

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2022
NAME OF PROVIDER OR SUPPLIER Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 W Dean Rd Milwaukee, WI 53223	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>42037</p> <p>Based on observation and interview, the facility did not provide a safe, clean, comfortable, and homelike environment for 2 (R41 and R20) of 15 residents reviewed.</p> <p>Findings include:</p> <p>On 6/13/22 at 2:50 PM, Surveyor made the following observations on the North Unit:</p> <p>*EZ stand mechanical lift was noted with a dark brown substance caked to the base of the machine with flaking paint chips</p> <p>*R41's room was noted with a sticky substance and multiple dark scratch markings on the floor room.</p> <p>*R20's wheelchair was noted in ill-repair with a tattered seat and missing padding to the right arm of their wheelchair.</p> <p>On 6/13/22, at 2:55 PM, Surveyor interviewed R20 who indicated they would like to have a new wheelchair as their current chair is old and worn out.</p> <p>The above findings were shared with NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B on 6/14/22. Surveyor requested any additional information related to the above observations. No additional information was provided.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41439</p> <p>Based on observation, interview and record review, the facility did not provide prompt efforts to resolve grievances for 1 (R34) of 15 sampled residents reviewed for grievances.</p> <p>R34 did not have access to WIFI which was R34's main source of communication and activities. R34 stated the WIFI has not been working since 6/10/22. As of 6/20/22, the WIFI was still not working for R34.</p> <p>Findings include:</p> <p>R34 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure with Ventilator Dependence, Morbid Obesity, Quadriplegia (Cervical 5-7 Complete), Hypertension, Atrial Fibrillation, Colostomy, and Anxiety Disorder.</p> <p>R34's Annual MDS (Minimum Data Set) assessment, dated 2/16/22, indicated R34 was cognitively intact for daily decision making and required extensive assistance with 2 staff for bed mobility, transfer, dressing, eating, and toileting. R34's MDS indicated functional limitations in bilateral upper and lower extremities.</p> <p>R34's Care Plan, dated 5/2/22, indicated R34 has potential to be verbally aggressive and acknowledges being demanding and particular about care and who provides the care. R34 self reports having OCD (Obsessive Compulsive Disorder) and that it causes him to be very particular if staff do not do things his way or that he cannot have certain staff. Revised: 5/30/22.</p> <p>Intervention: give R34 as many choices as possible about care and activities.</p> <p>On 6/13/22, at 10:07 AM, Surveyor observed R34 in bed reading a book and was connected to the ventilator. Surveyor interviewed R34 who stated the most pressing issue is that the call lights are not working. R34 stated the facility didn't order my colostomy bags and I don't have a spare tracheostomy tube. R34 stated the wall suction doesn't work so I have this bedside machine which doesn't work well. Surveyor observed bedside suction canister filled with 75% green thick substance (undated). R34 stated I have been here for [AGE] years and I don't want to move, I just want it all fixed. My WIFI is not working and I have been so upset since Friday 6/10/22.</p> <p>On 6/13/22 10:12 AM, Surveyor interviewed RN-E (Registered Nurse) who stated when she got here this morning (Monday) the call lights/WIFI were not working. RN-E stated when she left Thursday the call lights were working so now the staff are making constant rounds. RN-E stated no plan of action and assumes someone is coming today urgently. RN-E stated there is no WIFI on the ventilator unit so we have to chart in the medical record on the hard line computer. Surveyor noted the facility had provided residents with noisemakers such as tambourines and maracas and constant rounding to address the concern of the call lights not working.</p> <p>On 6/13/22, at 10:53 AM, Surveyor interviewed R34 who stated still having concerns about no replacement tracheostomy tube in case he has issues or an emergency.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/13/22, at 11:48 AM, Surveyor interviewed R34 who is still concerned about the lack of supplies, no extra tracheostomy tube, no colostomy bags, no WIFI and call lights not working.</p> <p>On 6/14/22, at 7:59 AM, Surveyor observed R34's room door is closed and staff informed this Surveyor it was too early to disturb him.</p> <p>Surveyor reviewed the facility grievance log and noted R34 filed a grievance on 4/24/22 regarding his issues about care and tracheostomy. The grievance is blank, with no follow up or resolution documented.</p> <p>On 6/14/22, at 10:15 AM, NHA-A (Nursing Home Administrator) provided this Surveyor with documentation indicating R34's grievance filed on 4/24/22 was acted upon on 4/27/22. Tracheostomy tube was on back order arriving 4/27/22. The resolution stated R34 requests certain RT (Respiratory Therapist) to change his tracheostomy tube and it was changed on 2/1/22.</p> <p>The resolution indicated the facility will encourage R34 to uses multiple RTs to help with the change. Facility Resident Advocate Program form indicated R34 responded to the question Do you feel afraid or angry because of staffing and/or the care you receive documenting R34 feels use to it. R34 was not satisfied with assistance from staff and concerns are not addressed.</p> <p>*Surveyor noted R34 chooses to only allow personally chosen staff to perform any designated task. i.e. bathing, wound /skin care, catheter changes.</p> <p>On 6/14/22, 3:38 PM, the Survey Team expressed concerns during daily exit regarding inoperable call lights and no WIFI in the ventilator unit.</p> <p>On 6/15/22, 8:10 AM, Surveyor interviewed ACT-R (Activities-also orders facility supplies) who stated she has no issues ordering supplies at this time and currently his (R34's) bags are on back order but no concerns yet that facility does not have them. This Surveyor was informed the facility did have extra supplies on hand at the facility but an order was placed for more supplies that are currently on back order.</p> <p>On 6/15/22, at 8:23 AM, Surveyor interviewed RTD-S (Respiratory Therapy Director) who stated R34 has a flexible Portex tracheostomy tube in now but none are currently available here in the facility. RTD-S stated we ordered 3 of them Monday 6/13/22. RTD-S stated R34 does have a Shiley Tracheostomy tube now in his drawer and there are 5 more of that type in the facility. RTD-S stated the flexibility is different but R34 had a Shiley type before the current ordered Portex tube.</p> <p>On 6/15/22, at 8:50 AM, Surveyor interviewed RTD-S who stated she just got a grievance dated 6/14/22 that R34 wanted a new suction machine as this one was not working. RTD-S stated she would follow up on it today. Surveyor informed RTD-S of observations of R34's suction machine being undated and 75% full of green thick substance.</p> <p>On 6/15/22, at 8:57 AM, Surveyor Interviewed Nursing Home Administrator (NHA)-A and asked if the ventilator unit WIFI would be fixed since it has been out since Friday 6/10/22 and residents are upset. NHA-A stated she would contact IT (Information Technology) again and have it reset.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/15/22, 1:02 PM, Surveyor noted WIFI continues to be inoperable in the ventilator unit for staff and residents.</p> <p>On 6/15/22, at 2:29 PM, Survey Team shared concerns during daily exit there continues to be no WIFI for ventilator dependent/bedbound residents. NHA-A stated they started trying to fix it Friday 6/10/22.</p> <p>On 6/20/22, at 7:57 AM, R34 stated no WIFI yet and remains upset.</p> <p>On 6/20/22, at 8:59 AM, Surveyor noted the ventilator unit has no WIFI access.</p> <p>On 6/20/22, at 9:25 AM, Surveyor interviewed NHA-A who stated a Tech will come out, WIFI is not working but we educated everyone on hot spots.</p> <p>On 6/20/22, Survey Team conducted the facility exit and the facility did not provide any further information regarding when the ventilator unit WIFI would be operational.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161</p> <p>Based on observation, interview and record review, the facility did not ensure 6 of 15 Residents (R40, R8, R25, R47, R34, R28) comprehensive care plans reviewed were revised and updated to reflect the Residents current needs.</p> <p>* R40's care plan did not address the need for compression stockings.</p> <p>* R8's care plan inaccurately reflected R8 had a Foley catheter.</p> <p>* R25's Active Care plan did not address her native language and interventions for communication. R25 did not have a care plan addressing her ventilator status and interventions. R25 did not have a discharge care plan in which a discharge was actively in progress.</p> <p>* R47's Active Care plan did not address R47's contractures or interventions to prevent further decline. R47 did not have a care plan addressing his ventilator status and interventions.</p> <p>* R34 Active Care plan did not address his colostomy and care concerns. R34 did not have a care plan addressing his ventilator status and interventions.</p> <p>* R28's smoking evaluation indicating R28 is an independent smoker, however, R28's care plan indicates that R28 should be supervised</p> <p>Findings include:</p> <p>1. R40 was admitted to the facility on [DATE] with a diagnosis that includes Dementia without Behavioral Disturbance, Diabetes Mellitus Type II, and Heart Failure.</p> <p>R40's quarterly MDS (Minimum Data Set) dated 4/7/22 does not document a BIMS (Brief Interview for Mental Status) score or memory problems for R40.</p> <p>Section G (Functional Status) documents that R40's bed mobility and transfer status did not occur and that R40 required no setup or physical help from staff.</p> <p>Section G0400 (Functional Limitation in Range of Motion) also documents that R40's functional limitations in range of motion were not assessed.