March Findings

F156 Notice of Rights, Rules, Services, Charges

SC: SS=D: Failed to have a system that used the required forms to provide denial notices with the required information to multiple residents

- Review of liability notices for multiple residents revealed lacked information on how to file an immediate appeal with QIO, QIO phone number & facility phone number; facility used res' health information claim number as res' ID number

F157 Notify of Changes (Injury/Decline/Room, Etc)

NE: SS=D: Failed to inform res' physician an incident of elopement

- Res with dementia & Bipolar; Record lacked documentation r/t res leaving facility unsupervised in previous month; interview with visitor reported saw res walking toward traffic down side street on street without sidewalk walking toward main road; visitor reported visitor told staff, staff retrieved res & returned to facility; staff called family but physician not informed of elopement

SE: SS=D: Failed to contact physicians r/t significant changes to status including discharge from facility & admission to hospital & PU occurrence

- Res with COPD with chest tube; NN documented res to hosp by EMS; nurse stated lung sounds different & notified DON & nurse did not call physician & assumed DON had notified physician; DON reported unable to locate physician order to transfer res to hospital
- Res without PU risk without cog impairment on adm MDS; 30 day MDS indicated res at risk for PU & with stg 1 & stg 2 PU; record lacked documentation of CP addressing skin integrity, wounds or PUs; record lacked evidence facility informed PCP of PUs upon return from hospital; record indicated res obtained PUs during hospitalization

F159 Facility Management of Personal Funds

W: SS=D: Failed to send out quarterly statements, follow acceptable accounting principles & allow residents access to funds on weekends

- Balance sheet revealed no documentation of interest paid & no quarterly statement available for multiple residents; res stated funds not available on weekends

SC: SS=E: Failed to ensure res had access to personal fund monies after hours & on weekends

- Res stated could not get money on weekends; res stated facility had told them that day that res could get money anytime not just weekdays; res stated before that day res could not get money on weekends because office staff not there but facility gave letter that day stating could get money on weekends; ledger with narcotics revealed total balance of $20.00 for res' use on evenings & weekends; failed to maintain funds available for use by residents with personal fund accounts & failed to inform res of right to access personal funds in evenings &/or weekends

F160 Conveyance of Personal Funds Upon Death

SE: SS=D: Failed to return funds within 30 days after res' death

- Review of res fund records revealed res with open account with balance with death on 1-17 and account open on 3-12

SE: SS=D: Failed to convey upon death within 30 days, funds managed by facility

- Res with open account on 3-17 & res transferred to hosp on 1-29 & expired at hosp on 2-2

SC: SS=D: Failed to convey within 30 days res' funds & final accounting of those funds to individual or probate jurisdiction administering res' estate

- Res expired 1-6 & account still open during survey; res expired on 7-15 & account disbursement on 10-1

F164 Personal Privacy/Confidentiality of Records

SC: SS=D: Failed to maintain res privacy by failure to effectively close privacy curtains during personal cares

- Res with mod cognitive loss with extensive assist; Observed staff assist res to dress & res' roommate in bed & staff left curtain between against wall allowing residents to see each other & during dressing bare chest exposed & after exposure staff grabbed curtain & pulled it ¼ closed still allowing residents to view each other; res reported curtain pulled inconsistently; res' roommate reported it bothered res in past when curtain not pulled completely

NC: SS=D: Failed to provide privacy while providing personal hygiene cares

- Observed 2 staff undressing res with curtains open in res' room then provided personal hygiene care while curtains remained open in res' room

SC: SS=D: Failed to ensure privacy during perineal care & offer privacy to a declining res on hospice; failed to ensure privacy of res needing assist prior to lift transfer

- Res with extensive assist of 2 with hospice r/t COPD; CP did not address privacy; progress notes revealed staff lacked any indication staff offered family any privacy as res progressed to end stages of life; observed staff provide perineal care by pulling curtain to block view from room door then removed res' pants & incontinent brief & during procedure adm nsg staff knocked on door & entered & reported completing repositioning rounds & stepped around curtain & spoke with staff about res' position in bed prior to care & during conversation res lay on back with peri-area exposed; family reported family had not been talked to or offered privacy & had been

wondering about privacy; staff reported unaware of any privacy offered to res & families of res on hospice; failed to ensure res' privacy during incontinent care & offer privacy to declining res while receiving hospice services in semi-private room

- Res with extensive assist of 2 & total dependence of 2 for transfers with catheter; observed staff entered room & walked to res' part of semiprivate room; roommate on own side of room watching TV; without pulling curtain staff rolled & repositioned res in bed & placed sling under res preparing to transfer with mechanical lift when staff reported needed to change leaking cath bag; staff pulled up res' pant leg & staff attempted to attach cath tubing to leg strap; another staff knocked & entered room, walked around curtain to res' side of room & reported needed keys without saying anything to res, only stood there & waited, then got keys from other staff member then left room; staff continued to assist res with transfer then out of room for res' smoke break; failed to ensure privacy of res in semi-private room during cath care & lift transfer

F166 Right to Prompt Efforts to Resolve Grievances

SE: SS=D: Failed to seek prompt resolution to resolve grievances by multiple residents in timely manner

- Res with mod cognitive deficit & depression; res reported missing personal item; family interview confirmed missing item for 3 months; SS staff unaware of missing item; nursing staff acknowledged res' report of missing item & staff failed to immediately report missing item to DON or supervisor; Adm staff unaware of missing item; failed to follow theft policy when res reported missing item 3 months prior & failed to make prompt effort to resolve res' reported missing item for at least 2 months
- Res with intact cognition; investigation documented res' family found res' piggy bank opened with bottom off, sitting crooked & missing $4.00 in quarters; res reported found confused res in res' room 3 days earlier; report documented staff questioned confused res' spouse & Adm staff offered to replace quarters when family let Adm know but staff reported no replacement of money as family never responded back; res reported Adm never came back & told res anything more about missing money from bank; failed to seek prompt resolution to resolve res' reported missing money grievance for 3 months

NC: SS=D: Failed to resolve grievances in prompt manner

- Observed alarm clock sitting on floor by res' bed & res stated asked staff for res' personal end table brought back to room which had been moved to facility's storage in Oct 2013 & had asked again recently & staff reported table no longer in storage & res immediately reported missing table to Adm & DON & told still looking for table; grievance log lacked report of res' missing property
- Grievance/complaint log lacked report r/t res' room trays & cell phone; NN stated res complained of increased neck pain & res would not come out for meals but would come out for pain meds & res called 911 on cell phone & police arrived at facility to check on res & res requested to go to ER & staff notified family who declined res to ER & facility asked family if cell phone could be removed & locked in med room & res' daughter gave permission; 4 months later SS noted stated res asked when would get cell phone returned & staff told res it was a "slow process" to get cell phone back & note revealed res became tearful; During current month staff told res could no longer have room trays (staff allowed res 3 room trays a week) & res capable of coming out for coffee several time before 7am; NN stated res refused to go to DR for supper & staff reminded res able to go to vending machine for snacks; res reported to surveyor cell phone taken away when called physician & police with neck pain & res stated had talked with administration about cell phone & eating in room without resolution to problem; no grievance report completed r/t cell phone or res wanting to eat meals in room

W: SS=D: Failed to ensure prompt efforts to resolve grievances

- Res with anxiety; reviewed grievance form from res when res reported issue with a staff member; grievance reported to nurse who failed to report grievance to administration & SS provided staff with education r/t grievance form & process; res stated staff member repeatedly attempted to give res wrong amount of pills at wrong times throughout day including giving pills meant for bedtime at 6pm & when res tried to explain routine to staff, staff became angry with resident & stated res self-centered & res reported res got upset & had difficulty sleeping because of pain & crying over incident; SS staff denied awareness of grievance reported to nurse

F167 Right to Survey Results-Readily Accessible

NC: SS=C: Failed to make previous survey results accessible to all residents without having to ask

- Observed survey results in notebook & stored in rack attached to wall in hallway of facility 5 feet 6 inches from floor; multiple res interview revealed res unaware of location of survey results; staff reported survey results not physically accessible

F170 Right to Privacy-Send/Receive Unopened Mail

NC: SS=C: Failed to provide right to privacy in written communications including right to send & promptly receive unopened mail

- Res stated did not receive mail on Saturdays; staff confirmed post office delivered mail to front office on Saturdays & Saturday mail distributed on Monday

SC: SS=E: Failed to ensure res' right to promptly receive mail on Saturdays

- Res reported residents did not get mail delivered on Saturdays & when mail delivered it was locked up over weekend until someone could go through it then a staff member would deliver it to residents on Monday; staff reported mail got delivered to res only sometimes on weekend when there was an activities staff member or SS to deliver it; failed to deliver mail to residents on Saturdays

F174 Right to Telephone Access with Privacy

SC: SS=D: Failed to ensure res personal clothing was labeled & stored correctly

- Personal inventory sheet did not address any individual pieces of clothing for res; SS notes for 3 months revealed no documentation addressing res; clothing needs, missing clothes or worn or torn clothing; observed shirts, pants, coats, shoes in closet & shirt lying in bed with res & res had one pair pants on person; observed clothing items labeled with another res' name & unrecognizable name on shirt & staff revealed those clothes not res' clothes; lacked policy r/t personal property; failed to ensure res' personal property properly stored by failure to ensure clothing was properly inventoried & labeled in closet

F202 Documentation for Transfer/Discharge of Res

NC: SS=D: Failed to include physician's documentation for reason for discharge for multiple residents for involuntary discharge

- MDS revealed res cognitively intact with physical & verbal behaviors to others & res with extensive assist; res with spina bifida & hx of bipolar; Notice of Involuntary Discharge revealed facility planned to discharge res for res' welfare & facility's inability to meet res' needs & health of other residents; record lacked documentation by physician r/t reason for res' involuntary discharge
- Res with severely impaired cognition & independent with ADLs; Notice of Involuntary Discharge revealed facility planned to discharge res for res' welfare, facility's inability to meet res' needs & health of other residents; record lacked documentation by physician r/t reason for res' discharge

F203 Notice Requirement Before Transfer/Discharge

NC: SS=D: Failed to document discharge for multiple res r/t involuntary discharge

- Record revealed no documentation discharge destination for involuntary discharge resident for multiple residents

F204 Preparation for Safe/Orderly Transfer/Discharge

NC: SS=D: Failed to send necessary paperwork to minimize risk of lack of appropriate care & to allow for a smooth transmission to another facility

- No active discharge plan for res; CP revealed res planned to remain in facility r/t res' progressive illness & safety issues; NN stated res left with family for transfer to another facility & belongings & meds sent with family; Adm staff from admitting facility stated res arrived at facility with MAR & H & P but without paperwork despite efforts r/t paperwork to assist with appropriate cares for res was never called back until 2 days later when facility sent MDS

F221 Right to Be Free From Physical Restraints

NC: SS=D: Failed to complete an ongoing/scheduled assessment for use of side rails

- CP indicated res used side rails for positioning & bed mobility & CP revealed no documentation to direct staff for provision of side rails; Side Rail Assessment lacked documentation of res' physical status including balance, bed mobility, transfer assistance & safety &/or need or use for res' side rails; observed res in bed with ¼ rails raised on both sides & observed res used rails for support during incontinent cares

F225 Investigate/Report Allegations/Individuals

NC: SS=D: Failed to report multiple unwitnessed falls

- Res with multiple unwitnessed injury & non-injury falls; staff verified 5 unwitnessed falls had not been reported to state agency
- Staff verified state agency not notified of unwitnessed fall with injury
- Res with unwitnessed fall with injury after being left unattended in W/C & state agency not notified

W: SS=D: Failed to thoroughly investigate & report allegation of abuse immediately to sate agency

- Res with mod dementia reported to CNA res had been "raped" night before, CNA reported to DON, incident revealed res interviewed by nsg & SS staff & documented res had confusion & incident reported to med director & QA; spouse reported res confused & thought at previous employment location & res had been raped at employment; other residents interviewed but no witness statements obtained at time of alleged incident & incident not reported to state agency

NE: SS=D: Failed to investigate & report to state agency incident of elopement

- Res with dementia & bipolar; visitor reported to surveyor visitor had observed res outside walking down side street toward main street & visitor reported to nurse; nursing did room search; retrieved res to facility & reported incident to family but facility failed to report incident to investigate & report to state agency

NE: SS=D: Failed to investigate & report to state agency loss of personal property

- Res with intact cognition; res stated had billfold with money stolen & had reported lost money & billfold to SS; staff stated billfold found in another res' room but could not remember date; when billfold returned to res res reported $3 missing nurse stated counted $8 in billfold a few days prior to become missing; res stated glad to get billfold back but concerned about missing money of $8; No grievance completed for missing billfold; failed to fill out grievance, investigate & report to state agency as required allegation of missing money

NC: SS=D: Failed to report to state agency a resident to resident altercation resulting in injury

- Res with dementia with behaviors of yelling, hitting & toileting in public places; NN revealed res with aggressive behaviors & roommate threw a water mug & hit res in face resulting in 2 lacerations of face with ER putting in sutures; record lacked documentation facility reported altercation with injury to state agency

NC: SS=D: Failed to report to state agency falls for multiple residents

- Res with cog impairment & extensive assist with unwitnessed fall with injury & second fall next day when staff witnessed res rolling out of bed with injury; staff reported incidents not reported to state agency
- Res with cog impairment with hx of falls; res with unwitnessed fall with injury; incident not reported to state agency

SC: SS=D: Failed to ensure all allegations of mistreatment & misappropriation of res property were immediately reported to administrator then to state survey agency & failed to thoroughly investigate each allegation

- Res with dementia without behaviors; inventory revealed res with wallet; ID note revealed res told staff res had $100 taken from wallet but family stated res had not had any money for awhile since last time wallet stolen; Note revealed staff member spent time with res to see how res doing & if hurt from altercation with res' temporary roommate from natural disaster & res stated other res hit res for no reason so kicked other resident then left; res stated had $100 missing last year then reported 2 $25 checks that disappeared in last year & had reported to office but did not remember who; staff reported other facility had completed investigation of res to res altercation but facility did not have any investigation from the incident; failed to ensure allegation of stolen wallet was immediately reported to adm & state agency & failed to investigate allegation of res to res abuse

F226 Develop/Implement Abuse/Neglect, Etc Policies

NE: SS=E: Failed to ensure contracted staff received training to ID & report abuse

- Housekeeping staff stated did not receive education on what abuse was or how to report abuse upon hire & had not attended any inservices on abuse; housekeeping staff revealed worked for company contracted by facility for housekeeping & laundry & if witnessed abuse would not intervene but would walk away & report it to charge nurse; Adm nsg staff revealed facility did not provide abuse training for housekeeping & laundry staff as employed by separate company

F241 Dignity & Respect of Individuality

NC: SS=E: Failed to promote care for residents in a manner & environment that maintained or enhanced each res' dignity

- Res with indwelling catheter; observed catheter drainage bag without a cover & hanging inside trash can at end of bed
- Observed res in DR with staff assist & staff placed vegetables in res' mouth & part of food fell onto res' clothing protector then staff used fork to scoop food from clothing protector & placed food into res' mouth then repeated behavior with jello

NE: SS=E: Failed to enhance dignity of res in DR on multiple occasions

- Res with hearing loss & declined to wear hearing aides or use amplifier; CP directed staff to adjust tone of voice & not yell when communicating; observed staff speak to res in very loud voice when advising res nurse had "forty other residents that wanted their pills"; family member reported staff speak to res in disrespectful manner; failed to provide dignity for res with visual & hearing impairments
- Observed staff fed residents having conversations amongst themselves & did not engage residents in conversation in multiple DRs

W: SS=D: Failed to promote care in manner & environment that maintained/enhanced dignity & respect in recognition of individuality (scolding an agitated resident & ignoring res' repeated requests)

- Res with Lewy Body dementia & behaviors; CAA referred to increasing agitation & physical aggression; observed staff attempt to toilet res & res became agitated & attempted to hit & kick staff & staff spoke to res in scolding tone, addressing res by full name rather than preferred nickname each time res attempted to kick staff; failed to treat res with dignity & respect including not addressing res by desired name
- Res with CHF exacerbated since recent hospitalization; res with depression with tearfulness & anxiety with yelling when staff asked res to perform ADLs with less assist from staff; observed staff perform incontinence care & res repeatedly stated felt embarrassed that res had to "go in my diaper" & that staff refused to allow res to use commode & moaned in pain; when seated in w/c res reported need to be repositioned r/t pain & staff did not respond to request & res continued to request repositioning; as staff left room res again requested repositioning and staff told staff to adjust in chair independently & res yelled "I can't sit like this", began to cry & yelled requesting to see charge nurse who arrived & instructed staff to reposition res with lift; res reported some staff rude & multiple staff do not listen to requests which had been reported & nothing changes; failed to treat res in dignified & respectful manner when staff ignored res' repeated requests to reposition r/t pain in hip causing res to become agitated & cry & failed to address/prevent res' embarrassment with bladder & bowel incontinence

SC: SS=E: Failed to serve meals in a manner that maintained dignity of residents sitting together at a table

- Observed 3 res in DR & 1st received food at 12:15 & res finished meal & left table at 12:50pm; 2 remaining, 2nd res received meal at 12:52pm though res unable to begin eating due to not having any silverware & res flagged down staff & received silverware at 12:55; 3rd res received meal at 1:05pm; res waited 45 minutes after staff served 1st res before able to eat while other res waited 55 minutes to receive meal; Res reported meal very good & stated it took long to get served; failed to have system to ensure all res at 1 table received food at same time so they could eat together

