| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165450 | A. Building<br>B. Wing | 10/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Accura Healthcare of Toledo, LLC | 403 Grandview Drive<br>Toledo, IA 52342 |

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| F 0567<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to manage his or her financial affairs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907<br><br>Based on clinical record review, staff and resident interviews and facility policy review, the facility failed to routinely honor same day requests for money from 1 of 3 residents reviewed ( Resident #44). Resident #44 stated she often had to wait longer than a day to receive her monthly $50 from the Social Services Designee (SSD). The facility reported a census of 48 residents.<br><br>Findings include:<br><br>A Minimum Data Set (MDS) assessment dated [DATE] documented diagnoses for Resident #44 that included anxiety, depression and Post Traumatic Stress Disorder (PTSD). A Brief Interview for Mental Status test revealed a score of 15 out of 15, which indicated this resident's memory and cognition was intact.<br><br>During interview on 10/12/22 at 2:37 PM, Resident #44 stated that she was waiting to receive her monthly $50 from the SSD. Resident #44 stated she often has to wait for her money and had asked staff several times this month to have social services bring her her money; she still hadn't received it. Resident #44 stated that happened all the time and she has to wait over a day to receive her money most of the time.<br><br>On 10/18/22 at 9:46 A.M., the SSD stated the residents tell her when they would like their $50. If they do not ask, she does not get the money for them and the $50 per month would remain in their account. The SSD said that if a resident would request to receive the $50 every month she would set that up for them, but no residents had asked for that. The SSD stated the facility kept $200 on site and so if that money is given out, a request after that could take 2 days to get more money. When asked if money is available on the weekends or off hours, the SSD stated yes, and that staff can access the $200 dollars that is kept at the facility. The SSD said residents have become upset before because she can't get their money to them right away, but they should know it could take 2 days or more.<br><br>The facility's Resident Trust Funds (RFMS) policy, revised on 11/1/21, documented that no more than $50 per day per resident will be issued in the form of cash. Larger requests for funds require a 24 hour notice or will be issued by a check.<br><br>Review of an undated RFMS list provided by the SSD revealed Resident #44 was on the list. |



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

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875<br><br>Based on clinical record review, staff interviews, and facility policy review the facility failed to notify the physician and family for a significant change in condition for 1 of 14 residents reviewed (Residents #32). The facility reported a census of 48 residents.<br><br>Findings include:<br><br>Resident #32's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact memory and cognition. The MDS indicated Resident #32 had highly impaired vision with object identification in question but his eyes appeared to follow objects. Resident #32 did not wear corrective lenses. The MDS included diagnoses of osteomyelitis of right ankle/foot, hypertension, heart failure, diabetes mellitus, dementia, and morbid obesity.<br><br>A Health Status Note dated 10/5/22 at 7:11 p.m. recorded the resident reported to staff that his vision had gotten worse. Resident #32 reported he could not see his clock except for the black coloring around the outer edges. Resident #32 reported to staff he was to notify his doctor if his eyesight became worse. The clinical record documented staff notified the physician via fax (facsimile) due to the doctor's office being closed. The resident's record lacked documentation if the facility received a return fax from the doctor's office, if the physician was aware of the decline in his vision and also lacked notification to the family regarding the decline in vision and change in condition.<br><br>During an interview on 10/17/22 at 4:04 p.m. Staff G, Assistant Director of Nursing reported she called the doctor's office regarding the fax sent out 10/05/22 and the office reported they did not have the fax.<br><br>The facility's Clinical Change in Condition Management Policy, revised June 2015, instructed the interdisciplinary team strives to identify and manage all residents that are experiencing a change in condition. The policy directed staff to contact the physician and provide clinical data and information about the resident's condition. The policy further directed staff to document the notification and physician response in the resident's medical record and to verify that a family or responsible party has been notified. |

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assure that each resident's assessment is updated at least once every 3 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441<br><br>Based on clinical record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments in a timely manner using the Resident Assessment Instrument (RAI) directed by Centers for Medicaid and Medicare Services (CMS) for 7 of 14 residents reviewed (Residents #2, #3, #5, #6, #7, #8 and #14). The facility reported a census of 48 residents.<br><br>Findings include:<br><br>Review of facility form titled Premier Estates of [NAME] Assessment History MDS 3.0 revealed the following:<br><br>a. Resident #2's quarterly assessment dated [DATE] completed 10/8/22.<br><br>b. Resident #3's quarterly assessment dated [DATE] completed 10/8/22.<br><br>c. Resident #5's quarterly assessment dated [DATE] completed 10/8/22.<br><br>d. Resident #6's quarterly assessment dated [DATE] in progress during the survey of 10/10 - 10/20/22.<br><br>e. Resident #7's quarterly assessment dated [DATE] completed 10/8/22.<br><br>f. Resident #8's quarterly assessment dated [DATE] completed 10/8/22.<br><br>g. Resident #14's quarterly assessment dated [DATE] completed 10/12/22.<br><br>During an in interview 10/20/22 at 11:00 AM, the Director of Nursing (DON) stated the facility does not have a policy in place for completing MDS assessments and the expectation is to follow the RAI cycle. The DON stated the expectation is for the MDS assessments to be completed in a timely manner. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441<br><br>Based on clinical record review and staff interview, the facility failed to complete a follow-up Preadmission Screening and Resident Review (PASRR) for two out of two residents reviewed who had a change in mental health diagnoses (Residents #8 and #44). The facility reported a census of 48 residents.<br><br>Findings include:<br><br>1. The annual Minimum Data Set (MDS) assessment dated [DATE] documented Resident #8 had diagnoses that included Huntington's disease, schizophrenia and depression. The MDS indicated the resident had no serious mental illness and had not met criteria for a Level 2 PASRR. The MDS documented she admitted to the facility on [DATE] and received antipsychotic and antidepressant medications for 7 of 7 days during the look-back period.<br><br>Review of the MDS assessment dated [DATE] revealed Resident #8 received antipsychotic and antidepressant medications for 7 of 7 days during the look-back period.<br><br>The Care Plan revised 8/24/22 revealed Resident #8 had a behavior problem with increased agitation, yelling and resistance to care. The Care Plan directed staff to monitor her behavior episodes and attempt to determine underlying cause.<br><br>The medical record revealed a PASSR Level 1 screening completed on 5/6/16 which documented nursing facility placement was appropriate for Resident #8 and no further Level 1 screening was required unless the resident was known to have or suspected of having a major mental illness. The PASSR Level 1 screening further documented Resident #8 did not have a major mental illness at the time of the screening including schizophrenia.<br><br>Resident #8's Medical Diagnosis list recorded diagnoses of schizoaffective disorder effective 6/29/16. The medical record lacked a Level II PASSR evaluation following her new mental health diagnoses.<br><br>During an interview 10/18/22 at 10:15 AM the Director of Nursing (DON) acknowledged a Level II PASSR evaluation had not been completed as expected following Resident #8's schizoaffective disorder diagnoses.<br><br>On 10/19/22 at 1:32 PM, the DON stated the facility did not have a policy for PASSR.<br><br>40907<br><br>2. The MDS assessment dated [DATE], documented Resident #44 had diagnoses that included anxiety, depression and Post Traumatic Stress Disorder (PTSD). A Brief Interview for Mental Status revealed a score of 15 out of 15, which indicated this resident's cognition was intact.<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Notice of PASRR Level II Outcome with a Notice Date of 3/30/22, documented that Resident #44 had diagnoses of recurrent severe major depressive disorder without psychotic disorder, mood disorder secondary to VCP (valosin-containing protein) and generalized anxiety disorder. A list of diagnoses printed on 10/18/22, documented that Resident #44 had a diagnoses of PTSD dated 4/1/21. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907<br><br>Based on clinical record review, resident and staff interviews, and facility policy review, the facility failed to update care plans with changes for 4 out of 16 residents reviewed (Residents #25, #44, #8 and #32). The facility reported a census of 48 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) assessment dated [DATE], documented Resident #25's diagnoses included hip fracture, acute respiratory failure, difficulty in walking and reduced mobility. The assessment documented she had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated moderately impaired cognition. The resident required a limited assist of 1 for transfers and ambulation.<br><br>During interview on 10/10/22 at 2:14 P.M., Resident #25 stated that she had went to rehabilitation (rehab) and then they stopped and haven't done anything since. She stated she had gotten pretty weak with walking. The resident stated that she would use her walker and staff would walk beside her with a belt on. She stated they did have her walking outside with assistance but they quit doing that.<br><br>A progress note dated 10/5/22 at 9:48 A.M., documented a care conference was held with Resident #25, the Licensed Home Administrator, the Director of Rehab, and the Social Services designee. Resident #25 continued to have unrealistic goals to return home independently. Since last Friday she had refused to participate in walk-to-dine program therapy had setup for her to continue to maintain strength. When asked why she was not walking to the dining room, she stated, I'm mad I wanted to go home last week. The resident was again educated on the goals she needs to be able to do in order to return to the community. Resident #25 reported her sister is out of the country for 1 year, so she had no support system in place at this time. Staff planned to obtain orders for therapy PT/OT (Physical Therapy/Occupational Therapy) and reviewed her I-POST (an advance health care directive) with no changes.<br><br>On 10/14/22, Resident #25 stated she did not want to walk to the dining room. She stated she has a cold right now and does not want to be in front of people.<br><br>On 10/18/22 at 11:11 A.M., the Director of Rehab, COTA (Certified Occupational Therapy Aide), stated Resident #25 was released from therapy on a walk-to-dine program. Resident #25 had been participating in the walk-to-dine program, but she hadn't been feeling well as of late so had been refusing.<br><br>Review of Resident #25's Care Plan after conversation with the Director of Rehab revealed no restorative interventions care planned for the resident.<br><br>2. The MDS assessment dated [DATE] documented diagnoses for Resident #44 included anxiety, depression and Post Traumatic Stress Disorder (PTSD). The resident scored 15 out of 15 on the BIMS test, indicating intact memory and cognition. Resident #44 required the extensive assistance of 2 for toilet use, transfers, and bed mobility.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #44's Care Plan instructed the following:<br><br>a. Resident #44 required intermittent assistance with using the restroom, initiated 4/12/21 and revised on 4/25/21.<br><br>b. Ensure the resident had an unobstructed path to the bathroom, initiated 4/12/21 and revised on 4/25/21.<br><br>c. Resident #44 generally utilized a commode independently and staff assist upon her request, initiated 4/12/21.<br><br>An email response from the Director of Nursing (DON) on 10/20/22 at 1:43 P.M., when asked about the above Care Plan interventions, the DON documented the resident used the bedpan.<br><br>42441<br><br>3. The MDS assessment dated [DATE] documented Resident #8 had diagnoses that included Huntington's disease, schizophrenia and depression. The MDS documented the resident had severely impaired cognition and received antipsychotic and antidepressant medications for 7 of 7 days during the look-back period.<br><br>Resident #8's Care Plan, revised on 8/24/22, lacked a focus area or intervention for diagnoses of schizophrenia.<br><br>During an interview 10/18/22 at 11:56 AM, the DON stated the expectation that schizophrenia would be addressed on Resident # 8's Care Plan.<br><br>During an interview 10/20/22 at 11:00 AM the DON stated a Care Plan is a working document and should be accurate and updated on an almost daily basis as it reflects what is going on with the resident at the time.<br><br>46875<br><br>4. Resident #32's MDS assessment of 7/15/22 identified a BIMS score of 15. The MDS indicated Resident #32 had highly impaired vision with object identification in question but his eyes appeared to follow objects. The MDS recorded Resident #32 did not wear corrective lenses. The resident's diagnoses included osteomyelitis of right ankle/foot, hypertension, heart failure, diabetes mellitus, dementia, and morbid obesity.<br><br>Review of Physician Progress notes revealed Resident #32 had an extensive medical history regarding his eye conditions. Resident #32 had been diagnosed ,d+[DATE] with Proliferative/Neurovascular Diabetic Retinopathy with macular edema and vitreous hemorrhage of the right eye. Resident #32 had a past eye surgery on 4/5/22 to his right eye.<br><br>A Health Status Note dated 10/5/22 at 7:11 p.m. recorded the resident reported to staff that his vision had gotten worse. Resident #32 reported he could not see his clock except for the black coloring around the outer edges. The clinical record recorded Resident #32 had eye surgery scheduled on 10/13/22. The surgery had been planned prior to Resident #32 reporting the decline in his vision.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Resident #32's Care Plan, revised 8/22/22. did not address Resident #32's past or present medical conditions and complications related to his vision. The Care Plan lacked any updates or changes since his decline in vision on 10/5/22. The Care Plan lacked any focus areas, goals or interventions related to Resident #32's vision problems.<br><br>The facility's policy titled Clinical Change in Condition Policy, revised June 2015, directed staff to review Care Plan goals and interventions, modify as indicated and update staff of changes.<br><br>During an interview 10/17/22 at 12:00 p.m. Staff G, Assistant Director of Nursing (ADON) reported she was not aware Resident #32's vision had declined. The ADON stated she would expect the resident's Care Plan to address his impaired vision and stated that is what the care plan is for.<br><br>During an interview on 10/18/2022 at 10:45 a.m. the DON stated the expectation that Care Plans be revised when changes occur. The DON reported the Care Plan is a working document. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875<br><br>Based on clinical record reviews, observations, resident and staff interviews, and facility policy review, the facility failed to provide care and services according to accepted standards of clinical practice for 4 of 4 residents reviewed (Residents #49, #30, #34, #32) for administration of medications and supplements. The facility reported a census of 48 residents.<br><br>Findings include:<br><br>1. Resident #49 admitted to the facility on [DATE], according to the clinical census form dated 10/13/22. Resident #49 did not have a Minimum Data Set (MDS) completed at the time of the survey.<br><br>A physician order dated 10/4/22 directed staff to administer psyllium (fiber) powder 58.6% 10 cubic centimeters (cc) by mouth one time a day in 8 ounces of juice or water to assist with bowel management.<br><br>Review of Resident #49's electronic medication administration record (EMAR) for October 2022 documented daily administration of psyllium powder.<br><br>On 10/12/22 at 8:10 a.m. observation revealed Staff A, Certified Medication Aide (CMA) prepare the resident's psyllium powder with water in a plastic cup. Staff A observed Resident #49 drink half of the medication and then left the room. Staff A failed to observe and ensure Resident #49 received all of the medication before leaving.<br><br>The facility policy titled Medication Administration revised January 2013 directed staff to remain with residents until all medication is taken.<br><br>During an interview on 10/12/22 at 10:20 a.m. the Director of Nursing (DON) reported she would expect the CMA to observe the resident take all of the fiber drink prior to leaving the room to ensure the resident received all the medication.<br><br>2. Resident #30's MDS assessment dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. The assessment documented diagnoses of cardiorespiratory conditions which included chronic obstructive pulmonary disease (COPD), Non-Alzheimer's dementia, and congestive heart failure (CHF).<br><br>The Care Plan revised 8/31/20 identified Resident #30 had diagnosis of COPD and instructed staff to give aerosol or bronchodilators as ordered and to monitor any side effects. The Care Plan also documented Resident #30 had impaired cognitive function and thought processes related to dementia.<br><br>A Physician Order dated 6/30/21 directed staff to administer Symbicort aerosol inhaler 2 puffs inhaled orally two times a day (BID) related to COPD.