</p> <p>R40's nursing note dated 6/2/22 documents, Health Status Note Text: Resident returned from hospital with orders to apply tubi grips to lower legs and to continue to elevate hands and to give Tylenol for pain as needed. Writer called and spoke to POA (power of attorney) with no further questions at this time. Resident is currently eating supper with no c/o (complains of) pain at this time.</p> <p>R40's hospital discharge documentation dated 6/2/22 documents under the Additional Instructions section, Elevation and compression stockings should be utilized to help with reducing swelling.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Surveyor was unable to locate any care plan intervention that documented the use of compression stockings by R40 as documented in R40's hospital discharge documentation dated 6/2/22.</p> <p>On 6/13/22 at 12:10 p.m., Surveyor observed R40 sitting in his wheelchair. Surveyor observed R40's feet to have dry skin and observed R40 not to be using any compression stockings as recommended in R40's hospital discharge documentation dated 6/2/22.</p> <p>On 6/14/22 at 7:47 a.m., Surveyor observed R40 sitting in his wheelchair. Surveyor observed R40 wearing regular/common socks and observed R40 not to be using any compression stockings as recommended in R40's hospital discharge documentation dated 6/2/22.</p> <p>On 6/14/22 at 12:32 p.m., Surveyor observed R40 sitting in his wheelchair. Surveyor observed R40 wearing regular/common socks and observed R40 not to be using any compression stockings as recommended in R40's hospital discharge documentation dated 6/2/22.</p> <p>On 6/14/22 at 12:32 p.m., Surveyor asked LPN (Licensed Practical Nurse)- C and CNA (Certified Nursing Assistant)-N, whom were caring for R40, if R40 refuses the use of compression stockings. LPN-C and CNA-N informed Surveyor that they were not aware that R40 used compression stockings.</p> <p>On 6/15/22 at 10:29 a.m., Surveyor observed R40 sitting in his wheelchair. Surveyor observed R40 wearing regular/common socks and observed R40 not to be using any compression stockings as recommended in R40's hospital discharge documentation dated 6/2/22.</p> <p>On 6/15/22 at 2:39 p.m., during the daily exit conference, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. At the time, no additional information was provided.</p> <p>On 6/16/22 at 9:06 a.m., NHA-A informed Surveyor that a care plan for the use of compression stockings was put in place for R40.</p> <p>On 6/20/22 at 9:34 a.m., Surveyor reviewed R40's medical record and noted that under R40's ADL (Activities of Daily Living) care plan under the Interventions section it documented COMPRESSION HOSE: Date Initiated: 04/18/2022.</p> <p>No additional information was provided.</p> <p>2. R8 was admitted to the facility on [DATE], and has diagnoses that include Chronic Obstructive Pulmonary Disease, chronic pain, Osteoarthritis, benign prostatic hyperplasia and acquired absence of right leg above the knee. R8's Minimum Data Set (MDS) assessment, dated 4/7/22 Section C: Cognitive Patterns is left blank, but a previous Quarterly MDS dated [DATE] his BIMS (Brief Interview for Mental Status) was scored at 15 which is cognitively intact. Section J: Personal Hygiene documents R8 requires extensive assistance for maintaining personal hygiene and one-person physical assist. Section H: Bladder and Bowel documents no indwelling catheter, no external catheter and no intermittent catheterization.</p> <p>On 6/13/22 at 1:06 PM Surveyor interviewed R8 and asked if he has a catheter. R8 stated no that he wears a brief and goes in them. Surveyor asked if he has had a catheter in the recent past and R8 stated no. Surveyor observed no catheter bag or tubing present during interaction.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/14/22 at 11:17 Surveyor reviewed the care plan dated 4/10/22. Under toileting section, it states to assist before morning cares, at bedtime and every 2-3 hours while awake and upon request. Care plan was updated on 4/25/22 and indwelling catheter care was added. Interventions include foley catheter care, changing of catheter, checking of tubing, and monitoring for pain and discomfort due to catheter. Surveyor reviewed Physician Orders and could not locate any physician orders for a catheter or orders for catheter type.</p> <p>On 6/14/22 at 11:25 Surveyor reviewed the record for urology consult or notes and none were able to be located. Surveyor reviewed CNA (Certified Nursing Assistant) Care Kardex which also documents that R8 has a foley catheter and care for that catheter.</p> <p>On 6/14/22 at 1:49 PM Surveyor interviewed Certified Nursing Assistant-Y (CNA-Y) and asked if R8 has a catheter. CNA-Y stated that he does not. She stated that a very long time ago when she worked with him at another facility he did.</p> <p>On 6/15/22 at 10:38 AM Surveyor interviewed Director of Nursing-B (DON-B) and asked if she was aware of R8 having a catheter. DON-B stated R8 does not have a catheter since I've been here (started April 2022). Surveyor referred DON-B to the care plan from 4/25/22 which states care plan and interventions for catheter care. DON-B stated it must be incorrect. Surveyor asked who is responsible for completing these sections and DON-B stated a unit nurse would be preferred however we currently have a nurse consultant completing them. DON- B stated, Yeah, this is wrong. I don't have him down for a catheter.</p> <p>On 6/15/22 at 3:30 PM during the daily exit conference, Surveyor informed NHA-A and DON-B of the above findings.</p> <p>Surveyor was not provided with any additional information.</p> <p>41439</p> <p>3. R25 was admitted to the facility on [DATE] with diagnoses including Respiratory Failure with Ventilator Dependence, Diabetes, Morbid Obesity, Anxiety/Depression, Hypertension, and Heart Failure.</p> <p>R25's primary language is Spanish with minimal understanding/ability to speak English. R25's discharge goal was to return to the community living with her daughter and support services.</p> <p>R25's 1/25/2021 14:22 Care Plan Note indicated IDT (Interdisciplinary team), Social worker, PT and RT met with R25 in her room with daughter via . unable to reach ICARE CM (Case Manager) left message for to update her on progress and discuss plan of care and discharge planning. RT updated that during the day [R25] is on trachea mask with 5 liters of O2 from 7:30am to 9:00pm and vent at night. [R25] will need a trilogly vent at home and training and education will be needed. PT and OT [R25] is a set up for upper ADL's and max assist for lower ADL's she is able to ambulate up to 90 Ft with Bariatric walker, bed mobility she is able to sit edge of bed using siderails (bed mobility). PT recommend shower bench for tub, hospital bed with side rails for bed mobility. Daughter states that goal is for her mom to discharge home with her in . area and transition to ICARE Community care in SW placed call to RN CM for ICARE provided her with updated progress and goal. States she will update team and begin process to send referrals to [NAME] ICARE agency and Home Care referrals for vent support and management. SW will continue to follow plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R25's 11/1/21 Annual MDS indicated she was cognitively intact but no CAA (Care Area Assessment) for return to community referral. R25 required extensive assistance with 2 staff for bed mobility and dressing, toileting and transfer required extensive assistance with 1 staff.</p> <p>R25's 5/1/22 Quarterly MDS was incomplete and inaccurate. R25's MDS indicated cognitive assessment was not completed/dashed. R25's bed mobility was independent but scored as assistance from 2 staff. R25 was scored as 0, 0 indicating independence in transfers, toileting, dress, eating, however R25 was ventilator dependent at night. R25's Section Q was not assessed including the discharge plan which was actively in progress.</p> <p>R25's Active Care plan did not address her native language and interventions for communication. R25 did not have a care plan addressing her ventilator status and interventions. R25 did not have a discharge care plan in which a discharge was actively in progress.</p> <p>On 6/15/22, at 2:29 PM, the Survey Team shared concerns regarding care plans.</p> <p>On 6/15/22, at 7:51 AM, Surveyor received R25's updated care plan from facility which included:</p> <p>R25 has a communication problem related to language barrier. She is .speaking.</p> <p>6/14/22.</p> <p>R25 will maintain current level of communication function by using appropriate gestures, responding to yes/no questions appropriately, and using communication board. Interventions include: Be conscious of R25's position when in groups, activities, dining room to promote proper communication with others. Communication: Allow adequate time to respond. Repeat as necessary. Do not rush. Request clarification from the resident to ensure understanding. Face when speaking, make eye contact, Turn off TV/radio to reduce environmental noise. Ask yes/no questions if appropriate, Use simple brief consistent words/cues, Use alternative communication tools as needed. R25 prefers to communicate in [native language]. R25 requires [native language]-English communication board to communicate. Ensure availability and functioning of adaptive communication equipment. 6/14/22.</p> <p>4. R47 was admitted [DATE] with diagnoses including Traumatic Brain Injury, Quadriplegia (Cervical 1-4 Incomplete), Heart Failure, Atrial Fibrillation, Cardiac Arrest, Passenger injured in collision with motor vehicles, Subarachnoid Hemorrhage (Brain Bleed), Respiratory Ventilator Dependence and GT (Gastrostomy Tube).</p> <p>R47's 5/17/22 Annual MDS (Minimum Data Set) indicated R47 was severely cognitively impaired with extensive assistance with 2 staff for bed mobility, transfer, toileting and total dependence for eating (GT feedings through artificial opening). R47's functional limitation was indicated for bilateral upper and lower extremities. R47's MDS did not have a CAA for ADLs (Activities of Daily Living).</p> <p>R47's Active Care plan did not address R47's contractures or interventions to prevent further decline. R47 did not have a care plan addressing his ventilator status and interventions.