- Observed res at DR table with napkin tucked into neck of shirt at 12: 25pm & res received plate & staff fed res at 1:41pm; while staff fed res, spilled on staff's uniform & staff took napkin from res & wiped uniform to clean up spill off uniform; staff then retrieved clean napkin & place din res' lap; staff gave res large bit that res unable to chew & res reached up & took part of food out of mouth & place it on plate & staff continued to feed res bites too large to chew comfortably
- Failed to maintain serve food to residents at same table at same time on multiple occasions
- Observed res with no food or drink available while other residents ate meals

NC: SS=E: Failed to promote care in an environment that maintains or enhances each res' dignity by leaving unused incontinent pads in chairs and couch in living rooms for multiple days

- Observed incontinent pads laying in multiple recliners in common areas & no residents seated in recliners on multiple occasions

NC: SS=E: Failed to promote care for res in manner & environment that maintains or enhances dignity & respect in DR

- Observed staff assist res with eating by placing spoon of food forcefully into res' mouth then placed spoon back to mouth before res had swallowed what was in mouth then placed glass of juice up to mouth & juice dribbled down res' mouth then took shoulder & pushed it against res' shoulder & stated "wake up" then took left hand to side of res' face & stated "you need to wake up"
- Observed res propelling self in w/c with 1 foot & unable to cross metal divider separating wood flooring & carpeting & attempted multiple times when staff walked by & did not offer assist & multiple staff in DR did not assist then res grabbed wall to help get over divider
- Observed multiple staff discussing personal events without including residents at table
- Observed res leaning in w/c propelling self with 1 foot pedal in place & res' arm hanging limply between legs
- Observed res pull tablecloth & spilled water onto table & res' pants & staff assisted res to same table without assisting res with wet clothing
- Observed staff seated beside res with clear discharge hanging from nose & res rubbed nose with thumb & finger & placed fingers into mouth without assist from staff to wipe nose
- Observed re res with clear drainage hanging from nose & rubbed nose leaving part of food from hand on nose & staff did not assist for 4 minutes
- Observed res in DR with head hanging down & arm hanging limply between legs
- Observed res bent forward at waist propelling self with 1 foot out of DR & back of shirt pulled up exposing res' back from middle of shoulder blades to top of pants & adm staff walked by & provided no assist to resident
- Observed res at table with eyes closed; staff assisted res with food by placing spoon forcefully into mouth & food ran out of res' mouth & staff used res' clothing protector to wipe mouth then moved to other side of res & reached around res' back, grabbed shoulder, pulled res back & forth with hand & stated wake up to res & res continued to be nonresponsive then staff placed another spoonful of food into res' mouth & food immediately ran out of res' mouth then wiped res' mouth with dirty clothing protector then pulled res' w/c away from table, grabbed res' arm forcefully, placing arm on w/c arm res, grabbed other arm in same manner then left res unattended & brought back a nurse to assist with transporting res to room; staff held res' legs up & walked backwards while nurse propelled w/c

SE: SS=D: Failed to promote care which enhances dignity when facility failed to ensure appropriate clothing attire

- Res without cog impairment with supervision with set for dressing with 25 pounds wt loss in past 180 days; observed res ambulating down hall with therapy & pants slipped from position on lower hips to res' knees, exposing res with pull-up brief then staff pulled pants up & held onto waistband to prevent pants from falling again; observed staff ambulating res to DR & as neared table res stated "they they go…" & pants fell to ankles with other residents in area; staff reported aware of wt loss but did not report to SS
- Observed licensed staff conduct assessment with bedroom door open & staff inquired of res r/t BMs

SE: SS=E: Failed to provide dining services in a manner to enhance self esteem & dignity of residents eating in assisted dining area

- Observed residents in assisted DR without table cloths; large wheeled green food cart remained in room after staff served residents meal tray; observation of main DR revealed table cloths on res' tables; observations on multiple occasions

F242 Self-Determination, Right to Make Choices

SE: SS=D: Failed to provide personal choices of awaking times

- Assessment indicated daily preferences being very important to resident; Res with declining cognition; SS notes documented res likes to get up as late as possible in AMs & go to bed around 6pm; staff reported start getting residents up for breakfast around 6am & some residents already up by 6am; Staff reported res gotten up by staff depending on res' daily schedule; res reported thought got up early; failed to honor res' choices to sleep in later in mornings & res revealed signs of being tired during day

SE: SS=E: Failed to honor res preferences for awakening in morning for multiple residents

- Assessment lacked indication of res' preferred wake-up time; res stated staff awakened res every day at 6am & then sat in recliner until 7am for breakfast & if res did not get up at 6 would miss breakfast but would like to sleep until 7am; staff reported has list of res to get up starting at 5am; observed res at 6:27am in recliner dressed & asleep
- Undated facility get up list evidenced res scheduled to get up by noc shift & list stated all res should be up to DR by 7am
- Staff reported day shift aides get 2 person assists up & noc shift aides get 1 person assist up
- Failed to determine & honor residents' choice of awakening times for multiple residents

SC: SS=D: Failed to respect right of res' preferences for bathing

- Interim CP revealed box next to choices blank & not checked; Comp CP revealed preference for bathing not addressed; staff reported res with confusion take options offered but don't usually ask res each time

NC: SS=D: Failed to allow multiple residents ability to make own choices r/t food choices, eating in own room or use of own cell phone

- Observed res in DR & not eating & staff stated "you don't like eggs, I know" but did not request substitute for egg from kitchen; Observed res refused oatmeal & staff continued to encourage until res angry then stated, "I don't like egg" & staff stated "I know that" but did not offer substitute food item; Observed staff encouraged res to drink juice & res stated "I'm asleep, leave me alone" then nurse continued to encourage to eat
- Res with intact cognition with neck pain; res called 911 on cell phone & police r/t neck pain; staff removed cell phone with permission of family member; res requested cell phone back 4 months later but staff did not return; res reported using phone to call family; res frequently requested room trays but came out of room for coffee & snack machine; facility refused to allow res use of own personal cell phone & not allowed to eat meals in room as requested

SE: SS=D: Failed to ensure res received care & services honoring res' right to sleep late

- Record lacked comprehensive or initial CP to ID res' preferences for care needs; res stated did not sleep as late as preferred r/t staff kept coming into room every little bit to awaken res then res just finally gets up but would prefer to sleep later

SE: SS=D: Failed to offer bathing choices

- Record revealed res liked to take bath but has adjusted to shower & prefers bathing in AMs; record lacked res' preference instructions; family reported res always took baths at home; failed to provide res with individualized bathing choices

F244 Listen/Act of Group Grievance/Recommendation

NC: SS=D: Failed to act on grievances & recommendations or provide a reason for not taking action on concerns voiced by resident council group regarding facility's rough, uneven parking lot

- Observed entryway/parking lot with numerous pot holes of various sizes in driveway & many potholes large enough to require person to walk around them; drive way with rough asphalt surface missing in areas causing areas 6 inches in depth; chunks of asphalt in grass-approach to facility & access to facility entrance required walking across rough uneven parking lot; res council minutes for 3 months over previous 12 months revealed documentation of res' complaints r/t rough, uneven asphalt surface; staff reported adm attempted to seek approval for repair of parking lot & was awaiting authorization to proceed

F248 Activities Meet Interest/Needs of Each Res

SC: SS=D: Failed to provide an ongoing program of activities designed to meet interests & psychosocial well-being of residents

- Res without dementia with extensive assist of 2; observed res in bed without radio or TV on; observed res in bed without any music or TV on all morning; res stated liked to visit with others & liked music; staff reported doing 1:1s but res did not like group activities; failed to adapt activity times to res' schedule & provide 1:1 visits to address res' preferences of 1:1 activities/communication; failed tohave radio on as res enjoyed

F250 Provision of Medically Related Social Service

NC: SS=D: Failed to provide psychosocial services to residents who experienced a resident to resident altercation

- Investigation revealed res exposed genitals to other resident & inappropriately touched res; NN revealed 2nd res "very guarded" next day & refused to let staff touch; note revealed staff unable to complete skin assessment r/t res asked staff not to touch res; record revealed no further documentation r/t incident or res' psychosocial well-being r/t incident; later documentation revealed res with increasing aggressive behaviors; staff confirmed res "frightened" after incident & staff failed to follow-up with res' psychosocial well-being

NC: SS=E: Failed to attain or maintain highest practicable physical, mental & psychosocial well-being for multiple residents

- Referenced F166, F242, F280
- Failed to maintain highest practicable physical, mental & psychosocial well-being r/t res grievances for res not being allowed to eat in room as requested or to use own personal cell phone; res' missing table; invitation & participation in care plan meetings

SC: SS=D: Failed to provide medically-related social services for multiple resident r/t dental services

- MDS revealed res without dental issues; SS notes revealed visiting dental clinic would be at facility in 2 months & SS sent dental consent & med hx to resp party to sign & return & record lacked any follow-up as to if family responded to request for consent; initial nsg assessment revealed res with some/all natural teeth lost & did not wear or have dentures; observed res with missing front teeth on bottom & numerous discolored carious teeth on top teeth & res stated teeth rotting & falling out & would like to see dentist
- MDS revealed res with extensive assist with personal hygiene without broken or loosely fitting full or partial dentures or oral issues; notes revealed SS staff sent dental consent & med hx to resp party to sign & return if wished res receive dental services; lacked follow-up as to if resp party responded to request for consent; res stated dentures did not fit as bottom dentures did not stay in place & had told staff about dentures ill-fit & had dental problems for 10-20 yrs

F252 Safe/Clean/Comfortable/Homelike Environment

NC: SS=E: Failed to provide meal service in DR that promoted homelike environment for res who ate meals in DR

- Observed staff serve res on trays & sat food trays on table & res ate from dinnerware sitting on trays on multiple occasions;

F253 Housekeeping & Maintenance Services

NC: SS=E: Failed to provide maintenance services necessary to maintain an orderly & comfortable interior for res

- Observed room with chipped paint behind recliner; scratched & discolored tile on floor & closet door scratched; BR with missing tiles & scrapes on bottom of res' BR door; gash above mopboard beside bed; dust particles & dead bugs in BR light fixture; room with numerous areas of chipped paint on wall; light fixture plugged into electrical outlet sitting in sink countertop; BR with missing screws ton top & bottom of grab bar on wall causing it to be loose; BR door rubbing on floor causing black mark on floor

NE: SS=E: Failed to provide services necessary to maintain sanitary & comfortable interior

- Observed strong urine odor in multiple res' rooms; loose handrail; stained couch in common area; chipped paint behind recliners; urine odor on furniture; dust & hair on top of curling stand in beauty shop; stand up lift with dirty base, missing plastic & dirty strap, dirty floor buffer on top of stand up lift

SE: SS=E: Failed to provide housekeeping & maintenance services to maintain a sanitary, orderly & comfortable interior in DRs

- Observed DR with multiple tables missing finish to wood edges of table & table tops with stains & with gritty surfaces; observed staff clean tables without moving condiments in center of table on some tables; observed multiple tables with loose food & fluid debris to table tops & upon movement of napkin holder & a tray holding condiments for table exposed sticky substance in center of table & brown substance; failed to clean & sanitize tables in res' DR in sanitary manner
- Observed metal tray racks with wheel rollers on bases with build-up of colored debris & rusty build-up on metal portion of wheel rollers; trash barrel sat in DR during meal service times & top of barrel with bag of clean clothing protectors atop lid & wheel rollers with soiled debris build-up
- Observed floor tiles with worn appearance & without shine; scuffed floor tiles contained widened gap between most of tiles oozing black substance within gaps; failed to maintain sanitary DR floors & service equipment
- Observed res room with paint area of mismatched colors & lacked paint around replaced paper towel holder; wall with several screw holes in wall & BR cabinet for sink with marred areas; Res BR toilet sat turned ¼ sideways on floor base & loose; BR sink drained slowly & sink faucets with build-up of discoloration & sink with rust areas; sink cabinet with marred areas; Res room carpeted wall above res' bed with large soiled areas & door with marred areas; Ceiling with cracks
- Res BR with broken towel bar with missing pieces; BR sink drained slowly; Shared BR contained unlabeled/identified toothbrush & toothpaste; wall with replaced soap dispenser wall with damage from prior dispenser with paint around a different color; res room closet door & door jam with loose & peeling paint; wallpaper border missing; ceiling with water spots discolored; exterior walls with cracks in corner; wood trim gapped with open spaces; BR with damage to wall behind soap dispenser & lacked paint; sink with denture brush & 3 tubes of toothpaste on back of sink unlabeled; door jams lacked paint in areas; room door jams with marred areas; carpet covered walls in hallways with stains & soiled areas
- Res BR with circular sunken spot; BR door jam with screw holes & floor tile with indentation; Res BR paper towel dispenser lacked paint around holder

SE: SS=E: Failed to provide housekeeping & maintenance services

- Observed res room with bedside stand with accumulation of rush; room lacked cove molding; room with scuffed & dirty door frame; privacy curtain with stains; W/P with rusted commode; wobbly chair; fish tank with green tinged, cloudy water with fish waste apparent in water
- Floral arrangement on wall with layer of grime/dust; BR with rust beside commode seat & under commode seat; non-functioning light bulbs; vinyl, blue triangle support with tears; vinyl rocker with tears on arms; beauty shop with base of chair rusted; DR with vent with build up of grime & rust; DR chairs with sticky substance on back of chairs

NE: SS=E: Failed to provide services necessary to maintain sanitary & comfortable interior of facility

- Observed room with multiple drywall patches of different color than rest of wall; peeling paint; unlabeled towel bars & unlabeled personal care items; stains around toilet base; missing tile in BR; knobs missing from dresser; stained caulking & tile around toilets; beauty shop with curlers & hair brushes with multiple strands of hair

NC: SS=E: Failed to provide maintenance services necessary to maintain an orderly & comfortable interior for residents

- Observed BR with cracked tiles next to toilet; room entrance door knob loose & separated from door on top; toilet seat with paint rubbed off; BR with rust colored caulking at base of toilet
- BR floor with gouges in linoleum; sink with rust colored stain; fastener holes above bed where another shelf had been removed & holes not repaired

NC: SS=E: Failed to provide housekeeping & maintenance services necessary to maintain a sanitary & orderly environment on interior & exterior

- Observed bugs in light fixture in storage room, in common area, & in hallway; BR with brown stained area in basin; down spout outside unbolted at bottom; kitchen wall with paint missing; lower door to kitchen with peeling paint; kitchen with brown stain under drain pipe

SE: SS=E: Failed to provide housekeeping & maintenance services necessary to maintain a sanitary, orderly & comfortable environment in halls & aviary room

- Observed loose floor tiles around edges; BR with scuffed & marred wall; cracked flooring; spider webs in BR vent; vents on top of HVAC units with discoloration; plastic protective sheet missing on door; closet door with loose & cracked veneer; HVAC unit missing paint; dirt on floor under HVAC unit; gouges & stains in corridor walls window blinds bent; dead bugs in BR light cover; privacy curtain loose & hanging off hooks; missing cove base; AC unit filter loose & falling off; aquarium noted in need of cleaning & water cloudy

NE: SS=E: Failed to maintain a comfortable & sanitary interior of facility in multiple areas on multiple days

- Observed cracked flooring behind toilet; semiprivate rooms towel bars lacked labeling; chipped paint, scuffed walls; rusted & uncovered toilet bolts; DR with peeling paint; urine splattered on wall next to toilet

SE: SS=E: Failed to provide housekeeping & maintenance services

- Observed res' room door & door frame with numerous scratched paint; radiator with scratches & nicks in paint; BR towel bars with rusted bases; skin drain & faucets with discoloration with lime build-up; windowsill with crack across entire width; BR grout missing; ceiling vent with grime; exposed bare floor with gap; hole in door; missing & broken tile under HVAC unit; BR wall tiles with missing grout; BR with putty on wall without paint; veneer on TV stand peeling off; BR floors with grime; door gouges; uncovered & unlabeled bath basin & bed pan on floor by toilet; ceiling vent & sprinkler head with layer of dust; beauty shop with lint build up on dryers & grime on floor

SC: SS=E: Failed to mark towel bars & personal items for multiple residents in co-mingled BRs

- Observed unmarked personal care items including toothbrushes & denture cups in shared BRs; towel bars unlabeled in shared BRs;

F256 Adequate & Comfortable Lighting Levels

NC: SS=E: Failed to provide adequate & comfortable lighting levels in multiple halls & in DR

- Observed multiple fluorescent lights burnt out & bugs in numerous ceiling lights in DR

F258 Maintenance of Comfortable Sound Levels

NE: SS=D: Failed to provide acceptable noise levels for residents

- Res interview revealed carts noisy at night in hall & disturbed sleep; res stated machine staff used to clean hall early in AM noisy; Observed housekeeping/laundry staff rolled carts & carts very loud & disrupted conversation due to noise level on multiple occasions

F272 Comprehensive Assessments

SC: SS=D: Failed to complete a further analysis of specific care areas for multiple residents

- Failed to conduct a complete further assessment to determine causal or confounding factors r/t use of psychoactive meds for multiple residents
- Failed to ensure comprehensive analysis of findings was completed r/t falls & psychotropic meds use by not IDing causal & other risk factors r/t falls & use of psychotropic meds

NE: SS=E: Failed to complete MDS & provide CAA in timely manner for multiple residents

- ARD of 7-11 & CAAs completed 9-11; staff reported aware of issue & working on timeliness of CAA completion
- ARD of 9-13 & completed 9-27 & CAAs completed 1-28
- MDS Section C Cognitive Patterns not completed & staff reported res refused & computer would not allow staff to complete for multiple residents
- ARD of 8-16 & CAAs completed 9-14
- ARD of 8-27 & CAAs completed 9-16

