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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 4/30/24 through 5/01/24. The following intake was investigated NC00216357. This intake resulted in immediate jeopardy. 1 of the 1 complaint allegation resulted in deficiency. Past noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J). The tag F689 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Responsible Party (RP) interview, and Medical Director interview, the facility failed to identify and enter reported allergies into the medical record for 1 of 3 residents reviewed for allergies (Resident #1). The findings included:	F 684	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 05/22/2024

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Review of a hospital discharge summary dated 11/15/20 Resident #1 had no known drug allergies.

Resident #1 was admitted to the facility on 11/18/20 with diagnoses which included dementia.

Record review of the census data revealed Resident #1 was transferred to the hospital on 2/09/22 and returned to the facility on 2/19/22.

Review of the hospital discharge summary dated 2/19/22 revealed Resident #1 had allergies to cocamidopropyl betaine (a product derived from raw coconut oil and is used in many personal care items to create a thick lather when combined with water often found in products such as shampoo, skin care products, and soaps), chloroxylenol (an antiseptic and disinfectant agent used for skin disinfection found in antibacterial soaps), and erythromycin (antibiotic). The hospital discharge summary reported the allergies to cocamidopropyl betaine and chloroxylenol were identified by a positive patch test (a skin allergen test when allergens were placed on the skin to identify allergies).

Record review of Resident #1's allergy list revealed an allergy to erythromycin was entered on 2/19/22 and an intolerance to perfume was entered into the record on 5/31/22. The cocamidopropyl betaine, chloroxylenol were not listed on Resident #1's medical record as allergies.

A telephone interview was conducted with Nurse #2 on 4/30/24 at 1:20 pm who revealed she

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entered the intolerance to perfume into the electronic medical record based on a report from Resident #1's Responsible Party (RP) and she did not recall any other allergies being reported. Nurse #2 was unable to recall if Resident #1 had any other allergies.

The Minimum Data Set (MDS) annual assessment dated 1/29/24 revealed Resident #1 had severe cognitive impairment.

During a telephone interview on 4/30/24 at 4:12 pm Resident #1's RP reported she had multiple conversations with facility staff, including nurses and Nurse Aides (NAs), regarding the allergy to soap and perfume. She stated the facility was aware soap and perfume was an allergy. The RP stated the staff were aware Resident #1 had an allergy to Soap #1 and the staff was only to use Soap #2 for her personal care needs. Resident #1's RP stated Soap #2 was a gentle liquid soap specifically for sensitive skin.

A telephone interview was conducted on 4/30/24 at 12:00 pm with NA #1. She stated she was not sure if Resident #1 had any allergies, but she stated she was aware Resident #1 was only allowed to have Soap #2 when care was provided. NA #1 stated she had received information in the past from the facility about only using Soap #2 for Resident #1 and she stated there was a sign in the room to use only Soap #2, but she was not sure if it was because of an allergy.

A telephone interview was conducted on 4/30/24 at 12:09 pm with NA #3 who had provided care to Resident #1 in the past and was aware of a perfume allergy but was not able to recall it being

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reported as an allergy to soap. NA #3 stated she was aware that Resident #1 was to use only Soap #2 and she was not to use other soap products.

During an interview on 4/30/24 at 12:49 pm with NA #4 she revealed she had provided care to Resident #1 and was aware of an allergy to soaps because the nurse told them, but she could not recall what specific soap.
An interview with the Medical Director was conducted on 4/30/24 at 1:09 pm who revealed she was notified of Resident #1's ingestion of soap and her being sent to the ED due to an allergic reaction. The Medical Director stated if Resident #1 had allergies listed on the hospital discharge record the facility staff should have documented them in the medical record, and if the staff was not sure of the allergy they should have attempted to confirm with the family. The Medical Director stated she would have to review the medical record before being able to state if Resident #1 had any allergies.

During an interview on 5/01/24 at 2:49 pm with the Director of Nursing (DON) and the Administrator the DON stated the nurse that completed the admission was responsible for entering any allergies. The DON stated the normal process of admission review was that the next day an admission audit tool was checked by another nurse to confirm the admission was completed. The DON stated she was not aware of Resident #1's reported use of a specific soap or any allergy to soap products. The DON and Administrator were unable to state why Resident #1's allergies were not placed on the medical record as documented on the hospital discharge summary.

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The facility provided the following corrective action plan with a completion date of 4/25/24:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
Resident #1 has a diagnosis of dementia, and allergies include erythromycin, perfume, chloroxylenol (an antiseptic and disinfectant agent used for skin disinfection found in antibacterial soaps), and cocamidopropyl betaine (a product used in many personal care items to create a thick lather when combined with water often found in products such as shampoo, skin care products, and soaps). The chloroxylenol, cocamidopropyl betaine was not listed in the resident's clinical record

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
On 4/24/24, the Second Shift Patient Care Coordinator initiated interviews with all alert and oriented residents to ensure all identified allergies are reflected in the clinical records for staff reference, including the demographics, and resident care guide. The interviews were completed by 4/24/24. There were no other concerns.

