

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>LODI CREEK POST ACUTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>321 WEST TURNER ROAD LODI, CA 95240</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following reflects the AMENDED findings of the California Department of Public Health during a Federal Recertification survey.  The facility census was 81. The sample size was 20.	F 000	F000 Preparation and/or execution of this Plan of Correction, inclusive of pages 1 through 58, does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code Section 1280. In response to the Department's findings we submit the following Plan of Correction which shall constitute Lodi Creek Post-Acute's credible allegation of compliance.	<i>Anna-Marie De Jesus</i>	
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5)  §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:  §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.  §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.  §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of 20 sampled residents (Resident 11 and Resident 20) had an informed consent for the use of antipsychotic medications (drugs that mainly treat psychosis-related conditions and symptoms), when:	F 552	F552 483.10(c)(1)(4)(5) RIGHT TO BE INFORMED/MAKE TREATMENT DECISIONS  <u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</u>  On 9/6/2024, the attending physician was notified by the DON that informed consent needed to be obtained for Resident 11. The informed consent was received.  On 9/3/2024, the attending physician was notified by the DON that informed consent needed to be obtained for Resident 20. The informed consent was received.  <u>How the facility will identify other residents having the potential to be</u>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Christian F. Marchese*

9/27/2024

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

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F 552	<p>Continued From page 1</p> <p>1. Resident 11's antipsychotic informed consent was not updated every six months; and,</p> <p>2. Resident 20 had no informed consent for an antipsychotic.</p> <p>This failure decreased the facility's potential to ensure residents or their responsible person(s) were fully informed of the risks, benefits, and alternative treatment options prior to the use of an antipsychotic medication.</p> <p>Findings:</p> <p>A review of Resident 11's "Admission Record," indicated Resident 11 was admitted to the facility in 2021 with diagnoses including depression (a serious medical illness that negatively affects how you feel, the way you think and how you act) and bipolar disorder (a mental health condition that causes extreme mood swings). The record further indicated Resident 11's sister was the Responsible Party (RP, a person designed to make healthcare decisions for the resident).</p> <p>A review of Resident 11's "Order Summary Report," dated 9/5/24, indicated Resident 11 had orders for aripiprazole (antipsychotic medication) 15 milligrams (mg, a unit of measurement) by mouth one time a day for bipolar disorder. Resident 11 had buspirone (an antianxiety medication) 100 mg by mouth at bedtime and venlafaxine (a depression medication) extended release (cannot be crushed) 75 mg by mouth in the morning for crying spells.</p> <p>A review of Resident 11's "Verification of Informed Consent Physical Restraint &amp; Psychotropic Medications," dated 6/16/21, indicated Resident</p>	F 552	<p><u><i>affected by the same deficient practice and what corrective action will be taken;</i></u></p> <p>Residents on psychotropic medications may be potentially affected by the cited deficiency.</p> <p>The clinical records of residents receiving psychotropic medications were reviewed and audited by the DON and Medical Record Director (MRD) on 9/4/2024. Residents on psychotropic medications were checked for the presence of the documented evidence that an informed consent was obtained by the physician. Any additional findings were corrected.</p> <p><u><i>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</i></u></p> <p>Starting on 9/10/2024, the DON in serviced Licensed Nurses regarding the facility's Policy and Procedure entitled "Informed Consent" and AFL 24-07. The emphasis of the training will be on the following:</p> <ul style="list-style-type: none"> <li>The physician will obtain an informed consent from the patient or patient's responsible party before allowing the resident to make a decision to undergo a therapy/ treatment (to include psychotropic medication use).</li> </ul>		

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F 552	<p>Continued From page 2</p> <p>11 had informed consent for buspirone, aripiprazole, and venlafaxine in 6/16/21.</p> <p>During an interview on 9/6/24 at 10:42 a.m. with the Director of Nursing (DON), the DON was aware Resident 11's informed consents for the psychotropic medications were last obtained in 2021 and confirmed informed consents needed to be updated every six months.</p> <p>A review of the facility's policy titled, "Informed Consent," dated 6/2021, indicated, " ...Obtaining informed consent is the responsibility of the licensed healthcare practitioner acting within the scope of his/her professional licensure performs ..." The policy further stipulated, "The facility staff shall verify the resident or his/her surrogate has given informed consent ... prior to the initiation of psychotherapeutic drugs ..."</p> <p>A review of Resident 20's "Admission Record," indicated Resident 20 was admitted in October 2023 with diagnoses including dementia (a decline in cognitive abilities that affects a person's ability to think, remember, and perform daily activities), psychotic disturbance, and schizophrenia (serious mental illness that affects a person's thoughts, feelings, and behaviors).</p> <p>A review of Resident 20's Minimum Data Set (MDS; a tool used to assess the health status of residents in nursing homes), dated 6/19/24, indicated Resident's 20 Brief Interview on Mental Status (BIMS) score was four out of 15 with severe cognitive impairment.</p> <p>A review of Resident 20's "Physician's Order Summary Report," indicated on 12/8/23 Resident</p>	F 552	<ul style="list-style-type: none"> <li>The informed consent will include but not limited to the nature of the treatment, information concerning the risks, complications and expected benefits or effects of the treatment or, any alternatives and their risks and benefits, and the patients' rights to decline to consent.</li> <li>Upon procuring informed consent, the primary physician must document it in the patient's medical record.</li> <li>The LN will verify that the patient's clinical record contains documentation that the patient/ patients' responsible party has given informed consent for the proposed treatment.</li> <li>Informed consent is required to be renewed every six months.</li> </ul> <p>The DON, or designee, will review the psychotropic orders for all new admissions, any re-admissions, as well as any new orders for psychotropic medications to ensure the orders are complete per regulatory requirements.</p> <p>The Medical Record Director, or designee, will conduct a monthly audit, x 3 months, of the clinical record of residents on psychotropic medication for validation of documented evidence the prescribing physician received an informed consent. Findings will be submitted to the DON.</p> <p>During the monthly Behavior and Psychotropic Management Committee meeting, the assigned IDT members will</p>		

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F 552	<p>Continued From page 3</p> <p>20 was orderd half tablet, 25 mg of quetiapine fumarate (a medication used to treat certain mental/mood disorders) by mouth two times a day for schizophrenia manifested by paranoia (the irrational and persistent feeling that people are out to get you or that you are the subject of persistent, intrusive attention by others), striking out, auditory hallucinations (hearing voices) informed consent by medical doctor.</p> <p>A review of Resident 20's "Medication Administration Record," dated 8/24, indicated Resident 20 was receiving half tablet of quetiapine 25 mg by mouth two times a day for schizophrenia.</p> <p>A review of Resident 20's "MD progress notes," dated 8/26/24, indicated an informed consent for quetiapine was not completed.</p> <p>A review of Resident 20's "Psychiatric Visit Progress Report," indicated Resident 20 was seen by a psychiatrist on 5/10/23 and 8/11/23.</p> <p>A review of Resident 20's electronic record indicated there were no progress notes that indicated an informed consent had been obtained by the physician nor by the psychiatrist.</p> <p>During an interview on 9/4/24 at 3:30 p.m., with Licensed Nurse 5 (LN 5), LN 5 stated licensed nurses might not start residents on antipsychotic medications until the physician had obtained an informed consent from the resident or RP. LN 5 further stated the physican was in charge of explaining and obtaining the informed consent for the prescribed antipsychotic and the licensed nurse should have called or talked to the resident or the RP to ensure the discussion occurred with</p>	F 552	<p>review the clinical record of residents on psychotropic medication for documented evidence the prescribing physician received an informed consent. Findings will be reported to the DON.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;</u></p> <p>The DON, or designee, will monitor for compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.</p> <p><u>Date corrective action will be completed.</u></p>	10/4/2024	

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F 552	<p>Continued From page 4</p> <p>the prescriber on the new medication and if they agreed to the medication and once this was confirmed then the medication can be started as prescribed to the resident.</p> <p>During an interview on 9/4/24 at 4:25 p.m., with the DON, DON stated the practice in the facility was the physician who ordered the antipsychotic medication must obtain the informed consent from the resident or RP. The physician will then document the informed consent was obtained in the clinical record of the resident. The informed consent has to be verified by the licensed nurse and then the medication or treatment can begin. DON further stated in general nurses could not give the medication unless the informed consent was verified, or in case of an emergency the physician will be notified and the physician might approve for the medication to be given.</p> <p>During an interview on 9/4/24 at 10 a.m. with the DON, DON stated there was no informed consent completed from 12/8/2023 through 9/3/24 for Resident 20. DON confirmed Resident 20 was started on quetiapine since 12/8/2023 through 9/3/24 without a duly completed informed consent. DON further stated an informed consent should had been verified before the administration of any antipsychotic medication.</p> <p>During an interview on 9/4/24 with the Quality Services Consultant (QCS), QSC stated nurses could not begin an antipsychotic medication without an informed consent being obtained by the physician and residents must have an informed consent before beginning the antipsychotic medication unless it was an emergency. QSC further stated the expectations were licensed nurses must verify with the resident</p>	F 552			

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F 552	<p>Continued From page 5</p> <p>or the RP that an informed consent was discussed, and completed by the physician.</p> <p>A review of facility's policy and procedure titled, "Informed Consent," revised June 2021, indicated: "1. The facility shall ensure the resident's rights are maintained and a copy of these rights and pertinent policies are made available to the resident and to any representative of the resident. Among these rights under this section are the right to: a. Receive in advance all information that is material to a decision to accept or refuse treatment,.. Guidelines 2. The facility staff shall verify the resident or his/her surrogate has given informed consent to the proposed treatment or procedure prior to the initiation of psychotherapeutic drugs, antipsychotic drugs..."</p> <p>A review of an All Facilities Letter (AFL) 24-07 dated February 28, 2024 indicated: "...Effective January 1, 2024, AB (Assembly Bill) 48 codifies existing regulations that state residents have the right to be free of psychotherapeutic drugs...Examination and Signatures...Before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtain informed written consent signed by the resident or or the resident's representative along with, the signature of the health care professional declaring the required material has been provided...Medical records...The signed written consent must be recorded in the resident's medical record. Before initiating treatment with psychotherapeutic drugs, facility staff must verify that the resident's health record contains written informed consent with the required signatures...Renewals of Informed Consents...Facilities must renew the written informed consent every 6 months...Updates to</p>	F 552			

