| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 385270 | A. Building<br>B. Wing | 05/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stanley Post Acute | 12045 SE Stanley Avenue<br>Milwaukie, OR 97222 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36494<br><br>Based on interview and record review it was determined the facility failed to ensure a resident was treated in a dignified manner for 1 of 4 sampled residents (#114) reviewed for dignity. This placed residents at risk for lessened quality of life. Findings include:<br><br>Resident 114 was admitted to the facility on ,d+[DATE] with diagnoses including end stage renal disease and depression.<br><br>A 3/20/24 Mistreatment Investigation revealed the following:<br><br>* Staff 2 (DNS) was informed on 2/27/24 Resident 114 had a concern regarding her/his care. Staff 2 spoke with Resident 114, who indicated the incident occurred roughly one week prior. During the night shift, a female staff member entered the resident's room because she/he had a bowel movement in bed. The staff person stated, Oh, you shit the bed. Resident 114 did not feel abused, but stated the staff person was rude. Resident 114 stated other staff assisted with cleaning her/him up.<br><br>*Staff 2 determined Staff 26 (Former RN) worked with Resident 114 on 2/19/24 during the night of the incident.<br><br>*Staff 26 recalled the incident and stated Resident 114 had a bowel movement, and poop was everywhere. Staff 26 denied making a derogatory comment towards Resident 114. Staff 26 stated she had a CNA and another nurse provide ADL care and clean the bed/bedding. Resident 114 was assisted back to bed.<br><br>*Staff 21 (LPN) reported Staff 26 worked the night shift on 2/19/24. While the CNA assigned to Resident 114 was on break, Resident 114's roommate peaked her/his head out and indicated they needed help in the room. Staff 26 went into the room and immediately came back to the nurses' station and stated, [She/He] shit everywhere, [she/he's] wiping it everywhere. Staff 26 asked Staff 21 to assist in cleaning Resident 114 up. The bedding was changed, and Resident 114 received a shower before being situated back in bed.<br><br>*Conclusion: Mistreatment was ruled out. Staff 26 provided all necessary cares at the time of the incident and denied speaking to Resident 114 in the alleged manner. No other resident concerns were reported. Staff 26 received education regarding customer service in the workplace.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/13/24 at 2:07 PM Witness 1 (Complainant) stated Resident 114 reported a bowel incident which occurred roughly in the middle of 2/2024. Witness 1 stated during the night, Resident 114 had a bowel movement, and a staff person entered the resident's room, saying, You shit all over yourself and the bed. Witness 1 stated Resident 114 was embarrassed and did not want to talk about the incident. Witness 1 stated the facility investigated the incident but Witness 1 was unsure of the outcome.<br><br>On 5/14/24 at 10:57 AM Resident 114 stated she/he recalled the incident, which happened during night shift. Resident 114 stated she/he had an accident (bowel movement) in bed. Staff 26 entered her/his room and stated, You shit all over the place. Resident 114 stated Staff 26 berated her/him and the incident was embarrassing. Resident 114 stated two other staff members assisted in cleaning her/him up.<br><br>Attempts were made on 5/15/24 and 5/16/24 to reach Staff 26, but were unsuccessful.<br><br>On 5/16/24 at 2:25 PM Staff 21 (LPN) stated she recalled the incident on 2/19/24 with Resident 114. Staff 26 approached the nurses' station and reported the resident, had shit everywhere. Staff 21 stated she and another CNA, along with Staff 26, cleaned up the resident and her/his bedding.<br><br>On 5/17/24 at 2:50 PM Staff 2 (DNS) stated she initiated and completed the investigation. Staff 26 denied she made derogatory comments towards Resident 114 and assisted in cleaning her/him. Staff 2 stated education was provided to Staff 26, and she did not return to the building after the 2/19/24 incident.<br><br>On 3/3/24, the Past Noncompliance was corrected when the facility completed the following:<br><br>1. Performed a thorough investigation of the incident and submitted a FRI on 2/27/24.<br><br>2. Interviewed Resident 114 and other residents in the facility and asked about care concerns.<br><br>3. Interviewed staff involved in the incident.<br><br>4. Educated Staff 26 and she did not return or work for the facility after 2/19/24 incident. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>36494<br><br>Based on observation, interview and record review it was determined the facility failed to assess self-administration of a medication for 2 of 3 sampled residents (#s 8 and 26) reviewed for self-administration of medication. This placed residents at risk for unsafe medication administration. Findings include:<br><br>The facility's Self-Administration Medication policy last revised on 3/2020, specified the following:<br><br>-Upon admission the resident's desire to self-administer is ascertained.<br><br>-During the 14-day admission assessment period the RCM (Resident Care Manager) evaluates the resident's ability to self-administer medications.<br><br>-If the resident has the cognitive, physical, and emotional ability to self-administer their own medications in a safe and prudent manner a plan for self-administration is established with the resident.<br><br>-A physician order is obtained indicating the specific medications that the resident is able to self-administer.<br><br>-The self-administration is on the resident's care plan to include location of drugs, documentation procedure, place of administration and specific medications.<br><br>-The resident is reevaluated for continued ability to self-administer their medications annually and with significant change in condition.<br><br>1. Resident 8 was admitted to the facility in 4/2024 with diagnoses including a stroke and heart disease.<br><br>A Physician Order dated 4/29/24 revealed Resident 8 was to receive Artificial Tears ophthalmic solution and to instill one drop in both eyes as needed for dry eyes daily.<br><br>A 4/30/24 Admission MDS indicated Resident 8 had a BIMS score of 14 and she/he was cognitively intact.<br><br>A review of Resident 8's clinical record revealed no evidence that a self-administration of medication assessment was completed.<br><br>Random observations from 5/13/24 through 5/16/24 revealed Resident 8 was in bed, and a small green bottle labeled Artificial Tears was on her/his bedside table.<br><br>On 5/14/24 at 10:40 AM Resident 8 stated the eye drops were for her/his eyes and she/he self-administered the eye drops.