br>Record review of the facility's policy titled, Care and Services, dated 06/2020 reflected the following:<br><br>Purpose<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER The Hillcrest of North Dallas | | STREET ADDRESS, CITY, STATE, ZIP CODE 18648 Hillcrest Rd Dallas, TX 75252 | |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | To ensure through an interdisciplinary team (IDT) process, that all residents receive the necessary care and services based on an individualized comprehensive assessment process.<br><br>Policy<br><br>Residents are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being level of in an environment that enhances quality of life in the scope of a long-term care facility. Care and services are provided in a manner that consistently enhances self-esteem and self-worth.<br><br>Procedure<br><br>The Facility will have sufficient staff to provides services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being as determined by individualized resident assessments and plans of care.<br><br>The IDT receives and reviews initial assessment information to ensure that members of the IDT interact with residents in a manner that enhances self-esteem and self-worth, such as activities related to bathing, grooming, dining, recreational and social opportunities.<br><br>The IDT facilitates opportunities for residents to exercise choice and self-determination during activities of daily living (ADLs).<br><br>The IDT informs residents of his/her medical treatment and honors the resident's right to refuse care or services as outlined in his/her plan of care and with the information related to the risk or benefits of refusal.<br><br>A. Licensed nurse discusses with the resident, family, legal representative - the possible consequences of the refusal and documents that interaction.<br><br>B. The Licensed Nurse notifies the physician of the resident's refusal of treatment.<br><br>The licensed nurse or designee documents and notifies the resident's physician and responsible party of:<br><br>A. Change in condition, including progress and/or decline in physical or mental function<br><br>B. Resident refusal of care or services<br><br>Record review of the facilities policy titled, Resident Rights dated 08/2020 reflected the following<br><br>Purpose<br><br>To promote and protect the rights of all residents at the Facility.<br><br>Policy<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | All residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility including those specified in this policy. The Facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The Facility will protect and promote the rights of the resident and provide equal access to quality of care regardless of diagnosis, severity of condition, or payment source.<br><br>The Facility will ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the Facility. Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights.<br><br>The Facility makes every effort to assist each resident in exercising his/her rights by providing the following services:<br><br>A. The Facility's Staff encourages residents to participate in planning their daily care routines (including ADLs).<br><br>Each resident is allowed to choose activities, schedules and health care that are consistent with his or her interests, assessments and plans of care, including:<br><br>B. Sleeping, eating, exercise and bathing schedules;<br><br>C. Personal care needs, such as bathing methods, grooming styles and dress; and<br><br>D. Health care scheduling, such as times of day for therapies and certain treatments. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786<br><br>Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs for two (Residents #1 and Resident #2) of three residents reviewed for pharmacy services.<br><br>1. The facility failed to give Resident #1 Acidophilus Lactobacillus Oral Capsule every 12 hours as ordered.<br><br>2. The facility failed to give Resident #2 Gabapentin every 12 hours as ordered.<br><br>This failure could affect residents by placing them at risk for a delay in medical treatment or worsening in condition.<br><br>Findings included:<br><br>Record review of Resident #1's face sheet, dated 08/29/24, reflected a [AGE] year-old female, with an initial admitted [DATE]. Resident #1 had a diagnosis of Acute Respiratory Failure (shortness of breath), Cellulitis of lower left limb (bacterial infection in the skin and underlying tissue), Type 2 Diabetes (high blood sugar), Neuromuscular Dysfunction of Bladder (nerves that control the bladder do not work properly), Morbid Obesity (body mass index of 40 or higher), Muscle Weakness, Hemiplegia and Hemiparesis following Cerebral Infarction (paralysis and weakness on one side of the body), and Need for Assistance with Personal Care.