STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265727	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDWOOD OF CARMEL HILLS	810 EAST WALNUT INDEPENDENCE, MO 64050

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)
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** Based on interview and record review, the facility failed to have grievance forms accessible for all residents, and educate residents and review the grievance policy and procedures on how to file a grievance, for 15 sampled residents (residents attending the Resident Council Group Interview Meeting, conducted as a part of the survey process). The facility census was 164 residents. 1. During Resident Council Interview on 3/3/20, beginning at 2:00 P.M., the group responses included: -Residents could not anonymously get a grievance form. -Residents were concerned about staff members knowing they were getting a grievance form. -Grievance forms were at the nurses' station and they are too high up for the residents to reach. -Residents did not know how to file a grievance. -Residents did not know if there was a grievance official. -Twelve of the fifteen residents present did not feel a resident or family group could complain about care without worrying that someone would get back at them. -Residents said retaliation included not getting ice water, not getting medication timely, not getting call light response in a timely manner, and not getting the help needed. During Resident Council Interview on 3/3/20, at the 2:40 P.M., one of the residents present, (Resident #2) said: -He/she observed a staff member being mean to another resident and reported the incident. -The staff member asked him/her if he/she told about the incident. -He/she was honest and told the staff member he/she reported the incident. -The staff member would no longer respond to his/her request, would not provide him/her with ice water, or anything. -Supervisory staff removed that staff member from caring for him/her, but this was an example of why residents worry about someone getting back at them. During Resident Council Interview on 3/3/20, at 2:43 P.M., one of the residents present, (Resident #109) said: -He/she asked a staff member for a washcloth. -The staff member was doing something on his/her phone, and did not respond. -He/she was too afraid of what would happen if he/she reported the incident. Record review of the Resident Council minutes dated 2/21/20, showed the meeting format included review of at least four resident rights per meeting, and the Activities Director presented on the following resident rights: -Residents have the right to have your own doctor. -Residents have the right to receive mail unopened. -Residents have the right to privacy. -Residents have the right to complain. During an interview on 3/04/20 at 8:03 A.M. Social Services Designee B said: -If residents have complaints, there are forms to be completed. -Social Services directs the information to the appropriate department head. -Residents can come to social services office for complaint forms. During an interview on 3/04/20 at 9:32 A.M., the Activities Director said: -Social Services would normally handle grievances. -He/She had not actually gone through how to file a formal grievance or use of grievance forms with the residents, but talked about how to complain at a recent Resident Council meeting. During an interview on 3/6/20 at 8:55 A.M., Social Services Designee A said: -Residents would submit grievance forms to the Social Services Department. -The location of the grievance forms changed, and they are now outside the social services office on a lower wall. (Note: The location of grievance forms changed after the Resident Council Interview.) During the Quality Assessment and Assurance (QAA) Interview on 3/09/20 at 11:33 A.M., the Administrator said: -Department heads meet monthly. -Questions are asked regarding frontline staff overall. -The committee also used Resident Council notes during QAA. During an interview on [DATE] at 1:00 P.M., the Director of Nursing (DON) said the placement of grievance forms should be accessible for all residents.
F 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one sampled resident (Resident #121) was free from restraints out of 32 sampled residents. The facility census was 164 residents. Record review of the facility's Restraints policy revised 2/2019 showed: -Residents shall be provided an environment that is restraint free, unless a restraint is necessary to treat a medical symptom in which case the least restrictive measure shall be used. -There must be a physician's orders [REDACTED]. -Before any restraint is used, the licensed nurse would verify that informed consent has been obtained from the resident/responsible party, and education was provided including the risks and benefits of the restraint. 1. Record review of Resident #121's Face Sheet showed he/she was admitted to the facility on [DATE] and had the following Diagnoses: [REDACTED]. -Unspecified dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses) with behavioral disturbance. -[MEDICAL CONDITION] with delusions (a type of serious mental illness called a [MEDICAL CONDITION]. People who have it cannot tell what is real from what is imagined. Delusions are the main symptom of delusional disorder). Record review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool required to be completed by facility staff for care planning) dated 11/5/19 showed he/she: -Was severely cognitively impaired. -Had short term and long term memory loss. -Had inattention and disorganized thinking. -Was rarely understood, had unclear speech, and rarely understands. -Needed the extensive assistance of two staff member with transfers, bed mobility, toileting, and personal hygiene. -Used a wheelchair for mobility. -A restraint was not used. Record review of the resident's Care Plan revised 2/13/20 showed he/she: -Needed activities he/she was cognitively able to enjoy. -Liked to wander around and clean. -Used a low Broda chair (a specialized wheelchair for positioning) for mobility and was able to propel himself/herself at times in the chair. -had a history of [REDACTED]. Record review of the resident's physician's orders [REDACTED]. Record review of the resident's medical record showed: -No assessment for the use of a Broda chair as a restraint. -No consent from the resident and/or the resident's responsible party for the use of a Broda chair as a restraint. Observation on 3/2/20 at 9:27 A.M. and 12:36 P.M. showed: -The resident was in his/her Broda chair trying to pull himself/herself forward by rocking back and forth with much effort using his/her upper body. -The resident was using his/her feet to try to pull the Broda chair forward. -The Broda chair wheels were locked. Observation on 3/2/20 at 12:36 P.M. showed: -A staff member moved the resident in his/her Broda chair by the dining area and locked the Broda chair wheels. -The resident was rocking his/her body hard back and forth, using his/her feet to pull the Broda chair forward. -The resident moved the Broda chair a couple of feet with much effort. -A staff member unlocked the Broda chair and moved the resident back into his/her original position and then locked the Broda chair wheels. -The resident rocked his/her body again, using his/her feet to pull the Broda chair sideways. -The resident did not show signs of distress. Observation on 3/4/20 at 7:29 A.M. showed: -The resident was in his/her Broda chair eating breakfast. -The resident's Broda chair wheels were locked. Observation on 3/4/20 at 9:08 A.M. showed: -A staff member took the resident to be weighed. -The staff member unlocked the Broda chair wheels and assisted the resident down the hall. -At 9:12

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

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

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F 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) A.M., the staff member brought the resident back to the common area in his/her Broda chair and locked the Broda chair wheels. Observation on 3/5/20 at 9:07 A.M. showed: The resident was in his/her Broda chair by the nurses station. -The Broda chair wheels were locked. -The resident tried to pull the chair forward by rocking his/her upper body back and forth and pulling with his/her feet. -The resident was able to turn the Broda chair at an angle but could not move the Broda chair any further. -The resident did not show signs of distress. During an interview on 3/6/20 at 8:52 A.M. Certified Nurses Assistant (CNA) J said: -The resident would stand up independently leaning forward so we (the staff) lock the Broda chair wheels. -The resident did like to move around the secure care unit. -A wheelchair was tried prior to the Broda chair. -The Broda chair was locked for safety. -He/she would move all around the unit when it was unlocked and try to transfer himself/herself. -He/she did wander into rooms when the chair was unlocked. -He/she could still move the chair some with it locked. During an interview on 3/6/20 at 9:05 A.M., Assistant Director of Nursing (ADON) B said: -He/she was the acting charge nurse today. -The resident had been in a Broda chair for a while and was previously unsafe in a wheelchair, so the Broda chair was used. -He/she would tip himself/herself forward in a wheelchair. -He/she locked the back wheels of the Broda chair when the resident was in the Broda chair. -When it was unlocked, the resident would go everywhere in the chair. -He/she would go the dining room, his/her office, and wander into resident rooms. -He/she could still move the Broda chair some when it was locked. -He/she was unsure if a restraint assessment had been completed for the resident's Broda chair. -He/she had not considered the Broda chair a restraint. During an interview on 3/6/20 at 12:15 P.M., Social Services Designee A and Social Services Designee B said: -Maybe the staff locked the Broda chair during meals. -The staff should not be locking the resident's Broda chair to keep him/her from wandering. -Locking the resident's Broda chair to prevent him/her from wandering was a restraint. -The resident liked to wander and locking his/her Broda chair would potentially cause negative behaviors. During an interview on [DATE] at 12:59 P.M., the Director of Nursing (DON) said: -The resident was confused and fidgety at times. -The resident did try to transfer himself/herself. -The resident was friendly and pleasant. -The resident liked to wander and the staff should not lock his/her wheelchair to keep the resident from wandering. -Locking the resident's Broda chair was a restraint and could cause behaviors.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accurately complete Minimum Data Set (MDS - a federally mandated assessment tool required to be completed by facility staff for care planning) assessments for two sampled residents (Residents #25 and #367) out of 32 sampled residents. The facility census was 164 residents. 1. Record review of Resident #25's Face Sheet showed he/she was admitted to the facility on [DATE]. Record review of the resident's Telephone Order Sheet (TOS) dated 12/3/19, showed an order for [REDACTED]. -His/her admitting [DIAGNOSES REDACTED]. dated 12/5/19, showed he/she was admitted to hospice. Record review of the resident's Significant Change MDS dated [DATE], showed he/she did not have a condition or chronic disease that may result in a life expectancy of six months or less. 2. Record review of Resident #367's Face Sheet showed he/she was admitted to the facility on [DATE]. Record review of the resident's care plan initiated 2/21/20, showed he/she had oral/dental health problems. Record review of the resident's Admission MDS, dated [DATE] showed he/she had no dental issues. Observation on 3/3/20 at 10:51 A.M. showed the resident had several missing and damaged teeth. 3. During an interview on [DATE] at 11:25 A.M., the MDS Coordinator said: -Resident #25's Significant Change MDS should have shown the resident had a condition or chronic disease that may result in a life expectancy of six months or less. -The MDS should accurately reflect the residents' conditions. During an interview on [DATE] at 1:00 P.M., the Director of Nursing (DON) said: -He/she would want the resident's MDS to be accurately updated when a resident goes on hospice. -The MDS correction was submitted as of [DATE].
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide residents and their representative with a summary of the baseline care plan for two sampled residents (Resident #50 and #126) out of 32 sampled residents. The facility census was 164 residents. Record review of the facility's Care Planning Policy dated February 2019, showed: -The facility will develop a person-centered baseline care plan for each resident within 48 hours of admission. -Once the baseline care plan is completed, the facility must provide the resident and/or the resident's representative with a written summary of the baseline care plan. -The baseline care plan summary must be provided to the resident and/or the resident's representative by the time the Comprehensive Care Plan is completed. -Care plan summaries should be provided in a language and manner that the resident and/or resident's representative can understand. -The medical record must contain evidence that the summary was given to the resident and/or resident's representative. 1. Record review of Resident #50's face sheet showed he/she was admitted to the facility 12/19/19. Record review of the resident's Admission Minimum Data Set (MDS - a federally mandated assessment tool required to be completed by facility staff for care planning) assessment, dated 12/25/19, showed: -The resident was moderately cognitively impaired. -He/she needed extensive assistance with activities of daily living. Record review of the resident's medical record showed his/her comprehensive care plan was initiated within 48 hours of admission and revisions made as of 1/3/20. Record review of the resident's progress note dated 12/20/2019, showed Social Services staff was to contact the resident's family member by phone for a conference meeting. During an interview on 3/03/20 at 10:43 A.M., the resident said: -He/she did not understand why he/she was still in the facility. -He/she did not receive a summary of his/her baseline care plan. 2. Record review of Resident #126's face sheet showed he/she was admitted to the facility 2/2/20. Record review of the resident's Admission MDS dated [DATE], showed: -The resident was moderately cognitively impaired. -He/She needed some assistance with activities of daily living. Record review of the resident's comprehensive care plan showed: -The first care plan focus was initiated 2/3/20. -Updates and revisions continued in February 2020. During an interview on 3/03/20 at 8:50 A.M., the resident said he/she did not receive a summary of his/her baseline care plan. 3. During an interview on 3/05/20 at 2:58 P.M., Social Services Designee A said: -A written copy of baseline care plan summary was not given to the residents, but he/she did talk with the residents. -A multi-disciplinary care plan meeting was held within 21 days of the residents' admission. -The resident attends the meeting and signs the care plan at that time. -He/she had not been giving the resident a copy of the care plan until their discharge.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person centered care plan for one sampled resident (Resident #126), out of 32 sampled residents. The facility census was 164 residents. Record review of the facility's Care Planning policy, revised February 2019, showed: -A comprehensive person-centered Care Plan would be developed for each resident. -Each resident's Comprehensive Care Plan would describe: --Services that were to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. --Any services that would be required, but were not provided due to the resident's exercise of rights, which includes the right to refuse treatment. -The Care Plan would include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. 1. Record review of Resident #126's face sheet showed he/she was admitted to the facility on [DATE]. Record review of the resident's Admission Minimum Data Set (MDS - a federally mandated assessment tool required to be completed by facility staff for care planning) assessment, dated [DATE], showed: -The resident was moderately cognitively impaired. -The resident needed limited assistance with his/her activities of daily living (ADL). -He/she currently used tobacco. During an interview on 3/3/20 at 8:55 A.M. the resident said: -He/she fell outside yesterday at around 4:00 P.M. in the smoking area. -Staff usually went out with him/her when he/she went out to smoke, but sometimes he/she went out on his/her own. -His/her cigarettes and lighter were kept in his/her coat pocket. Observation on 3/5/20 at 3:25 P.M. showed the resident returning from the smoking area with a staff member. Record review of the resident's care plan showed he/she did not have a smoking care plan. During an interview on [DATE] at 11:25 A.M., the MDS Coordinator said the Interdisciplinary Team prepares the resident's care plan. During an interview on [DATE] at 1:00 P.M., the Director of Nursing (DON) said he/she would expect there to be a smoking care plan for a resident that