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/16/24 at 11:42 AM Staff 6 (CNA) stated Resident 8 was confused at baseline. Staff 6 stated she did not notice the eyedrops on the resident's bedside table, but Resident 8 required assistance from a nurse in administering the eye drops.<br><br>On 5/16/24 at 2:39 PM and 3:20 PM Staff 12 (LPN-Resident Care Manager) stated she was unaware Resident 8 had eye drops accessible at her/his bedside table and thought maybe a family member brought the eye drops in. Staff 12 removed the eye drops from the resident's bedside table. Staff 12 stated the resident was not to self-administer eye drops unless a self-medication assessment was completed.<br><br>48830<br><br>2. Resident 26 was admitted to the facility in 1/2024 with diagnoses including paraplegia.<br><br>The 1/15/24 Admission MDS revealed Resident 26 was cognitively intact.<br><br>On 5/17/24 at 10:42 AM Resident 26 stated she/he kept a prescription medication, ipratropium bromide nasal spray (used for rhinitis), at her/his bedside in a locked box.<br><br>Resident 26's comprehensive care plan, last revised on 3/25/24, revealed the resident self-administered certain prescription medications including ipratropium bromide nasal spray.<br><br>A review of Resident 26's health record indicated a self-administration of medication evaluation was completed on 2/23/24, however, Resident 26 was not assessed to self-administer ipratropium bromide nasal spray.<br><br>On 5/17/24 at 11:14 AM Staff 36 (Agency RN) stated Resident 26 had self-administered ipratropium bromide nasal spray and reported to the charge nurse when she/he self-administered the medication and if the dose was effective. Staff 36 stated he then documented in the resident's medical record of the administration and the result.<br><br>On 5/20/24 at 1:57 PM Staff 12 (LPN Resident Care Manager) confirmed the resident was not assessed to self-administer ipratropium bromide nasal spray. |

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36494<br><br>Based on observation, interview and record review it was determined the facility failed to ensure resident personal property was identified upon admission, and clothing was retained and accessible for 2 of 4 sampled residents (#s 20 and 57) reviewed for personal property. This place residents at risk for loss of personal property. Findings include:<br><br>The facility's Resident Personal Items Safekeeping policy, last revised 4/2023, specified the following:<br><br>-All personal items, including but not limited to clothing, dentures, glasses, and hearing aids must be marked with the resident's name upon admission.<br><br>-The facility designee will assist residents and families with marking the personal belongings.<br><br>-On admission and thereafter each time a resident's personal possession is brought into the facility, the item will be recorded on the resident's inventory record by designated staff and signed by the resident or responsible party.<br><br>-If any personal items is lost during a resident's stay, an investigation will be completed by the facility and the results will be communicated to the resident and/or family.<br><br>-The Administrator/designee will discuss the method of replacement for lost items with the resident and/or family.<br><br>1. Resident 57 was admitted to the facility in 4/2024 with diagnoses including chronic heart failure and diabetes.<br><br>The Annual MDS dated [DATE] revealed Resident 57 had a BIMS score of 15 and was cognitively intact.<br><br>Resident 57's Inventory Record dated 4/19/24 revealed the resident had one pair of black shoes, navy blue sleeping shorts, a black pair of slacks and a black t-shirt.<br><br>On 5/13/24 at 11:40 AM, the resident was observed in bed wearing a facility nightgown. Resident 57 stated she/he wanted to be dressed in her/his own clothing but it was hit or miss if this was offered by staff. The resident stated she/he was uncertain of the location of her/his clothes.<br><br>Random observations from 5/14/24 through 5/17/24 revealed Resident 57 was either in bed wearing a facility nightgown or in bed with no nightgown on, with her/his chest exposed.<br><br>On 5/14/24 at 7:22 PM Staff 15 (CNA) and on 5/16/24 at 12:53 PM Staff 14 (CNA) stated Resident 57 requested to be dressed, but the resident did not have appropriate clothing to wear. Staff 14 and Staff 15 were unsure where the resident's clothes were, which was why Resident 57 was consistently in her/his nightgown. Staff 15 stated he reported the resident's lack of clothing to a nurse.<br><br>(continued on next page) |

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/17/24 at 4:01 PM Staff 9 (RNCM) entered the room with the surveyor and located Resident 57's black shoes, a pair of shorts and a black jacket. None of the items had Resident 57's name on them. Staff 9 reviewed Resident 57's Inventory Record and acknowledged the resident admitted with a pair of slacks and a T-shirt, which were not found in her/his room. Staff 9 stated no missing form was completed or missing items were reported to her regarding Reident 57's missing clothing items. Staff 9 stated Resident 57's clothing items were to be labeled, and any missing clothing items were to be reported. Staff 9 further stated the resident was to be dressed per her/his request.<br><br>48830<br><br>2. Resident 20 was admitted to the facility in 2020 with diagnoses including depression and anxiety.<br><br>The 4/2/24 Annual MDS indicated Resident 20 was cognitively intact.<br><br>On 5/14/24 at 2:43 PM during a resident group meeting, respect of resident's personal possessions was discussed. Resident 20 stated she/he submitted a grievance form in 3/2024 regarding missing and broken personal property, but was not reimbursed.<br><br>On 5/15/24 at 11:34 AM two submitted grievance forms, dated 3/21/24, were reviewed. One grievance form indicated the resident was missing several clothing items. The second grievance form indicated a staff member pulled down and damaged hanging lights in the resident's room. Both grievance forms indicated a reimbursement was approved by Staff 1 (Administrator) on 3/25/24.<br><br>A copy of the receipt for reimbursement was requested on 5/15/24 by the survey team.<br><br>On 5/16/24 at 11:00 AM two cash disbursement vouchers were provided and revealed a cash reimbursement for Resident 20's missing clothing and broken personal property was issued on 5/15/24.<br><br>On 5/16/24 at 3:04 PM Staff 3 (Corporate Social Service Director) confirmed the resident's request for reimbursement for personal possessions was not completed timely. |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36494<br><br>Based on interview and record review it was determined the facility failed to comprehensively assess 8 of 14 sampled residents (#s 25, 26, 32, 36, 52, 55, 57 and 114) reviewed for medications, pressure ulcers, ADLs, pain and nutrition. This placed residents at risk for unassessed needs. Findings include:<br><br>1. Resident 57 was admitted to the facility on ,d+[DATE] with diagnoses including chronic heart failure and diabetes.