**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT



**NAME OF FACILITY:** Complete Care At Brackenville Llc

**DATE SURVEY COMPLETED:** February 2, 2024

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|---|---|---|---|
| | A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.<br><br>Survey Dates: 01/30/24 to 02/02/24<br><br>Survey Census: 99<br><br>Sample Size: 22 | | |
| 3201 | Supplemental Residents: 48 | | |
| 3201.1.0 | **Regulations for Skilled and Intermediate Care Facilities** | | |
| 3201.1.2 | **Scope**<br><br>**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**<br><br>**This requirement is not met as evidenced by:**<br><br>Cross refer F550, F554, F600, F609, F610, F641, | Cross reference plan of correction for 2567 for survey ending February 2, 2024 for F Tag's F550, F554, F600, F609, F610, F641, F684, F689, F695, F725, F726, F761, F804, F809, F812 and F880. | |

Provider's Signature ______ Title Administrator Date 2/29/24

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| | 085042 | A. BUILDING ______ B. WING ______ | C 02/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMPLETE CARE AT BRACKENVILLE LLC | 100 ST. CLAIRE DRIVE HOCKESSIN, DE 19707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| E 000 | Initial Comments<br><br>A Recertification, Complaint and Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on January 30, 2024 - February 2, 2024. The facility was found to be in compliance with 42 CFR 483.73. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.<br><br>Survey Dates: 01/30/24 to 02/02/24<br>Survey Census: 99<br>Sample Size: 22<br>Supplemental Residents: 48 | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has 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 section.<br><br>§483.10(a)(1) A 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 | F 550 | | 3/19/24 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/02/2024

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.

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| F 550 | Continued From page 1<br>her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, interviews, and facility policy review, the facility failed to ensure elopement risks and wander guard assessments were updated to promote dignity for one Resident (R) 301 of two reviewed for elopement risk and wander guard use. The facility failed to ensure Certified Nursing Assistant (CNA)3 closed the privacy curtain while providing personal care to R39. R39's breasts and brief | F 550 | CNA did not pull window blind down prior to starting care, she also did not pull the privacy curtain between resident beds. When questioned about this she stated she knew she was supposed to do so, however, she forgot to address at this time. The root cause of the deficient practice is that the CNA failed to pull the window blind down and close the privacy | |

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| F 550 | Continued From page 2<br>were exposed to public view. Additionally, R89 was not provided an opportunity for dignity when she sat in her wheelchair, while wearing a brief for over an hour.<br><br>Findings include:<br><br>1. Review of a policy provided by the facility titled "Resident Alarms" dated 03/14/23 indicated, ". . .It is the policy of this facility to utilize residents' alarms in limited circumstances, in accordance with the resident's needs, goals, and preferences, so that the resident will be able to attain or maintain his or her highest practicable level of physical, mental, and psychosocial well-being. . .Wander/elopement alarms-includes devices such as bracelets. . .The facility shall establish and utilize a systemic approach for the safe and appropriate use of resident alarms, including efforts to identify risk; evaluate and analyze risk. . ."<br><br>Review of R301's electronic medical record (EMR) titled "Admission Record," located under the "Profile" tab indicated the resident was admitted to the facility on 05/01/23 with a diagnosis of anxiety disorder.<br><br>Review of R301's EMR titled admission "Minimum Data Set [MDS]" with an Assessment Reference Date (ARD) of 05/01/23 indicated the resident had a "Brief Interview for Mental Status [BIMS]" score of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident did not wander. The assessment indicated the resident was able to ambulate with supervision.<br><br>Review of R301's EMR titled "Elopement | F 550 | curtain between residents before providing care.<br><br>Resident #301 was discharged from the center on 6/2/2023.<br><br>All residents that currently have a wander guard will have an elopement assessment reviewed to determine the appropriate use of the wander guard for each resident with a wander guard bracelet.<br><br>The Nurse Practice Educator or Designee will re-educate the Licensed nurses and nursing management on the elopement policy for elopement risk and wander guard use based on the elopement assessment scoring to ensure appropriateness.<br><br>DON or designee will audit each resident whose elopement assessment requires a wander guard to ensure proper use of the wander guard and to ensure appropriateness weekly x 4. When audits are 100% compliant, audits will be completed monthly x 4. When audits are 100% compliant, audits will be completed quarterly.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan.<br><br>For residents 39 there was no negative outcome as a result of the deficient practice, | |

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| F 550 | Continued From page 3<br>Evaluation" located under the tab "Assessments " dated 05/02/23 indicated the resident scored a two which revealed the resident was at low risk for elopement.<br><br>Review of R301's EMR titled "Care Plan" located under the "Care Plan" tab failed to include the resident was at risk for elopement and required the use of a Wanderguard.<br><br>Review of R301's EMR titled nursing "Progress Notes," located under "Prog [Progress] Notes" tab dated 05/02/23 indicated the resident's elopement score was eight.<br><br>Review of R301's "Psychiatric Consultant Note" located under "Prog Notes" dated 05/15/23 indicated the resident had no elopement attempts.<br><br>Review of R301's nursing "Progress Notes" located under the "Prog Note" tab dated 06/02/23 indicated the resident left at 8:20 AM in her own vehicle and later returned at 8:42 AM. The progress notes revealed the resident left the facility without informing the facility.<br><br>During an interview on 02/01/24 at 11:12 AM, the Director of Nursing (DON) stated the facility did not use consents for the use of a wanderguard. The DON stated the best she could remember was R301 would leave the facility and not inform the staff. The DON stated the resident then agreed to wear the wanderguard device for approximately two weeks. The Regional Clinical Consultant was present during this interview.<br><br>During an interview on 02/02/24 at 12:42 PM, the Director of Social Services (DSS) stated the | F 550 | Resident refused to allow multiple staff members to put on her pants while she was sitting up in her wheelchair. 11-7 and 7-3 staff attempted to assist resident she stated her pants were in the dryer. Another nurse approached this resident who finally allowed her to put pants on her. Resident did come to doorway of bedroom but did not leave the room. The root cause of the deficient practice is that staff failed to properly cover the resident prior to the resident coming to the doorway.<br><br>Resident 89 was discharged from the center on 2/1/2024.<br><br>All other residents have the potential to be affected by this deficient practice.<br><br>The Nurse Practice Educator or designee will re-educate all nursing staff on maintaining resident privacy to ensure dignity during and after care.<br><br>DON or designee will complete audits on all shifts to ensure resident dignity during and after care is maintained. Audits will be conducted daily x□s 7 days on various shifts. When audits are 100% compliant, audits will be completed weekly x□s 3 weeks on various shifts.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan. | |

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| F 550 | Continued From page 4<br>resident was not considered an elopement risk but did have her car parked in the facility's parking lot. DSS stated the resident was alert and oriented and could go and do as she pleased.<br><br>During an interview on 02/02/24 at 1:54 PM, the DON stated the use of the wanderguard should have been placed in the resident's care plan. A request was made to interview the staff member who determined the use of the wanderguard. No staff member was identified by the end of the survey.<br><br>2. Review of a document provided by the facility titled "Promoting/Maintaining Resident Dignity" dated 03/14/23 indicated ". . .It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. . .All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. . .Maintain resident privacy. . ."<br><br>Review of R39's EMR titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 12/12/19 with a diagnosis of Alzheimer's disease.<br><br>Review of R39's EMR titled "Care Plan" located under the "Care Plan" tab dated 12/13/19 indicated the resident was totally dependent on staff for activities of daily living due to her diagnosis of Alzheimer's disease.<br><br>Review of R39's EMR titled annual "MDS" with an | F 550 | | |

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| F 550 | Continued From page 5 | F 550 | | |

ARD of 01/23/24 indicated the resident had a "BIMS" score of six out of 15 which revealed the resident was severely cognitively impaired.

An observation was conducted on 02/01/24 at 5:42 AM, CNA3 was observed to provide personal care to R39 and failed to pull the privacy curtain in the semi-private room. R39 had a roommate (R6) who was up in her wheelchair and facing R39 and CNA3 during the provision of care. R39 had her breasts exposed and observed CNA3 place an adult brief on the resident.

During an interview on 02/01/24 at 5:45 AM, Registered Nurse (RN)2 who was also the unit manager for the night shift stated her expectation was for the privacy curtain to be pulled between two residents for privacy and dignity reasons.

During an interview on 02/01/24 at 6:06 AM, CNA3 confirmed she did not pull the privacy curtain between R39 and R6.

During an interview on 02/01/24 at 6:09 AM, the DON stated the reason why there was a privacy curtain in a semi-private room was to be pulled during the provision of care and this would be her expectation as well.

3. Review of the facility policy titled, "Promoting/Maintaining Resident Dignity" revised on 03/14/23, revealed, "...It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality ...Respond to requests for assistance in a timely manner..."

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| F 550 | Continued From page 6<br><br>Review of R89's "Face Sheet" located in the EMR under the "Profile" tab, revealed R89 was admitted to the facility on 12/06/23 with diagnoses that included dementia and Alzheimer's disease.<br><br>Review of the "MDS" located in the EMR under the "MDS" tab with an "ARD" of 12/13/23 revealed a "BIMS" score of six out of 15 that indicated R89 had moderate cognitive impairment. This MDS also revealed R89 required substantial/maximal assistance for dressing the lower body.<br><br>Review of the "Care Plan" dated 12/21/23, located in the EMR under the "Care Plan" tab, revealed R89 had a self-care performance deficit related to limited mobility and required moderate assistance of one member of staff to dress.<br><br>Observation on 02/01/24 at 6:30 AM revealed R89 was sitting in a wheelchair in the doorway of her room. R89 was dressed in a shirt and a brief with both legs exposed from the upper thigh to the feet. R89 had a pair of slacks in her hand and asked RN2 if she would take the slacks and dry them. RN2 took the slacks, put them in a plastic bag, and put the bag into a hamper in the closet. RN2 did not put another pair of slacks on the resident and did not offer to provide coverage to R89's exposed legs. RN2 when exiting the room, called out to CNA7 to go in and help the resident.<br><br>Observation on 02/01/24 at 7:20 AM identified R89 was sitting in a wheelchair in the doorway of her room wearing a brief and her entire legs exposed. R89 was heard asking, "Are my pants dry, are my pants dry?" Observation revealed RN2 was at the medication cart across from | F 550 | | |

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| F 550 | Continued From page 7<br>R89's room preparing medications and did not provide any assistance to R89.<br><br>During an interview on 02/01/24 at 7:45 AM, CNA7 stated she was assigned to provide care to R89 on 02/01/24 for the 11:00 PM -7:00 AM shift. CNA7 stated she heard RN2 ask her to help R89, but she was providing care to other residents and did not go to help R89. CNA7 stated she told RN2 she was busy and could not help the resident.<br><br>Observation on 02/01/24 at 7:50 AM revealed R89 was sitting in a wheelchair in the doorway of her room with only a brief on and her entire legs exposed. Multiple staff were observed to walk by R89's room without intervening.<br><br>During an interview on 02/01/24 at 8:30 AM, RN2 stated she asked CNA7 to help R89 to put on new slacks. RN2 stated she did not know CNA7 did not assist R89 because she was doing a medication pass and was monitoring a resident after a fall. RN2 stated she asked CNA7 at least twice to provide assistance to R89 but did not know until later she did not assist the resident.<br><br>During an interview on 02/02/24 at 2:15 PM, the DON stated she would expect staff not to leave a resident exposed in a visible area. The DON stated RN2 and the other staff that were on the unit should have stopped and provided assistance to R89. | F 550 | | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp<br>CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that | F 554 | | 3/19/24 |

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| F 554 | Continued From page 8<br>this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview, record review, and facility policy review, the facility failed to assess one of one sampled resident (Resident (R) 65) for self-administration of medications. This failure led to medications being left at the bedside where they could be accessed by other residents.<br><br>Findings include:<br><br>Review of a policy provided by the facility titled "Resident Self-Administration of Medications" dated 2022 indicated ". . .It is the policy of this facility to support each resident's rights to self-administrator medications after the facility's interdisciplinary team has determined which medication's may be self-administered safely. . .When determining if self-administration of medication will be documented is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following. . .The medications appropriate and safe for self-administration. . .The resident's ability to ensure that medication is stored safely and securely. . .The care plan must reflect resident self-administration and storage arrangements for such medications. . ."<br><br>Review of R65's electronic medical records (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 03/03/23 with a diagnosis of polyosteoarthritis.<br><br>Review of R65's EMR titled quarterly "Minimum Data Set [MDS]" with an Assessment Reference | F 554 | Resident permitted to self administer eye drops. A family member reportedly brought in a box of prescription eye drops and did not notify staff, nor did the resident. Resident stated this was an old order that she no longer was using, and box was sealed. The root cause of the deficient practice is that the facility failed to have a process to monitor medications being self-administered by a resident.<br><br>Eye drops were removed from the bedside of resident #65.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>Al residents that self-administer medications will have their record reviewed to determine if self-administration is still appropriate and safe and will have their care plan updated as necessary.<br><br>The Nurse Practice Educator/Designee will re-educate all licensed nurses on the policy for self-administration of medication and identifying and removing/reporting medications at the bedside that are not appropriate for residents to self-administer based on the self-administration of medication assessment. Nurses will educate residents that are capable of self-administering, of the need for | |