</p> <p>On 6/15/22, at 2:29 PM, Survey Team shared concerns regarding care plans.</p> <p>On 6/15/22, at 7:45 AM, Surveyor received R47's updated care plan from facility which included:</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R47 has limited physical mobility related to contractures with goal free of complications related to immobility including contractures, thrombus formation, skin breakdown, fall related injury. Interventions: Monitor/document/report as needed any increased signs of immobility, contractures forming or worsening, thrombus formation, skin breakdown, fall related injury. Provide supportive care, assistance with mobility as needed, Document assistance as needed. PT/OT referrals as ordered and needed. 6/14/22.</p> <p>5. R34 was admitted to the facility on [DATE] and diagnoses including Chronic Respiratory Failure with Ventilator Dependence, Morbid Obesity, Quadriplegia (Cervical 5-7 Complete), Hypertension, Atrial Fibrillation, Colostomy, and Anxiety Disorder.</p> <p>R34's 2/16/22 Annual MDS (Minimum Data Set) indicated R34 was cognitively intact and required extensive assistance with 2 staff for bed mobility, transfer, dressing, eating, and toileting. R34's MDS indicated functional limitations in bilateral upper and lower extremities.</p> <p>R34's 5/19/22 Quarterly MDS indicated R34 was rarely understood and the BIMS was dashed (incomplete). In actuality, R34 is easily understood and cognitively intact.</p> <p>R34 Active Care plan did not address his colostomy and care concerns. R34 did not have a care plan addressing his ventilator status and interventions.</p> <p>On 6/15/22, at 2:29 PM, Survey Team shared concerns regarding care plans.</p> <p>No further information was provided regarding R34's care plan.</p> <p>Care Plan Staff interviews:</p> <p>On 6/14/22, at 1:30 PM, Surveyor interviewed LPN-C (Licensed Practical Nurse) who is also utilized as a preceptor. LPN-C stated she used to work here but just came back 2 months ago. LPN-C stated she has no access to the previous medical records system or care plans, only this current electronic system.</p> <p>On 6/14/22, at 1:35 PM, Surveyor interviewed CNA-O (Certified Nurse Assistant) who stated she doesn't have access to prior medical records system but I think they are trying to give us access but not yet.</p> <p>On 6/14/22, at 1:40 PM, Surveyor interviewed RT-P (Respiratory Therapist) who stated we don't have access to prior medical records system and I need it because my ventilator flowsheets are in there and now I just have to freehand the ventilator information.</p> <p>On 6/14/22, at 1:50 PM, Surveyor interviewed LPN-Q who stated working at the facility for 4 years. LPN-Q stated she doesn't have access to the old medical record system so we can't use it.</p> <p>38146</p> <p>6. R28 was admitted to the facility on [DATE] with diagnoses of weakness, paranoid schizophrenia, and repeated falls.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R28's Medicare 5-day MDS (minimum data set), dated 1/7/2022, documents R28's Brief Interview for Mental Status (BIMS) score to be 11, meaning R28 is moderately impaired for daily decision making.</p> <p>R28's Care Plan, dated 4/27/2022, states: R28 has potential for injury related to smoking. Interventions include, Inform resident of scheduled smoking times to ensure compliance. Keep smoking paraphernalia in a safe location away from the resident until scheduled smoking times. Resident to be supervised by assigned staff at all times during smoking activity.</p> <p>R28's smoking evaluation, dated 5/10/2022, indicates R28 a Independent and safe smoker: Capable and independent, requires no supervision to smoke.</p> <p>On 6/15/2022, at 9:25 AM, Surveyor interviewed LPN (Licensed Practical Nurse)-C. Surveyor asked LPN-C if R28 was able to smoke independently or if R28 is to be supervised. LPN-C reported that R28 can smoke independently.</p> <p>On 6/15/2022 at 2:28 PM, Surveyor shared the concern related to R28's smoking evaluation indicating R28 is an independent smoker, however R28's care plan indicates that R28 should be supervised.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41439</p> <p>Based on observation, interview, and record review, 2 (R47 & R40) of 15 sampled residents were not provided the treatment, care, and services in accordance with professional standards of practice.</p> <p>R47 was not observed wearing bilateral arm tubigrips (fabric sleeves for protection) as ordered by the physician on 4/28/22.</p> <p>On 6/13/22, 6/14/22, and 6/15/22, R40 was not wearing compression stockings per 6/2/22 hospital discharge instructions. In addition, there was no care plan in place for the use of compression stockings.</p> <p>Findings include:</p> <p>1. R47 was admitted [DATE] with diagnoses including Traumatic Brain Injury, Quadriplegia (Cervical 1-4 Incomplete), Heart Failure, Atrial Fibrillation, Cardiac Arrest, Passenger injured in collision with motor vehicles, Subarachnoid Hemorrhage (Brain Bleed), Respiratory Ventilator Dependence and GT (Gastrostomy Tube).</p> <p>R47's 5/17/22 Annual MDS (Minimum Data Set) indicated R47 was severely cognitively impaired with extensive assistance with 2 staff for bed mobility, transfer, toileting and total dependence for eating-(GT feedings through artificial opening). R47's functional limitation was indicated for bilateral upper and lower extremities.</p> <p>R47's 4/28/22 Physician order indicated: Apply Tubigrip sleeves to BUE (Bilateral Upper Extremities) for protection, monitor placement every shift</p> <p>On 6/13/22, at 9:33 AM, Surveyor observed R47 resting in bed on left side, with an air mattress, respiratory ventilator dependent with bilateral knees bent and contracted with arms bent at the elbows, no tubigrip sleeves were on R47's arms.</p> <p>On 6/14/22, at 7:55 AM, Surveyor observed R47 resting in bed, repositioned & changed by staff with knees bent and contracted, arms straight with crooked fingers, no tubigrip sleeves on arms.</p> <p>On 6/14/22, at 12:17 PM, Surveyor observed R47 has been repositioned with knees bent and contracted, no tubigrip sleeves on arms.</p> <p>On 6/15/22, at 8:20 AM, Surveyor observed R47 resting on left side, no tubigrip sleeves on arms.</p> <p>*Surveyor noted facility nurses are documenting R47's tubigrips are in place on every shift in the electronic medical records despite observations of R47 not having tubigrips in place for 3 days.</p> <p>On 6/15/22, at 12:56 PM, Surveyor interviewed CNA-O (Certified Nurse Assistant) who is the consistent caregiver in R47's unit. CNA-O stated R47 does not wear tubigrips and has never had tubigrips. Surveyor interviewed LPN-Q (Licensed Practical Nurse) who checked R47's medical record computer documentation. LPN-Q stated tubigrips have been documented as applied in R47's medical record every shift.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/15/22, at 2:29 PM, Survey Team shared concerns regarding R47's lack of tubigrips and documentation.</p> <p>On 6/20/22, at 8:00 AM, Surveyor observed R47 leaning to the right in the bed with tubigrips on bilateral upper extremities.</p> <p>36161</p> <p>2. R40 was admitted to the facility on [DATE] with a diagnosis that includes Dementia without Behavioral Disturbance, Diabetes Mellitus Type II, and Heart Failure.</p> <p>R40's quarterly MDS (Minimum Data Set) dated 4/7/22 does not document a BIMS (Brief Interview for Mental Status) score or memory problems for R40.</p> <p>Section G (Functional Status) documents that R40's bed mobility and transfer status did not occur and that R40 required no setup or physical help from staff.</p> <p>Section G0400 (Functional Limitation in Range of Motion) also documents that R40's functional limitations in range of motion were not assessed.</p> <p>R40's nursing note dated 6/2/22 documents, Health Status Note Text: Resident returned from hospital with orders to apply tubi grips to lower legs and to continue to elevate hands and to give Tylenol for pain as needed. Writer called and spoke to POA (power of attorney) with no further questions at this time. Resident is currently eating supper with no c/o (complains of) pain at this time.</p> <p>R40's hospital discharge documentation dated 6/2/22 documents under the Additional Instructions section, Elevation and compression stockings should be utilized to help with reducing swelling.</p> <p>Surveyor was unable to locate any physician order or care plan intervention that documented the use of compression stockings by R40 as documented in R40's hospital discharge documentation dated 6/2/22.</p> <p>On 6/13/22 at 12:10 p.m., Surveyor observed R40 sitting in his wheelchair. Surveyor observed R40's feet to have dry skin and observed R40 not to be wearing any compression stockings as recommended in R40's hospital discharge documentation dated 6/2/22.</p> <p>On 6/14/22 at 7:47 a.m., Surveyor observed R40 sitting in his wheelchair. Surveyor observed R40 wearing regular/common socks and observed R40 not to be wearing any compression stockings as recommended in R40's hospital discharge documentation dated 6/2/22.</p> <p>On 6/14/22 at 12:32 p.m., Surveyor observed R40 sitting in his wheelchair. Surveyor observed R40 wearing regular/common socks and observed R40 not to be wearing any compression stockings as recommended in R40's hospital discharge documentation dated 6/2/22.</p> <p>On 6/14/22 at 12:32 p.m., Surveyor asked LPN (Licensed Practical Nurse)- C and CNA (Certified Nursing Assistant)-N, whom were caring for R40, if R40 refuses the use of compression stockings. LPN-C and CNA-N informed Surveyor that they were not aware that R40 used compression stockings.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/15/22 at 10:29 a.m., Surveyor observed R40 sitting in his wheelchair. Surveyor observed R40 wearing regular/common socks and observed R40 not to be wearing any compression stockings as recommended in R40's hospital discharge documentation dated 6/2/22.</p> <p>On 6/15/22 at 2:39 p.m., during the daily exit conference, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. At the time, no additional information was provided.