

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/20/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175465	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2021
NAME OF PROVIDER OR SUPPLIER VIA CHRISTI VILLAGE PITTSBURG INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1502 E CENTENNIAL PITTSBURG, KS 66762		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and complaint investigation #152137, #160166 and #162242. This 2567 was electronically sent to the facility on 5/20/21.	F 000			
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657			

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 657	<p>Continued From page 1</p> <p>by:</p> <p>The facility reported a census of 74 residents with 22 residents included in the sample. Based on observation, record review and interview, the facility failed to review and revise the care plans for four of the residents sampled, including Resident (R) 2, R33, and R47 regarding timely interventions after falls to prevent further falls, and timely interventions to prevent further skin tears on the arms of one sampled resident R51.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The "Physician Order Sheet" (POS), dated 04/06/21, documented Resident (R)2 had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). <p>The "Significant Change Minimum Data Set" (MDS), dated 03/11/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. He required extensive assistance of two staff for bed mobility, transfers and toilet use. His balance was not steady, and he was only able to stabilize with staff assistance. He used a walker and a wheelchair for mobility and had two non-injury falls since the prior assessment.</p> <p>The "Falls Care Area Assessment" (CAA), dated 03/11/21, documented the resident had decreased safety awareness related to impaired cognition and used a wheelchair for most mobility needs.</p> <p>The falls care plan, updated 04/16/21, instructed staff to keep the resident's pathways clear and to</p>	F 657			

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F 657	<p>Continued From page 2</p> <p>provide adequate lighting due to the resident's decreased safety awareness. Staff were to ensure the resident had on appropriate foot wear at all times, to put him on the couch or the recliner following meals, and to initiate a toileting diary to determine appropriate toileting times for the resident.</p> <p>Review of the resident's electronic medical record (EMR), revealed a fall assessment, dated 04/16/21, which placed the resident at a high risk for falls.</p> <p>Review of the facility's fall report, documented 02/18/21, included: The staff discovered the resident lying on the floor of his room. The resident complained of right hip pain. The resident's ROM was intact and his neuro signs were within normal limits (WNL). The fall report lacked an analysis for the fall. The staff did not initiate an immediate intervention following this non-injury fall to prevent further falls.</p> <p>Review of the facility's fall report, documented 04/16/21, included: Staff discovered the resident on the floor in the commons room lying on his right side, propped up on his right elbow. His range of motion (ROM) was intact and he had no injuries. Staff assisted him up to his wheelchair with extensive assistance of two and taken to the bathroom. The resident had been incontinent of bowel. The fall report lacked analysis for the fall. The staff did not initiate an immediate intervention following this non-injury fall to prevent further falls.</p> <p>On 05/11/21 at 12:20 PM, the resident sat in his wheelchair in the dining room eating lunch. The</p>	F 657			

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F 657	<p>Continued From page 3</p> <p>resident wore appropriate footwear and an anti-rollback break was in place to the back of his wheelchair.</p> <p>On 05/11/21 at 01:10 PM, the resident rested in bed. The fall floor mat was in place on the floor next to his bed. The bed was in the lowest position.</p> <p>On 05/12/21 at 01:33 PM, Licensed Nurse (LN) G stated, when a resident fell, the nurse will initiate a new intervention and add it to the care plan.</p> <p>On 05/13/21 at 09:40 AM, Administrative Nurse D, stated it was his expectation that the nurse immediately initiate a fall intervention following each fall and add it to the care plan.</p> <p>The facility failed to review and revise the care plan following this dependent resident's falls to prevent further falls.</p> <p>The facility policy for "Falls", last approved 12/2019, included: The facility will update the care plan with new interventions.</p> <p>The facility failed to review and revise the care plan for this dependent resident following falls to prevent further falls.</p> <p>- The "Physician Order Sheet" (POS), dated 04/07/21, documented Resident (R) 33 had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).</p>	F 657		

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F 657	<p>Continued From page 4</p> <p>The Admission "Minimum Data Set" (MDS), dated 03/22/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. He required extensive assistance of two staff for bed mobility, transfers and toilet use. He had no falls since admission to the facility.</p> <p>The "Falls Care Area Assessment" (CAA), dated 03/22/21, documented the resident had not had any falls since admission to the facility and was at risk for falls due to an unsteady gait. Staff were to assist the resident with transfers and mobility.</p> <p>The Falls Care Plan, dated 03/15/21, instructed staff the resident was at risk for falls due to him being a recent admission to the facility. Staff were to keep his pathway clear, provide adequate lighting, and keep his bed at an appropriate height.</p> <p>Review of the resident's electronic medical record, revealed a fall assessment, dated 03/30/21, which placed the resident at a high risk for falls.</p> <p>Review of the facility's fall report, documented 03/23/21, included: The resident attempted to get up from his bed without assistance and was found on his back on the floor of his room. He had no injuries from the fall. The fall report lacked an analysis for the fall. The staff did not initiate an immediate intervention following this non-injury fall to prevent further falls.</p> <p>Review of the facility's fall report, documented 03/30/21, included: Staff discovered the resident</p>	F 657			

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F 657	<p>Continued From page 5</p> <p>on the floor of the hallway. He had stood up from his wheelchair, lost his balance and fell to the floor. Staff were unable to reach him before he landed on the floor. He received no injuries from the fall. The fall report lacked an analysis for the fall. The staff did not initiate an immediate intervention following this non-injury fall to prevent further falls.</p> <p>On 05/11/21 at 11:49 AM, the resident sat in his wheelchair in the dining area. He wore appropriate shoes.</p> <p>On 05/12/21 at 01:33 PM, Licensed Nurse (LN) G stated, when a resident fell, the nurse will initiate a new intervention and add it to the care plan.</p> <p>On 05/13/21 at 09:40 AM, Administrative Nurse D, stated it was his expectation that the nurse immediately initiate a fall intervention following each fall and add it to the care plan.</p> <p>The facility failed to review and revise the care plan following this dependent resident's falls.</p> <p>- Review of R 47's "Physician Order Sheet," dated 04/07/21, revealed diagnoses that included repeated falls, diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with polyneuropathy (nerve damage in multiple nerves), hypertension (elevated blood pressure) and dementia (progressive mental disorder characterized by failing memory, and confusion).</p> <p>The "Annual Minimum Data Set," dated 04/01/21,</p>	F 657			