On 4/24/24, the Second Shift Patient Care Coordinator initiated interviews with all resident representatives for all non-alert and oriented residents to ensure all identified allergies are reflected in the clinical records for staff reference, including the demographics, and resident care guide. The interviews were completed by 4/24/24

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for all resident representatives who were able to be reached. Four additional concerns were identified during the audit. The Patient Care Coordinator updated the resident record for all newly identified allergies. After 4/24/24, the Registered Nurse (RN) Unit Managers tracked and followed up with the families who could not be reached. The RN Unit Managers updated the clinical records for all identified areas of concern during the interviews. The audit was completed on 4/24/24 with one resident representative (RR) not able to be reached. The facility continued attempts to reach the RR. The RR responded on 4/30/24 with no additional allergies reported.

On 4/24/24, the Second Shift Patient Care Coordinator completed an audit of all residents identified with a soap allergy to ensure that the allergen was not present in the room. There were no identified areas of concern during the audit.

On 4/24/24, the Administrator initiated an audit of all residents' admission and readmission records to ensure all identified preadmission allergies are reflected in the facility's clinical records for staff reference, including the demographics and resident care guide. There were no areas of concern identified during this audit. The audit was completed by 4/24/24.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
On 4/24/24, the Director of Nursing initiated an in-service with all nurses regarding reviewing resident's admission and readmission records and speaking with the families on admission or readmission to identify all allergies and ensure the allergies are reflected in the clinical records

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including the demographics, and resident care guide.

All in-services for staff that worked were completed by 4/24/24. After 4/24/24, the SDC will monitor staff completion and all nursing staff that have not worked and received the in-services will complete it upon their next scheduled shift/prior to working.
All newly hired staff will be educated during orientation by the SDC regarding reviewing resident's admission and readmission records and speaking with the families on admission or readmission to identify all allergies and ensure the allergies are reflected in the clinical records including the demographics, and resident care guide. The SDC was notified of this responsibility by the Administrator on 4/24/24.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
The decision to monitor the system for residents' allergies was made on 4/24/24 by the Administrator and Director of Nursing and presented to the Quality Assurance (QA) Committee on 4/24/24.

The Treatment Nurse will monitor resident rooms to ensure identified allergens are not present in the resident's room daily x 1-week, biweekly x 3 weeks, and then weekly x 4 weeks and document on a resident census. The Administrator will immediately ensure all areas of concern are addressed during the audit. The Treatment Nurse was notified of this responsibility by the Administrator on 4/24/24.

The Minimum Data Set (MDS) Nurse will review

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all admission and readmission records weekly x 8 weeks to ensure all preadmission allergies are reflected in the facility's clinical records including the demographics, and resident care guide for staff reference. The MDS Nurse will update the records accordingly and the Director of Nursing will immediately retrain the nurse upon notification for all identified areas of concern. The MDS Nurse was notified of this responsibility on 4/24/24.

The Administrator and/or DON will present the findings of the audit tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions and the need for additional monitoring.

Date of corrective action completion: 4/25/24.

Onsite validation was completed on 5/01/24 through record review, staff interviews, resident interviews, and observations of resident rooms.

Record review of the staff education logs was completed with no areas of concern identified.

Staff were interviewed to validate the in-service was conducted and validated the education was completed regarding confirmation and documentation of resident allergies upon admission and readmission.

Interviews were conducted with those residents identified by the facility as alert and oriented and with documented allergies to confirm the allergies listed were correct. No concerns were identified.

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F 684	Continued From page 8 The Quality Assurance and Performance Improvement (QAPI) ad-hoc (special and immediate meeting held for a specific situation) meeting minutes from 4/24/24 were reviewed. The facility's corrective action plan was validated to be completed as of 4/25/24.	F 684		
F 689 SS=J	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: Based on record review and interviews with staff, Responsible Party (RP), Medical Director, Poison Control Center, and Hospital Physician, the facility failed to provide a safe environment to prevent an avoidable accident for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). Resident #1 had severe cognitive impairment, was dependent on staff for assistance, and was allergic to ingredients that were commonly found in shampoos, skin care products, and soap. On 4/23/24 Resident #1 had access to a bar of soap (Soap #1), she ingested the soap, and had an allergic reaction which included mouth and lip swelling and was transferred to the Emergency Department (ED) for further treatment. Resident #1 required intubation (a tube placed down throat into the trachea to facilitate airflow) and mechanical	F 689	Past noncompliance: no plan of correction required.	