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) smokes.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify a change in condition in a resident including a decrease of alertness, decreased blood pressure, and decreased [MED]gen saturation; to notify the resident's physician of the resident's change in condition in a timely manner; to transfer a resident to a hospital when requested by the resident's family in a timely manner, resulting in the resident requiring transportation to the hospital by Emergency Medical Services (E[CONDITION]) and admission to the Intensive Care Unit (ICU) due to critically low blood pressure for one sampled resident (Resident #316) out of 32 sampled residents. The facility census was 164 residents. Record review of the facility Change of Condition Notification policy dated February 2019 showed: -The purpose of the policy was to ensure that residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. -An acute change of condition (ACOC) is a sudden, clinically important deviation from a resident's baseline in physical, cognitive behavioral, or functional domains. -Clinically important means a deviation that, without intervention, may result in complications or death. -Members of the Interdisciplinary Team (IDT) are expected to report and document signs and symptoms that might represent and ACOC. -The facility will promptly inform the resident, consult with the resident's attending physician and notify the resident's legal representative when the resident endures a significant change in their condition caused by, but not limited to a significant change in the resident's physical cognitive, behavioral or functional status, a significant change in treatment and/or a decision to transfer or discharge the resident from the facility. -The licensed nurse will notify the resident's attending physician when there is a significant change in the resident's physical, mental or psychosocial status, e.g. deterioration in health, mental or psychosocial status, life-threatening conditions or clinical complications; a need to alter treatment significantly, a decision to transfer or discharge the resident from the facility. -The licensed nurse will assess the resident's change of condition and document the observations and symptoms. -The attending physician will be notified timely with a resident's change in condition. -Notification to the attending will include a summary of the condition change and an assessment of the resident's vital signs and system review focusing on the condition and/or signs and symptoms for which the notification is required. -In emergency situations, (e.g., a resident is experiencing unexpected shortness of breath, intense pain, unexpected bleeding, serious abnormal labs or x-ray) the licensed nurse will immediately call the attending physician; notify the nursing supervisor of an emergency situation. -The licensed nurse will notify the resident, the resident's responsible party, or the family/surrogate decision-maker of any changes in the resident's condition as soon as possible. -The licensed nurse will document the date, time and pertinent details of the incident and the subsequent assessment in the Nursing Notes. -The licensed nurse will document the time the attending physician was contacted, the method by which he/she was contacted, the response time, and whether or not orders were received. -The licensed nurse will update the care plan to reflect the resident's current status. -The licensed nurse will include the incident and brief details in the 24-Hour Report (a communication document between different shift charge licensed nurses regarding important resident condition and care needs). -If a resident is transferred to an acute care hospital the licensed nurse completes an inter-facility transfer form. -A licensed nurse will communicate any changes in required resident interventions to the IT members involved in the resident's care. -A licensed nurse will document each shift for at least 72 hours. -Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the 24-Hour Report. Record review of the facility Negative Pressure Wound Therapy (NPWT - also known as wound VAC - vacuum-assisted closure - an high level wound treatment for [REDACTED]. -The physician's orders [REDACTED]. -Dressings should be changed every 48 to 72 hours per physician order, but should not be less than two times per week. -The NPWT dressing should be removed if negative pressure is off for a period exceeding two hours; replace with a traditional dressing. 1. Record review of Resident #316's Admission Record showed he/she: -Was admitted to the facility on [DATE]. -Had [DIAGNOSES REDACTED]. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of sacral (large, triangular bone at the base of the spine and at the upper and back part of the pelvic cavity) region, and morbid (severe) obesity. Record review of the resident's Order Summary Report showed the following orders dated 2/11/20: -Admit to facility with a [DIAGNOSES REDACTED]. -[MEDICATION NAME] (anticonvulsant medication also used for pain management) 300 milligrams (mg), give one tablet by mouth three times a day for neuropathic pain (a complex, chronic pain state that usually is accompanied by tissue injury). -[MEDICATION NAME] ([MEDICATION NAME] - an opioid, sometimes called narcotic medication for moderate to severe pain with [MEDICATION NAME]) 5-325 mg, give one tablet by mouth every four hours for pain, give while awake, hold for sedation. -Complete blood count (CBC - a blood test used to evaluate overall health and detect a wide range of disorders including [MEDICAL CONDITION] and infection) and a comprehensive metabolic panel (CMP - a group of blood tests that provide an overall picture of your body's chemical balance and metabolism, i.e. the chemical processes in the body that use energy). Record review of the residents Nursing Note date 2/11/20 at 4:14 A.M. showed: -The resident was admitted to the facility. -He/she had a Foley catheter. -He/she complained of pain. -No mention of the resident's dressing/NPWT or his/her left buttock pressure ulcer. -No assessment of the resident's level of alertness. --NOTE: The facility staff documented the resident stage IV pressure ulcer was on his/her sacral area on his/her admission record dated 2/10/20. Record review of the resident's Physician Admission Progress Note dated 2/11/20 at 2:36 P.M. showed: -He/she was new to the facility coming from another skilled nursing facility with a history of the following Diagnoses: [REDACTED]. coli) bacteria live in the intestines of people and animals, and are key to a healthy intestinal tract. Most E. coli strains are harmless, but some can cause diarrhea through contact with contaminated food or water while other strains can cause urinary tract infections, respiratory illness and pneumonia). --Stage IV pressure ulcer. --Paralysis (loss of the ability to move, and sometimes to feel anything, in part or most of the body, typically as a result of illness, or injury). --Gastrointestinal (GI) bleed (any type of bleeding that starts in the digestive tract) related to perianal fistula (an abnormal tunnel that begins in the anus and exits through the akin near the rectum). --Hypoxemia (abnormally low [MED]gen concentration in the blood. -The resident was awake and alert, and his/her cognitive status showed no dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). -His/her stage IV pressure ulcer had a dressing and wound VAC. Record review of the resident's Progress Notes dated 2/11/20 through 2/15/20 showed: -No licensed nurse notes regarding the resident's wound VAC dressing. -No mention of the presence of or non-presence of his/her wound vac. -No notation regarding notification regarding the resident being sedated or having a decrease/change in his/her alertness/mental status. -No notation regarding a decrease in the resident's blood pressure. -No notation regarding a decrease in his/her [MED]gen saturation (blood [MED]gen level measured with a small device placed on a finger) . -No notation regarding the resident having repeated loose stools. -No notation regarding the resident's family being present at the facility, having concerns regarding the resident's condition and requesting the resident be transferred to hospital on [DATE]. -No notation of notification to facility management or to the resident's physician regarding a change in the resident's condition and the family requesting the resident be transferred to hospital on [DATE]. Record review of the resident's Medication Administration Record [REDACTED]. --Documentation showed staff administered one tablet on 2/15/20 at 4:00 A.M., 8:00 A.M., 12:00 P.M. and 4:00 P.M. Record review of the residents Nursing Note dated 2/15/20 at 11:13 P.M. showed: -The resident's family called 911 to take him/her to the hospital. -Emergency medical staff were at the facility at 9:30 P.M. and told the licensed nurse that a family member called 911 to send the resident to the hospital. -Emergency medical staff took the resident's blood pressure with a result of 107/43 (an abnormally low bottom/diastolic reading - normal range for a healthy adult at rest is 90/60 to 120/80), a low [MED]gen saturation of 88% (normal range is 90 to 100%). -He/she was responding to conversation and questions. -After the emergency medical staff took the resident's vital signs, they took him/her to the hospital. -The resident's physician and the Director of Nursing (DON) was notified. Record review of the resident's Situation, Background, Assessment, Recommendation Communication Recommendation (SBAR -a framework for communication between members of the health care team about a resident's condition) Form and progress note dated 2/15/20 at 10:00 P.M. showed: -The resident's family called 911 and the resident was taken to hospital. -He/she had prescribed pain medication and had taken medication prior to

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) the family arrival. -The form was blank for things that make the condition or symptom worse, things that make the condition or symptom better, treatment, primary diagnosis, changes in the last week, if resident was on [MEDICATION NAME] (blood thinner) the results of the last international normalized ratio (INR - a laboratory measurement of how long it takes blood to form a clot used to determine the effects of oral anticoagulants on the body's clotting system). -His/her vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions) were in normal range; his/her [MED]gen saturation level was 92% (low, normal range is 95 to 100%) and the form was blank regarding if the resident was receiving supplemental [MED]gen at the time of the [MED]gen saturation measurement and if so, the rate of administration (liters per minute). -The resident had mental status changes of decreased consciousness (sleepy, lethargic/sluggish). -The resident had respiratory symptoms of low [MED]gen saturations of 88%. -Recent lab results was blank. -Advanced care planning information was blank. -Assessment by Registered Nurse (RN) was that the resident's family called 911 and the resident was taken to the hospital; the resident had prescribed pain medications and had taken medication prior the family arrival. -Nursing Notes for additional information on the Change in Condition was blank. -The resident's Family/Health Care Agent was notified on 2/15/20 at 11:00 P.M. -The resident's change in condition was reported to the resident's Primary Care Clinician on 2/15/20 at 11:00 P.M. -The form was electronically signed by the Assistant Director of Nursing (ADON) on 2/17/20. Record review of the resident's hospital ICU Admission History and Physical (H&P) dated 2/16/20 showed: -He/she was admitted from his/her nursing home with altered mental status (A[CONDITION] - a disruption in how your brain works that causes a change in behavior. This change can happen suddenly or over days; A[CONDITION] ranges from slight confusion to total disorientation and increased sleepiness to coma) and buttock pain. -On arrival to the emergency room (ER) his/her only complaint was right buttock pain and he/she reported he/she had a chronic sacral wound. -He/she had a stage IV sacral ulcer, very large and deep and on examination, bone could be palpated (felt by placing a hand over the area and applying pressure). -E[CONDITION] reported his/her blood pressure had been low during transport to the hospital, 80s over 50s. -On arrival to the ER, he/she reported he/she had not been clean after his/her bowel movement many hours ago and he/she had a chronic wound in that area. -Report from E[CONDITION] was that the family noted a slight change from his/her normal mental status earlier in the day (2/15/20) at an undetermined time. -He/she was given two liters of fluids intravenously (IV - into a blood vein) with a good response of his/her blood pressure. -His/her wound VAC fell off two days ago per the RN report. -He/she was initially admitted to the hospital medicine team but his/her blood pressure dropped to 70s despite getting two liters of IV fluid in the ER. -She was started on [MEDICATION NAME] ([MEDICATION NAME] - a medication used to treat life-threatening low blood pressure that can occur with certain medical conditions or surgical procedures) temporarily via his/her peripheral IV line until ICU was consulted, placed a right intrajugluar vein (IJ) central line (insertion of a tube into the large vein on the right side of the neck that allows rapid high-volume fluid administration, administration of multiple medications, and hemodynamic monitoring that measures the blood pressure inside the veins, heart, and arteries, how much [MED]gen is in the blood, checks how well the heart is pumping; and is often used for reliable venous access in ill persons) and admitted him/her to the ICU. Record review of the resident's hospital History and Physical addendum dated 2/17/20 showed: -He/she was critically ill with imminent threat to his/her life. -His/her septic shock was being treated with broad spectrum (those able to treat a wide range of bacteria) antibiotics including [MEDICATION NAME] and Zozyn for urinary tract infection and pneumonia. -His/her urine culture was growing E. coli greater than 100,000. 2. During an interview on 2/15/20 at 8:11 A.M. RN B said: -During shift report for the 7:00 P.M shift change, the off going licensed nurse told him/her that the family wanted the resident to go to the hospital because the resident was sleeping. -He/she went to the resident's room around 7:14 P.M. -The resident said no when asked if he/she needed anything. -He/she went to the next hall and started doing his/her resident care. -Later he/she was told that 911 was in the facility, that the family had called for the resident to go to the hospital so he/she went to the resident's room and E[CONDITION] told him/her the family had called 911. -E[CONDITION] staff asked him/her what the resident's baseline was (the resident's usual condition, especially regarding mental alertness) and he/she said the resident could ask for what he/she needed and could use his/her call light. -If the resident had been in distress, he/she would have called the resident's doctor, but the resident was not in distress. -The family did not call him/her; they could have called the facility and asked for the nurse on duty. -The resident's [MED]gen saturation was 90% to 92%. -He/she could not turn the resident by himself/herself. -He/she first saw the resident at 7:15 P.M. -He/she had 12 residents needing Accuchecks (a blood sugar reading obtained by a small sample of blood from the finger) and residents also came to him/her for pain medications which had to be given on time. -He/she saw the resident at 8:00 P.M. and helped a Certified Nursing Assistant (CNA) to turn the resident in bed; he/she asked the resident if he/she was OK and the resident said yes. -He/she then went to do something else; he/she was always busy. -E[CONDITION] arrived at the facility at about 9:00 P.M. -E[CONDITION] checked the resident's vital signs and [MED]gen saturation and said they had to take him/her to the hospital. -He/she told E[CONDITION] that he/she had to go print something. -He/she called the resident's family and the resident's Nurse Practitioner (NP), he/she thought this occurred prior the E[CONDITION] taking the resident to the hospital. During an interview on 3/4/20 at 5:48 A.M. RN B said: -On 2/15/20 the resident's family called 911 to take him/her to the hospital. -E[CONDITION] arrived at the facility at 9:30 P.M. -E[CONDITION] told him/her a family member had called 911 to take the resident to the hospital. -E[CONDITION] took his/her vital signs; his/her blood pressure was low, 107/43 and his/her [MED]gen saturation was low at 88%. -He/she was responding to commands and questions. -After E[CONDITION] took the resident's vital signs, they took him/her to the hospital. -He/she notified the resident's physician and facility ADON A. During an interview on 3/4/20 at 6:22 A.M. RN B said: -When he/she came to work for the 7:00 P.M. to 7:30 A.M. shift on 2/15/20 the off going licensed nurse told him/her that the family wanted the resident to go to the hospital. -Later, the family called 911 from outside the facility to take the resident to the hospital. During an interview on 3/4/20 at 8:11 A.M. RN B said: -The family wanted the resident to go to the hospital because he/she was sleeping. -He/she went to the resident's room at around 7:15 P.M.; at that time the resident said he/she did not need anything. -He/she went to the next hall to complete blood sugar testing for residents; staff told her later that E[CONDITION] was at the facility and that the resident's family had called for him/her to be taken to the hospital. -He/she went to the resident's room; E[CONDITION] staff told him/her the resident's family had called for the resident to be taken to the hospital. -E[CONDITION] staff asked what was the resident's baseline, he/she responded that the resident was able to ask for what he/she needed and was able to use his/her call light. -He/she would have called the resident's physician but the resident was not in distress so he/she did not call the resident's physician. -The resident's family never called him/her; the family could have called the facility and asked for the nurse on duty. -He/she told E[CONDITION] that he/she needed to put a dressing on the resident's wound; E[CONDITION] told him/her there was no need to put a dressing on the resident's wound. -He/she was told the resident needed a dressing on his/her stage IV pressure ulcer when he/she first came to work for his/her 7:00 P.M. shift. -He/she could not turn the resident by himself/herself. He/she thought the resident had a wound VAC. During an interview on 3/4/20 at 9:21 A.M. RN B said -During the 7:00 P.M. shift change report, the off going licensed nurse told him/her the resident needed a dressing on his/her stage IV pressure ulcer. -He/she told the off going licensed nurse that he/she would put a dressing on the resident's stage IV pressure ulcer. -The off going licensed nurse had not told him/her that the resident was supposed to go the hospital. -After the shift report, he/she completed blood glucose monitoring for 12 residents. -He/she first saw the resident at 7:14 P.M. -Residents came to his/her for pain medication; he/she had to give pain medications on time. -He/she was always busy. -E[CONDITION] arrived at the facility at about 9:00 P.M.; -He/she then went to the resident's room. -E[CONDITION] took the resident's vital signs and [MED]gen saturation, told him/her the numerical results and said they had to take the resident to the hospital. -After E[CONDITION] took the resident to the hospital, he/she called the resident's Nurse Practitioner (NP). -He/she called the resident's family member who was the resident's DPOA, he/she thought this call was before E[CONDITION] took the resident to the hospital. During an interview on 3/5/20 at 1:38 P.M. Licensed Practical Nurse (LPN) D said: -The resident had a stage IV pressure ulcer. -The resident's wound VAC was not on when he/she got to work. -He/she discovered at about 11:00 A.M. or maybe around noon that the resident's wound VAC was not on his/her stage IV pressure ulcer; at that time he/she was helping another staff person turn and clean the resident because he/she had had a lot of loose stools. -The resident continued to have loose stools throughout the rest of the 7:00 A.M. to 7:30 P.M. shift. -He/she put a dressing on the resident's stage IV pressure ulcer at about 12:30 P.M. when he/she finished completed blood sugar testing for diabetic residents. -At that time, there could have been an old dressing in the bed but he/she could not remember, but there was not a dressing on the resident's buttocks. -The resident was receiving [MEDICATION NAME] every four hours around the clock, he/she had been tolerating the [MEDICATION NAME] but within an hour of getting her first dose for the 7:00 A.M. shift, the resident seemed