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F 552	Continued From page 6 Federal Regulations for SNFs [Skilled Nursing Facility], ICFs [Intermediate Care Facility] and Hospices [specialized care that provides physical comfort and emotional, social and spiritual support for people nearing the end of life]...AB 48 updates references to Federal regulations found in the HSC [Health and Safety Codes] section 1599.1(i)(2). The updated references align with the 2017 version of Title 42 of the Code of Federal Regulations (CFR)."	F 552			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)  §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.  §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655	F655 483.21(a)(1)-(3) BASELINE CARE PLAN  <u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u>  On 9/13/2024, the foley catheter for Resident 331 was discontinued.  <u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</u>  Residents with an indwelling catheter may be potentially affected by the cited deficiency.  The care plans of residents with an indwelling catheter were reviewed and audited by the DON and MRD on 9/26/2024. Any additional findings were corrected.  <u>What measures will be put into place or</u>		

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F 655	<p>Continued From page 7 admission.</p> <p>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident.</p> <p>(ii) A summary of the resident's medications and dietary instructions.</p> <p>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure a baseline care plan (instructions needed to provide effective and person-centered care for the resident developed within 48 hours of admission) for one of 20 sampled residents (Resident 331), when Resident 331's baseline care plan did not include an indwelling urinary catheter (IUC; a medical device that drains and collects urine from the bladder).</p> <p>This failure had the potential to place Resident 331 at risk for unmet care needs.</p> <p>Findings:</p> <p>A review of Resident 331's admission record indicated Resident 331 was admitted to the facility in August of 2024 with diagnoses that included urinary tract infection (when bacteria</p>	F 655	<p><u>what systemic changes the facility will make to ensure that the deficient practice does not recur;</u></p> <p>Starting on 9/10/2024, the DON in serviced Licensed Nurses on the importance to implement baseline care plans for residents with indwelling catheters.</p> <p>The DON, or designee, will review the baseline care plans for all new admissions, any re-admissions, as well as any new orders for indwelling catheters to ensure the care plans are complete per regulatory requirements.</p> <p>The MRD, or designee, will conduct a weekly audit, 4 x month, of the baseline care plans for residents with an indwelling catheter to ensure the care plan is present. Findings will be submitted to the DON.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;</u></p> <p>The DON, or designee, will monitor for compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.</p>		



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F 655	<p>Continued From page 8</p> <p>multiply in the urinary tract [kidneys, ureters, bladder and/or urethra]), sepsis (a severe response to infection which can lead to organ damage) and chronic kidney disease (when kidneys are damaged and can't filter blood properly).</p> <p>During an observation on 9/3/24 at 10:29 a.m., in Resident 331's room, Resident 331 was walking with use of a walker in his room while an IUC drainage bag was hanging from the walker.</p> <p>A review of Resident 331's "Order Summary Report," dated 9/4/24, indicated Resident 331 had an active order for an IUC and was started on 8/19/24.</p> <p>A review of Resident 331's care plans, initiated 8/19/24, did not indicate any care plan for an IUC.</p> <p>During an interview on 9/4/24 at 4:11 p.m. with Licensed Nurse 3 (LN 3), LN 3 stated if a resident had an IUC then she would expect the resident's care plan to indicate it, so staff will know the care the resident required.</p> <p>During a concurrent interview and record review on 9/4/24 at 4:24 p.m. with the Director of Staff Development (DSD), Resident 331's care plan was reviewed. The DSD confirmed Resident 331's care plan did not indicate Resident 331 had an IUC. The DSD confirmed Resident 331 was admitted with an IUC and she expected the IUC to be reflected on the resident's baseline care plan. The DSD added, the care plan is used to communicate to staff the care a resident needed and if an IUC was not on the care plan, staff might not know that an IUC existed or what care the resident needed related to it.</p>	F 655	<u>Date corrective action will be completed.</u>	10/4/2024	

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F 655	Continued From page 9  During an interview on 9/6/24 at 10:43 a.m., with the Assistant Director of Nursing (ADON), ADON stated care plans were important to provide guidance on how to care for the resident and expected a resident's IUC to be on the baseline care plan.  A review of facility policy and procedure titled, "Care Plans-Baseline," dated March 2022, indicated, " ...A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission ... the baseline care plan includes instructions needed to provide effective, person-centered care of the resident ... and must include ...but not limited to the following ...physician orders ...the baseline care plan is used until the staff can conduct the comprehensive assessment and develop a ...comprehensive care plan (no later than 21 days after admission) ..."	F 655			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657	F657 483.24(b)(2)(i)-(iii) CARE PLAN TIMING AND REVISION  <u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</u>  On 9/5/2024, the communication care plan for Resident 20 was reviewed and revised to include additional communication interventions, namely using a communication board and interpreter services.  On 9/5/2024, the Activities Director (AD)		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

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F 657	<p>Continued From page 10</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to revise and implement a communication care plan for one of 20 sampled Residents (Resident 20) who did not speak English.</p> <p>This failure increased Resident 20's potential to receive inadequate and inaccurate care.</p> <p>Findings:</p> <p>A review of Resident 20's "Admission Record," indicated she was admitted with diagnoses of dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), apraxia (a neurological disorder that makes it difficult to perform purposeful movements or tasks, even though the person understands the request and is willing to do it).</p> <p>During an observation on 9/3/24 at 11:24 a.m.,</p>	F 657	<p>placed a communication board in the residents room.</p> <p><u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</u></p> <p>All residents whose primary language is not English have the potential to be affected by the deficient practice.</p> <p>On 9/26/2024, the AD and Social Services Director (SSD) reviewed resident clinical records to identify other residents whose primary language is not English. Care plans were reviewed and any additional findings were corrected immediately.</p> <p><u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:</u></p> <p>Starting on 9/10/2024, the DON in-serviced Licensed Nurses regarding the interpreter service that is available 24/7, and the availability of communication boards.</p> <p>Starting on 9/19/2024, the DSD in-serviced CNA's regarding the interpreter service that is available 24/7, and the availability of communication boards.</p> <p>Upon admission, the Licensed Nurse will review resident demographics and language to determine if a communication</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	<p>Continued From page 11</p> <p>Resident 20 was sitting in her wheelchair. The Department was unable to communicate with Resident 20 in English. Resident 20 was observed communicating in a different language and had no communication board in her room.</p> <p>During an interview on 9/3/24 at 11:26 a.m. with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated he was assigned to Resident 20. CNA 4 confirmed Resident 20 spoke a different language and would communicate by gesturing. CNA 4 stated he communicated with Resident 20 by gesturing and she seemed to understand. CNA 4 was not certain what language Resident 20 was speaking. CNA 4 stated he could not find the communication board and if needed Resident 20 had a relative who worked in the dietary department and would be asked to interpret for the staff.</p> <p>During an interview on 9/3/24 at 11:35 a.m. with the Licensed Nurse 4 (LN 4), LN 4 confirmed Resident 20 spoke a different language and would communicate by gestures. LN 4 communicated with Resident 20 using gesturing. LN 4 was aware of a relative that worked in the kitchen who would be the interpreter and was not sure about the language Resident 20 was speaking. LN 4 was not aware if the facility had any translator services available.</p> <p>During an interview on 9/3/24 at 1:30 p.m. with the Director of Staff Development (DSD), DSD stated there were a language communication board and translator services available via phone. The translation services book had listed as "Mien" and translation services were available 24 hours a day seven days a week via phone.</p>	F 657	<p>board and interpreter services are needed.</p> <p>The AD will perform random observations of those residents whose primary language is not English to ensure they have a communication board in the room, as well as verify a communication board is present when the initial activities assessment is completed.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;</u></p> <p>The AD, or designee, will monitor for compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.</p> <p><u>Date corrective action will be completed.</u></p>	10/4/2024	