</p> <p>On 6/16/22 at 9:06 a.m., NHA-A informed Surveyor that a care plan for the use of compression stockings was put in place for R40.</p> <p>On 6/20/22 at 9:34 a.m., Surveyor reviewed R40's medical record and noted that under R40's ADL (Activities of Daily Living) care plan under the Interventions section it documented COMPRESSION HOSE: Date Initiated: 04/18/2022.</p> <p>No additional information was provided.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42037</p> <p>Based on observation, interview and record review, the facility did not ensure 2 of 7 Residents (R41 and R158) reviewed for pressure injuries received the necessary care treatment and services, consistent with standards of practice, to promote healing and to prevent new pressure injuries from developing.</p> <p>* R41 was identified at high risk for pressure injuries. R41 has pressure injuries to the coccyx, and bilateral heels. On 6/14/22 and on 6/15/22, R41's heels were not floated off of the air mattress as per care plan to float heels. On 6/15/22 at 11:40 A.M., R41's air mattress was not functioning.</p> <p>* On 6/10/22, R158 was readmitted into the facility with pressure injuries. The facility did not complete a comprehensive assessment of R158's pressure injuries upon readmission on 6/10/22 to include a description of the wounds, wound characteristics, measurements or staging of the wounds. There was no documentation of an assessment until 3 days later (6/13/22) when the wound Physician documented a Stage 2 pressure injury to the coccyx and an unstagable deep tissue injury of the left thigh (was meant to be left first medial toe and not left thigh). In addition, the facility did not implement treatment to R158's pressure injuries until 3 days later when R158 was seen by the wound Physician.</p> <p>Findings include:</p> <p>1. R41 was admitted to the facility on [DATE] with diagnoses including Multiple Myeloma, Diabetes Mellitus and Encephalopathy.</p> <p>A Braden scale score was conducted on 4/17/22 with a score of 10 indicating that R41 is at high risk for pressure injuries</p> <p>Pertinent care plans for R41 include the following:</p> <p>~ ADL: Self-Care deficit initiated on 4/10/22 with interventions that include in part; Pressure relief mattress, cushion in wheelchair, Float heels on a Wedge pillow initiated on 4/10/22.</p> <p>~ R41 has potential/actual impairment or wound to skin due to moisture and gastrostomy site initiated 2/15/22 with revision on 4/27/22. Interventions include in part; pressure relieving/reducing mattress to protect skin in bed initiated 2/15/22 and 4/27/22. Pressure relieving/reducing cushion in chair 2/15/22 with revision on 4/22/22</p> <p>~ R41 has pressure ulcers/wound and/or potential for pressure ulcer development r/t current medical status/disease process. Coccyx Stage 4, right heel unstageable, left heel unstageable. Initiated 4/14/22 with revision on 6/14/22.</p> <p>Interventions include but not limited to; Avoid positioning the resident on her coccyx initiated 4/14/22, requires a pressure relieving/reducing device on her bed and chair initiated 4/14/22, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate initiated 4/14/22.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R41 developed a unstageable pressure injury to the left heel on 4/18/22 while residing at the facility. R41 developed an unstageable pressure injury to the right heel on 4/27/22.</p> <p>R41's wound assessments include:</p> <p>Left heel:</p> <p>5/30/22 VOHRA Wound Evaluation & Management Summary indicates Unstageable due to necrosis of the left heel full thickness. Etiology Pressure, unstageable necrosis, 4 X 5 x 0.3 moderate serous, 30% slough, 70% granulation. Improved. Xeroform sterile gauze apply three times per week, foam with boarder apply three times per week.</p> <p>6/13/22 VOHRA Wound Evaluation & Management Summary indicates Unstageable due to necrosis of the left heel full thickness. Etiology Pressure. Unstageable necrosis, 4 X 4 X 0.3 moderate serous 30% slough, 70% granulation, no change, debridement.</p> <p>6/20/22 VOHRA Wound Evaluation & Management Summary indicates Unstageable due to Necrosis of the left heel full thickness. Etiology Pressure, Unstageable necrosis, wound 4 X 2.5 X 0.3, Exudate Moderate Serous, 30% Slough, 70% granulation, wound improved. Debridement. Xeroform sterile gauze apply three times per week, foam with border apply 3 times a week.</p> <p>Right heel:</p> <p>5/30/22 VOHRA Wound Evaluation & Management Summary indicates unstageable due to necrosis of right heel full thickness. Etiology Pressure, Unstageable Necrosis, 4.5 X 6 X Not measurable, 100% black necrotic tissue. No change, Betadine.</p> <p>6/13/22 VOHRA Wound Evaluation & Management Summary indicates Unstageable due to necrosis of the right heel full thickness. Etiology Pressure, unstageable necrosis, 4.5 X 6 X 0.1 moderate serous, 90% black necrotic tissue, 10 % slough, Alginate calcium apply daily, foam with boarder apply daily, debridement.</p> <p>6/20/22 VOHRA Wound Evaluation & Management Summary indicates</p> <p>Unstageable due to necrosis of the right heel full thickness. Etiology Pressure.</p> <p>Unstageable Necrosis, 4.5 X 6 x 01, 90% necrotic black tissue, 10% slough, no change. Alginate calcium apply daily, foam with border apply daily</p> <p>Dr. FF's progress note dated 6/20/22 states, Bilateral heels wound are unavoidable, secondary to off loading care plan in place (off loading boots and air bed), patient multiple co-morbidities (DM) CKD, COVID-19, history of protein-calorie malnutrition) and new findings of Peripheral arterial disease requiring vascular surgery intervention (angiography).</p> <p>Surveyor also noted the VOHRA Wound Evaluation & Management Summaries include ongoing assessments of an Unstageable due to Necrosis Coccyx Full Thickness wound with an Etiology of Pressure.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 6/13/22 VOHRA Wound Evaluation & Management Summary assesses this area as Etiology Pressure, stage 4, 9.5 x 10.5 x 0.3, undermining 2 cm at 11:00, 30% slough, 60% granulation, 10% skin. The assessment states, this wound is in an inflammatory stage and is unable to progress to a healing phase because of the presence of biofilm. Wound improved.</p> <p>As of 6/20/22 the VOHRA Wound Evaluation & Management Summary for the Coccyx indicates Etiology Pressure, stage 4, 9.5 x 10 x 1 cm, 2 cm at 11:00 o'clock 30% slough, 60% granulation, skin 10%. This wound in in an inflammatory stage and is unable to progress to a healing phase because of the presence of biofilm. Improved.</p> <p>The VOHRA Wound Evaluation & Management Summaries also include ongoing assessments of a Post-Surgical wound.</p> <p>The VOHRA Wound Evaluation & Management Summaries starting on 5/16/22 include the monitoring of a Venous Wound of the Left Calf full thickness with an etiology Venous, wound size 1 X 1 X 0.1.</p> <p>On 6/14/22 at 11:35 AM, Surveyor conducted interview with Medication Technician-D, who is currently working in the role of a CNA (Certified Nursing Assistant). Surveyor asked Medication Technician-D how staff would know what types of interventions to use for residents with pressure injuries. Medication Technician-D told Surveyor that each resident should have a care card to which informs staff how to provide care for residents. Medication Technician-D told Surveyor that if a resident has a pressure injury, they usually have an air mattress but that the nurses are in charge of monitoring the mattresses.</p> <p>Surveyor reviewed R41's CNA care card. Surveyor noted R41's CNA care card reads: Resident care .5.) Pressure relief: pressure relief mattress, cushion in wheelchair, float heels on a wedge pillow .resident requires a pressure relieving/reducing mattress to protect the skin while in bed.</p> <p>On 6/13/22 at 1:30 PM, R41 was observed on their back lying in their bed. Surveyor noted a functioning pressure relieving air mattress on R41's bed. Surveyor could not visualize R41's feet at this time.</p> <p>On 6/13/22 at 3:20 PM, R41 was observed on their back lying in their bed. Surveyor noted a functioning pressure relieving air mattress on R41's bed. Surveyor could not visualize R41's feet at this time.</p> <p>On 6/14/22 at 10:25 AM, R41 was observed on their back lying in their bed. Surveyor noted a functioning pressure relieving air mattress on R41's bed. Surveyor noted R41's heels directly on the bed and were not floated.</p> <p>On 6/14/22 at 1:25 PM, R41 was observed on their back lying in their bed. Surveyor noted a functioning pressure relieving air mattress on R41's bed. Surveyor noted R41's bilateral heels were directly on the bed and not floated.</p> <p>On 6/15/22 at 8:20 AM, R41 was observed on their back lying in their bed. Surveyor noted a functioning pressure relieving air mattress on R41's bed. Surveyor noted R41's bilateral heels were positioned directly on the bed.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/15/22 at 11:40 AM, R41 was observed on their back lying in their bed. Surveyor observed that R41's pressure relieving air mattress was not functioning at this time and the control box for the mattress was noted on the floor. Surveyor noted R41's bilateral heels were positioned directly on the bed and not floated.</p> <p>On 6/15/22 at 1:50 PM, R41 was observed on their back lying in their bed. Surveyor observed that R41's pressure relieving air mattress was not functioning at this time and the control box for the mattress was noted on the floor. Surveyor noted R41's bilateral heels were positioned directly on the bed and not floated.</p> <p>On 6/16/22 at 9:30 AM, R41 was observed laying on their left side in bed. Surveyor observed that R41's pressure relieving air mattress was functioning at this time. Surveyor noted R41's to be wearing bilateral pressure relieving boots to their feet at this time.</p> <p>On 6/20/22 at 12:05 PM, Surveyor shared concerns with NHA (Nursing Home Administrator)-A related to R41's skin integrity, including development of facility acquired pressure injuries to bilateral heels. Surveyor shared concern that use of a functioning air mattress, pressure relief boots or wedge cushions for R41's feet were not observed to be consistently implemented by the facility throughout the survey.