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F 657	<p>Continued From page 6</p> <p>assessed the resident with a Brief Interview for Mental Status score (BIMS) of 14, which indicated normal cognitive status. The resident required extensive assistance of two staff for bed mobility, transfers, and locomotion on the unit. The resident required staff assistance to maintain balance and had no impairments in range of motion in her upper or lower extremities.</p> <p>The "Falls Care Area Assessment" (CAA), dated 04/01/21, assessed the resident as having a high risk for falls. The facility determined the falls were a result of the resident transferring herself without asking for assistance of staff or using her call light. The resident required frequent reminders to ask for assistance but continued to attempt self-transfers. The resident was able to propel herself when in a wheelchair. The resident received therapy services for training and safety training.</p> <p>The "Care Plan," dated 02/15/21 and revised 05/05/21, instructed staff to know the resident had a memory problem with impaired decision-making skills and an impaired ability to comprehend due to dementia. The resident was blind in her right eye. The resident could propel herself when in the wheelchair for short distances. The resident was continent of bladder with occasional incontinent episodes. Staff were advised the resident chose to not request help with transfers at times, due to impulsiveness. The resident had a fall mat beside the low bed and a transfer bar. The resident should wear nonskid socks, had a soft touch call light, and nonskid strips on the fall mat. The care plan instructed staff to perform frequent visual checks of the resident. The resident required therapy for</p>	F 657			

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F 657	<p>Continued From page 7</p> <p>safety awareness and transfer techniques. Staff should encourage the resident to call for assistance as she had poor safety awareness.</p> <p>The "Safety Event Entry-Working Copy" dated 03/03/21, revealed dietary staff found the resident on the floor in her room on 03/01/21 at 02:15 PM. The resident stated she tried to find her remote. Measures in place included a low bed, assist rail, and nonskid socks. The facility failed to identify the casual factors of the resident's fall. The resident said she fell trying to reach for the remote. The new intervention for this fall indicated to obtain general lab per physician order. The facility obtained a urinalysis (UA) on 03/01/21 which was negative for urinary tract infection (UTI). No intervention was planned or implemented on the resident's care plan to prevent further falls.</p> <p>The "Safety Event Entry-Working Copy" dated 03/16/21 at 09:15 AM, revealed the resident was found on the floor with her head near the dresser and her legs on the bedside table, with the wheelchair next to the foot of the bed. The resident reported she was reaching forward to secure her cell phone charger on the bedside table and she slid off the edge of her wheelchair. The resident finished eating breakfast 15 minutes prior to the fall and propelled herself back to the room. The resident fell asleep during breakfast. The facility failed to identify the casual factors of the resident's fall. The resident said she was reaching for her cell phone charger on the table. The intervention for this fall was to complete a medication review and lab work. The facility obtained a UA on 03/19/21 (3 days after the fall), which revealed a UTI, then on 03/22/21, (3 days</p>	F 657			

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F 657	<p>Continued From page 8</p> <p>later and 6 days after the fall), the physician started the resident on antibiotics for the UTI.</p> <p>The "Safety Event Entry-Working Copy" dated 03/17/21 reported the resident was found on 03/17/21 at 01:00 PM, sitting in her room on the fall mat, the resident attempted to transfer herself from her wheelchair to bed. No immediate intervention was put in place. An intervention, dated 03/19/21 (2 days later), instructed staff to encourage the resident to wait for staff and use a mechanical lift if needed.</p> <p>The "Safety Event Entry-Working Copy" dated 04/24/21, documented on 04/24/21 at 09:20 AM, staff found the resident in her room on the floor. The resident reported she attempted to transfer herself from her wheelchair to her bed and fell, striking her head on the floor. The care plan intervention for this fall was to encourage the resident to propel her wheelchair close enough to the bed for safe transfers.</p> <p>The "Safety Event Entry-Working Copy" dated 05/04/21, revealed staff found the resident in her room, on the floor on 05/04/21 at 12:40 PM. The resident sustained a puncture wound to her middle forehead, had blood coming from both nostrils, and had a large skin tear with fat exposure to her right forearm. The facility failed to identify the casual factor of the resident's fall in her room, so they failed to plan and implement any new interventions to prevent further falls.</p> <p>Review of the "Emergency Department Provider Report," dated 05/04/21, revealed the resident required 11 sutures to the laceration on her forehead, sustained a laceration to her right</p>	F 657			

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F 657	<p>Continued From page 9 forearms, and had a closed nasal bone fracture.</p> <p>Observation, on 05/10/21 at 08:45 AM, revealed the resident propelled herself in her wheelchair towards her room. The resident had sutures in a cross formation on her forehead, and the top of her right hand had extensive bruising, with the right forearm wrapped with a dressing. The resident used the ball of her foot to propel herself, leaning forward in the chair. The resident's bed was in a low position and a fall mat was beside the bed. The resident's wheelchair had a self-locking device in place. The resident attempted to move in her wheelchair onto the fall mat beside her bed and reached forward with her outstretched arm towards her bed. Interview, at the same time with Certified Medication Aide (CMA) S, revealed staff needed to transfer the resident either to the toilet or bed after meals, but often the resident finished her breakfast and attempted to transfer herself to her bed before staff were done assisting other residents with eating their breakfast. CMA S stated they were in a dilemma when they left the residents still eating breakfast to transfer the resident, because she took a lot of time.</p> <p>Observation, on 05/12/21 at 09:45 AM, revealed Licensed Nurse (LN) I reported the resident was alert at times and cooperated with staff, but staff needed to keep her within their line of sight as she would try to transfer herself and did not use her call light.</p> <p>Interview on 05/11/21 at 09:26 AM, with CNA Q revealed the resident required two staff for transfers. Staff transferred the resident to bed or toilet as she preferred, after meals. CNA Q</p>	F 657			