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F 657	<p>Continued From page 12</p> <p>A review of Resident 20's Electronic Health Record (EHR) Resident Detail indicated Resident 20 spoke Laotian.</p> <p>During an interview on 9/4/24 at 2:30 p.m. with the Dietary Aide 2 (DA 2), DA 2 stated she had the same last name as Resident 20 but they were not relatives. DA 2 spoke the same language as Resident 20 and would help out whenever she was at work. DA 2 confirmed she was not the official interpreter for the facility and was only helping out when it came to interpreting.</p> <p>A review of Resident 20's care plan identified on 10/3/20, indicated Resident 20 had a psychosocial well-being problem related to problem solve and had language barrier. Care plan interventions indicated to increase communication between resident/family caregivers about care and living environment.</p> <p>During an interview on 9/5/24 at 3 p.m. with the Director of Nursing (DON), DON stated for residents with language communication problems who could not speak English, the staff if they spoke the resident's language would be asked to act as an interpreter. The use of a translation service interpreter was available 24 hours a day via phone. DON confirmed Resident 20 had a language barrier and some command of English and had a relative that would act as an interpreter. Other helpful tools would be a communication board at the resident's bedside and could be obtained from the activities department. The DON confirmed and stated the interpreter services and the language interpreter services via phone were not part of Resident 20's care plan interventions. The DON also confirmed the care plan was last revised on 10/3/2020 and</p>	F 657			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 13 the interpreter services should have been part of the interventions.  A review of facility policy titled, "Translation and/or Interpretation of Facility Services," revised 11/2020, indicated: "...This facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility...When encountering LEP individuals, staff members will conduct the initial language assessment (e.g., I Speak Cards) and notify the staff person in charge of the language access problem."  A review of facility's policy titled, "Care Plans, Comprehensive Person - Centered," revised 3/22, indicated: "...A comprehensive, person centered care plan that include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...The comprehensive person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being..."	F 657			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)  §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658	F658 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  <u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u>  On 9/8/2024, the MAR for Resident 331		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 658	<p>Continued From page 14</p> <p>Based on observation, interview, and record review the facility failed to provide care and services in accordance with acceptable professional standards of quality for two of 20 sampled residents (Resident 331 and Resident 135) when:</p> <ol style="list-style-type: none"> <li>1. Resident 331's peripherally inserted central catheter intravenous line (PICC IV: used to deliver medications into a vein over a long period of time) flushes (a procedure that uses a mixture of salt and water to clear an IV line and reduce the risk of infection) were not documented in accordance with professional standards; and,</li> <li>2. Resident 135's urinary drainage bag was not enclosed in a privacy bag, the urinary drainage bag collection tube was not kept properly positioned and kept free from kinks for optimal drainage.</li> </ol> <p>These failures decreased the facility's potential to prevent worsening of the residents' clinical condition.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. A review of Resident 331's admission record, indicated Resident 331 was admitted to the facility in August of 2024 with diagnoses that included urinary tract infection (UTI: when bacteria multiplies in the urinary organs), sepsis (a severe response to infection which can lead to organ damage), and chronic kidney disease (when kidneys are damaged and can't filter blood properly).</li> </ol> <p>A review of Resident 331's "Order Summary Report," dated 9/4/24, indicated an order for</p>	F 658	<p>was reviewed to ensure that the nurse performing the treatment was the nurse documenting in the medical record.</p> <p>On 9/3/2024, a privacy cover was placed over the urinary drainage bag for Resident 135, and the drainage tube was repositioned to prevent kinks and allow for optimal drainage.</p> <p><u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</u> <u>All residents with an IV and a urinary drainage bag have the potential to be affected by the deficient practice.</u></p> <p>On 9/26/2024, the MRD and DON performed an audit of the TAR for those residents with an IV treated by the LN in question to identify whether that nurse had documented in place of the treating nurse. No other findings were noted.</p> <p>On 9/26/2024, the MRD and DON performed an audit of residents with a urinary drainage tube to ensure any urinary drainage tubes were covered with a privacy bag. No other findings were noted.</p> <p><u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</u></p> <p>Starting on 9/10/2024, the DON in</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 658	<p>Continued From page 15</p> <p>Resident 331's PICC IV to be flushed every shift.</p> <p>During an interview on 9/4/24 at 2:49 p.m. with Licensed Nurse 5 (LN 5), LN 5 stated the nurse who performed a PICC IV flush was expected to document they did it. LN 5 added, it was not acceptable for a nurse who did not perform the flush to document that another nurse had done it.</p> <p>During an interview on 9/4/24 at 4:11 p.m. with LN 3, LN 3 stated when a nurse gave a medication then that same nurse should have documented giving the medication and it was not acceptable for a nurse who did not give the medication to document it was given.</p> <p>During a concurrent interview and record review on 9/4/24 at 4:24 p.m. with the Director of Staff Development (DSD), Resident 331's August 2024 medication administration record (MAR) and August 2024 progress notes were reviewed. The DSD confirmed the MAR indicated the PICC IV flush scheduled for 10 p.m. on dates 8/20-8/31/24 indicated a code nine on each date. The DSD stated code nine meant there should be a progress note related to the administration. The DSD reviewed Resident 331's progress notes from 8/21/24 through 8/31/24 and confirmed the progress notes indicated a nurse documented either a different nurse had done the flush or the other nurse would do the flush. The DSD stated she expected the nurse who administered a medication or flush to document they gave it on the resident's MAR. The DSD confirmed it was not acceptable for one staff member to document that another staff member gave a medication or flush.</p> <p>During a concurrent interview and record review</p>	F 658	<p>served the Licensed Nurses that they cannot document for another nurse and cannot document on a treatment that they did not perform, as well as the importance that all urinary drainage bags must be covered with a privacy cover. In addition, the Licensed Nurses were reminded that the urinary drainage bag tube should be kept free of kinks at all times so as to allow for optimal drainage.</p> <p>Starting on 9/19/2024, the DSD in serviced the CNA's that urinary drainage bags need to be covered with a privacy cover. In addition, the CNA's were reminded that the urinary drainage bag tubing should be kept free of kinks at all times so as to allow for optimal drainage.</p> <p>The MRD, or designee, will perform random audits of the clinical medical record of those residents with an IV to ensure that Licensed Nurses are not documenting for another nurse and performing their own treatments.</p> <p>The IP, or designee, will perform random observations of residents with urinary drainage bags to ensure they are covered with a privacy cover.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is</u></p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 658	<p>Continued From page 16</p> <p>on 9/6/24 at 10:43 a.m. with the Assistant Director of Nursing (ADON), Resident 331's August 2024 MAR and August 2024 progress notes were reviewed. The ADON confirmed from 8/20/24-8/31/24 the 10 p.m. PICC IV flush was documented code nine and corresponding notes indicated a nurse had documented that another nurse had either administered the PICC IV flush or would administer the PICC IV flush. The ADON acknowledged the documentation related to the flushes were not aligned with facility expectations, and the nurse who administered a medication or flushed must document they did it. The ADON confirmed the documentation did not align with professional standards expected of nurses.</p> <p>A review of facility's policy and procedures (P&amp;P) titled, "administering medications," dated April 2019, indicated, "... medications are administered in a safe and timely manner, and as prescribed... Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so....medications are administered in accordance with prescriber orders... the individual administering the medication initials the resident's MAR on the appropriate line after given each medication..."</p> <p>A review of the facility's P&amp;P titled, "Peripheral and Midline IV catheter Flushing and Locking," dated March 2022, indicated, "...document procedure in treatment administration record..."</p> <p>2. A review of Resident 135's "Admission Record," indicated Resident 135 was admitted to the facility with diagnoses of pneumonia (lung infection), urinary retention, and the presence of a urine catheter.</p>	F 658	<p><u>integrated into the quality assurance system;</u></p> <p>The DON, or designee, will monitor for compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.</p> <p><u>Date corrective action will be completed.</u></p>	10/4/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 658	<p>Continued From page 17</p> <p>During an observation on 9/3/24 at 12 p.m. Resident 135 had a foley catheter (a flexible tube that drains urine from the bladder into a bag outside the body) which was connected to a drainage bag. The drainage bag was draining amber colored clear urine and was found hanging on the resident's top bedside rail. The head of the bed was elevated approximately 30 - 35 degrees. The drainage bag was positioned higher than the resident's bladder, this prevented the free flow and drainage of urine from the bladder. There was no privacy bag to conceal the urinary drainage bag from view. Also, the drainage bag's collecting tubing was found to be kinked near the drainage bag. The presence of a kink in the collecting tubing prevented the free flow of urine into the drainage bag.</p> <p>During an interview on 9/3/24 at 1230 p.m., with Certified Nurse Assistant 3 (CNA 3), CNA 3 stated Resident 135's drainage bag must be enclosed in a privacy bag and confirmed the drainage bag must not be hanging from the top siderail and must be hanging lower than the resident's bladder. CNA 3 also stated the drainage bag must be below the level of the bladder of the resident and confirmed a kinked urine collection tubing. CNA 3 stated the kink in the collecting tubing, prevented the flow of urine into the drainage bag.</p> <p>During a concurrent interview on 9/6/24 at 11:19 a.m. with the Director of Nursing (DON), (ADON) and the Quality Services Consultant (QSC), they all confirmed the expectations were all the residents' foley drainage bags must be positioned lower than the level of the resident's bladders. The urinary drainage bag must be off the floor, and should have no kinks in the collecting</p>	F 658			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 658	Continued From page 18 drainage tube. All urinary drainage bags must be covered with a privacy bag.  Review of the facility policy titled, "Catheter Care, Urinary," revised 9/14, indicated: "...Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter tubing free of kinks. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the bladder."	F 658			
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)  §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:  §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...  §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:  §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,	F 676	F676 483.24(a)(1)(b)(1)-(5)(i)-(iii) ACTIVITIES DAILY LIVING (ADL's)/MNTN ABILITIES  <u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</u>  On 9/3/2024, a communication board was provided for Resident 1.  On 9/5/2024, the Administrator confirmed that a translation service is active and operational.  <u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</u>  All residents whose primary language is not English have the potential to be affected by the deficient practice.  On 9/26/2024, the AD and Social Services Director (SSD) reviewed resident clinical		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
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F 676	<p>Continued From page 19</p> <p>§483.24(b)(2) Mobility-transfer and ambulation, including walking,</p> <p>§483.24(b)(3) Elimination-toileting,</p> <p>§483.24(b)(4) Dining-eating, including meals and snacks,</p> <p>§483.24(b)(5) Communication, including</p> <p>(i) Speech,</p> <p>(ii) Language,</p> <p>(iii) Other functional communication systems.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to provide a communication board or use translator during assisting care for one resident (Resident 1) of 20 sampled residents.</p> <p>This failure decreased the facility's potential to meet Resident 1's ability to communicate her basic needs.</p> <p>Findings:</p> <p>A review of Resident 1's "Admission Record," indicated, Resident 1 was admitted to the facility in 2022 with diagnoses including depression (a serious medical illness that negatively affects how you feel, think, and act).</p> <p>A review of Resident 1's undated care plan titled, "[Resident 1] has a communication problem [related to] language barrier. Primary language is Portuguese," indicated the interventions were: "Listen attentively and allow ample time to communicate. Provide communication board. Utilize help of a translator or interpreter if</p>	F 676	<p>records to identify other residents whose primary language is not English. Care plans were reviewed and any additional findings were corrected immediately.</p> <p><u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</u></p> <p>Starting on 9/10/2024, the DON in-serviced Licensed Nurses regarding the use of communication boards and that interpreter service that is available 24/7.</p> <p>Starting on 9/19/2024, the DSD in-serviced CNA's regarding the use of communication boards and that interpreter service that is available 24/7.</p> <p>Upon admission, the Licensed Nurse will review resident demographics and language to determine if a communication board and interpreter services are needed.</p> <p>The AD, or designee, will perform random observations of resident rooms where communication boards should be present to ensure compliance.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance</u></p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 676	<p>Continued From page 20 applicable."</p> <p>During a concurrent observation and interview on 9/3/24 at 9:03 a.m. with Certified Nursing Assistant 2 (CNA 2) in Resident 1's room, CNA 2 confirmed she did not use translator nor communication pictures to communicate with her, but rather used body language, gesture or pointing to objects.</p> <p>During an interview on 9/3/24 at 12:01 p.m. with Resident 1's son, Resident 1's son stated Resident 1 spoke Portuguese and the facility's staff did not communicate well with Resident 1 and did not use the translator.</p> <p>During an interview on 9/6/24 at 8:39 a.m. with Licensed Nurse 4 (LN 4), LN 4 stated she used English and Spanish when speaking to Resident 1. LN 4 stated she used the son as a translator and did not use a translator service.</p> <p>During an interview on 9/6/24 at 10:40 a.m. with the Director of Nursing (DON), the DON stated the facility staff should have used communication board or phone translator when assisting Resident 1 with her daily living.</p> <p>A review of facility's policy titled, "Translation and/or Interpretation of Facility Services," dated 11/2020, indicated, "The facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility." The policy further stipulated, "Family members and friends shall not be relied upon to provide interpretation services for the resident."</p>	F 676	<p><u>system;</u></p> <p>The AD, or designee, will monitor for compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.</p> <p><u>Date corrective action will be completed.</u></p>	10/4/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 694 F 694 SS=D	Continued From page 21 Parenteral/IV Fluids CFR(s): 483.25(h)  § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two of 20 sampled residents (Resident 282 and Resident 331) who had Vascular Access Devices (VAD, thin flexible tube that provides access to veins for the delivery of IV [Intravenous, administered into a vein] medications) received the necessary care and services when:  1. Resident 282's Midline catheter (a type of VAD used for intravenous treatments of more than six days) was not monitored for signs and symptoms of infection every shift as ordered; and,  2. Resident 331's peripherally inserted central catheter intravenous line (PICC IV: a type of VAD used to deliver medications into a vein over a long period of time) was not monitored for signs and symptoms of infection every shift as ordered.  These failures placed the residents at risk for VAD related infections.  Findings:  1. A review of Resident 282's clinical record indicated he was admitted to the facility summer of 2024 with multiple diagnoses that included	F 694 F 694	F694 483.25(h) PARANTERAL/IV FLUIDS  <u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u>  On 9/11/2024, the TAR was reviewed for Resident 282 and 331 and the attending physician was notified that treatments had not been monitored for signs and symptoms of infection as per medical orders. Any new physician orders were carried out by the Licensed Nurse.  <u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</u>  All residents with an IV have the potential to be affected by the deficient practice.  On 9/26/2024, the MRD and DON reviewed the clinical records for those residents with an IV. Specifically signs and symptoms of infection were reviewed. No other findings were noted.  <u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</u>  Starting on 9/10/2024, the DON in served Licensed Nurses on the importance of accurately monitoring and		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 694	<p>Continued From page 22</p> <p>cellulitis (potentially serious bacterial skin infection) of the left lower limb.</p> <p>During an observation on 9/3/24 at 9:23 a.m. in Resident 282's room, Resident 282 was lying in bed with midline IV at left upper arm and dressing intact. Resident 282 stated he was getting IV antibiotics for his left leg cellulitis.</p> <p>A review of Resident 282's "Order Summary", dated 8/28/24, indicated "Assess midline site for S/S [signs/symptoms] of infection QS [every shift] and notify MD [Medical Doctor] if noted (Ensure all lumens have injection caps, lumens not in use are clamped) ..."</p> <p>A review of Resident 282's care plan indicated, "Resident is on IV Medications r/t [related to] left leg cellulitis...Check dressing at site as ordered...Monitor and report to MD PRN [as necessary] s/sx [signs and symptoms] of infection at the site: drainage, inflammation, swelling, redness, warmth ..."</p> <p>A review of Resident 282's Medication Administration Record (MAR) indicated to "Assess midline site for S/S of infection QS and notify MD if noted (Ensure all lumens have injection caps, lumens not in use are clamped) QS every shift ..." MAR further indicated from 8/28/24 to 9/4/24, out of 23 shifts, nine shifts were not signed as ordered.</p> <p>During a concurrent interview and record review on 9/5/24 at 9:19 a.m. with Licensed Nurse 6 (LN 6), LN 6 confirmed Resident 282's administration record to assess midline IV site every shift had nine shifts with no signature. LN 6 stated it should have been signed.</p>	F 694	<p>documenting the signs and symptoms of infection for those residents with an IV.</p> <p>The MRD, or designee, will perform a daily audit x 5 days of those residents with an IV. Specific attention will be given to missing infection signs and symptoms monitoring.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;</u></p> <p>The DON, or designee, will monitor for compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.</p> <p><u>Date corrective action will be completed.</u></p>	10/4/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 694	<p>Continued From page 23</p> <p>During a concurrent interview and record review on 9/5/24 at 10:30 a.m. with the Director of Nursing (DON), DON confirmed Resident 282's administration record to assess IV midline had shifts that were not signed. DON stated, "If the order says it's every shift, then it should be signed every shift." When asked if the order was not signed does it mean it was not done, the DON did not answer.</p> <p>During an interview on 9/5/24 at 11:15 a.m. with the Infection Preventionist (IP), IP stated he expected the midline IV to be monitored for signs and symptoms of infection every shift. IP stated midline IV was an easy portal of entry for infections that could affect Resident 282 because the route of entry for infection was faster.</p> <p>A review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered," revised March 2022, indicated, "...Each resident's comprehensive person-centered care plan is consistent with the resident's rights to...receive the services and/or items included in the plan of care ..."</p> <p>2. A review of Resident 331's admission record indicated Resident 331 was admitted to the facility in August of 2024 with diagnoses that included, urinary tract infection (when bacteria multiply in the urinary organs), sepsis (a severe response to infection which can lead to organ damage) and chronic kidney disease (when kidneys are damaged and can't filter blood properly).</p> <p>A review of Resident 331's order summary report, dated 9/4/24, indicated an active order for "...Assess PICC line on (RUA) [right upper arm]</p>	F 694			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 694	<p>Continued From page 24</p> <p>for S/S of infection QS and notify MD if noted (Ensure all lumens have injection caps, lumens not in use are clamped) QS every shift..."</p> <p>A review of Resident 331's PICC IV care plan, initiated 8/19/24, indicated, "...Risk for infection R/T [related to] catheter direct access to blood...interventions... Visually inspect I.V. [PICC IV] site QS, note any redness, swelling, pain or drainage, gently palpate areas around the insertion site for tenderness, phlebitis, inflammation or infiltration..."</p> <p>During an interview on 9/4/24 at 2:49 p.m. with LN 5, LN 5 stated registered nurses (RNs) are expected to assess a PICC IV site and to document it was done in the residents' MAR.</p> <p>During an interview on 9/4/24 at 4:11 p.m. with LN 3, LN 3 confirmed RNs are responsible for PICC IV site assessments and were expected to document the assessment was done in the residents' MAR.</p> <p>During a concurrent interview and record review on 9/4/24 at 4:24 p.m. with the Director of Staff Development (DSD), Resident 331's August 2024 MAR was reviewed. The DSD confirmed Resident 331's August MAR indicated the PICC IV site was expected to be assessed for signs and symptoms of infection on each shift and there was no documentation that the PICC IV site was assessed on the following scheduled dates and times: 6 a.m. on 8/25/24, 2 p.m. on 8/19-8/24/24, 8/26/24, 8/28/24, and 8/31/24, and 10 p.m. 8/19-8/31/24. The DSD stated the lack of documentation for those dates and times indicated the assessments were not done as ordered by the doctor.</p>	F 694			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 694	Continued From page 25  During a concurrent interview and record review on 9/6/24 at 10:43 a.m. with the Assistant Director of Nursing (ADON), Resident 331's August 2024 MAR was reviewed. The ADON confirmed Resident 331's PICC IV site assessments were not done as ordered by Resident 331's doctor and the missing assessments put Resident 331 at higher risk of getting an infection to the PICC IV site.  A review of the facility's policy and procedure titled, "Central Venous Catheter Care and Dressing Changes," revised March 2022, indicated, "...the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infection that are associated with contaminated, loosened, soiled, or wet dressings... perform site care and dressing change at established intervals....assessment observe insertion site and surrounding area for complications.... documentation...should be recorded in the resident's medical record..."			F 694			
F 698 SS=D	Dialysis CFR(s): 483.25(l)  §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary care and services for one of 20 sampled			F 698	F698 483.25(l) DIALYSIS  <u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</u>  On 9/11/2024, the attending physician was notified that input and output was not accurately measured per physician order for Resident 281. Any new physician orders were carried out by the licensed nurse.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 698	<p>Continued From page 26</p> <p>residents (Resident 281) who received hemodialysis (HD, a medical procedure that helps remove waste and excess fluid from the blood when the kidneys are unable to perform this function), when her output was not accurately measured as ordered.</p> <p>This failure increased Resident 281's risk in developing fluid overload.</p> <p>Findings:</p> <p>A review of the clinical record indicated Resident 281 was admitted to the facility in summer of 2024 with multiple diagnoses that included end stage renal disease (ESRD, permanent kidney failure that requires a regular course of dialysis or a kidney transplant) and fluid overload.</p> <p>During a concurrent observation and interview on 9/3/24 at 1:10 p.m. in Resident 281's room, Resident 281 was eating lunch. She stated she was feeling tired the day after HD, was urinating in the bathroom and was continent.</p> <p>A review of Resident 281's "Order Summary" dated 8/30/24, indicated to record intake and output (I&amp;O) in milliliters (ml; a unit of measure) every shift for fluid restriction and if Resident 281 was incontinent to put the number of incontinence episodes.</p> <p>A review of Resident 281's care plan indicated, "ESRD with interventions that included monitor fluid restrictions as ordered and monitor intake and output ..."</p> <p>A review of Resident 281's "Medication Administration Record (MAR)" for "Fluid</p>	F 698	<p><u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</u></p> <p><u>All residents who require dialysis have the potential to be affected by the deficient practice.</u></p> <p>On 9/26/2024, the MRD and DON audited the clinical records of those residents requiring dialysis to ensure that proper input and output measures were recorded accurately and per physician order. No other findings were identified.</p> <p><u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</u></p> <p>Starting on 9/10/2024, the DON in serviced the Licensed Nurses regarding the necessity to have input and output measures documented, properly to capture volume, for all dialysis residents who are continent, as per physician orders.</p> <p>The MRD, or designee, will audit the medical records monthly, x 3 months, of those continent residents with input and output orders to ensure that output is being measured properly and documented properly.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop</u></p>		