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	265727	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDWOOD OF CARMEL HILLS	810 EAST WALNUT INDEPENDENCE, MO 64050

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

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) sedated. --NOTE: The first dose for the 7:00 A.M. shift was scheduled to be administered at 8:00 A.M. and was documented as administered by the facility staff at 8:00 A.M. on 2/15/20. -He/she remembered taking the resident's vital signs and checking the resident's pupils and skin color. -The resident's skin was moist. -He/she thought he/she had done a blood sugar test for the resident, just to make sure his/her blood sugar was alright. --NOTE: There was no documentation in the resident's medical record of vital signs or blood sugar checks at that time by the facility staff. -He/she thought the resident's blood pressure was OK when he/she took it. -The resident's breathing rate was normal, her pulse was in the low 100s and he/she did not have a fever. -It seemed to him/her that resident's [MED]gen saturation was initially low; he/she turned the resident's [MED]gen up a little bit and then the resident's [MED]gen saturation came up to normal, as he/she slowly became more alert over the next couple of hours while he/she started to wake up more. --NOTE: The resident did not have a valid physician's orders [REDACTED]. of the resident's need for supplemental [MED]gen. -He/she took the resident's vital signs several times, he/she left the equipment for taking the resident's vital signs in the resident's room. --NOTE: There was no documentation by the facility staff of these vital signs in the residents medical record. -He/she was first aware the resident was without a dressing on his/her stage IV pressure ulcer at around the lunch hour. -He/she put a dressing on the resident's stage IV pressure ulcer at around 12:45 P.M, sometime before 1:00 P.M. -The resident had a family member visitor and told him/her that they were concerned the resident had a decreased level of consciousness. -He/she told the visitor that the resident had been having loose stools and discussed with the resident's family that the resident's decreased level of consciousness could be from a buildup of the resident's narcotic medication that he/she was getting every four hours. --NOTE: There was no documentation in the resident's medical record by facility staff related to concerns of sedation due to scheduled [MEDICATION NAME] administration and no documentation staff notified the resident's physician related to concerns of sedation or decreased levels of consciousness related to scheduled [MEDICATION NAME] administration). --NOTE: Documentation showed staff administered [MEDICATION NAME] 5/325 mg at 8:00 A.M., 12:00 P.M. and 4:00 P.M. on 2/15/20. -The resident started becoming more alert at about 4:00 P.M. -The family member wanted the resident to be sent out to the hospital to be evaluated sometime between 5:00 P.M. to 6:00 P.M. -At about 5:00 P.M. or 6:00 P.M. there was flooding in the building, on the 300 Hall (the resident's room was on the [LOC]). -He/she told ADON A that the resident's family member wanted the resident to be sent out to the hospital. -ADON A was going to go look at the resident and then the flood on the 300 hall happened. -He/she evacuated residents on the 300 hall out of their rooms and did not know if ADON A made it to the resident's room. -He/she told the resident's family member that he/she was not trying to ignore the resident; he/she thought the family member was going to be upset; it was like he/she had just disappeared, he/she was helping with the flood on the 300 hall. -The resident was more alert around that time and it seemed like the resident had come out of her prior state. -He/she became aware the resident did not have a dressing on just before the fire alarm went off because he/she was assisting in turning the resident as he/she had been incontinent of stool again; at that time he/she saw that the resident had bowel movement all over her old dressing and bowel movement was in the residents wound. -He/she made it back to the resident's room at 6:30 P.M., maybe; he/she had gone to the resident's room to check on him/her, the resident's family member had left. -At that time (6:30 P.M.) he/she knew the resident did not have a dressing on his/her stage IV pressure ulcer because his/her dressing came off earlier when he/she was turning the resident; that was at the time he/she put the dressing on the resident. -He/she was really busy and was behind on everything. -He/she remembered that he/she had told the oncoming 7:00 P.M. nurse that he/she had not called anyone yet about the family wanting the resident to be sent to the hospital because ADON A wanted to assess the situation. -ADON A had lost his/her stethoscope, he/she was going to go to the resident's room but then the flood happened. -He/she did think the resident had a wound VAC on because he/she did not need to change the resident's dressing on his/her stage IV pressure ulcer; he/she had looked at the wound VAC the previous day and it was operation correctly. -During the shift report he/she passed on that the resident did not have a dressing on his/her stage IV pressure ulcer. During an interview on 3/6/20 CNA L said: -The resident was not large. -He/she had in the past completed incontinence care for the resident. -He/she always took another staff person with him/her when he/she completed incontinence care with all residents. -The resident's level of alertness and ability to assist in turning in bed depended on the time of day; he/she routinely had to explain to the resident what was being done. -He/she was not aware of the resident ever having a change in condition or having loose stools. -The resident would get confused; he/she never appeared sedated. -The resident used [MED]gen, the resident had to put [MED]gen because he/she was short of breath. During an interview on [DATE] at 10:50 A.M., the ADON A said: -If a family member requested a resident be sent to the hospital, the licensed nurse was to assess the resident, based on the assessment notify the resident's physician, talk with the resident and the resident's responsible party (DPOA - the person named in a legal document to make health care decisions in the event the resident is unable) of the physician's recommendations and ability to treat the resident at the facility if able; if a the family and the resident still wanted for the resident to be sent to the hospital, the resident should be sent to the hospital by calling 911. -If a resident was showing signs of a change in condition licensed nurses were to assess the resident, notify the ADON or DON, notify the resident's physician, and follow the physician's orders [REDACTED]. -Licensed nurses should act or react to situations in a timely manner. -If an issue is identified, it should be addressed. -Licensed nurses should not wait to assess, treat, or notify the resident's physician of any issues brought to their attention. -The resident's family member who was in the facility who wanted the resident sent to the hospital was not the resident's DPOA. -He/she was in the facility at the time the family member was requesting the resident be sent to the hospital; he/she was on his/her way to assess the resident when an emergency happened and staff had to address the situation. -During the facility emergency the family member called 911. -The family member in the facility who wanted the resident sent to the hospital was not the DPOA. -The ADON was in the facility at the time the family member was requesting the resident be sent. -The ADON was on his/her way to assess the resident when an emergency happened and staff had to address the situation. -During the emergency is when the family member called 911. During an interview on [DATE] at 12:59 the DON said: -He/she had not been notified about the resident having a change of condition -He/she was not at the facility when the resident went out to the hospital. -He/she was told by the licensed charge nurse the resident was a little drowsy right before his/her family arrived at the facility. -The resident had received pain medication prior to his/her family member coming to the facility. -The residents [MED]gen saturations did drop below 90%, then when the licensed nurse talked with the resident, he/she was at baseline with cognition and his/her [MED]gen level went was back up. -He/she did not remember any reports of what the resident's blood pressure was from the licensed charge nurse. -If the family requested the resident to be sent to the hospital, the resident should be sent. -He/she expected the nurse to assess first and try some changes here, if possible. -He/she was unaware the family had expressed concerns earlier in the shift and had wanted the resident to go to the hospital. -The licensed nurse mentioned to the family that pain medication had been given. -A sprinkler head (a fire suppression device that provides a continuous overhead spray of water) had bust on the 300 hall early in the evening around 4-5 P.M. -The SBAR should be completed and filled out to the license nurse best ability, including all areas of the change of condition. -He/she would have expected the charge licensed nurse to pass on to the oncoming licensed nurse the information regarding the resident's change of condition. -The nurses should notify the ADON or the DON when the resident had a change in his/her condition. During an interview on [DATE] at 2:14 P.M. the Administrator said he/she had received a call from ADON A at 5/15 P.M. on 2/15/20 notifying him/her that a pipe had burst. During an interview on 3/12/20 at 8:27 A.M. the resident's physician said: -He/she expected that if a resident was deteriorating, the facility would send the resident out to the hospital timely. MO 809
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident with a Stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) remained clean, free of stool, and coved with a dressing per physician's orders [REDACTED]. IV pressure ulcer per the resident's physician's orders [REDACTED].#316) out of 32 sampled residents. The facility census was 164 residents. Record review of the facility Negative Pressure Wound Therapy (NPWT) policy dated February 2019 showed: -Licensed nurses will initiate and maintain NPWT as ordered by the attending physician. -The physician's orders [REDACTED]. -Dressings should be changed every 48 to 72 hours per physician order, but should not be less than two times per week. -The NPWT dressing should be removed if negative pressure is off for a period exceeding two hours; replace with a traditional dressing. 1. Record review of Resident #316's Admission Record showed he/she: -Was admitted to the facility on [DATE]. -Had [DIAGNOSES REDACTED]. Record review of the