<br><br>The 4/25/24 Admission MDS indicated Resident 57 received an antidepressant medication.<br><br>The Psychotropic Drug Use CAA associated with the 4/25/24 MDS indicated psych meds per physician orders. The CAA did not indicate a description of the problem, causes and contributing factors or how the resident's symptoms manifested or whether the medication was effective.<br><br>On 5/20/24 at 8:58 AM Staff 16 (MDS Coordinator) stated she was responsible for completing the MDS assessment and CAAs for all residents. Staff 16 stated she worked remotely and reviewed resident electronic medical records to complete the CAA section.<br><br>On 5/20/24 at 1:13 PM Staff 2 (DNS) stated she was unfamiliar with the process of completing the CAAs. Staff 2 stated Staff 16 was responsible for the MDS and CAA assessments, and there was daily communication regarding residents' assessments. Staff 1 (Administrator) and Staff 2 acknowledged the CAA was not comprehensive.<br><br>2. Resident 55 was admitted to the facility on ,d+[DATE] with diagnoses including a Stage 3 (full thickness tissue loss) pressure ulcer to the tailbone.<br><br>The Pressure Ulcer CAA dated 4/22/24 indicated Resident 55 needs assist with adls and transfers, has pressure injury to buttocks. The CAA did not include a description of the problem, causes and contributing factors, any alternatives discussed or tried or an overall analysis of the pressure ulcer.<br><br>On 5/20/24 at 8:58 AM Staff 16 (MDS Coordinator) stated she was responsible for completing the MDS assessment and CAAs for all residents. Staff 16 stated she worked remotely and reviewed resident electronic medical records to complete the CAA section.<br><br>On 5/20/24 at 1:13 PM Staff 2 (DNS) stated she was unfamiliar with the process of completing the CAAs. Staff 2 stated Staff 16 was responsible for the MDS and CAA assessments, and there was daily communication regarding residents' assessments. Staff 1 (Administrator) and Staff 2 acknowledged the CAA was not comprehensive.<br><br>3. Resident 36 was admitted to the facility on ,d+[DATE] with diagnoses including arthritis and polyneuropathy (nerve pain).<br><br>(continued on next page) |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The 11/17/23 Significant Change MDS and the 2/15/25 Quarterly MDS indicated Resident 36 received scheduled and PRN pain medication.<br><br>The Pain CAA associated with the 11/17/23 MDS indicated no change to plan of care. The CAA did not include a description of, how the resident displayed pain symptoms or whether the medications and any other interventions were effective.<br><br>On 5/20/24 at 8:58 AM Staff 16 (MDS Coordinator) stated she was responsible for completing the MDS assessment and CAAs for all residents. Staff 16 stated she worked remotely and reviewed resident electronic medical records to complete the CAA section.<br><br>On 5/20/24 at 1:13 PM Staff 2 (DNS) stated she was unfamiliar with the process of completing the CAAs. Staff 2 stated Staff 16 was responsible for the MDS and CAA assessments, and there was daily communication regarding residents' assessments. Staff 1 (Administrator) and Staff 2 acknowledged the CAA was not comprehensive.<br><br>4. Resident 114 was admitted to the facility on ,d+[DATE] with diagnoses including end stage renal disease and depression.<br><br>The 2/20/24 Admission MDS indicated Resident 57 received an antidepressant medication and was occasionally incontinent of urine and frequently incontinent of bowel.<br><br>The CAAs associated with the 2/20/24 MDS revealed the following:<br><br>-The Psychotropic Drug Use CAA indicated takes anti-depressants per physician orders. The CAA did not indicate a description of the problem, causes and contributing factors, how the resident's symptoms manifested or whether the medications were effective.<br><br>-The Urinary Incontinence and Indwelling Catheter CAA indicated has occasional incontinence and requires assistance with toileting. The CAA did not indicate a description of the problem, causes or contributing factors.<br><br>On 5/20/24 at 8:58 AM Staff 16 (MDS Coordinator) stated she was responsible for completing the MDS assessment and CAAs for all residents. Staff 16 stated she worked remotely and reviewed resident electronic medical records to complete the CAA section.<br><br>On 5/20/24 at 1:13 PM Staff 2 (DNS) stated she was unfamiliar with the process of completing the CAAs. Staff 2 stated Staff 16 was responsible for the MDS and CAA assessments, and there was daily communication regarding residents' assessments. Staff 1 (Administrator) and Staff 2 acknowledged the CAA was not comprehensive.<br><br>47005<br><br>5. Resident 25 admitted to the facility in 6/2022 with diagnoses including falls and chronic pain syndrome.<br><br>The 6/20/23 Annual MDS indicated Resident 25 received scheduled and PRN pain medication.<br><br>(continued on next page) |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Pain CAA associated with the 6/20/23 MDS indicated Resident 25 had pain that affected sleep, day-to-day activities and almost constant pain. The CAA did not include a location of the pain, how the resident displayed pain symptoms or whether the medications and other pain interventions were effective.<br><br>On 5/20/24 at 8:58 AM Staff 16 (MDS Coordinator) stated she was responsible for completing the MDS assessment and CAAs for all residents. Staff 16 stated she worked remotely and reviewed resident electronic medical records to complete the CAA section. Staff 16 further stated she communicated as needed with the Resident Care Managers and the IDT (Interdisciplinary Team).<br><br>On 5/20/24 at 1:13 PM Staff 2 (DNS) stated she was unfamiliar with the process of completing the CAAs. Staff 2 stated Staff 16 was responsible for the MDS and CAA assessments, and there was daily communication regarding residents' assessments.<br><br>6. Resident 32 admitted to the facility in 3/2024 with diagnoses including right lower extremity cellulitis and diabetes.<br><br>The 3/26/24 Admission MDS indicated Resident 32 received an antidepressant medication.<br><br>The Psychotropic Drug Use CAA associated with the 3/26/24 MDS indicated antidepressant use per physician orders. The CAA did not indicate a description of the problem, causes and the contributing factors, how the resident's symptoms manifested, or whether the medication was effective.