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ventilation (a form of life support that helps you breathe when you cannot breathe on your own) in the ED and continued to decline despite medical interventions. Resident #1 was placed on comfort measures and according to the death certificate expired on 4/26/24 from complications of anaphylactic shock (a severe, potentially fatal allergic reaction that is rapid in onset and requires immediate medical attention) due to accidental ingestion of soap.

The findings included:

Review of a hospital discharge summary dated 11/15/20 Resident #1 had no known drug allergies.

Resident #1 was admitted to the facility on 11/18/20 with diagnoses which included dementia.

Record review of the census data revealed Resident #1 was transferred to the hospital on 2/09/22 and returned to the facility on 2/19/22.

Review of the hospital discharge summary dated 2/19/22 revealed Resident #1 had allergies to cocamidopropyl betaine (a product derived from raw coconut oil and is used in many personal care items to create a thick lather when combined with water often found in products such as shampoo, skin care products, and soaps), chloroxylenol (an antiseptic and disinfectant agent used for skin disinfection found in antibacterial soaps), and erythromycin (antibiotic).

Record review of Resident #1's allergy list on revealed an allergy to erythromycin was entered on 2/19/22 and an intolerance to perfume was

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entered into the record on 5/31/22. The cocamidopropyl betaine and the chloroxylenol were not listed on Resident #1's medical record as allergies.

The Minimum Data Set (MDS) annual assessment dated 1/29/24 revealed Resident #1 had severe cognitive impairment, had adequate vision with corrective lenses, and was not coded for behaviors. Resident #1 was dependent upon staff for all activities of daily living (ADLs) which included eating and movement throughout the facility. Resident #1 was not coded for use of mobility devices.

Resident #1's care plan last revised 2/28/24 revealed a care plan was in place for decline in intellectual functioning related to dementia and was at risk for unmet needs with an intervention to allow resident sufficient time to verbalize needs. Resident #1 had a care plan for risk for inability to focus on objects, discriminate color, and adjust to changes in light and dark related to impaired peripheral (side) vision with an intervention to ensure eyeglasses were clean and worn.

The nursing progress note dated 3/19/24 at 8:03 pm by Nurse #1 revealed Resident #1 was observed with a large amount of chewed up tissue in her mouth. Nurse #1 removed all paper and small items from Resident #1's reach.

The nursing progress note dated 4/23/24 at 10:16 pm by Nurse #1 revealed that at approximately 8:00 pm she was notified that Resident #1 ate soap and was observed with swollen lips and face. Nurse #1 assessed Resident #1 and administered a dose of epinephrine (an

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emergency medication used to decrease the body's allergic reaction by relaxing the muscles in airway to make breathing easier) by injection. Resident #1 was transferred to the emergency department (ED) via ambulance at 8:20 pm.

A telephone interview was conducted on 4/30/24 at 1:27 pm with Nurse #1 who revealed she was notified by Nurse Aide (NA) #2 that Resident #1's face and lips were swollen. Nurse #1 stated when she entered the room, she did observe some small particles on Resident #1's lips and in her mouth but she was unable to determine what it was. She stated she did not know Resident #1 had eaten Soap #1 until NA #2 reported she had found the soap in Resident #1's hand. Nurse #1 reported she administered an epinephrine injection to Resident #1 because it was apparent that Resident #1 had an anaphylactic reaction (a severe, potentially fatal allergic reaction that is rapid in onset and requires immediate medical attention) after eating Soap #1. Nurse #1 stated she had previously witnessed Resident #1 place non-food items in her mouth, but it was not a frequent occurrence. Nurse #1 stated she was aware of Resident #1's allergies to erythromycin and perfume but she stated that she thought the perfume allergy was related to spray perfume and lotions, but she did not think it would include soap.

A telephone interview was conducted on 4/30/24 at 11:47 am with NA #2 who revealed she was assigned to Resident #1 on the evening of 4/23/24 when Soap #1 was ingested. NA #2 stated she was providing care to Resident #1's roommate with the curtain pulled when Resident #1 began "talking funny and was not sounding right" so she pulled the curtain and observed

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Resident #1's face and lips were swollen. NA #2 stated she immediately went to Resident #1 and grabbed her hand and that was when she saw the bar of Soap #1 in Resident #1's hand. She stated she knew it was Soap #1 because of the strong smell of the soap. NA #2 stated once she realized what happened her "heart dropped" because she knew Resident #1 was allergic to Soap #1. NA #2 reported she yelled for Nurse #1 and stayed with Resident #1 until Nurse #1 arrived. NA #2 stated she knew Resident #1's roommate used Soap #1, but she did not use Soap #1 on her shift and did not observe it on the bedside table in the room prior to the incident. She stated she did not know how Resident #1 was able to get the soap because she was not able to move herself around the room. NA #2 stated she had recently returned to work at the facility, and this was the first time she had provided care to Resident #1 since her return which was about two months prior. NA #2 stated she knew Resident #1 well from her previous employment with the facility and was aware of the allergy to Soap #1 since her previous time of employment. NA #2 stated she had received education from the facility during her previous time of employment and prior to providing care to Resident #1 regarding the allergy to Soap #1. NA #2 stated she thought there was a sign posted in the room about Resident #1's soap allergy.