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F 657	<p>Continued From page 10</p> <p>stated the resident tried to transfer herself from her wheelchair to her bed, but had an anti-slide device in the chair, anti-tip bars on the wheelchair, and a low bed.</p> <p>Interview on 05/11/21 at 02:01 PM with Therapy Consultant Staff (TCS) II revealed the resident was not safe to transfer herself from the wheelchair to the bed and required much cueing. The resident attempted to follow TCS II with the process of transferring but could not remember the steps. The resident was somewhat drowsy during the exchange. TCS II stated the resident had poor safety awareness.</p> <p>Interview on 05/11/21 at 03:15 PM with CNA MM revealed the resident required two staff to transfer, staff kept the resident's bed in a low position, and kept her door open to keep an eye on her.</p> <p>Interview on 05/12/21 at 02:44 PM, with CNA P revealed the resident had variable levels of alertness. CNA P stated the resident did not like to wait for staff assistance, did not use her call light, and tried to transfer herself. CNA P stated he was working when the resident last fell. CNA P stated the resident finished meals sooner than other residents and staff were often assisting residents that needed staff assistance with eating. CNA P stated staff tried to get her up last for meals, but the resident still finished her meals sooner than others and took herself to her room, did not use a call light, and attempted to transfer herself.</p> <p>Interview on 05/13/21 at 11:00 AM with Administrative Nurse D, revealed the resident</p>	F 657			

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F 657	<p>Continued From page 11</p> <p>had a normal BIMS score, but did require staff assistance for transfers. Administrative Nurse D stated multiple interventions were developed for the resident and the resident had multiple falls. Administrative Nurse D explained she thought staff had interventions in place for the resident's falls and that the Quality Assurance (QA) nurse reviewed the falls.</p> <p>On 05/13/21 at 11:20 AM, Administrative Nurse F reported being responsible for QA and that she reviewed the interventions put in place and then determined if they were appropriate. Nurse F explained she did the cause analysis on the falls but those were in the facility QA program so were unavailable for review.</p> <p>The facility policy "Accidents and Incidents-Investigating and Reporting " revised 01/2020, instructed staff accidents shall be investigated and reported and interventions initiated.</p> <p>The facility failed to determine the root cause for the resident's multiple falls and then failed to develop appropriate timely interventions to prevent further falls.</p> <p>- Review of resident (R)51's "Physician Order Sheet," dated 05/04/21, revealed diagnoses included Parkinson's (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) with visual hallucinations, dementia (progressive mental disorder characterized by failing memory, confusion) and diabetes (when the body cannot</p>	F 657			

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F 657	<p>Continued From page 12</p> <p>use glucose, not enough insulin made or the body cannot respond to the insulin).</p> <p>The "Annual Minimum Data Set," dated 07/23/20, assessed the resident with severe cognitive deficits, required extensive assistance of two staff for bed mobility, transfers and locomotion on the unit. The resident had no functional impairment of her upper or lower extremities.</p> <p>The "Falls Care Area Assessment" (CAA), dated 07/23/21, assessed the resident required staff assistance with ambulation and could propel herself in her wheelchair. The resident had decreased safety awareness and was at increased risk for falls/injury.</p> <p>The "Care Plan," reviewed 04/01/21, instructed staff the resident needed extensive assistance with bed mobility and preferred to have a side rail on the right side for positioning.</p> <p>A "Nurses' Note," dated 05/01/21, documented the resident sustained two skin tears on her left elbow when Certified Nurse Aide staff assisted the resident to the bathroom and the resident stuck her arm out, which caused two skin tears on her upper left forearm, one measured 6 by 0.1 centimeters (cm) and another 3.5 by 0.1 cm.</p> <p>The "Skin Evaluation Record," dated 05/10/21, documented a four cm "C" shaped left elbow skin tear.</p> <p>The "Skin Evaluation Record," dated 05/13/21, documented a right calf skin tear which measured 4 by 1.5 cm.</p>	F 657			

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F 657	<p>Continued From page 13</p> <p>Observation, on 05/10/21 at 04:10 PM, revealed the resident seated in her wheelchair. Her left elbow contained a crescent shaped skin tear approximately 3.5 cm and within this another skin tear approximately 2 cm. The resident did not have protective sleeves on.</p> <p>Interview, on 05/11/21 at 03:15 PM, with CNA MM, revealed the resident propels herself backwards and backs into things and may have gotten the skin tears from running into things.</p> <p>Observation, on 05/13/21 at 08:00 AM, revealed the resident seated in her wheelchair with CNA Q propelling her. The resident had a skin tear on her left elbow area in a crescent shape, approximately 2 cm. The resident positioned her unprotected left arm above the wheel on the wheelchair (no positioned on her lap) nearly touching the wheel as CNA Q propelled the resident.</p> <p>Interview, on 05/23/21 at 10:30AM with Administrative Nurse E, confirmed the lack of interventions and investigations for the skin tears. Administrative Nurse E stated she thought at one point in time the resident wore protective sleeves but could not find that intervention on the resident's care plan to instruct the staff.</p> <p>The facility policy "Skin Tears - Abrasions and Minor Breaks," dated 12/2016, instructed staff the to complete the investigation of causation and implement interventions to prevent additional abrasions.</p> <p>The facility policy "Accidents and Incidents-Investigating and Reporting," dated</p>	F 657			