<br><br>On 5/20/24 at 8:58 AM Staff 16 (MDS Coordinator) stated she was responsible for completing the MDS assessment and CAAs for all residents. Staff 16 stated she worked remotely and reviewed resident electronic medical records to complete the CAA section. Staff 16 further stated she communicated as needed with the Resident Care Managers and the IDT (Interdisciplinary Team).<br><br>On 5/20/24 at 1:13 PM Staff 2 (DNS) stated she was unfamiliar with the process of completing the CAAs. Staff 2 stated Staff 16 was responsible for the MDS and CAA assessments, and there was daily communication regarding residents' assessments.<br><br>48830<br><br>7. Resident 26 was admitted to the facility in 1/2024 with diagnoses including glaucoma and depression.<br><br>The 1/15/24 Admission MDS indicated Resident 26 had adequate vision and received an antidepressant medication.<br><br>The CAAs associated with the 1/15/24 MDS revealed the following:<br><br>-The Visual Function CAA indicated has glaucoma. No further information was provided specific to the resident's current visual functioning, use of visual appliances, or other treatments in place.<br><br>-The Psychotropic Drug Use CAA indicated takes antidepressants for depression. The CAA did not indicate a description of the problem, causes and contributing factors or how the resident's symptoms manifested or whether the medication was effective.<br><br>(continued on next page) |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 5/20/24 at 8:58 AM Staff 16 (MDS Coordinator) stated she was responsible for completing the MDS assessment and CAAs for all residents. Staff 16 stated she worked remotely and reviewed resident electronic medical records to complete the CAA section.<br><br>On 5/20/24 at 1:13 PM Staff 2 (DNS) stated she was unfamiliar with the process of completing the CAAs. Staff 2 stated Staff 16 was responsible for the MDS and CAA assessments, and there was daily communication regarding residents' assessments. Staff 1 (Administrator) and Staff 2 acknowledged the CAAs were not comprehensive.<br><br>8. Resident 52 was admitted to the facility in 4/2024 with diagnoses including depression.<br><br>The 4/10/24 Admission MDS indicated Resident 52 received an antidepressant medication.<br><br>The Psychotropic Drug Use CAA associated with the 4/10/24 MDS indicated received antidepressant per physicians orders. The CAA did not indicate a description of the problem, causes and contributing factors or how the resident's symptoms manifested or whether the medication was effective.<br><br>On 5/20/24 at 8:58 AM Staff 16 (MDS Coordinator) stated she was responsible for completing the MDS assessment and CAAs for all residents. Staff 16 stated she worked remotely and reviewed resident electronic medical records to complete the CAA section.<br><br>On 5/20/24 at 1:13 PM Staff 2 (DNS) stated she was unfamiliar with the process of completing the CAAs. Staff 2 stated Staff 16 was responsible for the MDS and CAA assessments, and there was daily communication regarding residents' assessments. Staff 1 (Administrator) and Staff 2 acknowledged the CAA was not comprehensive. |

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| Stanley Post Acute | 12045 SE Stanley Avenue<br>Milwaukie, OR 97222 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>41453<br><br>Based on interview and record review it was determined the facility failed to ensure a written summary of a baseline care plan was reviewed and provided to residents within 48 hours of admission for 2 of 3 sampled residents (#s 4 and 44) reviewed for care planning. This placed residents at risk for being uninformed about their plan of care. Findings include:<br><br>1. Resident 4 was admitted to the facility in 2022 with diagnoses including paralysis of left side and osteoporosis.<br><br>On 5/14/24 Resident 4's clinical record was reviewed. No record was found that Resident 4 had a baseline care plan reviewed or provided to her/him.<br><br>On 5/16/24 at 12:33 PM Staff 3 (Corporate SSD) confirmed no baseline care plan was discussed or provided to Resident 4.<br><br>2. Resident 44 was admitted to the facility in 2/2024 with diagnoses including heart failure and chronic kidney disease.<br><br>Resident 44's 2/2024 Admission MDS indicated she/he was cognitively intact.<br><br>On 5/14/24 Resident 44's clinical record was reviewed. No record was found that Resident 44 had a baseline care plan reviewed or provided to her/him.<br><br>On 5/16/24 at 12:33 PM Staff 3 (Corporate SSD) confirmed no baseline care plan was discussed or provided to Resident 44. |

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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** 36494<br><br>Based on interview and record review it was determined the facility failed to follow physician orders and provide bowel medication in a timely manner for 1 of 6 sampled residents (#57) reviewed for medications. This placed residents at risk for medical complications from constipation. Findings include:<br><br>The facility's Bowel Care Protocol Policy last revised on 2/2019, specified the following:<br><br>-At beginning of each shift the nurse will pull the bowel care report and identify residents that have not had a BM (Bowel Movement) for 3 days.<br><br>-Residents who have not had a BM in three days will be given MOM (Milk of Magnesia).<br><br>-If no BM by the following shift, a Dulcolax suppository is given.<br><br>-If resident continues without BM by the next shift a Fleets enema will be given.<br><br>-Residents who are noted as having small bowel movement will be assessed for constipation.<br><br>-If resident exceeds four days without a BM, the nurse will complete an abdominal assessment and the physician will be notified for further orders.<br><br>Resident 57 was admitted to the facility in 4/2024 with diagnoses including chronic heart failure and diabetes.<br><br>Resident 57's BM documentation from 4/19/24 through 5/9/24 revealed the following:<br><br>-4/26/24 through 5/1/24 (six days) Resident 57 did not have a BM.<br><br>-5/3/24 through 5/8/24 (six days) Resident 57 did not have a BM.<br><br>Resident 57's Physician Order Report signed by the physician on 4/22/24 included an order for polyethylene glycol packet. Staff were to administer 17 grams by mouth one time daily as needed for bowel care.<br><br>Resident 57's 5/2024 MAR revealed the polyethylene glycol packet was administered on 5/8/24 and was marked as U (unknown).<br><br>A Nutrition assessment dated [DATE] revealed Resident 57 had constipation and was placed on the bowel protocol with no BM for the prior week. Resident 57 had a large BM on 5/9/24.<br><br>A review of the resident's clinical record revealed no documentation bowel care was implemented timely or an abdominal assessment was completed.