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| F 554 | Continued From page 9<br>Date (ARD) of 11/28/23 indicated the resident had a "Brief Interview for Mental Status [BIMS]" score of 13 out of 15 which revealed the resident was cognitively intact.<br><br>Review of R65's EMR titled "Care Plan" located under the "Care Plan" dated 03/29/23 indicated the resident had a physician order for the self-administration of Latanoprost.<br><br>Review of R65's EMR titled "Physician Orders" located under the "Order" tab dated 03/29/23 indicated an order for Latanoprost ophthalmic solution to administer one drop in each eye. There were no orders for the administration of erythromycin ointment.<br><br>During an observation on 01/30/24 at 9:15 AM, R65 was seated in her wheelchair in her room. On the resident's over the bedside table, there was an unopened box which contained erythromycin dye drops and dated 03/10/23. In addition, there was a container of Latanoprost ophthalmic eye drops. At 12:13 PM, the erythromycin ointment was still on the resident's over the bedside table.<br><br>During an observation on 01/31/24 at 8:28 AM, R65 was in her room. On the resident's over the bedside table was the box which contained erythromycin eye drops.<br><br>During an interview on 01/31/24 at 8:29 AM, Licensed Practical Nurse (LPN) 2 stated R65 had a physician's order for Latanoprost ophthalmic eye drops. LPN 2 stated the eye drops were kept at the resident's bedside. LPN 2 then entered R65's room and confirmed the box of erythromycin and stated the medication should | F 554 | medications to be given to nurses to review and must have current order for the medication.<br><br>The DON or designee will review admission/readmission charts to verify self-administration assessment was completed accurately.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan. | |

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| F 554 | Continued From page 10<br>have been tossed since it was not approved for the self-administration by the resident.<br><br>During an interview on 02/01/24 at 11:12 AM, the Director of Nursing (DON) stated the facility was unaware R65 had the erythromycin ointment at her bed side. | F 554 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and policy review, the facility failed to ensure residents were protected from verbal abuse by staff for one resident (R)59 of seven residents reviewed for abuse in a total sample of 22 residents.<br><br>Findings include:<br><br>Review of the "Abuse, Neglect & Misappropriation" policy dated May 2021 revealed, "Each resident has the right to be free | F 600 | CNA refused to stop arguing with a resident at the nurses station, despite 3 other staff members telling her to stop. Nurse removed resident from the area and the CNA. The root cause of the deficient practice is the CNA engaging in a verbal argument with a resident.<br><br>Resident #59 had no negative affect from this deficient | 3/19/24 |

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| F 600 | Continued From page 11<br>from abuse ... "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish ... "Verbal abuse" means the use of oral, written, gestured language that willfully includes disparaging and derogatory terms to residents ..."<br><br>Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R59 was admitted to the facility on 09/18/20 with diagnoses which included anxiety disorder, mild dementia, and major depressive disorder.<br><br>Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 11/10/23 in the EMR under the "MDS" tab revealed R59 was intact in cognition with a Brief Interview for Mental Status (BIMS) score of 15 out of 15.<br><br>During an interview on 02/01/24 at 1:49 PM, R59 stated Certified Nursing Assistant (CNA)12 was "the worst of the worst." R59 stated CNA12 screamed at him one time when he was trying to talk to a nurse. R59 stated CNA12 told the nurse not to bother with him. R59 indicated CNA12 was verbally abusive towards him, it was upsetting, and he had reported the incident.<br><br>The facility's investigation into the allegation of "emotional abuse" by CNA12 towards R59 that occurred on 11/16/23 was reviewed. Review of the "Incident Report for Web Intake #83112" dated 11/16/23 and provided by the facility revealed the allegation of "Resident [R59] reported CNA [CNA12] was screaming at him while he was talking to a nurse [Licensed | F 600 | All other residents can be affected by this deficient practice.<br><br>The Nurse Practice Educator or Designee will re-educated on Abuse Identification and Prevention with a focus on intervening while abuse is occurring to ensure the residents safety and well-being.<br><br>The NHA or designee will review all allegations of abuse to ensure there was a proper response by staff when an allegation of abuse is reported, and initiates investigation per regulation.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan. | |

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| F 600 | Continued From page 12<br>Practical Nurse (LPN)9] at the end of the hall."<br><br>Review of a witness statement dated 11/16/23 by LPN9 revealed, "On 11/16/23 the writer was having a private conversation with [R59] in the nutrition rm [room]. The CNA [CNA12] gets up from desk and starts shouting at resident that his opinion does not matter and he should not be upset about his friend in 401 moving halls because she hated him. Several resident [names], 305 family member, and additional residents and their family members have heard this argument. My resident [R59] was so upset he was given a prn [as needed] Ativan [antianxiety medication] the first time in weeks. When he went up to the desk to ask her name [CNA12], she refused to give her name at all, reported to DON [Director of Nursing]."<br><br>Review of a witness statement dated 11/17/23 by CNA13 revealed, "I [CNA13] witness (sic) on 11/16/23 [R59] having a conversation with the charge nurse on 300 cart about another resident's medical record. The nurse was trying to explain to [R59] that she couldn't discuss another resident's medical record with him as the nurse was having this conversation with [R59], [CNA12] started screaming at [R59] "another resident's medical record isn't your business, you need to learn to mind your business." [CNA12] went back and forth with [R59] arguing with him for 5 mins [minutes]. As [R59] left the conversation rolling down the hallway, [CNA12] started antagonizing him laughing loudly." Additional staff statements were similar and/or did not contradict the statements of CNA13 and LPN9.<br><br>During an interview on 02/02/24 at 1:54 PM, the Administrator stated CNA12 was terminated on | F 600 | | |

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| F 600 | Continued From page 13<br>11/29/23 due to the investigation results of the incident between CNA12 and R59. The Administrator stated the allegation of verbal abuse was substantiated. | F 600 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported 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 not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of | F 609 | DON was notified via text, while sleeping, | 3/19/24 |

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F 609

Continued From page 14

facility policy, the facility failed to ensure that an allegation of neglect was reported to the State Survey Agency (SSA) in a timely manner for one resident (Resident (R) 297) reviewed for abuse/neglect in a total sample of seven residents. This failure had the potential for other allegations of abuse/neglect to not be reported in a timely manner. (Cross Reference F689)

Findings include:

Review of a policy provided by the facility titled "Abuse, Neglect & Misappropriation," dated 05/21 indicated ". . .Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the Licensed Nurse should. . .Contact the State Agency. . .Each covered, individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. . ."

Review of R297's electronic medical record (EMR) titled "Admission Record" indicated the resident was admitted to the facility on 10/20/22.

Review of R297's EMR titled admission "Minimum Data Set [MDS]" with an Assessment Reference Date (ARD) of 10/26/22 indicated the resident had a "Brief Interview for Mental Status [BIMS]" score of four out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident required extensive assistance of two staff members for bed mobility and was totally dependent on two

F 609

of a fall with ER transfer. DON forgot to report incident following day, therefore did not report within required time frame. The root cause of the deficient practice was the failure of the DON to report a fall with ER transfer at the time they were notified of the incident.

R297 was discharged from the center on 11/04/2022.

All other residents have the potential to be affected by this deficient practice.

The Regional Vice President or Regional Clinical Nurse will re-educate all managers on the requirements for Reporting incidents to the State of Delaware as per regulation.

The NHA or designee will review incidents to determine if self-reporting is required based on the reporting requirements within the required time frames.

Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan.

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| F 609 | Continued From page 15 staff for transfers.<br><br>Review of R297's EMR titled nursing "Progress Notes" located under the "Prog [Progress] Notes" tab indicated the resident sustained a fall on 11/04/22. The progress notes indicated the resident was found, face down, on the floor next to her bed.<br><br>Review of a hospital document provided by the facility titled "CT [computerized tomography] Scan without Contrast," dated 11/05/22 indicated R297 sustained head trauma with moderate to severe subdural hematoma.<br><br>Review of the facility's investigation provided by the facility titled "Incident Report," dated 11/14/22 indicated R297 sustained a fall on 11/04/22. The investigation revealed the facility's submitted their completed investigation on 11/14/22.<br><br>During an interview on 02/02/24 at 1:58 PM, the Director of Nursing (DON) stated a nurse called her to notify her of R297's fall. The DON stated she completely forgot about notifying the SSA. The DON stated the SSA notified her of the late reporting and requested she submit the investigation. | F 609 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. | F 610 | | 3/19/24 |

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| F 610 | Continued From page 16<br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of the facility policy, the facility failed to ensure that a thorough investigation of an allegation of staff-to-resident verbal abuse for one resident (R)346 of seven residents reviewed for abuse in a total sample of 22 residents.<br><br>Findings include:<br><br>Review of a policy provided by the facility titled "Abuse, Neglect & Misappropriation," dated 05/21 indicated ". . .Investigation of Alleged Abuse, Neglect and Exploitation. When suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation should be conducted. Components of an investigation may include. . .Interview the involved resident, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses. . .Interview all witnesses separately. Included roommates, residents in adjoining rooms, staff members in the area, and visitors in the area. Obtain witness statements, | F 610 | DON and ADON did interview all other interviewable residents assigned to the accused nurse to assess if any other residents had complaints or issues with care. None reported. Written interviews not available, unable to locate. The root cause of the deficient practice is failure to provide interview statements of other residents during an investigation<br><br>R346 was discharged from the facility 11/22/2023.<br><br>All other residents have the potential to be affected by this deficient practice.<br><br>The Regional Vice President or Regional Clinical Nurse will re-educate the NHA, DON, ADON and nursing on gathering statements from all other residents who may potentially be affected.<br><br>The center will implement a High-Risk Event checklist that will be followed for any reportable incident. The Center will also refer to the Division of Health Care | |

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| F 610 | Continued From page 17<br>according to appropriate policies. All statements should be signed and dated by the person making the statement. . ."<br><br>Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed R346 was admitted to the facility on 09/27/23 with diagnoses including epilepsy and history of cerebral infarction (stroke).<br><br>Review of the admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/30/23 in the EMR under the "MDS" tab revealed R346 was intact in cognition with a "Brief Interview of Mental Status (BIMS)" score of 15 out of 15.<br><br>Review of the "Incident Report for Web Intake #83118" dated 11/17/23 revealed an allegation of mistreatment as follows, "Resident [346] reported that the 11 - 7 nurse [Registered Nurse (RN)3] told her "I can not (sic) take care of you anymore, I can not (sic) deal with your crying."<br><br>Review of a follow up statement with R346 dated 11/17/23 revealed, "[R346] tells this nurse that she went out to the nursing station to request Tylenol and [RN3] stated she did not have time to take care of her and told her to go back to bed. [R346] left the area crying and returned to her room at the time.<br><br>Review of RN3's statement dated 11/19/23 regarding the incident with R346 revealed that, "at approximately 0510 [5:10 AM] [R346] was at the nursing station getting ready to smoke. I asked her if she could please not go, and if she could wait until later. I advised her that it wasn't safe for | F 610 | Quality Reporting Tips for further guidance when handling reportable events.<br><br>The NHA or designee will audit all allegations of abuse to ensure that appropriate interviews were completed to ensure a thorough investigation is conducted.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan. | |

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| F 610 | Continued From page 18 | F 610 | | |

her to go outside, that I could not watch her, and I had no one there to go outside with her ..."

There were no additional statements in the investigation file. There were no statements in the investigation file from other residents. The Director of Nursing (DON) confirmed the investigation file provided to the survey team was the complete investigation.

Review of the five-day investigation titled, "Incident Report for Web Intake #83118", dated 11/21/23, revealed, "[R346] came out of her room and proceeded to the nurses station around 5 am requesting to go smoke. [R346] reported that the 11 - 7 nurse [RN3] told her she did not want to take care of her anymore and was mean to her. When [R346] was interviewed by DON [Director of Nursing] she reported the 11 - 7 nurse was not mean, but abrupt in the way she spoke at times. Result of Investigation: [RN3] reported that the resident was requesting to go outside to smoke every few hours on the 11 - 7 shift. [RN3] told [R346] no one could go with her at that time and it was not safe for her to go outside alone at 5 am. [R346] reported to the nurse that she had just received some bad news and was crying, this is why she wanted to go outside. The nurse states the resident was upset that she told her she could not go outside to smoke at that time. During an interview with the DON the resident stated she did not have any issues with [RN3] providing care for her in the future. She just did not like the way the nurse spoke to her that evening."