</p> <p>38146</p> <p>2. R158 was admitted to the facility on [DATE], was hospitalized on [DATE] and readmitted to the facility on [DATE]. Diagnoses include: Dysphagia, Protein-calorie malnutrition, Emphysema, and Parkinson's Disease.</p> <p>R158's Care Plan Focus area documented:</p> <p>[R158] has the potential for pressure ulcer wound development r/t (related to) comorbidity disease processes - date Initiated 6/13/22.</p> <p>Interventions: Administer treatments as ordered and monitor for effectiveness;</p> <p>Follow facility policies/protocols for the prevention/treatment of skin breakdown;</p> <p>If a pressure injury or wound occurs, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate.</p> <p>[R158] has potential/actual impairment or wound to skin integrity of the r/t fragile skin - date Initiated 6/13/22.</p> <p>Interventions: Encourage good nutrition and hydration in order to promote healthier skin;</p> <p>Follow facility protocols for treatment of injury;</p> <p>Weekly treatment documentation to include any other notable changes or observations.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor's review of R158's Hospital Discharge Summary dated 6/10/22 which included no documentation of R158's pressure injuries.</p> <p>On 6/13/22 the Facility provided the Survey Team with a list of residents in the facility with pressure injuries. Surveyor noted R158 was on the pressure injury list which documented R158 to have a Left thigh pressure injury, unstageable DTI (Deep Tissue Injury) and coccyx pressure injury stage 2.</p> <p>Surveyor was unable to locate documentation the facility completed a comprehensive assessment R158's pressure injuries upon readmission to the facility on [DATE] to include a description of the wound characteristics, measurements or staging of the wounds. Surveyor noted no treatment for R158's pressure injuries was implemented until 3 days later, after R158 was seen by the wound Physician.</p> <p>On 6/14/22 at 11:45 AM Surveyor spoke with Director of Nursing (DON)-B. Surveyor asked DON-B where to find documentation of an admission assessment or measurements of R158's pressure injuries. DON-B reported documentation should be on the Admission Nursing Assessment. Surveyor and DON-B reviewed R158's Admission Nursing Assessment (dated 6/10/22) together. Surveyor noted there was no documentation of a DTI to R158's thigh or a stage 2 pressure injury to R158's coccyx. The Admission Nursing Assessment documented: Groin/rash, right knee (front) Other (specify), Left toe(s) scar, left gluteal fold pressure. DON-B stated: Where did she get this information? I'm going to have to talk to this nurse.</p> <p>Surveyor located a [NAME] wound Physician assessment for R158, dated 6/13/22, which documented: Stage 2 pressure wound coccyx partial thickness. 1.5 x (by) 1 x not measurable cm (centimeters). Exudate: Moderate serous. Xeroform sterile gauze apply once daily. Foam with border apply once daily. Unstageable DTI of the left, medial, first thigh partial thickness. 0.8 x 0.8 x not measurable cm. Exudate none. Skin prep once daily.</p> <p>Surveyor advised DON-B of the [NAME] wound MD assessment dated [DATE] which was 3 days after R158 admitted to the facility.</p> <p>On 6/15/22, at 8:34 AM, DON-B advised Surveyor R158 was admitted to the facility with the pressure injury to his coccyx. DON-B reported the admission assessment has drop down boxes to check. DON-B stated 54 (which is gluteal) was checked instead of 53 (which is coccyx) by mistake, which was missed and not added on the admission assessment. DON-B stated: I'm not sure if this nurse has been educated on measurements, but regardless, the expectation is for the nurse to document an assessment and description of the wound/what it looks like and that wasn't done. DON-B reported R158 did not have a DTI on the thigh, the Physician documented in error.</p> <p>Surveyor review of the Physician note dated 6/15/22 documents: The note on 6/13/22 stating that there is a DTI to the left 1st medial thigh was a data entry error. This is no wound to the left thigh, it was supposed to be a left 1st medial toe.</p> <p>Surveyor verified through observation R158 does not have a deep tissue injury to his left thigh.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/15/22, at approximately 3:00 PM, Surveyor advised Nursing Home Administrator (NHA)-A and DON-B of concern the facility did not complete a comprehensive assessment of R158's pressure injuries upon readmission to include a description of the wounds, wound characteristics, measurements or staging of the wounds. There was no documentation of an assessment until 3 days later when the wound Physician documented. In addition, the facility did not implement treatment to R158's pressure injuries until 3 days later when R158 was seen by the wound Physician. No additional information was provided.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161</p> <p>Based on observation, interview and record review, the facility did not ensure 1 (R8) of 4 residents reviewed had an environment free from accident hazards and adequate supervision provided to prevent accidents.</p> <p>R8 sustained a fall from his wheelchair while attempting to return inside from the facility smoking area. R8 was hospitalized from 4/14/22-4/20/22 related to a right hip fracture and multiple rib fractures related to the fall. R8 was not assessed for safety prior to the incident. The facility's fall investigation did not identify a root cause of the fall and did not implement interventions to prevent future falls. R8 has a history of unsafe practices when smoking including smoking in his resident room.</p> <p>Findings include:</p> <p>The facility's policy, entitled Facility Smoking Safety Policy, dated April 2020, states: To provide a safe and healthy living environment with respect for the health and well-being needs of each resident, staff member and visitor. In this effort, all residents will be supervised by staff while smoking in the designated smoking areas at designated smoking times. The times will be implemented at the discretion of the facility. It is also the objective of this policy to communicate to each resident their role and responsibility in following the rules outlined in this policy and ongoing compliance with this policy.</p> <p>Guidelines: .</p> <p>#2. Smoking is only allowed in designated areas established by the facility. The organization reserves the right to enforce a policy prohibiting resident from keeping any smoking materials in his/her possession for health, safety, and security reasons.</p> <p>#3. Individuals who are non-compliant, exercise poor judgment and show a lack of concern for the welfare of others will be counseled accordingly. Continued behavior at this level may result in a 30-day discharge.</p> <p>#6. It is against facility policy to carry a lighter (and other smoking materials i.e. cigarettes, tobacco, etc.) we are a lighter free facility. Being caught in possession with a lighter and/or cigarettes/smoking materials will be considered a violation of the policy and consequences will be reviewed on an individual basis.</p> <p>The following behaviors will jeopardize independent smoking privileges and alert for safe smoking re-assessment</p> <p>#1. Smoking in any non-designated area, such as a resident room, bathroom, hallways, elevators, stairways and/or a smoke free courtyard.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy, entitled Fall Prevention and Management, revised on 10/2018, states: This facility is committed to maximizing each resident's physical, mental and psychosocial wellbeing. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for prevention strategies and facilitates as safe environment as possible.</p> <p>Guideline:</p> <p>Upon Admission:</p> <p>#1. A fall risk evaluation will be completed on admission, readmission, quarterly, significant change and after each fall.</p> <p>Facility Guideline following a fall incident: .</p> <p>#4. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence.</p> <p>R8 was admitted to the facility on [DATE], and has diagnoses that include Chronic Obstructive Pulmonary Disease, chronic pain, Osteoarthritis, benign prostatic hyperplasia and acquired absence of right leg above the knee.</p> <p>R8's Minimum Data Set (MDS) assessment, dated 4/7/22 documents: Section C: Cognitive Patterns is left blank, but a previous Quarterly MDS dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 15 indicating R8 is cognitively intact for daily decision making. Section J: Personal Hygiene documents R8 requires extensive assistance for maintaining personal hygiene and one-person physical assist.</p> <p>On 6/14/22, at 11:18 AM, Surveyor reviewed R8's care plan dated 4/27/22. A care plan related to R8's smoking documents:</p> <p>Intervention include that (R8) will be encouraged to be compliant with supervised smoking and be free from injury;</p> <p>To inform [Resident's Name] of scheduled smoking times to encourage compliance;</p> <p>Keep smoking paraphernalia in a safe location away from the resident until scheduled smoking times;</p> <p>[Name of Resident] to be supervised by assigned staff at all times during smoking activity.</p> <p>Surveyor was unable to locate a fall risk assessment prior to the R8's fall on 4/14/22. R8's medical records indicate the last fall risk assessment was completed on 3/30/21.</p> <p>On 4/26/22, R8's fall prevention care plan was updated as R8 was assessed to be at high risk for falls as evidenced by MORSE FALL RISK Score of 60 r/t (related to) Deconditioning, Gait/balance problems, Unaware of safety needs.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/26/22, R8's care plan was updated to include information related to R8's fall on 4/14/22 outside while in the smoking area. R8's care plan documents R8 experienced a hip fracture r/t (related to) a fall while wheeling self-outside without assistance. Surveyor noted no new fall prevention interventions were documented following R8's fall on 4/14/22.