NC: SS=D: Failed to complete CAAs after completion of MDS

- Record revealed no CAA completed after completion of MDS

NC: SS=D: Failed to complete a comprehensive assessment of newly admitted resident in order to develop a comp CP

- MDS revealed staff unable to examine res' oral dental status; CAA lacked any info r/t res' broken, carious teeth; res with dysphagia; record lacked CAA or dental CP for resident

NC: SS=D: Failed to complete CAAs after completion of MDS

- No CAAs completed after staff completed annual MDS

SE: SS=D: Failed to complete a comprehensive assessment for multiple residents r/t potential restraints

- Annual MDS lacked ID of restraint use & CAA did not trigger for restraints; CP lacked ID of pommel cushion in w/c for positioning or restraint use; assessments lacked restraint assessment; observed pommel cushion in w/c; staff reported pommel needed to prevent sliding forward in chair seat
- Annual MDS revealed res without restraints & CAA did not trigger for restraints; Observed res with low bed with concave mattress; staff reported did not consider concave mattress a restraint so no restraint assessment completed

SC: SS=D: Failed to develop a comprehensive assessment for res through failure to do a thorough oral exam for dental issues

- Quarterly MDS indicated no dental issues; CAA did not trigger; CP failed to include any dental issues for res; nsg assessment revealed res with lost teeth & did not wear dentures; nsg assessment revealed res with missing front teeth on bottom & numerous discolored carious

teeth on top & res reported teeth rotting & falling out; failed to develop comprehensive assessment for res through failure to do a thorough oral exam for dental issues

F273 Comprehensive Assessment 14 Days After Admit

SC: SS=D: Failed to complete CAA for comprehensive admission assessments within required timeframe for multiple resident for nutrition, rehabilitation

- Review of MDS revealed res admitted on 10-15-13; Nutrition CAA completed 11-8 (25 days after admission)
- Res admitted 9-17-13; ADL CAA completed 10-14, 28 days after admission
- Res admitted 9-10-13, ADL CAA completed 9-29, 20 days after admission

W: SS=D: Failed to conduct admission comprehensive assessment within 14 days after res admitted to facility

- Res admitted to facility on 12-3; record lacked evidence that facility conducted adm MDS within 14 days

F274 Comprehensive Assess After Significant Change

NC: SS=D: Failed to complete a significant change MDS for multiple residents

- Res with significant change in improvement with ADLs; failed to complete sign chg MDS for res with major improvement in ADL function
- Failed to complete sig chg MDS for res with major decline in ADL function
- Failed to complete sig chg MDS for res with decline in ADLs

SE: SS=D: Failed to complete a timely significant change MDS for multiple residents including res with hospice admission & PU

- Quarterly MDS lacked ID of prognosis of less than 6 months; res admitted to hospice; no evidence facility completed sig chg MDS for 2 months 20 days later; failed to conduct timely sig chg assessment after admission to hospice services
- Res admitted to facility & transferred to hosp 3 days later with admission MDS dated 4 days after admission; res readmitted to facility with hospice services; failed to conduct timely sig chg MDS for res after admission to hospice svcs as required to ensure res received care based on individual needs
- Record lacked documentation of sig chg MDS & related CAA after return to facility from hospital with development of PUs

F275 Comprehensive Assess at Least Every 12 Months

SC: SS=E: Failed to complete triggered CAAs with annual comprehensive assessments within required timeframe for multiple residents for accidents, unnecessary meds, positioning, ADL assist, choices, dental, notification of change, accidents

- Annual MDS completed 1-13 & CAAs completed 2-7 25 days after MDS
- Annual MDS completed 12-18 & CAAs completed 1-3 16 days after MDS
- Annual MDS completed 6-3 & CAAs completed 6-21 18 days after MDS
- Annual MDS completed 7-29 & CAAs completed 9-9 42 days after MDS
- Annual MS completed 10-21 & CAAs completed 11-7 17 days after MDS

F278 Assessment Accuracy/Coordination/Certified

NE: SS=D: Failed to develop accurate assessments for res with foot ulcer, weight loss program & nutrition

- Sig chg MDS revealed res with PVD with extensive assist for ADLs without unhealed PUs, diabetic foot ulcers or other open lesions on foot; CAA revealed res goes to wound center & res at risk for PUs r/t refusal to get out to bed & refused showers; bruise investigation revealed res ran electric w/c into wall causing injury to feet with bruising; skin record revealed res with blister-like lesion with covering skin to area of black eschar to inner heel; res stated wound on heel not from w/c injury; failed to accurately assess lt foot wound to indicate ulcerated area developed from deep tissue injury
- MDS revealed res on phys ordered weight loss program with no wt loss or gain & not on mechanical altered or therapeutic diet; res with decline & received hospice svcs; POS lacked orders for phys prescribed wt loss program; staff stated if res received diuretic, should code MDS as wt loss regimen; failed to accurately record wt loss program on MDS
- MDS revealed res expected to gain wt because res on phys prescribed wt gain regimen; res weighed 315 pounds & res to receive LCS diet & refused to follow diet; phys order for res to receive reg diet with LCS & protein snack; failed to accurately code MDS r/t wt loss

W: SS=D: Failed to ensure accurate completion of comprehensive assessments

- MDS failed to ID res as wanderer; NN included multiple falls while wandering on & off neighborhood & "res recently in last 2-3 weeks has been wandering off unit"; observed res wandering on unit
- Failed to accurately reflect res status of fall with fracture prior to admission & that res received no restorative nsg svcs on multiple days
- Failed to accurately report on multiple quarterly MDSs to reflect correct number of falls res experienced, that res did not receive multiple days of active ROM & did not receive training as planned from restorative nsg svcs for bed mobility, transfers, walking & dressing/grooming

SC: SS=D: Failed to accurately assess & record information in MDS for multiple residents

- Res with dementia with behaviors with antipsychotic meds; res received Clonazepam PRN; documentation revealed res received PRN 5 times & res ADLs on unit were all independent with no help or setup from staff; NN revealed 1 note that res walked halls during waking

hours & no further charting of mobility noted; failed to accurately document assessment of res based on reproducible documentation on annual MDS

- MDS revealed res with extensive assist with personal hygiene; MDS did not ID if res had broken or loosely fitting full or partial dentures, mouth or facial pain discomfort or difficulty chewing; CAA revealed res with dentures without complaint of fit; res revealed res' dentures did not fit, esp bottom ones & had reported to staff; failed to accurately document res' oral conditions on MDS assessment

F279 Develop Comprehensive Care Plans

NC: SS=D: Failed to obtain a hospice CP

- Res with physician ordered hospice services; observed hospice services provided facility's CP indicated hospice aide services; no hospice CP for res in medical record

NC: SS=D: Failed to conduct comprehensive CP

- Res with COPD requiring oxygen; CP revealed no indication of or direction to staff r/t monitoring of res' oxygen dependency, expected level of oxygen to maintain & care of res' nasal cannula, tubing, concentrator & general oxygen dependency patient care

NE: SS=D: Failed to provide accurate, individualized CP

- Res with MI; CP lacked what services facility provided for res requiring PASRR; discharge plans in CP unclear

NE: SS=D: Failed to develop comprehensive CP in include nutrition & plate guard for multiple residents

- Res with intact cognition with independence with ADLs & with dialysis; Dialysis nurse recommended limiting sodium & fluid intake & RD recommended 48 oz per day; behavior note stated res not following food & fluid intake instructions & documented education; observed res eating taco salad & with bottle of pop; staff unaware of res' fluid/diet restrictions; care attendant sheet lacked any reference to monitor res' intake; failed to develop a comp CP to include fluid & dietary recommendations for dialysis res
- Res with UE impairment on 1 side with supervision for eating; CP lacked evidence res used plate guard during meals; Order for res to use plate guard during meals; Observed res with plate guard on multiple occasions

NE: SS=E: Failed to develop individualized & comprehensive CP for positioning, pain, ADLs, hospice & restorative services

- Res with pain with 5 pain meds ordered; CP noted comfort measures for pain but did not specify what measures were
- CP documented staff would assist res with repositioning as appropriate but did not include specific interventions
- CP documented staff would assist res with transfers as needed but did not include specific instructions
- Res with skin impairment; CP lacked documentation of individualized approaches to res' wound care, turning/reposition times, specific location of res' wounds, & res' regular attendance to local hosp wound care clinic
- Res with hospice; CP failed to indicate which services & supplies hospice provided
- Res with therapy/restorative aid program to eval & treat; CP lacked res' participation in restorative services
- CP lacked individualization r/t ADL & oral cares & failed to address res' oral needs for multiple residents

NC: SS=D: Failed to develop comprehensive CP for multiple residents

- MDS revealed res with no natural teeth or tooth fragments; CAA indicated res with natural teeth removed many yrs ago CP indicated res refused to wear dentures; res stated no teeth & never obtained dentures; staff reported inaccurate development of CP r/t oral status
- MDS indicated no dental problems; CP without instruction to staff for oral care; observed res without bottom dentures in mouth; SS stated res verbalized desire to get lower dentures replaced but did not document conversation; failed to develop CP including oral care

SE: SS=D: Failed to develop an individualized CP r/t PUs & wound care

- Res with stg 4 PU on admission; CP failed to address healing & prevention of further PUs; NN revealed family declined to proceed with recommended cares for wound & placed res on hospice after being advised to risk/benefits of wound care; res then admitted to hosp for wound tx with wound vac when readmitted; record lacked updated or revised CP & lacked new CP after admission
- POS lacked documentation of any tx for stg 1 or stg 2 PUs; record lacked documentation of sig chg MDS & related CAA upon return from hosp with development of PUs; record lacked CP addressing skin integrity, wounds or PUs; failed to develop CP to address development, healing & prevention of further PUs

NE: SS=E: Failed to develop individualized comprehensive CPs that accurately reflected res' status for behavior & emotional status, nutrition, pain, physical restraints, unnecessary meds & urinary catheters

- Urinary catheter CP lacked documentation reflected care of indwelling Foley cath when res had suprapubic cath
- Res with hx of wt loss; Nutrition CP lacked individualization r/t frequency that staff monitored weekly wts, frequency of lab monitoring, frequency of nutritional assessment & res' food preferences
- CP lacked individualization for nutrition including type of diet, type of supplement for weight monitoring, frequency of wt monitoring & food preferences; lacked measurable objectives
- CP lacked individualization for res for monitoring of behaviors & side effects for meds res received, specific lab tests, specific meds to monitor for changes, specific diet & supplements, food preferences, treatments, & absorbent products used by res; failed to include measureable objectives
- Failed to include measurable objectives & individualized care for res for med regimen & monitoring, artificial nutrition, amount of water to flush PEG tube, lab tests to perform & med clarifications in res' CP

SC: SS=D: Failed to develop a comprehensive CP for res reviewed for behavioral & emotional status

- Admit MDS revealed res with mild depression without behaviors; Sig chg MDS revealed res with physical behavioral symptoms to others & verbal behavioral symptoms to others & behaviors put others at significant risk for physical injury & significantly disrupted care or living environment & behaviors worse than previous assessment; CAA revealed res had assaulted partner & res removed from situation; CP without behavior or emotional issues included

F280 Right to Participate Planning Care-Revise CP

NC: SS=E: Failed to review & revise multiple res' CP after falls

- Res with high fall risk with multiple falls & CP not updated or revised after 1 fall; failed to review & revise CP after multiple falls & staff IDd res' orthostatic hypotension
- Res with multiple falls; CP did not have any updates after 1 recent fall
- Failed to review & revise fall/accident CP after each fall for multiple residents

NE: SS=D: Failed to revise CP for falls for multiple residents

- Res with hx falls; res with falls resulting in injury; CP lacked new intervention to prevent further falls
- Res with multiple falls; observed CP interventions not in place; Observed interventions implemented not included on CP

SC: SS=D: Failed to revise CP after each assessment for res r/t dehydration & increased need of staff assist with care

- Failed to review & revise CP to reduce risk of further dehydration after res experienced dehydration requiring IV fluids for multiple residents
- Failed to revise CP as res' requirement for assist with transfers & mobility increased

SC: SS=D: Failed to revise CP r/t accidents

- Res with normal cognition with fall hx with permission of family to drive home to check on cats; res with multiple falls; res with witnessed fall & staff failed to add new interventions to CP to prevent further falls; res with 4 falls without new interventions to prevent further falls; observed res without call light in reach; observed res without non-skid socks as CPd

NE: SS=D: Failed to revise CP

- Res with Trazadone for insomnia; CP did not include non-pharmacologic interventions for insomnia; res with weight loss & RD recorded res would benefit from gradual wt loss & physician order for weekly wts for 4 wks; no wt recorded since 2-15; CP lacked RD/physician recommendations for gradual wt loss & weekly wts; staff unaware of RD recommendations

NE: SS=D: Failed to revise CPs for multiple residents

- Res with restorative plan currently; CP IDd res receiving PT & OT; failed to revise CP when res discharged from therapy & started with restorative therapy
- Failed to revise CP when interventions were discontinued for res with frequent falls including discontinuing bed alarm

W: SS=D: Failed to review/revise multiple CP r/t accidents

- Res with poor safety awareness & resisted cares; CP lacked evidence of new intervention to prevent further falls after multiple falls
- Failed to review/revise CP to prevent further falls after res fell on multiple occasions
- Failed to revise CP after multiple falls

NC: SS=D: Failed to invite resident &/or family members to participate in CP & tx

- Record revealed no documentation of invitations sent to res' family members to attend CP mtgs; staff reported res' name omitted from list so invitation letter not sent to family

NC: SS=E: Failed to update or revise CP or invite resident or family to CP meetings for multiple residents

- Res with cognitive impairment & total assist; family unaware of a CP meeting for resident for a long time & had not been invited to CP mtg; SS verified no documentation of invited or who attends CP mtgs
- Failed to invite res to CP mtgs for multiple residents

NE: SS=D: Failed to revise comprehensive CP to reflect changes r/t use of palm guards & ROM exercises

- CP lacked documentation of revised phys orders to provide passive ROM to res' hands at hs & then apply palm guards & remove at specific time & lacked documentation res received fingernail care, lotion application or other hand hygiene

NE: SS=D: Failed to revise fall CP for res with accidents

- Res without dementia with extensive assist with fall risk; res with multiple falls; observed res without CPd interventions; staff stated intervention discontinued but not removed from CP

SC: SS=D: Failed to revise comprehensive CP for multiple residents reviewed for accidents, dialysis & hydration

- Res with renal failure with dialysis with fluid restriction; CP lacked frequency of fistura/graft site checks after dialysis; CP lacked res was non-compliant with fluid restriction; CP lacked specific instructions from dialysis facility for fistula/graft care after dialysis
- Res with Parkinson's with hx of falls; CP IDd fall dates but CP did not indicate res had fallen on those dates or any new interventions to prevent further falls
- Res with hx of falls with fx prior to admission; res with multiple falls with no new revisions to CP on multiple occasions
- Res with CVA; CP did not mention res' preferences for changing clothes after meals; observed res with shirt visibly soiled with food on multiple occasions & res stated did not want to feel "pressured" to change clothes & res felt had been "pressured too much on that"

SC: SS=E: Failed to ensure CPs updated when conditions changed for multiple residents

- Res admitted to hosp & foley inserted in hosp then DCd after return to facility; Staff revealed cath not CPd when res returned from hosp or when cath removed
- Res with hospice svcs with no desire for group activities but liked music, TV & pets; failed to revise CP to include res' likes of fingernail care, pets, devotional readings & music & failed to address res' past preferences & best times for res to be able to participate in activities
- Failed to review or update CP r/t res' decline & need for more staff assist; Failed to update & revise CP for decline in ADLs & need for increased staff assist
- Res left facility for planned surgery & returned with wounds with pain; CP had no revisions for pain mgmt. since res returned to facility; failed to update & revise CP with changes in pain meds

F281 Services Provided Meet Professional Standards

NC: SS=D: Failed to follow physician orders

- Observed staff prepare to administer meds & med card for Cardura read: 4mg po at hs; MAR instructed staff to administer Cardura 4mg po at hs with assigned time of 6pm; observed staff at 5:41pm preparing to administer meds; signed physician order instructed staff to give med at 8pm; failed to follow signed physician orders

NE: SS=D: Failed to provide a nutritional snack as ordered

- Record lacked CAA for nutrition or ADLs; res with prior wt loss & assist with meals; phone order for ½ peanut butter & jelly sandwich at all snacks & with all meals; observed res' meal tray without ½ peanut butter & jelly sandwich on multiple occasions; failed to provide nutritional snack to cog impaired res as ordered by physician

SC: SS=D: Failed to sufficiently care plan fluid restriction of newly admitted res to ensure needs met

- Res with ESRD with dialysis with fluid restriction; CP lacked amount of fluid restriction & how it was to be dispersed between nursing & dietary or that the res was not to have a container of water in room; ADL information sheet lacked information r/t fluid restriction; res with physician ordered fluid restriction of 1200cc; staff unaware of restriction or how much restriction; failed to have sufficient initial care planning to ensure staff knew how to provide care needed for res on fluid restriction

SE: SS=D: Failed to initiate an initial CP

- Res admitted on 3-5; record lacked comprehensive or initial CP to ID res' requirements or preferences for care needs

W: SS=D: Failed to complete an initial/admission CP with instructions to staff r/t hip fx & interventions to prevent repeated falls

