| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **105238** | A. BUILDING _____ B. WING _____ | **03/14/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **HERITAGE PARK REHABILITATION AND HEALTHCARE** | **2826 CLEVELAND AVE FORT MYERS, FL 33901** |

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) |
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| F 0578<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to follow resident advanced directives for 1 (Resident #909) of 6 resident records reviewed. Failure to follow the resident's advanced directive removed any chance of resuscitation after a cardiopulmonary arrest. The survey found Resident #909 was full code status and was found unresponsive in early morning hours of [DATE]. The staff nurse on duty did not perform cardiopulmonary resuscitation (CPR) or call [DATE]. On [DATE] at about 2:00 p.m., the Administrator was informed of the Immediate Jeopardy which began [DATE]. The facility developed and implemented a corrective action plan. Based on verification of the facility's corrective actions, the Immediate Jeopardy was removed [DATE] when all the available staff were trained, and mock drills were conducted. This lowered the scope and severity to D. The findings included: A review of the facility policy for Cardiopulmonary Resuscitation, N-302, revised [DATE] revealed Cardiopulmonary Resuscitation (CPR) will be provided to all residents who are identified to be in [MEDICAL CONDITION] unless such resident has a valid Do Not Resuscitate (DNR) order. Under the procedure section of the policy, item 2 indicated two licensed nurses are to verify Resident Identity and current physician order for [REDACTED].#909 revealed the resident was admitted to the facility on [DATE]. The physician orders revealed Resident #909 was a full-code (perform cardiopulmonary resuscitation in the event of a cardiopulmonary arrest). The orders were signed by the resident's physician. There was no Do Not Resuscitate (DNR) form present in the record. A Daily Skilled Nurse's Note dated [DATE] at 5:45 a.m., read Upon AM (morning) rounds resident in bed without respirations or heartrated (sic); DNR (Do Not Resuscitate) in place, son notified & confirmed DNR status; body cleaned dressed, son stated he will call facility back w/ funeral home info. The nurse's note was signed by Staff SS Registered Nurse (RN). The baseline plan of care, dated [DATE], revealed Resident #909 was listed as a full-code. The last page of the baseline care plan has an acknowledgement that reads Below are completion signatures and dates of those participating in the initial care plan development and summary. The document is signed by an unidentified Licensed Practical Nurse (LPN) and TO (unknown who TO is) with Resident #909's son's name printed on the representative signature line. On [DATE] at 11:10 a.m., Staff SS RN said she thought Resident #909 was a DNR. She said she verified code status when she spoke with Resident #909's son. She acknowledged she did not perform CPR on Resident #909. On [DATE] at 11:15 a.m., the Administrator confirmed there was no DNR form present on Resident #909's chart. She also confirmed the resident was a full-code at the time of his death. On [DATE] at 2:45 p.m., Resident #909's physician confirmed the resident was a full-code. The physician said if the order reads full-code then he's a full-code. He said he learned of Resident #909's death when he arrived at the facility on [DATE] at 11:00 a.m. He said no one called and informed him at the time of death. On [DATE] at 11:45 a.m., Resident #909's son and emergency contact said when his father resided at a sister facility in Naples, he discussed advance directives with them. He said he wanted them to do everything possible to save his life in case of [MEDICAL CONDITION] including CPR. Resident #909's emergency contact said no one from the facility ever called him to discuss anything. He said they did not even call to give him the room number where he was admitted to. Resident #909's son said the only phone call he got from the facility was on [DATE] around 4:00 a.m., to 5:00 a.m., to inform him of his father's passing. He said he has a lot of questions regarding his father's death but no one from the facility has called him to explain what happened. |
| F 0600<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, review of the facility's abuse and neglect policy, residents and administrative staff interviews and observation, the facility neglected to implement adequate and individualized interventions to address [MEDICAL CONDITION] resulting in risky behaviors, multiple falls and self-harm for 3 (Residents #67, #71, and #86) of 3 residents reviewed with [MEDICAL CONDITION]. In addition, the facility neglected to intervene and protect 2 (Resident #9 and #95) of 2 residents interviewed from repeated physical abuse from Resident #67 who was running into other residents with his motorized wheelchair when impaired. The on-going neglect of the facility to address Resident #67, #71, and #86's behavior when intoxicated or impaired and the failure to protect vulnerable residents from repeated physical abuse from Resident #67 resulted in immediate jeopardy starting on [DATE]. The Administrator was notified of the immediate jeopardy on 3/12/20 at 4:45 p.m. The immediate jeopardy was removed on 3/14/20 at 2:30 p.m., after credible evidence of measures taken. The severity was subsequently reduced to a E. The findings included: Cross reference to F607, F689, and F835. The facility policy N-1265, Abuse, Neglect, Exploitation and Misappropriation (revised 11/28/17) specified, It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment and exploitation .abuse is the willful infliction of injury, . intimidation . with resulting physical harm . or mental anguish. The facility policy S-332, Motorized Wheel Chairs-Scooters (11/30/14) specified, the operation of motorized wheelchairs/scooters will be restricted to residents that can demonstrate, through assessment, that they can safely operate the motorized device within the facility and outside grounds of the property .4. Residents will be re-assessed . upon incidents involving harm or injury to persons . 5. The safety of all persons in the facility is the primary concern when motorized wheelchairs/scooters are operated . the privilege to operate motorized wheelchair may be terminated upon occurrence of: A. Any injury to a person caused by the operation of the motorized wheelchair/scooter. B. Violation of any safety guidelines listed in this policy. C. Decrease in the resident's ability to operate the wheelchair safely as determined by re-assessment. 1. Review of the clinical record revealed Resident #67 was admitted to the facility on [DATE] with a medical history that included: [MEDICAL CONDITION], chronic pai[DIAGNOSES REDACTED], [DIAGNOSES REDACTED], repeated falls, depression. Review of the Nursing Progress notes revealed the following documentation: On 1/13/19 at 7:30 a.m., Staff noted blood on the bedspread. Resident said he had an altercation with another resident. The nursing progress notes documented Resident #67 was intoxicated and drinking alcohol on the facility premises 13 times from 4/9/19 through 2/28/20 despite education from the staff. On 7/18/19, the facility initiated a care plan indicating Resident #67 makes inappropriate sexual comments to female residents. The nursing progress notes documented Resident #67 was found on the floor a total of 5 times from 10/12/19 through 11/1/19. The documentation revealed Resident #67 had the smell of alcohol on his breath at the time of each incident. On 1/1/20 at 6:30 a.m., Resident #67 was found by staff lying on the grass (unknown where exactly) with 5 cans of empty cans of beer. He was incontinent of urine, verbally abusive to staff |

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 0600<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 1)<br>attempting to help him back in his w/c. A message was left for physician. On 2/28/20 at 1:45 a.m., the nurse was called to the patio by another resident. Resident was drinking beer and running into other residents with his motorized chair. They took him to his room and put him to bed. On 3/7/20 at 11:30 p.m., the nurse was called into the long hall because resident was running into other residents with his motorized chair. They took him to his room, but he left and went back outside and refused care. On 3/8/20 at 12:45 a.m., the nurse was called back outside to the patio by another resident, Resident #67 was intoxicated. He had a bag of beer hanging on his motorized wheelchair. He was using that chair to run into people and slamming into the chairs to make the chairs push into other people. Resident was told to stop. He yelled out F . you and tried to run over this nurse. Multiple attempts to redirect unsuccessful. Beer was removed from chair and he continued to curse, gestures and language. On 3/8/20 at 1:00 a.m., Nurse was called to patio again. Resident threatening other residents and attempting to hit them with his chair. Resident was removed and taken to the 3rd floor and the police were called.<br>Review of the care plan (provides direction for individualized care of the patient) for Resident #67 revealed Resident #67 was resistive to care due to alcohol intake and poor impulse control. On 3/10/20 at 5:35 p.m., the Administrator said residents sign out and if they are their own person, they are responsible for themselves. If they are drinking alcohol, they are educated and are offered Alcohol Anonymous. They also offered psychiatric services. If they drink alcohol on the property they are educated again, and staff take the alcohol away from them. The Administrator said the facility does not have a policy addressing the use of alcoholic beverages on the premises or the safety of residents when they leave the building. In an interview on 3/10/20 at 5:56 p.m., the administrator said, What can I do? A review of the facility Sign Out Log revealed Resident #67 had not signed himself out of the facility in the last 6 months. On 3/11/20 at 10:24 a.m., in an interview, the Physical Therapist said Resident #67 was assessed on 2/12/20 for the safe operation of the motorized wheelchair. The Physical Therapist said he was not aware Resident #67 was drinking alcohol and said the resident would not be safe to operate the motorized wheelchair when intoxicated. On 3/11/20 at 9:35 a.m., in an interview, Resident #95 said every time he was on the outside patio and Resident #67 sees him, he will yell and curse at him and try to run into his wheelchair with his motorized wheelchair. Resident #95 said I am really afraid of the guy. Resident #95 said when Resident #67 drinks, he is mean, and he scares me. Resident #95 said, Resident #67 drinks alcohol on the patio and the staff does not stop him. The resident said he reported the drinking and his safety concerns to the Administrator and Director of Nursing on multiple occasions. He said there were no staff on the patio to monitor the safety of residents. Resident #95 said he is not able to go out on the patio and enjoy himself because he does not know what Resident #67 will do to him, and if things continue, he would contact the police. On 3/11/20 at 11:05 a.m., in an interview Resident #9 said Resident #67 tried to run his motorized wheelchair into her on 3/8/20 and she had to put her walker in front of her to stop him. Resident #9 said she was fearful he would have hit her. Resident #9 uses a walker to ambulate and said Resident #67 was always running into her, so she uses the walker to block him. Resident #9 said when someone is running their motorized wheelchair into me, I feel unsafe. The resident said, when Resident #67 was intoxicated on the outdoor patio he would curse and yell at her. Resident #9 said she had reported Resident #67 to the Administrator, Director of Nursing and the unit nurse on multiple occasions. She said she called the Administrator on 3/8/20 and reported Resident #67's behavior on the patio. Resident #9 said she left the patio and went to the third floor of the facility to use the phone and Resident #67 tried to run his motorized wheelchair into her while she was on the phone. Resident #9 said she had to contact the police because she was afraid for her safety. On 3/11/20 at 11:20 a.m., in an interview, the Social Service Director said she tried to offer sober support to Resident #67. The Social Service Director said when she notices Resident #67 outside drinking alcohol, she doesn't approach him because the resident usually drinks in an empty lot that is not on the facility's premises. The Social Service Director said Resident #67 was his own person. She said she didn't know how he got the alcohol but all she can do is encourage him not to drink. The Social Service Director said, We have no consequences in place for his drinking or behavior. The Social Service Director added I heard the police were called on 3/8/20 to deal with Resident #67 about his drinking and because he was belligerent. I heard about it from other residents who said Resident #67 was drinking and banging around, a nurse said he smelled of alcohol. I believe there was one report about him running into residents. I did not investigate this with Resident #9. The Social Service Director said she said she would speak with Resident #95 about his concerns with Resident #67. The Social Service Director said, I was hoping the police would have put him jail so he would learn his lesson and know that would be the consequence if he acted up again and didn't change his behavior. On 3/12/20 at 12:45 p.m., in an interview the attending physician said he was aware Resident #67 consumed alcohol. He said it is our responsibility and liability for them. If the residents are drinking and off the premises and are impaired it is our responsibility and they are not safe.<br><br>2. In an interview on 3/11/20 at 12:06 p.m., Licensed Practical Nurse (LPN) Staff Q said Resident #71 does go out in his wheelchair and will go across the street to convenience stores. She said Resident #71 goes out with 2 other residents and they will come back intoxicated almost every night. Resident #71 does need assistance and will be incontinent when he is impaired. Staff Q said Resident #71 has fallen into the bushes and EMS has called and notified staff of resident being transferred to the emergency room (ER). Staff Q said the residents do not wear any identification bracelets. Staff Q said residents are to sign out with the nurse or receptionist downstairs and if do not return will call numbers on the face sheet and hold the bed for 8 days if Medicaid. On 3/11/20 at 3:41 p.m., Resident #71 was not observed in his room or on the unit. In an interview with LPN Staff Q at the time of the observation, she said Resident #71 had signed out at 3:20 p.m. In an interview on 3/11/20 at 3:53 p.m., LPN Staff R said Resident #71 has falls, skin tears, he sneaks beer into his room, and has to look for him up and down road where people have seen him drunk or in a bush somewhere. The resident will come back at night with skin tears, slurring his speech, and smelling of heavy alcohol use. The Administrator and Director of Nursing are aware. People in the community are calling the facility saying someone is outside under the tree drunk. Resident #71 will just slide out of his chair onto the floor when he is impaired, and it takes several staff to pick him up. She has never worked at a place where residents can spend most of the day out drinking and then staff has to deal with them when they come back intoxicated. In an interview on 3/12/20 at 8:45 a.m., Resident #71 said he goes outside in his wheelchair to get some sunshine with a few friends. The resident was observed to have a dressing on his left arm and said was a skin tear where he must have bumped into something. The resident said he does need help bathing and getting dressed. The resident said he has slipped out of his chair in the bathroom and acknowledged he had fallen when outside of the facility. Resident #71 said he has double vision and cannot always see the edge of the sidewalk and has fallen into the bushes and one time he did fall into the road. The resident said he has no way to contact the facility so relies on someone to stop their car and help him back up into his chair. He said staff have also come to look for him when he has fallen and not been able to get up off the ground. Resident #71's clinical record revealed [DIAGNOSES REDACTED]. An after-visit hospital summary, dated 1/13/19, indicated the resident had been in the ER for a closed head injury after a fall from his wheelchair, [MEDICAL CONDITION] and left arm swelling. The attached information defined [MEDICAL CONDITION] as when the amount of alcohol consumed impairs the ability to mentally and physically function. Alcohol directly impairs the normal chemical activity in the brain and can cause drowsiness, stupor, [MEDICAL CONDITION], and coma. [MEDICAL CONDITION] can also lead to dangerous and life-threatening activities. A review of the Interdisciplinary Progress Notes for Resident #71 revealed the following: On 6/16/19 at 4:00 p.m., the resident was observed with a can of beer, slurred speech and yelling/cursing at staff. At 4:30 p.m., the resident was observed in the hallway without a brief refusing any help from staff. The resident was cursing/yelling/screaming at staff while drinking alcohol/liquor. When nurse attempted to remove liquor, resident stated no and continued the behavior. At 9:00 p.m., the resident was observed sitting in his wheelchair drinking a can of beer in his room. The resident's speech was slurred and after talking with the resident he gave the can of beer to the nurse. On 8/13/19 at 10:35 p.m., Resident #71 was not in the facility. Staff went outside to look for the resident and observed him across the street. Staff had to cross the street to find the resident sitting in the car lane in front of a car dealership. The resident was covered in beer, had an open can of beer in his hand and 5 cans in his bag. Staff returned to resident to the facility. The resident was slurring his words, smelled of alcohol, and was unable to hold up his arms without assist. On 8/17/19 at 10:30 p.m., Resident #71 had not returned to the facility. Staff searched inside and out of the facility and could not locate him. Staff searched down the street and found the resident in front of the hospital parking lot in a bush. The resident had multiple skin tears, scratches across his back, and bruising on his right buttock and upper body. The resident said he fell off the sidewalk into the bush. Heavy smell of alcohol was noted, and the resident was drinking in the bush when found. On 11/2/19 at 9:30 p.m., Resident #71 was found on the floor in his room at 7:45 p.m. saying he slipped out of his chair. The resident appeared to be intoxicated and smelled of alcohol. The DON |