During an interview on 02/02/24 at 3:21 PM, the DON stated R346 had reported that she had asked for medication and RN3 had stated she did not have time or something like that. The DON

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| F 610 | Continued From page 19<br>stated she spoke with R346 and the resident did not mention anything about the medication. She stated she did not like how RN3 spoke to her. The DON indicated R346 stated RN3 was abrupt and R346 did not like it. The DON verified R346 did not say anything to her about wanting to go outside and smoke. | F 610 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure two (Resident (R) 70 and R26) out of 40 sampled residents had an accurate "Minimum Data Set (MDS)" assessment. Failure to code the "MDS" correctly could potentially lead to inaccurate assessment and care planning of the resident.<br><br>Findings include:<br><br>Review of the "RAI Manual", dated 10/01/19, indicated, ". . . It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT (Interdisciplinary Team) completing the assessment. . ."<br><br>1. Review of R70's electronic medical records (EMR) titled "Admission Record" located under | F 641 | Social worker coded resident as having clear speech. Resident is mostly non verbal and uses computer to communicate. When resident does speak she is very soft spoken, and at times, difficult to understand. According to REI manual for MDS coding, this should be coded as unclear speech .The root cause of the deficient practice is the failure of the Social Worker to code the MDS correctly for the category of clear vs unclear speech<br><br>Resident #70 expired 2/10/2024. Quarterly MDS ARD 11/2/23 B0600 was coded 0. Clear Speech- modified all MDS to accurately code B0600 1. Unclear speech.<br><br>All residents have the potential to be affected by this deficient practice. | 3/19/24 |

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| F 641 | Continued From page 20<br>the "Profile" tab indicated the resident was admitted to the facility on 05/13/22 with a diagnosis of amyotrophic lateral sclerosis (ALS) disease.<br><br>Review of R70's EMR titled quarterly "MDS" with an Assessment Reference Date (ARD) dated 11/02/23 indicated the resident had a "Brief Interview for Mental Status [BIMS]" score of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident had clear speech.<br><br>During an interview with R70 on 01/30/24 at 9:24 AM, the resident had no concerns about her care. During the interview, the resident was observed to use a program which has been applied to a laptop computer and she could move her eyes on the application to write out words to communicate. The resident did not use her voice to speak during this interview.<br><br>During an interview on 02/01/24 at 2:53 PM, the MDS Coordinator (MDSC) stated the MDS was to be accurate. The MDSC stated R70 did not have clear speech, but he did not complete the communication section of the MDS assessment.<br><br>During an interview with Social Services (SS) on 02/01/24 at 2:56 PM, the SS stated R70 was clear most of the time, but there were times she was not.<br><br>During an interview on 02/02/24 at 2:00 PM, the Director of Nursing (DON) stated the MDS was to be accurate. The DON stated she had conversations with R70, but her voice was low.<br><br>2. Review of R26's "Face Sheet" located in the | F 641 | The MDS Coordinator or Designee will re-educate the Social Service employees on the proper coding of the MDS for section B0600 Speech Clarity.<br><br>All active current residents most recent MDS transmitted from the period of 2/21/24-2/29/24 will be reviewed for accuracy of coding in MDS B0600 Speech Clarity.<br><br>The MDS coordinator or Regional MDS Coordinator will audit section B0600 Speech Clarity of 3 export ready MDS's Q week x 4 weeks, and 5 export ready MDS's Q month x 2 months to ensure proper coding of B0600 Speech Clarity.<br><br>Nurse completed quarterly assessment and marked oral section as unable to observe. Resident with notable chipped teeth. Nurse failed to make another attempt to assess oral cavity or pass on to next nurse to attempt. MDS nurse coded as no broken teeth and did not make own attempt to assess residents oral cavity. The root cause of the deficient practice is failure to code oral assessment correctly on the MDS.<br><br>Section L0200 Dental<br><br>Resident #26 had no negative affect by this deficient practice. Annual MDS ARD 1/4/24 L0200 was coded G. unable to examine. Modified the MDS L0200 to mark D. Obvious or likely cavity or | |

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| F 641 | Continued From page 21<br>EMR under the "Profile" tab, revealed R26 was admitted to the facility on 02/08/18 with diagnoses that included dementia.<br><br>Review of the "Nursing Admission/Readmission/Annual/Sig [significant] Change Assessment" dated 01/02/24, located in the EMR under the "Assessment" tab indicated, " ...Teeth/dentures unable to examine."<br><br>Review of the annual "MDS" located in the EMR under the "MDS" tab with an "ARD" of 01/04/24 revealed a "BIMS" score of three out of fifteen that indicated R26 had severe cognitive impairment and no "obvious or likely cavity or broken natural teeth."<br><br>Review of the "Report of Consultation- Dental" dated 07/11/23, located in the paper medical record revealed, " ...missing #13, #20 and #21 root tips, and #8 fractured extensively ..."<br><br>Observation of R26 on 01/30/24 at 10:21 AM, revealed R26 had a broken front tooth and missing teeth from the lower gum.<br><br>During an interview on 02/02/24 at 12:40 PM, the MDSC stated the MDS did not include R26 had broken and missing teeth because the assessment that was completed by nursing prior to the annual MDS revealed an assessment of R26's teeth could not be completed. The MDSC stated he did not review the dental consultation dated 07/11/23 that identified R 26 had broken and missing teeth prior to coding the annual MDS. | F 641 | broken natural teeth.<br><br>The MDS Coordinator or Designee will re-educate all licensed nurses on completing the Dental Assessment, to include how to re- approach if dental is unable to examine. MDS coordinator(s) will be re-educated on verifying L0200 dental assessments for residents that the nurse has coded as unable to examine. Clinical will conduct oral assessment on current residents to ensure accuracy.<br><br>All active current residents of the most recent MDS transmitted from the period of 2/21/24-2/29/24 will be reviewed for accuracy of coding in MDS L0200 Dental.<br><br>The MDS coordinator or Designee will audit the L0200 section of 3 export ready MDS's Q week x 4 weeks then 5 MDS's Q month x 2 months to ensure proper coding of L0200 dental section<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan. | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25 | F 684 | | 3/19/24 |

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| F 684 | Continued From page 22<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews, clinical record review, and facility policy review, the facility failed to ensure that a biopsied specimen for one Resident (R) 298 of one residents reviewed for surgical procedure in a total sample of 22 residents was handled properly after a surgical procedure and not destroyed prior to analysis by pathology.<br><br>Findings include:<br><br>Review of the facility policy, provided by the facility, titled "Biohazard Labeling" dated 01/19 indicated ". . .Any container used to store, transport, or ship blood or other potentially infectious materials must be properly labeled with a biohazard warning before it is transported within, or removed from, the premises. . ."<br><br>Review of R298's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 02/10/23, with diagnoses of muscle weakness and morbid obesity.<br><br>Review of R298's EMR titled admission "Minimum Data Set [MDS]" with an Assessment | F 684 | 11-7 nurse discarded a skin biopsy from the specimen refrigerator on west wing that was pending lab pick up. The nurse stated it was not labeled properly and he did not receive information from the 3-11 nurse about this specimen. The 11-7 nurse failed to look in residents chart and or PCC to obtain more information, nor did he speak with the Unit manager, prior to discarding the specimen. The root cause of the deficient practice is that an LPN discarded a skin biopsy specimen that was in the specimen refrigerator for lab pick up.<br><br>Resident #298 was discharged from the facility 6/1/2023.<br><br>All other residents have the potential to be affected by this deficient practice.<br><br>The Nurse Practice Educator or Designee will re-educate all nurses on the proper handling of items awaiting to be picked up by the lab for a biopsy and follow-up with supervisors regarding specimens prior to discarding the specimen. | |

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| F 684 | Continued From page 23<br>Reference Date (ARD) of 02/16/23 indicated the resident had a "Brief Interview for Mental Status [BIMS]" score of 15 out of 15 which indicated the resident was cognitively intact.<br><br>Review of R298's EMR titled nursing "Progress Notes" located under the "Prog [Progress] Notes" tab dated 02/28/23 indicated the resident returned from a dermatology appointment and was scheduled to have a skin tag evaluated on the resident's right buttock. The progress notes indicated the family member had a picture to show the dermatologist. The picture was sent to the wound surgeon and recommendations were received to excise the area.<br><br>Review of R298's EMR titled nursing "Progress Notes," located under the "Prog Notes" tab dated 03/02/23 indicated the wound doctor met with the resident and the resident indicated he was amicable to have the skin tag biopsied by the wound doctor.<br><br>Review of R298's EMR titled nursing "Progress Notes," located under the "Prog Notes" tab dated 03/08/23 indicated the wound surgeon completed a skin biopsy on the resident's skin tag. The progress notes indicated the specimen would be sent to the lab for testing.<br><br>Review of the employee file for Licensed Practical Nurse (LPN)5 indicated the staff member received corrective action on 03/09/23 due to LPN5 discarding a specimen due to a lack of a date on the container. The document indicated R298's name was on the specimen container. The document indicated there was evidence of the resident's procedure in the clinical records and LPN5 did not follow up with the previous shift | F 684 | The DON or designee will complete audits of all items awaiting a biopsy to determine if they were handled properly by the nursing staff and received by the lab 5 x/week x 2 weeks. If 100% compliant, audit 3x/week x 2 weeks and then monthly x3.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan. | |

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| F 684 | Continued From page 24<br>nor the supervisor regarding this specimen prior to discarding this specimen.<br><br>During an interview on 02/02/24 at 12:32 PM, the Director of Nursing (DON) stated the specimen container should have the order, date, resident's date of birth, staff initials and the date the specimen was collected. The DON stated a special specimen container had to be ordered to accommodate the procedure and the collection of the specimen.<br><br>An attempt was made to contact LPN5, and contact was not successful prior to the end of the survey. A request was made to speak with the wound surgeon, and contact was not successful prior to the end of the survey. | F 684 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of facility policy, the facility failed to ensure that supervision to prevent accidents for one Resident (R) 297 out of four sampled residents reviewed for accidents. This failure caused actual harm, when R297 sustained a subdural hematoma after a fall when Certified Nursing Assistant (CNA)1 left the resident sitting on the bedside, unattended, | F 689 | Resident was not noted in PCC as high fall risk as she had not had any previous falls at this facility to date. CNA stepped away from resident briefly and she attempted to stand alone causing her to fall and obtain injuries. The root cause for the deficient practice is the failure to take into consideration the residents possibility | 3/19/24 |

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| F 689 | Continued From page 25<br>while gathering supplies for the resident's personal care.<br><br>Findings include:<br><br>Review of a policy provided by the facility titled "Fall Prevention Program," dated 09/05/23 indicated ". . .Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. . .The facility utilizes a standardized risk assessment for determining a resident's fall risk. . . The risk assessment categories (sic) residents according to low, moderate, or high risk...Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. . .Low/Moderate Risk Protocols. . .Bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed...Call light within reach. . .Adequate lighting. . .Implement routine rounding schedule. . .Monitor for changes in resident's cognition, gait, ability to rise/site, and balance. . ."<br><br>Review of R297's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 10/20/22 with a diagnosis of Lewy Body (a form of dementia).<br><br>Review of R297's EMR titled "Nursing Admission/ Readmission/Annual/Sig [Significant] Change Assessment" dated 10/20/22 indicated the resident scored 14 and was considered to be at moderate risk for falls. | F 689 | for impulsive behaviors.<br><br>Resident 297 was discharged from the center on 11/4/2023.<br><br>All residents with a moderate or high risk for falls will have their care plan for falls reviewed for proper interventions and the care plan will be revised as necessary to reflect any necessary changes.<br><br>The Nurse Practice Educator or Designee will re-educate nursing staff on identifying residents that are moderate or high risk for falls and how to identify the interventions for those residents.<br><br>A systemic change will be that the center will implement an identifier to alert staff that a resident is at high risk for falls.<br><br>The DON or designee will complete audits daily x□s 7 days to ensure fall interventions are being followed by staff. Once audits are 100% compliant, the audits will be completed weekly x□s 4 weeks. Once audits are 100% compliant, audits will be completed monthly x□s 3 months.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan. | |

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Review of R297's EMR titled "Care Plan" located under the "Care Plan" tab dated 10/20/22 indicated the resident had impairments in activities of daily living and was totally dependent on one staff member for toileting. The care plan indicated the resident was at risk for falls related to deconditioning and directed the staff to keep the call light within reach for the resident and to anticipate the needs of the resident. The care plan indicated physical therapy (PT) was to assess and treat the resident as needed. The care plan dated 10/24/22 indicated the resident had a diagnosis of Lewy Body and had impaired cognition due to this dementia diagnosis. There were no interventions which identified the unpredictable behaviors associated (poor safety awareness and impulsivity) with the resident with Lewy Body or the Parkinson's related movement (rigidity) associated with Lewy Body and the interventions to prevent falls, and safety risks associated.

Review of a document provided by the facility referred to as "Kardex" (directs the CNA on how to provide resident care), dated 10/20/22 indicated R297's call light was to be within reach, and to follow the facility fall protocol. For bed mobility, the Kardex indicated the resident required extensive assistance of one staff to turn and reposition in bed.

Review of R297's EMR titled nursing "Progress Notes," dated 10/21/22 indicated the resident was difficult to redirect, had poor safety awareness, and would attempt to get out of her wheelchair/bed unaided.

Review of a document provided by the facility titled "Physical Therapy [PT] Evaluation & Plan of

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Care," dated 10/21/22 indicated R297 was moderate assistance for transfers. The PT evaluation indicated the resident's trunk strength moved through full range against gravity and needed slight to moderate assistance. The assessment indicated the resident had symmetrical posture but indicated the resident had impaired gross motor coordination. The PT evaluation provided a section titled "Assessment Summary" which revealed the resident required skilled PT services to minimize falls, decrease complaints of pain, evaluate need for assistive device.

Review of R297's EMR titled admission "Minimum Data Set [MDS]" with an Assessment Reference Date (ARD) of 10/26/22 indicated the resident had a "Brief Interview for Mental Status [BIMS]" score of four out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident required extensive assistance of two staff members for bed mobility and was totally dependent on two staff for transfers. The assessment revealed the resident had a history of falls without injury prior to her admission. Under the "Care Area Assessment" the resident triggered for falls and directed the staff to develop a care plan.

Review of a document provided by the facility titled "Occupational Therapy [OT]" dated 11/03/22 indicated R297's goal was to reach/retrieve cones stand by assistance to increase dynamic sitting balance; the precautions identified the resident was a fall risk and had a diagnosis of Lewy Body dementia.