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F 657	Continued From page 14 01/2020, instructed staff to investigate and initiate interventions. The facility failed to review and revise the care plan with interventions to prevent skin tears in this dependent resident with repeated multiple skin tears.	F 657			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents with 22 selected for review, which included eight residents reviewed for accidents. Based on observation, interview, and record review the facility failed to ensure appropriate fall interventions were in place by determining the causal factors of the fall for four of the eight sampled residents. Of these Resident (R) 47 fell and sustained a nasal fracture and forehead laceration which required 11 sutures, with R2 and R33 experiencing repeated falls. The facility further failed to investigate and develop interventions for one of the eight residents, R51 who sustained repeated skin tears to the arms on three occasions. Findings included:	F 689			

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F 689	<p>Continued From page 15</p> <p>- Review of R 47's "Physician Order Sheet," dated 04/07/21, revealed diagnoses that included repeated falls, diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with polyneuropathy (nerve damage in multiple nerves), hypertension (elevated blood pressure) and dementia (progressive mental disorder characterized by failing memory, and confusion).</p> <p>The "Annual Minimum Data Set," dated 04/01/21, assessed the resident with a Brief Interview for Mental Status score (BIMS) of 14, which indicated normal cognitive status. The resident required extensive assistance of two staff for bed mobility, transfers, and locomotion on the unit. The resident required staff assistance to maintain balance and had no impairments in range of motion in her upper or lower extremities.</p> <p>The "Falls Care Area Assessment" (CAA), dated 04/01/21, assessed the resident as having a high risk for falls. The facility determined the falls were a result of the resident transferring herself without asking for assistance of staff or using her call light. The resident required frequent reminders to ask for assistance but continued to attempt self-transfers. The resident was able to propel herself when in a wheelchair. The resident received therapy services for training and safety training.</p> <p>The "Care Plan," dated 02/15/21 and revised 05/05/21 instructed staff to know the resident had a memory problem with impaired decision-making skills and an impaired ability to comprehend due to dementia. The resident was blind in her right eye. The resident could propel</p>	F 689			

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F 689	<p>Continued From page 16</p> <p>herself when in the wheelchair for short distances. The resident was continent of bladder with occasional incontinent episodes. Staff were advised the resident chose to not request help with transfers at times, due to impulsiveness. The resident had a fall mat beside the low bed and a transfer bar. The resident should wear nonskid socks, had a soft touch call light, and nonskid strips on the fall mat. The care plan instructed staff to perform frequent visual checks of the resident. The resident required therapy for safety awareness and transfer techniques. Staff should encourage the resident to call for assistance as she had poor safety awareness.</p> <p>The "Safety Event Entry-Working Copy" dated 03/03/21 revealed dietary staff found the resident on the floor in her room on 03/01/21 at 02:15 PM. The resident stated she tried to find her remote. Measures in place included a low bed, assist rail, and nonskid socks. The facility failed to identify the casual factors of the resident's fall. The resident said she fell trying to reach for the remote. The new intervention for this fall indicated to obtain general lab per physician order. The facility obtained a urinalysis (UA) on 03/01/21 which was negative for urinary tract infection (UTI).</p> <p>The "Safety Event Entry-Working Copy" dated 03/16/21 at 09:15 AM, revealed the resident was found on the floor with her head near the dresser and her legs on the bedside table, with the wheelchair next to the foot of the bed. The resident reported she was reaching forward to secure her cell phone charger on the bedside table and she slid off the edge of her wheelchair. The resident finished eating breakfast 15</p>	F 689			

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F 689	<p>Continued From page 17</p> <p>minutes prior to the fall and propelled herself back to the room. The resident fell asleep during breakfast. The facility failed to identify the casual factors of the resident's fall. The resident said she was reaching for her cell phone charger on the table. The intervention for this fall was to complete a medication review and lab work. The facility obtained a UA on 03/19/21 (3 days after the fall), which revealed a UTI, then on 03/22/21, (3 days later and 6 days after the fall), the physician started the resident on antibiotics for the UTI.</p> <p>The "Safety Event Entry-Working Copy" dated 03/17/21 reported the resident was found on 03/17/21 at 01:00 PM, sitting in her room on the fall mat, the resident attempted to transfer herself from her wheelchair to bed. No immediate intervention was put in place. An intervention, dated 03/19/21 (2 days later), instructed staff to encourage the resident to wait for staff and use a mechanical lift if needed.</p> <p>The "Safety Event Entry-Working Copy" dated 04/24/21, documented on 04/24/21 at 09:20 AM, staff found the resident in her room on the floor. The resident reported she attempted to transfer herself from her wheelchair to her bed and fell, striking her head on the floor. The intervention for this fall was to encourage the resident to propel her wheelchair close enough to the bed for safe transfers.</p> <p>The "Safety Event Entry-Working Copy" dated 05/04/21, revealed staff found the resident in her room, on the floor on 05/04/21 at 12:40 PM. The resident sustained a puncture wound to her middle forehead, had blood coming from both</p>	F 689			