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| F 0600<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | (continued... from page 2)<br>was notified of the event. On 11/3/19 at 9:20 p.m., Resident #71 was intoxicated again at 5:00 p.m. medications held and placed on 30-minute checks. On [DATE] at 2:00 p.m., Staff received a call from EMS reporting Resident #71 had a fall in the bushes and was being taken to the emergency room (ER). A review of the hospital History and Physical dated [DATE], revealed the resident was brought to the ER with acute [MEDICAL CONDITION] after a fall out of his wheelchair into the bushes. The resident had altered mental status. [MEDICAL CONDITION] Fibrillation and was incontinent of urine. The history noted the resident has been admitted to the ER many times in the past for same reason. On 11/12/19 at 12:20 p.m., the resident was readmitted to the facility. At 10:50 p.m., the nurse noted the resident returned from outside after dinner time. Staff heard him throwing his dinner tray against the wall. Upon entering the room, the resident was angry and cursing. The resident's roommate said Resident #71 came over to his bed to attack him and tried to pull him out of bed. States they hit each other. On 12/10/19 at 1:00 p.m., the resident was given a [MEDICATION NAME] 5-325 milligrams (an opioid) pain pill for complaint of pain. At 1:15 a.m., Resident #71 was observed in his room opening a can of beer and drinking through a straw. Resident refused to give up the can of beer and the DON was notified. Drinking alcohol while taking powerful opioid painkillers can trigger a potentially deadly respiratory problem. (Opioids and Alcohol a Dangerous Cocktail: https://www.webmd.com/mental-health/addiction/news/ 208/opioids-and-alcohol-a-dangerous-cocktail) On 1/3/20 at 6:30 p.m., the resident was noted to have slurred speech, impairment, and smelled of alcohol noted upon return to the unit. Medications were held per doctors' orders. On 1/11/20 at 12:00 p.m., Resident #71 was administered the medication [MEDICATION NAME] for pain. At 1:00 p.m., the resident presented with slurred speech, smelled of alcohol, and was demanding the nurse give him another pain pill. On 2/4/20 at 7:35 p.m., the nurse received a phone call from another resident stating Resident #71 was laying on the highway, and two men tried to pick him up but couldn't, so they called 911. At 8:00 p.m., the resident was brought back to the facility by EMS/firefighter who reported the police noted the resident fell off the curb 2 blocks away. The resident was taken back to the unit cursing at staff and noted to smell of heavy alcohol. On 2/8/19 at 9:30 p.m., Resident #71 was non-coherent and is drunk. Scheduled medications were held. In an interview on 3/12/20 at 11:25 a.m., the Administrator said there is no set policy against drinking on the property but is addressed in the Welcome packet. The Administrator acknowledged she really doesn't know where Resident #71 goes when he leaves the property.<br><br>3. During an interview on [DATE] at 9:35 a.m., Resident #86 said she was in the hospital recently because she fell out of her motorized wheelchair. Resident #86 said she can't walk and is dependent on her wheelchair for mobility. Review of the clinical record revealed a Care Plan initiated on 2/1/19 indicating Resident #86 is non-compliant with facility (alcohol) drinking policy, disguises alcohol in containers. Interdisciplinary Progress Notes for Resident #86 revealed the following: On 9/8/19 at 5:00 p.m., Resident #86 was in a parking lot area next door, lying prone with the right side of her face on the concrete (ground). A passerby called 9-1-1 to get medical attention for Resident #86. There were beer cans on the ground at the scene of the fall. Resident #86 obtained a laceration to right eyebrow. There was a moderate amount of bright red blood to the area and a bruise to right cheek bone. Resident #86 was transported to the hospital via ambulance. The hospital Summary of Care dated 9/8/19 noted Resident #86 was admitted to the Emergency Department (ED) with [DIAGNOSES REDACTED]. On 9/23/19 at 6:00 p.m., Resident #86 was extremely impaired sitting on her motorized scooter. Resident #86 had ridden the scooter into her dresser and pushed it around the corner to her closet. Resident #86 tipped the overbed table and spilled water all over the floor and her laundry bag. Resident #86 had pushed her roommate's bed into the nightstand. Resident #86 almost ran into another resident in the hallway. On 10/8/19 at 1:30 p.m., Resident #86 was in her room alone drinking a large can of beer with a straw. Resident #86 was clearly impaired with slurred speech .smells of alcohol. The hospital Summary of Care dated 12/7/19 noted Resident #86 was admitted to the ED with [DIAGNOSES REDACTED]. On 12/10/19 at 12:30 p.m., the administrator met with Resident #86 to discuss frequent issues at night. Resident #86 is leaving center and her motorized wheelchair runs out of charge and she is stuck. The hospital Summary of Care dated 1/3/20 noted Resident #86 was admitted to the ED with [DIAGNOSES REDACTED]. On 1/29/20 the Social worker documented Resident #86 understands/responds and makes herself understood. Resident #86 continues to leave the property and returns impaired. Education ongoing. On [DATE] at 1:30 p.m., Resident #86 was impaired while in motorized scooter. On 2/11/20 Resident #86 was found on floor in bathroom bleeding. Resident #86 had been outside drinking beer. On 3/10/20 at 5:00 p.m., Resident #86 was yelling at the administrator, clearly impaired, and insisted going on leave of absence from the facility. The administrator signed Resident #86 out of the facility. During an interview on 3/11/20 at 5:12 p.m., the Administrator said Resident #86 signed out on 3/10/20 and has not returned to the facility. The Administrator admitted she had not done anything about it yet. She said she had not notified the police. Resident #86 had been gone for over 24 hours. After the interview, the Administrator contacted the police and the family. The family reported Resident #86 was at her boyfriend's place. |
| F 0607<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | **Develop and implement policies and procedures to prevent abuse, neglect, and theft.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, observation, resident and staff interview, the facility failed to operationalize their abuse policy and procedure, by failure to protect residents and prevent repeated physical abuse and subsequent injury for 2 (Residents #9 and #95) of 2 residents from Resident #67's physically aggressive behavior. The facility failed to develop a policy for residents related to resident alcohol and substance abuse. The facility failed to address the risky behavior of [MEDICAL CONDITION] of 3 (Residents #67, #71 and #86) of 3 residents reviewed. The on-going failure of the facility to address residents engaging in risky behaviors, such as [MEDICAL CONDITION], and the failure to protect Resident #9 and #95 from the repeated physical abuse from Resident #67's aggressive behavior resulted in Immediate Jeopardy starting on [DATE]. The Administrator was notified of the immediate Jeopardy on 3/12/20 at 4:45 p.m. The Immediate Jeopardy was removed on 3/14/20 at 2:30 p.m., after credible evidence of measures taken to correct the immediate jeopardy. The severity was subsequently reduced to a E. The findings included: Cross reference to F600 and F689. The facility policy N-1265, Abuse, Neglect, Exploitation and Misappropriation (revised 11/28/17) indicated Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include but are not limited to; .Failure to report observed or suspected abuse, neglect or misappropriation of resident property to the proper authorities . Non-action, which results in emotional, psychological or physical injury, is viewed in the same manner as that caused by improper or excessive action . Furthermore, the Administration of The Company recognizes that resident abuse can be committed by other residents, visitors, or volunteers . An employee shall be deemed to have violated his obligations . if he does any of the following: .Fails to report an incident of abuse witnessed by or known to him/her . The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation . Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations.<br><br>1. Clinical record review revealed Resident #71 [DIAGNOSES REDACTED]. A review of the interdisciplinary Progress Notes revealed on 11 different occasions (6/16/19, 8/13/19, 8/17/19, 11/2/19, 11/3/19,[DATE], 12/10/19, 1/3/20, 1/11/20, 2/4/20, [DATE]) Resident #71 was observed with beer, smelled of alcohol with slurred speech. On 2 different occasions, (8/13/19 and 8/17/19), Resident #71 was not in the facility. On 8/13/19 at 10:35 p.m., Staff had to cross the street to find the resident. He was covered in beer, had an open can of beer in his hand and 5 cans in his bag. Resident #71 was unable to hold up his arms without assist. On 8/17/19 at 10:30 p.m., staff found the resident in front of the hospital parking lot in a bush. The resident had multiple skin tears, scratches across his back, and bruising on his right buttock and upper body. The resident said he fell off the sidewalk into the bush. Heavy smell of alcohol was noted, and the resident was drinking in the bush when found. On 2 more occasions ([DATE] and 2/4/20), Resident #71 was off the premises, sustained a fall and 911 was called. A review of the hospital History and Physical dated [DATE], revealed the resident was brought to the ER with acute [MEDICAL CONDITION] after a fall out of his wheelchair into the bushes. The resident had altered mental status. [MEDICAL CONDITION] Fibrillation and was incontinent of urine. The history noted the resident has been admitted many times for same. On 2/4/20 at 7:35 p.m., the nurse received a phone call from another resident stating Resident #71 was laying on the highway, and two men tried to pick him up but couldn't, so they called 911. In an interview on 3/12/20 at 11:25 a.m., the Administrator said there was no set policy against drinking on the property but was addressed in the Welcome packet. The Administrator acknowledged she really didn't know where Resident #71 went when he left the property. |

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| | **105238** | A. BUILDING _____ B. WING _____ | **03/14/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **HERITAGE PARK REHABILITATION AND HEALTHCARE** | **2826 CLEVELAND AVE FORT MYERS, FL 33901** |

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 0607<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 3)<br>2. Review of the clinical record revealed Resident #67 was admitted to the facility on [DATE] with a medical history that included [MEDICAL CONDITION], repeated falls, depression. The Nursing Progress notes revealed the following documentation: On 1/13/19 at 7:30 a.m., Staff noted blood on the bedspread. Resident said he had an altercation with another resident. The nursing progress notes documented Resident #67 had beer, was intoxicated and drinking alcohol on the facility premises 13 times from 4/9/19 through 2/28/20 despite education from the staff. On 7/18/19, the facility initiated a care plan indicating Resident #67 makes inappropriate sexual comments to female residents. Resident #67 was found on the floor while intoxicated on 10/12/19, 11/1/19, 11/24/19 and twice on 11/25/19. On 2/28/20, 3/7/20 and 2 occasions on 3/8/20, the documentation revealed Resident #67 was intoxicated on the premises, yelling and cursing at staff and residents and running into other residents with his motorized chair. Review of the care plan (provides direction for individualized care of the patient) for Resident #67 revealed Resident #67 was resistive to care due to alcohol intake and poor impulse control. In an interview on 3/10/20 at 5:35 p.m., the Administrator said if the resident is their own person, they sign out of the facility and are responsible for themselves. The Administrator confirmed the facility does not have a policy addressing the use of alcoholic beverages on the premises or the safety of residents when they leave the building while intoxicated. A review of the facility Sign Out Log revealed Resident #67 had not signed himself out of the facility in the last 6 months. In an interview on 3/11/20 at 10:24 a.m., the Physical Therapist said Resident #67 was assessed on 2/12/20 for the safe operation of the motorized wheelchair. The Physical Therapist said he was not aware Resident #67 was drinking alcohol and said the resident would not be safe to operate the motorized wheelchair when intoxicated. In an interview on 3/11/20 at 9:35 a.m., Resident #95 said on multiple occasions when he was on the outside patio Resident #67 would yell and curse at him and try to run into his wheelchair with his motorized wheelchair. Resident #95 said I am really afraid of the guy and when he drinks, he is mean, and he scares me. Resident #95 said, Resident #67 often drinks alcohol on the patio and he had reported the drinking and his concerns for his own safety to the Administrator and Director of Nursing on multiple occasions. He said there was no staff on the patio to monitor the safety of the residents. Resident #95 said he is not able to go out on the patio and enjoy himself because he does not know what Resident #67 will do to him, and if things continue, he would contact the police. In an interview on 3/11/20 at 11:05 a.m., Resident #9 said Resident #67 tried to run his motorized wheelchair into her on 3/8/20 and she had to put her walker in front of her to stop him. Resident #9 said she was fearful because she uses a walker to ambulate and Resident #67 often attempts to run into her with his motorized wheelchair. Resident #9 said when someone is running their motorized wheelchair into me, I feel unsafe. Resident #9 said when Resident #67 was intoxicated he would curse and yell at her. Resident #9 said she had reported Resident #67 to the Administrator, Director of Nursing and the unit nurse on multiple occasions. Resident #9 said she had to contact the police on 3/8/20 because she was afraid for her safety. In an interview on 3/11/20 at 11:20 a.m., the Social Service Director said she tried to offer sober support to Resident #67. The Social Service Director said when she notices Resident #67 outside drinking alcohol, she doesn't approach him because the resident usually drinks in an empty lot that is not on the facility's premises. She said she didn't know how he got the alcohol but all she can do is encourage him not to drink. The Social Service Director said, We have no consequences in place for his drinking or behavior. The Social Service Director added I heard the police were called on 3/8/20 to deal with Resident #67 about his drinking and because he was belligerent. I heard Resident #67 was drinking and banging around, a nurse said he smelled of alcohol. I believe there was one report about him running into other residents. The Social Service Director said, I was hoping the police would have put him jail so he would learn his lesson and know that would be the consequence if he acted up again and didn't change his behavior. In an interview on 3/12/20 at 12:45 p.m., the attending physician said he was aware Resident #67 consumed alcohol. He said it is our responsibility and liability for them. If the residents are drinking and off the premises and are impaired it is our responsibility and they are not safe.<br><br>3. Review of the clinical record revealed Resident #86 was non-compliant with the facility's (alcohol) drinking policy and disguises alcohol in containers. Review of the interdisciplinary notes and hospital summary of care revealed on 9/8/19, 12/7/19, and 1/3/20 Resident #86 sustained a fall with injury while intoxicated requiring a transfer to the local emergency room . The 1/3/20 a hospital Summary of Care documented Resident #86 was admitted to the ED with [DIAGNOSES REDACTED]. On 9/23/19 and [DATE] the nurses' notes contained documentation Resident #86 was impaired on her motorized chair. On 2/11/20 the Resident had been outside drinking beer and was found on floor in bathroom bleeding. On 3/10/20 at 5:00 p.m., the nurse's note documented Resident #86 was yelling at the administrator, clearly impaired, and insisted going on leave of absence from the facility. The administrator signed Resident #86 out of the facility. In an interview on 3/11/20 at 5:12 p.m., the Administrator verified Resident #86 signed out and left the facility and had not returned. The Administrator said she had not done anything about it yet. She said she had not notified the police. Following the interview the Administrator notified the police and the family. The family reported Resident #86 was with her boyfriend. |
| F 0675<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Honor each resident's preferences, choices, values and beliefs.**<br><br>Based on record review, review of the facility's policy, staff and resident interview the facility neglected to intervene and address repeated allegations of resident to resident abuse for 2 (Resident #9 and #95) of 2 residents causing the residents to live in constant fear for their safety. The findings included: The Facility policy S-332, Motorized Wheel Chairs (effective 11/30/14) specified Residents will be re-assessed for continued ability to operate the motorized wheelchair upon incidents involving harm or injury to persons or physical damage to the facility property. Review of the nursing progress notes revealed the following documentation: On 2/28/20 at 1:45 a.m., writer called to the patio by another resident. This res (Resident #67) was drinking beer & running into other residents with his motorized chair. Taken to (his room), put to bed. On 3/7/20 at 11:30 p.m., Writer called to end of long Hall. Res (Resident #67) was running into people with his (motorized) chair. Taken to his room, left and went back outside - refused care. On 3/8/20 at 12:45 a.m., Writer alerted to outside patio by other residents. This resident is intoxicated has bag of beer hanging on (motorized) chair, he is using his motorized chair to run into people and slamming into chairs to make the chairs hit them as well. Res (Resident #67) was told to stop, and he yelled out (profanity) and tried running over this nurse. Multiple attempts to redirect made & unsuccessful. Beer was removed from chair and res continued with vulgar gestures & language. On 3/8/20 at 1:00 a.m., the nurse documented, Nurse was called to patio again res was threatening other res & attempting to hit them with his (motorized) chair. Res was removed from patio & taken to 3rd floor. In an interview on 3/10/20 at 6:30 p.m., the Administrator said she was not aware Resident #67 was running into other residents with his motorized wheelchair. The Administrator said she was not aware Resident #67 was drinking on the patio and said the staff would take it if they knew. The Administrator said she was not aware Resident #67 was having behaviors and said they would contact the doctor and Psychologist when residents were drinking or having behaviors. The Administrator said she had no policy on the use of alcohol by the residents in the facility. In an interview on 3/11/20 at 9:35 a.m., Resident #95 said every time Resident #67 sees him on the smoking patio he tries to run him over with his motorized wheelchair. Resident #95 said I am really afraid of the guy. Resident #95 said Resident #67 will run into my wheelchair all the time, yells and curses at me when he sees me. Resident #95 said Resident #67 almost pushed me over when using his motorized wheelchair when I was in my wheelchair. Resident #95 said Resident #67 drinks beer on the patio and is always drunk and no one does anything. Resident #95 said when Resident #67 drinks, he is mean and he scares me, he scares a lot of people. Resident #95 said, I have told the Administrator and the Director of Nursing several times and no one does anything. Resident #95 said he is not able to go out on the patio and enjoy himself because he does not know what Resident #67 will do and it frightens him. Resident #95 said I have a lot of problems with Resident #67, when he drinks, which is daily, I am frightened because I don't know what he is going to do to me. Resident #95 said there are no staff members on the patio to supervise the residents. Resident #95 said when I complain about it to the Administrator, she told me if something occurs on the patio after 10 p.m., she doesn't care because no one is supposed to be out there after 10:00 p.m. Resident #95 said if things continue, I will have to call the police. In an interview on 3/11/20 at 11:05 a.m., Resident #9 said Resident #67 tried to run her over on 3/8/20 with his motorized wheelchair. Resident #9 said Resident #67 ran into me with the motorized wheelchair and I had to put my walker in front of me to stop him or he would have hit me. Resident #9 said she uses a walker to ambulate and said Resident #67 was always running into me, so I have to use my walker to block him. I called the Administrator on 3/8/20 and reported him and she said, I took care of it already. I have reported him so many times to the Director of Nursing, the unit nurse and Administrator, and they do nothing. |
| F 0684<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide appropriate treatment and care according to orders, resident's preferences and** |