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDWOOD OF CARMEL HILLS	810 EAST WALNUT INDEPENDENCE, MO 64050

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) resident's Order Summary Report showed the following orders dated 2/11/20: -Admit to facility with a [DIAGNOSES REDACTED]. -[MEDICATION NAME] (anticonvulsant medication also used for pain management) 300 milligrams (mg), give one tablet by mouth three times a day for neuropathic pain (a complex, chronic pain state that usually is accompanied by tissue injury). -[MEDICATION NAME] ([MEDICATION NAME] opioid, sometimes called narcotic medication for moderate to severe pain with [MEDICATION NAME]) 5-325 mg, give one tablet by mouth every four hours for pain, give while awake, hold for sedation. -Complete blood count (CBC - a blood test used to evaluate overall health and detect a wide range of disorders including [MEDICAL CONDITION] and infection) and a comprehensive metabolic panel (CMP - a group of blood tests that provide an overall picture of your body's chemical balance and metabolism, i.e. the chemical processes in the body that use energy). Record review of the residents Nursing Note date 2/11/20 at 4:14 A.M. showed: -The resident was admitted to the facility. -He/she had a Foley catheter. -He/she complained of pain. -No mention of the resident's dressing/NPWT or his/her left buttock pressure ulcer. -No assessment of the resident's level of alertness. --NOTE: The facility staff documented the resident Stage IV pressure ulcer was on his/her sacral area on his/her admission record dated 2/10/20. Record review of the resident's Physician Admission Progress Note dated 2/11/20 at 2:36 P.M. showed: -He/she was new to the facility coming from another skilled nursing facility with a history of the following Diagnoses: [REDACTED]. coli) bacteria live in the intestines of people and animals, and are key to a healthy intestinal tract. Most E. coli strains are harmless, but some can cause diarrhea through contact with contaminated food or water while other strains can cause urinary tract infections, respiratory illness and pneumonia). --Stage IV pressure ulcer. --Paralysis (loss of the ability to move, and sometimes to feel anything, in part or most of the body, typically as a result of illness, or injury). --Gastrointestinal (GI) bleed (any type of bleeding that starts in the digestive tract) related to perianal fistula (an abnormal tunnel that begins in the anus and exits through the akin near the rectum). --Hypoxemia (abnormally low [MED]gen concentration in the blood. -The resident was awake and alert, and his/her cognitive status showed no dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). -His/her Stage IV pressure ulcer had a dressing and wound VAC (vacuum-assisted closure - an high level wound treatment for [REDACTED]. Record review of the resident's Skin and Wound Evaluation dated 2/11/20 showed: -He/she had a Stage IV pressure ulcer on his/her left buttock, present on his/her facility admission. -His/her Stage IV pressure ulcer measured 12.2 centimeters (cm) in length by 11.1 cm in width, a depth of 3.2 cm and with undermining (destruction of tissue or ulceration extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface). -The wound bed had 3.8% of granulation collection of pink-red moist cells that fill and open wound when it starts to heal) tissue; 10.10% slough (layer or mass of dead tissue separated from surrounding living tissue, yellow, tan, gray green or brown, usually moist and may be attached to the base of the wound or present in clumps throughout the wound bed), and 10.10% eschar (dead tissue that is hard or soft, usually black, brown or tan in color, and may appear scab-like, usually firmly attached to the base of the wound and often the sides/edges of the wound); [MEDICATION NAME] (white or yellowy shiny tissue that may cover chronic wounds) was present in the wound. -There was a moderate amount of serosanguineous (containing blood and watery drainage) and no odor. -The wound edges were both attached and unattached, the surrounding tissue was fragile (skin that was at risk for breakdown) and was normal in color, there was no induration (hardness) or [MEDICAL CONDITION] (swelling) and the temperature of the surrounding skin was normal. -The resident had no pain in the area of his/her right buttocks wound. -The primary dressing was negative pressure wound therapy. -Additional care included incontinence management, an air mattress with a pump, and repositioning/turning. --NOTE: The facility staff did not describe or document the measurements of the resident's right buttocks wound and did not identify the wound as a pressure or non-pressure wound. Record review of the resident's Order Summary Report showed the following orders dated 2/12/20: -treatment of [REDACTED]., followed by foam dressing twice daily until NPWT can be reapplied. Record review of the resident's Order Summary Report showed an order dated 2/13/20 for a Low Air Loss mattress (LAL mattress/LAM - A low air loss mattress is a mattress designed to prevent and treat pressure wounds; it is composed of multiple inflatable air tubes that redistribute pressure). Record review of the resident's care plan, dated 2/13/20 showed: -He/she had a self-care performance deficit and was totally dependent on one staff for repositioning and turning in bed. -He/she had pressure ulcers, including a Stage IV pressure ulcer on his her left buttocks. -Interventions included to administer treatment as ordered and to monitor the treatments for effectiveness, assist him/her to turn/reposition at least every two hours and more after is needed or requested LAL mattress, monitor the residents dressing every shift to ensure it is intact and adhering, report loose dressing to the licensed nurse, obtain and monitor lab/diagnostic work as ordered, report results to physician and follow up as indicated. Record review of the resident's Treatment Administration Record (TAR) dated 2/1/20 through 2/29/20 showed: - Treatment (TX) to left buttocks: Cleanse with Vashe solution, pat dry, apply NPWT at 125 mmHg on Monday, Wednesday, Friday and PRN; if unable to reapply NPWT, apply moistened 4x4 gauze with Vashe solution followed by dry dressing, followed by foam dressing twice daily until NPWT can be reapplied, as needed for wound if soiled or removed; start date 2/12/20 at 3:30 P.M. -The boxes for documenting completion of the resident's left buttocks treatment has Xs for 2/1/20 through 2/12/20 and was blank for 2/12/20 through 2/16/20 showing no documentation of completion of treatment to the resident's left buttock wound. --NOTE: The resident was sent to the hospital on [DATE]. No documentation by the facility staff the resident's NPWT treatment to his/her left buttocks was completed two out of two opportunities. --No documentation by the facility staff the resident's left buttock's wound treatment of [REDACTED]. --No documentation by the facility staff related to the resident's right buttocks wound. --No documentation by the facility staff related to the resident's low air loss mattress. Record review of the resident's Progress Notes dated 2/11/20 through 2/15/20 showed: -No licensed nurse notes regarding the resident's wound VAC dressing. -No mention of the presence of or non-presence of his/her wound vac. -No notation regarding notification regarding the resident being sedated or having a decrease/change in his/her alertness/mental status. -No notation regarding a decrease in the resident's blood pressure. -No notation regarding a decrease in his/her [MED]gen saturation. -No notation regarding the resident having repeated loose stools. -No notation regarding the resident's family being present at the facility, having concerns regarding the resident's condition and requesting the resident be transferred to hospital on [DATE]. -No notation of notification to facility management or to the resident's physician regarding a change in the resident's condition and the family requesting the resident be transferred to hospital on [DATE]. Record review of the resident's hospital Intensive Care Unit (ICU - a specialized area of a hospital where special medical equipment and services are provided for patients who are seriously injured or ill) Admission History and Physical (H&P) dated 2/16/20 showed: -He/she was admitted from his/her nursing home with altered mental status (A[CONDITION] - a disruption in how your brain works that causes a change in behavior. This change can happen suddenly or over days; A[CONDITION] ranges from slight confusion to total disorientation and increased sleepiness to coma) and buttock pain. -On arrival to the emergency room (ER) his/her only complaint was right buttock pain and he/she reported he/she had a chronic sacral (area above the tail bone) wound. -He/she had a Stage IV sacral ulcer, very large and deep and on examination, bone could be palpated (felt by placing a hand over the area and applying pressure). -E[CONDITION] reported his/her blood pressure had been low during transport to the hospital, 80s over 50s. -On arrival to the ER, he/she reported he/she had not been clean after his/her bowel movement many hours ago and he/she had a chronic wound in that area. -Report from E[CONDITION] was that the family noted a slight change from his/her normal mental status earlier in the day (2/15/20) at an undetermined time. -He/she was given two liters of fluids intravenously (IV - into a blood vein) with a good response of his/her blood pressure. -His/her wound VAC fell off two days ago per the Registered Nurse (RN) report. -He/she was initially admitted to the hospital medicine team but his/her blood pressure dropped to 70s despite getting two liters of IV fluid in the ER. -He/she was started on [MEDICATION NAME] ([MEDICATION NAME] -a medication used to treat life-threatening low blood pressure that can occur with certain medical conditions or surgical procedures) temporarily via his/her peripheral intravenous line until ICU was consulted, placed a right intrajugluar vein (IJ) central line (insertion of a tube into the large vein on the right side of the neck that allows rapid high-volume fluid administration, administration of multiple medications, and hemodynamic monitoring that measures the blood pressure inside the veins, heart, and arteries, how much [MED]gen is in the blood, checks how well the heart is pumping; and is often used for reliable venous access in ill persons) and admitted him/her to the ICU. Record review of the resident's hospital History and Physical addendum dated 2/17/20 showed: -He/she was critically ill with imminent threat to his/her life. -His/her septic shock was being treated with broad spectrum (those able to treat a wide range of bacteria) antibiotics including [MEDICATION NAME] and Zozyn for UTI and PNA. -His/her urine culture was growing E. coli greater than 100,000. -Awaiting culture and sensitivity but he/she seemed clinically improved. During an interview on 2/15/20 at 8:11 A.M. RN B said: -He/she went to the resident's room around 7:14 P.M. -The resident said no when asked if

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	265727	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDWOOD OF CARMEL HILLS	810 EAST WALNUT INDEPENDENCE, MO 64050

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) he/she needed anything. -He/she went to the next hall and started doing his/her resident care. -The E[CONDITION] staff said there was no need to do the resident's wound dressing. -He/she had been told by the off going licensed nurse that the resident did not have a dressing on his/her Stage IV pressure ulcer. -He/she could not turn the resident by himself/herself. -He/she thought the resident was supposed to have a wound VAC. -The off going licensed nurse said the resident needed a dressing but did not say the resident was going to the hospital. -He/she told the off going licensed nurse that he/she would put a dressing on the resident's pressure ulcer after he/she finished his/her Accuchecks (checking blood sugar level by obtaining a small drop of a resident's blood by pricking a finger with a sharp device and using use of a small machine that provides a numerical result). -He/she first saw the resident at 7:15 P.M. -He/she had 12 residents needing Accuchecks, residents also came to him/her for pain medications which had to be given on time. -He/she saw the resident at 8:00 P.M. and helped a Certified Nursing Assistant (CNA) to turn the resident (change the resident's position in bed); he/she asked the resident if he/she was OK and the resident said yes. -He/she then went to do something else; he/she was always busy. -E[CONDITION] arrived at the facility at about 9:00 P.M. During an interview on 3/5/20 at 1:38 P.M. Licensed Practical Nurse (LPN) D said: -The resident had a Stage IV pressure ulcer. -In the few days before the resident was transferred to the hospital a wet to dry dressing was being used for his/her Stage IV pressure ulcer. -The resident had a wound VAC for his/her Stage IV pressure ulcer and that dressing had come off and licensed nurses had not been able to correctly reapply the wound VAC. -The facility protocol was to apply a wet to dry dressing (a wet/moist gauze dressing is put on the wound and allowed to dry; wound drainage and dead tissue can be removed when the dressing is removed) until the facility wound nurse could reapply the wound VAC. -The resident's wound VAC was not on when he/she got to work. -He/she discovered at about 11:00 A.M. or maybe around noon that the resident's wound VAC was not on his/her stage IV pressure ulcer; at that time he/she was helping another staff person turn and clean the resident because he/she had had a lot of loose stools. -The resident continued to have loose stools throughout the rest of the 7:00 A.M. to 7:30 P.M. shift. -He/she put a dressing on the resident's stage IV pressure ulcer at about 12:30 P.M. when he/she finished completed blood sugar testing for diabetic residents. -At that time, there could have been an old dressing in the bed but he/she could not remember, but there was no dressing on the resident's buttocks. -During the shift report he/she passed on that the resident did not have a dressing on his/her Stage IV pressure ulcer. -He/she was first aware the resident was without a dressing on his/her Stage IV pressure sore at around the lunch hour. -He/she told the visitor that the resident had been having loose stools and discussed with the resident's family that the resident's decreased level of consciousness could be from a buildup of the resident's narcotic medication that he/she was getting every four hours. -At about 5:00 P.M. or 6:00 P.M. there was flooding in the building, on the 300 Hall (the resident's room was on the [LOC]). -He/she put a dressing on the resident's Stage IV pressure ulcer at around 12:45 P.M, sometime before 1:00 P.M. -Somehow with all the stools the resident was having, the dressing came off; he/she did not know exactly when the dressing came off. -He/she became aware the resident did not have a dressing on just before the fire alarm went off because he/she was assisting in turning the resident as he/she had been incontinent of stool again; at that time he/she saw that the resident had bowel movement all over her old dressing and bowel movement was in the residents wound. -He/she made it back to the resident's room at 6:30 P.M., maybe; he/she had gone to the resident's room to check on him/her, the resident's family member had left. -He/she saw the resident did not have a dressing on his/her stage IV pressure ulcer, at that time he/she was trying to find someone to clean the resident; he/she did not remember what happened, the resident was big and he/she could not turn the resident by himself/herself. -At that time (6:30 P.M.) he/she knew the resident did not have a dressing on his/her Stage IV pressure ulcer because his/her dressing came off earlier when he/she was turning the resident; that was at the time he/she put the dressing on the resident. -The time he/she put the dressing on the resident was around 12:30 P.M.; he/she was helping to turn the resident while being changed was around 4:00 P.M., or something like that. -He/she was really busy and was behind on everything. -When asked what was going on that was more important than putting a dressing on the resident's Stage IV pressure that had bowel movement in it, he/she said that he/she just did not remember; he/she had looked for someone to help him/he and could not find anyone. -He/she could have paged someone. -He/she was sure he/she had paged someone; he/she thought that was later. -When asked why he/she had not put a dressing on the resident's Stage IV pressure ulcer when he/she noticed there was no dressing, he/she said he/she did not know, he/she thought there was an ambulance for another resident, he/she just could not find anyone to help him/her with the resident; with the flood that was going on, then going being behind, just everything; it was just kind of chaotic; he/she thought that was after the flood; he/she did not know, it was all jumbled probably because it was so chaotic. -He/she did think the resident had a wound VAC on because he/she did not need to change the resident's dressing on his/her stage IV pressure ulcer; he/she had looked at the wound VAC the previous day and it was operation correctly. During an interview on 3/6/20 CNA L said: -The resident was not large. -He/she had in the past completed incontinence care for the resident. -He/she always took another staff person with him/her when he/she completed incontinence care with all residents. -The resident's level of alertness and ability to assist in turning in bed depended on the time of day; he/she routinely had to explain to the resident what was being done. -He/she was not aware of the resident ever having a change in condition or having loose stools. -The resident would get confused; he/she never appeared sedated. -The resident used [MED]gen, the resident had to put [MED]gen because he/she was short of breath. During an interview on [DATE] at 12:59 the Director of Nursing (DON) said: -He/she had not been aware the resident was having loose stools and that the dressing and wound VAC had been left off. -ADON A had said the resident had to have a dry dressing placed and had been cleaned up of loose stool when E[CONDITION] arrived. -A sprinkler head (a fire suppression device that provides a continuous overhead spray of water) had bust on the 300 hall early in the evening around 4-5 P.M. -He/she expected the resident's dressing to be changed when soiled. -The wound nurse would put a dry dressing in place until a wound VAC was placed back on the resident. -The staff should be following the physician's orders [REDACTED]. -The dressing and wound VAC should be placed back on the resident as soon as possible. -If this happen during the night, there should be a dry dressing in place. -If this happened at night or on weekends, a dry dressing should be placed. -The nurses should notify the ADON or the DON. During an interview on 3/12/20 at 8:27 A.M. the resident's physician said: -He/she expected licensed nurse's to check that the dressing is in place on a Stage IV pressure ulcer at least three times a day. -He/she expected that if a resident was deteriorating, the facility would send the resident out to the hospital timely. MO 809
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #143) was provided adequate incontinence care when he/she was visibly wet, had puddles under his/her wheelchair, and there was a strong urine odor in his/her room out of 32 sampled residents. The facility census was 164 residents. Record review of the facility's policy titled Perineal Care (washing the genitals and anal area) dated February 2019 showed: -The purpose was to maintain cleanliness of the genital area, to reduce odor, and to prevent infection of skin breakdown. -Perineal care was provided as part of a resident's hygienic program, a minimum of once daily and per resident need. 1. Record review of Resident #143's face sheet showed he/she admitted tot he facility on 2/9/20 with [DIAGNOSES REDACTED]. -[MEDICAL CONDITION] (your kidneys are damaged and can't filter blood the way they should). Record review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 2/15/20 showed he/she: -Was severely cognitively impaired with a BI[CONDITION] (brief interview for mental status) of six out of 15. -Required extensive assistance from two staff members for toileting. -Required limited assistance from one staff member for personal hygiene. -Was frequently incontinent of bowel and bladder function. Record review of the resident's Activities of Daily Living (ADL) self care performance care plan dated 2/9/20 showed he/she: -Required extensive assistance from staff with bathing/showering and personal hygiene. -Required limited assistance from staff with transfers. -Required set up assistance from staff with toileting. Record review of the resident's care plans last updated on [DATE] showed he/she had an Activities of Daily living (ADL) self-care performance deficit and had the following interventions: -For personal hygiene he/she required extensive assistance by two staff members. -For toileting he/she required set up assistance by one staff member. Observation on 3/4/20 of the resident showed: -At 4:02 A.M. he/she was in his/her wheelchair with his/her eyes closed. --The resident's pants were visibly wet. -At 7:09 A.M. he/she had a liquid substance on the floor under his/her wheelchair. --There was a significant smell of urine in room. -At 7:38 A.M. a Certified Nursing Assistant (CNA)