A follow-up interview was conducted on 4/30/24 at 12:37 with NA #2 who reported she was now not sure if she was told or knew about Resident #1's allergy to Soap #1, but stated she was aware of Resident #1's allergy to perfume.

An additional interview was conducted on 5/01/24 at 2:43 pm with NA #2 who reported when she

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saw Resident #1 had eaten Soap #1, she knew she had an allergic reaction because her lips and mouth were swollen so that may be why she previously reported that Resident #1 had an allergy to Soap #1. NA #2 stated she was aware Resident #1 was not allowed to have soap and that was why she stated in her earlier interview that Resident #1 had an allergy. NA #2 stated she knew of Resident #1's allergy to perfume and since Soap #1 had such a strong scent that may be what made her think she had an allergy and made her so upset when Resident #1 ate the soap. NA #2 stated that all the staff were aware to use only Soap #2 (a mild soap used for sensitive skin) for Resident #1 and she stated the facility had provided an in-service about it. She reported that when she was cleaning up after the incident, she did observe the empty clear plastic cup with soap residue on Resident #2's bedside table but did not see it prior to the incident. She stated she did not recall Resident #1 being close enough to the table to be able to reach the cup and Resident #1 was not able to move herself around the room, so she was not sure how she got the soap. NA #2 stated she gave incorrect information during the first interview because she had just woken up and was confused.

The hospital record with an admission date of 4/23/24 indicated Resident #1 presented to the emergency department from the facility after ingesting a bar of soap with associated lip swelling. While in the ED Resident #1's lip swelling continued to progress to angioedema (swelling under the skin associated with an allergic reaction) with respiratory difficulty and was intubated and placed on a ventilator. Resident #1 was admitted to the intensive care unit and listed as critically ill with acute respiratory

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failure and a high probability of sudden clinically life-threatening deterioration in condition. Resident #1 suffered a heart attack on 4/25/24 and was determined not to be a candidate for medical intervention. Resident #1 continued to decline despite medications to maintain blood pressure and mechanical ventilation for breathing and expired on 4/26/24.

The Certificate of Death revealed Resident #1 expired on 4/26/24 and the immediate cause of death was determined to be complications of anaphylactic shock due to accidental ingestion of soap.

A telephone interview was conducted on 5/01/24 at 8:44 am with the Hospital Physician who revealed Resident #1 was admitted to intensive care under his services after the ingestion of soap and anaphylactic shock. The Hospital Physician reported although it was not common to see such a severe reaction to the ingestion of soap products to this extent, but it was possible. He stated Resident #1's reported allergy to perfumes could have been the initial trigger to cause the severe anaphylaxis reaction. The Hospital Physician stated the hospital was unable to determine how much of the soap Resident #1 ingested, but any amount of soap ingested could pose a concern for a fragile resident. The Hospital Physician stated the stress of the severe anaphylaxis due to the soap ingestion triggered the additional events, including intubation, need for mechanical ventilation, and the increased stress on the heart muscle which led to the heart attack, and ultimately Resident #1's death.

During a telephone interview on 4/30/24 at 4:12 pm Resident #1's RP reported she had multiple

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conversations with facility staff, including nurses and NAs, regarding the allergy to soap and perfume. The RP stated the facility was aware soap and perfume was an allergy which caused Resident #1 to have swelling. She stated she specifically told the facility that soaps such as Soap #1 were not allowed to be used due to her history of skin cancer and her soap allergy. She stated when she visited the facility, she would often find other soap products in Resident #1's drawers or on her bedside table and she would throw them away. The RP reported that Resident #1's roommate had Soap #1 and she often observed the bar of Soap #1 left out by the staff within reach of Resident #1. The RP stated the staff were aware Resident #1 had an allergy to Soap #1 and was only to use Soap #2 for her personal care needs. The RP stated Soap #2 was a gentle soap specifically for sensitive skin. The RP stated that although Resident #1 did not remain in the same room throughout her time at the facility she remained in the same area, she had the same staff provide her care, and they were all aware of the soap allergy. She stated the facility had a sign posted on the wall in the room about not using soap due to allergy, but stated when she went to pick up Resident #1's personal items the sign was no longer on the wall. The RP stated that Resident #1 had vomited multiple times at the hospital, and she stated it was such a strong fragrance that she was able to smell Soap #1 from the hall. The RP stated Resident #1 continued to worsen and the RP was forced to make the decision to try no further life saving measures.