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F 689	<p>Continued From page 18</p> <p>nostrils, and had a large skin tear with fat exposure to her right forearm. The facility failed to identify the casual factor of the resident's fall in her room.</p> <p>Review of the "Emergency Department Provider Report," dated 05/04/21, revealed the resident required 11 sutures to the laceration on her forehead, sustained a laceration to her right forearms, and had a closed nasal bone fracture.</p> <p>Observation, on 05/10/21 at 08:45 AM, revealed the resident propelled herself in her wheelchair towards her room. The resident had sutures in a cross formation on her forehead, and the top of her right hand had extensive bruising, with the right forearm wrapped with a dressing. The resident used the ball of her foot to propel herself, leaning forward in the chair. The resident's bed was in a low position and a fall mat was beside the bed. The resident's wheelchair had a self-locking device in place. The resident attempted to move in her wheelchair onto the fall mat beside her bed and reached forward with her outstretched arm towards her bed. Interview, at the same time with Certified Medication Aide (CMA) S, revealed staff needed to transfer the resident either to the toilet or bed after meals, but often the resident finished her breakfast and attempted to transfer herself to her bed before staff were done assisting other residents with eating their breakfast. CMA S stated they were in a dilemma when they left the residents still eating breakfast to transfer the resident, because she took a lot of time.</p> <p>Observation, on 05/12/21 at 09:45 AM, revealed Licensed Nurse I and Administrative Nurse E,</p>	F 689			

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F 689	<p>Continued From page 19</p> <p>removed the resident's dressing from her right forearm. The resident had an extensive skin tear with an area not approximated deep layered skin, exposing subcutaneous fat, measuring two by four centimeters. Administrative Nurse E cleansed the area and redressed it with Vaseline gauze, and wrapped it with elastic gauze wrap. Interview, with LN I at that time, revealed the resident was alert at times and cooperated with staff, but staff needed to keep her within their line of sight as she would try to transfer herself and did not use her call light.</p> <p>Interview on 05/11/21 at 09:26 AM with CNA Q revealed the resident required two staff for transfers. Staff transferred the resident to bed or toilet as she preferred, after meals. CNA Q stated the resident tried to transfer herself from her wheelchair to her bed, but had an anti-slide device in the chair, anti-tip bars on the wheelchair, and a low bed.</p> <p>Interview on 05/11/21 at 02:01 PM with Therapy Consultant Staff (TCS) II revealed the resident was not safe to transfer herself from the wheelchair to the bed and required much cueing. The resident attempted to follow TCS II with the process of transferring but could not remember the steps. The resident was somewhat drowsy during the exchange. TCS II stated the resident had poor safety awareness.</p> <p>Interview on 05/11/21 at 03:15 PM with CNA MM revealed the resident required two staff to transfer, staff kept the resident's bed in a low position, and kept her door open to keep an eye on her.</p>	F 689			

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F 689	<p>Continued From page 20</p> <p>Interview on 05/12/21 at 02:44 PM, with CNA P revealed the resident had variable levels of alertness. CNA P stated the resident did not like to wait for staff assistance, did not use her call light, and tried to transfer herself. CNA P stated he was working when the resident last fell. CNA P stated the resident finished meals sooner than other residents and staff were often assisting residents that needed staff assistance with eating. CNA P stated staff tried to get her up last for meals, but the resident still finished her meals sooner than others and took herself to her room, did not use a call light, and attempted to transfer herself</p> <p>Interview on 05/13/21 at 10:45 AM with Administrative Nurse F, revealed staff provided multiple interventions for fall prevention.</p> <p>Interview on 05/13/21 at 11:00 AM with Administrative Nurse D, revealed the resident had a normal BIMS score, but did require staff assistance for transfers. Administrative Nurse D stated multiple interventions were developed for the resident and the resident had multiple falls. Administrative Nurse D explained she thought staff had interventions in place for the resident's falls and that the Quality Assurance (QA) nurse reviewed the falls.</p> <p>On 05/13/21 at 11:20 AM, Administrative Nurse F reported being responsible for QA and that she reviewed the interventions put in place and then determined if they were appropriate. Nurse F explained she did the cause analysis on the falls but those were in the facility QA program so were unavailable for review.</p>	F 689			

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F 689	<p>Continued From page 21</p> <p>The facility policy "Accidents and Incidents-Investigating and Reporting " revised 01/2020, instructed staff accidents shall be investigated and reported and interventions initiated.</p> <p>The facility failed to determine the root cause for the resident's multiple falls and failed to develop appropriate interventions for these repeated falls, with the most recent fall resulting in nasal fracture, a laceration to her forehead which required 11 sutures and a laceration (skin tear) to her right arm exposing subcutaneous tissue</p> <p>- Review of resident (R)51's "Physician Order Sheet," dated 05/04/21, revealed diagnoses included Parkinson's (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) with visual hallucinations, dementia (progressive mental disorder characterized by failing memory, confusion) and diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).</p> <p>The "Annual Minimum Data Set," dated 07/23/20, assessed the resident with severe cognitive deficits, required extensive assistance of two staff for bed mobility, transfers and locomotion on the unit. The resident had no functional impairment of her upper or lower extremities.</p> <p>The "Falls Care Area Assessment" (CAA), dated 07/23/21, assessed the resident required staff assistance with ambulation and could propel herself in her wheelchair. The resident had</p>	F 689			

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F 689	<p>Continued From page 22</p> <p>decreased safety awareness and was at increased risk for falls/injury.</p> <p>A "Nurses' Note," dated 05/01/21, documented the resident sustained two skin tears on her left elbow when Certified Nurse Aide staff assisted the resident to the bathroom and the resident stuck her arm out, which caused two skin tears on her upper left forearm, one measured 6 by 0.1 centimeters (cm) and another 3.5 by 0.1 cm.</p> <p>The "Skin Evaluation Record," dated 05/10/21, documented a four cm "C" shaped left elbow skin tear. The resident had fragile aging skin and bumped the elbow. Staff to try Geri sleeves again.</p> <p>The "Skin Evaluation Record," dated 05/13/21, documented a right calf skin tear which measured 4 by 1.5 cm.</p> <p>Observation, on 05/10/21 at 04:10 PM, revealed the resident seated in her wheelchair. Her left elbow contained a crescent shaped skin tear approximately 3.5 cm and within this another skin tear approximately 2 cm. The resident did not have protective sleeves on.</p> <p>Interview, on 05/11/21 at 03:15 PM, with Certified Nurse Aide (CNA) MM, revealed the resident propels herself backwards and backs into things and may have gotten the skin tears from running into things.</p> <p>Observation, on 05/13/21 at 08:00 AM, revealed the resident seated in her wheelchair with CNA Q propelling her. The resident had a skin tear on her left elbow area in a crescent shape,</p>	F 689			