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) entered the resident's room and asked him/her what he/she wanted for breakfast. --The CNA did not address the resident having wet pants, the liquid under his/her wheelchair, or the odor of urine in the room. -At 7:54 A.M. the resident had changed his/her location in his/her room and a puddle of liquid was under his/her wheelchair in the new location. --There was a significant smell of urine in the room. -At 7:59 A.M. the resident's breakfast was delivered to the resident in his/her room. --The resident was told his/her breakfast tray was delivered. --Staff did not address the resident having wet pants, the liquid under his/her wheelchair, or the odor of urine in the room. -At 9:30 A.M. two staff members entered the resident's room and began assisting the resident with cares including changing him/her out of wet clothes and cleaning up the puddles on the floor. Observation on 3/5/20 at 8:50 A.M. of the resident showed: -He/she was sitting in his/her wheelchair. -His/her room and the hallway in front of his/her room had a strong odor of urine. During an interview on 3/5/20 at 2:17 P.M. CNA E said: -Residents are checked for incontinence every two hours, before and after meals. -Residents should not be visibly wet for over 2 1/2 hours. During an interview on 3/5/20 at 2:18 P.M., Certified Medication Technician (CMT) A said: -Staff were to check residents for incontinence every two hours. -Residents should not be visibly wet for over 2 1/2 hours. During an interview on 3/5/20 at 2:19 P.M., CNA F said: -Residents were checked for incontinence every two hours. -Residents should not be visibly wet for over 2/12/ hours. During an interview on 3/5/20 at 2:20 P.M., Licensed Practical Nurse (LPN) C said: -He/she expected staff to check the residents every two hours for incontinence. -He/she expected staff to check all residents, not just resident who had been identified as incontinent, and make sure assistance was not needed. -Staff should help a resident who had wet pants to change into clean clothes and provide incontinence care. -Residents should not be left visibly wet for over 2 1/2 hours. During an interview on [DATE] at 10:50 A.M., the Assistant Director of Nursing (ADON) said: -It was not acceptable for staff to walk by a resident who had visibly wet clothing. -Staff should have addressed the resident's incontinence immediately upon noticing the resident needed to be changed. -Residents should not be left visibly wet for over 2 1/2 hours. During an interview on [DATE] at 1:45 P.M., the Director of Nursing (DON) said: -The resident should be treated with with dignity and respect. -The resident should be changed when needed, the resident should be checked every two hours at a minimum. -The staff should change the resident if the resident had visible wet clothes, and puddles on the floor under the resident's wheelchair, and strong urine odor in the resident's room. -The resident should not have been left in wet clothes for 2 1/2 hours.
F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet the behavioral needs for one sampled resident (Resident #85) who had an increase in his/her depression indicators out of 32 sampled residents. The facility census was 164 residents. Record review of the facility's Social Services Program policy updated 2/2019 showed: -The facility needed to provide medically related social services. -The director of social services and/or designee would meet with the resident to evaluate the psychosocial needs of the resident. -The resident needed to be assessed for negative impact on psychosocial development including anxiety, coping ability, depression, and anger. 1. Record review of Resident #85's Face Sheet showed he/she was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. -Major [MEDICAL CONDITION] (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living). -[MEDICAL CONDITION] disorder (a chronic mental health condition characterized primarily by symptoms of [MEDICAL CONDITION], such as hallucinations or delusions, and symptoms of a mood disorder, such [MEDICAL CONDITION] depression). -End stage [MEDICAL CONDITION] (kidney failure). Record review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool required to be completed by facility staff for are planning) dated 11/5/19 showed he/she: -Was moderately cognitively impaired. -Did not have depression indicators. -Was independent with supervision for Activities of Daily Living (ADLs-bathing, eating, dressing, grooming). Record review of the resident's Nurses Note dated 1/30/20 at 10:29 A.M. showed he/she had refused to get up in the morning and stated he/she wanted to go home. Record review of the resident's Nurses Note dated 1/30/20 at 1:09 A.M. showed: -The resident's family member was contacted and told the resident was trying to hide his/her medications and not wanting to eat. -The resident had been offered multiple choices of food and would refuse to eat what was offered. Record review of the resident's Nurses Note dated 2/3/20 showed he/she was having a decline, came out to eat breakfast, and then left without eating or taking his/her supplements. Record review of the resident's Nurses Note dated 2/11/20 showed: -The resident had refused to go to [MEDICAL TREATMENT] (process of cleansing the blood by passing it through a special machine - necessary when the kidneys are not able to filter the blood). -The resident stated he/she did not feel well and was not going to [MEDICAL TREATMENT]. -The resident was educated on the importance of going to [MEDICAL TREATMENT]. Record review of the resident's Nurses Notes dated 2/12/20 at 9:43 A.M. showed: -The resident had refused [MEDICAL TREATMENT] so the nurse went to talk to the resident about the effects of not going to [MEDICAL TREATMENT]. -The nurse had spoken with the resident's family member and explained the resident was refusing [MEDICAL TREATMENT], breakfast meals, and medications. -The family stated they would come to the facility to talk to the resident. Record review of the resident's Nurses Notes dated 2/12/20 at 9:53 A.M. showed: -The resident's family member and spouse came to the facility at lunch (on 2/11/20) and talked with the resident about his/her refusal of [MEDICAL TREATMENT], breakfast meals, and medications. -The resident voiced understanding of eating, taking medications, and going to [MEDICAL TREATMENT]. -The resident stated he/she was happy when his/her spouse visited. Record review of the resident's Care Plan updated 2/20/20 showed he/she: -Had impaired cognitive function or impaired thought processes due to his/her [DIAGNOSES REDACTED]. -Would remain in long term care and was encouraged to discuss feelings or concerns with placement. --Needed the staff to monitor him/her for signs of anxiety, fear, or distress. Record review of the resident's Social Services assessment dated [DATE] showed: -The resident was alert and oriented with some short term and long term memory loss. -There were no comments under the resident's mood section. -There were no comments made on the resident mental health/behavioral status related to his/her increase in depression. -There were no comments under the summary section. During an interview on 3/02/20 at 10:14 A.M., the resident said: -He/she was very independent. -He/she was unsure why he/she was here. -He/she was very frustrated related to placement here on a locked secure care unit. -He/she wanted to be with his/her spouse who lived in the area. -He/she could not state how long he/she had been at the facility. Observation on 3/2/20 at 12:51 P.M. showed the resident was in the main dining room eating his/her lunch independently. During an interview on 3/6/20 at 8:52 A.M. Certified Nurses Assistant (CNA) J said: -He/she encouraged the resident to call his/her family and come to activities. -The resident would state he/she missed his/her family and missed being at home. -The resident wanted to have someone to talk to him/her that can relate to him/her. -The resident had recently found a friend on the unit that was more alert and he/she talked with this resident more now. -The resident's family was aware the resident had depression at times. -The resident did refuse [MEDICAL TREATMENT] at times. During an interview on 3/6/20 at 9:05 A.M., Assistant Director of Nursing (ADON) B said: -He/she was the acting charge nurse today. -The resident refused [MEDICAL TREATMENT] one time and was getting depressed. -The resident also stopped eating so the family came to see him/her. -The resident was giving up is what we (the facility staff) thought. -He/she had a meeting with the family and resident. -The resident stated he/she was tired of [MEDICAL TREATMENT] and he/she was depressed. -He/she was not aware that social services was involved. -His/her family member stated he/she could not take care of him/her at home because his/her spouse had dementia and was already having to care for his/her spouse. -The resident had an increase in depression. -He/she did not talk to the family about behavioral health therapy. -The resident's therapy was seeing his/her spouse. During an interview on 3/6/20 at 12:15 P.M., Social Services Designee B said: -The resident was on the dementia unit but was still alert with some memory loss. -He/she was not aware of any depression. -The resident was always cheerful when he/she saw the resident. -When he/she assessed the resident on 2/20/20, the resident was cheerful. -He/she had been aware ADON A was going to talk to family about hospice (end of life care) due to refusal of eating. -He/she did look at nurses notes prior to interviewing and assessing the resident. -ADON A had mentioned it in a morning meeting about hospice. -He/she was unaware of the resident's depression. -He/she could refer residents for counseling services and the resident also was a veteran and had veteran's benefits where counseling services were offered. -Generally, the resident had a stoic affect during interviews. During an interview on [DATE] at 12:59 P.M. the Director of Nursing (DON) said: -The Social Services assessments should have captured the depression on the assessment and he/she expected Social Services to seek treatment including behavioral health counseling. -Social Services should have assessed the resident for his/her depression. -The resident was alert and oriented enough to receive counseling services.