<br><br>Resident #30's EMAR for October 2022 documented administration of the Symbicort inhaler twice a day.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 10/12/22 at 9:02 a.m. observation revealed Staff B, CMA provided the Symbicort inhaler to Resident #30. Resident #30 self-administered the inhaler. Resident #30 took two quick puffs from the inhaler, one after another. Resident #30 did not inhale or hold her breath during medication administration. Staff B did provide Resident #30 with instructions or directions on how to use the inhaler for maximum benefit.<br><br>The facility's policy titled Medication Administration Metered Dose Inhaler revised January 2013 instructed staff to complete the following steps when administering a inhaler:<br><br>Point #9 - Staff instruct the resident to exhale to their lungs, place the tip of the spacer in the mouth and maintain a tight seal.<br><br>Point #10 - Staff to instruct the resident to activate the inhaler during the first third of a slow maximal inhalation and continue to inhale until lungs are filled with air.<br><br>Point #11 - Staff to instruct the resident to hold their breath for 3-5 seconds, as able.<br><br>Point #12 - Staff are to wait at least one minute for multiple inhalations of the same drug.<br><br>During an interview on 10/12/2022 at 10:20 a.m. the DON reported she would expect the CMA to supervise the administration of the inhaler to ensure the inhaler is given appropriately according to standards of practice.<br><br>3. Resident #34's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS identified Resident #34 as having moisture associated skin damage in the seven-day lookback period. The MDS also identified the facility had placed a pressure reducing device in the resident's chair/bed and provided a treatment of ointment. The resident's assessment documented diagnoses that included hypertension, heart failure, diabetes mellitus, depression, and morbid obesity.<br><br>The Care Plan with revision date of 8/22/22 identified Resident #34 as at risk for impaired skin integrity. The Care Plan directed staff to encourage good nutrition and hydration in order to promote healthier skin.<br><br>The Dietitian's progress note dated 7/19/22 recorded that Resident #34 received Prostat twice a day to aid with meeting her protein needs for wound healing.<br><br>A Physician Order dated 4/19/22 directed staff to administer Prostat 30 cc twice a day in a drink of choice for wound healing. According to the resident's EMAR, staff failed to administer the resident's Prostat on the following dates:<br><br>a. 8/24/22<br><br>b. 8/25/22<br><br>c. 8/26/22<br><br>d. 8/27/22<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | e. 8/28/22<br><br>f. 8/29/22<br><br>g. 8/30/22<br><br>h. 8/31/22<br><br>i. 9/01/22<br><br>j. 9/02/22<br><br>Review of Progress Notes from 8/24/22 - 9/01/22 and 9/05/22 indicated the facility did not have Prostat available due to the medication not being available and out of stock.<br><br>4. Resident #32's MDS assessment dated [DATE] assessment identified a BIMS score of 15, indicating intact cognition. The MDS indicated Resident #32 had an unhealed stage three pressure ulcer during the seven day lookback period. The MDS also identified the facility had placed a pressure reducing device in the resident's chair and bed, provided pressure ulcer care, a turning program, in addition the facility added nutrition and hydration interventions. Resident #32's MDS included diagnoses of osteomyelitis of right ankle/foot, hypertension, heart failure, diabetes mellitus, dementia, and morbid obesity.<br><br>The Care Plan revised on 8/30/22 identified Resident #32 had a nutritional risk related to diagnoses of congestive heart failure, dementia, diabetes, obesity and history of pressure ulcers. The Care Plan directed staff to provide Prostat 30 milliliter four times a day to aid in wound healing.<br><br>The dietitian progress note dated 8/30/22 stated Resident #32 received Prostat twice a day to support protein needs for skin health. The progress note also stated the dietician recommended increasing the Prostat to four times a day.<br><br>A physician order dated 02/06/22 directed staff to administer Prostat 30 cc twice a day in 4 to 8 ounces of juice or water for wound healing. According to the EMAR, staff failed to administer the resident's Prostat on the following dates:<br><br>a. 8/24/22<br><br>b. 8/25/22<br><br>c. 8/26/22<br><br>d. 8/27/22<br><br>e. 8/28/22<br><br>f. 8/29/22<br><br>g. 8/30/22<br><br>(continued on next page) |

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| | 165450 | A. Building<br>B. Wing | 10/20/2022 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | h. 8/31/22<br><br>i. 9/01/22<br><br>j. 9/02/22<br><br>k. 9/03/22<br><br>l. 9/04/22<br><br>m. 9/05/22<br><br>Review of Progress Notes from 8/24/22-9/05/22 indicated the facility did not have Prostat available due to medication not being available and out of stock.<br><br>During an interview 10/18/22 at 10:45 a.m. the DON reported her expectations are for supplies like Prostat to be available. The DON stated if the supply is not available, she would expect staff to call different supply chains to locate it. The DON stated if staff could not locate the needed supply then she would expect staff to call the doctor for direction or different orders. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441<br><br>Based on clinical record review, resident and staff interview, and facility policy review, the facility failed to provide a restorative program for 2 of 2 residents reviewed (Residents #5 and #25). The facility reported a census of 48 residents.<br><br>Findings include:<br><br>1. The quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #5 documented diagnoses that included quadriplegia, muscle weakness and abnormal posture. The MDS recorded the resident had moderately impaired cognitive skills for daily decision making. The resident required the assistance of 2 staff for bed mobility, dressing and personal hygiene, and transfers. The assessment documented she had impaired range of motion (ROM) in both lower extremities and had no restorative nursing services.<br><br>Review of Resident #5's Care Plan initiated 8/29/19 and revised 8/22/22 documented the resident required a restorative program with the goal to maintain current level of function. The Care Plan directed the Restorative Nurse Aide (RNA) to complete passive ROM to both upper extremities, the Registered Nurse (RN) to monitor progress every month, and receive passive ROM to both lower extremities/stretches. The Care Plan documented Resident #5 would participate in the restorative program 2-3 times/week utilizing given interventions.<br><br>Review of Therapy/Nursing Communication dated 7/1/22 revealed staff to perform passive ROM to both the resident's upper extremities prior to applying hand splints.<br><br>During an interview 10/18/22 at 8:35 AM, Staff D, Certified Nursing Assistant (CNA) stated she does not do ROM with Resident #5 as it is to be done by a Restorative Aide (RA) and Staff D stated the facility has not an RA for a few years.<br><br>During an interview 10/18/22 at 8:45 AM the Director of Rehabilitation stated the facility does not have an aide to do restorative care.<br><br>Review of policy titled, Restorative Nursing, dated May 2014 revealed that providing restorative nursing care in a long term care facility required a management model to support the goals of restorative nursing.<br><br>During an interview 10/18/22 at 9:03 AM the Director of Nursing (DON) stated the facility does not have a written plan for a restorative program and she was unable to locate education provided to staff for performing ROM.<br><br>During an interview 10/20/22 at 11:00 AM the DON revealed need to make sure a program is in place with training for the Certified Nursing Assistants (CNAs) to work functional maintenance into daily care while working in conjunction with therapy.<br><br>40907<br><br>(continued on next page) |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. The MDS assessment dated [DATE] documented Resident #25's diagnoses included hip fracture, acute respiratory failure, difficulty in walking and reduced mobility. Resident #25 had a BIMS score of 11 out of 15, which indicated moderately impaired cognition. The resident required the limited assistance of one for transfers and ambulation.<br><br>During interview on 10/10/22 at 2:14 P.M., Resident #25 stated she went to rehabilitation (rehab) and then they stopped and haven't done anything since. The resident stated she had gotten pretty weak with walking. Resident #25 stated that she would use her walker and staff would walk beside her with a belt on. The facility did have her walking outside with assistance but they quit doing that.