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F 689	<p>Continued From page 23</p> <p>approximately 2 cm. The resident positioned her unprotected left arm above the wheel on the wheelchair (no positioned on her lap) nearly touching the wheel as CNA Q propelled the resident.</p> <p>Interview, on 05/23/21 at 10:30AM with Administrative Nurse E, confirmed the lack of interventions and investigations for the skin tears. Administrative Nurse E stated she thought at one point in time the resident wore protective sleeves but could not find that intervention on the resident's care plan to instruct the staff.</p> <p>The facility policy "Skin Tears - Abrasions and Minor Breaks," dated 12/2016, instructed staff the to complete the investigation of causation and implement interventions to prevent additional abrasions.</p> <p>The facility policy "Accidents and Incidents-Investigating and Reporting," dated 01/2020, instructed staff to investigate and initiate interventions.</p> <p>The facility failed to investigate and initiate interventions to prevent skin tears in this dependent resident with repeated multiple skin tears.</p> <p>- The "Physician Order Sheet" (POS), dated 04/06/21, documented Resident (R)2 had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).</p> <p>The "Significant Change Minimum Data Set"</p>	F 689			

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F 689	<p>Continued From page 24</p> <p>(MDS), dated 03/11/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. He required extensive assistance of two staff for bed mobility, transfers and toilet use. His balance was not steady, and he was only able to stabilize with staff assistance. He used a walker and a wheelchair for mobility and had two non-injury falls since the prior assessment.</p> <p>The "Falls Care Area Assessment" (CAA), dated 03/11/21, documented the resident had decreased safety awareness related to impaired cognition and used a wheelchair for most mobility needs.</p> <p>The quarterly "MDS", dated 12/17/20, documented the resident had a BIMS score of three, indicating severely impaired cognition. He required limited assistance of one staff for bed mobility, transfers, and toilet use. He had two non-injury falls since the prior assessment.</p> <p>The falls care plan, updated 04/16/21, instructed staff to keep the resident's pathways clear and to provide adequate lighting due to the resident's decreased safety awareness. Staff were to ensure the resident had on appropriate foot wear at all times, to put him on the couch or the recliner following meals, and to initiate a toileting diary to determine appropriate toileting times for the resident.</p> <p>Review of the resident's electronic medical record (EMR), revealed a fall assessment, dated 04/16/21, which placed the resident at a high risk for falls.</p>	F 689			

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F 689	<p>Continued From page 25</p> <p>Review of the facility's fall report, documented 04/16/21, included: Staff discovered the resident on the floor in the commons room lying on his right side, propped up on his right elbow. His range of motion (ROM) was intact and he had no injuries. Staff assisted him up to his wheelchair with extensive assistance of two and taken to the bathroom. The resident had been incontinent of bowel. The fall report lacked analysis for the fall. The staff did not initiate an immediate intervention following this non-injury fall.</p> <p>Review of the facility's fall report, documented 02/18/21, included: The staff discovered the resident lying on the floor of his room. Resident complained of right hip pain. The resident's ROM was intact and his neuro signs were within normal limits (WNL). The fall report lacked an analysis for the fall. The staff did not initiate an immediate intervention following this non-injury fall.</p> <p>On 05/11/21 at 12:20 PM, the resident sat in his wheelchair in the dining room eating lunch. The resident wore appropriate footwear and an anti-rollback break was in place to the back of his wheelchair.</p> <p>On 05/11/21 at 01:10 PM, the resident rested in bed. The fall floor mat was in place on the floor next to his bed. The bed was in the lowest position.</p> <p>On 05/12/21 at 01:33 PM, Licensed Nurse (LN) G stated, when a resident falls the nurse will complete an assessment. The nurse was to initiate a fall intervention immediately to prevent further falls.</p>	F 689			

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F 689	<p>Continued From page 26</p> <p>On 05/13/21 at 09:40 AM, Administrative Nurse D, stated it was his expectation that the nurse immediately initiate a fall intervention following each fall.</p> <p>The facility failed to initiate interventions following this dependent resident's two falls.</p> <p>The facility policy for "Falls", last approved 12/2019, included: The documentation of the identified interventions should be maintained in the resident's clinical record.</p> <p>The facility failed to timely implement adequate interventions to prevent further falls for this dependent resident.</p> <p>- The "Physician Order Sheet" (POS), dated 04/07/21, documented Resident (R) 33 had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).</p> <p>The Admission "Minimum Data Set" (MDS), dated 03/22/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. He required extensive assistance of two staff for bed mobility, transfers and toilet use. He had no falls since admission to the facility.</p> <p>The "Falls Care Area Assessment" (CAA), dated 03/22/21, documented the resident had not had any falls since admission to the facility and was at risk for falls due to an unsteady gait. Staff were to assist the resident with transfers and</p>	F 689			