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F 698	<p>Continued From page 27</p> <p>restriction I&amp;O: Record intake &amp; output QS [every shift] ..." from 8/30/24 to 9/4/24 indicated, Resident 281's output was marked as "x" number of times urinated and not the amount of output in ml.</p> <p>During a concurrent interview and record review on 9/5/24 at 9:19 a.m. with Licensed Nurse 6 (LN 6), LN 6 stated Resident 281 was continent. Resident 281's MAR for fluid restriction I&amp;O was reviewed and LN 6 stated "[Resident 281] was using the toilet, so I just asked for the number of times she went to the toilet." LN 6 confirmed the order for I&amp;O and stated "because she is continent there should be an amount of output there ... if [Resident 281] is incontinent you can write the number of times she was changed..."</p> <p>During a concurrent interview and record review on 9/5/24 at 10:35 a.m. with the Director of Nursing (DON), Resident 281's MAR for fluid restriction I&amp;O was reviewed. The DON stated staff should have entered the amount of the output because it was in the order.</p> <p>A review of facility's policy titled, "Output, Measuring and Recording," revised October 2010, indicated "...Verify that there is a physician's order for this procedure...The following information should be recorded on the bedside intake and output record and/or in the resident's medical record...The amount (in mLs) of output ..."</p> <p>A review of facility's policy titled, "End-Stage Renal Disease, Care of a Resident with," revised September 2010, indicated "Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of</p>	F 698	<p><u>a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;</u></p> <p>The DON, or designee, will monitor for compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.</p> <p><u>Date corrective action will be completed.</u></p>	10/4/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
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F 698	Continued From page 28 care..."	F 698			
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)  §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-  §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.  §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and  §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 755	F755 483.45(a)(b)(1)-(3) PHARMACY SRVCS/PROCEDURES/PHARMACIST/ RECORDS  <u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u>  On 9/4/2024, the ADON reviewed the E-kit logs for accuracy. No additional findings were identified. Pharmacy was also notified and E-kits in question were replaced the same day.  <u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</u>  All residents have the potential to be affected by the deficient practice.  On 9/4/2024, the ADON rounded the facility to check each medication storage room containing E-kits. One other E-kit was located and the ADON verified that the logs were signed properly.  <u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:</u>  Starting on 9/10/2024, the DON in served the Licensed Nurses on the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 755	<p>Continued From page 29</p> <p>review, the facility failed to provide pharmaceutical services to meet the needs of a census of 81 residents, when the emergency Kit (E-Kit, limited number of medications for use in an emergency) log was not filled out for two opened E-Kits.</p> <p>This failure increased the potential for the facility to not have the needed medications available during emergencies that could jeopardize residents' health and safety.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 9/4/24 at 10:01 a.m. with Licensed Nurse 3 (LN 3), stations one and two medication storage rooms had three E-Kits with injectable medications (medications to be administered by injection into the vein or muscle) with blue plastic locks. LN 3 stated the three E-kits with blue locks were recently opened. LN 3 confirmed two out of three E-kits were not logged in the E-kit log. LN 3 stated she does not know when the two E-kits were opened and the yellow form inside it were to be filled out and faxed to the pharmacy letting them know the E-kits were opened, then the yellow form will be placed in the binder and the white form should be placed inside the E-kits. LN 3 confirmed there were no yellow forms for the 3 opened E-kits in the binder.</p> <p>During a concurrent interview and record review on 9/4/24 at 10:30 a.m., the Assistant Director of Nursing (ADON) verified, the 2 opened E-kits were not logged in the E-Kit log.</p> <p>During an interview on 9/5/24 at 10:23 a.m., with the Director of Nursing (DON), DON stated she</p>	F 755	<p>on the policy pertaining to E-kit storage, usage, and accountability for signing when medications are used.</p> <p>The Licensed Nurse on each shift will check the E-kit log during change of shift to ensure that the logs are completed accurately and timely.</p> <p>The DON, or designee, will perform random observations of the E-kit logs to verify completion and accuracy.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;</u></p> <p>The DON, or designee, will monitor for compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.</p> <p><u>Date corrective action will be completed.</u></p>	10/4/2024	