<br><br>A progress note dated 10/5/22 at 9:48 AM documented a care conference was held with Resident #25, the Licensed Home Administrator, the Director of Rehab, and the nurse. Resident #25 continued to have unrealistic goals to return home independently. Since last Friday she has refused to participate in the walk-to-dine program therapy had setup for her to continue to maintain strength. When asked why she was not walking to the dining room, the resident stated, I'm mad I wanted to go home last week. The resident was again educated on the goals she needed to be able to do in order to return to the community. She reported that her sister is out of the country for 1 year, so she has no support system in place at this time. Staff planned to obtain orders for physical and/or occupational therapy (PT/OT) and reviewed her I-POST (advance healthcare directive) with no changes.<br><br>On 10/14/22 Resident #25 stated she did not want to walk to the dining room. She had a cold right now and does not want to be in front of people.<br><br>On 10/18/22 at 11:11 A.M., the Director of Rehab, COTA (Certified Occupational Therapy Aide), stated that Resident #25 was released from therapy on a Walk-to-Dine program. The resident had been participating in the Walk-to-Dine program, but she hadn't been feeling well as of late so had been refusing. She stated that their OT person had been home sick lately, so they set up a teleconference for this day to meet with OT and come up with a plan for ADLs (activities of daily living) - dressing toilet use, etc as they received a new order.<br><br>On 10/18/22 at 11:48 A.M., the Director of Rehab/COTA stated she could not find where rehab had given written direction to nursing staff regarding a walk-to-dine program. She provided a therapy change/cut notice with a date of 9/2/22 and a list of walk to dine residents with a date of 4/11/22. The director stated they normally give nursing staff a copy of the recommendations for restorative care when they discharge a resident out of rehab, but she was unable to show any communication. Review of the resident's Care Plan after the above conversation revealed there were no restorative interventions care planned for Resident #25. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875<br><br>Based on clinical record review, staff and resident interview, and policy review, facility staff failed to conduct thorough and ongoing assessments and failed to provide needed interventions for 2 of 14 residents reviewed (Residents #34 and #32). The facility reported a census of 48 residents.<br><br>Findings include:<br><br>1. Resident #34's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact memory and cognition. The MDS identified Resident #34 required extensive assistance of two people with bed mobility, transfers and toilet use. The MDS indicated Resident #34 had not walked in the room or hallway during the seven day look back period. The MDS identified Resident #34 as frequently incontinent of urine with moisture associated skin damage (MASD) in the seven day lookback period. The MDS also identified the facility had placed a pressure reducing device in the resident's chair/bed and provided a skin treatment. The assessment documented her diagnoses included hypertension, heart failure, diabetes mellitus, depression, and morbid obesity.<br><br>Resident #34's Care Plan revised 8/22/22 contained the following information:<br><br>a. Resident #34 has the potential for impaired skin integrity due to limited mobility and obesity. The care plan directed staff to:<br><br>- Avoid scratching and keep hand and body parts from excessive moisture. Keep fingernails short.<br><br>- Educate resident/family/caregivers of causative factors and measures to prevent skin injury.<br><br>- Encourage good nutrition and hydration in order to promote healthier skin.<br><br>- Follow facility protocols for treatment of injury.<br><br>- Identify and document potential causative factors and eliminate/resolve where possible.<br><br>- Keep skin clean and dry. Use lotion on dry skin.<br><br>- Monitor and document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, ect, to doctor.<br><br>- Pressure reduction mattress to bed.<br><br>- Resident is independent with turning and repositioning. Assist as needed.<br><br>- Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.<br><br>b. Resident #34 had bladder incontinence. The care plan directed staff to:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Assist Resident #34 to bathroom upon request.<br><br>- Encourage Resident #34 to use the toilet as she will allow and ask staff for assistance instead of soiling herself.<br><br>- Monitor/document/report to the doctor as needed possible causes of incontinence.<br><br>- Staff to assist with peri care every morning, evening, and as needed with incontinence episodes. Change incontinence products as needed.<br><br>The Braden Scale assessment (a tool used to evaluate risk of development of a pressure ulcer) documented a score of 10-12 indicated a high risk for pressure sore development, 13-14 meant moderate risk, and 15-18 meant a risk for pressure ulcer development. Review of the Braden Scale assessments completed for Resident #34 from 1/22 - 7/22 documented scores on the following dates:<br><br>Braden Scores:<br><br>a. 7/13/22 - 13.0<br><br>b. 4/15/22 - 13.0<br><br>3. 1/13/22 - 16.0<br><br>During an interview 10/11/22 at 12:52 p.m. Resident #34 reported she had a sore bottom and staff would apply zinc ointment to the area. Resident #34 stated she had a cushion in her wheelchair and preferred to sleep in her recliner. Resident #34 stated she took protein drinks. Resident # 34 reported that she wore incontinent briefs due to bladder incontinence and she was aware when she had an incontinence episode. Resident # 34 reported staff took her to the bathroom one time per night and it used to be two times per night around 1:00 a.m. and 4:00 a.m<br><br>Review of progress notes dated 10/06/22 at 2:44 p.m. revealed Resident #34 had a new open area to the left buttocks. Staff notified the physician and received new order to cleanse the area with cleanser, apply zinc twice a day and as needed until healed.<br><br>A non-pressure skin assessment completed 10/06/22 revealed Resident #34 had an open area to the right buttock. A physician order dated 6/28/22 directed staff to apply zinc to the right buttock twice a day until the area is healed.<br><br>On 10/12/22 at 12:42 p.m. observation revealed Resident #34 had open areas to both the right and left buttocks. Resident #34 denied discomfort or pain to the open areas. Resident #34 reported she slept in her recliner and did not sleep in her bed due to breathing difficulties. Resident #34's recliner did not have a pressure reducing device on it.<br><br>During an interview on 10/12/22 at 3:15 p.m. the Director of Nursing (DON) reported on 10/06/22 she completed Resident #34's weekly skin assessment. The DON reported Resident #34 had a new open area on her left buttocks but the area to the right buttocks was not new. The DON reported Resident #34 had a history of skin breakdown to her buttocks. The DON stated the new intervention was to educate overnight certified nursing assistants (CNAs) on rounding expectations and incontinence cares.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/13/22 at 1:00 p.m. with the DON and Staff H, Licensed Practical Nurse (LPN), the DON reported that she spent an hour with Resident #34 the previous evening discussing her plan of care. The DON reported Resident #34 agreed to lie down in her bed one time a day to assist with wound healing. Staff H reported Resident #34 had ongoing skin concerns to the right and left buttocks. The DON and Staff H thought the areas were related to Resident #34's frequent incontinence. The DON reported Resident #34's physician would round at the facility next week and evaluate the areas. The DON reported she did not complete an incident report for the left buttock wound on 10/06/22.<br><br>During an interview 10/18/22 at 10:30 a.m. Staff G, Assistant Director of Nursing (ADON) reported Resident #34's Primary Care Physician (PCP) saw resident on 10/17/22. The ADON stated the PCP felt the areas on the right and left buttocks were primarily from moisture but felt pressure could be a factor. The ADON stated the PCP was considering changing the current treatment.<br><br>On 10/18/22 at 10:45 a.m. the DON provided a handwritten document detailing Resident #34's history of open areas to the right and left buttocks. The DON reported the stars on the handwritten form represented the times the family and PCP were notified. The DON verified there were gaps in skin assessments from November 2021 to February 2022 and May 2022 to July 2022 for right buttocks. The DON verified there were also several weekly skin assessments missing. The DON stated she could not find documentation in the medical record when skin areas were resolved. The DON reported the expectation is to monitor and measure the skin areas weekly and if there are any declines in the skin areas to update the PCP and notify the family. The DON also stated that she would expect the facility to document in the medical record when an area is resolved.