A telephone interview was conducted on 4/30/24 at 3:50 pm with the Poison Control Center who revealed when someone had an allergy, each use

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or interaction with that allergen or biproduct could increase the risk for more severe and possibly an anaphylaxis reaction. The Poison Control Center stated that derivatives (substances created from chemical reaction from another component) from natural products, surfactants (chemical compounds created from natural products or synthetic chemical compounds), fragrance, dyes, or components of the products used to create soap products had the potential to induce an allergic reaction when ingested. The Poison Control Center reported that if bar soap was ingested most often would cause gastrointestinal system issues such as nausea, vomiting, and diarrhea, but for some a more severe allergic reaction could occur based on the individual and their health condition. The Poison Control Center stated if a bar of soap was ingested there could be a potential for an allergic reaction which is why the soap products have warning labels that state the products are for external use only.

A telephone interview was conducted on 4/30/24 at 12:00 pm with NA #1 who was assigned to Resident #1 during the 7:00 am-3:00 pm shift on 4/23/24. NA #1 stated she provided Resident #1 and her roommate with a bed bath during her shift that day. She stated she used Soap #1 for the roommate and when she was finished bathing Resident #1's roommate she placed Soap #1 in a cup and put it back in the top drawer of the roommate's dresser. She stated Resident #1 was unable to move herself around the room in her geriatric chair (a large, padded chair with wheels that reclines for comfort and positioning), and she does not know how she would have been able to get Soap #1 from the drawer. NA #1 stated she was not sure if Resident #1 had any allergies, but she stated she was aware Resident

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#1 was only allowed to have Soap #2 when care was provided. NA #1 stated she had received information in the past from the facility about only using Soap #2 for Resident #1 and she stated there was a sign in the room to use only Soap #2, but she was not sure if it was because of an allergy.

A telephone interview was conducted on 4/30/24 at 12:09 pm with NA #3 who worked on 4/23/24 during the 3:00 pm-11:00 pm shift. NA #3 stated she was not assigned to Resident #1 during the shift on 4/23/24 but had assisted NA #2 to provide care in the room. She stated she was alerted by NA #2 that Resident #1 had eaten Soap #1, but she reported she was not in the room when it occurred. NA #3 stated she had provided care to Resident #1 in the past and was aware of a perfume allergy but was not able to recall it being reported as an allergy to soap. NA #3 stated she was aware that Resident #1 was to use only Soap #2 and she was not to use other soap products when providing care. NA #3 stated she did observe a clear plastic cup with a bar of soap on Resident #1's roommate's bedside table when she was in the room prior to the incident. NA #3 stated Resident #1 was not able to move herself around the room, but she was unable to recall if Resident #1 was sitting close to the cup with the bar of Soap #1.

During an interview on 4/30/24 at 12:24 pm with the Supply Clerk she revealed the facility did not supply residents with bar soap which included Soap #1, but she stated families did bring in items for resident use. The Supply Clerk stated she was familiar with Resident #1's perfume allergy and that she had Soap #2 which was for sensitive skin, available in the resident's room and store

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room for bathing needs.

During an interview on 4/30/24 at 12:49 pm with NA #4 she revealed she had provided care to Resident #1 and was aware of an allergy to soaps because the nurse told them, but she could not recall what specific soap. NA #4 stated she used only Soap #2 for Resident #1, but she did not recall seeing a sign about an allergy to Soap #1 for Resident #1. NA #4 stated Resident #1's roommate used Soap #1 and it was put back in the top drawer of the dresser when staff were done using it.

An interview was conducted on 4/30/24 at 1:09 pm with the Medical Director who revealed she was notified of Resident #1's ingestion of soap and her being sent to the ED due to an allergic reaction. She stated Resident #1 had very sensitive skin and used gentle skin products that she was aware of, but she stated she was not aware of an actual allergy to soap or perfume. The Medical Director stated she was not aware of Resident #1 having an allergic reaction of any kind related to soap or perfumes prior. The Medical Director stated generally an intolerance to perfume would not necessarily correspond to an actual allergy, but she would have to review the medical record before being able to state if Resident #1 had any allergies.

During an interview with the Director of Nursing (DON) and Administrator on 5/01/24 at 2:49 pm the DON revealed she was not aware of Resident #1's allergy to soap and further stated that perfume was not a true allergy but an intolerance. She stated when the Nurse Aides saw perfume listed, they did not understand the difference between an allergy and an intolerance, so they

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were reporting they were aware of an allergy to perfume when it was not an allergy. The DON stated she was not aware of any education provided to staff regarding Resident #1's reported soap allergy. The DON stated she did not recall any conversation with Resident #1's RP regarding the use of specific soap or an allergy to soap and she did not recall a sign being posted in the Resident #1's room about a soap allergy. The Administrator revealed she was not aware Resident #1 had any prior behaviors of eating non-food items and would not have expected Resident #1 to ingest soap prior to the event. She stated she was unsure how the facility could have prevented the incident because to her knowledge Resident #1 had not demonstrated this type of behavior prior to this incident. The Administrator and DON stated they were unable to determine how Resident #1 obtained Soap #1 and what happened to make Resident #1 eat it.