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| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 4)<br>**goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, review of policies and procedures, resident and staff interview, the facility failed to demonstrate and coordinate effective coordination and obtain timely follow up services for 1 (Resident #99) of 1 resident reviewed with skin conditions. The findings included: The facility policy PS-125 Medical Consultations revised 8/24/17, specified the member of the medical staff requesting a consultation will order the consultation and a Request for Consultation will be initiated by nursing to the consulting physician. On 6/30/20 at 11:45 a.m., Resident #99 said he had a body rash that has been ongoing for months and was treated for [REDACTED]. He said he was seen by a dermatologist for the rash on several occasions. Resident #99 said his primary care physician ordered a consult on 6/22/20 with an allergist, but it had not been arranged and he did not know why. Resident #99 said the rash hurts and itches and felt that his symptoms had gone on long enough. A review of the clinical record documented the following: a. On 2/21/20 Resident #99 was seen by his physician for skin rash, refer to dermatology consult. b. On 3/24/20 the physician progress notes [REDACTED]. c. On 4/3/20 the Dermatology Progress Note documented Resident #99 was seen for body rash, suspicious for crusted scabies. d. On 4/10/20 the follow up dermatology consult documented, rash on abdomen and body, multiple sites consistent for scabies infestation. e. On 6/8/20 a follow up dermatology consult for evaluation and management of [MEDICAL CONDITION]. Results of pathology reports, arthropod bites vs drug eruption. Recommendations to see allergist and follow up with PCP for medication reconciliation. f. On 6/22/20 the Primary Care Physician order [REDACTED]. On 6/30/20 at 12:00 p.m., in an interview the Assisted Director of Nursing (ADON), said she tried to schedule an appointment for Resident #99 and had contacted 2 allergists, but they did not accept his insurance. The ADON confirmed she did not document her attempts to arrange the allergy consult ordered on [DATE]. The ADON said she did not make any other attempts to schedule a consult with the allergist and said, I told the nurse to do it. The ADON said she did not recall which nurse she spoke with and did not document her collaboration with the nursing staff regarding the consult for Resident #99. On 6/30/20 at 12:15 p.m., in an interview the Administrator said, the facility was not able to find a physician who would accept Resident #99's insurance. The Administrator said, 2 attempts to contact an allergist were completed and the nurse was attempting to contact another allergist for Resident #99. The Administrator confirmed there was no documentation the staff attempted to contact the allergist as ordered for Resident #99. |
| F 0689<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, resident and staff interview, the facility failed to provide adequate supervision to prevent accidents for 7 (Residents #71, #86, #107, #104, #67, #117, and #224) of 13 sampled residents. The facility was allowing residents to leave the facility to unknown destinations, becoming impaired by alcohol both while on or off the property, and placing themselves and other citizens in danger. Residents (#71 and #107) endanger themselves by crossing a 6-lane street in their wheelchairs while intoxicated. The facility failed to supervise Resident #67 who was repeatedly running into other residents with his motorized wheelchair when impaired. The facility allowed an untrained staff member to transport a resident in a vehicle, resulting in a fall with injury. The facility failed to properly supervise residents when smoking. This failure resulted in Resident #71 being hospitalized for [REDACTED]. The facility's failure to provide adequate supervision to protect residents and others resulted in substandard quality of care at the Immediate Jeopardy level starting on 3/12/20. The Administrator was notified of the immediate Jeopardy on 3/12/20 at 4:45 p.m. The Immediate Jeopardy was removed on 3/14/20 at 2:30 p.m. after credible evidence of measures taken to correct the immediate jeopardy the severity was reduced to a E. The findings included: Cross reference to F600, F609, and F835. 1. In an interview on 3/11/20 at 12:06 p.m., Licensed Practical Nurse (LPN) Staff Q said Resident #71 goes out in his wheelchair and will go across the street to convenience stores. She said Resident #71 goes out with 2 other residents and they will come back intoxicated almost every night. Resident #71 needs assistance and will be incontinent when he is impaired. Staff Q said Resident #71 has fallen into the bushes and EMS has called to notified staff of resident being transferred to the emergency room (ER). Staff Q said the residents do not wear any identification. Staff Q said residents are to sign out with the nurse or receptionist downstairs before they leave. If they do not return the facility will call the numbers listed on the face sheet and hold the resident's bed for 8 days if they are Medicaid. Staff Q said Resident #71 has been observed off the property to the right of the facility under a tree and police frequently monitor the area. In an interview on 3/11/20 at 3:53 p.m., LPN Staff R said Resident #71 has falls, skin tears and sneaks beer into his room. Staff has to look for him up and down roads where people have seen him drunk or in a bush somewhere. The resident will come back at night with skin tears, slurring his speech, and smelling of heavy alcohol use. The Administrator and Director of Nursing are aware. People in the community are calling the facility saying someone is outside under the tree drunk. Resident #71 will just slide out of his chair onto the floor when he is impaired, and it takes several staff to pick him up. She said she has never worked at a place where residents can spend most of the day out drinking and then staff have to deal with them when they come back intoxicated. In an interview on 3/12/20 at 8:45 a.m., Resident #71 said he goes outside in his wheelchair to get some sunshine with a few friends. The resident was observed to have a dressing on his left arm and said was a skin tear where he must have bumped into something. The resident said he has slipped out of his chair in the bathroom and acknowledged he had fallen when outside of the facility. Resident #71 said he has double vision and cannot always see the edge of the sidewalk and has fallen into the bushes and one time he did fall into the road. The resident said he has no way to contact the facility so relies on someone to stop their car and help him back up into his chair. He said staff have also come to look for him when he has fallen and not been able to get up off the ground. In an interview on 3/12/20 at 10:14 a.m., the Director of Rehabilitation said Resident #71 has falls because he is impaired. Therapy treated him for 3-4 months for 2 different occasions. This puts his staff at risk as they don't want to work with him when he is impaired. These residents who are out in their wheelchairs impaired can get in an accident. The road in front of the facility has a lot of car accidents, and the Administrator has told him it is the resident's right to do whatever they want. When Resident #71 is not impaired he can safely use his wheelchair, but he is probably outside drinking right now. The Director said there are 2 other residents with power chairs who have the same behavior. Resident #71's clinical record revealed [DIAGNOSES REDACTED]. An after-visit hospital summary, dated 1/13/19, indicated the resident had been in the ER for a closed head injury after a fall from his wheelchair, [MEDICAL CONDITION] and left arm swelling. The attached information defined [MEDICAL CONDITION] as when the amount of alcohol consumed impairs the ability to mentally and physically function. Alcohol directly impairs the normal chemical activity in the brain and can cause drowsiness, stupor, [MEDICAL CONDITION], and coma. [MEDICAL CONDITION] can also lead to dangerous and life-threatening activities. A review of the Interdisciplinary Progress Notes for Resident #71 revealed the following: On 8/13/19 at 10:35 p.m., Resident #71 was not in the facility. Staff went outside to look for the resident and observed him across the street. Staff had to cross the street to find the resident sitting in the car lane in front of a car dealership. The resident was covered in beer, had an open can of beer in his hand and 5 cans in his bag. Staff returned to resident to the facility. The resident was slurring his words, smelled of alcohol, and was unable to hold up his arms without assist. On 8/17/19 at 10:30 p.m., Resident #71 had not returned to the facility. Staff searched inside and out of the facility and could not locate him. Staff searched down the street and found the resident in front of the hospital parking lot in a bush. The resident had multiple skin tears, scratches across his back, and bruising on his right buttock and upper body. The resident said he fell off the sidewalk into the bush. Heavy smell of alcohol was noted, and the resident was drinking in the bush when found. On 11/2/19 at 9:30 p.m., Resident #71 was found on the floor in his room at 7:45 p.m. saying he slipped out of his chair. The resident appeared to be intoxicated and smelled of alcohol. The Director of Nursing (DON) was notified of the event. On [DATE] at 2:00 p.m., Staff received a call from EMS reporting Resident #71 had a fall in the bushes and was being taken to the ER. A review of the hospital History and Physical dated [DATE], revealed the resident was brought to the ER with acute [MEDICAL CONDITION] after a fall out of his wheelchair into the bushes. The resident had altered mental status and was incontinent of urine. The history noted the resident has been admitted to the ER many times in the past for the same reason. On 11/12/19 at 12:20 p.m., the resident was readmitted to the facility. At 10:50 p.m., the nurse noted the resident returned from outside after dinner time. |