Review of a document provided by the facility titled "OT," dated 11/04/22 indicated R297 was

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able to sit upright at edge of bed with supervision. The OT notes indicated the resident had fall precautions for being a fall risk and again identified the resident had a diagnosis of Lewy Body dementia.

Review of a document provided by the facility titled "Change in Condition Evaluation" dated 11/04/23 indicated R297 indicated the resident had an increase in agitation and restlessness during the night shift. The document indicated the resident sustained a fall and sustained a contusion to the scalp which measured approximately four inches with copious amounts of bleeding. The document revealed the resident attempted to get out of bed on her own when the CNA briefly left the room. The resident was found on the floor with her face down and next to her bed. The resident's representative and medical provider were notified. The medical provider ordered the resident to be immediately transferred to the local hospital for evaluation and treatment. Licensed Practical Nurse (LPN)3 completed the note but is no longer employed at the facility.

Review of the facility's investigation dated 11/04/22 indicated R297 sustained a fall, and the fall was unwitnessed with injuries. The investigation confirmed the resident sustained a laceration to the left temporal area and was on heparin. The facility investigation confirmed the medical provider ordered R297 to be sent to the hospital. The investigation indicated CNA1 was previously in the resident's room and the resident was on safety monitoring due to increased agitation and the report revealed the resident was alert and oriented times one (the higher the number the more alert the resident was to

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person, place, surroundings, and time). The investigation indicated a root cause analysis was completed and determined the resident was supervised throughout the day due to her level of confusion and impulsive behaviors secondary to her diagnosis of Lewy Body dementia. The investigation revealed the resident appeared to be getting tired and a CNA took the resident to her room, provided personal care, and toileted the resident. The investigation revealed the resident was then placed into bed by a CNA. The investigation indicated the CNA and a nurse and left the room. During this time the resident attempted to get out of her bed. The CNA returned and the resident refused to lay down in bed. The CNA reported she left the resident sitting on the bed when she left to gather supplies needed to care for the resident. When the CNA returned, approximately five minutes later, she found the resident on the ground and immediately called for assistance. As part of the investigation, the facility indicated therapy deemed the resident safe to sit on the edge of the bed without the need of physical support. However, the above investigation did not include the level of supervision needed to keep R297 safe.

Review of a document provided by the facility titled "Witness Statement" dated 11/04/22 and written by LPN1 indicated she had monitored R297 on her entire shift since the resident made several attempts to get up out of her wheelchair and walk and she was unable to redirect the resident. LPN1 was no longer an employee at the facility.

Review of a document provided by the facility titled "Witness Statement" dated 11/04/22 and written by LPN3 indicated R297 was on safety

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monitoring during his shift due to an increase in anxiety and restlessness. LPN3 wrote that within a short period of time the resident got up on her own and attempted to walk and was found face down.

Review of a document provided by the facility titled "Witness Statement" dated 11/04/22 indicated CNA1 stated R297 was left sitting on the side of her bed, when she and the nurse walked away. CNA1 indicated she was gone for approximately five minutes and when she returned the resident had fallen. CNA1 stated the resident had on anti-slid socks on.

A request was made to the facility to contact CNA1 for an interview, and this was not successful prior to the end of the survey.

Review of a document provided by the facility titled "CT [computerized tomography] Scan without Contrast," dated 11/05/22 indicated R297 sustained head trauma with moderate to severe subdural hematoma.

Review of a type written document provided by the facility untitled and dated 11/16/22 indicated LPN3 wrote a statement which indicated R297 was observed to be highly agitated and restless and was repeatedly attempting to get up from her wheelchair. The statement indicated that staff were concerned for the safety of the resident and every effort was made to provide one on one supervision for her. The statement revealed the resident was left sitting upright on her bed with both feet on the ground when the CNA stepped outside of the room briefly to gather supplies and when the CNA returned the resident had fallen.

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| F 689 | Continued From page 31<br>During an interview on 02/01/24 at 8:40 AM, the Director of Rehabilitation (DOR) stated a resident with a diagnosis of Lewy Body was considered to be at risk for falls. The DOR stated typically there would be interdisciplinary notes or mention of recommendations in the therapy notes, but verified there were none. The DOR stated the resident should not have been left alone by the staff since the resident required supervision.<br><br>During an interview on 02/01/24 at 11:12 AM, the DON confirmed CNA1 sat R297 on the side of the bed and the resident then fell. The DON stated supervision did not mean to have a staff member's hand on the resident. The DON stated therapy did not meet with the staff to discuss the resident's need for supervision with the diagnosis of Lewy Body. The DON confirmed the resident was left alone when CNA1 left the resident alone to gather supplies to complete the resident's personal care. The DON stated the process was for staff to gather supplies before care was rendered to a resident. The DON stated she did not have access to the remaining hospital records other than the CT scan from 11/04/22. The Regional Clinical Consultant was present during this interview. | F 689 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, | F 695 | | 3/19/24 |

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and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations, and interviews, the facility failed to provide respiratory care per standards of practice for two of two sampled residents (Resident (R) 91 and R16). Specifically, the facility failed to ensure respiratory equipment was stored properly for R91 and R16. The failure to store respiratory equipment consistent with professional standards had the potential to cause contamination and damage to the respiratory equipment.

Findings include:

Review of a undated policy provided by the facility titled "CPAP [Continuous Positive Airway Pressure], CPAP-AUIO [continuous positive Airway pressure with Auto-titration], BiPAP [Bilevel Positive Airway Pressure], AUIO-PAP [Auto-titration Bilevel positive Airway pressure], & [and] BiPAP ST [Bilevel Positive Airway pressure with spontaneous/timed rate]" indicated ". . . When not in use, store clean machine in drawstring back in the respiratory closet. . ." The policies did not address the storage of a nebulizer machine face mask between use.

1. Review of R91's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the resident was admitted to the facility on 01/09/24 with a diagnosis of chronic obstructive pulmonary disease (COPD).

Review of R91's EMR titled "Care Plan" located under the "Care Plan" tab dated 01/10/24 indicated the goal was to improve the resident's

F 695

Nurse did not replace CPAP into plastic bag after removing from resident . Plastic bags were available at this time. Nurse not able to give reason as to why this happened, other then she forgot to replace the mask into bag. The root cause of the deficient practice is nurse did not place the respiratory equipment in a labeled plastic bag to store between uses.

Resident #91 was discharged 2/23/2024. Resident 16 will be provided with bags to ensure respiratory equipment is stored properly.

All other residents with respiratory equipment will be provided bags to ensure respiratory equipment is stored properly as per center policy.

The Nurse Practice Educator or Designee will re-educate all nursing staff on the policy for proper storage of respiratory equipment.

The DON or designee will complete audits daily x□s 7 days to determine that respiratory equipment is stored properly. When audits are 100% compliant, then audits will be completed weekly x□s 4 weeks. When audits are 100% compliant, audits will be completed monthly x□s 3 months.

Results of audits will be presented to the Quality Assurance Performance

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| F 695 | Continued From page 33<br>pulmonary function related to his COPD diagnosis.<br><br>Review of R91's EMR titled "Physician Orders" located under the "Order" tab dated 01/12/24, to administer Arformoterol tartrate (a bronchodilator) 15 micrograms (mcg)/2 milliliters (ml) twice a day to treat the resident's COPD.<br><br>Review of R91's EMR titled admission "Minimum Data Set [MDS]" with an Assessment Reference Date (ARD) of 01/13/24 indicated the resident had a "Brief Interview for Mental Status [BIMS]" score of 11 out of 15 which revealed the resident was moderately cognitively impaired.<br><br>During an observation and interview on 01/30/24 at 10:05 AM, R91 was in his wheelchair and his nebulizer machine was observed on his bedside table. The resident stated he used the nebulizer machine twice a day. The mask, which was attached to the hose, which was connected to the nebulizer, machine was uncovered.<br><br>During subsequent observations on 01/30/24 at 2:13 PM and 01/31/24 at 8:15 AM, R91 was in his room. The mask, which was attached to the hose, which was connected to the nebulizer machine, remained uncovered.<br><br>During an interview on 01/31/24 at 8:25 AM, Licensed Practical Nurse (LPN)2 stated the facility's process for respiratory equipment and storage was to clean the mask with soap and water and then place the mask in a plastic bag. LPN 2 stated placing the mask in a plastic bag was to prevent infections and this was the standard of practice for respiratory equipment. | F 695 | Improvement Committee for further evaluations, recommendations, and sustainability of plan. | |

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| F 695 | Continued From page 34<br>2. Review of R16's "Physician Orders" dated 01/06/24, located in the EMR under the "Orders" tab revealed, "CPAP: Personal machine from home, ok to use preset settings from home (Bleed in 2 L[liters] O2 [oxygen] (concentrator to top of machine)) on HS [hours of sleep] /off AM [morning] for sleep apnea."<br><br>During observations on 01/30/24 at 9:25 AM, 01/30/24 at 2:00 PM, and 01/31/24 at 9:00 AM revealed R16's CPAP tubing and nasal sponges were lying on top of the CPAP machine on the nightstand uncovered.<br><br>During an interview on 01/31/24 at 8:30 AM, Registered Nurse (RN)1 stated respiratory equipment should be placed in a plastic bag when not in use. RN1 stated it was the responsibility of the charge nurses to ensure respiratory equipment is placed in a plastic bag when not in use. RN1 confirmed R16's CPAP nasal sponges were on top of the CPAP machine on the bedside stand uncovered.<br><br>During an interview on 02/02/24 at 2:15 PM, the Director of Nursing (DON) stated the facility practice is to store the residents' respiratory equipment in a plastic bag when not in use. | F 695 | | |
| F 725 SS=E | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by | F 725 | | 3/19/24 |

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| F 725 | Continued From page 35<br>resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews the facility failed to have sufficient staff on a 24-hour basis to care for residents' needs, as identified through the facility assessment staff-to-resident ratios and the "Payroll Based Journal (PBJ) Staffing Data Report" supplied from the Centers for Medicare and Medicaid Services (CMS), resident council minutes, and views from the resident group. Additionally, the facility failed to respond in a timely manner to the needs of six residents (R)1, R44, R59, R33, R50, and R89 reviewed out of a total sample of 22.<br><br>Findings include:<br><br>Review of the "Payroll Based Journal (PBJ) Staffing Data Report" for fiscal year quarter four | F 725 | Due to the Governor waiving the staffing ratios, the center was not monitoring compliance with the staffing ratios based on Eagles Law. Center never adjusted the Facility Assessment to reflect that staffing ratios were waived by the Governor . The root cause of the deficient practice is the facility did not adjust Facility Assessment to reflect current guidelines<br><br>Slow response time due to staff providing care to other residents .The root cause for the deficient practice is that facility staff failed to answer the call bells timely.<br><br>Resident was not up for bingo because | |

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for 2023 [July 2023 through September 2023] and supplied by CMS revealed the facility triggered for excessively low weekend staffing as determined by information submitted by the facility.

Review of the "Facility Assessment Tool" reviewed 07/24/23 and supplied by the facility, revealed the nurse to resident ratios for different shifts to be 1:15 [nurse to resident] for 7:00 AM to 3:00 PM; 1:23 for 3:00 PM to 11:00 PM; and 1:20 for 11:00 PM to 7:00 AM. The indicated Certified Nursing Assistant (CNA) to resident ratios to be 1:8 for 7:00 AM to 3:00 PM; 1:10 for 3:00 PM to 11:00 PM; and 1:20 for 11:00 PM to 7:00 AM.

Review of staffing schedules supplied by the facility for July 2023 through September 2023 revealed multiple weekends with different shifts falling below the intended ratios determined by the facility.

In an interview on 02/02/24 at 3:20 PM the CNA-Staffing Coordinator (CNA-SC) stated the information submitted to CMS for the fourth quarter was correct. The CNA-SC stated the ratios determined in the facility assessment are the standard for staffing and the facility strives to meet that standard. The CNA-SC stated there were many call-ins during that time.

1. Review of the quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 11/08/23 in the electronic medical record (EMR) under the "MDS" tab revealed R1 was admitted to the facility on 09/04/21. Review of the Brief Interview for Mental Status (BIMS) revealed that R1 was moderately impaired in cognition with a score of 11 out of 15.

F 725

staff were not aware of residents personal preferences nor did they ask her about her routine. The root cause of the deficient practice is facility failed to have a process for communicating resident preferences to the staff.

Both residents received their medications as requested and ordered. PRN medication was provided after medication pass. Resident with seizure medication not aware of the standards of medication administration allowing nurses to administer medications one hour prior to and after the prescribed time for administration. The root cause for the deficient practice is the facility failed to have a process to communicate proper medication times the the residents.

All residents have the potential to be affected by this deficient practice.

Staff will be re-educated on identifying resident preferences and documenting resident refusals when residents decide not to follow their own preferences.

The Nurse Practice Educator or Designee will re-educate nurses on the standards for administration of PRN pain medications.

The Nurse Practice Educator or Designee will re-educate all staff on responding to call bells in a timely manner.