<br><br>Record review of Resident #1's MDS, dated [DATE], reflected a BIMS score of 15 which indicated she was cognitively intact.<br><br>Record review of Resident #1's physician's order dated, 03/23/23 reflected an order for Acidophilus Lactobacillus Oral Capsule, give one tablet by mouth every 12 hours for antidiarrheal.<br><br>Record review of Review of Resident #1's Medication Admin Audit Report dated 08/30/24 reflected the following:<br><br>Acidophilus Lactobacillus Oral Capsule (Lactobacillus) Give 1 capsule by mouth every 12 hours for Antidiarrheal<br><br>Scheduled for 8:00 AM and 20:00 (8:00 PM)<br><br>Acidophilus Lactobacillus was marked as given on 08/03/24 at 11:25 AM<br><br>Acidophilus Lactobacillus was marked as given on 08/03/24 at 19:57 (7:57 PM)<br><br>Acidophilus Lactobacillus was marked as given on 08/04/24 at 10:17 AM<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Acidophilus Lactobacillus was marked as given on 08/04/24 at 19:47 (7:47 PM)<br><br>Acidophilus Lactobacillus was marked as given on 08/11/24 at 11:38 AM<br><br>Acidophilus Lactobacillus was marked as given on 08/11/24 at 20:09 (8:09 PM)<br><br>Acidophilus Lactobacillus was marked as given on 08/12/24 at 9:33 AM<br><br>Acidophilus Lactobacillus was marked as given on 08/12/24 at 20:40 (8:40 PM)<br><br>Record review of Resident #1's Progress Notes on the resident's electronic record revealed no documentation on 08/03/24, 08/04/24, 08/11/24, or 08/12/24, regarding the late medication pass.<br><br>Record review of Resident #2's face sheet, dated 08/30/24, reflected a [AGE] year-old male, with an admitted [DATE]. Resident #2 had a diagnosis of Type 2 Diabetes (high blood sugar), Essential Hypertension (high blood pressure), Muscle Weakness, and Poly Neuropathy (damage affecting nerves).<br><br>Record review of Resident #2's MDS, dated [DATE], reflected a BIMS score of 15 which indicated he was cognitively intact.<br><br>Record review of Resident #2's physician order dated 11/03/22, reflected an order for Gabapentin, give 1 capsule by mouth every 12 hours for polyneuropathy.<br><br>Record review of Resident #2's Medication Admin Audit Report dated 08/30/24 reflected the following:<br><br>Order Summary<br><br>Gabapentin Capsule 300 MG Give 1 capsule by mouth every 12 hours for Polyneuropathy<br><br>Scheduled for 8:00 AM and 20:00 (8:00 PM)<br><br>Gabapentin was marked as given on 08/01/24 at 8:10 AM<br><br>Gabapentin was marked as given on 08/01/24 at 21:21 (9:21 PM)<br><br>Gabapentin was marked as given on 08/03/24 at 9:34 AM<br><br>Gabapentin was marked as given on 08/03/24 at 19:34 (7:34 PM)<br><br>Gabapentin was marked as given on 08/04/24 at 9:35 AM<br><br>Gabapentin was marked as given on 08/04/24 at 19:40 (7:40 PM)<br><br>Gabapentin was marked as given on 08/05/24 at 9:19 AM<br><br>Gabapentin was marked as given on 08/05/24 at 21:47 (9:47 PM)<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Gabapentin was marked as given on 08/06/24 at 9:15 AM<br><br>Gabapentin was marked as given on 08/06/24 at 21:08 (9:08 PM)<br><br>Gabapentin was marked as given on 08/07/24 at 7:19 AM<br><br>Gabapentin was marked as given on 08/07/24 at 21:11 (9:11 PM)<br><br>Record review of Resident #2's Progress Notes on the resident's electronic record revealed no documentation on 08/01/24, 08/03/24, 08/05/24, 08/06/24, or 08/07/24 regarding the late medication pass.<br><br>In an interview on 08/29/24 at 10:20 AM, Resident #2 stated he was the lived in the facility for about two years and was an active member of the resident council. He stated some staff members were recently fired, and that did not make the facility any better. Resident #2 stated he did not receive his medication on time unless certain nurses were at work. He stated a lot of times the medication was given an hour to an hour and a half late. He stated now he has an agreement with the weekday morning staff member to give his medications before the other residents to ensure he gets his medication on time. Resident #2 stated the other shifts and on the weekends was a different story. He stated he did not get his medications on time during those times. He stated it's really slow on the weekends.<br><br>In an interview on 08/29/24 at 3:35 PM, the ADON stated he had not received any complaints about late medications. He stated he would check into resident concerns. In the same interview, Corporate Nurse B stated the facility would complete an audit and safe surveys to ensure residents were receiving their medications.