The Administrator was notified of immediate jeopardy on 4/30/24 at 5:10 pm.

The facility provided the following corrective action plan with a completion date of 4/25/24:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Resident #1 has a diagnosis of dementia, and allergies include erythromycin, perfume, chloroxylenol (an antiseptic and disinfectant agent used for skin disinfection found in antibacterial soaps), and cocamidopropyl betaine (a product used in many personal care items to create a thick lather when combined with water often found in products such as shampoo, skin care

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products, and soaps). The chloroxylenol, cocamidopropyl betaine was not listed in the resident's clinical record. On 4/23/24, at 8:00 pm, the Certified Nursing Assistant (CNA) #2 entered Resident #1's room and observed Resident #1 with a swollen red face, swollen lips, and was difficult to understand. Resident #1 had a piece of her roommate's soap (Soap #1) in her hand. The resident refused to open her mouth for CNA #2. CNA #2 immediately notified the nurse, and upon assessment, a small particle of soap was observed in Resident #1's mouth. The nurse notified the physician, and orders were received to administer an Epi-pen (a pen used to treat life-threatening, allergic emergencies) and to call 911. The Epi-pen was administered, and Resident #1 was transferred to the local Emergency Department with a diagnosis of anaphylaxis (life-threatening allergic reaction). While in the emergency department, Resident #1's lip swelling continued to progress to angioedema (swelling under the skin associated with an allergic reaction) with respiratory difficulty and was intubated (a tube placed down the throat into the trachea to facilitate airflow) and placed on a ventilator (a machine that helps a person breath with when intubated). Resident # 1 expired in the hospital on 4/26/24. Following the incident, the Administrator immediately initiated an investigation. The investigation was completed 4/24/24. It could not be determined how the resident obtained the soap.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On 4/23/24, the Administrator completed an audit of all resident's rooms utilizing a resident census

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to ensure all soaps, lotions, medications, and shampoos were stored in appropriate containers and not easily accessible to cognitively impaired residents with behaviors of ingesting non-edible items/ objects when not supervised and in use. All other items were stored in appropriate containers or in drawers.

On 4/24/24, the Second Shift Patient Care Coordinator initiated interviews with all alert and oriented residents to ensure all identified allergies are reflected in the clinical records for staff reference, including the demographics, and resident care guide. The interviews were completed by 4/24/24. There were no other concerns.

On 4/24/24, the Second Shift Patient Care Coordinator initiated interviews with all resident representatives for all non-alert and oriented residents to ensure all identified allergies are reflected in the clinical records for staff reference, including the demographics, and resident care guide. The interviews were completed by 4/24/24 for all resident representatives who were able to be reached. Four additional concerns were identified during the audit. The Patient Care Coordinator updated the resident record for all newly identified allergies. After 4/24/24, the Registered Nurse (RN) Unit Managers tracked and followed up with the families who could not be reached. The RN Unit Managers updated the clinical records for all identified areas of concern during the interviews. The audit was completed on 4/24/24 with one resident representative (RR) not able to be reached. The facility continued attempts to reach the RR. The RR responded on 4/30/24 with no additional allergies reported.

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On 4/24/24, the Second Shift Patient Care Coordinator completed an audit of all residents identified with a soap allergy to ensure that the allergen was not present in the room. There were no identified areas of concern during the audit.

On 4/24/24, the Administrator initiated an audit of all residents' admission and readmission records to ensure all identified preadmission allergies are reflected in the facility's clinical records for staff reference, including the demographics and resident care guide. There were no areas of concern identified during this audit. The audit was completed by 4/24/24.

On 4/24/24, the Staff Development Coordinator (SDC) initiated interviews with all staff regarding the following: Do you know any resident who has ingested a non-edible item/ object? If yes, resident name, date of event, actions taken? The SDC will immediately forward the interviews with identified behaviors to the Director of Nursing. The Director of Nursing (DON) upon receipt of the interview will ensure that all residents identified with behaviors of ingesting non-edible item/ object have been addressed, including an assessment of the resident, removal or proper storage of the object, implementation of intervention depending on the root cause, physician and resident representative notification, documentation in the clinical record, and the behavior is reflected on the care plan. The interviews will be completed by 4/24/24. After 4/24/24, the SDC will monitor staff completion, and all staff that have not worked and received the interview will complete it upon their next scheduled shift. The Director of Nursing was notified of this responsibility by the Administrator on 4/24/24.