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F 755	Continued From page 30 expected the staff to fill out the E-kit log form as soon as they took out the medication.  A review of the facility's policy titled, "Emergency Pharmacy Service and Emergency Kits," dated 2007, indicated "...Upon removal of any medication or supply item from the emergency kit, the nurse documents the medication or item used on an emergency kit log. One copy of this information should be immediately faxed to the pharmacy with the original prescriber order or refill request form and placed within the resealed emergency kit until it is scheduled for exchange. The hard copy will be retained in the nursing care center ..."	F 755			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehensive assessment of a resident, the facility must ensure that---  §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758	F758 483.45(c)(3)(e)(1)-(5) FREE FROM UNNEC PSYCHOTROPIC MEDS/PRN USE  <u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</u>  On 9/6/2024, physician orders for buspirone were clarified for Resident 11 to reflect monitoring behavior and side effects, appropriate diagnosis, and manifestation for use.  <u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</u>  On 9/4/2024, the MRD audited all other residents with psychotropic orders to check for the proper manifestations for		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758	<p>Continued From page 31</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one resident (Resident 11) out of 20 sampled residents received proper monitoring for psychotropic medication (any drug that affects brain activities associated with mental processes and behavior) when there was no manifestation, no diagnosis identified, and no side effect monitoring for Resident 11's buspirone (an antianxiety medication).</p> <p>These failures placed Resident 11 at risk for</p>	F 758	<p>use, accurate diagnosis, and behavior and medication side effects related to the prescribed medication. Any findings were addressed immediately.</p> <p><u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</u></p> <p>Starting on 9/10/2024, the DON in serviced Licensed Nurses as to proper completion of an order for psychotropic medications. Specifically, the Licensed Nurses were in serviced on proper diagnosis, behavior monitoring, side effects monitoring, and informed consent.</p> <p>During the monthly Behavior and Psychotropic Management Committee meeting, the appointed IDT members and Pharmacist will review the psychotropic drug orders, proper monitoring, diagnosis, proper indications for use, behaviors, and medication side effects, and informed consent. The MD will be notified as needed for any new orders per the Pharmacist recommendations. Findings will be reported to the DON.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance</u></p>		



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F 758	<p>Continued From page 32</p> <p>unnecessary psychotropic medication use side effects.</p> <p>Findings:</p> <p>A review of Resident 11's "Admission Record," indicated Resident 11 was admitted to the facility in 2021 with diagnoses including depression (a serious medical illness that negatively affects how you feel, the way you think and how you act) and bipolar disorder (a mental health condition that causes extreme mood swings).</p> <p>A review of Resident 11's Minimum Data Set (MDS, an assessment tool), dated 6/20/24, indicated Resident 11 scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) indicating her cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was mildly impaired.</p> <p>A review of Resident 11's "Order Summary Report," dated 9/5/24, indicated Resident 11 had buspirone 100 milligram (a unit of measure) by mouth at bedtime. There was no diagnosis, manifested by, and side effect monitoring for buspirone in the orders.</p> <p>During a concurrent interview and record review on 9/5/24 at 9:53 a.m. with the Medical Record Director (MRD), the MRD confirmed she did not see documentation of the side effect monitoring for buspirone in the Medication Administration Record.</p> <p>During an interview on 9/6/24 at 9:07 a.m. with the Director of Nursing (DON) and Assistant DON (ADON), the ADON confirmed a psychotropic</p>	F 758	<p><u>system;</u></p> <p>The DON, or designee, will monitor for compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.</p> <p><u>Date corrective action will be completed.</u></p>	10/4/2024	

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F 758	Continued From page 33 medication should have a diagnosis, manifested by or evidence by, and inform consent and stated without diagnosis, manifested by, and inform consent, the order would be an incomplete order. ADON further stated the resident or family member would not know why the resident is taking the psychotropic medication.  A review of the facility's policy titled, "Psychotropic Medication Use," dated 7/2022, indicated, "Psychotropic medication management includes: indications for use and monitoring of behavior ... adequate monitoring for efficacy and adverse consequences ..."	F 758			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761	F761 483.45(g)(h)(1)(2) LABEL/STORE DRUGS AND BIOLOGICALS  <u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</u>  On 9/4/2024, the Licensed Nurse removed the expired medications from the medication cart and from the medication storage room.  On 9/4/2024, the Licensed Nurse discarded the medications from the medication storage room and from the medication storage cart without an unopened date.  On 9/4/2024, the Licensed Nurse contacted the pharmacy to have the identified medications consisting of an unclear and torn label destroyed and replaced.		

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F 761	<p>Continued From page 34</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were labeled, stored, and disposed of consistently according to standards of practice for a census of 81, when:</p> <ol style="list-style-type: none"> <li>1. Expired medications were not removed from the medication cart and the medication storage room;</li> <li>2. Pharmaceutical products were found in the medication storage room and the medication cart without an opened date;</li> <li>3. Pharmaceutical products with an unclear and torn label was found in a medication cart;</li> <li>4. Loose medications were found in a medication cup in the first drawer of the medication cart; and,</li> <li>5. A white powdered medication in medication cups were left unattended at the resident's bedside.</li> </ol> <p>These failures had the potential to result in the lack of effectiveness of the medications, increase the potential for medication administration errors and jeopardize residents' health and safety.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview on 9/4/24 at 10:01 a.m. with Licensed Nurse 3 (LN 3), in station one and two medication storage room there was an opened bottle of pantoprazole suspension (medication to treat high levels of stomach acid) with a discard date of 7/10 in the</p>	F 761	<p>On 9/4/2024, the Licensed Nurse removed the loose pills found in a medication cup in the first drawer from the medication cart.</p> <p>On 9/3/2024, the Licensed Nurse properly discarded the white powdered medication from the Residents bedside.</p> <p><u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</u></p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>On 9/9/2024, the DON inspected all medication carts and medication storage rooms to ensure there were no expired medications. No new findings were identified.</p> <p>On 9/9/2024, the DON inspected all medication carts and medication storage rooms to ensure there were no medications with an unopened date. No new findings were identified.</p> <p>On 9/9/2024, the DON inspected all medication carts and medication storage rooms to ensure there were no medications with unclear or torn labels. No new findings were identified.</p> <p>On 9/9/2024, the DON inspected all medication carts to ensure there were no loose pills. No new findings were identified.</p>		

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F 761	<p>Continued From page 35</p> <p>medication refrigerator. LN 3 stated, "It's [pantoprazole] past the date ...should have been discarded."</p> <p>During a concurrent observation and interview on 9/4/24 at 12:36 p.m. with LN 1, in station one medication cart two, LN 1 confirmed there was an opened regular insulin(a medication used to control high blood sugar) 100 units/milliliters (u/ml; a unit of measure) vial with an opened date of 7/22/24 and labelled to discard after 31 days. LN 1 stated the insulin should have been discarded on 8/22/24.</p> <p>During an interview on 9/5/24 at 10:35 a.m. with the Director of Nursing (DON), DON stated if the medication was expired, then it should have been destroyed.</p> <p>A review of the facility's policy titled, "Medication Labeling and Storage", revised February 2023, indicated, "...Multi-dose vials that have been opened or accessed ...are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial..."</p> <p>2. During a concurrent observation and interview on 9/4/24 at 10:01 a.m. with LN 3, in station one and two medication storage room, LN 3 confirmed there was an opened vial of tuberculin purified protein derivative (PPD, solution used to help diagnose tuberculosis) without an opened date and discard date.</p> <p>During a concurrent observation and interview on 9/4/24 at 12:36 p.m. with the Quality Services Consultant (QSC), in station one medication cart two, QSC confirmed there was an opened umeclidinium (a medication to treat chronic</p>	F 761	<p>On 9/9/2024, the DON inspected all Resident rooms for white powdered medication left at the bedside. No new findings were identified.</p> <p><u><i>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</i></u></p> <p>Starting on 9/10/2024, the DON in serviced Licensed Nurses regarding the following:</p> <ul style="list-style-type: none"> <li>• The importance of discarding any medication that has expired on the medication carts or in the medication storage rooms.</li> <li>• The importance of dating any medication that has been opened on the medication carts or in the medication storage rooms.</li> <li>• The importance of verifying that all medications have a clear and untorn label at all times.</li> <li>• The importance of checking all drawers of the medication carts to ensure that there are no loose pills in the drawers.</li> <li>• The importance of not leaving any medications at the bedside of the residents, unless the Resident has been deemed capable of self-administration through the completion of a proper assessment.</li> </ul> <p>The DON, or designee, will perform spot checks of medication carts and medication</p>		