<br><br>The handwritten document provided by the DON for Resident #34 ' s right and left buttocks wounds revealed the following dates and measurements for each area:<br><br>Right Buttocks<br><br>a. 10/28/21- 1.0 cm x 0.2 cm x 0 cm (length x width x depth)<br><br>b. 11/04/21- 1.0 x 0.2 cm x 0 cm<br><br>c. 11/11/21- 0.4 cm x 0.2 cm x 0 cm<br><br>d. 11/18/21- 0.1 cm x 0.1 cm 0 cm<br><br>e. 2/24/22- 2.0 cm x 1 cm x 0.3 cm<br><br>f. 3/10/22- 2.0 cm x 2.0 cm x 0.2 cm<br><br>g. 3/17/22- 1.7 cm x 0.7 cm x 0.1 cm<br><br>h. 3/24/22- 1.4 cm x 0.6 cm x 0.2 cm<br><br>i. 4/7/22- 1.0 cm x 1.0 cm x 0.1 cm<br><br>j. 4/14/22- 1.0 cm x 1.0 cm 0.1 cm<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | k. 4/21/22- 0.6 cm x 0.7 cm x 0 cm<br><br>l. 5/12/22- 0.5 cm x 0.5 cm x 0 cm<br><br>m. 7/07/22- 2.1 cm x 1.6 cm x 0 cm<br><br>N. 7/14/22- 1.9 cm x 1.2 cm x 0.1 cm<br><br>O. 8/11/22- 0.7 cm x 0.3 cm x 0 cm<br><br>p. 8/18/22- 0.7 cm x 0.2 cm x 0 cm<br><br>q. 8/26/22- 0.7 cm x 0.2 cm x 0 cm<br><br>r. 9/01/22- 0.3 cm x 0.7 cm x 0 cm<br><br>s 9/15/22- 0.5 cm x 0.9 cm x 0.2 cm<br><br>t 9/22/22- 0.8 cm x 0.8 cm x 0.1 cm<br><br>u. 9/29/22- 0.7 cm x 0.8 cm 0.1 cm<br><br>v. 10/06/22- 3.5 cm x 3.2 cm x 0.1 cm<br><br>w. 10/23/22- 1.0 cm x 1.0 cm 0.1 cm<br><br>Left Buttocks<br><br>a. 10/28/21- 2.0 cm x 0.5 cm x 0 cm<br><br>b. 11/4/21- 1.7 cm x 0.5 cm x 0 cm<br><br>c. 11/11/21- 0.9 cm x 0.3 cm x 0 cm<br><br>d. 11/18/21- 0.1 cm x 01 cm x 0 cm<br><br>e. 10/06/22 1.0 cm x 1.0 cm x 0.1 cm<br><br>f. 10/13/22 1.0 cm x 1.0 cm x 0.1 cm<br><br>The clinical record lacked wound evaluation/assessment completion for the following weeks:<br><br>a. November 25, 2021 - February 17, 2022<br><br>b. March 3rd<br><br>c. March 31st<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | d. April 28th<br><br>e. May 5th<br><br>f. May 19, 2022 -July 7, 2022<br><br>g. July 21st<br><br>h. July 28th<br><br>i. August 4th<br><br>j. September 8th<br><br>The resident's clinical record lacked documentation on when an open area would close/heal and/or when an area would redevelop.<br><br>The resident's clinical record lacked skin and bladder interventions to prevent and maintain the skin integrity such as a bladder program to decrease incontinence, a re-positioning program to decrease pressure and a pressure reducing device to her recliner. The clinical record lacked notifications to the physician to look at alternative treatment options for the right buttocks. The facility applied zinc ointment as a treatment to the right buttocks since the end of June 2022. The right buttock open area did not resolve with the zinc treatment and at times worsened.<br><br>During interview on 10/18/22 at 2:08 p.m. the DON reported the facility received a verbal order to change Resident #34's treatment order for the right and left buttocks. The new order directed staff to apply Purocol and cover with Optifoam, change every third day and as needed until healed.<br><br>During an interview 10/19/22 at 2:37 p.m. Resident #34's PCP stated he saw Resident #34 on rounds on Monday, 10/17/22. The PCP reported he felt the open areas on the right and left buttocks were a combination of moisture and pressure. The PCP stated Resident #34 was incontinent, wore Depends (adult incontinence briefs) and had limited mobility so there was a lot of moisture on the skin and then she sat causing pressure on top of the moisture. The PCP stated he made a change in the treatment plan and the Nurse Practitioner would re-evaluate the resident in a couple of weeks. The PCP reported there is not any way to keep Resident #34 dry and felt the facility took her to the bathroom often.<br><br>2. Resident #32's MDS assessment dated [DATE] assessment identified a BIMS score of 15. The MDS indicated Resident #32 had highly impaired vision with object identification in question but his eyes appeared to follow objects. The MDS indicated Resident #32 did not wear corrective lenses. The MDS recorded his diagnoses included osteomyelitis of right ankle/foot, hypertension, heart failure, diabetes mellitus, dementia, and morbid obesity.<br><br>During an observation 10/11/22 at 10:39 a.m. Resident #32 sat in his wheelchair and when approached, he reached his hands in the air as if he was going to grab something. An unknown staff member at the nurse's desk explained to Resident #32 there was nothing there to grab.<br><br>During an interview 10/11/22 at 10:39 a.m. Resident #32 reported he could hardly see anything and the change/decline in his vision happened suddenly about a week ago.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The clinical record revealed Resident #32 had an extensive medical history regarding eye conditions. Resident #32 had been diagnosed in April 2022 with Proliferative/Neurovascular Diabetic Retinopathy with macular edema and vitreous hemorrhage of the right eye. Resident #32 had a past eye surgery on 4/05/22 to his right eye.<br><br>Review of progress notes dated 10/05/22 at 7:11 p.m. revealed Resident #32 reported to staff his vision had gotten worse. Resident #32 reported he could not see his clock except for the black coloring around the outer edges. The clinical record revealed Resident #32 had eye surgery scheduled on 10/13/22. The surgery was planned prior to Resident #32 reporting the recent decline in his vision.<br><br>The clinical record lacked follow-up assessments for Resident #32's visual decline.<br><br>Review of progress notes dated 10/14/22 at 9:33 a.m. revealed Resident #32's eye surgery did not occur. According to the documentation, Resident #32 was taken to the wrong location and his eye surgery rescheduled for a later date.<br><br>During an interview on 10/17/22 at 3:15 p.m. Resident #32 stated he was highly disappointed in not having his eye surgery. Resident #32 voiced his frustrations on how his decline in vision had affected his day to day activities. Resident #32 stated that he can't see what he is eating anymore. He voiced frustration when watching sports on television as he can only listen to the commentators. Resident #32 stated he had hoped to have improved vision by Thanksgiving, now he hoped by Christmas.<br><br>The facility policy titled Clinical Change in Condition Management revised June 2015 instructed the interdisciplinary team strives to identify and manage all residents that are experiencing a change in condition. The policy stated daily observation and communication is important in identifying changes in residents that require further investigation. Daily observation included changes in physical assessment. The policy directed staff to assess resident clinical status when a change in condition is identified and review the resident's medical record including primary diagnostic and medical history. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907<br><br>Based on clinical record review, observation, and resident and staff interviews, the facility failed to have sufficient nursing staff to answer call lights in a timely manner for 4 out of 16 residents reviewed (Residents #18, #25, #44 and #34). Through one observation and 4 staff interviews, call lights were not answered within the required 15 minutes. The facility identified a census of 48 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) assessment dated [DATE], documented Resident #18's diagnoses included anxiety, depression and muscle weakness. A Brief Interview for Mental Status (BIMS) documented a score of 15 out of 15, which indicated intact memory and cognition. This resident required supervision with set-up help only for toilet use.<br><br>On 10/10/22 at 3:42 P.M., when asked if staff answer call lights in a timely fashion, Resident #18 laughed. She said that as a general rule it takes 30 minutes to an hour before her call light is answered. She added that it always takes that long, unless she blew her whistle. Resident #18 stated if she blew her whistle she would get a whole [NAME] responding. Observation at the time revealed a whistle around the resident's neck.<br><br>2. The MDS assessment dated [DATE], documented Resident #25's diagnoses included hip fracture, acute respiratory failure, difficulty in walking and reduced mobility. Resident #25 had a BIMS score of 11 out of 15, which indicated moderately impaired memory and cognition. This resident required a limited assist of 1 for transfers and ambulation and extensive assist of 1 for toilet use.<br><br>During observation and interview on 10/10/22 at 2:11 P.M. when asked about call light response times Resident #25 stated they are bad about answering the call light and repeated, pretty bad. Observation revealed the resident's call light as activated when the interview started. The resident stated she thought they needed a new system and staff were not over there watching the hall she lived on. Resident #25 stated that one time she had to wait over 2 hours for staff to answer her call light, and that's been several months ago. On 10/10/22 at 2:32 PM, the interview continued and the call light was still sounding. Staff answered the call light at this time. The resident stated to the staff member that her call light had been on for an hour. The staff member replied it's been a half an hour, then asked Resident #25 if she needed something? Resident #25 stated she had needed help to go to the bathroom but she just went on her own. The CNA apologized.<br><br>3. The MDS assessment dated [DATE] documented diagnoses for Resident #44 that included anxiety, depression and Post Traumatic Stress Disorder (PTSD). The assessment documented a BIMS score of 15. The resident required the assistance of 2 for toilet use, transfers, and bed mobility.