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F 689	<p>Continued From page 27 mobility.</p> <p>The Falls Care Plan, dated 03/15/21, instructed staff the resident was at risk for falls due to him being a recent admission to the facility. Staff were to keep his pathway clear, provide adequate lighting, and keep his bed at an appropriate height.</p> <p>Review of the resident's electronic medical record, revealed a fall assessment, dated 03/30/21, which placed the resident at a high risk for falls.</p> <p>Review of the facility's fall report, documented 03/23/21, included: The resident attempted to get up from his bed without assistance and was found on his back on the floor of his room. He had no injuries from the fall. The fall report lacked an analysis for the fall. The staff did not initiate an immediate intervention following this non-injury fall tp prevent further falls.</p> <p>Review of the facility's fall report, documented 03/30/21, included: Staff discovered the resident on the floor of the hallway. He had stood up from his wheelchair, lost his balance and fell to the floor. Staff were unable to reach him before he landed on the floor. He received no injuries from the fall. The fall report lacked an analysis for the fall. The staff did not initiate an immediate intervention following this non-injury fall to prevent further falls.</p> <p>On 05/11/21 at 11:49 AM, the resident sat in his wheelchair in the dining area. He wore appropriate shoes.</p>	F 689			

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F 689	<p>Continued From page 28</p> <p>On 05/12/21 at 09:39 AM, Certified Nurse Aide (CNA) PP, checked on the resident who was sleeping in his bed. The resident had a fall floor mat next to his bed and wore non-slip socks.</p> <p>On 05/12/21 at 01:33 PM, Licensed Nurse G stated, when a resident fell, the nurse will complete an assessment. The nurse was to initiate a fall intervention immediately to prevent further falls.</p> <p>On 05/13/21 at 09:40 AM, Administrative Nurse D, stated it was his expectation that the nurse immediately initiated a fall intervention following each fall.</p> <p>The facility failed to initiate interventions following this dependent resident's falls.</p> <p>The facility policy for "Falls", last approved 12/2019, included: The documentation of the identified interventions should be maintained in the resident's clinical record.</p> <p>The facility failed to timely implement adequate interventions to prevent further falls for this dependent resident.</p>	F 689			
F 692 SS=D	<p>Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)</p> <p>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p>	F 692			

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F 692	<p>Continued From page 29</p> <p>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents with 22 residents sampled, including six residents reviewed for nutrition. Based on observation, interview, and record review, the facility failed to identify, plan, and implement timely interventions to maintain nutritional status for one of the six residents reviewed, Resident (R) 172.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The "Physician Order Sheet" (POS), dated 05/13/21, documented Resident (R)172 had a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion), irritable bowel syndrome (IBS- abnormally increased motility of the small and large intestines), anxiety, fractures and other multiple trauma. <p>The "Admission Minimum Data Set" (MDS), dated 04/29/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She was</p>	F 692			

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F 692	<p>Continued From page 30</p> <p>independent with eating and only required setup help. She had no swallowing or dental issues, and no weight loss or gain. She was 60 inches tall and her weight was 114 pounds (lbs).</p> <p>The "Nutritional Care Area Assessment" (CAA), dated 05/03/21, did not trigger for further review.</p> <p>The Activities of Daily Living (ADL)/Functional Status CAA, dated 05/03/21, documented the resident received a regular diet and consumed 51-75% of most meals with no nutritional concerns at that time.</p> <p>The "ADL Care Plan," updated 05/10/21, instructed staff the resident was at risk for weight loss due to low intake at some meals. Snacks and beverages of choice were to be offered. Staff were to consider adding calorie and protein supplements and vitamins, as recommended, (done 05/11/21). Staff were to consult the dietician, as needed (PRN). Staff were to assess the resident's likes, dislikes and preferences (done 05/13/21), to obtain weights per the facility policy, and to notify the physician with any significant changes. The resident received a regular diet with thin liquids.</p> <p>Review of the Electronic Medical Record (EMR) in the facility's documentation system, revealed the resident's weight upon admission to the facility on 04/22/21 was 113.8 lbs. On 05/01/21, the resident's weight was 108 lbs. The resident's weight on 05/12/21, was 102.8 lbs.</p> <p>Further review of the resident's EMR, revealed a "Nutritional Risk Assessment," completed on 05/10/21, which revealed the resident's meal</p>	F 692			

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F 692	<p>Continued From page 31</p> <p>intakes ranged from 51-75%. The resident's estimated nutritional needs were estimated to be 1127 calories, 39-49 grams (gr) protein, and 1475 milliliters (ml) of fluids. The only intervention to prevent weight loss was for the staff to obtain weekly weights.</p> <p>A "Progress Note" in the resident's EMR, dated 05/10/21, contained Consultant staff GG's recommendations. The facility staff sent it to the physician on 05/10/21, 18 days after the resident admitted, and 2 days after the facility staff weighed the resident and documented a six pound weight loss. On 05/11/21, the physician returned it with a new order, which included Vitamin C 500 milligrams (mg), twice daily (BID) for supplement, and Ensure Enlive (A nutritional supplement) 90 ml, four times a day, for supplement. Staff were to continue monitoring the resident's weights and follow up with the physician after two weeks.</p> <p>A "Progress Note" in the resident's EMR, dated 05/13/21, documented a request for an order for super cereal (a high calorie hot cereal), due to the resident's declining weight.</p> <p>Review of the resident's EMR, from 05/01/21 through 05/12/21, revealed the resident consumed 50-100% of her breakfast and 26-100% of lunch and dinner. Intake of snacks, or if a snack was given, were not documented.</p> <p>On 05/12/21 at 09:00 AM, the resident sat in the recliner in her room with the breakfast tray in front of her. The resident consumed 50% of her breakfast which consisted of biscuits, gravy, and bacon.</p>	F 692			