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F 761	<p>Continued From page 36</p> <p>obstructive pulmonary disease) 62.5 micrograms (mcg; a unit of measure) inhaler and an opened fluticasone furoate/vilanterol (a medication to treat asthma; a lung disease) 100mcg/25mcg inhaler without an opened date and discard date.</p> <p>During a concurrent observation and interview on 9/4/24 at 1:09 p.m. with LN 1, in station one medication cart two, LN 1 confirmed there was a bottle of valproic acid (a medication to treat seizures or mental or mood problems) 250 milligrams (mg; a unit of measure)/five ml oral solution and a bottle of lactulose (a medication used to treat constipation) 10 grams (g; a unit of measure)/15ml solution without opened date and discard date.</p> <p>During an interview on 9/5/24 at 10:23 a.m. with the DON, DON stated when the staff opens the medication it should be dated on the date it was opened.</p> <p>A review of the facility's policy titled, "Administering Medications", revised April 2019, indicated, "...When opening a multi-dose container, the date opened is recorded on the container..."</p> <p>A review of the facility's policy titled, "Medication Labeling and Storage," revised February 2023, indicated, "...Multi-dose vials that have been opened or accessed ...are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial..."</p> <p>3. During a concurrent observation and interview on 9/4/24 at 12:36 p.m. with QSC, in station one medication cart two, QSC confirmed there was an opened albuterol sulfate (a medication to treat</p>	F 761	<p>storage rooms to ensure there are no expired medications. Findings will be documented by the DON, or designee.</p> <p>The DON, or designee, will perform spot checks of medication carts and medication storage rooms to ensure there are no open medications without an open date. Findings will be documented by the DON, or designee.</p> <p>The DON, or designee, will perform spot checks of medication carts and medication storage rooms to ensure there is a clear and untorn label on all medications. Findings will be documented by the DON, or designee.</p> <p>The DON, or designee, will perform spot checks of medication carts and medication storage rooms to ensure there are no loose pills in the drawers of the medication storage carts. Findings will be documented by the DON, or designee.</p> <p>The DON, or designee, will perform spot checks of resident rooms to ensure that medications are not left at the bedside of the Resident. Findings will be documented by the DON, or designee.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is</u></p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

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F 761	<p>Continued From page 37</p> <p>asthma) 90 mcg inhaler with a torn label and an opened budesonide and formoterol fumarate dihydrate (a medication to treat asthma) 160 mcg/4.5 mcg inhaler with a torn and unclear label.</p> <p>A review of the facility's policy titled, "Medication Labeling and Storage", revised February 2023, indicated, " ...1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 2. The medication label includes, at a minimum: a. medication name (generic and/or brand); b. prescribed dose; c. strength; d. expiration date, when applicable; e. resident's name; f. route of administration; and g. appropriate instructions and precautions ...8. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items ..."</p> <p>4. During a concurrent observation and interview on on 9/4/24 at 1:14 p.m. with LN 7, in station three medication cart three, a medication cup with two blue and white colored capsules and one pink colored tablet were found in the first drawer of the cart. LN 7 stated she was supposed to discard the capsule and the tablet. LN 7 further stated the capsules were empty and the pink tablet fell out of the pack and she was going to waste it later in the medication room at station one medication disposal bin.</p> <p>During an interview on 9/5/24 at 10:23 a.m. with the DON, DON stated loose pills should be thrown in the drug buster (a medication disposal system that uses a solution to deactivate or dissolve medications) in the medication cart.</p>	F 761	<p><u>integrated into the quality assurance system;</u></p> <p>The DON, or designee, will monitor for compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.</p> <p><u>Date corrective action will be completed.</u></p>	10/4/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 761	<p>Continued From page 38</p> <p>DON further stated loose and opened pills are not supposed to be kept in the medication cart and should be disposed immediately in the drug buster.</p> <p>A review of the facility's policy titled, "Medication Labeling and Storage", revised February 2023, indicated, "1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received...2. The nursing staff is responsible for maintaining medication storage...in a safe manner...11. Medications may not be transferred between containers..."</p> <p>5. During an observation on 9/3/24 at 12:26 p.m. in a resident's room, there were white powdered medications in two cups placed at resident's bedside.</p> <p>During an interview on 9/3/24 at 12:33 p.m. with LN 3, LN 3 confirmed the white powdered medication should not be at the resident's bedside and stated it should have been stored in the medication cart or treatment cart. LN 3 further stated there were residents who wander in the facility and they could have access to the medication if not stored properly.</p> <p>During an interview on 9/6/24 at 1:28 p.m. with the DON, DON confirmed the medication should have been stored and locked in the cart or medication room to prevent other residents from getting it.</p> <p>A review of the facility's policy titled, "Medication Labeling and Storage," dated 2/2023, indicated "The facility stored all medications and biological in locked compartments..."</p>	F 761			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812 SS=E	<p>Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to accurately check and test sanitizing solutions in the kitchen for a census of 81, when:</p> <ol style="list-style-type: none"> <li>1. The dishwasher sanitizing solution was not accurately checked for effectiveness; and,</li> <li>2. The Quaternary Ammonium Compound (QAC; a type of chemical that is used to kill bacteria, viruses, and mold) was not tested at the right temperature and concentration.</li> </ol> <p>These failures had the potential to expose residents to foodborne illnesses from improperly sanitized eating utensils served with the</p>	F 812	<p>F812 483.60(i)(1)(2) FOOD PROCUREMENT, STORE/PREPARE/ SERVE-SANITARY</p> <p><u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u></p> <p>On 9/4/2024, the faded and unclear chlorine test strip bottle was immediately discarded and a new test strip bottle was opened and placed into use</p> <p>On 9/4/2024, QAC bucket contents were discarded and the thermometer was tested to verify its proper calibration.</p> <p><u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</u></p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>On 9/4/2024, the Registered Dietician (RD) rounded the kitchen to ensure there were no other faded and unclear chlorine test strip bottles, as well as verified there was only one QAC bucket being tested. No other findings were identified.</p> <p><u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:</u></p>		