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F 0740 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 8)
F 0742 **Level of harm -** Minimal harm or potential for actual harm **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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to adequately assess one sampled resident (Resident #154) for ongoing appropriate interventions related to the resident's behaviors; to complete a thorough investigation of an incident and provide appropriate monitoring at the time of the incident that occurred on [DATE]; to notify the physician of one closed record resident's (Resident #85) mental status changes with increasing behaviors and failed to adequately monitor the resident as the behaviors increased out of 32 sampled residents. The facility census was 164 residents. Record review of the facility's Behavior-Management policy revised 2/2019 showed: -The key components were: --Identifying residents whose behaviors may pose a risk to self or others. --Develop practical care strategies based on assessed needs. --Implementing a behavioral management program. --On-going assessment and monitoring, and evaluation of the effectiveness of the behavioral management program including medications. -If a resident exhibits behaviors, the staff were to: -Ensure the safety of the resident as well as other residents. -Document the notification of the physician and family. -The charge nurse would assign a staff member to monitor/shadow the resident as needed. 1. Record review of Resident #154's Face Sheet showed he/she was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. -[MEDICAL CONDITION] disorder (a chronic mental health condition characterized primarily by symptoms of [MEDICAL CONDITION], such as hallucinations or delusions, and symptoms of a mood disorder, such [MEDICAL CONDITION] depression). Record review of the resident's admission Minimum Data Sheet (MDS-a federally mandated tool required to be completed by facility staff for care planning) dated 11/20/20 showed he/she: -Was severely cognitively impaired. -Had no behaviors. -Needed limited staff assistance of one staff member for transfers and locomotion (using a wheelchair). Record review of the resident's Behavioral Note dated 12/22/19 showed: -The resident was exhibiting physical aggression towards other residents. -No behaviors observed on this shift. -The resident was on 30 minute checks. -The resident's family visited today for approximately three hours. -The family encouraged positive behavior with the resident. Record review of the resident's Social Services Notes dated 12/22/19 showed: -A family meeting was held with the Administrator and Director of Nursing (DON) to discuss his/her behavior towards one resident. -The Administrator related to the family the resident had been aggressive toward another resident and the family had addressed the issue with the resident. -The resident agreed to stay away from the resident and discontinue his/her aggressive behavior. Record review of the resident's 15 minute checks sheets showed the resident was on 15 minute documented checks from 12/22/19 at 8:15 A.M. through 1/6/20 at 12:00 A.M. Record review of the resident's Behavior Note dated 1/12/20 at 12:28 P.M. showed: -The resident was harassing other residents and attempting to hit them. -The resident was not being provoked by other residents. -The resident was offered snacks and activities to re-direct him/her. -The DON was notified. -The resident was placed on one-on-one monitoring. Record review of the resident's Behavior Note dated 1/12/20 at 12:48 P.M. showed: -The nurse had called the resident's family member and explained the resident was cursing and trying to hit other residents. -The family member stated he/she was aware of these inappropriate behaviors. -The family member stated if the resident needed medications or needed to be sent to the hospital for a psychological evaluation he/she would support this. -The resident was placed on one-on-one care and monitoring. Record review of the resident's physician's orders [REDACTED]. Record review of the resident's Behavioral Note dated 1/14/20 showed: -The resident continued on 15 minute checks due to aggressive behaviors towards others. -The resident had no aggressive behaviors today. Record review of the resident's Physician's Progress Note dated 1/21/20 showed the resident's behaviors had improved since adding the [MEDICATION NAME] medication. Record review of the resident's 15 minute check sheets showed the resident had been on 15 minute checks from 2/4/20 at 6:45 P.M. through [DATE] through 8:00 P.M. Record review of the resident's Behavioral Note dated 2/5/20 showed: -Another resident was calling names in passing which caused a verbal altercation between the resident and Resident #154. -The residents were advised to keep their distance from each other and the residents stated ok. Record review of the residents Behavioral Note dated [DATE] at 6:24 A.M. showed: -The resident continued to be combative and hit other residents, grabbing female staff butts, and yelling throughout the night from his/her room. -When staff go to his/her room, he/she stated nothing was needed. -The resident continued to come behind the nurses' station and when asked not to, he/she was not redirectable. -He/she was refusing medications, treatments and cares. -He/she would continue to monitor per the physicians orders. Record review of the resident's Behavioral Note on [DATE] at 5:00 P.M., showed by the Assistant Director of Nursing (ADON) A: -The staff reported to him/her the resident was not cooperative with cares, was verbally inappropriate and/or trying to hit the staff. -ADON A had visited with the resident to discuss his/her behaviors and the resident politely responded he/she did not know what ADON A was talking about. -The resident yelled at a staff member who walked by for absolutely no reason. -ADON A told the resident his/her behaviors were inappropriate. -The resident stated he/she would not do it again. -The resident's medications were reviewed and the [MEDICATION NAME] had been discontinued through a gradual dose reduction. -He/she spoke with the physician and [MEDICATION NAME] medication was started again. -The physician ordered a psychological evaluation. -At this time, the resident was at dinner and did not present with any aggressive behaviors. Record review of the resident's Behavioral Note dated 2/7/20 at 7:14 A.M. showed: -The resident was at the front desk and he/she was cussing at the staff and telling them that he/she was not going to leave the nursing station. -The resident continued to hit the female staff on the butt when the night nurse asked him/her to stop the behaviors and tried to redirect him/her, he/she was still being combative but stated that he/she would stop. -The resident then seen another resident (Resident #38) from the 100 hall and he/she mobilized up to him/her in a wheelchair and struck him/her in the shin. -At this point the night nurse assisted the resident to his/her room and attempted to find out why he/she was continuing to strike the other residents and cuss out the staff. -The resident stated that he/she did not know why he/she was doing it but he/she just wanted to. -He/she then let him/her know this was not appropriate and that if he/she was not going to stop this behavior then he/she could not be out in the common area. -The resident stated that he/she would stop with the behavior and then he/she went and sat in the hall when 15 minutes later we (the staff) heard a resident (Resident #137) screaming help. -A Certified Nurses Assistant (CNA) came down the hall and asked if he/she would stop hitting and leave out his/her room. -The resident then struck the CNA. -He/she spoke to the residents and called Resident #137's family member. -Resident #137's family member called the police and the resident pressed charges. -The resident called the police names and asked them if they wanted him/her to kick their ass and at that point they placed the resident under arrest. -The Administrator and DON were notified at that time. -The resident was escorted out the building with the police at 9:19 P.M. (on [DATE]). Record review of the resident's 15 minute check sheets dated [DATE] showed the resident was monitored at the nurses station from 8:00 P.M. until the resident was arrested. Record review of the resident's Behavioral Note dated 2/7/20 showed: -The resident's family member called the facility. -The resident had been admitted to the hospital and had a Urinary Tract Infection (UTI - an infection of one or more structures in the urinary system). Record review of the facility investigation dated 2/7/20 completed by the Interim Administrator showed: -An Incident Report: -On [DATE], Resident #154 entered Resident #137's room to talk to his/her friend. -Resident #154 was confused thinking Resident #137's roommate was his/her friend. -Resident #137 said that his/her roommate was not his/her friend and asked Resident #154 to leave the room. -Resident #137 used his/her wheelchair to physically push Resident #154 out of the room. -When Resident #154 got in Resident #137's personal space and he/she started pushing Resident #154 back, Resident #154 started flailing his/her hands. -Resident #154 had brushed against Resident #137's right lower cheek. -Resident #137 stated it did not hurt. -Resident #137's family member called the police and Resident #154 was taken to jail. -Resident #154 was moderate to severely cognitively impaired and was found to have a UTI. -Interview with Resident #137: He/she was in his/her room when a noise was heard outside. -Resident #154 entered Resident #137's room and said he/she was visiting his/her friend pointed at the sleeping roommate. -Resident #154 was confused and thought the sleeping roommate was his/her friend. -Resident #137 corrected Resident #154 and when Resident #154 continued to enter the room near his/her roommate, Resident #137 tried to use his/her wheelchair to flush Resident #154 out of the room. -Resident #137 got close to Resident #154 who was flailing his/her arms and he/she felt a light contact but it did not hurt. -Another resident came in and pulled Resident #154's wheelchair out of the room. -Resident #137 tried to swing at Resident #154 but the other resident got in-between them. -The nurse came and took Resident #137 to the nurses station. -The conclusion was Resident #154 entered Resident #137's room to talk to his/her friend. Resident #154 was confused and

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F 0742 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) thought the sleeping roommate was his/her friend. Resident #137 tried to physically push Resident #154 out of the room. When Resident #154 got into the personal space of Resident #137, Resident #154 started flailing his/her hands and brushed against his/her cheek. Resident #137 was not injured. --There was not documentation that showed staff interviews were completed, other resident interviews were conducted, including Resident #38, or that Resident #154 was put on additional monitoring after kicking Resident #38 in the shin. Record review of the resident's Admission Summary dated 2/10/20 at 3:08 P.M. showed: -The resident was readmitted to the facility (to the special care unit (SCU - a living area of the facility secured with alarmed doors for residents with behavior symptoms and dementia). -The resident appeared to be verbally and physically abusive to residents and staff. Record review of the resident's Behavioral Note dated 2/10/20 at 3:31 P.M. showed: -The resident was groping female staff, punching staff, and sitting in front of the exit door. -The resident was swinging at the nurse and punched him/her in the stomach and stated I'm getting out of here. -The physician gave orders to [MEDICATION NAME] (an anticonvulsant used to treat mood disorders) 250 mg twice a day and monitor the resident for safety. Record review of note text on 2/10/20 at 6:55 P.M. written by the DON showed: -He/she had visited with the resident's family to review plan of care. -The resident was going to be placed on [MEDICATION NAME] 2 mg to also help with aggressive behaviors. -The resident was on one-on-one monitoring tonight and tomorrow. -The family member was ok with this plan of care and understood if the medication was not effective the resident would be referred to geriatric in-patient psychiatry for evaluation and medication adjustments. -The family member was fine with that and understanding of the special needs of his/her family member. Record review of the resident's Physician's Progress Note dated 2/11/20 showed: -The resident had continued to have aggressive behaviors. -The resident was non-compliant with medications. -The resident had been at the hospital and treated for [REDACTED]. -Social Services would work on getting the resident a psychological evaluation. Record review of the resident's Social Services Note dated 2/12/20 showed: -There were no beds available at a local psychiatric hospital. -The resident was no longer requiring one on one monitoring. -He/she was told to check back tomorrow to see if a bed was available. -A referral was sent to other (psychiatric) facilities. Record review of the resident's Nurses Notes dated 2/19/20 showed: -The resident was alert and calm this morning but seemed to be sleepy today. -The resident's morning medication was held and the resident was watched for continued sedation. -The DON was on the SCU and talked with the resident. Record review of the resident's Care Plan dated 2/28/20 showed the resident: -Had verbally and physically aggressive behaviors related to dementia with behaviors. -Would use profanity and was combative with staff. -Had reports of resident physically hitting, throwing things, and swinging arm at the staff. Record review of the resident's Behavioral Notes dated [DATE] at 12:15 P.M. showed: -The resident's family members visited. -The resident had been combative during the shift and was being monitored closely. -The resident was re-directed when combative, offered snacks and activities. Record review of the resident's Behavioral Notes dated [DATE] at 3:44 P.M. showed: -The resident had been aggressive and attempting to hit other residents off and on this shift. Record review of the resident's Behavioral Notes dated 3/2/20 at 11:05 A.M. showed: -The resident had been very aggressive today towards staff and other residents. -The resident argued with a female resident on the couch and tried to hit at her hand. -The nurse spoke with the DON and the nurse practitioner would be notified in the morning. Record review of the resident's physician progress notes [REDACTED]. -The resident hit a staff member in the throat, used inappropriate language, and inappropriately was touching staff. -The resident's [MEDICATION NAME] had been discontinued in an attempt to wean the resident off the medication. -The resident's [MEDICATION NAME] medication was being restarted. Record review of the resident's Order Note dated 3/3/20 showed: -The resident was started on [MEDICATION NAME] 0.5 mg for increased aggressive behaviors. -The resident was starting on a lower dose of the medication. Observation on 3/4/20 at 9:30 A.M. showed the resident was asleep on the couch and did not have behaviors. Observation of the resident on 3/5/20 at 8:42 A.M. showed: -He/she was outside the dining area and self-propelled his/her wheelchair towards the dining room. -Bumped into a female resident's wheelchair accidentally. -He/she grabbed at the female resident's arm and the staff immediately intervened and took the resident by the television area away from other residents. -He/She watched television with no other behaviors exhibited. During an interview on 3/5/20 at 3:09 P.M., CNA A and CNA B said: -CNA A: --The resident had behaviors of getting violent towards staff and other residents. --He/she saw the resident get verbally aggressive on the couch last week and the nurse intervened immediately. --The resident would grab at staff members breasts. -His/her behaviors were better since medications were changed but the resident still had behaviors every once in a while. -CNA B: --The resident had gone to the hospital and was now on the SCU. --He/she had new medications and seemed to be better with less behavioral episodes. -The CNAs had not witnessed any physical altercations towards other residents. During an interview on 3/5/20 at 3:21 P.M., CNA C said: -He/she had not witnessed a physical altercation involving the resident. -He/she had been told Resident #137 had been hit in the face. -He/she did see Resident #137 coming up the hall holding his/her face. -The nurse kept Resident #137 at the nurses station. -The resident kept trying to go into the nurses station. -The resident tried to hit residents and staff every day. -The resident would hit other residents and staff almost every day. -This was a regular thing when he/she was on the skilled unit. -He/she did not remember seeing a CNA on that hall at the time Resident #137 came up the hall. -He/she was unsure who witnessed anything. During an interview on 3/6/20 at 7:11 A.M., Licensed Practical Nurse (LPN) A said: -When the resident was on the unit prior to his/her hospital stay, the resident had behaviors of hitting, yelling, combativeness. -He/she would be redirected but would continue the behavior. -He/she would throw items at staff and refuse cares. -He/she would grab at the staff, inappropriate touching in all inappropriate areas. -He/she would be in the hall and feel a hand on his/her butt. -The resident kept having behaviors towards Resident #38. -Resident #38 was hit by the resident prior to the incident and was following him/her around and kicked Resident #38. -Resident #38 was assessed with [REDACTED].#38 was deaf, had a tablet, and could use sign language. -He/she separated the resident and Resident #38. -He/she took the resident into his/her room and talked to him/her and would state he/she knew what he/she was doing. -He/she punched CNA D, staff member in the stomach when he/she was in the doorway and was being moved due to blocking the doorway. -The resident had Resident #137 blocked in his/her room after this. -Resident #137 tried to go out of his/her room because he/she was blocked in, then started yelling for help. -CNA D went to the room and he/she got up to go down to the room and the resident was in the hallway. -CNA D stated the resident was Resident #137's room and Resident #137 had been punched in the face. -The resident was taken to his/her room. -He/she took Resident #137 to the nurses station and he/she kept asking for his/her family member. -Resident #137 was crying, upset, and wanted to talk to his/her family member. -Resident #137 called his/her family member and told him/her she was hit in the face. -He/she also notified the DON and was told to put Resident #154 on 15 minute checks. -The resident was already on 15 minute checks. -He/she did not place the resident on more monitoring. -He/she notified the Interim Administrator and left a message. -The family member hung up and called 911. -The family member, per Resident #137 was on his/her way up. -He/she was going to get a a urinary laboratory test on the resident to see if he/she had a UTI. -The police came and talked to both of the residents. -The resident was out of his/her room and was sitting on the outside of the nurses station. -The resident did not touch anyone but was aggressive. -The police officer was trying to talk to Resident #154 and he/she said I'm going to [***] you up and Do you want to be next. -The police officer tried to talk him/her down but he/she kept being aggressive and tried to kick the police officer. -The resident said to the police he/she wanted to press charges. -The police arrested him/her and took him/her from the building. -The resident was taken to the police station and then to the hospital. -When he/she came back he/she was drugged up. -The resident was lethargic so the Nurse Practitioner reduced the medications. -He/she was better with behaviors now. -He/she was not touching staff as much as he/she was. -He/she was not grabbing at residents as much as he/she was. -He/she still refused medications. -He/she assessed Resident #137 and his/her face was flushed so it was hard to tell for injury. -When he/she assessed him/her later when he/she stopped crying, there were no signs of injury or marks on his/her face. During an interview on 3/6/20 at 9:05 A.M., Assistant Director of Nursing (ADON) B said: -The resident had behaviors. -When he/she first came back here after his/her hospital stay he/she was cussing at the staff, pinching the staff, and patting staff bottoms. -The resident was so much better now and the behaviors had decreased. -He/she was cussing at the residents and was aggressive towards other residents. -He/she would sit in front of other residents and shake his/her fist at them. -The resident never made any physical contact with other residents. -For the first two days after being placed on the unit, he/she was on one-on-one monitoring on the unit. -Medication changes were made by the physician related to his/her behaviors to his/her [MEDICATION NAME] and the physician added [MEDICATION NAME]. -The behaviors were better and the resident had a few moments of behaviors since then. -We held the [MEDICATION NAME] because he/she was lethargic and he/she started to get aggressive again. -He/she was seen by the nurse practitioner yesterday and the [MEDICATION NAME] was increased and the [MEDICATION NAME] was restarted. During an interview on 3/6/20 at 11:55 A.M., ADON A said: -The resident had behaviors and would lash out once in a while. -He/she had behaviors around Resident #38, like shouting to get out of