</p> <p>Surveyor reviewed R8's Smoking Evaluation dated 5/10/22. This assessment determines R8 is independent and safe smoker: Capable and independent, requires no supervision to smoke. Surveyor is unable to locate a smoking assessment prior to the 5/10/22 smoking assessment. Surveyor requested any other smoking assessments from the facility for R8 since admission.</p> <p>On 6/20/22 at 9:52 AM DON-B stated she is not able to locate any additional smoking assessments.</p> <p>On 6/13/22, at 10:26 AM, Surveyor observed R8 in bed with a cigarette box on the side table. Surveyor asked R8 if he always has his cigarettes in his bedroom and R8 stated there are no cigarettes. R8 opened the cigarette box and this Surveyor observed only a lighter in the cigarette box. Surveyor asked R8 how he was doing and if he had any concerns with the care he was receiving in the facility. R8 stated he fell over backwards in his wheelchair and stated I should sue this place. There is a drop off in the concrete and it should be level. Surveyor asked how the fall happened. R8 stated, I was going backwards trying move out of the way and went off the concrete and fell backwards in my chair. Surveyor asked R8 if he sustained any injuries and R8 said, I bumped my head, broke 3 ribs and broke my hip. I was sent to the hospital.</p> <p>On 6/14/22, at 10:40 AM, Surveyor reviewed R8's medical record which documents:</p> <p>On 4/14/2022, at 16:00 (4:00 PM), Note Text: The resident was outside in the smoking area, tried to open the door for another resident and his W/C (wheelchair) tipped backwards with him landing on the ground hitting his head. Staff was alerted to the incident. The writer was summoned to the incident area. Assessment obtain, Lg. (large)hematoma noted to the back of his head and Left Hip Pain. 911 was called. A cool pack was applied to the back of the resident head. Resident will be transported to FMH (name of hospital) for Eval (evaluation) & (and) TX (treatment). [Name of Nurse Practitioner] NP (Nurse Practitioner) was notified, Facility DON (Director of Nursing) [Name of DON] RN (registered Nurse) MSN (Master of Science Nursing) is aware. Caseworker [name of case worker] from MCFC (Milwaukee County Family Care) was updated. Resident is self POA (Power of Attorney) and agrees with Transport to [Name of Hospital].</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/14/22, at 10:36 AM, Surveyor reviewed the facility completed Caregiver Misconduct Incident Report submitted to the State Agency on 4/15/22. The report documented resident was outside smoking and was opening door to come back into the building, The Resident's wheelchair wheel went off the sidewalk and he fell backwards in his chair hitting the ground. Hospital called today stating resident had received broken ribs and would be in the hospital for a bit. A summary of events was written by the Nursing Home Administrator-A (NHA-A). Summary dated 4/18/22 states: Approximately 12:30pm called to the smoking area [name of resident] had fallen. [Name of resident] was lying on the ground on his wheelchair as if the chair had tipped back. [Name of Resident] was screaming in pain, the EMS (Emergency Medical Services) was called and transferred [name of resident] to ER (emergency room). Another resident was inside and stated he had just come in and when he turned around, he saw [name of resident] through the window on the ground. That resident summoned help from a Med Tech (Medication Technician) and other staff members arrived to offer assistance and call the ambulance. Background: [Name of resident], . [Name of resident] has a BIMS score of 15, is able to make his needs known. [Name of resident] diagnosis includes but is not limited to: COPD (Chronic Obstructive Pulmonary Disease), Chronic pain syndrome, alcohol abuse, paraplegia, anxiety disorder. [Name of resident] has a history of smoking and has been able to take himself outside to smoke. [Name of Resident] was admitted to the hospital with hip fracture and rib fractures. Conclusion: No abuse suspected, [Name of resident] is independent in his making his needs known. Care plan updated to have resident on supervised smoking program with smoking times.</p> <p>Surveyor reviewed the Discharge Summary from R8's hospital stay from 4/14/22 - 4/20/22, which documents: [Name of resident] was admitted [DATE] for a fall, rib fractures and right hip fracture. He was discharged from the hospital on 4/20/22. Discharge diagnoses: fall with right hip fracture and multiple rib fractures, acute hypoxic respiratory failure, and abnormal stress CT (Computed Tomography) scan. R8 was discharged with oxycodone PRN (as needed) for pain control, scheduled Tylenol, and Lidoderm patches. Trauma surgery was consulted. No need for surgical intervention and recommended conservative management. Orthopedic service consulted regarding right hip fracture and the following is a quote from their recommendations on 4/16/22: I do not believe any surgical intervention is warranted. I think with his fall, he strained his left hip which is arthritic and contracted. That will cause a lot of significant inflammation about the hip with pain. The right femoral neck I think is chronic in nature and fixation of that would not be of benefit for him, as he does not weight-bear. I advise him on icing left hip and soft tissues about the left hip, pain management and giving this time to calm down. I assume that this will take a good 4 to 6 weeks at least to abate.</p> <p>On 6/14/22, at 2:22 PM, Surveyor reviewed R8's medical record which documents:</p> <p>On 4/20/2022, at 14:47 (2:47 PM), Note Text: Re admit: Resident arrived via ambulance, admitted to Rm (Room) [room number documented] Alert & o x4 (oriented to person, place time and situation), able to make needs known. Resp (Respirations) even non labored. LCTA. (Lungs Clear to Auscultation). No s/s (signs/symptoms) of distress. Denies Pain @ (at) this time. DX (diagnoses): S/P (status Post) Fall with Right Hip FX (fracture) and Multiple Rib Fractures. S/P Right AKA (Above Knee Amputation), ROM (Range of Motion) WNL (Within Normal Limits) x 4 extremities, No cyanosis or Edema noted. Skin W/D (Warm/Dry) to touch, bottom remains reddened with skin intact. Diet Reg (regular) with Thin Liq. (liquids) 1800 cc (cubic centimeters) fld (fluid) restriction daily. LBM (Last Bowel Movement) 4/20/22. Wt. (Weight) 211.5 LBS. (pounds). [Name of Nurse Practitioner] NP updated NNO (no New Orders). All orders faxed to the pharmacy. Vss (Vital Signs Stable).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/14/22, at 1:58 PM, Surveyor inspected the designated courtyard smoking area for residents. Upon exiting door, there is a 2-3 inch drop from sidewalk to grass level. All concrete is observed to be intact.</p> <p>On 6/15/22, at 9:41 AM, Surveyor reviewed the facility fall investigation report dated 4/14/22, at 14:00 (2:00 PM) which documents: R8 had a fall on 4/14/22 in the courtyard when R8 was trying to open the door and his wheelchair tipped backwards and he fell . Under Predisposing Environmental Factors, the none box is checked. Under Predisposing Situation factors the none box is checked. The Other Info (information) section is left blank. Surveyor identified the facility did not include staff statements. Surveyor noted the fall investigation report does not identify any environmental concerns as the cause of the fall, nor does it identify a root cause of the fall.</p> <p>On 6/15/22, at 9:45 AM, Surveyor interviewed LPN (Licensed Practical Nurse)-J and asked if she was working on 4/14/22 the day R8 fell in the courtyard. LPN-J stated, I was working and responded. R8 was laying back tipped in wheelchair. R8 was trying to reach the door to open it for another resident to come back in and there is a slight incline in the ground towards the door. His wheelchair must have gone backwards and went down into grass. Surveyor asked LPN-J to describe the position of the wheelchair and the sidewalk and grass. LPN-J stated that the wheelchair was backwards, half on the grass and half on the concrete. 911 was called immediately.</p> <p>On 6/15/22, at 10:45 AM, Surveyor interviewed DON (Director of Nursing)-B and asked if she was working on the day of R8's accident on 4/14/22. DON-B stated she was working but did not go outside to assist. She stated, from my understanding, R8 was trying to get in and when opening the door, he rolled backwards, and he rolled off the sidewalk into grass. Surveyor asked if the facility implements scheduled smoking times and DON-B stated, we currently don't have scheduled smoke times. Surveyor asked DON-B if she was aware of any other residents falling in the courtyard. DON-B stated not that she was aware of.</p> <p>On 6/15/22, at 3:08 PM, Surveyor interviewed Maintenance Staff (MS)-I. Surveyor asked MS-I if he was made aware of the concern related to the concrete outside in the courtyard that is used for residents to smoke, to be at higher level than the grass. MS-I stated, yes, I notice the height difference when I cut the grass. Surveyor asked MS-I if he is aware of any residents falling outside due to the level difference of the concrete and grass. MS-I stated it was brought to his attention when he heard a resident fall backwards trying to get back in. Surveyor asked if anyone assessed the outside environment after that fall. MS-I stated, I'm not sure. MS-I stated we are talking about how to resolve it. The sidewalk is not very wide. Surveyor asked if there are any active plans to correct the level of grass and concrete at this time. Maintenance-I stated no, we might put some dirt down. Surveyor asked if MS-I recalls anyone else being injured outside. He stated that he doesn't recall anyone else being injured outside. Surveyor and MS-I went outside to the courtyard where residents smoke and R8 had fallen. MS-I measured the difference in height of sidewalk with his standard tape measure. MS-I measured from the top of the concrete sidewalk down to grass level. MS-I stated there is a 3-inch difference between the concrete and grass. Surveyor asked MS-I how long the grass and concrete has been like this, MS-I stated the whole time I have worked here. When asked how long he has worked at this facility MS-I stated 8 years.