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812	<p>Continued From page 40 residents' meals.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview with the Registered Dietitian (RD) and the Dietary Aide 1 (DA 1) on 9/4/24 at 1:34 p.m. in the kitchen, the dishwashing activity was observed. DA 1 stated she was doing the dishwashing and the dishwashing machine was a low temperature dishwasher. DA 1 also stated she did not know what should the low temperature dishwashing machine's minimum operational temperature be. The temperature gauge of the machine while operating was observed and registered a temperature of 110 degrees Fahrenheit (a unit of temperature measurement). DA 1 demonstrated how the sanitizing solution was checked to ensure it was at an effective concentration level, stated the sanitizing solution used was Chlorine, took a test strip and placed it into the liquid collected at the bottom of the machine. DA1 confirmed the Chlorine testing indicated a reading of 100 parts per million (ppm; described concentrations of chemicals dissolved in a solvent, typically water) after she compared it with the testing bottle's colored bars. The test strips container's color bars were observed to be faded and hard to read. The test strips container expiration date was also faded and difficult to visualize. DA 1 confirmed that the test strips container's color bars were faded and the expiration date was not visible and stated she compared the color to as close as she could to the faded color bars. RD confirmed the color bars were faded and the expiration date of the test strip container was also faded and difficult to read and stated the accuracy of the Chlorine test would be hard to visually verify the accuracy of</p>	F 812	<p>On 9/17/2024, the RD and Certified Dietary Manager (CDM) in serviced the dietary team on the importance of checking the chlorine test strip bottle expiration date and PPM measures are clear and legible prior to testing the low temperature dishwasher. In addition, the dietary team was in serviced on the proper testing process for the QAC bucket used for sanitization.</p> <p>The CDM, or designee, will perform random spot checks of the chlorine test strips, as well as verify the temperature of the QAC bucket, to ensure proper compliance.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;</u></p> <p>The CDM, or designee, will monitor for compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.</p> <p><u>Date corrective action will be completed.</u></p>	10/4/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812	<p>Continued From page 41 the readings.</p> <p>2. During a concurrent observation and interview with DA 1 on 9/4/24 at 1:34 p.m. in the kitchen, DA 1 demonstrated how to wash dishes with a three compartment sink. DA 1 stated QAC was used for the sanitation of dishes and the disinfection of the kitchen surfaces with a "red bucket" container. DA 1 conducted testing with a test strip after mixing a QAC solution and water form a QAC mixing station. DA 1 dipped the QAC test strip for 10 seconds and read the result, which was 400 ppm. The QAC testing strip instructions from the manufacturer were to dip the chemical strip into the formula at a temperature of 65 to 75. DA 1 measured the temperature in the QAC red bucket using the kitchen's digital thermometer which indicated 63 degrees Fahrenheit. DA 1 confirmed the solution was tested in cold water and was below the manufacturer's recommendation for testing.</p> <p>Duirng an interview on 9/4/24 at 2 p.m. with the RD, RD stated the QAC chemical test strip per manufacturer's recommendation must be tested at a minimum temperature of 65 degrees Fahrenheit. The temperature reading was verified with the RD and was below the manufacturer's recommendation. RD confirmed the QAC testing result was at 400 ppm and stated the manufacturer's recommendation must be followed to ensure the accuracy of the readings.</p> <p>A review of the Food and Drug (FDA) 2022 Food Code section 4-501.116 on Warewashing (dishwashing) Equipment, Determining Chemical Sanitizer Concentration it indicated that "the effectiveness of chemical sanitizers is determined primarily by the concentration and pH of the</p>	F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 812	Continued From page 42 sanitizer solution. Therefore, a test kit is necessary to accurately determine the concentration of the chemical sanitizer solution." The FDA Food Code further explained in section 4-703.11 on Hot Water and Chemical Sanitation that "Efficacious sanitization depends on warewashing being conducted within certain parameters. Time is a parameter applicable to both chemical and hot water sanitization. The time hot water or chemicals contact utensils or food-contact surfaces must be sufficient to destroy pathogens that may remain on surfaces after cleaning. Other parameters, such as rinse pressure, temperature, and chemical concentration are used in combination with time to achieve sanitization."	F 812			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880	F880 483.80(a)(1)(2)(4)(e)(f) INFECTION PREVENTION & CONTROL  <u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</u>  On 9/5/2024, LA removed her gloves and performed proper hand hygiene.  On 9/4/2024, the Infection Preventionist (IP) initiated enhanced standard precautions (EBP) for Resident 331.  On 9/3/2024, the CNA performed hand hygiene for Resident 335.  On 9/3/2024, all ice was removed from the resident room water pitchers, hydration carts containing ice, and medication carts with ice. Ice was purchased from a local		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 43</p> <p>arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and</p>	F 880	<p>store and placed in a cleaned and sanitized cooler for temporary use. Water pitchers were then cleaned, refilled with clean ice, and replaced in the resident rooms. The ice machine was deep cleaned by the manufacturer recommended service provider, per the manufacturer's cleaning instructions.</p> <p><u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</u></p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>On 9/5/2024, there was only one LA working.</p> <p>On 9/4/2024, the IP reviewed all residents requiring EBP. Any additional findings were remedied immediately.</p> <p>On 9/3/2024, other residents were offered to perform proper hand hygiene prior to meals.</p> <p>On 9/3/2024, there was only one ice machine in the facility.</p> <p><u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:</u></p> <p>On 9/25/2024, the IP in serviced the laundry team on the importance of</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 44</p> <p>transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow infection control practices for a census of 81 when: 1. Laundry Aide (LA) did not maintain hand hygiene practices while handling clean and soiled linen in the laundry; 2. Enhanced based precautions (EBP) were not initiated timely for Resident 331's indwelling medical devices; 3. Staff did not ensure Resident 335 performed hand hygiene before being served lunch on 9/3/24; and 4. The ice machine was not properly cleaned.</p> <p>These failures had the potential to spread infection among residents.</p> <p>Findings:</p> <p>1. During an observation on 9/5/24 at 12:10 p.m. with LA at the laundry area, LA was handling cleaned linen with gloved hands. There was no hand hygiene prior to wearing gloves to handle clean linen. Then LA removed gloves and put on new gloves, gown, and face mask to handle soiled linen. There was no hand hygiene performed after removing and putting on gloves. While handling soiled linen, LA removed gloves and put on new gloves in three different occasions and did not perform hand hygiene practices.</p>	F 880	<p>performing proper hand hygiene while handling clean and dirty laundry.</p> <p>On 9/10/2024, the IP in serviced the Licensed Nurses regarding the rules and regulations pertaining to EBP, with emphasis on implementing precautions timely.</p> <p>On 9/26/2024, the IP in serviced Licensed Nurses and CNA's regarding the importance of using proper hand hygiene for residents prior to and after eating or handling food.</p> <p>On 9/25/2024, the RD in serviced the CDM and Maintenance Director on the importance of maintaining an ice machine that is sanitary.</p> <p>The IP, or designee, will perform random observations weekly to ensure proper hygiene is being practiced by the laundry personnel. Findings will be reported to the Administrator.</p> <p>The Licensed Nurse, or designee, will review new admissions, or re-admissions, to identify whether EBP are necessary. Should precautions be identified they will be implemented at time of admission or readmission. The IP, or designee, will perform random audits of those requiring EBP and then ensure implementation was timely.</p> <p>The IP, or designee, will perform random observations weekly to ensure that proper</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 45</p> <p>During an interview on 9/5/24 at 12:30 p.m. with LA, LA confirmed she did not perform hand hygiene practices before touching clean linen, before donning and after removing gloves. LA stated there could be a contamination of soiled and clean linen.</p> <p>During an interview on 9/6/24 at 10:33 a.m. with the Infection Preventionist (IP), the IP expected staff to wash hand or use hand sanitizer prior to put on and removing gloves.</p> <p>A review of the facility's policy titled, "Department (Environmental Services) - Laundry and Linen," dated 1/2014, indicated "Wash hands after handling soiled linen and before handling clean linen." The policy further stipulated, "Always wash hands after completing the task and removing gloves. Wash hands before handling clean linen."</p> <p>A review of the facility's policy titled, "Handwashing/Hand Hygiene," dated 8/2019, indicated, "Hand hygiene is the final step after removing and disposing of personal protective equipment."</p> <p>2. A review of Resident 331's admission record, indicated Resident 331 was admitted to the facility in August of 2024 with diagnoses that included, urinary tract infection (UTI; when bacteria multiply in the urinary organs), sepsis (a severe response to infection which can lead to organ damage), and chronic kidney disease (when kidneys are damaged and can't filter blood properly).</p> <p>A review of Resident 331's "Order Summary Report," dated 9/4/24, indicated Resident 331 had an active order that started on 8/19/24 for an</p>	F 880	<p>hand hygiene is being practiced with Residents prior to and after eating or handling food. Findings will be reported to the Administrator.</p> <p>The RD, or designee, will perform spot checks of the inside of the ice machine monthly, and clean as needed. The service provider for the ice machine will perform scheduled maintenance at least every six months per manufacturer's recommendations. Findings will be reported to the Certified Dietary Manager and to the Administrator.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;</u></p> <p>The IP, or designee, will monitor for compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.</p> <p><u>Date corrective action will be completed.</u></p>	10/4/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
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F 880	<p>Continued From page 46</p> <p>indwelling urinary catheter (IUC: a medical device that drains and collects urine from the bladder) and a peripherally inserted central catheter intravenous line (PICC IV: a long thin tube put into a vein used to deliver medications over a long period of time).</p> <p>During an interview on 9/4/24 at 1:52 p.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated a timely set up of personal protective equipment (PPE: supplies, such as gloves, gowns, face masks, goggles, to minimize exposure to hazards) and signage indicating a resident was on a transmission based precaution (TBP: the use of additional PPE is required when a resident is suspected or known to be infected or a carrier of a transmissible agent) or EBP was important. CNA 2 added if TBP/EBP were not set up timely, staff could be going in and out of the room without use of recommended PPE and risk the spread of germs to residents and staff.</p> <p>During a concurrent observation and interview with Resident 331 on 9/4/24 at 2:13 p.m., outside Resident 331's room was a posted sign indicating Resident 331 was on EBP and listed the recommended PPE to wear when assisting him. Next to the door was a cart with PPE supplies. Resident 331 stated he had been in the facility for over two weeks and was placed on EBP today.</p> <p>Duirng an interview on 9/4/24 at 2:27 p.m. with CNA 7, CNA 7 stated residents with indwelling medical devices would be put on EBP and staff relied on the nurse who processed the resident's admission to set up TBP/EBP signage and supplies when indicated, so staff would know how to prevent the spread of infections while working with the resident.</p>	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 47</p> <p>During an interview on 9/4/24 at 3:02 p.m. with the IP, the IP stated EBPs were important in controlling the spread of infections in the facility and the facility will implement EBP for residents with indwelling medical devices such as an IUC and PICC IV. The IP confirmed Resident 331 was admitted over two weeks ago with a PICC IV and IUC but had not been put on EBP until today. The IP acknowledged the best practice was to initiate EBP as soon as possible to limit the spread of infection and Resident 331's EBP should have been implemented sooner.</p> <p>A review of the facility's policy and procedure titled, "Enhanced Barrier Precautions," dated August 2022, indicated, "... enhanced barrier Precautions (EBPs) are used as an infection prevention and control intervention...EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not apply...EBPs are indicated....for residents with wounds and/or indwelling medical devices... the EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical devices that places them at increased risk..."</p> <p>3. A review of Resident 335's admission record, indicated Resident 335 was admitted to the facility in August of 2024 with diagnoses that included heart disease, muscle weakness, and UTI.</p> <p>A review of Resident 335's minimum data set (MDS: an assessment tool), dated 8/21/24, indicated Resident 335 did not have memory problems and required staff supervision and</p>	F 880			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 48</p> <p>assistance with personal hygiene including washing hands.</p> <p>A review of Resident 335's care plan, initiated 8/17/24, indicated, "[Resident 335] is a high risk for infection ... interventions ...observe good hand hygiene ..."</p> <p>During an observation on 9/3/24 at 11:48 a.m., in the communal dining room, Resident 335 was sitting at a table when facility staff asked Resident 335 to return to her room and Resident 335 left the dining room. At 11:59 a.m. Resident 335 returned to dining room and sat at a table waiting for lunch while no staff offered to assist Resident 335 with hand hygiene. At 12:06 p.m. Resident 335 was served her lunch meal.</p> <p>During an interview on 9/3/24 at 12:09 p.m., Resident 335 stated staff had not helped her or ensured she performed hand hygiene prior to serving her lunch.</p> <p>During an interview on 9/3/24 at 12:10 p.m. with Restorative Nursing Assistant 1 (RNA 1), RNA 1 stated staff were expected to offer residents hand sanitizer prior to meals. RNA 1 further stated staff had "just forgot today" to offer Resident 335 hand sanitizer when she returned.</p> <p>During an interview on 9/3/24 at 12:19 p.m. with RNA 2, RNA 2 acknowledged when a resident left the dining room and came back, the resident should have been offered hand sanitizer before eating.</p> <p>During an interview on 9/6/24 at 12:08 p.m. with CNA 3, CNA 3 stated he is often assigned to work in the dining room during lunches. CNA 3</p>	F 880			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 49</p> <p>confirmed staff were expected to offer and or assist residents with hand hygiene prior to getting served their food to prevent residents from getting sick.</p> <p>During an interview on 9/6/24 at 12:12 p.m. with the IP, IP stated he expected staff to offer residents hand hygiene prior to meals for infection prevention purposes.</p> <p>A review of the facility's P&amp;P titled, "Handwashing/Hand Hygiene," dated August 2019, indicated, "...this facility considers hand hygiene the primary means to prevent the spread of infections...all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in prevention the transmission of healthcare-associated infections....use an alcohol-based hand rub....or, alternatively, soap... and water for the following situations...before and after eating or handling food..."</p> <p>4. During a concurrent observation and interview on 9/3/24 at 10:31 a.m. with the Maintenance Director (MD), the kitchen's ice machine was inspected. On the top panel of the ice machine there was a white plastic covering the cascading water portion of the ice machine, the plastic cover was lifted up and exposed the left and right bottom portions of the ice machine. A white paper napkin was used to wipe the bottom left and right side portions of the ice machine. The bottom right and left hand corner of the ice machine was observed to have the presence of a blackish colored material that adhered to the white paper napkin. MD confirmed the findings found on the white paper napkin and stated the blackish growth should not be there and the ice machine was not clean.</p>	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 50  During an interview on 9/3/24 at 10:45 a.m. with the Administrator (ADM) and the Certified Dietary Manager (CDM), CDM confirmed the presence of the blackish growth and stated it should not be there and the ice machine was not clean. ADM also confirmed the blackish growth that was on the white napkin.  A review of facility's policy and procedure, titled "Ice Machines and Ice Storage Chests," revised 1/12, indicated: "...Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice...Our facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions."	F 880			
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)  §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain an essential kitchen equipment in good working order and repair for a census of 81, when freezer number (#) six was observed to have an internal temperature of 10 degrees Fahrenheit (a unit of measure for temperature) and was not in good repair.  This failure had the potential for residents to become sick from food borne illnesses.	F 908	F908 483.90(d)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  <u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</u>  On 9/3/2024, the Maintenance Director realigned the freezer seal to ensure proper operation of the freezer and the CDM replaced the thermometer in freezer #6.  <u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</u>  All residents have the potential to be		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 908	<p>Continued From page 51</p> <p>Findings:</p> <p>During a concurrent observation and interview on 9/3/24 at 8:25 a.m. with the Certified Dietary Manager (CDM) in the kitchen dry storage area, freezer # six was inspected and the thermometer inside the freezer indicated the temperature was 10 degrees Fahrenheit. A box of turkey ham was stored in the freezer and was rock hard to touch. CDM confirmed the thermometer indicated 10 degrees Fahrenheit and stated the freezer temperature must be kept at zero degrees Fahrenheit or lower. CDM further stated Freezer # six's door seals were not forming a tight seal. Freezer # six had an accumulation of frost inside the top part of the freezer. CDM stated a latch at the bottom part of the freezer door was needed so it can be in closed and locked position and to ensure a tight seal was maintained. CDM confirmed freezer # six's seals were loose and there was a built-up of frost in the freezer because of the inadequate seal and stated she regularly had been removing the frost built up and a new freezer was needed.</p> <p>A review of the facility's policy titled, "Food Storage," dated 1/1/17, indicated: "...Frozen foods shall be stored and displayed in their frozen state unless being thawed in accordance with the current Food Code."</p> <p>A review of the Food and Drug Administration article titled, "Refrigerator Thermometers - Cold Facts about Food Safety, dated 3/5/24, indicated "To ensure that your refrigerator is doing its job, it is important to keep its temperature at 40 °F[Fahrenheit] or below; the freezer should be at 0 °F."</p>	F 908	<p>affected by the deficient practice.</p> <p>On 9/3/2024, the CDM inspected all other freezers to ensure door seals were seated properly and that temperatures were within acceptable range per regulation. Additional thermometers were placed in each freezer as a secondary measure of temperature compliance.</p> <p><u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</u></p> <p>On 9/17/2024, the RD and CDM in-serviced the dietary staff on proper checking and logging the freezer temperatures, as well as verifying that the seals on the doors are functioning properly.</p> <p>The RD, or CDM, will perform random audits of the freezer temperature logs and thermometers, as well as check that the freezer doors are sealed properly.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;</u></p> <p>The CDM, or designee, will monitor for</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 919 F 919 SS=E	Continued From page 52 Resident Call System CFR(s): 483.90(g)(1)(2)  §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-  §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure six residents (Resident 14, 26, 30, 38, 42, and 51) out of 20 sampled residents had call lights (equipment used by a patient to alert or communicate with a caregiver) within easy reach or call lights that were operable.  This failure had the potential for residents to be unable to contact nursing staff when needed.  Findings:  A review of Resident 51's Admission Record, indicated Resident 51 was admitted to the facility in October 2021 with diagnoses which included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and dementia (a group of thinking and social symptoms that interferes with daily functioning).  During a concurrent observation and interview on 9/3/24 at 10:37 a.m. with Resident 51, in Resident 51's room, Resident 51's call light was	F 919 F 919	compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.  <u>Date corrective action will be completed.</u>  F919 483.90(g)(1)(2) RESIDENT CALL SYSTEM  <u>How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</u>  On 9/3/2024, the Maintenance Director replaced the broken call lights for Residents 26, 30, and 51.  On 9/3/2024, the Maintenance Director replaced the missing call light for Resident 38.  On 9/3/2024, the CNA placed the call light within reach for Residents 14 and 42.  <u>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</u>  All residents have the potential to be affected by the deficient practice.  On 9/3/2024, the Maintenance Director rounded the facility to ensure that all call lights were not missing and functioning	10/4/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 919	<p>Continued From page 53</p> <p>observed coiled on the wall where the call light attaches, broken, without a button to push. Resident 51 stated "I don't know where my call light is."</p> <p>During a concurrent observation and interview on 9/3/24 at 12:58 p.m. with Certified Nursing Assistant 9 (CNA 9), in Resident 51's room, CNA 9 confirmed Resident 51's call light was out of reach and inoperable. CNA 9 stated "It doesn't work, the button is broken."</p> <p>A review of Resident 51's care plan indicated Resident 51 was at risk for falls and staff needed to "place call light within easy reach."</p> <p>A review of Resident 42's Admission Record, indicated Resident 42 was admitted to the facility in April 2023 with diagnoses which included senile degeneration of the brain (loss of intellectual ability).</p> <p>During a concurrent observation and interview on 9/3/24 at 10:55 a.m. with Resident 42, in Resident 42's room, Resident 42's call light cord was observed wrapped around the bed rail hanging off the right side of the bed close to the floor. When questioned if Resident 42 could reach the call light, Resident 42 stated, "I can't find the call light, they should have that where I can reach it."</p> <p>During a concurrent observation and interview on 9/3/24 at 11 a.m. with CNA 9, in Resident 42's room, CNA 9 confirmed Resident 42's call light was not easily within reach.</p> <p>A review of Resident 42's care plan indicated Resident 42 was at risk for falls and staff needed</p>	F 919	<p>properly. No other findings were identified.</p> <p>On 9/3/2024, the CNA's verified that all call lights were within reach of the residents.</p> <p><u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:</u></p> <p>On 9/24/2024, the Administrator reviewed the policy for call lights with the Maintenance Director, and special attention was given to ensuring call lights are not missing and not broken at all times.</p> <p>Starting on 9/10/2024, the DON in serviced Licensed Nurses on how to log broken call lights, where to find spare call lights, and the importance to check that call lights are within reach of the residents when in their room.</p> <p>Starting on 9/19/2024, the DSD in serviced CNA's on how to log broken call lights, where to find spare call lights, and the importance to check that call lights are within reach of the residents when in their room.</p> <p><u>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action</u></p>		