<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 | On 5/16/24 at 10:53 AM Staff 4 (LPN) stated Resident 57 struggled with constipation and was frequently on the bowel list. Staff 4 stated she followed bowel protocol: if Resident 57 had no BM after three days, the resident was administered MiraLAX (a laxative) during the morning shift. If there was still no BM by the following shift, the resident received Senna (a laxative). If these measures yielded no results, Staff 4 stated she contacted the provider for a possible enema.<br><br>On 5/17/24 at 4:01 PM Staff 9 (RNCM) stated Resident 57 had problems with BMs and was frequently on the bowel list. Staff 9 stated residents did not have standing PRN bowel orders and depended on the doctor. Staff 9 acknowledged the findings and stated Resident 57's bowel protocol needed to be initiated due to her/his constipation.<br><br>On 5/20/24 at 1:13 PM Staff 2 (DNS) stated staff were expected to implement and adhere to the bowel protocol. Additionally, if a resident had no BM by day four staff were to contact the physician and conduct a bowel assessment. |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36494<br><br>Based on observation, interview and record review it was determined the facility failed to provide appropriate foot care for 3 of 3 sampled residents (#s 26, 41 and 57) reviewed for foot care. This placed residents at risk for lack of nail care and infections. Findings include:<br><br>1. Resident 41 was admitted to the facility on ,d+[DATE] with diagnoses including diabetes.<br><br>A Physician Order dated 3/27/24 directed a licensed nurse to check Resident 41's fingernails and toenails once a week on bath day. The order indicated to trim as needed every day shift on Wednesdays for diabetic nail checks. Staff were directed to document (+) if the nails were trimmed and (-) if nail trimming was not needed.<br><br>A review of the LN Task from 3/2024 through 5/2024 revealed the following:<br><br>-3/27/24 nails did not need trimmed.<br><br>-4/3/24, 4/10/24 and 4/17/24 nails did not need trimmed. 4/24/24 Resident 41 refused nail care.<br><br>-5/1/24 nails did not need trimmed. 5/8/24 Resident 41 refused nail care.<br><br>A Progress Note dated 5/9/24 revealed Staff 9 (RNCM) entered Resident 41's room to offer toenail care. Resident 41 initially stated she would allow toenail care without clippers only for toenails to be filed down. Resident 41 allowed Staff 9 to file three out of 10 toenails and then declined to have the rest of the toenails trimmed.<br><br>On 5/13/24 at 10:44 AM Resident 41 stated she/he was a diabetic for [AGE] years and needed her/his toenails treated by a podiatrist which was not scheduled. Resident 41 indicated staff were unable to cut her/his thick toenails and made her/him uncomfortable when staff attempted to complete the nail care.<br><br>Random observations from 5/13/24 through 5/16/24 revealed Resident 41 was in bed and her/his toes were observed with all toenails discolored, deformed, thickened (half-an-inch) and longer than one inch. Resident 41's right large toenail was brownish/black.<br><br>On 5/14/24 at 6:46 PM Staff 32 (CNA) and on 5/16/24 at 11:42 AM Staff 6 (CNA) entered the room with the surveyor and acknowledged Resident 41's toenails were long, thick, discolored and indicated the toenails were, awful. Staff 32 stated she noticed the resident's long and discolored toenails. Staff 6 stated nail care was provided by the nursing staff because Resident 41 was diabetic. Staff 6 and Staff 32 stated the resident occasionally declined showers due to anxiety but accepted a bed bath.<br><br>On 5/16/24 at 9:47 AM Staff 11 (LPN) stated nurses were responsible for diabetic nail care. Staff 11 stated Resident 41's toenails were thick, long, and difficult to trim and needed to be addressed. Staff 11 stated nurses completed weekly skin checks which included observing finger and toenails.<br><br>(continued on next page) |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/16/24 at 2:54 PM Staff 9 (RNCM) stated nurses were expected to complete nail care for diabetic residents. Staff 9 stated Resident 41 was a brittle diabetic, who occasionally declined nail care. Staff 9 stated she attempted to file Resident 41's toenails but the resident did not allow Staff 9 to complete the task. When asked about a podiatry appointment, Staff 9 stated LTC (Long Term Care) residents were placed on the in-house podiatry list. Staff 9 stated the care managers assisted with appointments, including podiatry outside of the facility.<br><br>2. Resident 57 was admitted to the facility in 4/2024 with diagnoses including chronic heart failure and diabetes.<br><br>The Annual MDS dated [DATE] revealed Resident 57 had a BIMS score of 15 and was cognitively intact.<br><br>A Physician Order dated 4/24/24 directed a licensed nurse to check fingernails and toenails once a week on bath day. The order indicated to trim as needed every day shift every Wednesday for diabetic nail checks. Staff were directed to document (+) if nails were trimmed and (-) if nail trimming was not needed.<br><br>A review of the LN Task from 4/2024 through 5/2024 revealed the following:<br><br>- On 4/24/24, 5/1/24, 5/8/24 and 5/15/24 nails did not need trimmed.<br><br>On 5/13/24 at 11:40 AM and 5/16/24 at 11:16 AM the resident stated her/his toenails were long, thick, and needed to be trimmed.<br><br>Random observations from 5/13/24 through 5/16/24 revealed Resident 57 was in bed and her/his toes were observed with all toenails longer than one inch, and his second toenails were deformed, thickened (half-an-inch) and discolored.<br><br>On 5/16/24 at 10:53 AM Staff 4 (LPN) stated Resident 57 was diabetic and nurses were responsible for addressing all nail care. Staff 4 stated she was not sure if the resident's toenails were long, but if she was unable to address Resident 57's nail care then she reported it to the care manager to schedule a podiatry appointment.<br><br>On 5/16/24 at 2:54 PM and 5/17/24 at 4:01 PM Staff 9 (RNCM) stated nurses were expected to provide nail care for diabetic residents. If staff were unable to perform diabetic nail care, staff were expected to report this to her. Staff 9 entered the room with the surveyor and acknowledged Resident 57's toenails were long and were not treated appropriately.<br><br>48830<br><br>3. Resident 26 was admitted to the facility in 1/2024 with diagnoses including paraplegia.<br><br>The 1/15/24 Admission MDS revealed Resident 26 was cognitively intact.<br><br>On 5/13/24 at 2:18 PM Resident 26 stated her/his toenails were long, thick, and caught on the inside of her/his socks. Resident 26 stated she/he wanted her/his toenails trimmed and voiced her/his concern to staff, but no one followed up with her/him. Resident 26's toenails were observed to be long in length, thick, fungal, and jagged.