The Nurse Practice Educator or Designee will re-educate all nurses on the

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During an interview on 01/30/24 at 11:27 AM, R1 was observed to be lying in bed in a hospital gown. Her breakfast tray remained on the over bed table which was placed over the bed. R1 stated, "Today is supposed to be bingo." R1 stated she wanted to go but was dependent on staff to get out of bed, dressed, and into the wheelchair. R1 stated the staff used the Hoyer lift to get her out of bed which required two staff. R1 stated staff left her in bed when she would like to get up early. R1 stated she woke up early and would like to go to breakfast in the dining room. R1 stated staffing was a problem, especially on the weekends. She stated there was, "no one around" and there was, "not enough staff." R1 stated she had been wet at night and not been changed for the whole night.

During an interview on 01/30/24 at 12:59 PM, R1 continued to be in bed in her gown and had been served lunch. R1 stated the staff had not gotten her up or bathed her (bed bath). R1 stated she had informed the staff she wanted to get up to go to bingo this afternoon.

2. Review of the undated "Admission Record" in the EMR under the "Profile" tab revealed R44 was admitted to the facility on 05/23/20.

Review of the quarterly "MDS" with an ARD of 01/08/24 in the EMR under the "MDS" tab revealed R44 was intact in cognition with BIMS score of 15 out of 15.

During an interview on 01/30/24 at 3:09 PM, R44 stated there were not enough staff, especially on the weekends. He stated his essential needs might be met but there were not enough staff to take care of the details. R44 stated he had waited

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administration of medications per facility policy.

The NHA or designee will complete 5 resident audits/week x 4 weeks to determine if their personal preferences are being met. When audits are 100% compliant the NHA or designee will complete 3 resident audits/week x 3 weeks. When audits are 100% compliant, the NHA will conduct 1 audit/week x 2 weeks.

The DON or designee will complete 5 random audits per week x□s 2 weeks of medication administration to determine medications were administered per the facility policy. When audits are 100% compliant, 3 random audits will be completed per week x□s 2 weeks. When audits are 100% compliant 1 random audit per week will be completed x□s 2 weeks

Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan.

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| F 725 | Continued From page 38<br>a long time for his call light to be answered on weekends or at night. He stated at night it was quiet, "like a tomb." R44 stated staff flitted in and out and were busy with other residents. R44 stated he tried to get his incontinence brief changed by 9:45 PM because if he waited longer, the staff might not come and his brief might not be changed.<br><br>3. Review of the undated "Admission Record" in the EMR under the "Profile" tab revealed R59 was admitted to the facility on 09/18/20.<br><br>Review of the quarterly "MDS" with an ARD of 11/10/23 in the EMR under the "MDS" tab revealed R59 was intact in cognition with a BIMS score of 15 out of 15.<br><br>During an interview on 01/30/24 at 3:37 PM, R59 stated it was hard to get PRN (as needed) pain medication on the evening shift. R59 stated he asked and asked and had to wait for the night nurse to give it to him, indicating there was not enough staff at night.<br><br>4. Review of the undated "Admission Record" in the EMR under the "Profile" tab revealed R33 was admitted to the facility on 12/05/23.<br><br>Review of the admission "MDS" with an ARD of 12/12/23 in the EMR under the "MDS" tab revealed R33 had a BIMS score of 14 out of 15 indicating she was cognitively intact.<br><br>During an interview on 01/30/24 at 11:27 AM, R33 stated the facility was, "short on help." R33 stated when she used her call light there had been times when she waited an hour for it to be answered. R33 stated, "Weekends are terrible and nights." | F 725 | | |

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R33 stated she needed staff assistance to change her incontinence brief. R33 stated there was a recent incident in which she had urinated three times in her brief before staff came to change her.

5. Review of the undated "Admission Record" in the EMR under the "Profile" tab revealed R50 was admitted to the facility on 09/01/23.

Review of the annual "MDS" with an ARD of 11/20/23 in the EMR under the "MDS" tab revealed R50 was intact in cognition with a BIMS of 15 out of 15.

During an interview on 01/30/24 at 10:11 AM, R50 stated the agency nurses were not good and they were not familiar with what her needs were. R50 stated there were delays in getting her seizure medications when the facility was short staffed. R50 stated staffing was more problematic on the weekends.

Review of the "Resident Council Minutes" from June 2023 through December 2023 revealed concerns with staffing.
a. "June 2023 Resident Council Meeting" minutes included the following comments:
"Nursing: Being shorthanded is a problem, the nurse should tell you what medicines that are in your cup if you ask, and you should receive your list of medications upon request, a resident stated she stays wet too long, low pay is causing staff to leave ... some of the new CNAs have attitudes when you try to talk to them, new staff need to know their patients issues, CNAs say they will be back and you never see them again ..."

b. "August 2023 Resident Council" meeting

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minutes included the following comments: "Nursing: Not enough aides on the floor, Nurses come in and are told to go home, several staff have left ... Aides are not coming in to pick up trays and beds are not being made."

c. "October 2023 Resident Council" meeting minutes included the following comments: "A resident stated she was giving medication and am medication was very late ... On weekends the dining rooms are being closed forcing the residents who enjoy eating in the dining rooms to eat in their rooms."

d. "Resident Council November 2023" meeting minutes included the following comments: "The agency CNAs seem to not know their residents and treat several residents as if they were a burden on 3-11 and 11-7 [shifts] ... Agency CNAs will not give their name ...No back up on 3-11 shift if someone calls out. Call bells ringing too long. 3-11/11-7."

e. "Resident Council December 2023" meeting minutes included the following comments: "Nursing: 3-11/11-7 call bells ringing too long ... Weekends are shorthanded ..."

Resident group meeting was held on 1/31/24 at 10:30 AM where eight of nine residents R42, R50, R55, R61, R67, R73, R77, and R78) stated there was not enough CNAs, licensed practical nurses (LPNs), and registered nurses (RNs) working. The residents stated staff would respond to a call light by entering their room, turn off the light, state they would return, leave the room, and never come back. The group stated the weekends, and the night shift were the worst.

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5. Review of R89's "Face Sheet" located in the EMR under the "Profile" tab, revealed R89 was admitted to the facility on 12/06/23 with diagnoses that included dementia and Alzheimer's disease.

Review of the "MDS" located in the EMR under the "MDS" tab with an "ARD" of 12/13/23, revealed a "BIMS" score of six out of 15 that indicated R89 had moderate cognitive impairment and required substantial/maximal assistance for dressing the lower body.

Observation on 02/01/24 at 6:30 AM revealed R89 was sitting in a wheelchair in the doorway of her room. R89 was dressed in a shirt and a brief with both legs exposed from the upper thigh to the feet. R89 had a pair of slacks in her hand and asked RN2 if she would take the slacks and dry them. RN2 took the slacks, put them in a plastic bag, and put the bag into a hamper in the closet. RN2 when exiting the room, called out to CNA7 to go in and help the resident.

Observation on 02/01/24 at 7:20 AM identified R89 was sitting in a wheelchair in the doorway of her room wearing a brief and her entire legs exposed. R89 was heard asking, "Are my pants dry, are my pants dry." Observation revealed RN2 was at the medication cart across from R89's room preparing medications and did not provide any assistance to R89.

During an interview on 02/01/24 at 7:45 AM, CNA7 stated she was assigned to provide care to 12 residents on the 600 unit on 02/01/24 for the 11:00 PM -7:00 AM shift. CNA7 stated she heard RN2 ask her to help R89, but she was providing care to the other residents on the unit and could not go to help R89. CNA7 stated she told RN2

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| F 725 | Continued From page 42<br>she was busy providing end of shift care to the other residents and could not assist R89. CNA7 stated, "There was no one else to ask for help."<br><br>Observation on 02/01/24 at 7:50 AM revealed R89 was sitting in a wheelchair in the doorway of her room with only a brief on and her entire legs exposed. Multiple staff were observed to walk by R89's room without intervening.<br><br>During an interview on 02/01/24 at 8:30 AM, RN2 stated she asked CNA7 to help R89 to put on new slacks. RN2 stated she did not know CNA7 did not assist R89, RN2 stated she asked CNA7 at least twice to provide assistance to R89 but did not know until later that CNA7 was too busy to assist the resident.<br><br>During an interview on 02/02/24 at 2:15 PM, the Director of Nursing (DON) stated the nurse should help the CNA when they ask for assistance to provide care to residents. The DON stated RN2 should have reported to the Unit Manager when she came on duty at 6:30 AM that she needed help with getting care completed for residents. | F 725 | | |
| F 726 SS=D | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and | F 726 | | 3/19/24 |

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diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations, interviews, and review of the facility assessment, the facility failed to ensure one Certified Nursing Assistant (CNA)3 was competently trained to provide one Resident (R)39 personal care in a dignified manner (Cross Reference F550). Additionally, the facility failed to ensure one Licensed Practical Nurse (LPN) 5 was competent to handle a biopsied specimen and not to destroy it prior to analysis by a pathologist (Cross Reference F684).

Findings include:

Review of a document provided by the facility titled "Facility Assessment Tool," dated 06/06/23

Cross reference plan of correction for F550 for R39 and F684

CNA did not pull window blind down prior to starting care, she also did not pull the privacy curtain between resident beds. When questioned about this she stated she knew she was supposed to do so, however, she forgot to address at this time. The root cause of the deficient practice is that the CNA failed to pull the window blind down and close the privacy curtain between residents before providing care.

R39 had no negative outcome as a result

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| F 726 | Continued From page 44<br>indicated ". . . [Name of the facility] has an extensive library of clinical policies and procedures that are developed through a Governing body, Regional Clinical Staff and at the center level. Policies and procedures are based on federal and state regulations, standards from professional organizations and professional clinical resources, an annual review is performed by the Practice Councils and the center Quality improvement Committee to determine if updates are needed. However, policies and procedures are updated throughout the year if practice standards change. New policies and procedures are developed as new population trends and needs are identified. . . [Name of the facility] has established a set of Standards and procedures for Licensed Independent Practitioners. All providers credentialed to provide care in our centers receive a copy of this detailed document, as do our center leaders. Topics covered by this are broad, including expectations around patient evaluation, visit frequency, documentation, care planning, laboratory testing. . .inter-professional communication and medical orders. . ."<br><br>1. Review of CNA3's employee record indicated the staff member was hired on 10/13/23.<br><br>Review of a document provided by the facility titled "Job Description/Competency" indicated the CNA position was ". . .To provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan and as may be directed by your supervisor in accordance with current federal, state, and local standards governing the facility. . .Ensure that all residents are treated with. . .dignity and respect. . ." | F 726 | of the negative practice<br><br>All other residents have the potential to be affected by this deficient practice.<br><br>The Nurse Practice Educator or designee will re-educate all nursing staff on maintaining resident privacy to ensure dignity during and after care.<br><br>CNA3 will be required to repeat the Relias training Essentials for Resident Rights.<br><br>DON or designee will complete audits on all shifts to ensure resident dignity during and after care is maintained. Audits will be conducted daily x□s 7 days on various shifts. When audits are 100% compliant, audits will be completed weekly x□s 3 weeks on various shifts.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan.<br><br>11-7 LPN discarded a skin biopsy from the specimen refrigerator on west wing that was pending lab pick up. The nurse stated it was not labeled properly and he did not receive information from the 3-11 nurse about this specimen. The 11-7 nurse failed to look in residents chart and or PCC to obtain more information, nor did he speak with the Unit manager, prior to discarding the specimen. The root | |

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| F 726 | Continued From page 45<br>Review of a document provided by the facility titled "Relias" for CNA3 indicated on 10/17/23 CNA3 took a training on "Essentials of Resident Rights."<br><br>During an observation on 02/01/24 at 5:42 AM, the surveyor knocked on closed R39 and R6's room door and was told to enter by CNA3. CNA3 was observed next to the bed of R39. R39 was observed with her breasts exposed and her brief being changed by CNA3. The privacy curtain was not pulled. R39's roommate, R6, was up in her wheelchair facing CNA3 and R39. The curtain of the window was up one quarter of the way and faced the facility's parking lot. CNA3 was asked why the privacy curtain was not pulled and CNA3 then pulled the curtain between the two residents.<br><br>During an interview with CNA3 on 02/01/24 at 6:06 AM, she said that she had been a CNA for the past seven years and made a mistake by not providing privacy between R39 and R6.<br><br>During an interview on 02/01/24 at 3:55 PM, the Director of Nursing (DON) stated CNA3 needs to have re-education on privacy and dignity.<br><br>2. Review of LPN5's employee filed indicated the staff member was hired on 08/21/18.<br><br>Review of a document provided by the facility titled "Job Description/Competency" indicated the purpose of the LPN position was ". . .To provide direct nursing care to residents under the medical direction and supervision of the residents' attending physicians, the Director of Nursing Services, and the Medical Director of the facility. . ." | F 726 | cause of the deficient practice is that an LPN discarded a skin biopsy specimen that was in the specimen refrigerator for lab pick up.<br><br>Resident #298 was discharged from the facility 6/1/2023.<br><br>All other residents have the potential to be affected by this deficient practice.<br><br>The Nurse Practice Educator or Designee will re-educate all nurses on the proper handling of specimens awaiting to be picked up by the lab.<br><br>Nurse Practice Educator or designee will complete competency on specimen handling with all nurses and they will receive a copy of the lab service and reporting policy<br><br>The DON or designee will complete audits of all specimens awaiting pick up by laboratory daily x 7. When 100% compliant, then weekly x 4.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan. | |