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F 692	<p>Continued From page 32</p> <p>On 05/12/21 at 12:03 PM, Certified Medication Aide (CMA) R, served the resident lunch which consisted of cheese ravioli, steamed zucchini and garlic toast. The staff assisted the resident with setting up the meal and then left the room. The resident fed herself approximately 50% of the meal.</p> <p>On 05/13/21 at 09:32 AM, the resident consumed only a few bites of her pancake. Staff failed to offer anything else to eat to the resident.</p> <p>On 05/13/21 at 11:51 AM, Certified Nurse Aide (CNA) OO, weighed the resident on the wheelchair scale in the shower room. After subtracting the weight of the wheelchair, foot pedals and blanket, CNA OO reported the resident's weight was 104 lbs.</p> <p>On 05/11/21 at 08:41 AM, the resident stated she has no discomfort with chewing or swallowing. The resident stated she was not currently eating well due to not always liking what staff served her. The staff did not check in with her to offer something else to eat.</p> <p>On 05/12/21 at 10:43 AM, CMA R, stated the staff would take the resident her meals and help her set it up and then go in and take the meal trays out of the room after the meals. The resident was able to tell staff what she wanted to eat, so they did not offer her anything else when she did not eat well. Staff R stated he did not know if the resident had a weight loss or know what she preferred to eat. He would need to look at the care plan for more information as he did not know much about her.</p>	F 692			

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F 692	<p>Continued From page 33</p> <p>On 05/13/21 at 11:49 AM, Dietary staff BB stated, the nurses would tell her when a resident had weight loss. This resident had not had a weight loss. The CNAs would follow up with residents to ensure they were eating okay or if they wanted something else to eat for their meal.</p> <p>On 05/13/21 at 11:51 AM, CNA OO stated, staff were to weigh the resident weekly. Staff OO was unsure if the resident had weight loss. The resident did not require assistance with eating. Staff will take her meal tray and then pick it up when she was done eating.</p> <p>On 05/12/21 at 01:33 PM, Licensed Nurse G stated, staff weighed the resident weekly as the resident was newly admitted to the facility. When a resident had a weight loss, the weight team would send a fax to the doctor to have supplements added. The weight team or the dietician tracked the weights and informed the nurses of which residents had a weight loss. The weight team met weekly.</p> <p>On 05/13/21 at 09:56 AM, consultant staff GG stated, the staff would notify the physician and the RD of a significant weight loss as soon as the facility identified the weight loss. The weight team met weekly to discuss resident weights and notify the physician of any resident who may need supplements due to weight loss. Staff should have notified the physician of the resident's significant weight loss on 05/01/21 but did not notify the physician until 05/10/21 when new orders were received for the supplements.</p> <p>On 05/12/21 at 10:12 AM, Dietary staff CC</p>	F 692			

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F 692	Continued From page 34 stated, the weight team reviewed weights every week and consultant staff GG made recommendations. Staff CC stated she was not aware of the resident's weight loss. On 05/12/21 at 01:30 PM, Consultant staff HH stated, he would expect staff to notify him immediately of a resident with a significant weight loss. The facility policy for "Significant Weight Loss/Gain," last approved 01/2019 included: . . . a nursing or nutrition associate should notify the health care provider of any significant weight change that is unexplainable or in which the RD requested a nutritional intervention. The facility failed to timely identify, plan, and implement interventions to prevent continued weight loss for this resident who recently returned from the hospital.	F 692			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing,	F 880			

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F 880	<p>Continued From page 35</p> <p>identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p>	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175465	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2021
NAME OF PROVIDER OR SUPPLIER VIA CHRISTI VILLAGE PITTSBURG INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1502 E CENTENNIAL PITTSBURG, KS 66762		
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F 880	<p>Continued From page 36</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility reported a census of 74 residents. Based on observation, interview and record review, the facility failed to ensure sanitary laundering of linen soiled with blood to prevent cross contamination with blood borne pathogens.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Observation, on /05/12/21 at 08:59 AM, revealed Laundry staff U, processing laundry. Laundry Staff U stated the current load in the washer, contained "yellow bag" (contaminated) personal clothing and linens. Laundry staff U stated she chose the "personal" cycle to wash this load. Staff U stated the linen contained soiling with blood and thought the "personal" cycle dispensed enough bleach to remove the blood stains but preserved the colors of the personal laundry. Laundry staff U stated she did not have a manufacturers formula chart to determine which setting for soiled laundry, colors, delicate etc., but there were several cycles to choose from when she set the load function on the machine. Observation revealed, after the 	F 880			

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F 880	<p>Continued From page 37</p> <p>cycle completed, Laundry Staff U, removed the clothing and linen (towels, sheets, and blankets) and proceeded to process them in the dryer. Laundry Staff U stated the laundry then would be distributed to the residents of the facility. (This laundry was not dedicated to the resident with the "yellow bag").</p> <p>Interview, on 05/12/21 at 09:30 AM, with Maintenance staff V, revealed the washer used low temperature water and chemicals for processing the laundry. Maintenance Staff V stated the chemical manufacturer did not supply a formula chart for the various cycles in the washing machine and did not know if the amount of bleach dispensed in the "Personal" cycle was enough to eliminate blood borne pathogens. The facility did not monitor or test the amount of chemical needed to eliminate the blood borne pathogens.</p> <p>Interview, on 05/17/21 at 11:30 AM, with the chemical supplier staff JJ, revealed the "Personal" cycle dispenses less bleach to preserve the colors of personal laundry. Staff JJ stated to kill most of the blood borne pathogens, he would recommend using the "Heavy Load" setting.</p> <p>The facility provided an undated policy for, "Laundry and Infection Control" which instructed staff a wash option under the heading "C-Diff (a spore producing pathogen)/Isolation" on the laundry controller which is designed to treat any contaminated/red bag clothing with a 125 parts per million chlorine rinse that will produce hygienically clean laundry.</p>	F 880			

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F 880	Continued From page 38 The facility failed to monitor or test to ensure the "personal" setting on the washing machine, dispensed enough chemical (chlorine bleach) to remove blood borne pathogens for laundry that was used by residents throughout the facility to prevent the spread of infection.	F 880			