- Record lacked any type of initial/temporary CP to instruct staff on needed cares or interventions to prevent repeated falls for res; staff unaware of any interventions & stated res would call if needed assist

F309 Provide Care/Services for Highest Well-Being

NC: SS=D: Failed to reposition res within 2 hours for res with hx of PU

- Res with risk for PUs with pressure relieving devices; record revealed res with hx of red & opened areas; with physician orders for geri chair & release & reposition every 2 hours; observed res without repositioning for 2 hrs 35 min, 2 hr 30 min; failed to reposition timely

NC: SS=D: Failed to provide necessary care & treatment for res for oxygen therapy

- Res with COPD; Lacked CAA summary including causes of triggered areas & lacked resident's care needs in triggered areas; CP lacked indication or direction to staff r/t monitoring of res' oxygen dependency, expected level of oxygen dependency, expected level of oxygen to maintain care of nasal cannula, tubing, concentrator & overall care for res who was oxygen dependent; res with O2 @ 3 liters/nasal cannula; res with incident found in respiratory distress with saturation of 42%, slumped to one side of bed & nurse increased oxygen to 6 liters, then administered Albuterol with order, then sent res to ER; record without documentation of res' oxygen saturation &/or monitoring for 6 days prior to incident for res with COPD; failed to provide necessary care, treatment & assessment including medical & nursing care for res who received oxygen therapy & staff found res with low sat

NE: SS=D: Failed to provide wound care as ordered

- Res with dementia; res at risk for PU & extensive assist with repositioning; phys order for skin prep to heel daily & float heel & pressure relieving boot; skin assessment revealed clear heel blister; observed large area of redness with peeling skin to heel open to air; observed wound care to heel completed by staff & observed heel in direct contact with bed; observed res in bed with heels in direct contact with bed; failed to provide wound care & failed to float heels as ordered

W: SS=D: Failed to provide multiple residents with necessary care & services (timely/thorough assessments for skin related issues) to attain/maintain res' highest practicable physical well-being

- Res with normal cognition with skin lesions with treatment; CP did not include skin care interventions, but then updated to note "follow up scabies Vaseline BID, & Kenolog for 2 wks; with later note for Benadryl cream for itching; res with multiple orders for dermatitis & scabies; NN lacked description of res' skin when issue first noted; multiple notes related to skin rash with treatments; record lacked evidence staff monitored res' skin between 10-19 & 1-2 but during that time NN documented res received new orders to treat skin issues but lacked documentation of res' skin condition; record lacked evidence that staff monitored res' skin from 1-4 to 1-30, 2-8 to 2-20; res reported had itchy, rashy skin with treatments but staff had not told res what caused skin issue; failed to monitor condition of res' skin while needing multiple skin treatments as ordered by physician

- Res quarterly MDS revealed res without skin issues; CAA unobtainable; CP instructed staff to perform weekly skin assessments; record revealed physician order for Elimite to affected areas; NN revealed res had re-emergence of s/s of scabies & treated with scabicide; record lacked documentation of skin from 11-12 to 12-10; observed res with multiple red, inflamed areas to chest & abdomen; lacked documentation of skin condition in record; failed to complete accurate, thorough skin assessments during time res received tx for scabies

SC: SS=D: Failed to consistently follow physician orders r/t fluid restriction

- Res with ESRD with dialysis with physician ordered fluid restriction of 1200/day; ADL CP lacked any information r/t fluid restriction; meal tickets without information to inform dietary staff res on fluid restriction; observed res with large cup in room ½ full; staff revealed no sign indicating fluid restriction; multiple staff members unaware of fluid restriction or amount of fluid restriction or if res should have fluids available in room

NC: SS=D: Failed to provide ongoing monitoring, reassessments & interventions for lack of routine BMs

- Res with phys orders for multiple laxatives all PRN; BM records indicated res lacked BMs for: 7 days, 5 days, 7 days & MAR lacked documentation staff administered PRN laxatives as ordered; NN lacked documentation staff provided res with abdominal assessment r/t lack of BM

NC: SS=D: Failed to provide proper positioning

- Res with rt hemiparesis; CP without documentation r/t proper positioning of rt arm; observed res on multiple occasions with rt arm hanging between legs in w/c at DR table & in w/c without positioning device for arm on w/c; observed res leaning to rt side with rt foot on w/c foot pedal & propelling self with lt foot down hallway with arm hanging between legs; observe res in bed without pillows under rt arm to support arm; observed res at DR table with head hanging down & rt arm hanging between legs on multiple occasions; therapy staff reported res not evaluated for positioning device in w/c

NC: SS=D: Failed to maintain highest practicable physician, mental, & psychosocial well being in accordance with comprehensive assessment & CP r/t pain management

- Res with mod dementia with extensive assist with scheduled pain meds & antidepressant & ABT; res with routine Tylenol; NN revealed res with moaning & grimacing & staff administered Tylenol but res continued with moaning & grimacing; staff stated did not notify physician r/t wanted to talk to PCP not on-call physician; failed to provide adequate pain control

SE: SS=D: Failed to provide services to assess & alleviate pain

- Res with dementia with no scheduled pain med or non med interventions for pain with hospice svcs; CAA addressed staff evaluate res for pain when behaviors exhibited but no pain interventions in place; observed res with moaning & guarding during positioning; observed res with contractions of hands without interventions; staff reported do not assess res for pain routinely; failed to assess & provide interventions as planned for hospice res' pain to ensure comfort

SC: SS=D: Failed to provide necessary care & services to attain or maintain res' highest practicable physical well-being to dialysis care

- Res with acute kidney failure with dialysis; CP lacked frequency of fistula/graft site checks after dialysis; follow-up instructions from dialysis center with specific instructions to observe access for bleeding q 30 min for 4 hrs after dialysis & to palpate for thrill/auscultation of bruit q 8 hrs & remove bandage after 12 hrs & leave catheter dsg on & only allow chg by dialysis staff with instructions sent on every day of dialysis for previous 2 months; multiple occasions NN revealed staff checked res access site for bleeding & thrill/bruit 1x & no further; TAR lacked directions for staff to check fistula/graft site q 30 min x 4 hours after dialysis; failed to check res' fistula/graft site for bleeding after dialysis as directed by dialysis center

SC: SS=D: Failed to provide pain management for res who had pain during dressing changes

- Res hospitalized for surgical repair of PU & returned with MRSA in wound, osteoarthrosis, stg 4 PU & chronic pain; res required 4 staff to move res in bed; CP lacked specific interventions for staff to address breakthrough pain that occurred with dressing changes of res' wounds; Phys order for oxycodone daily intended to start on day of order; first dose of med administered 4 days later & mistakenly gave it a later start date in electronic record; observed res yelled out with repositioning prior to dressing change & during dressing change & repositioning after dressing change; no PRN pain meds administered prior to dressing change as ordered; res reported hospital staff administered pain meds prior to dressing changes which was effective but staff at this facility did not offer pain meds prior to dressing changes; nsg staff reported not nsg practice to pre-medicate res with pain meds prior to dressing changes; failed to provide pain relief measures including administering PRN pain meds prior to dressing changes

F312 ADL Care Provided for Dependent Residents

NE: SS=D: Failed to provide necessary services for ADLS

- Res with cog impairment, impaired vision & extensive assist with ADLs with palliative care; observed res eating lunch with hair uncombed on multiple occasions; observed res at DR table & not eating & without staff assist

W: SS=D: Failed to provide necessary services to maintain good grooming & personal hygiene when staff failed to clean res sufficiently after bowel incontinence

- Res with CHF & obesity; observed staff wore gloves & assisted res with bladder & bowel incontinence & staff cleaned front area with wipe, threw wipe in trash & other staff turned res to side & used 1 wipe at a time to clean bowel incontinence approx. 10 times but BM remained on res' upper/middle buttock, lower/mid buttock & rt buttock; staff removed soiled gloves, placed on new gloves & placed clean brief under res' rt buttock; staff's gloves had stool on them when pulled out from under res; staff took wipe 3 x's but failed to

remove stool on res' upper/mid buttock & outer rt buttock; staff removed soiled gloves, placed on clean gloves & put clean brief under res; staff verified failed to thoroughly clean res when left stool on buttocks

SE: SS=D: Failed to ensure residents received adequate fingernail hygiene needs

- Observed staff assist res with arising cares but staff failed to provide cleaning of res' fingernails/hands for res with total dependence for ADLs; observed staff failed to provide fingernail/hand hygiene on multiple occasions; observed res with fingernails with obvious build-up of soiled debris under long nails on multiple occasions

SC: SS=D: Failed to ensure res received necessary services to maintain good oral hygiene

- Res with dementia with extensive assist; CAA revealed res with extensive assist with ADLs but staff reported res did own oral care; CP included new onset of dental care & res required some assist in cleaning teeth but did not include how often to clean res' teeth; oral care documentation revealed staff documented provision of oral care daily; observed res with large build-up of residue along gum line & pieces of food in teeth on multiple occasions

NC: SS=D: Failed to provide assistance with oral care & timely repositioning

- Res with hx of poor chewing ability with pureed diet & required encg to eat & risk for PUs with assist with oral care; observe res without pressure relieving device in w/c seat as CPd & staff combed res' hair without performing oral care for res then pushed res into dark DR with no lights on & up to table & stayed in DR without lights for 25 minutes; observed res continued in DR with eyes closed for 1 hr 40 minutes; res taken to DR at 6:20am & served bkfst at 8:15am; at 9am res in w/c alone at DR table; res without repositioning for 2 hours 30 minutes; no oral care observed; failed to provide ADL assist for oral care or repositioning

NE: SS=D: Failed to cue res for toileting as CPd

- Res with mod dementia with supervised set up with occasional incontinence of B&B; prompted toileted plan with planned schedule; observed staff failed to cue res to toilet as CPd for 3 ½ hours

SC: SS=D: Failed to provide oral care for res that required assist

- Res with obvious or likely cavity or broken natural teeth; Observed res without a toothbrush or toothpaste available in BR & teeth with white plaque; res reported never got teeth cleaned

SC: SS=D: Failed to ensure each res received necessary services to maintain good grooming & oral hygiene

- Res without dementia with extensive assist of 1-2 for ADLs with hospice services; observed res with large amt of dried drainage on eyes & eye lashes & with long, dirty fingernails with worn, grown out polish; observed res with lg amt brown food debris on both sides & all around bottom of lwer mouth & in teeth; with dry flaky lips & with drainage stuck to eye lashes; observed staff enter room & assisted with incontinent care then removed res' shirt without providing any facial grooming or lip or oral care; observed staff offer dink after incontinent care but reported res' mouth so dry res could not sip from straw so staff drizzled water into res' mouth with straw then gave straw to res to drink from it then applied moisturizer to res' lips then left room; failed to provide adequate oral care, nail care & facial grooming

F314 Treatment/Svcs To Prevent/Heal Pressure Ulcers

NE: SS=D: Failed to follow CP & provide interventions to prevent development of PUs for res with hx of PU

- Res with cog impairment & total dependence & not at risk for PUs; CP with interventions; observed res without CP interventions; observed staff not offer ordered protein snack; observed res without repositioning for 3 hours 5 minutes; observed res in bed without foot buddy in place as CPd

W: SS=D: Failed to ensure res received necessary tx & svcs (documentation of daily wound assessments & to float heels as CPd) to promote healing & prevent infections

- Res with mod impaired cognition with extensive assist with occasional incontinence & unstageable wound to heel with eschar with CP interventions for wound care; record revealed physician order & PT orders for treatment; record lacked documentation of weekly skin assessment with measurements of wound for 16 day time span from 1-24 to 2-10; record lacked evidence of daily wound assessments during res' dressing changes; observed staff remove old dressing prior to res' bath; staff cleansed area with wound cleaner & patted dry then dressed wound; staff reported only documented in clinical record if wound appeared different & staff does not document on condition of wound daily when changing dressing
- Res with severe cog impairment with extensive assist with 1 healed PU & other skin problems present with hospice svcs; res with high risk for PUs; From 6-18-13 to 12-30-13 staff failed to document condition of wound on heel daily & staff completed 36 assessments with 33 lacking documentation of any assessment of wound condition or surrounding tissue; staff failed to complete daily skin assessment for wound & multiple assessments lacked of any further assessment of wound condition or surrounding tissue; observed staff reposition with foot pressing into mattress without heel protectors or heels floated as CPd; staff revealed res had new wound that appeared a few days previously; failed to float heels & place heel protectors to promote healing & prevent PUs from developing; failed to document condition of res' wounds daily with dressing changes

SE: SS=D: Failed to provide timely position changes for multiple residents to prevent PUs

- Res with dementia & aphagia & PU risk; observed in w/c without repositioning for 3 hrs 15 minutes
- Res with total dependence & skin risk; Observed res without repositioning for 3 hrs, 3 hrs 15 min, 3 hrs 15 minutes

- Res with extensive assist with skin risk; Observed res without repositioning; CP lacked individualized times for staff to reposition res; observed res without repositioning for 2 hr 50 minutes

NE: SS=G: Failed to ensure residents with PUs received necessary care & services to promote healing of & prevent new PUs from developing

- Res with extensive assist for ADLs with indwelling supra pubic catheter with PU risk; admitted with 1 stg 2 PU, 1 Stg 3 or 4 PU; 14 day MDS lacked documentation of stg 2 PU & recorded 1 stg 3 & 1 stg 4 PU with PU interventions; CP lacked documentation of a turning, repositioning or ADL schedule & lacked documentation res attended wound care center; res developed stg 2 PU to heel which progressed to stg 3; CP did not document res' ischial wound, healed, reopened &/or current physician ordered treatment; CP lacked documentation of new interventions for ischial wound, lacked new interventions for wound which re-opened & lacked current physician's treatment order for wounds; Observed res without CPd & ordered interventions; Observed staff not reposition or encourage res to reposition for 2 hours 30 minutes; failed to prevent development of avoidable stg 3 heel PU; failed to provide care as planned after development of stg 3 PU; failed to prevent re-opening of bilat ischial wounds

W: SS=D: Failed to document condition of PUs on daily basis for multiple residents

- Quarterly MDS revealed res with 2 stg 2 PUs with eschar, dressings on bilat heels with comfort measures; Daily wound monitoring flow sheet revealed staff failed to document 14 of 16 days in previous month for 1 PU & 13 of 16 days in previous month & 10 days in current month; observed res without floating of heels on multiple occasions; failed to document condition of res' 2 PUs daily; failed to reposition res as CPd & failed to float heels as CPd
- Res without risk for PUs on Braden & CAA did not trigger; skin assessment revealed blister on heel & failed to indicate stg of wound IDd on 11-20; wound assessment documented on: 12-2, 12-23, 1-13, 1-20, 1-27, 2-17, 2-14, 3-10 (14 days); failed to ensure res received necessary tx & svcs when failed to document condition of heel blister on daily basis

SE: SS=D: Failed to implement effective interventions to prevent development of PUs

- POS lacked documentation of stg 1 or stg 2 PUs but with order for ointment to buttocks for skin irritation but lacked order for care of PUs; MDS revealed no risk for PUs & no PUs present; 30 day MDS revealed PU risk & res with stg 1 & stg 2 PU; record lacked documentation of sig chg MDS & related CAA upon return to facility with development of PUs; CP failed to address healing & prevention of further PUs; Res hospitalized with development of PUs at hospital; res readmitted with tx orders; record lacked telephone or verbal orders with instructions on how to treat PUs & surgical incisions or instructing staff to replace ordered tx or moisture barrier; Record lacked documentation facility applied ordered tx & no record physician advised of current PUs or incision sites for orders; dietary profile lacked any documentation of current skin issues or PUs; record failed to evidence res' low protein & albumen levels addressed; record lacked evidence of any assessment or measurement of areas for 18 days after admission; discharge note 13 days later noted both PUs healed; failed to follow discharge phys orders for tx; failed to notify PCP for further instructions for tx & abnormal lab values; failed to follow facility wound protocol to implement interventions to prevent development of new PUs

NE: SS=D: Failed to prevent reoccurring development of an avoidable PU & failed to provide interventions as planned

- Weekly skin review lacked documentation of pea sized open area on coccyx; res with suprapubic cath; observed res without repositioning for 2 hrs 45 minutes; record lacked documentation r/t proper setting for res' bariatric air mattress; staff unaware of appropriate mattress settings; staff reported had checked res' coccyx & did not see open area & with surveyor wiped off Calazime & observed open area & staff revealed unaware of open area; failed to assess, document, provide support surfaces as planned, & reposition dependent res as planned who developed open area on coccyx & had hx of open areas to coccyx

W: SS=D: Failed to provide multiple residents with necessary treatment & services (timely repositioning) to promote healing of existing PUs & prevent development of new PUs

- Res with extensive to total assist with mech lift for transfers with 2 assist; observed res without repositioning for 3 hrs 45 minutes, 2 hrs, 55 minutes
- Res with limited assist for ADLs with occasional incontinence; res developed red groin & cream applied; observed res without repositioning for 2 hrs 40 minutes & 3 hrs 25 minutes & 5 hrs 40 minutes (one time when res refused but staff failed to document refusal) & 5 hrs 35 minutes without repositioning; observed res without pressure relieving device in w/c as CPd
- Res with dependence for ADLs with 3 PUs all stg 1s with catheter; observed res without repositioning for 3 hrs 20 minutes, 4 hrs, 4 hrs 47 minutes & 5 hrs 47 minutes; observed res with loose incontinent stool some wet & some dried during period lacking repositioning

SC: SS=G: Failed to provide consistent accurate placement of pressure relieving boots & timely repositioning services to a dependent resident to prevent development of an avoidable PU