<br><br>In an interview on 08/30/24 at 11:55 AM, Resident #1 stated sometimes the medication was given late. She stated the staff are busy, and sometimes the medication is given later in the day. She stated she did not have any side effects, but she would like to get her medication like the doctor ordered.<br><br>In an interview on 08/30/24 at 3:20 PM, the DON stated he did not receive any complaints from residents regarding late medications. He stated the expectation is for a resident to receive their medications up to an hour before or an hour after the scheduled medication time. The DON stated any late medications passes should be documented in the electronic record. The stated the nurses and ADON was responsible for ensuring the documentation was completed. He stated the risks of late medication passes depends on the medication, but he was not made aware of any late medication passes or any adverse effects.<br><br>In an interview on 08/30/24 at 3:37 PM, the Administrator stated he had not received any complaints about medications given passed the scheduled time. He stated late medications passes should be documented on the resident's electronic record and the medication administration record has an area to mark an exception. He stated the risk of not giving medications on schedule or according to the physician's order is a medication dosage could be given too close together.<br><br>Record review of the facility's in-serviced titled, Medication Pass dated 08/29/24, reflected the following:<br><br>(continued on next page) |

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| The Hillcrest of North Dallas | 18648 Hillcrest Rd<br>Dallas, TX 75252 |

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) |
|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | All routine medications are to be given within one hour of scheduled time.<br><br>Medication administration is to be documented at the time of med pass.<br><br>Record review of the facility's undated policy titled, Medication Administration reflected the following:<br><br>To provide practice standards for safe administration of medications for residents in the Facility.<br><br>Medications may be administered one hour before or after the scheduled medication administration time.<br><br>Nursing Staff will keep in mind the seven rights of medication when administering medication:<br><br>A. The right medication<br><br>B. The right amount<br><br>C. The right resident<br><br>D. The right time<br><br>The Rule of 3 - The Licensed Nurse administering medications will perform 3 checks comparing the physician's order, pharmacy label, and Medication Administration Record (MAR).<br><br>IV. Compare the Licensed Practitioner's prescription/order with the MAR (first check).<br><br>V. Compare the Licensed Practitioner's order with the pharmacy label on the medication package<br><br>(second check).<br><br>VI. Compare the pharmacy label and MAR (third check).<br><br>VII. Any discrepancies identified during the first, second, and/or third check must be resolved prior to the administration of any medication. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676315 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/30/2024 |
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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786<br><br>Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 3 residents (Resident #1) observed for accuracy of medical records.<br><br>The facility failed to document Resident #1's bed bath refusals on the same day for each refusal.<br><br>This deficient practice could place residents at risk for errors in care and treatment.<br><br>The findings were:<br><br>Record review of Resident #1's face sheet, dated 08/29/24, reflected a [AGE] year-old female, with an initial admitted [DATE]. Resident #1 had a diagnosis of Acute Respiratory Failure (shortness of breath), Cellulitis of lower left limb (bacterial infection in the skin and underlying tissue), Type 2 Diabetes (high blood sugar), Neuromuscular Dysfunction of Bladder (nerves that control the bladder do not work properly), Morbid Obesity (body mass index of 40 or higher), Muscle Weakness, Hemiplegia and Hemiparesis following Cerebral Infarction (paralysis and weakness on one side of the body), and Need for Assistance with Personal Care.<br><br>Record review of Resident #1's MDS, dated [DATE], reflected a BIMS score of 15 which indicated she was cognitively intact.<br><br>Record review of Resident #1's Care Plan, dated 03/18/24 reflected Resident #1 was at risk of skin breakdown and has an ADL self-care performance deficit. Resident #1's care plan noted a two staff requirement for assistance with bathing.<br><br>Record review of a shower schedule dated 08/17/24, reflected Resident #1 was scheduled to get baths on Monday, Wednesday, and Friday during the 6:00 AM to 2:00 PM shift.