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During interview on 10/11/22 at 10:58 A.M., Resident #44 stated staff take a long time to get here. When asked how long it took for staff to answer her call light, Resident #44 stated that yesterday it took about 40 minutes and added that it's taken up to 1 1/2 hours before. Resident #44 stated that it's not the staffs' fault, there just aren't enough of them, and staff do try. Resident #44 stated she is continent and just needed someone to put a bedpan under her. Staff just can't get here in time.<br><br>In an email dated 10/18/22 at 1:43 P.M., the Director of Nursing (DON), wrote that the facility did not have a call light system that records the call lights.<br><br>In an email dated 10/20/22 at 11:30 p.m., the Director of Nursing (DON) responded to emails requesting a call light response policy and if she had any issues with call light response. The DON wrote that she had not noticed issues with the call lights. The DON wrote that she was surprised by the question and planned to attend the next resident council meeting if residents wanted her to and ask them some of these directed questions so she knows the concerns and then they could work on them. The DON wrote that it's not once been voiced to her and she felt as though they (the residents) would tell her. The DON added that the facility did not have a call light response policy/protocol and that they would follow the guidelines.<br><br>46875<br><br>4. Resident #34's MDS assessment dated [DATE] assessment identified a BIMS score of 15. The MDS identified Resident #34 required the assistance of two with transfers and toilet use, had not walked in past seven days and as frequently incontinent of urine. The MDS identified Resident #34 had moisture associated skin damage in the seven day lookback period. Resident #34's assessment recorded diagnoses that included hypertension, heart failure, diabetes mellitus, depression, and morbid obesity.<br><br>During an interview on 10/12/22 at 12:42 p.m. Resident # 34 reported that staff came to take her to the bathroom last night and she had to use her call light for help. Resident #34 reported she used her call light around 3:00 a.m. for help and staff did not come to assist her to the bathroom until after 4:00 a.m. Resident #34 reported she used a clock on her wall to keep track of time. Resident #34 reported she was incontinent of urine while waiting for help and that did not make her feel good. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907<br><br>Based on clinical record review, staff and consultant pharmacist interviews, the facility failed to ensure monthly regimen review (MRR) recommendations, which included Gradual Dose Reduction (GDR) recommendations, were consistently followed up on by the physician with rationale for 4 of 5 residents reviewed (Residents #3, #7, #22 and #42). The facility reported a census of 48 residents.<br><br>Findings include:<br><br>1. A Minimum Data Set (MDS) dated [DATE], documented Resident #3's diagnoses included Non-Alzheimer's dementia and depression. This MDS documented that Resident #3 received daily antipsychotic and antidepressant medications.<br><br>Progress Notes recorded a pharmacist made recommendations for Resident #3 during MRRs on 3/8/22 and 6/8/22 and the facility was unable to provide the recommendations or the physician's response.<br><br>2. The MDS assessment 8/26/22, documented Resident #7's diagnoses included both Alzheimer's disease and Non-Alzheimer's dementia. This MDS documented that Resident #7 received daily antipsychotic, antidepressant and medications.<br><br>Progress Notes for Resident #7 recorded the pharmacist made recommendations on the following dates:<br><br>a. 6/16/21 a GDR was recommended with a physician's response of 'No Way!!!'. No rationale was provided.<br><br>b. 10/23/21 a GDR was recommended with a physician's response on 11/19/21 agreeing to the GDR; however no parameters were documented with what the GDR would be.<br><br>c. 5/10/22 recommendations were documented in the resident's progress notes, but the facility was unable to show what the recommendations were or the physician's response.<br><br>3. The MDS assessment dated [DATE], documented Resident #22's diagnoses included anxiety and depression. The assessment documented that Resident #22 received a daily antidepressant medication.<br><br>Progress Notes for Resident #18 documented the pharmacist made recommendations on the following dates without a physician's response on 3/8/22, 5/10/22 and 7/17/22.<br><br>The facility was unable to provide all of the recommendations documented in the above resident's progress notes.<br><br>During interview on 10/13/22 at 3:35 p.m., when asked about the MRRs, the Director of Nursing (DON) acknowledged the facility could not provide all recommendations from the pharmacists nor could they provide all of the physician's responses. The DOM acknowledged that one of the responses from the physician to a recommendation was 'No Way'.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 10/23/22 at 9:48 a.m., the Consultant Pharmacist stated that Resident #3 had GDR recommendations for bupropion, trazadone, and quetiapine with a request to provide rationale for continuation if no reduction on 9/9/22. She stated the recommendation stated this resident was a fall risk and the physician has not responded. The Pharmacist added that she had difficulty getting responses and the facility was not good about getting responses back to her within 30 days or by the following month when she would do the next monthly MRR. She stated if the facility does not have a response, she usually let the facility know she still needed one and then if it goes another month she would submit the same recommendations again. This Pharmacist stated that she had asked for a GDR review on 5/10/22 for Resident #7 and still had not received a response. She'd requested a GDR again on 8/9/22 and still had not received a response. The GDR request was to decrease Seroquel, Cymbalta, and alprazolam. The Pharmacist stated that the response of 'No Way!!!' from the physician was clear that he did not want a dosage reduction; however it lacked rationale as to why a GDR should not be attempted. The Pharmacist stated that for Resident #22 she requested a GDR for fluoxetine on 3/8 /22 and 5/10/22. She stated she received a response on 7/21/22 to increase her fluoxetine.<br><br>In email sent on 10/20/22 at 11:05 a.m., the DON documented the facility did not have a drug regimen review or a gradual dose reduction policy.<br><br>42441<br><br>4. The MDS assessment dated [DATE] documented Resident #28's diagnoses included Alzheimer's disease, psychotic disorder and depression. The BIMS for the resident documented a score of 3 out of 15 which indicated severely impaired cognition. The resident required supervision form ambulation and transfers.<br><br>A Consultant Pharmacist's report dated 6/8/22 documented this resident had been receiving Lexapro 20 milligrams (mg) daily and Quetiapine 100 mg (an antipsychotic) every night for Alzheimer's disease and recurrent depression was due for a review. The pharmacist recommended no reduction at the time due to the safety of the resident and asked if the physician agreed to provide specific rationale. The recommendation lacked a response from the physician. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907<br><br>Based on clinical record review and staff interview, the facility failed to limit an as needed psychotropic medication for one of 5 residents reviewed (Resident #18). Review of this resident's records revealed that Resident #18 had an as needed (PRN) antianxiety medication ordered for more than 14 days. The facility reported a census of 48.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) assessment dated [DATE], documented that Resident #18 had a diagnosis of anxiety and depression.<br><br>A pharmacy Consultation Report dated 11/12/21 to 11/15/22 documented that Resident #18 had a PRN order for an anxiolytic (antianxiety medication) without a stop date: alprazolam 0.5 mg once daily PRN. The report recommended to please consider discontinuing PRN alprazolam. It further recommended/documented if the medication cannot be discontinued at this time, current regulations required that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period. This report documented the rationale for recommendation as CMS required that PRN orders for non-antipsychotic psychotropic drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended-time period and the duration for the PRN order.<br><br>Resident #18's Medication Administration Record for 11/21 documented alprazolam 0.5 milligrams, give by mouth every 24 hours PRN for anxiety related to anxiety disorder. The medication contained an initiation date of 9/28/21 and a discontinuation of 11/19/21.<br><br>During interview on 10/13/22 DON at 3:35 p.m., the Director of Nursing (DON) acknowledged that PRN psychotropic medications should only be ordered for 14 days unless the physician provided rationale and that PRN antipsychotics could not be given for more than 14 days. In an email dated 10/20/22 at 11:05 a.m., the DON documented the facility did not have a drug regimen review or a gradual dose reduction policy. |