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| F 726 | Continued From page 46<br>Review of R298's clinical records indicated the resident had a biopsy of a skin tag on 03/08/23.<br><br>During an interview on 02/02/24 at 12:32 PM, the DON stated LPN5 reported he had thrown out the specimen taken from R298's skin. The DON stated specimens should be in the appropriate container, labeled and dated, and the initials of the nurse should be on the container. The DON stated LPN5 reported the specimen container did not have the correct label on it and therefore tossed it in a biohazard container. The DON stated her expectation for LPN5 was to look up the procedure the resident had, verify, and label the container correctly. The DON stated the nurse should have contacted the lab to have them collect the item. The DON stated this was a standard of practice.<br><br>An attempt was made to contact LPN5 and it was not successful prior to the end of survey. | F 726 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized | F 761 | | 3/19/24 |

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| F 761 | Continued From page 47<br>personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and facility policy review, the facility failed to ensure one of two medication rooms was secured by closing and locking the door to the room. This failure had the potential of permitting unauthorized individuals access to the medication storage room.<br><br>Findings include:<br><br>Review of the facility policy titled, "Medication Storage" revised on 03/13/23 indicated, "It is the policy of this facility to ensure that all medications housed on our premises will be stored in the. . . medication rooms according to the manufacturer's recommendations . . . and security. . .All drugs and biologicals will be stored in locked . . . medication rooms."<br><br>Observation on 02/01/24 at 5:47 AM revealed the door to the medication storage room propped open by a plastic milk crate. Registered Nurse (RN)2 was then observed to push the crate out of the way and allow the door to close.<br><br>During an interview at 5:47 AM on 02/01/24 RN2 | F 761 | 11-7 nursing staff propped medication room door open for convenience of refilling OTC medications and placing pharmacy delivery while finishing shift. When questioned about this nurses stated understanding that door should be closed and locked at all times, and agrees that medication storage policy not followed at this time. The root cause of the deficient practice is the nursing staff failed to keep medications behind double locks by propping the medication room door open with trash can.<br><br>All residents had the potential to be affected by this deficient practice.<br><br>The Nurse Practice Educator or Designee will re-educate all nurses on the policy for securing medication rooms by closing and locking the door to prevent unauthorized individuals access to the medication storage room.<br><br>The DON or designee will conduct audits to ensure medication room doors are | |

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| F 761 | Continued From page 48<br>confirmed the medication room door had been propped open and stated, "So I shut it." She stated it should not be propped open.<br><br>During an interview with the Director of Nursing (DON) on 02/02/24 at 6:12 AM she stated her expectation was for staff to ensure the medication room door was closed to secure the medications stored inside. | F 761 | closed and locked daily x□s 7 days. When audits are 100% compliant, audits will be conducted weekly x□s 4 weeks. When 100% compliant, audits will be completed monthly x□s 3 months.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan | |
| F 804 SS=E | Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and policy review, the facility failed to ensure the food was palatable for four of 22 sampled residents (Resident (R)1, R59, R33, and R65) and residents attending Food Committee meetings. The food was not at a palatable temperature when residents received their meals; condiments were not consistently provided, and food was not flavorful/prepared properly.<br><br>Findings include:<br><br>Review of the "Food: Quality and Palatability" | F 804 | Dietary department has not had consistent oversight by a Food Service Director. Dietary department has had turnover in all levels of staff over the past 3 years. The root cause of the deficient practice is the lack of consistent Food Service Director available in the Dietary department.<br><br>R1, R59, R33, R65 will have their food preferences reviewed by the Food Service Director or designee and have their meal tickets updated for any necessary | 3/19/24 |

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| F 804 | Continued From page 49<br>policy dated February 2023 revealed, "Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature."<br><br>1. Resident interviews with R1, R59, R33, and R65 revealed concerns with food palatability:<br><br>a. During an observation and interview on 01/30/24 at 11:27 AM, R1 was observed with her breakfast tray (scrambled eggs, toast, orange juice) remaining on the overbed table in front of her untouched. R1 stated the eggs were cold when she received them, and she had not eaten them. R1 stated dinner was the worst meal and it usually consisted of sandwiches and stale bread.<br><br>During an observation on 01/30/24 12:59 PM, R1 was served her lunch which included a hot dog with mustard. When asked if she liked ketchup with her hot dog, R1 stated the only condiment she received was mustard. R1 stated she had her own salt and pepper packets because she did not receive it with meals.<br><br>Review of the quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 11/08/23 in the electronic medical record (EMR) under the "MDS" tab revealed R1 was moderately impaired in cognition with a Brief Interview for Mental Status (BIMS) score of 11 out of 15 (score of 8 - 12 indicates moderate impairment).<br><br>b. During an interview on 01/30/24 at 3:37 PM, R59 stated the meat was always overcooked. R59 stated the food was cold when he received his tray in his room. He stated his room was the | F 804 | changes.<br><br>All residents will have their meal preferences reviewed and have their meal ticket updated for any necessary changes.<br><br>The Registered Dietician or Designee will re-educate dietary staff on providing the proper items on the tray based on the meal ticket for each residents likes, dislikes, allergies, and order.<br><br>The Registered Dietician or Designee will re-educate all dietary staff on serving foods and drinks at the proper temperature for all food items. Re-education will include temperature ranges for all food and drink items and utilizing hot bases when appropriate.<br><br>The Registered Dietician or Designee will re-educate Cooks on proper procedure for preparing mechanically altered food items.<br><br>The Food Service Director or designee will interview and complete Food Service Resident Satisfactory Survey for 5 residents per week for 2 weeks. When 100 % compliant, audit 3 residents/week x 2 weeks. When 100% compliant 1 resident/week x 2 weeks. Areas identified as per resident surveys will be addressed by the Food Service Director or designee.<br><br>The Food Service Director or designee will audit the tray line daily x□s 7 days to ensure trays delivered to the floor contain the appropriate items as posted on the | |

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| F 804 | Continued From page 50<br>last one at the end of the hall and he was served last. R59 stated he often asked staff to reheat his meal.<br><br>Review of the undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed Resident (R)59 was admitted to the facility on 09/18/20.<br><br>Review of the quarterly "MDS" with an ARD of 11/10/23 in the EMR under the "MDS" tab revealed R59 was intact in cognition with a BIMS score of 15 out of 15.<br><br>c. During an interview on 01/30/24 at 11:27 AM, R33 stated the, "food is lousy, never warm and always cold."<br><br>Review of the undated "Admission Record" in the EMR under the "Profile" tab revealed R33 was admitted to the facility on 12/05/23.<br><br>Review of the admission "MDS" with an ARD of 12/12/23 in the EMR under the "MDS" tab revealed R33 had a BIMS score of 14 out of 15 indicating she was cognitively intact.<br><br>d. During an interview on 01/30/24 at 9:08 AM, R65 stated she had concerns about the food. R65 stated the temperature of the food was a problem and the food was not cooked properly.<br><br>Review of the "Admission Record" in the EMR under the "Profile" tab revealed R65 was admitted to the facility on 03/03/23.<br><br>Review of the quarterly "MDS" with an ARD of 11/28/23 in the EMR under the "MDS" tab revealed R65 was cognitively intact with a BIMS | F 804 | menu. When audits are 100% compliant, audits will be completed weekly x□s 4 weeks. When weekly audits are 100% compliant, audits will be completed monthly x 4.<br><br>The Food Service Director or designee will complete 3 audits per week for 3 weeks of pureed foods to ensure that they are at the proper texture. When these audits are 100% compliant the audits will be completed 2 x□s per week for 2 weeks. When the audits are 100% the audits will be completed once per week for 2 weeks.<br><br>The center will continue to hold monthly Food Committee meetings separate from the Monthly Resident Council meetings.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan. | |

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| F 804 | Continued From page 51 | F 804 | | |

score of 13.

2. Review of the "Food Committee Meeting Minutes" from June 2023 through December 2023 revealed concerns with the food.
a. "June 2023 Food Committee Meeting Minutes" included the following comments:
"Rolls become soft under the warmer tops."
"Veggies are cooked too long ..."

b. "July 2023 Food Committee Meeting Minutes" included to following comments:
"Several residents stated the kitchen is not using the hot bases to keep the food warm."
"A resident stated no relish, sugar, applesauce, available ..."

c. "Food Committee Meeting Minutes 08/10/23" included the following comments:
"The food this week was horrible (sic) she received under cooked potato wedges. No lettuce and tomato on her sandwich for dinner ..."
"Does not like the angel food cake says its dry and mealy."

d. "Food Committee Notes 11/09/23" included the following comments:
"Too much moisture in the vegetables."
"Overcooked vegetables."
"Residents state the (sic) don't like the coffee."

e. "Food Committee 12/14/23" minutes included the following comment:
"Eggs cold."

3. The posted menu in the hallway outside the dining room revealed lunch on 01/30/23 consisted of smothered chicken thigh, whole kernel corn, oven brown potatoes, corn bread, and sliced

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pears or the alternate of hot dogs on bun, baked beans, and coleslaw.

On 01/30/24 at 12:21 PM, staff went into the dining room where residents were sitting and passed out drinks. There were approximately 15 residents in the dining room. Meal service began at 12:26 PM. Meal service was observed continuously through 1:01 PM and none of the residents were served margarine with the corn bread. In addition, the only condiment served with the hot dogs was mustard, except for one resident who specifically asked for ketchup. None of the residents were offered or had salt and pepper available.

4. On 02/01/24 two test trays were evaluated by the Dietary Manager (DM), the Regional Dietary District Manager (RDDM) and the surveyor. The first test tray was a regular diet on the 200-hall meal cart and the second test tray was a pureed diet on the 100-hall meal cart.

a. On 02/01/24 at 8:38 AM, staff pushed the 200-hall cart down to the 200 hall.

On 02/01/24 at 8:52 AM, all the residents had received their meals. The test tray consisting of scrambled eggs, an apple muffin, and juice was evaluated. The temperature of the scrambled eggs was adequately hot; however, the eggs had an unappealing spongy texture. The DM verified the eggs were cooked in the steamer which contributed to the unusual texture. The cranberry juice was cool at 56 degrees Fahrenheit (F); it was not cold. The DM stated the goal for cold beverages was under 41 degrees.

b. On 02/01/24 at 9:05 AM, staff pushed the

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100-hall cart down to the 100 hall.

On 02/01/24 at 9:34 AM, staff came and removed the last resident's tray. The test tray was evaluated at this time. The test tray consisted of pureed eggs, pureed apple muffin, oatmeal, milk, coffee, and apple juice. The pureed muffin was pasty in texture and salty. The RDDM tasted the pureed muffing and agreed the texture was not right. The RDDM stated the texture became gummy if the bread product was pureed too long. The apple juice was cool but not cold at 59 degrees F and the milk was cool but not cold at 56 degrees F. The coffee was lukewarm and bitter; it was 112 degrees F and the RDDM stated coffee should be between 140 - 160 degrees F.

5. During an interview on 02/02/24 at 11:37 AM the Registered Dietitian (RD) stated she completed meal tray assessment audits. One concern was that residents stated the food was not hot enough. The RD stated a lot of the cold foods (beverages, fruits, puddings) she audited were above temperature and were too warm. The RD stated she had suggested to dietary staff to refrigerate cold foods ahead of time; however, this had not been consistently implemented. The RD stated her audits showed the hot food temperatures had improved but the cold food temperatures were a work in progress.

During an interview on 02/02/24 at 4:34 PM the Administrator stated the dietary department had been working on cold food temperatures to ensure foods such as fruit and desserts were cold enough when served to residents. He stated the meal tray audits showed mixed results as far as foods being refrigerated the night before and being sufficiently cold when residents received

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| F 804 | Continued From page 54<br>their meals. | F 804 | | |
| F 809<br>SS=E | Frequency of Meals/Snacks at Bedtime<br>CFR(s): 483.60(f)(1)-(3)<br><br>§483.60(f) Frequency of Meals<br>§483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.<br><br>§483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.<br><br>§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review and policy review, the facility failed to ensure there was not more than a 14-hour time span between dinner and breakfast the next day. This failure affected approximately 19 residents out of 99 total residents, who ate in the west dining room. The extended time between dinner and breakfast had not been approved by the resident group.<br><br>Findings include: | F 809 | Dietary department has not had consistent oversight by a Food Service Director. Dietary department has had turnover in all levels of staff over the past 3 years. The root cause of the deficient practice is the lack of consistent Food Service Director available in the Dietary department.<br><br>All residents have the potential to be affected by this deficient practice. | 3/19/24 |

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| F 809 | Continued From page 55 | F 809 | | |

Review of the "Frequency of Meals" policy dated October 2022 revealed, "The time between a substantial evening meal and breakfast the following day will not exceed 14 hours, except when a nourishing snack is served at bedtime. Up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span and a nourishing snack is provided."

1. Review of the undated "[Name of facility] Meal Service Times" provided by the facility and posted on the wall near the dining room revealed a 14-and-a-half-hour gap between dinner and breakfast for residents eating the dining rooms:
"Breakfast
Cart service for hallways begins at 8:00 am
Dining room opens at 8:00 am

Lunch
Cart service for hallways begins at 12:00 PM
Dining room service begins at 12:00 PM

Dinner
Cart service for hallways begins at 5:15 PM
Dining rooms open at 5:30 PM"

2. Review of the "Resident Council May 2023" meeting minutes revealed, "Beginning April 3rd, cart service will begin at 5:15 pm. Dining rooms will be served at 5:30 pm. Regulations state that there cannot be more than fourteen hours between dinner and breakfast. The change puts us at fourteen hours and 30 minutes."