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F 0742 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 10) the way because Resident #38 was deaf. -The resident assumed Resident #38 was not listening. -The resident was placed on 15 minutes checks because he/she would try to keep an eye on him/her to prevent an incident from happening. -He/she rarely had behaviors towards other residents. -There was no physical contact prior to the incident. -The resident mainly had issues with Resident #38. -He/she was here on the day [DATE]. -He/she had started 15 minute checks due to Resident #154 following Resident #38 more on 2/3/20. -He/she had left before the incident occurred. -He/she was also started on [MEDICATION NAME] for behaviors at one time. -The resident had many behaviors per staff and more at night. -When the resident was aggressive towards Resident #38, he/she expected the nurse to separate the residents. -Both residents should be assessed for injuries. -He/she expected the nurse to notify the resident's family and Physician. -The resident was on 15 minute checks. -He/she expected the charge nurse to separate the residents and get orders from the doctor for monitoring. -He/she would expect the nurse to bring the resident to the nurses station to be watched and call the physician for orders. -The monitoring depends on the incident. -If someone was on one-on-one monitoring, he/she did not know what documentation was required. -Investigations were completed by an incident report started by a nurse. -The DON and/or Administrator would do the full investigation. -The management always interviewed the staff and residents who were involved or witnessed it. -The nurse would document skin assessments and assess all residents involved. -If there was an injury, this would go on a risk management report. During an interview on [DATE] at 10:47 A.M., the Interim Administrator said: -He/she was the interim administrator at the time of the incident. -He/she had received a call from LPN A around 9:45 P.M. and there was an incident between the resident and Resident #137. -LPN A stated that the resident was going across the hall into Resident #137's room and Resident #137 was trying to keep him/her out of his/her room. -LPN A stated there was no injury to either resident. -LPN stated the resident was taken out of Resident #137's room. -He/she talked to multiple CNAs but no one witnessed what happened. -He/she had received statements from all CNAs but was unsure why they were not with the investigation. -He/she did not read the nurses note related to the incident. -He/she did not interview Resident #38. -He/she did interview Resident #137 the next day and he/she stated Resident #154 brushed his/her cheek while his/her arms were flailing around and never stated he/she was hit or slapped. -The nurse was responsible for putting in further interventions and would not comment on expectations of monitoring. -CNA D did give a statement. -He/she asked everyone on that shift what happened and no one saw it per the CNA. -Resident #137 told him/her a hand went by his/her cheek but he/she was not actually hit. During an interview on [DATE] at 12:59 P.M.,the Director of Nursing (DON) said: -If resident had a change and was more aggressive, the nurse should have had close monitoring and not to let the resident out of sight. -Depending on the incident itself, the staff would look back at the documentation (nurses notes) to include in the investigation. -There was no injury as a result of the incident. -Staff and residents should be interviewed and this should be included in the investigation. 2. Record review of Resident #132's Face Sheet showed the resident was admitted to the facility on [DATE]: -With the following Diagnoses: [REDACTED]. -[MEDICAL CONDITION]. -[MEDICAL CONDITION] ([MEDICAL CONDITION] - a disease process that decreases the ability of the lungs to perform ventilation). -And was his/her own responsible party. Record review of the resident's Care Plan dated [DATE] showed: -The resident was verbally aggressive with staff and other residents. -The resident would try to manipulate staff. Record review of the resident's Behavior Note dated [DATE] showed: -The resident came to the nurse at 4:30 A.M. and wanted to file a complaint about someone stealing his/her cigarettes. -The nurse stated he/she was unaware of this matter. -The nurse asked the resident to lower his/her voice in which the resident began to get louder stating he/she did not appreciate someone stealing his/her cigarettes. -The resident went to his/her room and continued to yell for 20 minutes then came back to the nurse and said he/she had found his/her cigarettes and lighter and he/she had taken his/her [MED]gen off to go outside and smoke. -The resident was told he/she did not have permission to go out and smoke and he/she should remain in the building. -The resident stated he/she had told his/her roommate if he/she was not back in 30 minutes to call the police because he/she had stopped breathing. Record review of the resident's Social Services Notes dated [DATE] showed: -The DON and Social Services Designee B met with the resident about the smoking policy and the resident re-signed the smoking policy. -They discussed the recent event of bullying residents in the smoking area and he/she denied these allegations and stated he/she would adhere to the smoking policy. Record review of the resident's Behavior Note dated [DATE] at 9:41 A.M. showed: -The resident was speaking to his/her roommate in a very condescending tone. -The resident was going on about being accused of stealing a resident's prostitute perfume stating he/she could take that bottle of dollar[***]and shove it up his/her ass. -The resident said he/she left a dollar out on the floor so the other resident could buy a better smelling bottle of perfume for the residents. -There was no dollar in the hallway. -The resident went in the hallway then returned to the room and continued to speak to his/her roommate telling him/her he/she was paying more for a two week stay than the roommate and the roommate needed to move out of the room because his/her fat ass isn't going to tell me to shut up. -The nurse spoke with the ADON and a room move was completed for the resident's roommate because he/she was almost in tears because of constant belittling. -After a room move was completed the roommate broke down in tears and said he/she had put up with his/her ridicule until he/she talked about my family and how fat he/she was. --There was no staff documentation that showed the resident had been monitored or if the physician was notified of the resident's behaviors. Record review of the resident's Nurses Notes dated [DATE] at 7:45 P.M. showed: -The resident had repetitive statements which were upsetting other residents. -The resident continued to yell and cause other resident's to feel unsafe and irritated Resident #80 at which point he/she yelled back at the resident. -This nurse heard this and came around the corner and tried to re-direct the resident and offered to take him/her outside. -The resident was educated that he/she was upsetting others. -The resident continued to yell across the hall at Resident #80. -This nurse immediately intervened making each resident go in separate directions. -The resident went to the smoking area then went to bed. -There were no further issues. --There was no staff documentation that showed the resident had been monitored or if the physician was notified of the resident's behaviors. Record review of the resident's Nurse Notes dated 2/28/20 at 6:26 A.M. showed: -The resident came to the nurses desk this morning telling staff good morning and state he/she was getting some fresh air. -The resident was not making repetitive statements or being verbally aggressive. -At approximately 7:00 A.M. this nurse heard the resident come back from the smoking area making repetitive statements again. -The resident said he/she had hot lined the nurse. -The nurse did not say anything to the resident at that time. -The resident pushed his/her wheelchair over by the wall and continued to talk to himself/herself about multiple things. -The resident appeared to be in a repetitive loop. -These behaviors were continuous and non-stop after the resident returned from the smoking area. Record review of the resident's Nurses Note dated 2/28/20 at 6:50 A.M., showed: -The resident continued to come to the nurses station and was yelling for assistance. -The resident was asked to lower his/her tome and the resident said he/she was going to call the Administrator and let him/her know the staff were being mean to him/her and he/she had already called the State Agency (SA). -The resident was told he/she had the right to call the SA but did not have the right to be disruptive to other residents. -The resident stated he/she would continue to call the state and tell the Administrator the staff was mean to him/her until he/she got them all fired. Record review of the resident's Behavioral Note dated 2/28/20 at 8:50 A.M. showed: -The resident was sitting in his/her doorway stopping everyone and anyone who would listen to him/her that a hotline call was made because the nightshift nurse was being mean to him/her and screaming. -The hotline nurse stated they would come and do a welfare check on him/her and make sure that LPN B would lose his/her license. Record review of the resident's Nurses Note dated 2/28/20 at 11:40 A.M. showed the resident left the facility against medical advice. During an interview on 3/3/20 at 8:22 A.M., Registered Nurse (RN) A said: -The resident had been at the facility before and was normally fine. -The resident was being obnoxious and disruptive of other residents by going in and out of their rooms and being hateful. -The resident was rambling on about how his/her sister stole his/her cigarettes and money. -The resident was getting on to other residents about their television being loud. -He/she heard shouting and Resident #132 was in the hallway and Resident #80 came out of his/her room. -Multiple residents were saying shut up. -Resident #132 was yelling shut your [***] ing TV off to Resident #80. -He/She went down the hallway, came around the corner, and told the residents to stop and go to their rooms. -She stated to quit yelling and acting like children. -Resident #80 was very passive and never argued normally. -The resident had went to bed and slept through the night. -The resident had a history of [REDACTED]. -He/she thought the resident was just having a bad day based on his/her history
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation, interview and record review, the facility failed to ensure hot foods on a room tray for one sampled resident (Resident #4) was maintained at or around 120 degrees Fahrenheit (F) at the time the food was delivered to his/her room and, failed to maintain food temperatures on the steam table at or close to 135 F during the entirety of the