<br><br>(continued on next page) |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/16/24 at 10:34 AM Resident 26 stated she/he had a bath on 5/15/24 and requested her/his toenails to be trimmed or at least filed and the CNA stated they would let the nurse know. The resident stated the nurse did not talk with her/him.<br><br>On 5/16/24 at 11:16 AM Staff 12 (LPN Resident Care Manager) stated toenail care was provided on bath days for the resident and Staff 12 expected it to be completed.<br><br>On 5/16/24 at 2:57 PM Staff 3 (Corporate Social Services Director) stated the facility had a podiatrist that rounded every three months and podiatry services were offered to all residents. Staff 3 stated the podiatrist could not see every resident on the list, so a rotation was completed. Staff 3 stated Resident 26 was on the podiatrist's list to be seen on the next rotation. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47005<br><br>Based on observation, interview, and record review it was determined the facility failed to ensure interventions were in place to prevent smoking related accidents for 1 of 2 sampled residents (#32) reviewed for accidents. This placed residents at risk for smoking-related accidents. Findings include:<br><br>The facility's 10/2023 Smoking Policy and Procedure indicated the following:<br><br>-Residents who wish to smoke are evaluated for their ability to smoke safely. A smoking evaluation is completed at admission or at the time they decided to smoke, to evaluate their ability to smoke safely.<br><br>-Definition of Smoking Materials: Cigarettes, Cigars, Pipes, Novelties - E-Cigarettes, Vapor Devices, Ignition Sources.<br><br>-Residents who do not adhere to the smoking policies are subject to revocation of their ability to smoke while a resident at the facility.<br><br>Resident 32 admitted to the facility on [DATE] with diagnoses including right lower extremity cellulitis and diabetes.<br><br>A 4/28/24 progress note revealed a fire alarm was triggered when Resident 32 stated she/he burned papers in her/his room which caused the room to fill with smoke and Resident 32 was found in possession of a torch lighter.<br><br>A 5/9/24 progress note revealed Resident 32 was smoking in her/his room. Staff reviewed the smoking policy with the resident. Lighters and smoking materials were removed from the resident's room.<br><br>Resident 32's smoking care plan was initiated on 5/13/24 which revealed the resident was an unsupervised smoker. The care plan did not include safe storage of the smoking paraphernalia and interventions to regarding previous smoking incidents that occurred in the resident's room.<br><br>On 5/15/24 at 10:36 AM Staff 28 (CNA) stated Resident 32 was a smoker who smoked in her/his room and did not smoke in the designated smoking area. Staff 28 stated Resident 32 was supposed to keep her/his smoking paraphernalia in a lockbox in her/his room.<br><br>On 5/16/24 at 10:59 AM Resident 32 was observed seated at the edge of the bed with a four-inch green tubular-shaped canister with a pink bejeweled handle. Resident 32 stated it was her/his blow torch lighter and demonstrated that the lighter was operational. Resident 32 stated the facility kept taking her/his lighters and she/he kept replacing them. Resident 32 stated she/he was allowed to keep lighters in her/his lockbox.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/16/24 at 1:40 PM Staff 23 (CMA) stated she had seen Resident 32 with smoking paraphernalia in her/his room but was not sure what rules Resident 32 was supposed to follow. Staff 23 stated Resident 32 had been caught smoking in her/his room several times but was still allowed to keep her/his smoking paraphernalia in her/his room. Staff 23 stated she informed the charge nurse of the smoking paraphernalia.<br><br>On 5/16/24 at 3:06 PM Staff 35 (LPN) stated she considered Resident 32 a smoker and all her/his smoking paraphernalia including marijuana, cigarettes and lighters were in a lockbox in her/his room. Staff 35 stated Resident 32 had smoking paraphernalia confiscated the previous week due to smoking in her/his room and staff were told to do a visual sweep of Resident 32's room whenever staff went into the resident's room.<br><br>A SNF Smoking Safety Evaluation completed on 5/16/24 revealed Resident 32 was a supervised smoker, was not receptive to supervision, was unwilling to store her/his smoking items with the facility and continued to make unsafe smoking choices.<br><br>On 5/20/24 at 10:42 AM Staff 2 (DNS) acknowledged the safety concerns associated with Resident 32's possession of incendiary devices in the facility, and history of unsafe behaviors including smoking in her/his room. Staff 2 acknowledged a smoking assessment was not completed until 5/16/24, and the care plan was not updated regarding the safety concerns. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>48830<br><br>Based on observation, interview, and record review it was determined the facility failed to maintain oxygen equipment and ensure oxygen was administered as ordered for 1 of 2 sampled residents (#46) reviewed for oxygen therapy. This placed residents at risk for increased risk for respiratory failure. Findings include:<br><br>Resident 46 was admitted to the facility in 2/2024 with diagnoses including acute and chronic respiratory failure with hypoxia (not enough oxygen in the blood) and hypercapnia (buildup of carbon dioxide in the bloodstream).<br><br>The 2/9/24 Admission MDS indicated Resident 46 was cognitively intact.<br><br>The 5/13/24 physician order for Resident 46 revealed the resident used continuous oxygen with a flow rate of two liters since 4/25/24.<br><br>On 5/13/24 at 12:04 PM Resident 46 was observed to use an oxygen concentrator with a flow rate of three liters. The external filter on the oxygen concentrator was observed to have a layer of dust when touched with a finger. The resident stated she/he used oxygen most of the time but could not state how many liters were prescribed.<br><br>On 5/16/24 at 11:21 AM Staff 12 (LPN Resident Care Manager) observed the resident and equipment. Staff 12 acknowledged the physician's order was not followed regarding the oxygen flow rate and the external filter of the oxygen concentrator was not clean. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36494<br><br>Based on observation, interview and record review it was determined the facility failed to ensure a resident's ordered pain medication was available and effectively managed the resident's severe pain for 1 of 1 sampled resident (#36) reviewed for pain management. This failure placed residents at risk for unrelieved pain. Findings include:<br><br>Resident 36 was admitted to the facility in ,d+[DATE] with diagnoses including rheumatoid arthritis, a fractured tibia and polyneuropathy (nerve pain).