- Res re-admitted to facility after hospitalization for surgical repair of PU; res admitted with stg 4 PU to sacrum non-healing & DM; res required extensive assist of 2 for bed mobility & res at risk for other PUs; CAA revealed res 4 person assist for bed mobility; CP instructed staff to place booties to relieve pressure on both heels & feet; res went to hospital for planned surgical intervention to aide in healing of a non-healing PU & returned to facility; CP lacked new revisions developed by staff to aide in assist of healing of surgical wound; phys note revealed res with 5 wounds: sacral surgical wound, rt lateral buttocks surgical wound, rt medial buttocks wound & lateral ankle wound; Braden revealed mild risk with score of 15; NN in current month revealed res found in bed with foot resting against foot board with development of stage 1 to plantar surface of foot & 2nd area on lateral foot surface & note failed to ID how long it had been since staff last repositioned res or if res had been wearing pressure relieving boots as planned; phys note revealed res with 2 new, unstageable PUs to foot; observed res in bariatric bed with foot board with boot not placed on foot correctly so area on foot from toes to mid-foot

exposed; res reported bed broke & laid there until staff fixed bed; staff reported bed malfunctioned & res sat in upright position with foot pressing against footboard & note failed to address if res had been wearing planned pressure relieving boots at that time or if staff had placed them on res correctly; statement did not indicate how long it had been since staff had assisted with repositioning when bed broke; phys reported it would take 1-2 hours of pressure to develop wounds

F315 No Catheter, Prevent UTI, Restore Bladder

NC: SS=D: Failed to provide services to encourage prevention of infections for res with indwelling urinary catheters

- Res with catheter with cath care q shift & PRN; Observed cath bag hanging on trash can at foot of bed without dignity cover on multiple occasions; observed bag hanging from recliner touching floor on multiple occasions; observed staff empty bag without cleaning end of drainage spigot with alcohol on multiple occasions; staff unaware of need to clean spigot before or after emptying bag; policy instructed staff to clean spigot with disinfectant sponge before & after emptying urine
- Res with Rocephin for UTI & Diflucan for UTI; & Amoxicilling for UTI; Observed res with catheter with cath tubing draped over front of res' legs & collection bag resting on floor; observed tubing touching floor under w/c

NE: SS=E: Failed to assess multiple residents for urinary incontinence

- Res with functional incontinence with scheduled toileting plan; record revealed no documentation of scheduled toileting from 1st thru 11th of month & res incontinent on all shifts 12th-26th; voiding diary lacked evidence staff monitored res' voiding pattern from 9pm-6am on all days of diary; observed res with strong urine odor & observed res wet; failed to complete 3 day voiding diary & follow CP
- Res with dementia incontinent, not on toileting program & received diuretic; incontinence assessment indicated res always continent; voiding diary lacked evidence staff monitored res' voiding pattern from 9pm thru 6am for 3 days; observed res with strong urine odor & staff removed saturated brief; observed res with reddened coccyx; observed staff failed to toilet per CP schedule; failed to assess res' voiding pattern & failed to follow toileting plan
- Res with impaired cognition & total dependence; quarterly assessment indicated res never incontinent of stool & never voided without incontinence & res on check & change schedule; voiding diary lacked evidence staff monitored res' voiding pattern after 8pm until 6 am each day of diary; observed staff failed to cleanse entire genital area during peri care; observed staff did not toilet res for 3 hours 5 minutes; failed to assess res' voiding pattern & failed to check & change res every 2 hrs as CPd
- Res with dementia with antipsychotic meds; CP revealed res on check & change program; 3 day voiding diary lacked documentation from 8pm to 6am; observed res in bed on yellow stained pad soaked in urine with very strong odor; failed to complete 3 day voiding diary & follow CP

W: SS=D: Failed to ensure res with urinary incontinence received appropriate treatment & services to restore as much normal bladder function as possible when staff failed to toilet res according to CP

- Res with Lewy body dementia; assessment failed to mention type of urinary incontinence; 3 day voiding diary completed with CPd toileting program; Observed staff failed to toilet after meal as CPd on multiple occasions

W: SS=D: Failed to provide necessary treatment & services (handling of catheter bag & catheter tubing) to prevent UTIs with indwelling urinary catheter & failed to implement individualized toileting plan to restore as much normal bladder function as possible for incontinent resident

- Res with indwelling catheter & always incontinent of bowel; CAA lacked any completion r/t cause of incontinence problem; observed res in w/c with 6 inches of catheter tubing directly on floor under w/c on multiple occasions; observed tubing drug on floor during transport in w/c; staff passed cath bag to other staff by tossing bag along floor & during transfer res stepped on tubing; observed res in shower with tubing & collection bag directly on floor under shower chair; during transfer bag & tubing on floor & tubing pulled tightly during dressing
- Urinary CAA lacked causal factors & documented res with occasional incontinence of bowel & frequent incontinence of bladder; record lacked incontinent assessment or 3 day voiding pattern for review; failed to assess, plan & implement an individualized toileting plan to restore as much normal bladder function as possible for incontinent confused res

SC: SS=D: Failed to provide necessary care & services to attain or maintain a res' highest practical physical well-being for res with urinary catheter

- Res with DM & UTI on admission with no dementia; res incontinent prior to hospitalization with catheter inserted during hospitalization; observed res without catheter; observed res without repositioning & surveyor requested incontinence check after 2 hrs 45 minutes without check & staff reported res "just damp"; lacked evidence bladder chart (voiding assessment) restarted when catheter removed; failed to assess & document res' bladder function to maintain highest practicable level of function after removal of res' catheter

F318 Increase/Prevent Decrease in ROM

SE: SS=D: Failed to ensure services provided to maintain & prevent avoidable decline in ROM

- Res with dementia & CVA & hospice svcs; lacked CAA addressing ROM; res with extensive to total assist with ADLs; observed res with hands clenched & arm tightly against chest; observed res with moaning & guarding when moved; res without pain mgmt. plan; lacked ROM plan; lacked restorative plan; staff reported movement caused pain & lacked pain assessments; failed to assess, develop a program & provide interventions to maintain & prevent decline in ROM

F322 NG Treatment/Services-Restore Eating Skills

W: SS=D: Failed to ensure res with G tube received appropriate treatment & services to ensure tube placement in order to prevent aspiration

- Res with g-tube for majority of calories; res with stroke; phys orders for tube feeding & flushing of tube; NN revealed staff noted flange of tube no flush with abdomen & when checked for placement tube did not seem to be in place & phys notified with order to transfer res to ER for eval; res returned with new peg tube; hosp h & p noted res with displaced g-tube & was out approx. 5cm with ruptured balloon; observed staff auscultate for placement with audible "bubbling" sounds from tube without aspirating for stomach contents with flange not flush with res' abdomen, nurse then poured 35mL of water into syringe & water did not flow & nurse milked tubing then used plunger to push water through tube then nurse administered multiple crushed meds using 20-35mL between meds & using syringe plunger to push meds & water through tube with total of 915mL of water given during observation & at no time did contents of syringe flow freely through tube; failed to ensure proper placement of feeding tube prior to administration of meds & water

NE: SS=D: Failed to educate staff on proper use of a declogger (device used to break up blockages in feeding tube)

- Res with g-tube with order for declogger; observed staff attempt to administer water flush & water wound not go down by gravity; staff used flexible plastic rod 16 inches long inserted into feeding tube & released blockage; observed staff instill 240cc water flush to tube via gravity; staff reported no instruction on how to use declogger; facility lacked evidence nurses were trained on how to use declogger with tube feeding

F323 Free of Accident Hazards/Supervision/Devices

NC: SS=E: Failed to ensure environment remained free of accident hazards

- Observed breakroom door with sign "under construction" & key pad attached to ddor but door unlocked with hazardous chemical accessible; door in breakroom exited to outside courtyard area which opened automatically & no alarm sounded & courtyard with broken plastic chair, rolled up electrical cord & matches accessible
- Observed multiple boxes of fluorescent lights stacked on top of a table in a common area

NC: SS=E: Failed to ensure adequate supervision to prevent accidents for multiple residents with falls

- Res with hx of falls with fracture; observed res without CPd interventions; Left alone in toilet & res fell & sustained hip fx
- Failed to develop & implement new interventions for res after fall to prevent further falls for multiple residents
- Res experienced fall after left unattended in common area; failed to provide supervision to prevent falls for res with fall risk & hx of falls
- Res with multiple unwitnessed falls with & without injury; multiple falls without new interventions to prevent further injuries; failed to provide adequate supervision

NE: SS=D: Failed to provide supervision to prevent accidents for multiple residents

- Res with CVA; res with fall CP interventions & at fall risk; observed res without CPd interventions; res with witnessed fall without injury
- Res with hx of falls with CP interventions with fall risk; NN revealed res with unwitnessed fall in BR; investigation revealed 2 staff transferred res onto toilet then 1 left & 1 left BR with door partially open & sat on res' bed, then CNA heard sound & found res in BR on floor; CP not revised to implement new interventions to not leave res unattended in BR; failed to provide appropriate interventions & failed to revise CP to prevent further falls
- Res with hx of falls with CP interventions; res with multiple witnessed falls; NN revealed staff DCd chair alarm; observed staff amb res without CPd gait belt & walker; observed another res attempt to pull res off couch; failed to implement appropriate intervenitons for res with fall hx

W: SS=E: Failed to ensure res' environment remained free of accidents & hazards when staff stored potentially hazardous chemicals & tools in areas accessible to residents; failed to store an oxygen tank in secure manner

- Observed accessible hazard chemicals in therapy dept under sink
- Observed oxygen canister placed upright without secure holder in res room

SC: SS=D: Failed to ensure staff consistently provided care as planned for res at risk for falls

- Res with fall risk with multiple previous falls; Res with high fall risk; observed staff transfer res without gait belt on multiple occasions

SE: SS=E: Failed to store chemicals in safe manner

- Observed accessible hazardous chemicals in res BR

SC: SS=D: Failed to provide interventions to prevent falls

- Res with fall hx; res with multiple falls since admission & during past survey period; res fell on 4 occasions & failed to develop new CP interventions in an attempt to prevent further falls; Observed res without CPd interventions on multiple occasions

SC: SS=E: Failed to ensure each res' environment remained free of accident hazards

- Observed accessible hazardous chemicals at nurses station in multiple locations

NE: SS=J: Failed to provide adequate supervision to prevent res with dementia from leaving facility without staff knowledge & walking on 2 lane street without sidewalds on cold windy evening which put res in immediate jeopardy & failed to place timely interventions in place for res with falls; failed to ensure door alarms functioned properly

- Res with dementia & bipolar with limited assist for ADLs & independent with walking in room & locomotion off unit; CAA revealed res needing frequent redirection & orientation; Behavior CAA revealed res wanders & somewhat aggressive & resisted cares; Wandering behavior CP resolved 9-13; res with antipsychotic & antidepressants daily with high fall risk; elopement risk form documented res not at risk for elopement/wandering; elopement book kept at front desk lacked information r/t resident; record lacked any documentation r/t

res leaving facility unsupervised in early evening; weather report for day of incident reported temp at 28.9 degrees with wind chill of 19.8; observed secured door with code instructions to open door at front door; adm nsg staff reported staff on duty at time of incident no longer worked at facility & visitor reported visitor saw res outside & reported to nurse; res found down street approx. ¼ mile from facility; Adm instructed staff to educate res about leaving building without staff knowledge & instructed staff to place Wanderguard on res; Adm nsg staff unaware of which door res used to exit; other Adm nsg staff reported res had requested family to bring cigarettes & family member said no & res upset so res left to get cigarettes; staff unaware of exact date of incident; Adm nsg staff stated res alert & cognition intact & did not consider incident an elopement; facility did not complete investigation; visitor reported incident to facility; staff did not place Wanderguard on TAR to check for placement & functioning; staff made out check sheet to check res every 15 minutes during night; failed to provide secure environment for wandering, cognitively impaired ambulatory res at fall risk who went out unknown exit door & walked in street ¼ mile to strip mall unsupervised which put res at immediate jeopardy; abated deficiency to G

- Res with dementia with fall risk with fall risk interventions; CP lacked interventions to minimize res' falls when sat at DR table or on sofa; CP did not include res with non-skid strips at bedside or riser on toilet or alarm on bed; NN revealed res on floor with injury & chest X-ray res with pneumonia; res with further fall with head injury; res with multiple falls; Observed res in DR without chair alarm; failed to place timely interventions for severely cognitively impaired res with hx of falls
- Observed exit doors checked & door immediately opened without 15 second delay & 1 short alarm sounded then alarm stopped; door monitor logs did not specify which doors wandering monitoring system staff checked

NE: SS=E: Failed to implement fall prevention interventions as planned for res with hx of falls

- Res with total assist with ADLs with fall hx; CP with interventions for falls of personal alarm & pressure alarm on bed when in bed; TAR lacked documentation staff checked function of alarms; Observed res without CPd interventions
- Observed storage room door open with paper cutter inside door

W: SS=E: Failed to implement appropriate fall prevention strategies to prevent additional falls, failed to investigate causal factors of falls & failed to use fall prevention devices as directed by CP

- Failed to utilize tab alarm as CPd when res fell; failed to investigate cause of res' fall & failed to review/revise CP to prevent further falls
- Failed to ensure use of fall prevention interventions & failed to review/revise CP to prevent further falls when res fell on multiple occasions
- Observed accessible hazardous chemicals
- Failed to evaluate res' falls for causal factors & implement fall prevention strategies to prevent future falls; failed to document new fall prevention intervention to prevent further falls; observed CPd fall interventions not implemented (fall mat)

NC: SS=E: Failed to provide safe environment for cog impaired residents

- Observed unlocked tx cart with no staff in attendance

NC: SS=E: Failed to ensure res' environment remained free of accident hazards as possible

- Observed housekeeping staff spray mattress with liquid from spray bottle & stated would clean room after sprayed another res' mattress with disinfectant; observed mattress saturated with disinfectant; observed housekeeping staff spray handrails and disinfectant dripped off railing onto floor & residents leaving DR & walking down hall while housekeeping staff talked with another housekeeper then housekeeper wiped off handrails; observed housekeeper spray leather recliners with disinfectant and dripped onto floor as went back to wiping handrails; observed housekeeping staff spray mattresses with disinfectant dripping onto floor; inappropriate use of disinfectant

W: SS=D: Failed to provide multiple residents with adequate supervision & assistive devices to prevent accidents (implement interventions to prevent further falls & failure to investigate causal factors r/t falls)

- Res with high fall risk; CP lacked a toileting plan; res with multiple falls; staff documented in NN a new intervention but failed to implement intervention on CP; Fall without new intervention to prevent further falls on multiple occasions; failed to investigate causal factors & failed to implement new interventions
- Res admitted in current month after fall at home; no initial/temporary CP found; res requested grab bars which facility installed 5 days later; observed res without safety interventions to prevent falls (no shoes & regular cotton socks for ambulation)
- Res with high fall risk; CP failed to include updates following multiple falls; observed res with pants dragging floor on multiple occasions; observed res carrying blanket dragging floor with res stepping on blanket

NE: SS=D: Failed to provide safe transfers, failed to follow CP & failed to provide safe res equipment for res with hx of falls

- Res with severe dementia with limited assist for ADLs & extensive assist with toileting; res with multiple non-injury falls; CP instructed staff to not leave res unattended in BR; res with witnessed fall; observed staff left res unattended in BR on multiple occasions; observed bed cane on bed with gap of 2 ½ inches; observed staff transfer res without gait belt; res' family stated did not want res to be left unattended in BR; failed to use gait belt for safe transfers; failed to monitor res while on toilet; failed to ensure bed cane fit snuggly to prevent entrapment of res

NC: SS=D: Failed to provide interventions to prevent accidents

- Res with mod dementia with 2 person assist with freq incontinence; res at risk for falls; Res with unwitnessed fall & intervention included to encg res to use pendant alarm without any new interventions to prevent future falls

SC: SS=G: Failed to thoroughly investigate all falls & implement appropriate fall interventions to prevent accidents for multiple residents; failed to ensure res environment remained free of accident hazards by failure to properly secure chemicals

- Res with severe dementia with extensive assist of 1 with multiple falls with recent hip fx; failed to determine root cause of fall or revise CP for multiple falls; observed res without CPd fall interventions; failed to investigate root cause of multiple falls, implement appropriate fall interventions to prevent further falls including supervision & implement planned interventions resulting in hip fx
- Res with Parkinson's & unsteady gait; res with unwitnessed fall & investigation lacked information r/t when staff last provided care for res & if interventions were or were not in place as planned; res with witnessed fall & staff did not investigate to determine cause of fall or revise CP with new interventions; res with unwitnessed fall & investigation lacked information as to when staff last provided cares & if interventions to prevent falls were followed as planned; failed to thoroughly investigate falls to determine cause & evaluate effectiveness of current fall prevention measures
- Observed Yankee candle metered deodorizing refill cans unlocked & accessible; H2O2 cleaner/disinfectant in shower room accessible to res; Carpet pre-spray & spotter accessible; Lysol accessible

SC: SS=E: Failed to ID causal factors of falls & develop & implement interventions after each fall in an attempt to prevent further falls; failed to safely store chemicals & meds