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F 689	Continued From page 23 On 4/24/24, the Unit Managers reviewed all current residents' progress notes from 3/1/24-4/23/24. The purpose of the audit is to ensure that all residents identified with behaviors of ingesting non-edible items/ objects have been addressed, including an assessment of the resident, removal or proper storage of the object, implementation of an intervention depending on the root cause, physician and resident representative notification, and the behavior is reflected on the care plan/care guide. There were no additional areas of concern noted during the audit. The audit was completed by 4/24/24. On 4/24/24, a resident council meeting was conducted by the Activity Staff with alert and oriented residents with education on how to properly store soaps, lotions, shampoo, and chemicals when not in use. On 4/24/24, the Activity Staff provided individual education to all alert and oriented residents who did not attend the resident council meeting. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 4/23/24, an in-service was initiated with all staff (from all departments) by the Director of Nursing regarding ensuring all soaps, lotions, medications, and shampoos are stored in appropriate containers and not easily accessible to cognitively impaired residents with behaviors of ingesting non-edible items/ objects when not supervised and in use. On 4/24/24, an in-service was initiated by the SDC with all staff (from all departments)	F 689		

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regarding immediately reporting to the nurse resident's behaviors of ingesting non-edible items/ objects (which would include new behaviors and prior behaviors).

On 4/24/24, the Director of Nursing initiated an in-service with all nurses regarding the following: 1.) what to do when a resident ingests non-edible items/ objects to include but not limited to assessment of the resident, notification of 911 as necessary, removal or proper storage of the object, implementation of an intervention depending on the root cause, physician and resident representative notification, documentation in the progress notes, ensuring the behavior is reflected on the resident care plan/care guide, and 2.) reviewing resident's admission and readmission records and speaking with the families on admission or readmission to identify all allergies and ensure the allergies are reflected in the clinical records including the demographics, and resident care guide.
All in-services for staff that worked were completed by 4/24/24. After 4/24/24, the SDC will monitor staff completion and all nursing staff that have not worked and received the in-services will complete it upon their next scheduled shift/prior to working.
All newly hired staff will be educated during orientation by the SDC regarding the following: 1.) ensuring all soaps, lotions, medications, and shampoos are stored in appropriate containers and not easily accessible to cognitively impaired residents with behaviors of ingesting non-edible items/ objects when not supervised and in use and 2.) immediately reporting to the nurse resident's behaviors of ingesting non-edible items/ objects. Additionally, newly hired nurses will receive education during orientation by the

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SDC regarding the following: 1.) what to do when a resident ingest non-edible items/ objects to include but not limited to assessment of the resident, notification of 911 as necessary, removal or proper storage of the object, implementation of an intervention depending on the root cause, physician and resident representative notification, documentation in the progress notes, ensuring the behavior is reflected on the resident care plan/care guide, and 2.) reviewing resident's admission and readmission records and speaking with the families on admission or readmission to identify all allergies and ensure the allergies are reflected in the clinical records including the demographics, and resident care guide. The SDC was notified of this responsibility by the Administrator on 4/24/24.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The decision to monitor the system for residents ingesting non-edible items/ objects and allergies was made on 4/24/24 by the Administrator and Director of Nursing and presented to the Quality Assurance (QA) Committee on 4/24/24.

The Unit Managers will review progress notes 5 x per week x 4 weeks, then weekly x 1 month to identify residents that ingest non-edible items/ objects and ensure completion of an assessment of the resident, notification to 911 as necessary, removal or proper storage of the object, implementation of an intervention depending on the root cause, physician and resident representative notification, documentation in the progress notes and the behavior is reflected on the care plan utilizing an audit tool. The audit will

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be discussed during the cardinal Interdisciplinary (IDT) meeting (clinical meeting) and written on the audit tool by the Activity Staff with oversite by the Administrator and/or Director of Nursing.

The Director of Nursing will immediately implement corrective actions upon identification of areas of concern including retraining of staff. The Unit Managers were notified of this responsibility by the Director of Nursing on 4/24/24.

The Treatment Nurse will monitor resident rooms to ensure inedible materials including soaps are in appropriate containers and stored properly and identified allergens are not present in the resident's room daily x 1-week, biweekly x 3 weeks, and then weekly x 4 weeks and document on a resident census. The Administrator will immediately ensure all areas of concern are addressed during the audit. The Treatment Nurse was notified of this responsibility by the Administrator on 4/24/24.

The Minimum Data Set (MDS) Nurse will review all admission and readmission records weekly x 8 weeks to ensure all preadmission allergies are reflected in the facility's clinical records including the demographics, and resident care guide for staff reference. The MDS Nurse will update the records accordingly and the Director of Nursing will immediately retrain the nurse upon notification for all identified areas of concern. The MDS Nurse was notified of this responsibility on 4/24/24.

The Administrator and/or DON will present the findings of the audit tools to the Quality Assurance Performance Improvement (QAPI)

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Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions and the need for additional monitoring.

Date of immediate jeopardy removal and corrective action completion: 4/25/24.