<br><br>A Physician Order dated [DATE] directed staff to administer Percocet (pain medication), one tablet , d+[DATE] MG (oxycodone with acetaminophen) by mouth six times a day related to displaced bicondylar fracture of the right tibia.<br><br>Resident 36's ,d+[DATE] MAR revealed the resident was administered Percocet on [DATE] at 2:00 AM. The resident was not administered Percocet on [DATE] at 6:00 AM, 10:00 AM or 2:00 PM.<br><br>A Physician Order dated [DATE] directed staff to administer oxycodone 10 MG with 325 MG Tylenol, one tablet by mouth one time only for pain.<br><br>Resident 36's ,d+[DATE] MAR revealed the resident was administered a one time oxycodone dose on [DATE] at 1:20 PM.<br><br>Resident 36 did not receive her/his pain medication on [DATE] for 11 hours and 20 minutes.<br><br>A review of Resident 36's pain levels from a scale of zero through 10 (zero no pain and 10 being the worst pain possible) on [DATE] and [DATE] revealed the following:<br><br>*[DATE] the resident did not report any pain.<br><br>*[DATE] at 2:52 PM the resident reported a pain level of six.<br><br>*[DATE] at 6:02 PM the resident reported a pain level of nine.<br><br>*[DATE] at 9:13 PM the resident reported a pain level of six.<br><br>On [DATE] at 11:18 AM and at 12:30 PM Resident 36 was observed in bed, lying on her/his right side facing away from the door, and rocking back and forth in bed. Resident 36 stated she/he was painful and very uncomfortable because she/he did not receive the scheduled Percocet since 3:00 AM. Resident 36 stated the facility staff were working on obtaining the medication.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On [DATE] at 9:37 AM Staff 11 (LPN) stated the night shift nurse administered Resident 36's last dose of scheduled Percocet in the early AM hours on [DATE] and placed a call to the in-house physician for a new prescription because the Percocet prescription expired. Staff 11 stated the resident received a one time dose at approximately 1:30 PM. Staff 11 stated she offered ice or heat packs for the resident's pain, but she/he declined. Staff 11 stated Resident 36 was grimacing when up in her/his wheelchair. Staff 11 stated CMAs typically reordered medications, including if a resident needed a new prescription.<br><br>On [DATE] at 11:42 Staff 6 (CNA) stated on [DATE] (Monday), Resident 36 was in her/his room, in bed and rocking back and forth due to pain. Staff 6 stated the resident was visibly painful, was less verbal and did not eat breakfast. Staff 6 stated the resident expressed frustration because the facility was out of her/his pain medication. Staff 6 reported her concern to the nurse.<br><br>On [DATE] at 1:15 PM Staff 10 (LPN) stated he administered the last Percocet to Resident 36 in the early morning on [DATE]. However, Staff 10 could not access the Cubex (an automated medication dispensing system) because the resident's prescription was expired and he communicated this with the oncoming nurse. Staff 10 contacted the in-house physician to request a new prescription. Staff 10 stated CMAs were responsible for ensuring timely medication reorders were completed. Staff 10 stated CMAs were expected to request refills when there were only seven days of medication remaining in the prescription.<br><br>On [DATE] at 11:03 AM Staff 5 (CMA) stated Resident 36 received Percocet every four hours. Staff 5 stated she was responsible for ensuring residents' medications did not run out. Staff 5 stated when the resident had only four tablets remaining, she requested additional medication through the electronic record which went directly to the pharmacy. Staff 5 stated if a prescription was expired, she reported it to a nurse, who contacted the physician to request a new prescription.<br><br>On [DATE] at 3:46 PM Staff 9 (RNCM) stated she was aware Resident 36 ran out of her/his Percocet. The resident was in pain, and it was unclear why the one time dose took so long to be received. Staff 9 stated on [DATE] Resident 36 was in her/his doorway, appeared anxious, and in pain. Resident 36 requested Staff 9's assistance in obtaining her/his pain medication. Staff 9 stated Resident 36 should not have run out of her/his pain medication and staff were to request new refills three days prior to running out.<br><br>On [DATE] at 1:19 PM Staff 2 (DNS) acknowledged Resident 36's Percocet was not administered on [DATE] per physician orders. Staff 2 stated nonpharmacological pain interventions were offered to the resident until staff could address the situation. Staff 2 stated CMAs were responsible for ensuring medications were ordered for all residents and prescriptions did not expire. Staff 2 stated somehow Resident 36's medications were overlooked. |

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|---|---|---|---|
| | 385270 | A. Building<br>B. Wing | 05/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stanley Post Acute | 12045 SE Stanley Avenue<br>Milwaukie, OR 97222 |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observe each nurse aide's job performance and give regular training.<br><br>47005<br><br>Based on interview and record review it was determined the facility failed to ensure CNAs received annual performance reviews for 4 of 5 randomly selected CNAs (#s 15, 23, 24, and 25) reviewed for staff performance reviews. This placed residents at risk for lack of care by competent staff. Findings include:<br><br>On 5/17/24 at 9:58 AM a review of facility personnel records with Staff 31 (Human Resource Director) indicated the following:<br><br>- Staff 15 (CNA) was hired on 8/17/22; no annual performance review was completed.<br><br>- Staff 23 (CMA) was hired on 8/31/20; no annual performance reviews were completed.<br><br>- Staff 24 (CNA) was hired on 6/16/16; no annual performance reviews were completed.<br><br>- Staff 25 (CNA) was hired on 4/11/16; no annual performance reviews were completed.<br><br>On 5/17/24 at 4:04 PM Staff 1 (Administrator) stated it was his expectation the annual performance reviews were completed annually. Staff 1 confirmed the annual performance reviews were not completed for Staff 15, Staff 23, Staff 24, or Staff 25. |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47005<br><br>Based on observation, interview, and record review it was determined the facility failed to provide person-centered approaches to behavioral symptoms for 1 of 2 sampled residents (#32) reviewed for psychosocial well-being. This placed residents at risk for unmet psychosocial and mental health needs. Findings include:<br><br>Resident 32 admitted to the facility on [DATE] with diagnoses including right lower extremity cellulitis and diabetes. The resident did not have a documented diagnosis related to mental health or trauma at the time of admission.