3. Review of the undated, "West Dining Room" list revealed there were 19 residents who customarily ate their meals in the dining room.

**Provider's Plan of Correction (F 809):**

The times for dinner and breakfast meal service will be adjusted to comply with the 14-hour rule as required by regulation.

The Food Service Director or designee will audit the mealtimes daily x□s 7 days to ensure compliance with the 14-hour rule. When audits are 100% compliant, audits will be completed weekly x□s 4 weeks. When those audits are 100% compliant the audits will be completed monthly x□s 3 months.

Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan.

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4. During an interview on 02/01/24 at approximately 7:30 AM, the Regional Dietary District Manager (RDDM) stated the 14 and a half hour time lapse between dinner and breakfast the next day applied to residents eating in the dining room. The RDDM stated they had been trying to come up with the best timing for meal service but the timing was tricky. They had tried to serve residents in the dining room breakfast first, but there were late risers and it worked better to serve them after the meal carts which contributed to the longer lapse between dinner and breakfast.

During an interview on 02/01/24 at 7:42 AM, the Dietary Manager (DM) stated the dining rooms were served last after the 600 hall, 300 hall, 200 hall, 500 hall, and 100 hall carts.

5. During a meal observation for breakfast on 02/01/24 at 8:56 AM, only two out of the 12 residents in the main dining room had received their meals. There were 10 residents in the main dining room waiting for breakfast. Several of the residents waiting for their meals, including R17 and R50, stated they were hungry. R50 stated breakfast was typically served by 8:45 AM. Observation revealed the last resident was served breakfast at 9:17 AM, making the time span more than 15 hours from dinner the day before.

6. During an interview on 02/02/24 at 12:21 PM, the Activity Director (AD) stated she took minutes at the resident council meetings. She stated a change had been made in the mealtimes and it had been communicated to residents in the resident council meeting (May 2023). The AD stated she was not aware of the resident group

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| F 809 | Continued From page 57<br>approving the time more than 14 hours.<br><br>During an interview on 02/02/24 at 11:37 AM, the Registered Dietitian (RD) stated the facility had changed the dinner time and previously had changed the breakfast time. She stated the time span between dinner and breakfast should not be more than 14 hours.<br><br>During an interview on 02/02/24 at 1:54 PM, the Administrator stated the facility had discussed the greater than 14-hour time span between dinner and breakfast with the residents; however, did not get approval from the resident group. | F 809 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by: | F 812 | | 3/19/24 |

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| F 812 | Continued From page 58<br>Based on observation, interview, record review, policy review, and review of the US (United States) Food Code, the facility failed to ensure the kitchen was maintained in a sanitary condition to prevent the potential spread of foodborne illness to 97 out of 99 residents. Specifically, the facility failed to maintain a sanitary kitchen; label, date, and store food properly; use the handwashing sink for handwashing only and ensure a garbage can was in place; ensure equipment was clean; ensure staff followed hand hygiene/glove use standards; and ensure staff had their hair covered. The facility failed to ensure proper infection control practices were maintained for a sugar and a flour container which held scoops previously used by the kitchen staff. The facility failed to ensure Dietary Aide (DA)1 removed his personal disposable cup from a reach in refrigerator which could potentially contaminate food items which were then served to residents.<br><br>Findings include:<br><br>US Food Code 2022-- Indicated "...Explaining correct procedures for cleaning and sanitizing utensils and food-contact surfaces of equipment. . .Employees are properly sanitizing cleaned multiuse equipment and utensils before they are reused. . .an employee shall eat, drink. . .only in designated areas where the contamination of exposed food, clean equipment, utensils, and linens. . .During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored. . .In food that is not time/temperature control for safety food with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour, or cinnamon. . | F 812 | Dietary department has not had consistent oversight by a Food Service Director. Dietary department has had turnover in all levels of staff over the past 3 years. The root cause of the deficient practice is the lack of consistent Food Service Director available in the Dietary department.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>Regional Dietary Manager or Designee will re-educate all dietary staff on proper sanitation practices in the kitchen specifically labeling and dating of food, no food in the hand sinks, hand hygiene while serving food, proper use of hairnet, proper storage of scoops, no storage of employee personal items in the refrigerators/freezers, a garbage can must be near hand sinks, cleaning of commercial equipment after use and how to alert maintenance of issues that need to be addressed by maintenance.<br><br>The tile around floor drains and baseboards pulling away from the walls will be repaired.<br><br>The refrigerators and microwaves in the pantry on each unit will be cleaned. Pantry refrigerators and microwaves will be monitored for cleanliness weekly.<br><br>A systemic change will be that the pantry refrigerators and microwaves will be placed on a regular cleaning schedule. | |

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| F 812 | Continued From page 59<br>.refrigerated, ready-to eat, time/temperature control for food safety food is prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5º[degrees] C[Celsius] (41ºF [Fahrenheit]) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. ..."<br><br>Review of the "Food Preparation" policy dated February 2023 revealed, "1. All staff will practice hand washing techniques and glove use. 2. Dining services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. 3. All utensils, food contact equipment, and food contact surfaces will be cleaned and sanitized after every use ... All staff will use serving utensils appropriately to prevent cross contamination ... All refrigerated, ready-to-eat ... prepared foods ... will be labeled and dated with a "prepared date" (Day 1) and a "use by date" (Day 7)."<br><br>Review of the dietary department "Staff Attire" policy dated October 2023, "All staff members will have their hair off the shoulders, confined in a hair net or cap ..."<br><br>Review of the "Foods Brought by Family/Visitors" policy dated October 2019 revealed, "Food brought to the facility by visitors and family is permitted ... Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility-prepared food ... Perishable foods must be stored in re-sealable | F 812 | The Nurse Practice Educator or Designee will re-educate all staff on proper storage of resident food items in the pantry refrigerator.<br><br>The FSD or designee will complete sanitation audits twice daily x□s 7 days. When audits are 100% compliant, audits will be conducted twice weekly x□s 4 weeks. When audits are 100% compliant audits will be completed twice monthly x□s 3 months.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan. | |

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containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the "use by" date."

1. During the initial tour conducted on 01/30/24 at 8:30 AM, the Dietary Manager (DM) provided a tour of the kitchen. At 8:35 AM, observed a container of sugar and a container of flour with scoops inserted into both the sugar and the flour. The DM stated this was improper use of scoops to leave them in the containers and it was a potential infection control issue. At 8:36 AM, the DM opened a reach-in refrigerator, and he confirmed the food inside was a meal from the previous night's meal. The following items were observed in separate containers covered with plastic wrap with no date when the items were either served or last date to be used by: peas, chicken, rice, and peas and carrots. Finally, there was a disposable cup, with no lid and filled with a reddish liquid. DA1 stated the juice was his and did not respond when asked why he stored it in a refrigerator that contained food that potentially could be served to residents. The DM confirmed that all the food identified in the refrigerator was undated and should have been dated.

2. During kitchen observations on 02/01/24 from 7:24 AM - 8:28 AM the following concerns were noted:

a. There was a piece of pineapple in the handwashing sink. The Regional District Dietary Manager (RDDM) verified the presence of the pineapple, removed it, and stated the handwashing sink should be used for handwashing only and not for food preparation. In addition, there was no garbage can in the proximity of the handwashing sink for disposal of

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| F 812 | Continued From page 61<br>paper towels. The RDDM guided the surveyor to the dish machine room to a garbage can to dispose of the used paper towels. The RDDM verified there should be garbage can in the handwashing sink area.<br><br>b. The commercial slicer was observed with a large plastic bag covering it. When the bag was removed the back side of the slicing blade had food/grease residue present on the edge of the blade ½ inch wide. The RDDM stated the plastic bag covering the slicer indicated the slicer had been cleaned and was ready to be used. The RDDM stated the slicer would need to be cleaned prior to use, verifying the presence of the grease/food residue.<br><br>c. There were three floor drains in the kitchen. There were deteriorated/missing tiles around each of the three floor drains. The RDDM stated he habitually noted on his monthly inspection reports for the tile around the floor drain in the area between the walk-in refrigerator and freezers. The RDDM verified the condition of the tile floor for all three drains and indicated repair was needed.<br><br>d. The base board behind the handwashing sink was partially affixed and there was a section of approximately three feet coming away from the wall. A section of approximately three feet of the base board near the door into kitchen from dining room was also not affixed and was coming away from the wall. There was accumulated grime along the baseboard/floor at the dining room/kitchen entrance.<br><br>e. DA2 was observed in the kitchen with long braids that were not covered with a hair covering. | F 812 | | |

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DA2 was observed assisting with tray line during lunch meal service. Only the top of DA2's hair was covered with a hair net. The DM verified DA2's hair was not adequately covered during an interview on 02/01/24 8:38 AM.

f. Cook1 was observed to dish up residents' meals for the 600 cart, the 300 cart, and the 200 cart from 8:01 AM - 8:38 AM using a gloved hand to put toast on the plates. There were no utensils present and Cook1 touched multiple other items with the same gloved hand. Cook1 touched plates, bowls, utensils, the counter, etc. with the same gloved hands. The DM stated in an interview on 01/01/24 at 8:38 AM that Cook1 should not be using the same gloves to touch ready to eat food and other items due to the potential for cross contamination.

During an observation on 02/01/24 at 6:48 AM, the unit refrigerator in the east side nourishment room was noted with large brown/beige food spills and beverage spills on the shelves and bottom surface of the refrigerator. There were a variety of general snacks, and beverages as well as items for specific residents. There was a croissant sandwich in a box without a name or date. There was chicken with a resident's name noted but no date. The interior of the microwave in the nourishment room was covered with food spills/spatters.

3. Review of the RDDM's monthly "Unit Inspection Food Reports" for a six-month period preceding the survey revealed similar concerns to those found during the survey:

a. Review of the " Unit Inspection Food Report" dated 08/18/23 revealed unsatisfactory markings

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| F 812 | Continued From page 63 | F 812 | | |

for: "Floors clean and dry/tiles unbroken in dishwashing area" and floors clean and dry/tiles unbroken in walk-ins" with a notation "floor in between walk-in and doors."; "Equipment properly stored when not in use" with a notation "ensure slicer and mixer detail cleaned after each use and covered when not in use."; "Food products are used or discarded by the expiration date" with a notation "ensure all items labeled and dated, opened items dated for expiration ..."; and "Proper Snack/nourishment refrigerator temperatures are maintained and food items are dated and labeled" with a notation "inspect daily."

b. Review of the " Unit Inspection Food Report" dated 09/25/23 revealed unsatisfactory markings for: "Floors clean and dry/tiles unbroken in dishwashing area" and floors clean and dry/tiles unbroken in walk-ins" with a notation "floor in between walk-ins."; and "Foods in the refrigerator/freezer are covered, labeled, dated, and shelved to allow circulation" with a notation of, "monitor labeling and dating for 100% accuracy.";

c. Review of the " Unit Inspection Food Report" dated 10/22/23 revealed unsatisfactory markings for: "Floors clean and dry/tiles unbroken in dishwashing area" and floors clean and dry/tiles unbroken in walk-ins" with a notation "floor in between walk-in and freezer."

d. Review of the " Unit Inspection Food Report" dated 11/29/23 revealed unsatisfactory markings for: "Floor clean and dry/tiles unbroken in walk ins" with a notation "floor between walk-in and freezer."; "Foods in the refrigerator/freezer are covered, labeled, dated, and shelved to allow circulation" with a notation of, "monitor labeling

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| F 812 | Continued From page 64 | F 812 | | |

and dating for 100% accuracy."; "Snack/nourishment refrigerators on the unit (s) are maintained to prevent the potential for foodborne illness" with a notation "continue to monitor."; and Proper snack/nourishment refrigerator temperatures are maintained and food items are dated and labeled" with a notation "continue to monitor."

e. Review of the " Unit Inspection Food Report" dated 12/21/23 revealed unsatisfactory markings for: "Floor clean and dry/tiles unbroken in walk ins" with a notation "floor between walk-in and freezer."; and "Foods in the refrigerator/freezer are covered, labeled, dated, and shelved to allow circulation" with a notation of, "monitor labeling and dating for 100% accuracy."

f. Review of the " Unit Inspection Food Report" dated 01/26/24 revealed unsatisfactory markings for: "Food in the refrigerator/freezer are covered, labeled, dated, and shelved to allow circulation" with a notation, "all prepped items need to be labeled with production and expiration date ..."; "Staff are following ... policy for food storage and leftovers" with a notation of, "storage of partially used items - need to be properly covered and dated with expiration also."; "Proper snack/nourishment refrigerator temperatures are maintained and food items are dated and labeled" with a notation "need to inspect on a daily basis."; and Under "Comments" a notation read, "scoop in pudding container, container not labeled."

4. Review of all the work orders for the kitchen for the past six months showed the deteriorated tiles around the floor drains and baseboard coming away from the wall had not been reported or slated for repair.