- Res with 30 falls in previous 11 months; review of investigations revealed none of investigations IDd last time staff toileted or saw res or included witness statements from staff to determine root causes of falls to implement appropriate & effective interventions; observed res without CPd interventions on multiple occasions; failed to prevent further falls by failure to thoroughly investigate after each fall to ensure res' comfort needs were met & ensure res had adequate supervision & failed to follow CP interventions to prevent falls
- Res with dementia with behaviors & fall risk & elopement risk; fall investigation failed to thoroughly investigate cause of res' fall as well as determine when staff had observed res prior to fall for multiple falls; facility failed to obtain witness statements about incident or when staff last observed res prior to fall; observed res without CPd interventions in place; res with incident of leaving unit without supervision by pressing on door for 15 seconds; failed to thoroughly investigate cause of res' falls & provide adequate supervision as planned when res was in courtyard area
- Observed med cart unlocked & accessible to residents; observed treatment cart unlocked & accessible & staff reported staff took keys home 2 days ago & needed to be brought back & until that happened no key for tx cart available so cart turned to face wall; observed med cart unlocked with keys on top of cart & staff reported accidentally put wrong keys in pocket; observed staff left vials of insulin on top of med cart; failed to ensure safe med storage
- Observed cleaner & unmarked fluid unlocked & unattended on multiple occasions; revealed PT/restorative room unlocked & unattended with unlocked cabinets with hazardous chemicals; failed to securely store hazardous chemicals

F325 Maintain Nutrition Status Unless Unavoidable

NC: SS=D: Failed to implement interventions to promote adequate nutritional status & implement physician ordered supplements; failed to implement RD recommendations after physician agreed to recommendation to prevent weight loss

- Res with severe cognitive loss with total assist with mechanical soft diet; Record revealed res with gradual weight loss over 3 months; RD with recommendations for supplemental shakes with meals & physician directed staff to fortify foods & offer supplements 11 days after RDs recommendations; Record revealed no documentation of physician's order for fortified foods or supplements; staff unaware of diet orders

NE: SS=D: Failed to document percentages of supplement consumed

- Res with total assist & supervision with eating with dialysis & Nepro nutritional supplement drink TID; MAR lacked % of supplement consumed; res with wt loss over 6 months

F327 Sufficient Fluid to Maintain Hydration

SE: SS=D: Failed to ensure res received hydration throughout day

- Res with nectar thick liquids with meals in assisted dining; CP to encg fluids to 1000cc/day using nosey cup; RD recommendations for 2000cc/day; fluid intake records revealed res with 200-1200cc/day including all meals, snacks & med passes; observed res with lips & tongue dry with grooves & staff failed to offer drink of water during cares

F329 Drug Regimen Free from Unnecessary Drugs

NC: SS=D: Failed to adequately monitor bowel management program for multiple residents & failed to follow-up on effectiveness of PRN pain med

- Res with constipation with multiple laxative orders routine & PRN/bowel protocol & res with acute pain with PRN pain med with side effect of constipation; res admitted to hospital for severe constipation; record revealed res without BM: 3, 3, 3, 4 days with no record staff administered bowel meds as ordered; record revealed staff administered PRN pain meds on multiple occasions & MAR revealed no documentation of reassessment for effectiveness of pain med
- Res with order for routine laxative; record revealed res without BM: 4 days, 4 days & MAR revealed no documentation staff administered laxatives as ordered; failed to adequately monitor bowel pattern & administered ordered meds

NE: SS=D: Failed to monitor BMs for res who received constipation meds

- Res with constipation dx; res with laxative daily; bowel monitoring form indicated res without BM for: 4 days without evidence staff administered PRN meds; lacked policy for physician standing orders for daily bowel monitoring

- Res with constipation & hx of fecal impaction & laxation BID; BM monitoring form revealed res without BM for 5 days without evidence staff administered PRN med for bowel management; failed to monitor for effectiveness of med & provide PRN med per standing orders

W: SS=D: Failed to ensure multiple residents did not receive unnecessary meds when staff failed to monitor target behaviors for res with psychoactive meds

- Res with Abilify for dementia with behavioral disturbances; record lacked evidence staff monitored for targeted behaviors that staff hoped to control with use of Abilify
- Res with Zyprexa for psychosis; AIMS revealed mild involuntary body movements; record lacked system to monitor targeted behaviors r/t Zyprexa
- Res with Buspar & Risperdal for dementia with behavioral disturbances; record lacked evidence staff monitored for targeted behaviors that staff hoped to control with use of antipsychotics

SE: SS=D: Failed to adequately monitor meds r/t antihypertensive med

- Res with metoprolol with BP & pulse weekly; CP lacked interventions r/t monitoring res' antihypertensive med; Dec MAR recorded 1 BP; NN in Dec recorded 1 BP at 158/98; Jan MAR recorded 1 BP & 1 pulse; Feb MAR recorded 2 BPs & 2 pulse readings; Feb MAR recorded 3 BP & pulse; staff confirmed no IDd BP parameters set by physician

SC: SS=E: Failed to monitor for targeted behaviors for multiple residents on psychoactive meds

- Res with Seroquel & Cymbalta; review of behavior management record revealed staff monitored only for sadness & sheet showed no episodes of sadness during February; failed to monitor inappropriate behaviors of res; observed res without behaviors; staff reported res with inappropriate sexual behaviors to staff; failed to establish need for psychoactives by failure to monitor & document all relevant behaviors every time occurred & failed to document results of planned interventions to behaviors
- Res with Risperdal, buspar & celexa; behavior monitoring form for Feb showed res had behavior of resistive to care & wandering once during month; observed res without behaviors; staff reported behaviors not monitored on monitoring form; failed to establish need for psychoactive meds by failure to monitor & document all relevant behaviors every time they occurred & failed to document results of planned interventions to behaviors
- Res with Risperdal, Melatonin, valium, celexa with recent increase in celexa for depression; behavior monitoring sheets for Jan, Feb, Mar had no information to ID what behaviors, interventions or what meds res taking; staff reported res without behaviors or problems sleeping at noc & no non-pharmacologic interventions to enhance sleep; behavior monitoring revealed yelling at staff & failed to address paranoia (Risperdal); failed to establish need for psychoactives res took by failure to monitor & document all relevant behaviors every time they occurred & failed to document results of planned interventions to behaviors

NE: SS=D: Failed to effectively monitor meds

- Res with Ambien for sleep, Depakote for bipolar d/o, Seroquel for bipolar, trazadone for insomnia, clonazepam for agitation/anxiety; behavior flow records included Depakote, Seroquel, ambien, trazadone & clonazepam for insomnia & manic behaviors with all meds listed on 1 flow record & record did not ID targeted behaviors to monitor for each medication
- Res with celexa, Seroquel, trazadone, Xanax; PRN Xanax administered on multiple occasions without documentation on MAR r/t to effectiveness; behavior monitoring included res with schizophrenia, psychosis & depression & targeted behaviors included insomnia & continuous screaming or yelling; monitoring sheet did not specify target behaviors of each medication; sheet lacked documentation for Xanax; failed to monitor effectiveness of psychotropic meds

NC: SS=D: Failed to adequately monitor blood sugar levels & administer insulin per results as ordered

- Res with diabetes with dialysis sliding scale insulin phys orders and notification parameters; TAR revealed staff failed to administer ordered insulin on 1 occasion & administered incorrect dose on 2 occasions & on days following both occasions res' blood sugar was elevated above parameters; TAR revealed elevated blood sugar levels above ordered notification parameters on 2 occasions & no documentation physician notified as ordered

W: SS: E: Failed to monitor for potential side effects and adverse reactions IDd in BBWs for multiple residents

- Temporary CP lacked information r/t meds with BBWs; res with Zoloft, Lasix, Coumadin & lovenox
- CP lacked information r/t meds with BBWs; res with Xaralta
- Failed to monitor warfarin, Plavix, Lopressor & Lasix with BBWs
- Failed to monitor meds with BBWs for Xarelta & Lasix
- Failed to monitor meds with BBW for ciprofloxacin\

NC: SS=D: Failed to ensure residents remained free from unnecessary meds

- Res with Zyprexa, trazadone, Ativan, Haldol; CP without interventions other than meds to promote sleep at noc; dx for Zyprexa, trazodone & Haldol for dementia & Ativan for anxiety; NN lacked documentation of any behaviors when PRNs administered on multiple occasions in multiple months; no documentation of behaviors or non-pharmacologic interventions attempted for resident; observed res with drowsiness & somnolence during breakfast in AM after Ativan administered at hs; failed to implement non-pharmacologic interventions such as sleep hygiene methods to promote sleep for res who's PRN anxiety med was increased to daily & staff unable to awake res for ADLs including mealtime

SE: SS=D: Failed to monitor for behaviors & lacked blood sugar monitoring r/t sliding scale insulin administration

- Hospice res with Ativan, Risperdal, Lexapro & Seroquel; multiple months MAR lacked ID of targeted behavior monitoring for Risperdal & Seroquel
- Res with Geodon, Lexapro; MARs for multiple months lacked ID of targeted behaviors to monitor use of Geodon; failed to monitor res for insulin & blood sugar management when facility to monitor & administer insulin per sliding scale guidelines; POS revealed res with sliding scale insulin orders qid; blood sugar records revealed lack of any evidence blood sugar levels checked on multiple occasions

W: SS=D: Failed to monitor targeted behaviors for multiple residents using Seroquel

- Res with anxiety, depression & psychosis with tearful episodes & disorganized thinking; res with Seroquel for psychosis; record lacked documentation for target behaviors for Seroquel
- Res with intact cognition & moderate depression; res with Seroquel for psychosis; observed res with agitation r/t how egg on tray prepared; record lacked targeted behaviors for use of Seroquel

NE: SS=D: Failed to monitor & document bowel medication; failed to monitor & document effectiveness of PRN hypnotic

- Res with insomnia with Ambien PRN for sleep & itching for itching d/o; AIMS completed; current MAR revealed PRN Ambien administered 19 times & 8 doses lacked documentation of effectiveness of med; previous month revealed PRN Ambien administered 10 doses without documentation of effectiveness of medication
- Res with constipation with multiple laxative administration both routine & PRN; record revealed res without BM for: 7 days, 5 days, 7 days without documentation res received PRN laxative as ordered

SC: SS=E:

- Res with dementia/anxiety/depressive d/o; MDS revealed no depression with delusions & without wandering behaviors with routine Ativan, PRN Ativan & Haldol; res received PRN Ativan for verbal aggression & note did not indicate staff attempted any non-pharmacologic interventions prior to medication res with PRN Ativan; MAR for previous month revealed res received multiple doses of PRN Ativan and PRN Haldol & NN revealed no corresponding NN indicating what specific targeted behaviors triggered use of PRN Ativan administrations on multiple occasions & lacked any documentation of non-pharmacologic interventions prior to administration of PRN meds on multiple occasions; staff reported facility did not use specific record for behavioral monitoring; failed to attempt non-pharmacologic interventions prior to medicating res with Ativan & failed to ID & monitor for specific targeted behaviors
- Res with Alzheimers, anxiety, depression with Citalopram & Seroquel routinely & PRN clonazepam; EMAR revealed res received PRN Clonazepam 9 times & 8 of 9 EMAR notes stated "anxiety" as reason given without specific targeted behavior & effectiveness was charted as "effective", "not effective" or "somewhat effective"; observed res wandering hallways on multiple occasions; failed to appropriately monitor for specific targeted behaviors for res taking Seroquel & citalopram & failed to documents alternatives tried prior to PRN administration; failed to adequately document specific behaviors exhibited for PRN administration
- Res with Lexapro but mood score of 0 indicating no depression; DRR revealed no GDR recommended for Lexapro; staff reported charted by exception; failed to appropriately monitor for specific targeted behaviors for Lexapro & lacked GDR for med

F332 Free of Medication Error Rates of 5% or More

W: SS=D: Failed to provide education for influenza vaccine for multiple residents

- Records revealed multiple influenza vaccine administered with no evidence of education provided

NC: SS=D: Failed to administer meds free of errors & as ordered by physician during med observation

- Res with order for phenytoin 300mg q 12 hrs per peg tube & hold peg tube feeding 1 hr prior to & immediately following administration of phenytoin; nurse stated had taken order to administer phenytoin 30-60 minutes prior to peg tube feeding; Observed staff administer peg tube feeding immediately following administration of phenytoin; failed to administer meds without error

SC: SS=D: Failed to have a med administration error rate of 5% or less with 2 med errors, one related to failure to flush between administration of G-tube meds for res & another for failure to administer total dose of Buspirone

- Observed staff state G-tube is supposed to be flushed with 30mL of water prior to & following administration of meds; observed staff crush 2 meds in one med cup, dissolved them in water, flushed G-tube with 30mL of water, administered both meds and finished with flush of 30mL; staff failed to follow policy to flush tube with water following each med dose
- Observed staff administer 1 tablet of Buspirone 10mg; bottle label stated 10mg give 1 tablet & MAR stated 15mg 1 tablet; phys order was for 10mg TID & had handwritten note to side of order that stated 15mg & bottle contained ½ tabs in bottle

F353 Sufficient 24-hr Nursing Staff Per Care Plans

NC: SS=E: Failed to provide sufficient staff to provide services to meet needs of residents

- Observed main entrance unlocked & res seated on edge of bed with call light on & res asking for help & res stated light had been activated for "some time"; observed SCU doors open with no staff present in area; observed staff enter unit & leave unit without checking on residents; fall log revealed 16 falls from 12-13 to 2-14; observed res at doorway of SCU for 2 hours per record, then later in day res attempted to leave facility activating alarm on multiple occasions; staff reported feeling "overwhelmed" at times when covering SCU units & other unit; staff reported short staffed; call light logs revealed 10.6 minutes, 9.4 minutes, 22 minutes during nighttime hours

NE: SS=E: Failed to provide sufficient staff to ensure enhancement of res' needs

- Observed res did not receive meal for 45 after res brought to DR; observed 2 staff members in locked unit with 1 res wandering requiring assist & other res ate food off other res' plates & 4 res did not eat & did not receive assist from staff after 2 more staff arrived to assist; observed staff administer ordered med 1 hr 20 minutes after scheduled time of administration; staff reported sometimes not enough staff to assist res in timely manner; staff reported staffing per company policy; family stated more staff needed to assist with feeding; staff reported hard to get morning meds passed timely

NC: SS=F: Failed to provide sufficient staff to ensure provision of services to meet needs of res residing in facility

- Observed res spill water on DR table & in lap & staff did not assist res to change wet clothing; at 6am observed 1 CNA & 1 licensed nurse on duty for 20 residents; at 3:08pm 1 CNA on duty & began passing 3pm snacks then placed snack cart in nurses' station while answered call lights & provided cares to residents at 3:30 SS started passing snacks until received request from other staff then adm staff began passing scheduled 3pm snacks to res; nsg schedules revealed 1 CNA & 1 licensed nurse on duty from 6-7am, 2-4pm, 9-10pm & 10pm-6am; res council minute notes revealed res with concern about meals not served on time & only 1 staff member available to serve evening meals for multiple months; resident with concern nurse aides too rushed in providing cares & prolonged call light responses & meal tray left in room all day; res stated no enough staff to address res' needs & prolonged call light responses; staff reported difficulty when working with 1 CNA r/t 2-assist cares in facility; failed to provide sufficient staff

W: SS=F: Failed to provide sufficient nsg staff to attain/maintain highest practicable physical, mental & psychosocial well-being of each resident

- Res reported waiting long time during noc for toileting help; res stated "it takes forever for someone to answer my call light" & facility without enough staffing on most weekends; res reported no one around at noc; res reported not enough staff during meal times; family member reported lack of enough staff especially on weekends; res reported wait long time to answer call light; res reported not enough staff especially at noc; staff reported did not complete cares due to lack of staffing; licensed staff reported lacked time to monitor direct care staff's techniques or assist direct care staff with res care due to time constraints & agency staff not trained about individualized res care; staffing schedules revealed agency staff 25-75% of time; res council minutes revealed res commented about lack of sufficient staffing
- Referenced: F314, F315, F323

F362 Sufficient Dietary Support Personnel

SC: SS=F: Failed to have sufficient staff to carry out functions of serving meals in a timely manner to residents eating meals served from kitchen

- Observed noon meal available 11:30-1:30; observed res at table waiting prolonged period of time to be served & res not served at same time; failed to have sufficient staff to carry out functions of serving meals in timely manner

F363 Menus Meet Res Needs/Prep in Advance/Followed

SE: SS=E: Failed to follow menu for res on pureed diets & gluten free diet

- Observed prep of pureed diets & staff failed to follow recipe for multiple pureed foods
- Res with gluten free diet order; menu called for gluten free bread, but not served & staff denied knowing what gluten free was

NC: SS=F: Failed to follow prepared menu developed by consultant RD

- Menu called for breaded fish, pasta, brussels spouts, dinner roll & fruit & observed served chicken fried steak, green bean casserole, baked apples & sliced bread; menu different on multiple days from what was served; staff reported meals substituted because kitchen getting ready for spring/summer menus & using what food items were available in kitchen; failed to serve meals to residents consistent with planned menu prepared by consultant RD

F364 Nutritive Value/Appear, Palatable/Prefer Temp

NC: SS=D: Failed to serve food at proper temps

- Observed staff serve room tray & temp of room tray revealed fried chicken at 138 degrees & staff started to leave room when surveyor requested meal be reheated then staff took food tray to kitchen & reheated then brought food tray back with chicken at 168 degrees
- Observed glass of milk in DR on table for breakfast meal at 7:45am; res arrived at table at 8:05am & surveyor requested temp check of milk with temp of 42 degrees & surveyor requested milk removed & replaced

F366 Substitutes of Similar Nutritive Value

SE: SS=D: Failed to offer choices of food substitutes to multiple residents dining in assisted DR