<br><br>Record review of Resident #1's Progress Notes reflected the following late entries for shower/bed bath refusals documented by LVN C:<br><br>All refusals were documented on 08/29/24 after the start of the investigation:<br><br>Progress notes created on 08/29/24 noted:<br><br>Resident #1 refused a bed bath on 08/05/24<br><br>Resident #1 refused a bed bath on 08/07/24<br><br>Resident #1 refused a bed bath on 08/12/24<br><br>Resident #1 refused a bed bath on 08/16/24<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #1 refused a bed bath on 08/19/24<br><br>Resident #1 refused a bed bath on 08/21/24<br><br>Resident #1 refused a bed bath on 08/26/24<br><br>In an interview on 08/29/24 at 3:04 PM, Caregiver A stated she provided care to Resident #1 and last gave her a bed bath about two weeks ago. She stated since then she was not sure if any other staff members provided bed baths or showers to Resident #1. Caregiver A stated Resident #1 was a larger woman and required a two person assist. Caregiver A stated she recalled Resident #1 refused a bed bath last week, and due to the short staff recently, Resident #1 might not have received the care she requested. She stated she would tell a nurse when a resident refused a shower or bed bath and then the nurse would be the one to document the refusal in the resident record.<br><br>In an interview on 08/30/24 at 2:45 PM, LVN C stated he had helped Resident #1, and she did not complain about not getting bed baths. LVN C stated he tried to document on a resident immediately, but at the worst at the end of each shift. LVN C stated he did not know how he missed documenting the bed bath refusals from Resident #1. He stated he noticed this week, he did not document the refusals, so he started going back yesterday to document her refusals. LVN C stated the risk of late documentation was a resident not getting the appropriate care. He stated the next shift might not have been aware that a resident still needed a bed bath or shower.<br><br>In an interview on 08/30/24 at 2:56 PM, the ADON stated he trained his staff to ask questions to see why a resident refused and to see if they could come back later to give the bed bath or shower. The ADON stated the shower and bed bath refusals were documented on paper and staff would tell a nurse about the refusal. He stated the nurse would be responsible for documenting on the resident's electronic record and notifying a family member. The ADON stated the nurse should document during that shift or within 24 hours at the latest.<br><br>In an interview on 08/30/24 at 3:20 PM, the DON stated the staff were expected to document before their shift ended. He stated late documentation could intervene with a resident's care. He stated the facility had meetings every morning to review charts and to follow-up with any concerns. He stated he was not sure how the late documentation for Resident #1's refusals were missed. The DON stated the refusals should be documented immediately or by the end of the shift. He stated the refusals should have been documented in the progress notes and the family should be notified. He stated the ADON would check to ensure other nurses and caregivers were documenting the refusals either in the resident's electronic record or the shower sheets.<br><br>In an interview on 08/30/24 at 3:37 PM, the Administrator stated the facility started in-services to ensure staff know the importance of documenting timely. He stated the expectation is for staff to document during their shift or within 24 hours at the latest. He stated all refusals should be documented on the resident's electronic record. He stated refusals could not be followed-up on if the refusal was not documented on time.<br><br>Record review of the facility's policy titled, Documentation Nursing dated 06/2020, reflected the following:<br><br>Purpose<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | To provide documentation of resident status and care given by nursing staff.<br><br>Policy<br><br>Nursing documentation will be concise, clear, pertinent, accurate and evidence based. Narrative charting, as outlined in specific policies and procedures, will be used for initial treatments or procedures.<br><br>Nursing staff will not falsify or improperly correct nursing documentation.<br><br>Procedure<br><br>ADL Documentation<br><br>A. The CNA will document the care provided on the facility's method of documentation, manually or electronic.<br><br>B. The CNA will sign each entry on the ADL Flow Sheet in the appropriate area of the record according to the date and shift that services were performed.<br><br>Documentation will be completed by the end of the assigned shift. |