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| F 0689<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 5)<br>Staff heard him throwing his dinner tray against the wall. Upon entering the room, the resident was angry and cursing. The resident's roommate said Resident #71 came over to his bed to attack him and tried to pull him out of bed. States they hit each other. On 2/4/20 at 7:35 p.m., the nurse received a phone call from another resident stating Resident #71 was laying on the highway, and two men tried to pick him up but couldn't, so they called 911. At 8:00 p.m., the resident was brought back to the facility by EMS/firefighter who reported the police noted the resident fell off the curb 2 blocks away. The resident was taken back to the unit cursing at staff and noted to smell of heavy alcohol. In an interview on 3/12/20 at 11:25 a.m., the Administrator said there is no set policy against drinking on the property but is addressed in the Welcome packet. The Administrator acknowledged she really doesn't know where Resident #71 goes when he leaves the property. The Administrator said that is why they have a protocol in place if the resident returns to facility impaired to hold the medications. The Administrator said if the resident has capacity and signs himself out, he is responsible for himself out in the community and not much I can do. She cannot ensure his safety if the resident is not here.<br><br>2. Clinical record review revealed Resident #117 was admitted the facility on 2/13/20. The [DIAGNOSES REDACTED]. The resident required extensive assistance of 2 persons to move between surfaces, including to or from bed, chair, wheelchair, standing position. The resident used a wheelchair. The facility determined Resident #117 was at risk for falls and a care plan was developed. The care plan dated 2/27/20 indicated Resident #117 was at risk for falls related to difficulty walking, muscle weakness, lack of coordination. The goal was to minimize the risk of sustaining a serious injury. The interventions included to anticipate and meet the resident's needs. Review of the initial occupational therapy evaluation completed on 2/14/20 revealed Resident #117 required maximal assistance for transfers. The therapist documented the resident had mild impairment for problem solving, safety awareness, insight and judgement. During an interview on 3/10/20 at 12:35 p.m., Resident #117 said he had multiple falls at home prior to admission to the facility. He said he fell twice at the facility. Resident #117 said he has a bad knee and on [DATE] he sustained a 3rd fall when he tried to stand up and fell from the facility's transport van. A review of the Interdisciplinary Progress Notes for Resident #117 revealed the following: On 3/7/20 at 8:45 a.m., Resident fell from w/c (wheelchair). Resident states that he was trying to pick up things from floor & (and) fell from w/c. 0(no) injuries noted. On 3/7/20 at 10:00 a.m., Resident slid from w/c again trying to pick up items from floor. 0 (no) injuries noted. Resident denied hitting head. Staff to monitor for safety. On [DATE] at 9:40 a.m., . Resident left facility this am (morning) for outside apt (appointment). Upon return resident tried to transfer himself from van to wheelchair. Resident fell to ground & (and) hit head .Resident was noted to have laceration to scalp. MD (physician) notified. New order to transfer to ER (emergency room ) for treatment and evaluation. During an interview on 3/11/20 at 10:20 a.m., Physical Therapist Staff DD said Resident #114 is not safe to transfer by himself due to poor safety awareness. The therapist said the resident needs supervision for safe mobility. He explained Resident #117 has limited insight to his condition and thinks he can do more than he can. If not supervised there is a high likelihood that he will transfer without supervision and fall. He is not able to exit the van safely and should be transported in a wheelchair for outside appointments. The therapist said no one has consulted with them about safe transfer and transport for this resident. During an interview on 3/11/20 at 10:25 a.m., LPN Staff Y said the maintenance assistant transported Resident #117 to an outside appointment on [DATE]. Upon return to the facility, the maintenance assistant left the resident unattended to get his wheelchair. She said instead of waiting, Resident #114 stepped down out of the van and fell . She said the resident thought he could get out of the van on his own and fell . During an interview on 3/11/20 at 10:35 a.m., the Director of Rehabilitation said I maintain what I said, he (Resident #117) is not safe to go on a regular transport. My initial recommendation for him would be in a wheelchair but no one asked us. During an interview on 3/11/20 at 10:40 a.m., the maintenance assistant said he mainly works in the maintenance department but if they need him to take someone to an outside appointment, he usually does it. He said no one gave him any instructions on how to transport Resident #117. He said, I was just told to take him up there. He said the resident usually gets his wheelchair to go to his outside appointment because he got bad legs but on [DATE] he did not use the wheelchair. The maintenance assistant said when he returned to the facility, he went to get a wheelchair and for some reason Resident #117 stepped out of the transport van and did not wait for him. He said he was not aware of specific instructions to transport residents and has never received any training on how to safely transport, transfer or supervise residents during transport. During an interview on 3/11/20 at 10:45 a.m., Certified Nursing Assistant (CNA) Staff CC said Resident #117 is not able to ambulate by himself. She said, if he tries to get up, he will fall. During an interview on 3/11/20 at 10:48 a.m., the DON said they meet every morning and discuss the residents who have balance issues with therapy and how they're progressing. She said the therapy department lets them know how these residents can be transferred and transported but she does not have documentation on that. During an interview on 3/11/20 at 11:00 a.m., the maintenance department supervisor said there is an online training that is required for any driver when they are transporting patients. He said the maintenance assistant had not received the training. 3. Review of the policy and procedure titled Smoking Policy with an effective date of 11/30/14 (no revision date) revealed Residents will be evaluated for safety regarding smoking upon admission and quarterly . Smoking materials will be retained and stored by the nursing staff for residents identified by their care plans as not being responsible to possess materials without supervision. Unsafe smokers will wear smoking aprons while smoking. Review of the clinical record revealed Resident #117 was admitted to the facility on [DATE]. The admission data collection completed on 2/13/20 indicated Resident #114 does not smoke, including electronic cigarettes. On 3/11/20 at 10:10 a.m., Resident #117 was not in his room. The Assistant Director of Nursing (ADON) said Resident #117 is a smoker and was probably outside on the smoking patio. On 3/11/20 at 10:16 a.m., Resident #117 was observed slumped over in his wheelchair unsupervised with a lit cigarette on the outside smoking patio. Resident #117 was not wearing a smoking apron. The observation was made in conjunction with the ADON who said Resident #117 should not be smoking unsupervised. She said she will complete a smoking evaluation for Resident #117. On 3/11/20 after the observation, the Administrator completed a smoking evaluation and determined Resident #117 was an unsafe smoker. She documented Resident will have supervised times per center protocols. 4. During an interview on 3/10/20 at 11:25 a.m., when asked about the facility's rules for smoking Resident #224 said he did not require supervised smoking. A pack of cigarettes and a lighter was observed in the room on the bedside table. On 3/12/20 at 2:58 p.m., Resident #224 was observed smoking unsupervised on the outside smoking patio. He was not wearing a smoking apron. Review of the clinical record revealed Resident #224 was admitted to the facility on [DATE]. The admission/readmission data collection revealed documentation the Licensed Nurse documented Resident #224 does not smoke, including electronic cigarettes. Thorough review of the clinical record, including the thinned record failed to reveal documentation of a safe smoking assessment. During an interview on 3/12/20 at 2:10 p.m., the Medical Records Supervisor said she never removes the smoking assessment from the clinical record. She verified the lack of a safe smoking evaluation for Resident #224. During an interview on 3/12/20 at 2:25 p.m., Unit Manager Staff Q verified the lack of a smoking assessment to ensure Resident #224 was safe to smoke unsupervised.<br><br>5. Clinical record review revealed Resident #67 had [DIAGNOSES REDACTED]. A review of the Interdisciplinary Progress Notes for Resident #67 revealed the following: On 4/9/19 at 9:15 a.m., Resident #67 was in the lobby with 2 cans of beer. He was educated on protocol of no alcohol on the premises. Resident said he understood. On 10/4/19 at 9:45 a.m., Staff reports resident sitting outside drinking late nights. Redirection unsuccessful. Met with resident. Discussed rules/protocol again. Resident understands but voices he doesn't care. On 10/2/19 at 3:00 a.m., Resident #67 returned from the patio smelling of alcohol and was assisted to bed. On 11/1/19 at 12:25 a.m., Resident #67 was seen in the smoking patio drinking alcohol. He was unable to transfer self to w/c(wheelchair). Staff had to transfer him. On 11/25/19 at 11:00 p.m., he returned to his room smelling of alcohol and returned to bed. On 11/18/19 at 7:00 p.m., the resident refused to sign out and left the facility. On 11/25/19 at 12:00 a.m., Resident slipped from his w/c in his room. Resident does seem to be intoxicated but able to follow commands. On 12/11/19 at 5:00 p.m., Resident #67 was out of the building on the patio drinking. On 12/12/19 at 12:00 a.m., Resident #67 was outside on the patio drunk. He refused to come into the building. The resident came in later and went to bed. On 1/1/20 at 6:30 a.m., Resident #67 was found by staff lying on the grass (unknown where exactly) with 5 cans of empty cans of beer. He was incontinent of urine, verbally abusive to staff attempting to help him back in his w/c. On 2/28/20 at 1:45 a.m., the nurse was called to the patio by another resident. Resident was drinking beer and running into other residents with his motorized chair. They took him to his room and put him to bed. On 3/7/20 at 11:30 p.m., the nurse was called into the long hall because resident was running into other residents with his motorized chair. They took him to his room, but he left and went back outside and refused care. On 3/8/20 at 12:45 a.m., the nurse was |

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|---|---|---|---|
| | 105238 | A. BUILDING _____ B. WING _____ | 03/14/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| F 0689<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 6)<br>called back outside to the patio by another resident because Resident #67 was intoxicated. He had a bag of beer hanging on his motorized wheelchair. He was using that chair to run into people and slamming into the chairs to make the chairs push into other people. Resident #67 was told to stop. He yelled out F . you and tried to run over this nurse. Multiple attempts to redirecting unsuccessful. Beer was removed from chair and he continued to curse, gestures and language. On 3/8/20 at 1:00 a.m. Nurse was called to patio again. Resident #67 threatening other residents and attempting to hit them with his chair. Resident was removed and taken to the 3rd floor and the police were called. In an interview on 3/10/20 at 5:35 p.m., the Administrator said residents sign out and if they are their own person, they are responsible for themselves. If they are drinking alcohol, they're educated and are offered Alcohol Anonymous. They also offered psychiatric services. If they drink alcohol on the property they are educated again, and staff take the alcohol away from them. The Administrator said the facility does not have a policy addressing the use of alcoholic beverages on the premises or the safety of residents when they leave the building. In an interview on 3/10/20 at 5:56 p.m., the Administrator said, What can I do? She said she offered a flag for motorized wheelchair used by Resident #67, but he refused. A review of the facility Sign Out Log revealed Resident #67 had not signed himself out of the facility in the last 6 months. 6. Clinical Record review revealed Resident #104 had [DIAGNOSES REDACTED]. The care plan initiated on [DATE] specified Resident #104 had a cognitive impairment due to dementia and [MEDICAL CONDITION]. The interventions included to cue and reorient the resident and supervise as needed. The care plan identified Resident #104 was at risk for injury from falls. On [DATE] at 4:33 p.m., in an interview, Resident #104 said he leaves the facility to get his alcohol and drinks in the empty parking lot next door to the facility. The resident said he does not always sign himself out when he leaves the facility. A review of the facility Sign Out Log revealed Resident #104 had not signed out of the facility in the last 6 months. 7. Review of the Clinical Record revealed Resident #107 [DIAGNOSES REDACTED]. The record documented an emergency room visit dated 5/31/19 in which<br>the resident stated he drinks 1 six pack per day of alcohol. A psychiatric evaluation on 5/9/19 documented the resident identifies alcohol as his drug of abuse and had struggled with alcohol dependency most of his adult life. On 11/11/19 the Licensed Clinical Social Worker documented Resident #107 admitted to daily alcohol use. During an interview on [DATE] at 11:40 a.m., Resident #107 had a strong odor of alcohol on his breath and said he drank one and half beer this morning. He said he signs out of the facility sometimes and tells staff where he is going. Resident #107 said he will go across the busy 6 lane road unsupervised in his wheelchair and buys alcohol. He said he drinks the alcohol in the parking lot next to the facility and then returns to facility. During an interview on 3/10/20 at 4:58 p.m., Registered Nurse Staff B said when Resident #107 returns to the facility and has been drinking alcohol we put him back to bed. If they bring in alcohol to the facility, we remove it and call the doctor. If they were drinking in the room, we remove the alcohol and explain to them why. She said, you have no control over the residents that drink. During an interview on 3/11/20 at 10:42 a.m., Resident #107 said he signs out of the facility when he leaves to buy beer. The resident said he will cross the street in his w/c (wheelchair) to buy the beer. The clinical record included a physician order [REDACTED].#107 to go on leave of absence without supervision. During an interview on 3/12/20 at 10:19 a.m., the DON said there was a new order for Resident #107 to leave the facility without supervision. She said he is his own responsible party. The DON said Resident #107 was educated on 8/30/19 about the signing out process and said she was aware the resident had dementia and drinks alcohol every day. The DON said she did not know where Resident #107 obtained the alcohol and did not know what the resident did when he leaves the facility because he was his own person. The DON said when the resident leaves the building, she has no responsibility for the resident. A review of the facility Sign Out Log revealed Resident #107 did not sign out of the facility in the last 6 months.<br><br>During an interview on [DATE] at 9:35 a.m., Resident #86 said she was in the hospital recently because she fell out of her motorized wheelchair. Resident #86 said she can't walk and is dependent on her wheelchair for mobility. During an interview on 3/12/20 at 4:53 p.m., the Business Office Manager said she was injured by Resident #86 when the resident was operating her motorized wheelchair while drunk. The Business Office Manager said she underwent surgery to her left knee and is still receiving medical treatment due to the injury inflicted by Resident #86. Review of the clinical record included a Care Plan initiated on 2/1/19 indicating Resident #86 is non-compliant with facility (alcohol) drinking policy and disguises alcohol in containers. A review of the Interdisciplinary Progress Notes and hospital records for Resident #86 revealed the following: On 9/8/19 at 5:00 p.m., Resident #86 was in a parking lot area next door, lying prone with the right side of her face on the concrete (ground). A passerby called 911 to get medical attention for Resident #86. There were beer cans on the ground at the scene of the fall. Resident #86 obtained a laceration to right eyebrow. There was a moderate amount of bright red blood to the area and a bruise to right cheek bone. Resident #86 was transported to the hospital via ambulance. The hospital Summary of Care dated 9/8/19 revealed Resident #86 was admitted to the ED (Emergency Department) with [DIAGNOSES REDACTED]. On 9/23/19 at 6:00 p.m., Resident #86 was extremely impaired sitting on her motorized scooter. Resident #86 had ridden the scooter into her dresser and pushed it around the corner to her closet. Resident #86 tipped the overbed table and spilled water all over the floor and her laundry bag. Resident #86 had pushed her roommate's bed into the nightstand. Resident #86 almost ran into another resident in the hallway. On 10/8/19 at 1:30 p.m., Resident #86 was in her room alone drinking a large can of beer with a straw. Resident #86 was clearly impaired with slurred speech .smells of alcohol. The hospital Summary of Care dated 12/7/19 revealed Resident #86 was admitted to the ED (emergency department) with [DIAGNOSES REDACTED]. On 12/10/19 at 12:30 p.m., the Administrator met with Resident #86 to<br>discuss frequent issues at night. Resident #86 is leaving center and her motorized wheelchair runs out of charge and she is stuck. The hospital Summary of Care dated 1/3/20 documented Resident #86 was admitted to the ED with [DIAGNOSES REDACTED]. On 1/29/20 the Social worker documented Resident #86 understands/responds and makes herself understood. Resident #86 continues to leave the property and returns impaired. Education ongoing. On [DATE] at 1:30 p.m., Resident #86 was impaired while in motorized scooter. On 2/11/20 Resident #86 was found on floor in bathroom bleeding. Resident #86 had been outside drinking beer. On 3/10/20 at 5:00 p.m., Resident #86 was yelling at the administrator, clearly impaired, and insisted going on LOA (leave of absence) from the facility. The administrator signed Resident #86 out of the facility. During an interview on 3/11/20 at 5:12 p.m., the Administrator said Resident #86 signed out on 3/10/20 and has not returned to the facility. The Administrator said she has not done anything about it yet and had not notified the police. At the time of the interview Resident #86 has been gone from the facility for more than 24 hours. |
| F 0700<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, staff and resident interview, the facility failed to ensure 1 (Resident #116) of 1 resident reviewed was assessed for the safe use of bed rails, alternative interventions were attempted, and informed consent obtained prior to the use of bed rails. The findings included: The facility policy N-1282, Side Rail/Bed Rail (effective 4/19/18) indicated alternative interventions were to be attempted and documented in the medical record prior to the use of side rail/bed rails. Prior to installation of a side rail/bed rail, complete the side rail/bed rail evaluation to evaluate the resident for risk of entrapment. Review the risk and benefits with the resident and/or representative and obtain consent. In an interview on 3/10/20 at 10:15 a.m., Resident #116 said he did not have any bedrails on his bed. On 3/11/20 at 9:22 a.m., Resident #116 was observed in bed with the left bed rail raised and a urinal hanging on it. An Admission Data Collection form completed by Licensed Practical Nurse (LPN) Staff T, indicated Resident #116 was admitted to the facility on [DATE] at 4:00 p.m. Section N of the assessment indicated the resident was using side rails and to complete additional Side Rails Evaluation. A Side Rail Evaluation form was completed on 2/14/20 and indicated quarter side rails were recommended. The section for side rail alternatives attempted and if the resident requested side rails was blank. An Informed Consent for The Use of Bed Rails was signed by Resident #116 on [DATE]. The bed rails were in use immediately upon the resident's admission to the facility, no alternatives were attempted, and prior to informed consent being obtained. In an interview on 3/11/20 at 12:06 p.m., LPN Staff Q said when a resident comes into the facility, the bed rails are already |