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| F 812 | Continued From page 65<br><br>5. During an interview on 02/02/24 at 11:37 AM, the Registered Dietitian (RD) stated she completed monthly inspections of the kitchen and had identified a concern with an employee's open beverage in the kitchen. The RD stated utensils should be used for serving toast and not gloved hands due to the potential for cross contamination due to it being a ready to eat food. The RD stated there should be a garbage can designated to be in the handwashing sink area. The RD stated she had identified concerns with the cleanliness of the nourishment rooms; however, the dietary department was not responsible for maintaining/cleaning them. | F 812 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment | F 880 | | 3/19/24 |

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conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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| F 880 | Continued From page 67<br>infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, interviews, and policy review for four of 11 (Residents (R) 22, 91, 400, and 401) reviewed for medication administration, the facility failed to ensure the Evencare G3 glucometer used for diabetic monitoring was cleaned and disinfected per the manufacturer's instructions, failed to ensure hand hygiene was performed by one staff per facility policy, failed to store trash and personal belongings per infection control practices, and failed to wear Personal Protective Equipment (PPE) per facility policy for three staff. This failure puts residents and staff at potential risk of developing infections.<br><br>Findings include:<br><br>Review of the Evencare G3 glucometer manufacturer guidelines revised on 02/18 indicated " ...The EVENCARE G3 Meter should be cleaned and disinfected between each patient ...To disinfect your meter, clean the meter surface with one of the approved disinfecting wipes ...Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use ..."<br><br>Review of the instructions located on the PDI Sani-cloth bleach germicidal disposable wipe label revealed, " ...Disinfects in 4 minutes ..."<br><br>Review of a facility policy titled "Glucometer | F 880 | Glucometer<br>Nurse cleaned glucometer properly, however did not allow glucometer to air dry as policy dictates. Nurse was distracted by resident that had fall a few moments prior to incident as well as assisting CNAs with morning care. The root cause of the deficient practice is the nurse failed to allow the appropriate dwell time for the product used to clean the glucometer.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>The Nurse Practice Educator will re-educate all nurses on the proper cleaning of the glucometer with competencies completed.<br><br>The NPE/or designee will observe 2 nurses/shift for proper use and cleaning of glucometer four times per week until consistently reach 100% compliance. Then, observe 2 nurses/shift 2 times per week until you reach 100% compliance. Then observe 2 nurses/shift 1 time per week x 2 weeks until you consistently reach 100% compliance. FINALLY, observe licensed staff performing proper use and cleaning of glucometer one time per month until 100% compliant. | |

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| F 880 | Continued From page 68<br>Disinfection" revised on 03/14/23 indicated, ..."Retrieve (2) disinfectant wipes from the container ...Using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer. After cleaning, use the second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions. Allow the glucometer to air dry ..."<br><br>1. Review of R91's "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab revealed R91 was admitted to the facility on 01/09/24 with diagnosis of type 2 diabetes mellitus.<br><br>Review of the "Physician Orders" located in the EMR under the "Orders" tab revealed, " ...Fingerstick blood glucose ..."<br><br>Observation on 02/01/24 at 7:40 AM, revealed Registered Nurse (RN) 2 went into R91's room to perform a fingerstick using the Evencare G3 glucometer. RN2 inserted a test strip in the glucometer, then took an alcohol wipe and wiped R91's' finger. RN2 then took a lancet and pricked his finger, applied the test strip to the tip of the finger and obtained a blood sample. After obtaining the fingerstick, RN2 went to the medication cart and opened a PDI Sani-cloth to clean the Evencare G3 glucometer. RN2 wiped the entire glucometer, took a tissue from off the medication cart and dried the entire glucometer. The glucometer was placed into an alcohol prep box on top of the medication cart to store.<br><br>During an interview on 02/01/24 at 7:45 AM, RN2 stated she cleaned the glucometer with one PDI wipe and then used a tissue to dry the | F 880 | Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan.<br><br>Staff Personal Belongings<br>Staff working in Covid outbreak area had personal belongings present on the hallway. When questioned about this they kept belongings close by to attempt to avoid leaving the Covid designated area too often throughout the day. The root cause of the deficient practice is that staff were found with personal belongings in resident care areas.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>The Nurse Practice Educator will re-educate all staff on storage of personal items such as backpacks, coats, and personal drinks.<br><br>The systemic change will be all staff will be required to store personal items in lockers available for their use.<br><br>The DON or designee will complete rounds daily x□s 7 days to ensure that staff are not storing personal items in resident areas such as patient rooms or hallways. When audits are 100% compliant, the audits will be completed weekly x□s 4 weeks. When the audits are 100% the audits will be completed | |

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| F 880 | Continued From page 69<br>glucometer. RN2 stated she used the same procedure to clean the Evencare G3 glucometer after obtaining R22, R400, and R401's fingerstick this morning. RN2 stated she was not aware of the facility policy directed to use two wipes to clean the glucometer. RN2 stated she did not know the glucometer should air dry before the next use.<br><br>During an interview on 02/01/24 at 10:00 AM, the Director of Nursing (DON) stated the facility policy requires to wipe the glucometer with two wipes if the glucometer is visibly soiled with debris or blood. The DON stated the facility is currently using the PDI Bleach Sani-cloth to clean the Evencare G3 glucometer and with this product the glucometer should dwell to air dry for four minutes.<br><br>Review of R22's "Physician's Order" dated 01/11/24, located in the EMR under the "Orders" tab revealed, " ...Check blood sugar one time a day ...every Monday and Thursday ..."<br><br>Review of R400's "Physician Orders" dated 01/28/24, located in the EMR under the "orders" tab revealed, " ...Check blood sugar two times a day ..."<br><br>Review of R401's "physicians Orders" dated 01/03/24, located in the EMR under the "Orders" tab revealed, " ...Check blood sugar once a day ..."<br><br>Review of residents on the 600 unit revealed R22, R91, R400, and R401 have physician orders for fingerstick glucose checks and did not have a blood-borne pathogen diagnosis. | F 880 | monthly x□s 3 months<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan.<br><br>Garbage Storage<br>Soiled utility room had trash canister that was overflowing. Housekeeping staff not available to empty on 3-11, or 11-7 shifts. Housekeeping currently does not have staff past 6pm.The trash container available at this time was not large enough to hold the amount of trash produced over second and third shifts without being emptied. The root cause of the deficient practice is that the trash bin in the soiled utility room was not large enough to contain the waste collected from the 3-11 and 11-7 shifts.<br><br>The NHA or Designee will re-educate all housekeeping staff on the timely disposal of trash in the soiled utility room.<br><br>Systemic change will be that the center will purchase larger trash bins for the soiled utility rooms on each unit to be able to hold the garbage generated throughout off shifts.<br><br>The Housekeeping director or designee will complete audits of the soiled utility rooms to determine if the trash was disposed of timely daily x 14 days until 100% compliance. Then 3x/week x 2 | |

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| F 880 | Continued From page 70<br>2. Review of the facility policy titled, "Hand Hygiene," revised on 03/14/23 revealed, "...Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table ...Before and after removing personal protective equipment (PPE), including gloves..."<br><br>Observation on 02/01/24 at 6:10 AM, revealed RN2 went into R401's room to disconnect the (Intravenous) IV tubing from the Peripheral Inserted Central Catheter (PICC) line. RN2 performed hand hygiene and donned gloves. RN2 disconnected the IV tubing from the lumen of the PICC line and flushed the line with ten cubic centimeters (cc) of normal saline and placed a cap on the line. RN2 removed the glove from her left hand and carried the soiled IV tubing down the hall to the medication cart with the gloved right hand and disposed of the IV tubing in the trash on the side of the medication cart. After disposing of the soiled IV tubing, RN2 removed the glove from her right hand and walked to R401's bathroom, opened the door and began to wash her hands. RN2 did not perform hand hygiene after removing her gloves and before touching the bathroom doorknob. During an interview at the time, RN2 stated she should have performed hand hygiene before touching the bathroom doorknob, but she forgot.<br><br>During an interview on 02/02/24 at 2:15 PM, the DON stated the facility policy indicates for staff to perform hand hygiene or hand washing after removing gloves and before touching other surfaces.<br><br>3. Observation on 02/01/24 at 6:00 AM of the 600 unit with RN2 revealed a sweatshirt hanging from | F 880 | weeks until 100% compliant, and then 1x/week x 8 weeks until 100% compliant.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan.<br><br>PPE Masks<br>Staff observed with N95 mask on improperly. Both straps placed around back of head and not one on top and one at bottom of head. PPE policy not followed at this time. The root cause of the deficient practice is the staff did not follow the process for applying and wearing N95 masks in the facility.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>The Nurse Practice Educator or Designee will re-educate all staff on how to wear N-95 masks properly.<br><br>The DON or designee will complete rounding audits on all shifts daily x□s 7 days to ensure compliance with proper placement of N95 masks. When audits are 100% compliant, audits will be completed weekly x 4 weeks. When audits are 100% compliant, then audits will be completed monthly x 3 months.<br><br>Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further | |

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| F 880 | Continued From page 71 a hook on the side of the Personal Protection Equipment (PPE) cart that was in the hallway and an aluminum water bottle on a shelf in the clean linen cart. During an interview at the time, RN2 stated the sweatshirt and water bottle belonged to Certified Nursing Assistant (CNA) 7 who was working on the unit. RN2 stated for infection control reasons, personal belongings should be stored in the employee lounge area and not on a PPE cart or linen cart.<br><br>During an interview on 02/01/24 at 6:10 AM, CNA7 stated she put her sweatshirt on the PPE cart and the water bottle inside the clean linen cart when she came on duty. CNA7 stated her sweatshirt and water bottle should have been left in the staff locker room area.<br><br>During an interview on 02/02/24 at 2:15 PM, the DON stated staff's personal belongings should be kept in the staff locker room area for infection control purposes.<br><br>4. Observation on 02/01/24 at 6:10 AM revealed RN2 went into the East unit soiled utility room to dispose of the plastic bag with the soiled IV tubing. Observation of the room revealed seven bags of soiled trash on the floor in front of a large grey trash bin. The trash bin was filled with soiled trash bags that were above the sides of the bin. During an interview at the time, RN2 stated the bags must have fallen out of the trash bin because it was over full.<br><br>During an interview on 02/01/24 at 6:15 AM, the DON stated housekeeping is responsible to empty the trash bins when they are full. The DON confirmed the trash bags should not be on the floor of the soiled utility room and should be | F 880 | evaluations, recommendations, and sustainability of plan.<br><br>Hand Hygiene<br>Nurse did clean hands properly with hand sanitizer, however when entering a residents room she touched the residents bathroom door knob prior to assisting resident with care and did not clean her hands again prior to this care. Nurse was rushing to assist with patient care as well as monitor high fall risk resident who had fall moments prior to this incident. The root cause of the deficient practice is that the nurse did not perform hand hygiene prior to caring for the resident<br><br>All residents have the potential to be affected by this deficient practice.<br><br>The Nurse Practice Educator will re-educate all staff on proper hand hygiene.<br><br>The NPE or designee will observe 5 staff/shift demonstrating proper hand hygiene five times per week until consistently reaching 100% compliance. Then, observe 5 staff/shift performing proper hand hygiene 2 times per week until you reach 100% compliance. THEN observe 5 staff/shift performing proper hand hygiene 1 time per week until you consistently reach 100% compliance. FINALLY, observe 5 staff/shift performing proper hand hygiene 1x per month until 100%. | |

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| F 880 | Continued From page 72<br>contained in the trash bin.<br><br>During an interview 02/01/24 at 3:45 PM, the Environmental Director (ED) stated housekeepers leave work for the day at 3:00 PM and it was the facility practice for housekeepers to empty the trash bins in the soiled utility rooms round 2:30 PM before they left for the day. The ED stated if staff need the trash bins emptied after hours, the nursing supervisor has her number and can call her to come back to the facility. The ED stated if the trash bins were not large enough on a unit, she could order larger ones for the facility.<br><br>During an interview on 02/02/24 at 2:15 PM, the DON stated the nurse supervisors are responsible to respond to issues after hours which would include contacting a department head if necessary.<br><br>5. Review of the undated Center for Disease Control and Prevention (CDC) educational material for donning and doffing personal protection equipment (PPE) stated, " ... 2. Mask or Respirator . . . secure ties or elastic bands at middle of head and neck . . ." The Director of Nursing (DON) stated staff were educated using the CDC instructions for donning and doffing PPE.<br><br>Observation on 1/30/24 at 12:40 PM revealed RN1 was wearing an N95 mask that was below her nose and the two elastic straps used to secure the mask on the face and form a seal were both at the base of her neck.<br><br>Observation on 1/30/24 at 12:44 PM of the East nurses' station revealed LPN5 and LPN2 were | F 880 | Results of audits will be presented to the Quality Assurance Performance Improvement Committee for further evaluations, recommendations, and sustainability of plan. | |

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| F 880 | Continued From page 73<br>seated at the station. LPN5 had both elastic straps at the base of her neck, LPN2 had only one elastic strap on her mask that was placed around the crown of her head, there was no visible second elastic strap.<br><br>Interview with RN1 on 1/30/24 at 12:41 PM stated her mask was not on correctly but "she had to wash her hands before she adjusted her mask."<br><br>Interview with LPN5 and LPN2 at 12:45 PM at the nurses' station revealed both nurses knew they did not have their masks on correctly. LPN5 immediately repositioned her straps so that one was at the crown of her head and the other at the base of her neck. LPN2 stated it was difficult to get a strap over her hair to the base of her neck, but she immediately obtained a new mask and applied the elastic straps correctly.<br><br>Interview with the Director of Nursing (DON) on 2/02/24 at 2:03 PM revealed all staff had been fit tested for wearing N95 masks. She stated her expectation was that staff wore the mask correctly if they were going to wear one. | F 880 | | |