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/15/22, at 3:15 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A. Surveyor asked NHA-A if a root cause was identified for R8's fall that occurred on 4/14/22. NHA-A stated, no there was not. NHA-A stated because of the change in ownership, it is hard. We have been thinking about moving the smoking area to a different area where the ground is more level and one that is not by a dining room. NHA-A stated the downside is the potential area has no shade. Surveyor asked if anyone physically investigated the outside smoking area after the incident on 4/14/22. NHA-A stated, I'm not seeing any documentation of that; new owners have hired a landscaping company to look at what we can do to level out the grass and concrete. Surveyor asked if there is any scheduled date for this to be done and NHA-A said not at this time.</p> <p>On 6/14/22, at 9:06 AM, Surveyor observed R8 in bed with a cigarette box on his bed with lighter next to it. Surveyor asked R8 when the last time was he had a cigarette. R8 stated it's been a week since I've been able to go outside and smoke. I have no cigarettes to smoke. Surveyor asked R8 if he was on a smoking schedule. R8 stated, I've never been told of a smoking schedule. Surveyor asked if staff stay outside with him while he smokes and R8 stated only once in a while will staff stay outside. Surveyor asked R8 if he has ever smoked in his room. R8 stated, In the past I have smoked in the room when staff would not take me out. What else am I supposed to do if they don't get me up. Surveyor asked if the facility ever told R8 that he was going to be discharged from the facility due to smoking in his room. R8 stated, yes. They told me I'd have to leave and gave me a 30-day notice. Surveyor asked if this notice was in writing. R8 stated it was verbally told to him.</p> <p>On 6/14/22, at 11:15 AM, Surveyor reviewed R8's medial record which documents R8 has a history of smoking in his room.</p> <p>R8's medical record documents a progress note dated 2/6/22, at 18:30 (6:30 PM) Nurses Note: writer smell smoke in resident room asked resident if he was smoking, resident stuck up middle finger and stated F*** You. writer walked out room and put him on 24-hour report staff will monitor this pm (evening) shift, for smoking.</p> <p>Progress Note dated 3/18/22, at 10:17 AM, documents: Social Services: Writer spoke with CM (Case Manager) about resident smoking in the room and his 30-day notice given to him 3/14. She let writer know that a group home will be coming to evaluate him next week for placement in their facility.</p> <p>Progress Note dated 4/18/2022, at 8:08 AM, documents: Note Text: [Name of Resident] has been found with a strong smell of tobacco smoke in his room, with smoking items, i.e., cigarette(s) and lighters, and had admitted to smoking while he is in his room in bed. [Resident's Name] is alert and oriented with a BIMS score of 15. He stated he receives his smoking paraphernalia from his case manager upon request, explaining he has run out of his cigarettes. It was discussed with his case manager that by choosing to smoke in his room he is putting his ability to stay here in jeopardy and putting the safety of other residents at risk. [Name of Resident] has been on a supervised smoking schedule since admission but voluntarily chooses to disregard this schedule and takes himself outside independently. He is care planned for this behavior.</p> <p>Progress Note dated 4/22/2022, at 4:49 AM, documents: Note Text: resident smoking in bed yelled at staff close the damn door, get out of here.</p> <p>Progress Note dated 6/7/22, at 6:44 AM, Patient room has a strong odor of nicotine. Nurse inquired and resident stated that he smokes, and the smell is from him.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/14/22, at 11:02 AM, Surveyor interviewed Activity Director-R. Surveyor asked Activity Director-R if she was aware of R8 having a smoking schedule. Activity Director-R stated that she heard that R8 had fallen in the courtyard after smoking and since then she guessed R8 was on a smoking schedule. Activity Director-R stated she is not aware of what R8's smoking schedule is. Surveyor asked Activities Director-R if she is aware of where R8 keeps his cigarettes and lighter when not using them. Activities Director-R stated that the nurse keeps cigarettes and lighters.</p> <p>On 6/14/22, at 11:26 AM, Surveyor interviewed Certified Nursing Assistant-Y (CNA-Y) and asked if R8 had a smoking schedule. CNA-Y stated no, he does not have a smoking schedule. Surveyor asked where R8 keeps his smoking materials when not in use. CNA-Y stated that the nurse keeps R8's cigarettes and lighter.</p> <p>On 6/14/22, at 11:33 AM, Surveyor interviewed Licensed Practical Nurse-J (LPN-J) and asked where R8 stores his smoking materials when not in use. LPN-J stated they are kept in the narcotic box. Surveyor asked if R8 should have access to his lighter in his bedroom, LPN-J stated no. Surveyor asked LPN-J if R8 is supervised when he goes outside to smoke, and LPN-J stated staff are always present. LPN-J stated R8 will not smoke in his room or in any room of the facility.</p> <p>On 6/15/22, at 9:16 AM, Surveyor interviewed Nursing Home Administrator-A (NHA-A) regarding the 30-discharge notice provided to R8. NHA-A stated that his case manager found R8 a place to live in Oshkosh however there is a contractual thing going on. NHA-A also stated that she spoke with the Ombudsman, and she said that we could not discharge R8 from the facility because there was no proof R8 was actually smoking in his bedroom. NHA-A stated the Ombudsman suggested placing another smoke detector above his bed so that if R8 is smoking it should go off and that would provide the facility proof of R8 smoking in his room. NHA-A confirmed there was an additional smoke detector above R8's bed. Surveyor asked NHA-A about the facility's current smoking policy and storage of resident lighters. NHA-A stated they have been trying to revise the smoking policy. Resident lighters should not be kept in resident rooms. NHA-A stated the Ombudsman told us we cannot take a residents' lighter if they refuse to give it to us. It has been a challenge that we are still working on.</p> <p>On 6/15/22, at 10:45 AM, Surveyor interviewed Director of Nursing-B (DON-B). Surveyor asked if R8 is supposed to be supervised while smoking. DON-B stated no R8 is an independent smoker and R8 can handle materials safely himself. Surveyor asked where R8's smoking materials should be stored, and DON-B stated on the nursing carts. Surveyor asked DON-B if the facility has any scheduled smoking times. DON-B stated no, currently there are no scheduled smoking times for any resident. DON-B stated we would like to eventually go to that in the future.</p> <p>On 6/16/22 at 10:55 AM Surveyor interviewed DON-B and asked her what the plan is going forward to keep R8 safe while outside smoking. DON-B stated that the smoking policy we were trying to implement with schedules times is not happening since Ombudsman says we cannot stop R8 going out on his own. We have been looking into getting the smoking area moved. R8 can smoke when he wants, and we can send someone outside with him. Surveyor asked if they are providing supervision currently for him. DON-B stated we can pull someone to go outside with R8. DON-B stated the facility didn't have any documentation that says someone is going out with him, but he is being escorted outside. It's not supervision of his smoking. He is independent in that, but staff is staying outside for the duration of smoking.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/20/22 at 9:52 AM Surveyor spoke with DON-B. DON-B confirmed she cannot locate any smoking assessment prior to the fall on 4/14/22. Also stated she cannot find a fall assessment prior to the fall on 4/14/22.		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161</p> <p>Based on record reviews and interviews, the facility did not adequately address Nutrition needs for 1 (R40) of 4 residents reviewed for Nutrition.</p> <p>* R40 was to be placed on a fluid restriction related to bilateral lower extremity edema. The facility did not implement R40's fluid restriction per physician orders.</p> <p>Finding include:</p> <p>R40 was admitted to the facility on [DATE] with a diagnosis that includes Dementia without Behavioral Disturbance, Diabetes Mellitus Type II, and Heart Failure.</p> <p>R40's quarterly MDS (Minimum Data Set) dated 4/7/22 does not document a BIMS (Brief Interview for Mental Status) score or memory problems for R40.</p> <p>Section G (Functional Status) documents that R40's bed mobility and transfer status did not occur and that R40 required no setup or physical help from staff.</p> <p>Section G0400 (Functional Limitation in Range of Motion) also documents that R40's functional limitations in range of motion were not assessed.</p> <p>R40 did not have a CAA (Care Area Assessment) completed for nutrition or hydration.</p> <p>R40's nursing note dated 6/2/22 documents, Health Status Note Text: Resident returned from hospital with orders to apply tubi grips to lower legs and to continue to elevate hands and to give Tylenol for pain as needed. Writer called and spoke to POA with no further questions at this time. Resident is currently eating supper with no c/o (complains of) pain at this time.</p> <p>R40's physician progress note dated 6/7/22 documents, Chief complaint: Nursing home readmission recent hospitalization were worsening lower extremity edema; HPI (History of Present Illness): Patient is an [AGE] year old male . He was admitted was treated monitored at some renal failure as well as worsening lower extremity edema. Discharge back to facility for ongoing care. There was no signs symptoms of venous thromboembolism. Was sitting up in chair. Concern about pain in both lower extremity does have 4+ edema. Used to be on diuretics which was stopped. All hospital records were noted case was discussed with the nursing staff; Plan: Admit patient to nursing home. Patient will benefit from leg elevation; Will put him on Lasix 20 mg (milligrams) q.a.m. (every morning). Monitor basic metabolic panel. Fluid restriction .Discussed with nursing staff admission medications were reviewed and reconciled. Please see orders in the chart.