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| F 0700<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 7)<br>on the bed. The resident's preference will determine if the bed rails are up or down. If the resident wants the bed rails, will see if they can use them for mobility and then explains the risks of being up. If the resident wants to keep the bed rails, she has them sign a consent. She does not offer any alternatives to the bedrails. In an interview on 3/11/20 at 4:35 p.m., the Director of Nursing and Administrator both confirmed the facility does an assessment for bedrail's on admission, no alternatives are attempted prior to use, and the bed rails are already on the bed. |
| F 0740<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure each resident must receive and the facility must provide necessary behavioral health care and services.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, and staff interviews, the facility failed to provide necessary behavioral health care and substance abuse services for 1 (Resident #67) of 5 residents reviewed for [MEDICAL CONDITION]. This has the potential to lead to serious health consequences. The findings included: Record review revealed Resident #67 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Resident Education Record for Resident #67 included the Administrator's notation on 8/31/19, Discussed ETOH is not to be brought in center. Res(ident) must have (Doctor's) order. Do not give ETOH to peers. The Social Service Director progress note on 1/28/20 stated, evaluation regarding ETOH abuse treatment options given however declined. The medical record review revealed no additional documented attempts to offer Alcoholics Anonymous or [MEDICAL CONDITION] or behavioral health services to Resident #67. Nursing Progress Notes for Resident #67 included: On 7/23/19 at 5:30 a.m., Resident #67, noted to have gone back outside to smoking patio, proceeded to get electric w/c (wheelchair) stuck in the grass/mud next to concrete pad next to patio, beer spilled all over himself and his (motorized) chair; 5 staff members finally able to get him out of the mud at which time he said (profanity), wheeled to the porch, flipped over a table and ashtray, refused to come inside to get cleaned up. On 8/18/19 at 12:00 a.m., Resident #67, still outside on patio. Went out to get him again told him to wrap up smoking his cigarette and come inside. He had an empty beer can sitting on the table which I picked up and threw away. He then started cursing and saying (profanity, repeated profanity). Then he threw a lit cigarette at me and hit me with it. On 10/2/19 at 3 a.m., Resident #67, returned to floor from patio smelling of alcohol. On 10/4/19 at 9:45 a.m., Administrator documented, staff report res(ident) is sitting outside drinking late nights. Redirection unsuccessful. Met with res(ident) - discussed rules/protocol again. Res(ident) understands but voices he doesn't care. On 11/1/19 at 11:30 p.m., Resident #67, seen out on smoking patio drinking. On 1/24/20 at 11:00 p.m., Resident #67, came to room in wheelchair with alcohol on his breathe at 8:30 p.m., slipped out of (motorized) wheelchair in his room. On 11/25/19 at 12:00 a.m., Resident #67, Received report that resident slip from his (motorized) wheelchair in his room. Resident had a fall . Resident does seem to be intoxicated but able to follow command. On 11/25/19 at 10:30 p.m., Resident #67, smelled of ETOH On 12/12/19 at 12:00 a.m., Resident #67, Staff told nurse, Res(ident) drunk on Patio and needs help coming in. Went to get Res, Res(ident) refused to come in building. On 12/26/19 at 3:00 a.m., Resident #67, Res(ident) came up elevator smelled of ETOH. On 1/1/20 at 8:30 a.m., Resident #67, Resident was found by staff at approximately 6:50 a.m., lying on the grass, he (error) sitting alongside his (motorized) wheelchair with 5 cans empty beers. Resident was incontinent of urine and verbally abusive to staff who were attempting to get him back in the chair. Refused to answer what happened or if anything was hurt . refused any further discussion . On 2/28/20 at 1:45 a.m., Resident #67 Writer called to patio by another resident. This res was drinking beer and running into other residents with his (motorized) chair taken to room, put to bed, refused care. On 3/7/20 at 11:30 p.m., Resident #67, Writer called to end of long hall. Res. was running into people with his (motorized) chair. Taken to his room, resident left and went back out-side. Refused care. On 3/8/20 at 10:20 p.m. - 12:45 a.m., Resident #67, Writer alerted to outside patio by other residents. This resident is intoxicated has bag of beer hanging on (motorized) chair, he is using his motorized chair to run into people and slamming into chairs to make the chairs hit them as well. Res(ident) was told to stop, and he yelled out (profanity) and tried running over this nurse. Multiple attempts to redirect made and unsuccessful. Beer was removed from (motorized) chair and resident continued with vulgar gestures and language. On 3/8/20 at 1:00 a.m., Resident #67, Nurse was called to patio again res(ident) was threatening other res and attempting to hit them with his (motorized) chair. Res was removed from patio and taken to 3rd floor. A review of the Psychology Progress Note dated 12/7/19, 12/20/19, 1/10/20 and 2/1/20 revealed no documentation Resident #67 was provided substance abuse counseling or services. During an interview on 3/10/20 5:56 p.m., the Administrator said there was no policy for residents drinking alcohol in the facility. The Administrator stated, What can I do? She said they evaluate for him for safety and notify the Medical Director. In an interview on 3/11/20 at 11:20 a.m., the Social Service Director said she tried to offer sober support to Resident #67. The Social Service Director said when she notices Resident #67 outside drinking alcohol, she doesn't approach him because the resident usually drinks in an empty lot that is not on the facility premises. The Social Service Director said, Resident #67 was his own person and didn't know how he got the alcohol, and all she can do is encourage him not to drink. The Social Service Director said I tried to talk to Resident #67 about sober support and Alcoholics Anonymous. If he was not ready to quit, maybe he could slow down his drinking. The Social Service Director said, We have no consequences in place for his drinking or behavior. |
| F 0741<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interview, the facility failed to ensure the staff received necessary training in behavioral health care to manage residents with substance abuse and mental/behavior health disorders. This has the potential to lead to serious injuries, psychological and health consequences for all residents. The findings included: A record review for Resident #67, revealed [DIAGNOSES REDACTED]. The clinical record included documentation of multiple incidents of physical abuse of other residents, verbal aggression to other residents and staff, and falls due to ETOH intoxication. Review of the current education calendar (2020) for nurses and staff did not include planned training on alcohol dependency or Mental Health Disorders. On 3/11/20 at 9:52 a.m., Certified Nursing Assistance (CNA) Staff L said Resident #67 drinks almost every day, is nasty, belligerent and tries to hit her. She said at least every day he is refusing care. She goes into his room [ROOM NUMBER]-6 times to get him to shower. Sometimes the nurse goes in to talk to him. CNA Staff L said she is afraid of him because he might hit her. On 3/13/20 at 2:35 p.m., during an interview the Nurse Educator said the on-line training required by the facility for the staff did not include education in mental health disorders and substance abuse by the residents. The Nurse Educator said she had provided drug/[MEDICAL CONDITION] in the workplace for employees only. The Nurse Educator verified she has not educated the staff on the care and services for residents dealing with substance abuse and mental/behavior health disorders in the past year. |
| F 0759<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure medication error rates are not 5 percent or greater.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, clinical record review and staff interviews, the facility failed to administer medication according to physician's orders for 1 (Residents #35) of 6 residents observed for medication administration. The facility failed to ensure its medication error rate remained below 5%. Five licensed nurses with 31 opportunities on two different shifts were observed. Two medication errors were identified resulting in an error rate of 6.45% rate. The findings included: Observation on 3/11/20 at 8:34 a.m., Registered Nurse (RN) Staff B prepared to administer 9 different medications to Resident #35, including [MEDICATION NAME] inhaler 110 micrograms (mcg) and 1 tablet of multi-vitamin with minerals. RN Staff B administered all the oral medications, including 1 tablet of multi-vitamin with minerals to the resident with a glass of water. She then administered two puffs of [MEDICATION NAME] orally to Resident #35. Reconciliation of the observation with the physician's orders revealed an order for [REDACTED].#35. She also verified she should have administered a tablet of a plain multi-vitamin without minerals to the resident. She said she will contact the physician and inform him she failed to follow medication orders. |
| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br>**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** |

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| F 0812<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 8)<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, and staff interview, the facility failed to maintain the kitchen and pantry's in a clean and sanitary manner that is in good repair by having openings into the ceiling with potential contamination of the food areas; uncleanable surfaces in food storage areas, clean surfaces near food preparation equipment, and outdated/unlabeled food items. The findings included: 1. On [DATE] at 9:19 a.m., during the initial tour of the kitchen, the following was observed: The food storage shelves in the walk in refrigerator were rusted/corroded creating uncleanable surfaces; the top of the dish machine was heavily soiled with debris and corrosion; 12 inch by 6 inch and 4 inch by 6 inch holes were present in the ceiling over the dish machine; the metal rack storing the dishes was heavily rusted/corroded; a large section of missing ceiling tiles was present above air conditioner unit leaving the kitchen open to potential contamination from the area above the ceiling; the back of the metal beverage machine table was heavily rusted/corroded with dust accumulated along the pipes, potentially contaminating resident plates sitting on the warmer next to it; the dry storage area has a hole into ceiling around a pipe; rusted wheels on carts; the doors to the kitchen were both soiled/stained and the frame to the double door was heavily rusted. 2. On [DATE] at 9:51 a.m., the first-floor pantry was observed. The interior of the microwave was rusted along the top and bottom edges with a soiled paper towel inside; an ear of corn in the husk was on top of the microwave; an unidentified item was wrapped in tin foil on the table; the drawers to the table under the microwave are soiled; a Ziploc bag of candy and nuts was unlabeled; in the bottom drawer was an opened unlabeled jar of peanut butter; the metal tray under the coffee maker was soiled with spillage; and inside the freezer was an unlabeled food item. 3. On [DATE] at 9:58 a.m., the third-floor pantry was observed. The cart holding the coffee maker has an unlabeled Ziploc bag of strawberries next to 2 wheelchair battery packs; the second shelf has a plastic bin with several food items, a knife and debris; the inside of the microwave had an area of rust on the lower inside; the counter to the left of the sink had an open package of fries on a paper towel; a can of ravioli was stored in the side cabinet and expired [DATE]; the inside of the freezer was heavily soiled with a brown substance which had dripped down into the rubber seam; the brown substance was also along the inside shelves of the freezer door both upper and lower; and in the lower bin of refrigerator was an unlabeled brown fast food bag. 4. On [DATE] at 10:15 a.m. the second-floor pantry was observed. Spillage was present on the metal tray under the coffee maker; and the ceiling tile was dislodged with exposure to area above. 5. On [DATE] at 10:35 a.m., the pantries were observed along with the Dietary Manager. He acknowledged the areas of concern and removed the unlabeled and outdated items. 6. On [DATE] at 8:45 a.m., a tour of dietary was conducted with the Dietary Manager and facility's contracted food services District Manager. The previous areas were again observed. The District Manager said he had tried to clean the calcium deposits and rust off the top of the dish machine but was unable to remove the debris. He observed the missing tiles over the air conditioner unit and confirmed there should be a barrier to the ceiling to prevent dust and debris from dropping down into the kitchen. *Photographic evidence obtained* |
| F 0835<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | **Administer the facility in a manner that enables it to use its resources effectively and efficiently.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interviews with residents and nursing and administrative staff, observation, record and policy review, facility administration failed to ensure the facility's Alcoholic Beverages policy, Abuse/Neglect policy, and Smoking policy, were implemented and followed to protect the rights of all residents. The facility failed to have an effective infection control program putting all residents at risk for parasitic skin infections, by not monitoring residents with a rash. This failure of the administration to protect the residents from being a danger to self and others resulted in physical abuse of residents repeatedly being subjected to an impaired resident running into them with his motorized wheelchair; neglect by allowing residents to leave facility to unknown destinations, becoming impaired when on or off property and placing themselves and other citizens in danger by crossing or falling into the street; allowing a resident to be transported by untrained staff and then falling sustaining a laceration; and not ensuring residents who smoke were properly supervised. The administration's failure to provide adequate supervision and protect residents from abuse/neglect resulted in Immediate Jeopardy starting on 3/12/20. The Administrator was notified of the Immediate Jeopardy on 3/12/20 at 4:45 p.m. The Immediate Jeopardy was removed on 3/14/20 at 2:30 p.m. after credible evidence of measures were taken to correct the immediate jeopardy and the severity was reduced to a E. The findings included: Cross reference F600, F607, F689, and F880. The facility's policy Abuse, Neglect, Exploitation & Misappropriation N-1265, revised on 11/28/17; included all reported events (bruises, skin tears, falls, inappropriate or abusive behaviors) will be investigated by the Director of Clinical Services, patterns or trends will be identified that might constitute abuse. Administration recognizes that resident abuse can be committed by other residents. This information is forwarded to the Executive Director, who will serve as abuse coordinator. The abuse coordinator will refer any or all incidents and reports of abuse to the appropriate state agencies. The facility's identified policy for Alcoholic Beverages, page 19 of the Welcome packet; included To protect the rights of all residents, any resident returning to the Facility, following a therapeutic home visit leave, who is under the influence of alcohol or drugs, and whose behavior is inappropriate, will not be readmitted to the facility. The facility's Smoking Agreement/Notice of Policy dated 01/2020; indicated Residents electing to smoke will be provided a safe smoking assessment to determine and evaluate each resident's ability to safely smoke. Because violations of the smoking policy can lead to catastrophic consequences, the smoking policy will be vigorously applied without exception. The Job Description for Executive Director I (Administrator) included: Maintain and guide the implementation of facility policies and procedures . and to Ensure a safe, clean, and comfortable environment for residents, visitors, and staff. The Job Description for the Director of Nursing included: To assume the primary role in the delivery of high quality, efficient and safe patient care . Maintain and guide the implementation of current policies and procedures . Report and investigate all allegations of resident abuse. On 3/11/20 at 9:35 a.m., in an interview, Resident #95 said every time Resident #67 sees him on the smoking patio he tries to run him over with his motorized wheelchair. Resident #95 said Resident #67 will run into my wheelchair all the time, yells and curses at me when he sees me. He almost pushed me over one day. Resident #95 said Resident #67 drinks beer on the patio and is always drunk, no one does anything. When Resident #67 drinks, he is mean and he scares me, he scares slot of people. Resident #95 said, I have told the Administrator and the Director of Nursing and no one does anything. On 11/11/19 at 11:05 a.m., in an interview Resident #9 said Resident #67 tried to run her over on 3/8/20. Resident #9 said Resident #67 ran into me with the motorized wheelchair and I had to put my walker in front of me to stop him or he would have hit me. Resident #9 said she uses a walker to ambulate and said Resident #67 was always running into me and I have to use my walker to block him. I called the Administrator on 3/8/20 and reported him and she said, I took care of it already. I have reported him so many times to the Director of Nursing, the unit nurse and Administrator, they do nothing. In an interview on 3/10/20 at 6:30 p.m., the Administrator said, the facility is not responsible for Resident #67 if he is intoxicated and leaves the facility grounds in his motorized wheelchair. She said she was not aware Resident #67 was running into other residents with his motorized wheelchair. The Administrator said she was not aware Resident #67 was drinking on the patio and had no policy on the use of alcohol by the residents in the facility. The Administrator said she had no policy on the safety of impaired residents who leave the facility and cross the 6-lane road in front of the facility. The Administrator said she was not responsible for the resident's safety if they signed out of the facility, and said what can I do? 2. In an interview on 3/11/20 at 3:53 p.m., Licensed Practical Nurse (LPN) Staff R said Resident #71 has falls, skin tears, sneak's beer into his room, and has to look for him up and down road where people have seen him drunk or in a bush somewhere. The resident will come back at night with skin tears, slurring his speech, and smelling of heavy alcohol use. The Administrator and Director of Nursing are both aware. Resident #71's clinical record revealed on 8/13/19 at 10:35 p.m., staff found Resident #71 across the street sitting in the car lane in front of a car dealership. The resident was covered in beer, had an open can of beer in his hand and 5 cans in his bag. On 8/17/19 at 10:30 p.m., staff found Resident #71 in front of the hospital parking lot in a bush with multiple skin tears, scratches across his back, and bruising on his right buttock and upper body. Heavy smell of alcohol was noted, and the resident was drinking in the bush when found. On [DATE] at 2:00 p.m., staff received a call from EMS reporting Resident #71 had a fall in the bushes and was being taken to the ER. A review of the hospital History and Physical dated [DATE], revealed the resident was brought to the emergency room (ER) with acute [MEDICAL CONDITION]. In an interview on 3/12/20 at 12:10 p.m., the Administrator said she is the Risk Manager for the facility. If a resident fell when outside the facility and staff have knowledge of this, they were to make out an incident report. The Administrator said she had no incident report for [DATE] regarding any fall for |