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| F 0774<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Help the resident with transportation to and from laboratory services outside of the facility.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907<br><br>Based on clinical record review and interviews with residents and staff, the facility failed to ensure one resident (#44) of 14 reviewed was returned to the facility from an emergency room (ER). Resident #44 reported she was left in the ER hallway for hours because the facility had not paid the local ambulance bill. The facility identified a census of 48 current residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) assessment dated [DATE] documented diagnoses for Resident #44 that included anxiety, depression and Post Traumatic Stress Disorder. A Brief Interview for Mental Status revealed a score of 15 out of 15, which indicated this resident's memory and cognition was intact. Resident #44 required the extensive assistance of 2 with transfers, did not walk and used a wheelchair for locomotion.<br><br>On 10/12/22 at 2:37 PM, Resident #44 requested to talk with a surveyor. The resident stated she felt upset about having to wait so long in the ER before someone would bring her back to the facility. She stated that she had told the Hospice nurse that she felt suicidal. The resident said that she was joking but the Hospice nurse told her she had to report it. The resident stated she then went to the ER for assessment and after assessment, she was cleared to return home. Resident #44 stated she waited for hours in the ER hallway before the hospital's ambulance would bring her back. She found out later that the ambulances nearest to the facility would not provide return services to this facility related to financial reasons. The resident stated she used to live in the facility's town and knew some of the ambulance crew. The resident stated the facility had an outstanding bill to the community ambulance, and the facility would not pay their bill. She said it was awful sitting there in the hallway waiting. It was embarrassing. She was told she had to wait until the hospital's EMS was free to bring her back to the facility. The resident could not say the exact date this occurred but said it should be in her chart.<br><br>Resident #44's Progress Notes documented the following:<br><br>a. On 7/22/22 at 1:00 p.m., Hospice nurse here to see Resident #44. When she went to the room, the resident stated she was going to fire Hospice and then commit suicide, I don't know how I will do it, maybe slit my throat but I have a plan. The Hospice nurse brought this to the author's attention. They discussed that since the resident had a plan, she needed to go to the ER and be assessed. The Hospice nurse stayed in the resident's room with her. Staff received an order to send to ER and called Resident #44's daughter to let her know.<br><br>b. On 7/22/22 at 1:25 p.m., staff phoned 911 regarding the resident's transfer. EMS arrived at 1:50 p.m. and took Resident #44 to ER. The hospital was notified of transport, and report was given<br><br>c. On 7/22/22 at 7:11 p.m., staff received a call from the ER and Resident #44 was coming back. The resident's CT (CAT scan) and all other testing was WNL (within normal limits).<br><br>d. On 7/23/22 at 2:03 a.m., this resident was wheeled into the unit (facility) by EMS about 1:15 a.m. She was made comfortable in bed and asked for her night pills.<br><br>(continued on next page) |

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| F 0774<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 10/13/22 at 3:35 p.m., the Director of Nursing (DON) stated the previous facility owners were not paying their bills. The DON stated that with the new company they are able to pay bills and receive services. The new company took over 1-2 months ago. The DON acknowledged that the local ambulance would not transport residents related to an outstanding bill. The Maintenance Director stood with the DON during the interview and agreed with the DON about the ambulance not getting paid and now they are. The DON stated they are paying their bills now. The DON was not aware of a situation where a resident had to wait for hours in the ER for transport back to the facility due to no ambulance service. Upon request, the facility did not provide a contract or policy regarding ambulance transportation. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>40907<br><br>Based on facility record review, clinical record review, observations, and interviews, the facility failed to ensure one resident (#35) served lunch on 10/12/22 received food that was mechanically altered (cut up) per the resident's diet order. The facility reported a census of 48 residents.<br><br>Findings include:<br><br>A Diet Type Report printed on 10/20/22 at 2:06 p.m. documented that Resident #35's diet order was soft texture and bite sized.<br><br>The Care Plan for Resident #35 documented an intervention revised on 4/19/22 that directed staff to serve his diet as ordered: soft and bite sized texture.<br><br>During the noon meal service on 10/12/22, the cook placed a dish of whole pears on Resident #35's tray, then placed it on the cart to be delivered to his room. After all trays on the meal cart were placed and a dietary aide prepared to deliver the trays on the cart, Staff K, cook, and the Certified Dietary Manager (CDM) were questioned if the food was going to be served as it was on the cart. Both staff said yes. When they were asked about #35's pears being whole, they both verified they should have cut up his pears into bite sized pieces. They both verified that his meal ticket that was placed on his tray stated pears-chilled and cut up. The cook took the pears off of the tray cut them up, recovered them, then the meal trays were taken from the kitchen to be delivered to residents' rooms.<br><br>A Therapeutic Diets policy revised on 9/2017, documented a mechanically altered diet meant one in which texture of the diet is altered. When the texture is modified, the type of texture must be specific and part of the physicians' or delegated registered or licensed dietitian's order. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>40907<br><br>Based on observations, staff interviews, and facility record review, the facility failed to store food in accordance with professional standards for food service safety. During tour of the kitchen, observations noted the floors were dirty, the dishwasher had a layer of crumbs on top, unlabeled and dented cans, 2 pitchers of unlabeled ice tea, and the posts from the hood were greasy and covered with dust. The facility reported a census of 48.<br><br>Findings include:<br><br>On 10/10/22 at 12:48 PM, a tour of the kitchen was conducted with the Licensed Nursing Home Administrator (LNHA) and the Certified Dietary Manager (CDM). There were several 15 ounce (oz) tomato cans not dated, the CDM stated she had just got them a couple of weeks ago, she knows this because she ordered them. Two of the cans were dented as well as one large can. The CDM stated they must have dented the large can when they put it on the shelf. The CDM gathered the cans up and stated she was going to get rid of them; they normally do not accept dented cans. The posts coming down from the exhaust hood were greasy with dust clinging to them. The CDM stated the posts are cleaned when the pieces for the hood are cleaned and that pieces for the hood were at the car wash. Continued observation revealed the kitchen floors were dirty with a loaf of bread laying on the floor, The CDM picked up the bread, along with a plate and a pen off of the floor. The CDM then threw the loaf of bread that laid on the floor onto a shelf on top of the other loaves of bread. When one dirty spot was pointed out to the CDM, she stated staff are sweeping right now and that spot was where they swept to but the observation revealed other soiled areas. Continued observation revealed 2 ice tea pitchers sat on the sink and neither were labeled. The CDM stated staff made the tea today and they hadn't labeled them yet. The top of the dishwasher contained a thick layer of what looked to be crumbs. The CDM stated, 'oh yea, those are crumbs'. Observation revealed the dry storage room floors were dirty and a cob web running from the floor to a shelving unit. The CDM stated the facility had lost its floor guy and he'd clean everything. The CDM asked the LNHA if they were getting a new floor guy and he stated they are working on it. The CDM acknowledged the floors needed to be cleaned and the dishwasher and posts from the hood needed to be cleaned.<br><br>Upon request, the facility did not provide a policy for keeping the kitchen clean. Staff did provide an undated cleaning schedule. The schedule directed that every cook and aide should sweep and mop the floor after each shift and assigned one staff the duty of cleaning the dish machine. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>42441<br><br>Based on facility record review and staff interview, the facility failed to ensure the required staff attended quarterly Quality Assurance (QA) committee meetings and failed to have a QA meeting for 2 out of 4 quarters reviewed. The facility reported a census of 48 residents.<br><br>Findings include:<br><br>QA meeting attendance forms for the third quarter revealed the following:<br><br>a. 7/27/21 lacked record of the Medical Director (MD) being present.<br><br>b. 8/24/21 lacked record of the Director of Nursing (DON) being present.<br><br>c. 9/22/21 lacked record of the DON being present.<br><br>Facility record review revealed a QA meeting was not held during the fourth quarter of 2021.<br><br>During an interview 10/18/22 at 2:02 PM, the Administrator acknowledged all the required members were not present during the third quarter 2021 QA meetings and a QA meeting was not held in the fourth quarter of 2021 as expected. |