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F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) breakfast and noontime meals and. This practice of holding cooked food on a steam table with temperatures over 135 F overcooks the food items and lowers the nutrient levels, values and benefits of those food items, affecting all of the residents who receive hot meals from the facility's kitchen. These practices potentially affects all of the residents who receive their meals from the facility's kitchen. The facility census was 164 residents. 1. Observations on 3/4/20 between 5:05 A.M. and 1:10 P.M. in the kitchen showed the following: -Breakfast room trays were being placed in an open, metal-framed service carts with a clear plastic coverings, holding approximately 12 to 16 room trays per cart. -At 7:25 A.M., the room trays were starting to be placed into the serving cart. -At 7:45 A.M., the room trays were finished being placed on the service cart and delivered to the 300 hallway. -At 7:46 A.M., on the 300 hallway, the room trays were delivered to the various residents. -At 7:50 A.M., on the 300 hallway, food temperatures on a test tray were obtained. -The temperature of the scrambled eggs was 99.4 F (eight degrees below the standard of 120 F), cool to the touch and taste. -At 7:50 A.M., Certified Nursing Assistant (CNA) A acknowledged the temperature of the scrambled eggs was not at 120 F. During interview on 3/04/20 at 7:52 A.M. CNA A, said: -He/she did not know what the temperature of hot foods should be at the time of service. -Food issues were reported to the charge nurse who then, reports the issues to dietary. -He/she had not seen anyone take food temperatures in a long time. During interview on 3/04/20 at 8:12 A.M., Resident #79 said food is usually cold, arrives late, and the menus are the same. During interview on 3/04/20 at 8:22 A.M., Resident #70 said that the food is cold, carb heavy and not much of a variety. 2. During an observation and interview on 3/4/20 at 12:28 P.M., the Registered Dietician: -Verified the temperatures obtained of the mixed vegetables of broccoli and carrots on the steam table to be 161.5 F. -When asked of what the proper cooking and holding temperatures of vegetables were to be, she referred me to the Dietary Manager (DM). -When asked of what happened to food and vegetables when they are overcooked, she referred to the DM. During an interview on 3/4/20 at 12:32 P.M., the DM said: -That they usually sampled room trays for temperatures and tastes once a week but could not remember if they had done so in the past week. -The room tray service had some problems in the past. -The cook should taste the foods for temperatures and tastes. -Taking cooked foods' temperatures at the oven or stove should indicate whether they were sufficiently cooked or overcooked. -The cook should taste the food for temperatures and tastes. -Taking cooked foods' temperatures at the oven or stove should indicate whether they were sufficiently cooked or overcooked. -Steam table temperatures should not be more than 160 F. -When foods and vegetables are overcooked, they lose their nutrient values. Record review of the 2013 edition of the Food and Drug Administration (FDA) Food Code Chapter 3-202.11, showed, (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under Section 3-501.19, and except as specified under paragraph (B) and in paragraph (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (Celsius) (135 F) or above (for hot foods), except that roasts cooked to a temperature and for a time specified in paragraph 3-401.11(B) or reheated as specified in paragraph 3-403.11(E) may be held at a temperature of 54 C (130 F) or above; or (2) At 5 C (41 F) or less (for cold foods). Record review of the 2013 edition of the FDA, Chapter 3-401.13, showed, Fruits and vegetables that are fresh, frozen, or canned and that are heated for hot holding need only to be cooked to the temperature required for hot holding. These foods do not require the same level of microorganism destruction as do raw animal foods since these fruits and vegetables are ready-to-eat at any temperature. Cooking to the hot holding temperature of 57C (135F) prevents the growth of pathogenic bacteria that may be present in or on these foods. In fact, the level of bacteria will be reduced over time at the specified hot holding temperature.
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure ample amounts of food on the regular menu was prepared to serve all residents, including sampled residents (Resident's #80 and #369), and to ensure regular food preference items were available at meal time for two sampled residents (Resident's #52 and #146) out of 32 sampled residents. The facility census was 164 residents. Record review of the facility's Dietary: Resident Preference Interview policy, revised February 2019, showed: -Staff would complete the dietary questionnaire upon admission, readmission and no less than annually to capture the resident's dietary preferences. -The tray card would reflect resident preferences. 1. Record review of Resident #80's face sheet showed he/she was admitted to the facility 10/25/19. Record review of the resident's Quarterly Minimum Data Sheet (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 1/19/20 showed. -The resident had a Brief Interview of Mental Status (BI[CONDITION]) of 15 showing he/she was cognitive intact. -He/she had no special nutrition approaches noted. Observation on 3/2/20 at 9:10 A.M., showed: -The resident received his/her breakfast. -Staff delivering room trays told the resident he/she was getting toast and gravy because the kitchen ran out of biscuits for the biscuits and gravy. -Note: Biscuits and gravy was the main item on the breakfast meal. During an interview on 3/2/15 at 10:15 A.M., the resident said: -He/she gets a room tray at all meals. -He/she was on a regular diet. -This morning the dietary department ran out of biscuits and gravy, and he/she had to have toast and gravy. -Last night he/she asked for chocolate milk, but they were out of chocolate milk. -He/she has to go to the kitchen almost every day to complain because he/she is not served double portions as ordered, and staff does not get his/her meal order right. 2. Record review of Resident #369's face sheet showed he/she was admitted to the facility 2/28/20. Record review of the resident's medical record did not show specific orders for his/her diet. During an interview on 3/2/20 at 10:22 A.M., the resident said: -He/she discharged from the hospital and came to the facility three days ago. -He/she was not able to get the biscuits and gravy that was on the menu for breakfast. -Nothing seemed to have gone well since he/she arrived late Friday evening. 3. Record review of Resident #52's face sheet showed he/she was admitted to the facility 6/18/15. Record review of the resident's Quarterly MDS dated [DATE], showed he/she: -Was cognitively intact. -Had a poor appetite. -The resident weighed under 100 pounds. Record review of the resident's Care Plan showed: -A focus area initiated 1/3/19, revised 1/7/19, stating the resident had a behavior problem: His/her goal was to gain weight, but he/she was refusing to eat food he/she requested from dietary. -The resident made continuous calls to the staff to report food and weight concerns. Record review of the resident's Nutrition/Dietary Note dated 8/12/19, showed: -The resident was on a regular diet with regular textures. -The resident reported he/she had a good appetite, but does not like the food. -The resident did not like pork, milk or eggs. -The resident had a wide range of intakes. Observation on 3/4/20 at 6:57 A.M. showed Certified Nurse Assistant (CNA) K taking resident's order for the breakfast meal. During an interview at 6:59 A.M., CNA K said: -The staff goes to the residents to ask what they would like for breakfast before the residents go to the dining room. -They also take meal orders for room tray service. Observation on 3/4/20 at 8:10 A.M. showed the resident receiving his/her breakfast. -The resident received 2 slices of white toast with no butter, oatmeal and water. -The resident did not want the breakfast because it was not what he/she ordered. Review on 3/4/20 of the resident's breakfast meal order ticket showed the resident ordered three slices of crispy wheat toast with very little butter, oatmeal with brown sugar and three cups of water with no ice. Observation on 3/4/20 at 8:15 A.M., showed the Interim Administrator came in to talk with the resident about his/her breakfast. -The Interim Administrator was assisting in the kitchen. -He/she told the resident they were out of brown sugar and wheat bread, and offered the resident something else. Observation on 3/4/20 at 8:24 A.M., showed the Director of Nursing (DON) delivered three slices of toast covered in butter that was not melting. During an interview on 3/4/20 at 8:25 A.M. the resident said: -The staff thinks he/she is too finicky, but he/she does not like white bread and they seem to not be able to get the orders correct. -The kitchen runs out of staple items often, like the brown sugar. -It seems to have been worst lately. -His/her family is bringing in food for him/her a couple of times a week so that he/she can eat and enjoy the food. -He/she likes to eat, but what he/she eats matters to him/her. -My order specifically said very little butter and the substitute toast came slathered in butter. Observation of the preparation of the noon meal on 3/4/20 at 11:35 A.M. showed: -The DON requested a grilled cheese sandwich on wheat toast for a resident. -The dietary aide informed the DON that they were out of wheat bread. -The dietary aide said they were expecting a food delivery the next morning. 4. Record review of Resident #146's face sheet showed he/she was admitted to the facility 8/9/18. Record review of the resident's Quarterly MDS dated [DATE], showed: -The resident had a BI[CONDITION] of nine, indicating mild cognitive impairment. -The resident had no special nutritional approaches noted. Observation on 3/5/20 at 9:40 A.M., showed the resident received a room tray for the breakfast meal, but did not get what he/she ordered. -A staff member came in to let the resident know he/she would need to order something different because they ran out of oatmeal. -The resident said he/she likes oatmeal for breakfast. -CNA K said to the resident he/she knew the resident liked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265727	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REDWOOD OF CARMEL HILLS	810 EAST WALNUT INDEPENDENCE, MO 64050

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F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) oatmeal and tea every morning. -The resident asked, How did they run out of oatmeal? -CNA K said he/she did not know how they ran out of oatmeal, but cream of wheat was available. -CNA K asked the resident to try cream of wheat. -The resident agreed to try the cream of wheat. -A staff member delivering the cream of wheat to the resident told the resident he/she brought him/her some brown sugar to add to the cream of wheat to possibly make it better. During an interview on 3/5/20 at 10:19 A.M., the resident said: -He/she tried to eat the cream of wheat he/she was served after finding out the kitchen staff ran out of oatmeal. -He/she could not eat the cream of wheat because he/she did not care for cream of wheat. During an interview on [DATE] at 1:00 P.M., the DON said: -He/she would expect the dietary staff to have enough food prepared for residents to receive what is on the menu. -There was actually wheat bread in the kitchen. -Dietary had new management staff.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review, the facility failed to properly store food in the refrigerated walk-in unit and to practice sanitary procedures before food preparation tasks. These practices potentially affects an unknown number of residents who received their meals from the facility's kitchen. The facility census was 164 residents. 1. Observations on 3/4/20 between 5:05 A.M. and 1:10 P.M. in the kitchen showed the following: -At 5:05 A.M. in the kitchen, tomatoes and pickles stored on a shelf out their original containers in the refrigerated walk-in unit, were not dated as to when they were opened or how long they had been opened. -The floors near the food preparation table, the electrical floor outlet near the steam table and floors surrounding the steam table were greasy, visibly and to the touch. -There were two pieces of juice dispensing equipment, both with one nozzle connected to each to each of them, dispensing beverages of orange juice, a lemon beverage, cranberry juice, nectar honey and water. These nozzles were sticky with multi-colored debris on the inside and outside of the nozzles. -The gray-colored, trashcans and lids contained sticky, red debris on the outer sides of the containers and their lids. -Several utensils with rubberized handles were either chipped, cracked, missing their protective coating or all of those characteristics, making it difficult to clean and sanitize the utensils for use. -The spice containers were dirty, grimy and greasy to the touch. -The rubberized floor mats used surrounding the dish wash and 3-compartment sink areas were dirty and greasy. -The gray-colored trashcan and lid located in the rehabilitation dining room under the big clock contained sticky, red debris on the outer sides of the container and its lid. -At 12:59 P.M. and 1:03 P.M., two different dietary aides went from the serving/steam table area to discard trash, opened the gray-colored trashcan's lid with their gloves on, and returned directly to the serving/steam table area to continue touching plating and serving food without washing their hands. During an interview on 3/4/20 at 1:08 P.M., the Dietary Manager said: -The kitchen floors and dish mats were not cleaned properly by the previous (night) shift. -The nozzles of the juice and beverage dispensing equipment and spice containers were not listed on any cleaning schedules, but would be placed on one. -The gray-colored trashcans and their lids were on a weekly cleaning schedule, but he did not think that they were cleaned in the previous week. -The dietary staff will be in-serviced on hand-washing techniques when handling trash to be discarded in the gray-colored trashcans. Record review of the facility's kitchen equipment cleaning schedule (undated), showed the nozzles of the juice and beverage dispensing equipment and spice containers were not listed on the cleaning schedules. Also, the kitchen and dish-washing area floor mats were supposed to be cleaned nightly with the gray-colored trashcans and their lids cleaned on a weekly basis or as needed. Record review of the 2013 edition of the Food and Drug Administration (FDA) Food Code Chapter 2-301.14, showed, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under (Section) 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLESERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in (paragraph) 2-403.11(B); (D) Except as specified in (paragraph) 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands. Record review of the 2013 edition of the FDA Food Code Chapter 3-501.17, showed, (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under (Section) 3-502.12, and except as specified in (paragraphs) (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5C (41F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (paragraphs) (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (paragraph) (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. Record review of the 2013 edition of the FDA Food Code Chapter 4-601.11, showed, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. Record review of the 2013 edition of the FDA Food Code Chapter 4-602.11, showed, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned: (1) Except as specified in (paragraph) (B) of this section, before each use with a different type of raw animal FOOD such as beef, FISH, lamb, pork, or POULTRY; (2) Each time there is a change from working with raw FOODS to working with READY-TO-EAT FOODS; (3) Between uses with raw fruits and vegetables and with TIME/TEMPERATURE CONTROL FOR SAFETY FOOD; (4) Before using or storing a FOOD TEMPERATURE MEASURING DEVICE; and (5) At any time during the operation when contamination may have occurred. Record review of the 2013 edition of the FDA Food Code Chapter 4-602.11, showed, Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues.
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep all essential equipment working safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that the facility's kitchen range hood (an open metal enclosure over cooking surfaces through which air is drawn in from the surrounding spaces to exhaust heat and grease, and to control the flow of rising hot air into the range hood and filter grease) exhaust fan was in operational and functional condition. By having a faulty exhaust system the facility is placing in jeopardy the entire kitchen staff of smoke inhalation and the risk of grease building up in the hood creating a fire thus, affecting and the facility residents. The facility census was 164 residents. 1. Observations on 3/4/20 between 5:05 A.M. and 1:10 P.M. in the kitchen, showed the kitchen range hood's exhaust system non-functional and non-operational. During an interview on 3/4/20 at 6:05 A.M., the Dietary Cook said that he/she had been working at the facility for approximately two to three weeks and since that time, the range hood exhaust fan has not worked. During an interview on 3/4/20 at 6:10 A.M., the Maintenance Director said the faulty part of the range hood exhaust fan was a relay switch and had been on order for about one week now. During an interview on 3/4/20 at 12:28 P.M., the Dietary Manager said that the faulty part of the range hood exhaust system was ordered on [DATE]. Record review of the 2013 edition of the Food and Drug Administration (FDA) Food Code Chapter 4-301.14, showed, If a ventilation system is inadequate, grease and condensate may build up on the floors, walls and ceilings of the food establishment, causing an insanitary condition and possible deterioration of the surfaces of walls and ceilings. The accumulation of grease and condensate may contaminate food and food-contact surfaces as well as present a possible fire hazard.