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| F 0835<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | (continued... from page 9)<br>Resident #71. The Administrator reviewed the resident's record and said when the resident fell in the bushes and was taken to the ER, he did not return to the facility so there would be no incident report for her to review. The Administrator confirmed she did not do any review of the circumstances leading up to the incident resulting in hospitalization of the resident upon his return. 3. During an interview on 3/10/20 at 11:25 a.m., when asked about the facility's rules for smoking Resident #224 said he did not require supervised smoking. A pack of cigarettes and a lighter was observed in the room on the bedside table. On 3/11/20 at 10:15 a.m., and 3/12/20 at 2:58 p.m., Resident #224 was observed smoking unsupervised on the outside smoking patio. Review of the clinical record revealed no safe smoking assessment was done for Resident #224. On 3/11/20 at 10:16 a.m., Resident #117 was observed slumped over in his wheelchair unsupervised with a lit cigarette on the outside smoking patio. On 3/11/20 the Administrator completed a smoking evaluation and determined Resident #114 was an unsafe smoker 4. Residents #89, #104, #39, #45, #42, #92, and #71, #14, and #99, were reviewed during survey for suspicious rashes. In an interview on 3/10/20 at 5:30 p.m., LPN Staff R said a few residents had rashes that were suspicious for scabies, and the whole unit was treated a couple of months ago. Staff R said most of the suspected residents had an itchy red rash. Some of the residents went to a dermatologist who would say the rash was scabies and some would say it was something else. In an interview on 3/12/20 at 10:53 a.m., the Director of Nursing and Assistant Director of Nursing were unable to provide evidence of any monitoring or tracking of the rashes through the facility's infection control program and had no documentation of an investigation into all the resident's with rashes. 5. On [DATE], Resident #117 returned to the facility in the transport van being driven by the maintenance assistant. Resident #117 fell to the ground and sustained a laceration to his scalp. The resident was transferred to the ER for evaluation and treatment. In an interview on 3/11/20 at 10:40 a.m., the maintenance assistant said he mainly works in the maintenance department but if they need him to take someone to an outside appointment, he usually does it. He said no one gave him any instructions on how to transport Resident #117. The maintenance assistant said when he returned to the facility, he went to get a wheelchair and for some reason Resident #117 stepped out of the transport van and did not wait for him. He said he was not aware of a specific instruction to transport residents and has never received any training on how to safely transport and supervise residents during transport. In an interview on 3/12/20 at 12:10 p.m., the Administrator said she is the Risk Manager for the facility. If a resident fell when outside the facility and staff have knowledge of this, they were to make out an incident report. The Administrator said she had no incident report for [DATE] regarding any fall for Resident #71. The Administrator reviewed the resident's record and said when the resident fell in the bushes and was taken to the ER, he did not return to the facility so there would be no incident report. The Administrator confirmed she did not do any risk management review of this incident and he was treated as a readmission when he returned on 11/12/19. The Administrator said she did not review the circumstances leading up to the incident resulting in hospitalization of the resident. The Administrator said there is no job description for Risk Management and is part of QAPI. |
| F 0838<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to thoroughly evaluate residents needs and update the facility assessment to identify resources to provide necessary care and services to residents affected with the Novel COVID-19 [MEDICAL CONDITION] infection. The findings included: Review of the facility assessment tool with an update on 6/23/20 revealed the purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. In the infection control program part of the risk assessment dated [DATE] the facility documented the probability of exposure to [DIAGNOSES REDACTED] (severe acute respiratory syndrome)/Other respiratory illness was 0/Never. The facility also documented the probability of the lack of emergency preparedness plan (exposure to infectious agents or diseases) was 0/Never. On 6/22/20, when the facility completed mass testing, 34 residents and 10 staff members tested positive for COVID-19. There was no evidence the facility revised the assessment and infection control risk assessment to identify the resources needed to care for the residents. On 7/1/20 at 10:15 a.m., the infection preventionist said she had no documentation regarding education and COVID-19 assessment or preparedness. She said she participated in the update of the facility assessment on 6/23/20 but had no documentation of changes made once 34 residents and 10 staff were identified to have the COVID-19 virus. She said the Administrator had access to the revised facility assessment but did not share it with her. On 7/1/20 at 10:25 a.m., the Director of Nursing (DON) said the Administrator had all the records with the updated facility assessment. The DON said he did not have access to the documentation and did not participate in the revision of the facility assessment even though his name was listed as one of the persons involved in completing assessment. |
| F 0842<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review and staff interview, the facility failed to maintain complete and accurate records for 2 (Residents #42 and #39) of 3 residents reviewed for wounds. Accurate records are necessary to document the course of a resident's care provided by the facility. The findings included: 1. On 3/10/20 at 9:33 a.m., Resident #39 was observed to have a soiled dressing dated 3/6/20, on her right lateral foot. The resident said she could not really remember how the wound occurred but was supposed to get the dressing changed every day. Resident #39's clinical record revealed a Non-Pressure Skin Condition Record indicating on 2/10/20 an open area was noted on the resident's right lateral foot that measured 2.0 centimeters (cm) by 1.0 cm in size. A physician's orders [REDACTED]. The February Treatment Administration Record (TAR) indicated the dressing started on 2/10/20 and was to continue to 3/1/20. There was no indication of any treatment being done on 2/11/20, 2/25/20, 2/27/20, or 2/29/20. The March TAR indicated the dressing was done on 3/1/20 but was not discontinued and there was no documentation of the physician being notified in regard to the status of Resident #39's wound. There was no dressing on 3/2/20 but the dressing was done on 3/3/20, 3/4/20, and 3/5/20. There was no indication any dressing was done on 3/6, 3/7 and [DATE]. 2. On [DATE] at 1:05 p.m., Resident #42 was observed to have a bandage on his left middle finger. A review of Resident #42's medical record revealed a physician's orders [REDACTED]. The Treatment Administration Record for March was reviewed on 3/10/20. There was no documentation of the treatment being done in the a.m. on 3/2/20; or in the a.m. or p.m., on 3/5/20, and 3/7/20. In an interview on 3/13/20 at 9:59 a.m., Licensed Practical Nurse Staff Q confirmed the missing documentation. Staff Q said the protocol is for staff to circle their initials and document the reason the treatment was not done. In an interview on 3/13/20 at 10:26 a.m., the Director of Nursing (DON) said there was no policy in regard to documentation, but the protocol would be for nurses to circle their initials and document the reason the treatment was not done. Staff should also notify the physician. The DON said recently the consultant pharmacist reported missing documentation of medications during her monthly review and staff education was provided. The DON said she would have to check with the Assistant Director of Nursing (ADON) to see when this was done. In an interview on 3/13/20 at 10:33 a.m., the ADON said the pharmacist did review omissions in treatment record documentation as well as medications during the in-service on 1/30/20. The in-service record was reviewed for Common Pitfalls of Documentation and only 9 of the facility's 23 nurses attended in addition to the ADON. |
| F 0843<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care.**<br><br>Based on administrative staff interview, the facility failed to provide documentation of a transfer agreement with any local hospitals to ensure safe, orderly and timely transfers of residents when medically necessary. The findings included: On 3/12/20 at 6:45 p.m., the Administrator said the facility did not have a transfer agreement with any local hospitals. She said she has been employed at the facility since 2009 and they never had a transfer agreement. |
| F 0867<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** |

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| F 0867<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 10)<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and administrative staff interview, the facility failed to have an effective, systemic on-going Quality Assurance and Performance Improvement (QAPI) program. The facility failed to recognize on-going areas of deficient practice and failed to implement immediate appropriate corrective actions to address quality deficiencies with significant high risk to the health and safety of residents. The facility failed to ensure proper surveillance, data analysis, outbreak management and prevention of further infections of residents and staff, as it relates to an outbreak of scabies. This failure of infection prevention and control practice placed all current residents and staff at risk for infection outbreaks. The facility failed to operationalize their abuse policy and procedure and failed to protect residents from repeated physical abuse and subsequent from an intoxicated resident's physically aggressive behavior. The facility neglected to implement adequate and individualized interventions to address [MEDICAL CONDITION] resulting in risky behaviors, multiple falls and self-harm for 3 (Resident #67, #71 and #86) of 3 residents reviewed with known [MEDICAL CONDITION]. Cross reference to F 600, F 607 and F 689 The findings included: Review of the policies and procedures Performance Improvement Committee (Quality Assurance) with a revision date of 6/30/17 revealed The committee with assure QAPI activities have written indicators and standards/thresholds for evaluation, that appropriate actions are implemented, and that such correction has been evaluated by subsequent monitoring. Review of the facility's QAPI plan revealed documentation (facility name) QAPI program encompasses all areas that impact quality of care, quality of life, resident choice and care transition with participation from all disciplines. We will utilize available data .and internal metrics to set strategic goals, monitor and continuously improve outcomes on behalf of those we serve. 1. On 3/13/20 at 1:50 p.m., during a review of the facility's QAPI program, the Administrator said she was the person in charge of QAPI and Risk Management. The Administrator said she gathers information for QAPI meetings from concerns identified by unit managers, monthly staff meetings, daily morning and afternoon meetings, and resident council minutes. The Administrator said she was familiar with residents being intoxicated and falling in the street. She said the residents were counseled and educated on rehabilitation and the non-compliance was documented in their care plans. The Administrator said she was also aware of an episode when a resident used the motorized wheelchair aggressively toward other residents. The Administrator verified the lack of intervention to address the risky behavior of residents engaging in [MEDICAL CONDITION]. She recognized the QAPI committee failed to implement immediate corrective actions to protect vulnerable residents from the repeated physical abuse from Resident #67's aggressive behavior. In response to the infection control related to the identification and treatment of [REDACTED]. She said currently the issues that QAPI identified were meal cart delivery time, call lights not answered in a timely manner and food quality.<br><br>2. In an interview on 3/12/20 at 12:54 p.m., the facility's Medical Director (MD) said he would consider it a big liability for an impaired resident to go out into the street area and fall. He has instructed staff for residents to hold narcotics and pain medications if obviously impaired. The MD said he has been contacted by staff about other physicians' residents being impaired as well and when this occurred, he did instruct staff to remove any alcohol from the resident's room. The MD acknowledged residents were a danger to themselves and others when impaired and out of facility. He said he did attempt to go to the QAPI meeting monthly and the issue with residents being intoxicated was discussed. He did advise them what things they should do to address this issue. |
| F 0880<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, review of policies and procedures and staff interview, the facility failed to ensure proper surveillance, data analysis, outbreak management and prevention to prevent the spread of infection to residents and staff. The facility failed to thoroughly assess and implement adequate interventions for 5 (Resident #89, #42, #14, #92, and #82) of 5 residents reviewed with ongoing rash. The facility failed to maintain proper contact precaution to minimize the spread of [MEDICAL CONDITION] infection for 1 (Resident #14) of 1 resident who shared a room with an infected resident. In addition, the facility failed to follow proper infection prevention and control technique during wound care for 2 (Resident #26 and #28) of 2 residents observed for wound care. This failure of the facility to implement and maintain infection control practices places residents and staff at risk for infection outbreaks. The findings included: According to information on the Centers for Disease Control and Prevention website, scabies outbreak suggests that transmission has been occurring within the institution for several weeks to months thus increasing the likelihood that some infested staff or patients may have had time to spread scabies elsewhere in the community, including to other facilities. Measures to control scabies in an institution depend on factors such as how many cases are diagnosed or suspected, how long infested persons have been at the institution while undiagnosed and/or unsuccessfully treated, and whether any of the cases are crusted (Norwegian) scabies. Because it is so highly transmissible, crusted scabies requires rapid and aggressive detection, diagnosis, infection control, and treatment measures to prevent and control spread. Long-term surveillance for scabies is imperative to eradicate scabies from an institution. (https://www.cdc.gov/parasites/scabies/health_professionals/control.html) The facility policy and procedure IC-310, Infection Prevention and Control Program (reviewed 9/1/17) indicated the elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, outbreak management, prevention of infection, and employee health and safety. Oversight - the infection preventionist and Infection prevention and control committee are to review surveillance date on potential issues and trends. Surveillance - tools are used for recognizing the occurrence of infections, recording their numbers and frequency, detecting outbreaks and epidemics, monitoring employee infection and detecting unusual pathogens with infection control implications. Data Analysis - Data gathered during surveillance is used to oversee infection and spot trends. Calculating numbers. Categorizes each infection by body site/organism (scabies) and record the number of infection or resident with rashes. Outbreak Management - is a process that consists of: Determining the presence of an outbreak Managing the affected residents Preventing the spread to other residents Documenting information about the outbreak Reporting the information to appropriate public health authorities Educating the staff and the public Monitoring for recurrences Reviewing the care after the outbreak has subsided; and Recommending new or revised policies to handle similar events in the future. Prevention of infection - identifying possible infection, avoid complications, educate staff, enhance screening, immunize, implement appropriate precautions and follow established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). 1. In interview on 3/12/20 at 10:53 a.m., the Infection Control Nurse Staff O said that there were only 5 residents in the facility with a rash and itching. When asked about the other 7 residents who were identified with itching and rashes by the surveyors, she was unable to answer. When asked to show her documentation of the history of the rashes and possible scabies outbreak in the facility, Staff O produced 5 sheets of paper with infection control log or monthly line listing report on the top. Each sheet had rashes written across the top. The first list dated 9/4/19 and contained 15 resident names that were identified as starting symptoms of a rash and itching on 8/27/19 and all residents that resided on the 3rd floor of building. The infection control nurse Staff O said no skin scraping were done on any of the residents. When was asked how she learned about these residents with rashes she said the nurses came and told her & the Director of Nursing (DON) on the same day. She did not report she started an investigation or did a facility-wide sweep. She did say she sent the list to the department of health (DOH) on 9/4/19. She could show no follow-up for any of the 15 residents identified in the following months. Staff O had a log with 6 names for November 2019 and 3 names for February 2020, but had no rashes recorded for the months of October, December, or January. Each log had only names and no other information for tracking such as room number, onset date, if they had this on admission, if they had a test to confirm, if the rash was treated, retreated or resolved. They could not produce a log of rashes for December 2019, and the January 2020 log had no rashes documented. The February 2020 log had 3 names on it but again did not have any tracking details or other vital information. Staff O acknowledged that the monthly tracking logs had no detailed information on it. Review of other infection control logs produced by Infection Control Nurse Staff O and the DON from August 2019 to February 2020 showed only a few residents each month with any infections. August 2019 - only 3 urinary tract infections [MEDICAL CONDITION] were reported [DATE] - 4 UTIs and on case of [MEDICAL CONDITION] (C. diff) October 2019 - 2 UTIs November 2019 - 3 UTIs, date of onset put in wrong order as if log all at the same time and got them out of order December 2019 - 1 UTI infection all month nothing else recorded for the month no date of onset January 2020 - 4 UTIs and 1 URI (upper respiratory infection), dates out of order as if copied onto log for a monthly report from lab. February 2020 - 5 UTIs and multiple out of order in recording results |