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|---|---|---|---|
| | 165450 | A. Building<br>B. Wing | 10/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Accura Healthcare of Toledo, LLC | 403 Grandview Drive<br>Toledo, IA 52342 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>46875<br><br>Based on observations, staff interviews, and facility policy review, facility staff failed to follow hand hygiene and disinfecting practices consistent with accepted standards of practice for 3 of 5 residents observed during the medication administration task (Residents #49, #45 and #30). The facility reported a census of 48 residents.<br><br>Findings include:<br><br>Observation on 10/12/22 at 8:10 a.m. revealed Staff A, Certified Medication Aide (CMA) failed to complete hand hygiene prior to preparation of Resident #49's medications. Staff A then entered Resident #49's room, administered the resident's medications using a spoon and applesauce and exited the room without performing hand hygiene.<br><br>Observation on 10/12/22 at 8:32 a.m. revealed Staff B, CMA did not clean or disinfect vital sign equipment (blood pressure wrist cuff, thermometer and pulse oximeter machine) after using it to measure Resident #45's vital signs. Staff B placed the used vital sign equipment in the medication cart. Staff B also failed complete hand hygiene after measuring Resident #45's vital signs and administering his medications.<br><br>Observation on 10/12/22 at 9:02 a.m. revealed Staff B failed to complete hand hygiene prior to entering Resident #30's room to measure her vital signs and administer her medications. After completing the tasks, Staff B left the resident's room but did not perform hand hygiene before exit. Continued observation revealed Staff B then touched multiple items on and in the medication cart with her contaminated hands. When asked, Staff B confirmed she had not completed hand hygiene. Staff B also failed to clean or disinfect vital sign equipment after using it with Resident #30. Staff B placed the used vital sign equipment into the medication cart.<br><br>The facility's policy titled Hand Hygiene, revised March 2022, instructed the facility requires healthcare providers to perform hand hygiene per the Centers for Disease Control (CDC) recommendations which include immediately before touching a resident or the resident's immediate environment and after contact with contaminated surfaces.<br><br>The facility's policy titled Infection Control Equipment, revised March 2015, directed that the facility will appropriately care for resident/patient care equipment and supplies to prevent them from becoming sources of infection. All used equipment and supplies are considered contaminated with potentially infectious material and will be cleaned and disinfected or sterilized as applicable before use with another resident/patient.<br><br>During an interview on 10/18/22 at 10:45 a.m. the Director of Nursing (DON) stated that she expected staff to use hand sanitizer or wash their hands between residents and that she would also expect staff to clean equipment after use and in between residents. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875<br><br>Based on clinical record review, observation, resident and staff interviews and maintenance record reviews, the facility failed to maintain patient care equipment in a safe operating condition for 1 of 5 residents reviewed (#34) who a mechanical lift. Staff failed to assure the facility's sit-to-stand mechanical had a lift leg strap in place per manufacturer's guidelines. The facility reported a census of 48 residents.<br><br>Findings include:<br><br>Resident #34's Minimum Data Set (MDS) assessment dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact memory and cognition. The assessment recorded that Resident #34 required extensive assistance of two persons with transfers and toilet use and that she had not walked in the past seven days. Resident #34's assessment documented diagnoses that included hypertension, heart failure, diabetes mellitus, depression, and morbid obesity.<br><br>The resident's Care Plan, revised 8/22/22, directed staff to transfer Resident #34 with a mechanical lift and two staff members.<br><br>Observation on 10/12/22 at 12:42 p.m. revealed Staff C, Certified Nursing Assistant (CNA) and Staff D, CNA transfer Resident #34 with a Joerns sit-to-stand mechanical lift from the resident's wheelchair to the toilet. During the transfer, the lift had no leg strap applied around both of Resident #34's lower extremities. The sit-to-stand lift had two black buckles located on each side of the knee pad where a leg strap would attach to. Staff C reported there had not been a leg strap on the sit to stand mechanical lift for a very long time. Resident #34 stated she had never had a leg strap applied around her legs during the lift to stand transfer.<br><br>During an interview on 10/12/22 at 1:32 p.m. the Director of Nursing (DON) stated she was aware that the sit-to-stand lift machine did not have a leg strap. The DON thought the replacement leg strap had been ordered. The DON stated she'd been in her current position for four weeks and identified the concern when assisting a resident using the sit-to-stand mechanical lift.<br><br>During interview on 10/12/22 at 3:13 p.m. with the DON and Staff E, Maintenance Director, the DON reported the Joerns sit-to-stand lift used for Resident #34's transfers required a leg strap per manufacturer's instructions. The DON provided a work request form dated 10/3/22 which documented her request for the sit-to-stand lift to have its bottom strap replaced. The work request documented that Staff E reviewed the request on 10/03/22 and Staff E stated that he ordered the replacement leg strap on 10/12/22. The DON reported they took the Joerns sit-to-stand lift off the floor and would not use it until the rental company replaced the lift or the replacement leg strap was in place.<br><br>Observation on 10/13/22 at 8:30 a.m. revealed the Joerns sit-to-stand mechanical lift in the conference room and not available for staff use. Interview with the DON at that time revealed the facility paid to have the leg strap overnighted.<br><br>(continued on next page) |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interviews on 10/13/22 at 9:27 a.m. Staff F, CNA and Staff C reported the facility had two styles of sit-to-stand mechanical lifts and staff can use either lift on the residents as they are interchangeable.<br><br>On 10/13/22 at 11:52 a.m. the DON reported five residents lived in the facility that used the sit-to-stand lifts for transfers.<br><br>During an interview on 10/18/22 at 2:00 p.m. the DON reported the replacement strap was applied to the sit-to-stand mechanical lift that day.<br><br>The Joerns User Instructions Manual dated 2014 contained a picture of the sling in use on page 11. The page showed Figures A and B illustrating use of the leg strap to the resident's lower extremities during transfer. The manual directed that Joerns Healthcare recommended a thorough inspection and test of the lift and lifting accessories, slings, and scales is carried out on a regular basis. The facility provided a work history report documenting the lifts are to be inspected weekly. Review of the work history reports documented under task completion either no action recorded or marked done on time.<br><br>During an interview on 10/19/22 at 11:43 a.m. Staff E stated if the lift inspection is documented as marked done on time, it meant he completed the inspection on time, however, not entered into the system until a later date. If the form stated no action required it meant he completed the inspection with no concerns.<br><br>On 10/20/22 at 8:04 a.m. the facility provided the guide/steps that are completed when inspecting the mechanical lifts weekly. The steps listed are the following:<br><br>a. Inspect the caster base<br><br>b. Inspect the shift handle<br><br>c. Inspect the mast<br><br>d. Inspect the boom<br><br>e. Inspect the swivel bar<br><br>f. Inspect the lift pump/actuator assembly<br><br>g. Inspect all surface on the lift to ensure they are in good repair<br><br>h. Check the battery if applicable<br><br>i. Inspect the brakes<br><br>j. Inspect the remote controls<br><br>k. Inspect the control panel<br><br>(continued on next page) |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | I. Inspect the electrical cords<br><br>The guide stated to remind the nursing staff to inspect all slings:<br><br>1. Check all slings and attachment points<br><br>2. Inspect sling material for wear<br><br>3. Inspect lifting straps for wear<br><br>Items identified as poor condition should be removed from service. |