<br><br>A 3/22/24 psychiatric consultation note stated Resident 32 was, labile, cycling through post traumatic memories of fighting in the war with very graphic, disturbing traumatic content, despondent memories and escalating despair. The note recommended Resident 32 continue with psychotherapy treatments.<br><br>A 4/3/24 physician visit note revealed Resident 32 was distressed from experiences with her/his time in the war.<br><br>On 5/15/24 at 10:36 AM Staff 28 (CNA) stated Resident 32's behaviors included talking to herself/himself about the war, keeping the curtain drawn, startling easily and overreacting at times when startled.<br><br>On 5/16/24 at 10:59 AM was observed Resident 32 pacing in her/his room while appearing to talk to herself/himself and rubbing her/his head. Resident 32 stated her/his had was not good as a result of her/his experiences in war. Resident 32 recalled a mental health consult around the time of admission and stated she/he would continue to see someone for her/his mental health if offered.<br><br>On 5/17/24 at 3:12 PM Staff 9 (RNCM) stated a psychiatric consult was requested for Resident 32 at the time of admission because the resident expressed concerns regarding post-traumatic stress disorder (PTSD).<br><br>A review of Resident 32's clinical record on 5/17/24 revealed no care planned intervention to address Resident 32's mental health needs, and no indication the resident received follow-up treatment related to mental health needs since the 3/22/24 psychiatric consultation.<br><br>On 5/17/24 at 3:17 PM Staff 37 (LPN Resident Care Manager) acknowledged there was no evidence to indicate Resident 32 received mental health treatment since the 3/22/24 psychiatric consultation.<br><br>On 5/20/24 at Staff 2 (DNS) acknowledged Resident 32 did not have any follow-up mental health treatment after the initial consultation and the resident's care plan was not updated to reflect the resident's mental health needs and interventions. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>48830<br><br>Based on observation and interview it was determined the facility failed to ensure proper labeling of biologicals for 1 of 2 medication rooms reviewed for medication storage. This placed residents at risk for reduced efficacy of medication. Findings include:<br><br>According to the Center for Disease Control and Prevention: Multi-Dose Vial Safety Reminders (2023):<br><br>-When you first put a clean needle in the vial, write the date and time on the label.<br><br>-The beyond-use-date refers to the date after which an opened multi-dose vial should not be used. The vial should be discarded within 28 days of the opened date.<br><br>On 5/20/24 at 12:40 PM during a review of station one medication storage room with Staff 2 (DNS), one vial of lidocaine solution was observed to be opened with no open date. The vial indicated it was a multiple dose vial.<br><br>On 5/20/24 at 12:44 PM Staff 2 acknowledged the vial of lidocaine solution was opened and not labeled with an open date. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48830<br><br>Based on observation, interview and record review it was determined the facility failed to protect resident identifiable information and ensure records were accurate for 2 of 4 sampled residents (#s 41 and 42) reviewed for record management and insulin. This placed residents at risk for unauthorized use of their personal information and inaccurate treatment. Findings include:<br><br>1. A review of the facility's 12/2023 HIPAA (Health Insurance Portability and Accountability Act) Compliance policy indicated the facility was to safeguard all forms of PHI (Protected Health Information) for each resident.<br><br>On 5/17/24 at 12:33 PM resident identifiable information including Resident 41's name, medication type, prescription number, and the resident's physician's name was observed inside a clear plastic garbage bag with no lid located on the side of a nurse treatment cart. The treatment cart was in the hallway close to the front entrance of the facility and available for anyone in the facility to see. Other items observed in the garbage bag with the resident identifiable information included used gloves and an opened alcohol wipe packet.<br><br>On 5/17/24 at 12:36 PM Staff 27 (Corporate RN) acknowledged the garbage bag contained resident identifiable information and further acknowledged resident identifiable information was not to be placed in any garbage. Staff 27 stated the expectation was for staff to place any resident identifiable information in a secure confidential shred bin located inside the facility.<br><br>41453<br><br>2. Resident 42 was admitted ,d+[DATE] with a diagnosis of Type 1 Diabetes.<br><br>A 3/5/24 Significant Change of Condition MDS indicated Resident 42 was cognitively intact.<br><br>a. The 3/11/24 at 9:48 AM progress note indicated Resident 42 was Hypoglycemic with glucose readings of 61 and 91 before breakfast. Post breakfast it was reported to the licensed nurse that Resident 42 refused breakfast, had a blood glucose level of 37, was diaphoretic and was arousable but was not completely conscious or awake. The Licensed Nurse documented giving 15oz of juice, an intramuscular shot of glucagon, and gel applied to gums (a substitute for oral tablets when swallowing capability is in question).<br><br>The 3/2024 Diabetic administration record indicated the Glucagon emergency kit, Glucose Oral tablet Chewable 4gm (to be given if blood glucose reading was below 70), and the Hypoglycemia protocol (to be initiated for a blood glucose reading below 70 and patient is showing symptoms) was not administered.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/17/24 at 10:17 AM Staff 2 (DNS) stated the progress note which indicated Resident 42's blood glucose reading was 61 before breakfast was incorrect and should not have been in the progress note. Staff 2 stated the actions taken by the licensed nurse in the same progress note were documented correctly. Staff 2 confirmed the diabetic administration record did not show the interventions administered to Resident 42 on 3/11/24.<br><br>b. The 5/16/24 progress note indicated Resident's blood sugar dropped to 67, [orange juice] given, and provider notified.<br><br>A review of the 5/2024 Diabetic Administration Record (DAR) revealed the record did not reflect the interventions documented in the progress note.<br><br>On 5/17/23 at 11:16 AM Staff 33 (LPN) confirmed the DAR did not reflect the actions taken by Staff 34 (LPN) to remedy Resident 42's low blood glucose levels. Staff 33 stated Resident 42 had PRN orders for low blood glucose, and interventions were to be documented in the DAR.<br><br>On 5/17/24 at 10:17 AM Staff 2 (DNS) was provided with these findings. Staff 2 confirmed the DAR was blank for 5/16/24. |