Onsite validation was completed on 5/01/24 through record review, staff interviews, resident interviews, and observations of resident rooms.

Record review of the staff education logs was completed with no areas of concern identified.

Staff were interviewed to validate the in-service was completed on putting away all personal care items including soaps, lotions, and shampoo when not in use. Staff interviews validated the completion of the education regarding identification and reporting resident behaviors of ingesting non-edible items or objects, and steps to take when the behavior was observed. Staff interviews were conducted and validated the education was completed regarding confirmation and documentation of resident allergies upon admission and readmission.

Resident Council Meeting Minutes and signature log were reviewed.

Record review of the facility audits of personal care items was conducted and validated by observations of random resident rooms for personal care items which included soap, lotions, and shampoo to be stored properly and not within reach of cognitively impaired residents.

Interviews were conducted with those residents

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F 689	Continued From page 28 identified by the facility as alert and oriented and with documented allergies to confirm the allergies listed were correct. No concerns were identified. A review was completed of the resident progress note audit with no identified concerns noted. The Quality Assurance and Performance Improvement (QAPI) ad-hoc (special and immediate meeting held for a specific situation) meeting minutes from 4/24/24 were reviewed. The facility's immediate jeopardy removal date of 4/25/24 and the corrective action plan with a completon date of 4/25/24 were validated.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but	F 867		5/24/24

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not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to

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ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s)

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F 867	Continued From page 31 functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Responsible Party (RP), Medical Director, Poison Control Center, and Hospital Physician, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 3/28/23 complaint investigation survey. This was for one recited deficiency on the current complaint investigation survey of 5/01/24 in the area of Provide Supervision to Prevent Accidents (F689). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F689: Based on record review and interviews with staff, Responsible Party (RP), Medical Director, Poison Control Center, and Hospital Physician, the facility failed to provide a safe environment to prevent an avoidable accident for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). Resident #1 had severe cognitive	F 867	F867 QAPI/QAA Improvement Activities On 5/20/24, the Facility Consultant initiated an audit of previous citation and action plan from 3/28/23 to present related to F689 To Provide Supervision to Prevent Accidents to ensure the Quality Assurance (QA) committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by the Administrator for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include but not limited to the education of staff. The audit will be completed by 5/24/24. On 5/20/24, the Facility Consultant initiated an in-service with the Administrator, Director of Nursing (DON) and Unit Managers regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction	

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F 867	Continued From page 32 impairment, was dependent on staff for assistance, and was allergic to ingredients that were commonly found in shampoos, skin care products, and soap. On 4/23/24 Resident #1 had access to a bar of soap (Soap #1), she ingested the soap, and had an allergic reaction which included mouth and lip swelling and was transferred to the Emergency Department (ED) for further treatment. Resident #1 required intubation (a tube placed down throat into the trachea to facilitate airflow) and mechanical ventilation (a form of life support that helps you breathe when you cannot breathe on your own) in the ED and continued to decline despite medical interventions. Resident #1 was placed on comfort measures and according to the death certificate expired on 4/26/24 from complications of anaphylactic shock (a severe, potentially fatal allergic reaction that is rapid in onset and requires immediate medical attention) due to accidental ingestion of soap. During the 3/28/23 complaint investigation survey the facility failed to provide incontinent care safely for a resident who required extensive staff assistance which resulted in bruises to all extremities and the left side of the face, a laceration on left forehead 0.5 centimeters (cm) in length, multiple skin tears to the upper right arm, fractures of the left and right distal femurs (fracture of the thigh bone that occur just above the knee joint), a right lateral tibia plateau fracture (a break of the larger lower leg bone below the knee), and suffered pain of the face and lower extremities. An interview was conducted on 5/01/24 at 2:49 pm with the Administrator who revealed the facility's QAA committee had completed the	F 867	if needed to prevent the reoccurrence of deficient practice to include updated advance directives. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 5/24/24. All newly hired Administrator, DON and Unit Managers will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns, to include F689 To Provide Supervision to Prevent Accidents will be taken to the Quality Assurance committee for review monthly x 6 months by the Director of Nursing. The Quality Assurance committee will review the data and determine if a plan of correction is being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the DON. The Facility Nurse Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the QA Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include F689 To Provide Supervision to Prevent Accidents and all current citations and that the QA plans are followed and	

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F 867	Continued From page 33 education and auditing and resolved the plan of correction for the previous deficient practice. The Administrator stated she was not aware Resident #1 had any prior behaviors of eating non-food items and would not have expected Resident #1 to ingest soap prior to the event.	F 867	maintained monthly x 6 months and QAPI quarterly x 2 quarters. The Facility Consultant will immediately retrain the Administrator, DON, and Unit Managers for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Director of Nursing to the Committee monthly x 6 months and QAPI quarterly x 2 quarters for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	