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| F 0880<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Some | (continued... from page 11)<br>by dates. No current month of March 2020 presented for review. There was no tracking of Healthcare Acquired Infections were noted. no room numbers were tracked, no MDRO (MulitDrug Resistent Organisms) were tracked as noted on long term residents. There was no tracking of trends It appears that the logs were written all at the same time in the same handwriting and with the same pen. On 3/12/20 at 11:00 a.m., the DON said that they made out an Ad Hoc Quality Review Meeting on 9/6/19 about the number of scabies cases suspected on the 3rd floor of the building. Data just states multiple resident identified with mild rash. Root cause analysis - contact [MEDICAL CONDITION] unknown cause. Plan - topical treatment per order, daily showers, linen change daily, deep clean rooms, bag and launder personal clothing, treat staff per medical director (MD) prescription medication topically, report to Department of Health, medication reviews by MD. The issues with resident rashes were not followed up on in the next couple month Quality Assurance & Performance Improvement meetings. The Infection Control Nurse and DON could not show any investigation or problem solving as it relates to the large number of rashes in the building. No follow up was done after this meeting no evidence was presented that rashes were tracked until resolved for the 8/27/19 list of 15 residents. No follow-up or list of staff treated and resolved. No tracking of the rashes in facility for the next 7 months. Only names on a sheet without room numbers, where the rash was, when it was first noted, event or new medication or treatment around the time of rash. On 3/12/20 at 11:10 a.m., the infection control nurse or DON could not show documentation that staff were trained or in-services on the spread of possible scabies in the facility and how to prevent and report any further rashes. The Infection Control Nurse or DON could not produce any documentation of how many staff members need to be treated for [REDACTED]. The nurse said a resident with [DIAGNOSES REDACTED] may be out of there room if they wash their hands. When asked if she knows for sure if the resident is washing their hands, she said no. When infection control nurse and DON were asked how they are tracking resident with respiratory symptoms such as cough and/or fever, but not a positive chest x-ray, they did not answer, and could not produce documentation that any symptoms like that were in the building. She said that she does not interview staff about signs and symptoms or when the rash started or circumstances around when it appeared. On 3/17/20 10:50 a.m., a call was placed to the Lee County Department of Health (DOH). The DOH staff said she was aware of the scabies outbreak in August of 2019 and had received a faxed scabies line list from the facility on 9/4/19. She said the department then sent out an information sheet on Crusted [REDACTED] and how to handle it. On 3/17/20 at 10:53 a.m., a call was placed to another staff member at the DOH. He said he was aware of the scabies outbreak at the facility. He looked up the file and said that the facility had sent a scabies line list of 15 residents that had been found to have rashes and itching. He said that the DOH had sent an information sheet on the Crusted [REDACTED] for them to follow. He said neither the DOH or the Program Manager, had not heard back from them since they sent the list. He called and left a message on November 4, 2019 asking for a follow-up and the cases in the facility. A message was left with Director of Nursing with no return call received from the facility. Then on January 13, 2020, another call was placed to the administration at the facility and a message was left asking for a follow up on the scabies outbreak in August. No return call was ever received from the facility. On [DATE] at 12:13 p.m., observed Resident #89 itching his lower legs, pulling his pant legs up and digging at his skin. While watching him for over 15 minutes he was seen to be itching his head, arms and hands in a vigorous manor. Resident seemed to have a grimacing look on his face with his teeth clenched as he scratched the different parts of his body. On 3/10/20 at 2:10 p.m., observed resident in the dining room area sitting next to a table. He was itching his lower legs and his forearms in a vigorous manor and said to this surveyor, can you help me with this itching? It is so terrible! Resident had a worried look on his face and then continued to scratch his stomach and underarms. On 3/10/20 at 10:30 a.m., in interview with Assistant Director of Nursing/Infection Control nurse, she said that the facility has had no confirmed positive cases of scabies in the last year. She said they have had a lot of rashes, but they have been sending them to the dermatologist and they have not confirmed scabies. 2. Record review of dermatology consult on 10/11/19 recorded that Resident #89 had a [DIAGNOSES REDACTED]. Resident had been treated with [MEDICATION NAME] cream on 1/10/19. Resident record shows that resident continued with almost continuous itching and on 1/8/20 order for hold all medications for 30 days from 1/8/20 to [DATE] to see if medication were causing him to itch. Review of skin monitoring sheet multiple skin tears from areas of itching over the months. In interview on 3/10/20 at 10:14 a.m., LPN Staff Q said Resident #89 was tested for scabies at the dermatologist on 6/14/19 and was not shown to have scabies at that time. But he has not been tested since. She said the resident was treated for [REDACTED]. In interview on 3/11/20 at 9:41 a.m., Certified Nursing Assistant (CNA) Staff I said Resident #89 has been itching for a long time now she said that the nurse puts cream on him. She said the itching interferes with his eating and sleeping she thinks because he is always itching. She said there was a lot of other residents who have rashes too. On 3/11/20 at 9:41 a.m., observed resident skin with assistance of CNA Staff I, resident bilateral lower legs had multiple scratch marks on them with 2 open areas that have slight bleeding on his left leg. His left forearm had to 2 large skin tears the CNA said was caused from his constant itching. Top of resident's head had 4 open areas of raised red rash that resident was scratching. Residents left lateral back from his spine to shoulder blade and rib area had multiple area of purpura (any of several hemorrhagic states).<br><br>3. [MEDICAL CONDITION] (C. diff) is an infectious bacterium that causes symptoms ranging from diarrhea to life-threatening inflammation of the colon. The bacteria and their spores are found in feces. People can get infected if they touch surfaces contaminated with feces, and then tough their mouth. Healthcare workers can spread the bacteria to their patients if their hands are contaminated. Review of facility policy and procedure [MEDICAL CONDITION] (9/1/17) revealed: [MEDICAL CONDITION] infection will be considered in residents with an acute onset of diarrhea (three or more unformed stools within 24 hours) or abdominal pain . 10. Residents with diarrhea associated with [DIAGNOSES REDACTED]icile (i.e., residents who are colonized and symptomatic) will be placed on Contact Precautions. a. Healthcare workers will wear gloves and gowns upon entering the room of a resident with [DIAGNOSES REDACTED]icile infection and will remove gowns and gloves prior to exiting the room. f. Residents with [DIAGNOSES REDACTED]icile infection will be placed in a private room if available. If a private room is not available, residents will be cohorted with a dedicated commode for each resident. 11. When caring for residents with diarrhea or fecal incontinence caused by [DIAGNOSES REDACTED]icile, staff will maintain vigilant hand hygiene. Hand washing with soap and water is superior to ABHR (alcohol-based hand rub) for the mechanical removal of [DIAGNOSES REDACTED]icile spores from hands. 12. Glove use when caring for residents with [DIAGNOSES REDACTED]icile infection, washing hands with soap and water upon exiting the room of a resident with [DIAGNOSES REDACTED]icile infection AND strict adherence to hand hygiene in general is considered best practice. Observation of Resident #224's room on [DATE] at 9:20 a.m., revealed a large blue rack hanging on the bedroom door containing isolation gowns, gloves and masks. Clinical record review revealed on 3/7/20 Resident #224's stool culture came back positive for [DIAGNOSES REDACTED]icile. On [DATE] at 9:30 a.m., Resident #224 said he is on isolation for [DIAGNOSES REDACTED]. He said no one has told him he couldn't leave his room. He said he leaves his room every day to go smoking. Resident #224 said he uses the urinal and shares the toilet with his roommate, Resident #14. The resident was alert and oriented and able to answer questions appropriately. Observation of the room and the bathroom failed to reveal the presence of a dedicated commode for Resident #224 or #14. On [DATE] at 4:45 p.m., Resident #14 said he is incontinent of urine but uses the bathroom when he needs to have a bowel movement. Resident #14 said no one has told him he couldn't use the bathroom. Resident #14 was able to answer all questions appropriately during the interview. On [DATE] at 10:00 a.m., CNA Staff A was observed changing the sheets on Resident #224's bed who is on contact precaution for [DIAGNOSES REDACTED]. She removed the bed sheets and placed them in a plastic bag. CNA Staff A removed her gloves and left the room without washing her hands. She took the bag of contaminated laundry to the soiled utility room on the second floor and discarded the bag. She did not wash her hands before leaving the soiled utility room. On [DATE] at 10:15 a.m., CNA Staff A said she did not know what Resident #224 was on isolation for. She said no one told her. CNA Staff A said she did not wear a gown to change the bed because the resident was not in the room. She said she is only obligated to wear personal protective equipment when the resident is in the room. On 3/10/20 at 11:00 a.m., Resident #224 was observed leaving his room without washing his hands. On 3/10/20 at 8:30 a.m., Resident #14 was observed using the toilet in the bathroom he shared with Resident #224. On 3/10/20 at 8:40 a.m., Unit Manager Licensed Practical Nurse Staff Q verified Resident #14 was using the same toilet as Resident #224 who is on isolation for [DIAGNOSES REDACTED]. On 3/11/20 at 4:40 p.m., the DON said she would have given a commode to Resident #14, but she didn't have one in the building at the time the roommate was diagnosed with [REDACTED]. She said the CNA's were educated on taking Resident #14 to the bathroom in the shower room. She said Resident #14 is very strong and sometimes transfers himself to the bathroom independently. The DON provided the survey team with an education in-service attendance record dated 3/7/20 in which they discussed personal protective equipment and handwashing with 14 CNA's. CNA Staff A was not on the list of attendees. On 3/11/20 at 10:00 a.m., |