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F 919	<p>Continued From page 54</p> <p>to "be sure the resident's call light is within reach and encourage the resident to use it."</p> <p>A review of Resident 14's Admission Records, indicated Resident 14 was admitted to the facility in February 2022 with diagnoses which included hemiplegia (paralysis on one side of the body) and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures).</p> <p>During an observation on 9/3/24 at 3:35 p.m. in Resident 14's room, Resident 14 was unable to locate the call light. Resident 14 attempted to locate the call light in the bed; however, with contractures (limited range of motion) to Resident 14's right hand, Resident 14 was unable to locate the call light on the right side of the bed.</p> <p>During a concurrent observation and interview on 9/3/24 at 3:40 p.m. with CNA 6 in Resident 14's room, CNA 6 was unable to locate Resident 14's call light. CNA 6 had to dig under two of Resident 14's pillows to locate the call light. CNA 6 stated, "[Resident 14's] right hand is very contracted and needs the call light closer to [Resident 14's] left hand."</p> <p>A review of Resident 14's care plan indicated Resident 14 was at risk for falls and injuries and to "keep call light within reach." Resident 14's care plan also indicated Resident 14 had a self-care deficit and to "[keep] call light within reach and answer promptly."</p> <p>A review of Resident 38's Admission Record, indicated Resident 38 was admitted to the facility in March 2023 with diagnoses which included encephalopathy (any brain disease that alters</p>	F 919	<p><u>evaluated for its effectiveness. The POC is integrated into the quality assurance system;</u></p> <p>The DON, or designee, will monitor for compliance and will report trends to the monthly QAPI Committee meeting for recommendation and follow through x 3 months then evaluate.</p> <p><u>Date corrective action will be completed.</u></p>	10/4/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>055289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/06/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>LODI CREEK POST ACUTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>321 WEST TURNER ROAD LODI, CA 95240</b>		
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F 919	<p>Continued From page 55</p> <p>brain function or structure) and chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe).</p> <p>During a concurrent observation and interview on 9/3/24 at 3:47 p.m. with CNA 5 in Resident 38's room, CNA 5 confirmed that Resident 38 did not have a call light available.</p> <p>During a concurrent observation and interview on 9/3/24 at 4:06 p.m., with the Maintenance Director (MD) in Resident 38's room, the MD confirmed Resident 38 did not have a call light. The MD stated, "Call lights that aren't working or if the resident doesn't even have one, I should be notified immediately."</p> <p>A review of Resident 38's care plan indicated Resident 38 had a risk for further falls due to poor or no safety awareness and to "place the call light within easy reach and to remind [Resident 38] to call for assistance."</p> <p>A review of Resident 30's Admission Record, indicated Resident 30 was initially admitted to the facility in August 2023 with diagnoses which included COPD and diabetes mellitus, type 2 (DM II, a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>During a concurrent observation and interview on 9/3/24 at 3:53 p.m., with CNA 5, in Resident 30's room, CNA 5 confirmed Resident 30's call light was broken and inoperable. CNA 5 stated, "There's no button, there should be a button."</p> <p>A review of Resident 30's care plan, indicated</p>	F 919			



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F 919	<p>Continued From page 56</p> <p>Resident 30 was found on the floor sitting next to her bed and wheelchair. The nursing staff initiated the following interventions to decrease Resident 30's risk for falls, "Encourage to use call for help before attempting to transfer or ambulate ...keep call light within reach and answer promptly."</p> <p>A review of Resident 26's Admission Record, indicated Resident 26 was initially admitted to the facility in March 2021 with diagnoses which included Huntington's disease (an inherited condition in which nerve cells in the brain break down over time) and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).</p> <p>During a concurrent observation and interview on 9/3/24 at 4:06 p.m. with the MD, in Resident 26's room, the MD confirmed Resident 26's call light was broken and inoperable. The MD stated, "These call lights that aren't working should be reported to me immediately ...this needs to be fixed immediately."</p> <p>During an interview on 9/5/24 at 4:03 p.m. with the Director of Nursing (DON), the DON stated, "Call lights are expected to be close to resident, within easy reach; and the call light needs to be working ... without the call light residents would not be able to alert staff for their needs or if there was a safety concern."</p> <p>A review of the facility's policy and procedure (P&amp;P) titled, "Call System, Resident," dated September 2022, indicated "Each resident is provided with a means to call staff directly for assistance from his/her bed ...the resident call system remains functional at all times."</p>	F 919			

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F 919	Continued From page 57  A review of the facility's P&P titled, "Answering the Call Light," dated September 2022, indicated "Be sure that the call light is plugged in and functioning at all times ...Ensure that the call light is accessible to the resident when in bed ...and from the floor ...Report all defective call lights to the nurse supervisor promptly."	F 919			