- Observed res seated around tables in assisted DR & staff sat beside residents; res in assisted DR were all served same food items & multiple res indicated did not like foods offered & staff failed to offer or provide residents with alternatives to refused food items on multiple occasions & staff stated did not know what foods res liked to eat;

F368 Frequency of Meals/Snacks at Bedtime

W; SS=E: Failed to offer snacks at bedtime daily to residents living on main nursing unit

- Menus approved by RD revealed res should receive bedtime snacks daily; "Snack Book" revealed staff failed to offer bedtime snacks on multiple days on multiple units; resident stated staff failed to consistently provide snacks in evening & had to remind staff needed more juice & snacks passed in "hit and miss" manner;

F371 Food Procure, Store/Prepare/Serve-Sanitary

NC: SS=F: Failed to prepare, distribute & serve food under sanitary conditions & keep equipment maintained in a safe operating condition

- Observed unlabeled foods in fridge, hotdogs with ice attached & stuck together; coffee maker with puddle of brown liquid under spigot on floor; cabinet with corner black & soft when touched under coffee pot; area around dishwasher buckled, cracked & missing; back splash behind counter loose & pulling away from wall; countertops cracked & multiple areas with missing formica; floor tiles cracked/broken; soffit above cupboards with ragged edges
- Observed multiple staff with hair covering with hair hanging out
- Observed plate cover with piece broken off side; tape on serving tray with name written on it with another piece of tape with another name
- Observed chest freezer with ice build-up on all sides; observed brown, greasy substance caked on back splash by stove
- Observed trash cans in kitchen without lids
- Observed staff scoop ice using ice scoop from ice machine place ice scoop inside res' cup then poured ice back into contaminated ice machine
- Observed staff handle res' glasses of fluids with ungloved hands & fingers touching rim of glass then handles same res' cup with ungloved hands & fingers touching rim of coffee cup

NE: SS=F: Failed to store, prepare, distribute & serve food under sanitary conditions

- Observed freezer with foods with expired dated & foods with freezer burn & bags sticky
- Observed temp of wash cycle for dishwasher at 150 degrees & 180 degrees for rinse cycle & staff reported dish machine not checked daily for sanitation concentration; observed staff wore gloves to dip rag into disinfecting solution & wiped stove & with same gloves scooped potatoes from one pan to another; observed staff coughed & yawned at table without covering mouth while feeding residents
- Observed staff changed gloves multiple times & left dirty gloves sitting on table between self & a resident eating at table
- Observed staff removed gloves, pushed open a trash can lid & did not wash hands after coming in contact with dirty flap of trash can & picked up bowl & poured boiled potatoes into large blender, turned on blender, took dirty dishes to sink then washed hands & donned gloves; observed staff touch face with gloved hand, removed gloves & did not wash hands before donning clean gloves; observed staff drop plastic bag on floor & then placed bag on res' serving tray; observed staff wore gloves to feed res, used gloved hand to wipe res' hair out of face & continued to feed resident

W: SS=E: Failed to store, prepare & distribute food within main kitchen area under sanitary conditions when staff failed to serve food to res during meal service in sanitary manner & failed to take temps of all food items prior to meal service

- Observed staff touch multiple food items then reached into bag of buns without using tongs or changing gloves; touched box on floor with trash before handling food products; went to DR then returned drinking from cup & failed to wash hands then touched cooked meat with bare hands while placing meat on bun; touched utensil drawer, microwave then used contaminated gloves & touched food item
- Observed staff failed to take temps of foods on steam table prior to serving residents including pureed foods; review of temp log book revealed incomplete documentation of food temps on multiple occasions

SC: SS=F: Failed to store food in sanitary manner by having unmarked undated foods in fridge, freezer & dry storage room; staff failed to wear hairnets while handling dishes & serving food in kitchen; failed to replace DR light bulbs; failed to supervise & prevent res from pouring artificial sweetener from res' spoon & tablecloth into container of sugar

- Observed maintenance staff change light bulb in DR while multiple res remained in DR eating meal in area where staff changed light bulb
- Observed staff assist 2 res with meal & 3rd res opened artificial sweetener & poured on spoon & spilled some on tablecloth then res reached sugar container & removed lid & dumped all sweetener from spoon into sugar then place sugar container back on table
- Observed undated thawed health shakes & magic cups; freezer with opened bags of multiple food items; dry storage room with opened bags on food items all undated
- Observed staff with ball cap on & hair stuck out on sides & under cap in back with nothing to contain hair, then after prompting put on hairnet but neither hair net or ball cap contained all hair
- Observed staff clear DR tables of dishes & without hairnet

SE: SS=F: Failed to store, prepare, distribute & serve food under sanitary conditions in kitchen

- Observed dietary delivery carts transporting food with 2 sides open to air & individual plates & glasses for res were not covered
- Observed staff handle salad & dessert plates with thumbs over edge of plate when transferring from serving tray to table
- Hall trays with multiple foods not covered when taken from kitchen down hallway; res asked for assist & used ungloved hand to slice open piece of corn bread & apply margarine then failed to wash hands
- Observed meat items on counter thawing at room temp; open cereal boxes without dates & interior bag & box tops open to air; fridge with multiple open & partially used bottles of salad dressing without dates; staff with no covering on facial hair of beard & mustache; shelf with adhesive covering torn on edge of shelf; dish cart with bowls stored face down & food debris & dust on cart; spoons & ladles

with food particles on utensils & inside drawer; backsplash with splatters; cabinet with dried food particles on shelves with clean dishes stored face down on shelves; stacked trays & trays with dust & food particles; kitchen ceiling with light fixtures without covers & fixtures with covers with numerous small dead bugs; window with AC with dust on all vents, broken vent & missing vent; window with brown splatters; cabinets with chips in paint; wall corners with chipped paint & plaster; doors with gouges & chipped/splintered wood

- Outside food storage building with dust & unfinished walls & concrete floors; building with unused rusty industrial machines, lawn mower & maintenance items & hazardous waste container adjacent to freezer; exposed rafters with multiple wasp nests; 1 freezer not operational & unplugged with visible layer of dust covering freezer; another freezer with multiple meat items with dust covering freezer & biohazard container in front of freezer; another freezer with food items with rust & dust; another freezer with food items with dust; observed staff remove food items from outside building & placed food items on top of another dusty freezer while closed/locked freezer then brought food items to kitchen & placed foods on food prep counter
- Fridge with night snacks in hot water boiler room off DR

NE: SS=F: Failed to utilize precautions to minimize transmission of infection; failed to transport clean laundry in sanitary manner

- Observed housekeeping/laundry staff transporting clean linens in cart uncovered
- Observed housekeeping/laundry staff wore gloves to clean res' room; label of sanitizer lacked information about specific organisms effective with or contact time; staff unaware of contact time for products used to clean rooms & unaware of how to clean isolation room

W: SS=E: Failed to prepare & serve food in sanitary manner during preparation of pureed foods & while taking food temps which affected multiple residents including residents who received pureed diet

- Observed staff wore gloves while preparing pureed food & touched controls with food spillage, touched outside of food processor lid with contaminated gloved hand while blending meat then used clean spatula to place blended meat into bowl, covered item & placed in oven, placed food processor in dishwasher, removed gloves, washed hands & put on new gloves
- Observed staff contaminate gloves by touching dishwasher handle then placed food into clean food processor, touched bread with contaminated glove then placed bread into processor & while blending touched inside of processor lid with contaminated glove, used clean spatula to place food item in bowl, covered item & placed in oven
- Observed staff use alcohol wipe to clean thermometer & placed thermometer into meat item on steam table then used same alcohol wipe to clean thermometer & placed thermometer into another food item; hen used same alcohol wipe to clean thermometer to check multiple other food items

NC: SS=E: Failed to serve food & drinks under sanitary conditions to residents

- Observed staff remove plastic covers off assorted beverages & handled glasses by drinking surface as placed drinks on tables
- Observed staff placed hands under shirt & adjusted front of pants then walked to beverage area, rubbed face with both hands & handled/served res' drinks without washing hands

NC: SS=D: Failed to serve res' food under sanitary conditions

- Observed nsg staff with ungloved hands place cookie on napkin; observed nsg staff scratch head & inside of ear with hand then rubbed eyes, then picked up garlic bread with hand & placed in res' mouth then placed hand inside shirt & scratched chest close to underarm then picked up res' spoon with hand & assisted res with meal

SE: SS=F: Failed to store, prepare & serve food under sanitary conditions

- Observed fridge with outdated foods; top of snack cart with Ensure not stored on ice with temp of 47.8 degrees; cabinets in DR with glass cover & glass with layer of grime & multiple scuff marks & counter top missing area; plastic tubs in dry storage area with grime on outside & handles & lip of lid with grime; kitchen island with layer of food particles; counter lacked laminate

W: SS=E: Failed to store & serve food under sanitary conditions when staff failed to wear hair coverings during food service & failed to properly obtain temps for cold foods prior to meal service

- Observed staff in kitchenette area without hair coverings while dietary staff served food to res from steam table
- Observed staff checked temp inside fridge which registered as 48 degrees then wrote 48 on log for temp of milk, dessert & salad; verified each food should be checked at cold foods should be colder than 41 degrees

SE: SS=F: Failed to store, prepare & distribute food under sanitary conditions

- Observed plastic lids of sugar & flour with dried food particles; frozen meat submerged in sink with cold standing water covering to thaw; plastic pitcher on top of snack cart with label of "protein milk" & pitcher lacked any cooling agent on multiple occasions with temp of 62, 61.6 degrees; staff hair not secured with hair net or other type of hair covering; cooking skillets, baking sheets with accumulation of dark substance on inside of pans

SC: SS=E: Failed to prepare, serve & store food under sanitary conditions by handling of utensils & silverware & proper cleaning of thermometer while taking temps of pureed foods; failed to label thickened juice & discard it by use date

- Observed staff pick up scoop spoon from rolling island that contained various food items & other kitchen items on it then used spoon to serve carrots to res during meal; staff went to black cart with mixed silverware laying on shelf & sifted thru silverware with bare hands touching eating surfaces of silverware to give to res then set a place at a table for res & silverware was placed on bare table with no napkin to sit silverware on & staff did not wash hands prior to handling utensils
- Observed staff place entrée into blender & pureed food item then picked up spatula from another counter & mixed mixture & while mixing lid lay on counter with counter contacting food surfaces then lid placed back on blender; Observed staff scooped entrée into plate

& took blender to dish washing area & rinsed container & ran it through dishwashing cycle then pureed other food in blender then retrieved thermometer, wiped thermometer on rag laying on back of counter then placed thermometer into food item then placed food item in microwave to be reheated then re-wiped thermometer with same rag & temped food item; failed to prepare & serve food under sanitary conditions by proper handling of utensils, silverware & proper cleaning of thermometer while taking temps of pureed foods

- Observed bottles of Thick & Easy without open dates in fridge; failed to properly label opened food items with opening date

SC: SS=E: Failed to ensure staff washed hands prior to serving room trays & touching drinking surface of res' straw

- Observed direct care staff assist res with peri-care removed gloves & offered res a drink of water but reported res' mouth so dry needed to moisten it first so staff who had not washed hands after providing peri-care picked up res' straw, capped top off & drizzled it into res' mouth then stuck straw in res' mouth for res to drink; then staff left room with bag of trash containing soiled incontinence product, put it into soiled utility room trash & did not wash hands then started passing res meal trays for res who ate in rooms, grasped cups by inside & outside of drinking surface & gave to residents

F411 Routine/Emergency Dental Services in SNFs

NC: SS=D: Failed to promptly obtain dental services for resident

- MDS revealed res with no dental problems with therapeutic diet; observed res without bottom dentures in mouth; SS stated res had mentioned would like lower dentures replaced & no documentation of statements; failed to provide or obtain from outside source dental services to meet needs for res whose loose bottom dentures unusable

F412 Routine/Emergency Dental Services in NFs

SC: SS=D: Failed to provide from an outside source routine & emergency dental services

- Res with extensive assist with hygiene without MDS dental issues; CP failed to ID dental isssues; SS notes revealed consent mailed to resp party for dental services without any follow-up as to if resp party responded to request for consent; assessment revealed res with lost teeth without dentures; observed res with missing front teeth on bottom & numerous discolored carious teeth on top; res stated teeth were rotting & falling out; failed to provide routine & emergency dental svcs to meet needs of resident

F425 Pharmaceutical Svc-Accurate Procedures, RPh

NE: SS=E: Failed to clarify incomplete med orders for multiple residents & failed to observe res take meds

- MARs lacked route for administration of multiple meds for multiple residents; MAR indicated antipsychotic held due to "unavailability of med" without physician order to hold medication; failed to complete med orders & failed to obtain an order to hold scheduled meds
- Observed staff enter room to administer meds & staff left room without observing if res took med
- Failed to have complete med orders with a route of medication administration

W: SS=D: Failed to ensure accurate administration of all drugs (failed to administer Vitamin B12 injection due to unavailability)

- Res with phys order for Vitamin B12; MAR lacked evidence staff administered injection from 2-5 to 2-28 with documentation that drug "not available"

SC: SS=D: Failed to ensure all meds administered via enteral tube were administered according to facility policy

- Physician order for meds to be administered per G-tube without order that meds could be mixed together administered as a cocktail via enteral tube; observed staff crush all meds together, pour them into small med cup then added water to cup then checked for placement of enteral tube then took spoon & stirred crushed meds in cup with water, poured unmeasured amount of water in tube & allowed it to drain into res' stomach via gravity flow then poured dissolved meds into tube & flushed with water then poured can of liquid nutritional supplement in tube & allowed to flow via gravity

NE: SS=D: Failed to clarify unclear physician's order & administer med correctly

- Observed staff apply gloves & administer topical Voltaren gel; MAR read: "Voltaren 1% gel, apply 1 topically QID for pain"; staff stated knew how much gel to apply from being trained & acknowledged MAR did not accurately tell staff how much med to apply; failed to clarify unclear order & administer med correctly

SC: SS=F: Failed to ensure safe storage of stock meds & med on med & tx carts

- Observed staff closed med cart & went to res' room & left med cart unlocked & accessible to residents
- Observed staff walked out from a res' room & turned tx cart around so front of cart faced wall & cart unlocked & accessible
- Observed med cart outside res room with keys on top of cart
- Observed staff draw up insulin & left vials on top of cart & left cart unattended

F428 Drug Regimen Review, Report Irregularities, Act On

W: SS=D: Failed to ensure consultant pharmacist reported any drug irregularities to attending physician & DON related to behavior monitoring for resident that received psychotropic meds

- Noted findings cited in F329; DRR with no mention of irregularities r/t behavior monitoring with use of psychotropic meds

SE: SS=D: Failed to ensure BP monitoring & lack of bowel movement monitoring

- Cited findings noted in F329; consultant pharmacist reported "miss some things sometimes"

SC: SS=E: Failed to provide pharmaceutical services that IDd irregularities r/t behavior monitoring for multiple residents

- Cited finding noted in F329; pharmacist reported did not hunt for behavior monitoring sheets because "half the time they are not completed properly"

NC: SS=D: Pharmacy consultant failed to ID & report drug irregularities r/t monitoring res' blood sugars & drug irregularities with administratin of insulin

- Cited findings in F329

W: SS=E: Failed to ensure consultant pharmacist IDd drug irregularities & reported irregularities to attending physician & DON r/t meds with BBWs

- Cited findings in F329

SE: SS=D: Consultant pharmacist failed to ID & recommend to facility for physician notification lack of behavioral monitoring & lack of blood sugar monitoring r/t to administration of sliding scale insulin

- Cited findings in F329

NE: SS=D: Pharmacy consultant failed to ID med irregularities for multiple res

- Cited findings in F329

SC: SS=E: Pharmacist failed to ID irregularities of DRR r/t monitoring of specific targeted behaviors for meds ordered, lack of a GDR & failure of staff to attempt non-pharmacologic interventions prior to giving PRN meds for behavior mgmt.