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| F 0880<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Some | (continued... from page 12)<br>the nurse documented in Resident #14's record Resident noted to transfer self to bathroom in room. Resident educated on asking staff for assist with toileting. Made aware that toilet could not be shared at this time. MD (physician) made aware. Order noted to monitor for s/s (signs and symptoms) of N/V (Nausea and Vomiting) and diarrhea. No discomfort or distress noted at this time. On 3/11/20 at 7:10 p.m., the nurse documented on the Resident Education Record form for Resident #224, Patient verbalized understanding of handwashing instructions given, before and after using bathroom and giving self-peri care after using bathroom. 4. On [DATE] at 4:45 p.m., Resident #14 was observed in his wheelchair. He was alert and oriented to time place and person. He answered questions appropriately. The resident's arms had multiple small red pimple areas to both arms and lower outer legs. Two large scratch marks with dried up blood and rash observed to the left outer lower leg. Resident was constantly scratching his right forearm and complained of intense, constant itching. On [DATE] at 5:30 p.m., the licensed nurse documented C/O (complain of) right itch. Noted multiple sm (small) open areas on skin. New order to cleanse skin tear to right forearm. Pat dry. Apply Xeroform and dry dressing once daily X (for) 14 days. No signs of infection noted. The nurse did not document the location of the open areas. On 3/10/20 at 9:10 a.m., during an interview unit manager Licensed Practical Nurse Staff Q said around the holidays Resident #14 started complaining that his back itches. She said he has not seen the dermatologist, but the attending physician treated him with [MEDICATION NAME] cream (anti-parasite) [MEDICATION NAME] but it didn't get better. She said they try to keep his nails trimmed and they are applying [MEDICATION NAME] cream (corticosteroid). She said she could not remember when the attending physician last saw him, but he said to continue with the [MEDICATION NAME] cream. On 3/10/20 at 9:15 a.m., the resident's skin was observed with the unit manager LPN Staff Q. Multiple red pimple like areas were observed on the Resident's upper left back, both thighs, abdomen, arms and legs. The resident's right arm was bandaged with rolled gauze. Resident #14 remained with Large scratch marks to the left outer leg. Resident #14 exclaimed, It itches like crazy. He thanked the surveyor for looking at his skin. On 3/11/20 clinical record review failed to note documentation the physician was notified Resident #14's rash had spread beyond his back. On 3/11/20 at 2:00 p.m., during an interview the attending physician was notified of the resident's skin observation on 3/10/20. He said he would assess the resident's skin. On 3/12/20 at 12:12 p.m., during an interview Resident #14 continued to complain about his skin. He said he was miserable and itching all the time. Resident repeated he was miserable, and his back was constantly itching. On 3/12/20 at 2:57 p.m., Resident #14 was observed in the outside smoking patio. Resident complained of intense itching to his left arm. He said he was miserable all the time, it never stops itching. On 3/12/20 at 5:45 p.m., CNA Staff A said Resident #14 has had the rash to his legs, arms, abdomen and back for a long time. She said he is always itching. On 3/13/20 at 11:45 a.m., the unit manager LPN Staff Q said she has been employed at the facility for 6 years. For 5 years she has been the unit manager. She said she also provides direct care to the residents, including administer medications 3 to 4 days each week. She said it's hard to keep up with everything and that's how things get missed or overlooked. She said no one ever told her that the resident's rash had spread beyond his back. She said the nurses are responsible to do their own skin sweeps. If there are areas of concern, they tell her, and she would call the physician. She said in the case of Resident #14 no one has informed her. Resident #14's clinical record was reviewed and indicated the physician had ordered treatment on 11/18/19 with Ivermectin and [MEDICATION NAME] cream (anti-parasite). The resident was to take Ivermectin (anti-parasite) 3 milligrams (mg), 5 tablets by mouth on arrival from the pharmacy; [MEDICATION NAME] cream (anti-parasite) 5% apply head to toe during the 3:00 p.m., to 11:00 p.m. shift; shower on the 7:00 a.m. to 3:00 p.m. shift; Repeat in 1 week. The physician also ordered daily showers for 3 weeks. The resident was to also have [MEDICATION NAME] (anti-fungal) 100,000 units/gram, and [MEDICATION NAME] (corticosteroid) 0.05% topically to the entire body daily for 21 days. On 11/25/19, the physician ordered showers twice a day for 21 days and continued the daily [MEDICATION NAME] cream and [MEDICATION NAME] cream for 21 days to the entire body. The order also included 4 tablets of Ivermectin 3 mg by mouth to be given once by mouth for a [DIAGNOSES REDACTED]. Review of the skin evaluation revealed on 12/3/19 and 12/17/19, 1/17/20, 1/14/20, 1/21/20 the Licensed Nurse documented Resident #14 had a rash. The nurse did not document the location or describe the rash. On 2/4/20 the skin evaluation had documentation of treatment in progress but did not had documentation of the skin condition. On 2/11/20, 2/18/20, and 2/25/20 the nurse documented a previously identified rash and marked the resident's back as the location. On 3/7/20 the licensed nurse documented Resident continues with rash to back, cream applied. On 3/3/20 and 3/10/20 the nurse documented the resident's skin was intact. Review of the physician's progress notes revealed on 11/21/19, 12/24/19, 1/29/20 and 2/26/20 the attending physician documented the resident's skin had no rash. On 2/26/20 the physician documented Resident #14 said I feel ok.<br><br>5. On [DATE] at 1:05 p.m., Resident #42 was observed walking around the unit and requested to be interviewed. The resident said he starts itching every time he gets a shower. The resident was wearing pants that extended just past his knees, exposing the skin on his lower legs. The resident was observed to have multiple small pimple like areas, some with crusted/scabbed (dried blood), on both his lower legs, ankles, and feet. The resident said he was not sure how long he had this rash and may have started last summer. The resident was also observed to have a bandage on his middle finger. On 3/10/20 at 11:38 a.m., LPN Staff W was observed doing wound care to Resident #42's finger. The rash was noted to still be present on the resident's lower extremities. Staff W also observed the rash and said she would have to ask LPN Staff Q about it. In an interview on 3/10/20 at 5:30 p.m., LPN Staff R said a few residents had rashes that were suspicious for scabies, and the whole unit was treated a couple of months ago. Staff R said most of the suspected residents had an itchy red rash. Some of the residents went to a dermatologist who would say the rash was scabies and some would say it was something else. Staff R said she was not aware of any rash on Resident #42 but would do a skin check on him. The Skin Evaluation records for February and March 2020 were reviewed and indicated the last skin sweep for Resident #42 was on 2/17/20. Resident #42's clinical record was reviewed and indicated the physician had ordered treatment for [REDACTED]. The resident was to take daily showers for 21 days; change linen daily for 21 days; [MEDICATION NAME] cream (anti-parasite) apply topically from neck to toes on 11/26/19 and shower on 11/27/19, repeat in 1 week on 12/3/19; Ivermectin (anti-parasite) 3.0 mg take 4 tablets upon arrival from pharmacy; [MEDICATION NAME] (anti-fungal) cream apply topically to entire body for 21 days; and [MEDICATION NAME] (topical steroid) 0.05% apply topically to entire body for 21 days. The Interdisciplinary Progress notes were reviewed and there was no documentation of any rash being present or skin condition being treated from 11/3/19 through [DATE]. On 3/10/20 at 9:35 p.m., LPN Staff R noted Resident #42 was complaining of itching. Small red bumps/rash noted to both feet, ankles, arms and upper back. Physician notified and new order for [MEDICATION NAME] cream 1% apply to rash twice a day for 14 days and [MEDICATION NAME] ([MEDICATION NAME]) 10 mg 1 tablet daily for itching. Cream applied with, resident saying thank you. In an interview on 3/13/20 at 9:51 a.m., LPN Staff Q said in November 2019, there were 7 to 8 residents with scabies type rashes so all residents on second floor, including Resident #42 were treated. 6. On 3/10/20 at 11:55 a.m., Resident #92 was observed self-propelling about the hallway. The resident was wearing shorts and had a rash with small red pimple like bumps with some scabbed areas noted on his left thigh. Resident #92 said he was not sure what the rash was but itches, so he scratches it. In an interview on 3/11/20 at 9:13 a.m., LPN Staff X said she sometimes will notice rashes on residents but is not aware of Resident #92 currently having a rash. On 3/11/20 at 10:04 a.m., Resident #92's skin was observed along with LPN Staff X. The resident said he had been itching on his bottom. Observed the resident's left hip area had several areas of scabbed tracking type rash extending down into his groin; on his left buttocks area; large areas of the rash along his back; areas on his left thigh; around his waist; both arms; and right inguinal area. The resident said he started itching about 2 days ago, especially on his bottom. On 3/11/20 at 10:10 a.m., LPN Staff Q also observed the resident's skin and confirmed the rash was suspicious for scabies. Staff Q said she would notify the resident's physician. In an interview on 3/13/20 at 10:02 a.m., LPN Staff Q said the resident has been placed on contact precautions for suspected scabies and is being treated with [MEDICATION NAME] cream.<br><br>7. The facility Policy N-1310, Dressing Change (revised 12/6/17) specified a clean dressing will be applied by a nurse to a wound as ordered .assemble equipment as needed for dressing change .place supplies on a prepped work space .perform hand hygiene and apply gloves .remove soiled dressing .remove gloves and perform hand hygiene .apply gloves and cleanse wound as ordered .remove gloves and perform hand hygiene .apply treatment as ordered and discard gloves and perform hand hygiene. On 3/11/20 at 11:00 a.m., during an observation of wound care for Resident #26, Registered Nurse (RN) Staff B washed her hands for 10 seconds and left the bathroom. Staff B pulled the privacy curtain closed and moved the bedside table closer to the bedside. Staff B donned gloves but did not wash her hands. Staff B observed the wound, touching the wound tissue with her gloved hands and then opened the sterile bottle of solution and cleansed the wound. Staff B changed gloves and did not wash her hands. Staff B donned gloves and applied the dressing. Staff B completed the wound care for Resident #26 and doffed the |

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| F 0880<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Some | (continued... from page 13)<br>gloves but did not wash her hands. On 3/12/20 at 11:00 a.m., during an observation of the wound care for Resident #28, RN Staff B washed her hands for 10 seconds and donned a pair of gloves. Staff B went to the treatment cart to gather her supplies with the gloves on. Staff B then went into the bathroom and wet a paper towel with water and washed the resident's bedside table. Staff B removed the gloves and washed her hands for 6 seconds. Staff B went back to the treatment cart, gathered the supplies (dressings, scissors, medicated ointment, tape) and placed them on the bedside table. Staff B opened a sterile barrier and placed it on the table, then moved the supplies on to the barrier. Staff B opened the dressings and discarded the wrappers in the trash can, then using her gloved hand Staff B pushed the wrappers into the trash can. Staff B removed the soiled dressing wearing the same gloves and cleansed the wound on the left foot with the wound cleanser. Staff B removed her gloves and applied a clean pair without cleansing her hands. Staff B completed the wound care to the left foot, removed the gloves and washed her hands for 10 seconds and donned a clean pair of gloves. The RN removed the soiled dressing from Resident #28's right foot, placing it into a red bag and cleansed the right foot with wound cleanser, while wearing the same gloves. Staff B removed the soiled dressing from the red bag to check the drainage on the soiled dressing. Staff B removed the gloves and washed her hands for 4 seconds and applied clean gloves. Staff B completed the wound care as ordered for Resident #28's right foot, doffed the gloves and washed her hands for 10 seconds. On 3/13/20 at 9:13 a.m., Staff B said she was not aware that she did not wash hands for 20 seconds and did not know she was required to wash her hands when she removed the soiled gloves and applied the clean gloves.<br><br>8. According to record review of the physician order [REDACTED].#82 was ordered to have Weekly Skin Sweeps on Thursday during the 7 a.m. to 3 p.m. shift. Review of the care plan initiated 11/12/19 showed Resident #82 was at risk for skin breakdown. The interventions initiated on 11/12/19 included weekly skin checks. According to record review of the physician order [REDACTED].#82 was ordered [MEDICATION NAME] Cream 5%, apply neck to toes. Shower the next day during the 7:00 a.m. to 3:00 p.m. shift and repeat in one week. According to record review of the November 2019 Skin Evaluation for Resident #82, skin checks were performed on 11/7/19 and 11/14/19. Skin evaluations for the next two weeks were blank. The instructions for the skin evaluation were: Licensed Nurse will complete Skin Evaluation weekly and prior to discharge or transfer. According to record review of the physician order [REDACTED].#82 was ordered [MEDICATION NAME] Cream 5%: Apply topically from neck down to toes over entire body; repeat in one week for Diagnosis: [REDACTED].#82 was ordered [MEDICATION NAME] ([MEDICATION NAME]) Cream; apply to body, leave on overnight, repeat in one week, Diagnosis: [REDACTED].#82, skin checks were performed on 2/3/20 and 2/17/20. Skin evaluations for two of the weeks were blank. According to record review of the physician's orders [REDACTED].#82 was ordered to have skin sweeps (evaluations) weekly on Thursday during the 7 a.m. to 3 p.m. shift. On 3/12/20 at 12:32 p.m., during an interview with LPN Staff Q she said Resident #82 went to the Dermatologist on 2/7/20 and was treated for [REDACTED]. |
| F 0881<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Implement a program that monitors antibiotic use.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on staff interview and policy and record review, the facility failed to show evidence of a working and effective antibiotic stewardship program. The findings included: Review of the facility's Antibiotic Stewardship program policy revealed the following. The program is to include clinicians, infection preventionists/infection control nurse, quality improvement staff, laboratory staff and nurses. This program should include a 48-hour time-out which is done by pharmacy or medical doctor review. This is to assess changes for route, dose adjustments, unnecessary antibiotic use, and detection and prevention of MDRO (multi-drug resistant organisms). The program is to have tracking antibiotics prescribing and resistance patterns. Reporting antibiotic use and resistance to all necessary staff. and education for all staff and clinicians as needed. During an interview on 3/12/20 at 11:25 a.m., with infection control nurse, Staff O she said for her antibiotic stewardship program she writes down on a form what antibiotics a resident is placed on and then attaches the lab for the organism if it was a urinary tract infection. She could not produce written antibiotic use protocols on antibiotic prescribing, including the documentation of the indication, dosage and duration of use of antibiotics in the facility. She acknowledged that she does not do periodic review of antibiotic use by prescribing practitioner. During an interview on 3/12/20 at 11:27 a.m., the Director of Nursing could not acknowledge whether the antibiotic use monitoring system is reviewed when the resident is new to the facility, when residents return to the facility or are transferred from a hospital or other facility. She could not show documentation of protocols to optimize the treatment of [REDACTED]. She was also unable to show a system for the provision of feedback reports on antibiotic use, antibiotic resistance patterns based on laboratory data and prescribing practices for the prescribing practitioners. From review of the documents viewed the facility does not have an effective antibiotic stewardship program. |
| F 0921<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and interview, the facility failed to maintain a safe, functional, sanitary and comfortable environment for residents, staff and public. The facility failed to repair damaged and missing tiles in residents' rooms, failed to properly store resident care items, failed to maintain clean high touched areas in residents' bathrooms and facility stairs. For 8 of 22 rooms on the second floor of the facility. The findings included: Observation on 3/10/20 at 12:58 p.m., revealed room [ROOM NUMBER] C had a missing tile next to air conditioning (AC) unit. The base of toilet was heavily soiled. The same observation was made on 3/11/20 at 12:25 p.m. Observation on 3/10/20 at 1:01 p.m., revealed room [ROOM NUMBER]A had an area next to AC unit missing. The toilet was soiled. A mop was stored in the corner of the bathroom. The same observation was made on 3/11/20 at 12:15 p.m. Observation on 3/10/20 at 11:49 a.m., of room [ROOM NUMBER] B revealed the wall had a missing tile and was soiled with debris around electrical to AC unit. The handrail in the bathroom was stained and stains were observed around the base of the toilet. The same observation was made on 3/11/20 at 12:15 p.m. Observation of room [ROOM NUMBER] on 3/10/20 at 11:13 a.m., revealed the grout around toilet with large accumulation of brown substance. An unlabeled urinal was hooked to the handrail in the bathroom. On 3/11/20 at 12:16 p.m. The grout around the toilet remained with large accumulation of brown substance. Observation of room [ROOM NUMBER] B and 219 C on 3/10/20 at 10:45 a.m., revealed the following: A tile was missing around the electrical outlet to the left of AC (air conditioning) unit. The cover of the AC unit was soiled with brown drippage. The floor of the room was soiled and sticky under foot. A ceiling tile in front of the window was heavily strained. The bathroom had chipped tile in front of riser to the shower. A resident cushion was on floor in the shower. The base of the toilet was heavily soiled and stained. The floor was soiled with debris. 2 unlabeled wash basins being nested on the floor to the right of the toilet. The inside of the toilet bowl was heavily stained with brown substance. The AC vent in the ceiling was dusty. The same observation was made on 3/11/20 at 12:20 p.m. Observation of room [ROOM NUMBER] B on 3/10/20 at 11:05 a.m., revealed exposed electrical wires next to AC unit. The same observation was made on 3/11/20 at 12:16 p.m., and a brown substance was observed on the bathroom walls. Observation of room [ROOM NUMBER] C on 3/10/20 at 11:05 a.m., revealed exposed detached electrical wires next to AC unit. Resident care items were not stored in sanitary manner. The same observation was made on 3/11/20 at 12:16 p.m. Multiple observations on 3/10/20 through 3/13/20 of front and rear stairwells of the facility revealed odors of urine in front and back stairwells and sticky bannisters. During an interview on 3/11/20 at 10:15 a.m., the facility's contracted account manager reported he has been covering as a supervisor at the facility since 3/11/20. He said there were 3 housekeepers in the facility, one is assigned to each floor. He also said there was one floor tech who cleans the floors in resident rooms and facility hallways. On 3/12/20 at 2:00 p.m., observed a brown multi-legged insect crawling on the wall in room [ROOM NUMBER]. The door in the stairwell on the first floor opening to outside patio has large gap when closed. The Minimum data set office was noted to have large opening next to AC unit in wall. On 3/13/20 at 9:15 a.m., Licensed Practical Nurse (LPN) Staff Q said the residents' rooms could be cleaner. She reported the housekeepers do not deep clean residents' rooms as often as they should. On 3/13/20 at 9:20 a.m., LPN Staff Y said the residents' rooms could be cleaner. She said there were not enough housekeepers, and she thought there should be at least 2 housekeepers on the first floor to keep the residents' rooms clean. On 3/13/20 at 9:40 a.m., Registered Nurse Staff B said residents' rooms needed to be cleaned more. |