</p> <p>Surveyor was unable to locate any documentation in R40's medical record that indicated that R40 was on a fluid restriction or had fluid monitoring place per R40's physician's progress note dated 6/7/22.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/14/22 at 2:17 p.m., Surveyor spoke with Dietician-K regarding R40's fluid intake. Surveyor asked Dietician-K if R40 was currently on any fluid restrictions or fluid monitoring. Dietician-K informed Surveyor that she was not aware of any fluid restrictions or fluid monitoring being in place for R40.</p> <p>On 6/14/22 at 2:29 p.m., Surveyor spoke with Dietary Supervisor-G regarding R40's fluid intake. Surveyor asked Dietary Supervisor-G if R40 was currently on any fluid restrictions or fluid monitoring. Dietary Supervisor-G informed Surveyor that she was not aware of any fluid restrictions or fluid monitoring being in place for R40.</p> <p>On 6/15/22 at 2:39 p.m., during the daily exit conference, Surveyor informed NHA (Nursing Home Administration)-A and DON (Director of Nursing)-B of the above findings.</p> <p>No additional information was provided as to why R40 did not have fluid restrictions in place per R40's physician notes dated 6/7/22.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36161</p> <p>Based on observation and interview the facility did not ensure that food was stored, prepared and served under sanitary conditions in 1 of 1 kitchen. Staff were observed touching ready to eat food after touching non-sanitized food surfaces with no barrier or handwashing.</p> <p>This deficient practice had the potential to affect 35 of 57 residents served on the rehab, west and east units.</p> <p>* On 6/14/22, Dietary Aide-L was observed touching ready to eat food with a gloved hand after touching non-sanitized food surfaces (counter, lid covers, and food cart) and place the food item onto plates for residents to eat.</p> <p>* On 6/24/22, Dietary Supervisor-G was observed touching ready to eat food with a gloved hand after touching non-sanitized food surfaces (counter, lid covers, and food cart) and place the food item onto plates for residents to eat.</p> <p>Findings include:</p> <p>The facility policy, entitled Handwashing Guidelines for Dietary Staff, revision date of 6/15/22, states Handwashing is necessary to prevent the spread of bacteria that may cause foodborne illnesses. Dietary employees shall clean their hands in a handwashing sink or approved automatic handwashing facility and may not clean hands in a sink used for food preparation, warewashing, or in a service sink used for the disposal or mop water or similar waste.</p> <p>Compliance Guidelines:</p> <p>6. Frequency of Handwashing: Dietary employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single use articles and also in the following situations:</p> <p>j. After engaging in any activity that may contaminate the hands.</p> <p>1. On 6/14/22 at 12:10 PM Dietary Aide-L was observed serving food from a steam table in the rehab unit. Dietary Aide-L touched counter and lid cover with her gloved hand and then grabbed corn bread and placed it on a plate. This plate was then served to a resident. Dietary Aide-L with the same gloved hand touched the counter and lid cover and picked up corn bread and placed it on a plate. Lid cover was placed over plate with same gloved hand. This plate was then served to a resident. Dietary Aide-L then touched the counter, lid cover and picked up corn bread and placed it on a plate with the same gloved hand. She then placed a lid cover over plate and a staff member served the plate of food to a resident.</p> <p>The Surveyor noted that Dietary Aide-L did not remove her gloves or wash her hands after contaminating her gloves by touching non-sanitized food surfaces and before touching ready to eat food.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. On 6/14/22 at 12:18 PM Dietary Aide-L was observed at the steam table in the main servery for east and west units. Dietary Aide-L touched counter with gloved hand and then grab corn bread and place it on the plate, grab lid cover and touch food cart with the same gloved hand. At 12:19 PM Dietary Aide-L was observed touching the counter with gloved hand and then grab corn bread and place it on the plate, grab lid cover and touch food cart with the same gloved hand. This was observed a total of 8 times. Surveyor asked Dietary-Aide-L what unit she was preparing food for and she stated west unit. Dietary-Aide-L stated there are a total of 10 residents on west unit.</p> <p>The Surveyor noted that Dietary Aide-L did not remove her gloves or wash her hands after contaminating her gloves by touching non-sanitized food surfaces and before touching ready to eat food.</p> <p>3. On 6/14/22 at 12:26 PM Dietary Supervisor-G was observed at the steam table in the main servery for east and west units. Dietary Supervisor-G touched counter with gloved hand and then grab corn bread and place it on the plate, grab lid cover and touch food cart with the same gloved hand. At 12:28 PM Dietary Supervisor-G was observed touching the counter with gloved hand and then grab corn bread and place it on the plate, grab lid cover and touch food cart with the same gloved hand. At 12:29 PM Dietary Supervisor-G was observed touching the counter with gloved hand and then grab corn bread and place it on the plate, grab lid cover and touch food cart with the same gloved hand. This was observed a total of 6 times. Surveyor asked Dietary Supervisor-G what unit she was preparing food for and she stated east unit. Dietary Supervisor-G stated there are a total of 13 residents on east unit.</p> <p>The Surveyor noted that Dietary Supervisor-G did not remove her gloves or wash her hands after contaminating her gloves by touching meal tickets and before touching ready to eat food.</p> <p>On 6/16/22 at 10:25 Surveyor interviewed Dietary Manager-F. Dietary Manager-F indicated that dietary staff should not be touching ready to eat food with contaminated gloves. Surveyor informed Dietary Manager-F on the concerns with staff touching ready to eat food after touching non-sanitized food surfaces with no barrier or handwashing. Dietary Manager-F</p> <p>stated that he will start re-educating the staff and that he will look into getting tongs or wax paper for staff to use when serving ready to eat food.</p> <p>On 6/20/22 at 1:15 PM during the daily exit conference, Surveyor informed Nursing Home Administrator-A and Director of Nursing-B of the above findings.</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p>38146</p> <p>Based on interview and record review, the facility did not ensure 1 of 1 Medication Technician certification reviewed was current. This has the potential to effect 48 of 57 residents residing on the East, North, West, and Rehabilitation Units.</p> <p>A staff member worked as a medication technician from 8/10/2021 to 6/14/2022 without a Medication Technician certification.</p> <p>Findings include:</p> <p>On 6/13/22 Surveyor requested a list of current staff employed by the facility. Medication Technician-V was documented as being a current employee with a hire date of 8/10/2021.</p> <p>On 6/14/2022 surveyor reviewed credentials provided by the facility for 7 staff members. Surveyor noted Medication Technician-V was eligible to work as a CNA (Certified Nursing Assistant) in federally certified nursing homes. Surveyor was unable to locate documentation that Medication Technician-V was certified to pass medications.</p> <p>On 6/14/2022 at 3:38 PM during the daily meeting with the facility, surveyor shared concerns related to being unable to locate documentation that Medication Technician-V is certified to pass medications. NHA (Nursing Home Administrator)-A reported that Medication Technician-V was off the floor as a medication technician and was sent home to look for the certification.</p> <p>On 6/15/2022 at 9:00 AM, NHA-A reported that the certification for Medication Technician-V was not located.</p> <p>On 6/16/2022 at 8:54 AM surveyor interviewed HR (Human Resources) Director-X with NHA -A present. HR Director-X explained the hiring process to surveyor. Surveyor asked how the facility ensures staff have the licenses and certifications needed. HR Director-X reported once a staff member is hired, a background check is completed, and the applicable license is verified before the staff member begins working. HR Director-X reported a spread sheet is kept with onboarding information on it for all staff members that are hired. Surveyor asked if Medication Technician-V was hired as a Medication Technician. HR Director-X reported he believed Medication Technician-V was hired as a Medication Technician. HR Director-X reported that they left a voicemail on Medication Technician-V's phone requesting their Medication Technician Certification.</p> <p>On 6/20/2022 at 9:26 AM, Surveyor interviewed NHA-A. NHA-A reported that Medication Technician-V was unable to produce their certification and was terminated from the facility on 6/17/2022. NHA-A reported that training has begun for the HR department on ensuring appropriate credentials for staff. Surveyor asked if Medication Technician-V was full time or part time. NHA-A reported that Medication Technician-V was full time and worked as both a Medication Technician and a CNA.</p> <p>(continued on next page)</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 6/20/2022 at 9:59 AM, Surveyor interviewed Scheduling Coordinator-W. Surveyor asked what units Medication Technician-V was scheduled to work on as a Medication Technician. Scheduling Coordinator-W reported that Medication Technician-V was scheduled to work on all units with the exception of the ventilator unit (9 residents on the ventilator unit at the time of survey).</p> <p>At the time of exit, no additional information was provided by the facility.</p>		