- Cited findings in F329

F431 Drug Records, Label/Store Drugs & Biologicals

NC: SS=D: Failed to ensure correct labels were affixed to med cards during observation of med pass

- Observed staff administer hs meds at 5:36pm; order for med BID at 8am & 6pm; label on med card did not match MAR; label not changed after physician changed order from daily to BID
- Observed multiple syringes in fridge with clear liquid & barrel of syringe marked with black marker with first names of residents; staff reported insulin had been drawn up in AM & placed in fridge for administration to residents at noon

W: SS=D: Failed to store meds at safe temp (Calccitonin Nasal Spray stored in freezer labeled "do not freeze")

- Observed med room fridge with temp of 26 degrees F with Calcitonin Nasal Solution in freezer section; med remained unopened & contents did not appear to be crystallized; instructions included store 36-46 degrees & freezing should be avoided; temp logs revealed staff documented temps ranging from 24-30 degrees in fridge

SE: SS=E: Failed to ensure staff did not administer expired insulin to multiple residents

- Observed vials of insulin with expired open dates on multiple occasions; staff reported that consultant pharmacist had indicated Novolog insulin does not expire if kept refrigerated & provided noted from consulting pharmacist indicating "Lantus insulin good for 28 days after opening & any other insulin was good as long as refrigerated until gone"; facility's policy revealed Lantus & Humalog good for 28 days after opening & humulin & Novolog good for 30 days after opening; pharmacist stated lantus expired in 28 days & did not recall how long Novolog retained potency; Manufacturer indicated Novolog opened or unopened expired after 28 days & Lantus expired 28 days after opened

SC: SS=E: Failed to properly label & store insulin

- Observed fridge with insulin with expired dated & undated insulin vials; observed insulin pen with date written onto line for "expired date" & nurse reported someone had just written date on wrong line; observed insulin pen without an open date; observed insulin pen at room temp & staff unaware of when out of fridge but reported not in use

NE: SS=D: Failed to dispose of expired meds

- Observed prefilled syringes of heparin flush with expired date

NC: SS=D: Failed to ensure appropriate labeling of expiration dates for insulin pens for multiple residents

- Observed opened & unlabeled novolog insulin flex pen with no date on pen; multiple opened & undated levimir insulin flex pen

NC: SS=D: Failed to ensure appropriate labeling of insulin pens

- Observed multiple undated opened insulin pens

SE: SS=E: Failed to maintain clean & sanitary conditions in med rooms

- Observed bottom of fridge door drug floor when opened & freezer with build-up of ice & fridge & freezer without thermometer & fridge temp measured 45 degrees; inside fridge door with colored sticky substance & unlabeled drinks & bottom with food particles; laminate in front of sink with missing, peeling laminate

W: SS=E: Failed to store meds at safe temperature & remove expired drugs from circulation

- Observed stock vitamins expired; observed fridge with temp of 34 degrees
- Observed fridge logs with missing values on multiple days in multiple areas

SC: SS=E: Failed to establish a system to ensure that expired meds were removed & disposed of after expiration

- Observed multiple outdated meds & treatment ointments; observed cream & earwax removal drops with no res label
- Observed insulin with outdated discard date; staff unaware of how often or who checks med carts for expired meds

F441 Infection Control, Prevent Spread, Linens

NC: SS=E: Failed to provide a safe, sanitary environment to help prevent development & transmission of disease & infection

- Observed 3 boxes of elbow protectors with floor storage
- Observed housekeeping staff spray sink with disinfectant then immediately wipe sink, sprayed toilet seat with disinfectant then immediately wipe sink, poured toilet bowl cleaner into toilet bowl, let it set for 4 minutes, scrubbed toilet then flushed toilet; manufacturer recommendations for disinfectant required minimum of 10 minute wet time & toilet bowl cleanser to remain 10 minutes before flushing toilet; staff unaware of recommendations or how to clean a room with C-diff

NC: SS=E: Failed to provide safe, sanitary & comfortable environment to prevent disease & infection & to implement IC measures for diabetic residents using facility's glucometer

- Observed housekeeping staff clean res' rooms immediately wiping fixtures without drying time per recommendations of wet time of 10 minutes
- Observed staff perform blood glucose & nurse failed to use any disinfectant to clean glucometer before, during or after obtaining blood glucose for multiple residents & staff failed to perform hand hygiene & wear gloves during accucheck

NE: SS=D: Failed to wash hands & failed to disinfect surfaces in res room according to manufacturer's guidelines

- Observed housekeeping staff place trash bag on floor prior to placing on housekeeping cart; staff failed to change gloves & wash hands between soiled & clean surfaces; failed to allow recommended wet time; staff reported rooms only spot cleaned r/t short staffed; staff unaware spray had to remain wet on surfaces for 10 minutes; staff did not wash hands after handling commode bucket

W: SS=F: Failed to wash hands after removing contaminated gloves & demonstrate proper hand hygiene with use of gloves as indicated by accepted professional standards; failed to ensure adequate sanitation of res rooms; failed to establish an infection control program that investigated, controlled & prevented infections

- Observed staff cleaned peri area & applied barrier cream & did not change gloves after peri care provided then touched res' clothing & other objects; staff failed to perform hand hygiene before exiting room
- Observed staff wash hands then touched inside of sink with hands 3 times before getting a towel & did not re-wash hands after touching inside of contaminated sink
- Observed staff provide peri care & removed soiled pad with gloved hands then obtained package of wipes, cleaned peri area & applied barrier ointment with contaminated gloves then removed gloves & applied new pair of gloves but failed to wash hands before applying new gloves
- Observed housekeeping staff spray bowl cleaner & cleaned toilet immediately after spraying cleaner in toilet; manufacturer recommendations for bowl cleaner to have contact time for 10 mintues
- Staff revealed facility does not track or trend outbreak of scabies due to not knowing when original start date was & scabies affected 4 residents & no investigation done to determine cause of scabies

SE: SS=E: Failed to maintain an ongoing infection control program to prevent cross contamination & spread of infection from res with IDd C-diff

- Observed housekeeping staff clean res with C-diff room; staff swept floor, used dust pan to pick up trash then returned dust pan & broom directly on cart, then mopped room without using Dispatch cleaner; staff sprayed cleaner on cloth & cleansed room & BR door handles before staff emptied trash cans then wiped inside/outside of trash cans with wet cloths then wiped part of mattress that showed around overlay & side rails with different cloths sprayed with cleaner; staff cleaned inside of toilet bowl without cleanser & placed brush in holder directly back to cart holder

SE: SS=F: Failed to develop, implement & maintain infection control program to prevent spread of infection within facility

- Observed nurse administer Albuterol nebulizer & after completed staff rinsed chamber & mouth piece in BR sink & returned to res' storage area but mouth piece dropped onto res' recliner then between O2 concentrator & staff re-rinsed mouthpiece & attached all pieces; with water dripping from vent tube & without drying, placed nebulizer pieces into plastic bag hanging from bedside table; policy instructed staff to allowed pieces to air dry after washing
- Observed housekeeping carts with no bleach containing products on cart; staff revealed would clean C-diff room with bleach solution but unaware of concentration
- Monthly infection control log failed to document culture results, nosocomial status & trends of infections in facility; no analysis of logs other than specific infection data & culture result not reviewed & did not trend infection for facility

NE: SS=F: Failed to track & trend infections

- IC reports lacked information to track & trend infections; failed to have complete IC program that trended all infections in facility
- Observed housekeeping staff mopped floor & floor dried in 4 minutes; manufacturer recommendations with wet time of 10 minutes

W: SS=F: Failed to properly sanitize res' rooms

- Observed housekeeping staff flush toilet & wiped toilet brush around inside of bowl, under side of seat & toilet itself then poured small amt of cleanser in bowl & used toilet brush to clean immediately then took damp rag & cleaned under toilet rim then top then placed dirty rag in trash sack on cart & flushed toilet; label revealed wet time of 10 minutes for disinfectant

NC: SS=D: Failed to follow acceptable standards of infection control practices r/t handling & storage of equipment for nebulizer tx's or oxygen use

- Observed oxygen tubing with nasal cannula not bagged & draped over O2 concentrator on multiple occasions Observed nurse administer aerosol tx per nebulizer then transported un-bagged reusable nebulizer equipment to med room, rinsed equipment with water & placed it on paper towel to dry

NC: SS=E: Failed to establish & maintain an IC program designed to provide a safe, sanitary & comfortable environment & to help prevent development & transmission of disease & infection

- Observed oxygen tubing & nasal cannula lying on floor in res' room on multiple occasions; housekeeping staff unaware of what C-difficile infection was or if staff cleaned room differently; housekeeping supervisor unaware of what C-diff was & unable to remember when facility had any training r/t infection control practices for facility; adm staff stated did not track infection in facility; IC record indicated last tracking of infection surveillance report was 9-13;
- Observed nsg staff don clean gloves & perform personal hygiene on res, pulled res' pants up & transferred res to recliner with soiled gloves
- Observed soiled wash cloth with brown colored substance on it & staff washed res' face & eyes with soiled washcloth & washcloth used was other resident in room's washcloth

W: SS=F: Failed to track location infections were acquired; failed to ascertain effectiveness of antibiotics used; failed to provide appropriate infection control practices during wound care

- Infection Control log lacked tracking of where infection was acquired & if antibiotics used were effective
- Observed nurse place contaminated gloves on res' dresser/TV stand & on bedside tray table & after dressing completed, picked up gloves & placed soiled gloves in trash then washed hands then failed to disinfect bedside table & dresser/TV stand before leaving room

NE: SS=F: Failed to maintain ongoing IC r/t cleaning res' rooms & handwashing in multiple areas

- Observed sign at elevator informing visitors to limit visits r/t facility experiencing GI flu; observed staff enter res' room of res with GI symptoms, removed items, entered DR, visiting with other employee without washing hands before entering res' room or after depositing retrieved item from room
- Observed housekeeping staff don gloves & cleaned sink & outer surface of toilet with cleaner that indicated without germicidal properties; after changing gloves staff wiped down all surfaced in room with unlabeled product which was determined not to have germicidal properties; housekeeper stated did not change cleaning agents when GI outbreak occurred

SE: SS=E: Failed to maintain a IC program to prevent spread of infection to residents

- Observed shoes in seat of w/c with soles down & no w/c pedals in place on w/c then res seated in w/c with shoes directly on floor; observed res incontinent wetness in w/c & staff failed to provide services to disinfect w/c seat but wiped seat with peri wipes; licensed & housekeeping staff failed to verify isolation requirements for res with c-diff

SC: SS=E: Failed to ensure proper hand-washing after glove usage, ensure removal on contaminated gloves to prevent spread of infection during dressing change, keep urinary catheter bag off floor & disinfect areas where urine had dripped or spilled

- Observed staff assist res with peri-care, put on clean gloves, removed a clean wipe & used hand to wipe res then contaminated other hand by transferring soiled wipe to left hand to throw away & after staff wiped res with rt hand, asked res to grab hand so res could assist with rolling over in bed then assisted res to roll onto side then assisted with peri-care by using rt hand then moved items around in room then removed glove & continued to assist with peri-care; staff continued to have soiled gloves on during entire process & did not remove them until after staff put new incontinence brief on resident, then offered water & drizzled water with straw
- Observed res with catheter bag laying partially on floor on multiple occasions; & cath bag fell onto floor
- Observed staff enter room & stepped in puddle of urine as catheter bag leaked onto floor & staff did not clean bottom of shoes after stepping in urine before leaving room & walking to other areas of facility then set graduated cylinder down in puddle of urine then emptied catheter bag & did not use alcohol swabs before or after opening drainage port on catheter bag then staff touched items in room with same gloved hands as when emptied catheter bag; staff removed gloves after wiping up urine with paper towels & applied new gloves without washing hands & flicked urine onto gloves & res' sheets during process
- Observed dressing change & failed to appropriately change gloves & wash hands then placed contaminated pen back into uniform pocket

F463 Resident Call System-Rooms/Toilet/Bath

SC: SS=E: Failed to ensure call light system functioned in a manner to allow residents to signal nsg staff of need for assistance

- Observed red emergency call light failed to work for all call lights tested; 1 bedside call light failed to function when pushed; 2 call lights broken at push button area failed to function

NE: SS=D: Failed to ensure functioning call light system

- Observed call light did not light in hallway or on panel in 1 room

NE: SS=E: Failed to ensure functioning call light system for multiple beds & BRs on multiple halls

- Observed call system did not light on panel &/or did not activate; BRs lacked pull cord to activate call light; call light log lacked evidence of what portion system or which call lights were checked

F464 Requirements for Dining & Activity Rooms

SE: SS=D: Failed to ensure sufficient space to accommodate res needs in assisted dining area

- Observed staff brought dependent res into dining area then brought another res into DR & moved first res to accommodate newly arrived second res up to table; third res brought into DR & res sat in middle of DR while staff propelled 2nd res up to table; after 2nd & 3rd res positioned, 1st res replaced back at original table space; observed inadequate space in assisted area DR

NC: SS=D: Failed to provide sufficient space in DR to accommodate res' needs at meals

- Observed res seated in DR & staff wheeled other res into DR & interrupted res, requiring res to stand up & move chair so other res could get to table then another res entered with walker & oxygen concentrator & again interrupted res from meal requiring res to stand up & move chair so other res could get to table

F465 Safe/Functional/Sanitary/Comfortable Environment

SE: SS=E: Failed to maintain a clean & sanitary environment in kitchen areas

- Observed dishwasher side of kitchen with missing paint in large areas; floor tiles in main kitchen heavily soiled with discolored build-up areas under kitchen equipment items & around legs of equipment; wall behind & under dishwasher with soiled floor tiles with colored splatters & build-up of various substances; wall tiles above dishwasher with tiles with black substance within grout lines; kitchen area lacked any ID of daily cleaning of areas

SE: SS=C: Failed to provide maintenance services to multiple dryers in facility

- Observed outside of 3 dryers with multiple areas of rust & peeling paint

SE: SS=E: Failed to maintain a functional & sanitary environment in kitchen area

- Observed kitchen floor with multiple areas of marred, discolored, & soiled areas on tile

SE: SS=D: Failed to provide maintenance services in soiled/clean utility rooms

- Observed soiled utility room with counter top with caulking loose from counter hung on wall; inside of door frame by latch with cracks; scrape on door frame with gouges; discoloration of drain & faucet base & handles with white discoloration build-up

F467 Adequate Outside Ventilation-Window/Mechanic

SE: SS=E: Failed to provide adequate ventilation in beauty shop

- Observed beauty shop lacked any type of outside ventilation; staff revealed had been informed of requirement last year but beauty shop had never had outside ventilation & has not had a problem

F514 Res Records-Complete/Accurate/Accessible

NE: SS=D: Failed to document in medical record incident of elopement for res who left without authorization

- Record lacked documentation of res leaving facility unsupervised

F520 QAA Committee=Members/Meet Quarterly/Plans

SC: SS=F: Failed to utilized QAA program to ID & develop an effective correction plan for quality deficiencies

- Referenced: F241, F272, F280, F281, F371, F364, F309, F323, F329, F428, F425, F463

SE: SS=C: Failed to maintain a quality assessment & assurance committee which included a physician designated by facility

- Review of quarterly committee members sign in sheets for QA failed to include a physician's attendance

NE: SS=F: Failed to have a QAA Committee that IDd issues that required plans of action

- Adm stated QAA did not address elopements & door alarms because no concerns IDd
- Referenced: F157, F225, F280, F323, F329, F514, S1116

W: SS=F: Failed to ensure QAA committee developed & implemented appropriate plans of action to correct IDd quality deficiencies

- Referenced: F280, F314, F323, F371, F441

SC: SS=F: Failed to develop & implement an effective system to ensure that action plans were developed through QAA program to address concerns IDd in survey findings

- Referenced: F156, F250, F272, F278, F280, F309, F312, F323, F329, F353, F371, F412, F428, F431, multiple state tag

SC: SS=F: Failed to have an effective QAA program to ID & correct quality deficiencies

- Referenced: F159, F164, F170, F174, F225, F248, F280, F309, F312, F315, F323, F332, F425, F441

S600 Dietary Services

NE: SS=F: Failed to have a CDM during survey

- Staff stated did not have CDM yet

S1116 Bathing Room

NE: SS=E: Failed to have enough bathing units for res of facility

- Observed facility with 2 bathing units & neither had hydrotherapy (W/P); 6 resident with access to showers directly from room; staff reported W/P did not function & facility removed unit during current month; facility without bathing units at rate of 1:15

S1166 Nursing Facility Support System

W: SS=E: Failed to have an emergency call system that produced a differentiating sound or bulb to show an emergent call light

- Observed call lights failed to have a differentiating sound or bulb designating a regular versus an emergent call light in one area; staff unaware call lights needed a differential noise or light

SC: SS=F: Failed to have an emergency call system that differentiated between non-emergent & emergent care areas & failed to have a policy to ensure all calls activated from an emergency location received a higher response

- Failed to have a call light system that distinguished between emergent & non-emergent locations & failed to have a policy to ensure calls activated from an emergency location received a high priority response from staff

S1172 Nursing Facility Support System

SC: SS=F: Failed to have a preventative maintenance program for call light system to include weekly testing of system

- Failed to test call light system weekly

SC: SS=F: Failed to have a preventative maintenance program to check call lights weekly

- Failed to check call lights weekly

S1173 Nursing Facility Support System

SC: SS=F: Failed to have an emergency call button within resident reach next to each shower or bathtub

- Failed to have an emergency pull cord within res reach next to each shower or bathtub area

S1174 Door Monitoring System

SE: SS=C: Failed to electronically activate exterior doors to enclosed courtyard

- Observed patio doors failed to produce an audible alarm when opened even though key pad had red light on key pad to indicate alarm activated on multiple occasions

NE: SS=F: Failed to monitor exit doors

- Observed front door not monitored by facility staff & door unlocked & when opened did not alarm

SC: SS=E: Failed to ensure an interior door that opened to another type of adult care home, whose exterior doors were not all monitored, alarmed when opened

- Failed to ensure adequate monitoring & alarming of interior door leading from LTC facility to AL facility with an unmonitored door in adjoining hallway

SC: SS=E: Failed to ensure an exterior door alarmed when opened

- Failed to ensure exterior door remained alarmed at all times

S1176 Door Monitoring System

SC: SS=F: Failed to have a door monitor system that remained activated until facility staff manually reset the monitor/alarm

- Observed all exit door monitors/alarms checked & 2 had a pull-tab alarm that was not functional & with a secondary alarm but it automatically shut off after 1 ½ minutes

S1354 Heating, Ventilation & AC

SC: SS=E: Failed to utilize adequate ventilation through exhaust fan in beauty shop

- Observed exhaust fan in beauty shop was not operational & lacked suction as it would not hold tissue to cover

SC: SS=E: Failed to utilize adequate ventilation through exhaust fan in beauty shop while res received services

- Failed to ensure staff used ventilation fan in beauty shop to ensure adequate ventilation & protect res from chemical odors

S1364 Electrical Requirements

SC: SS=D: Failed to maintain hydroculator on a ground fault circuit interrupter

- Observed hydroculator in therapy dept & cord not plugged into GFCI outlet