## SJEC Results from Department of Health Surveys and Inspection Reports

- DOH cited SJEC for placing residents in immediate jeopardy.
    - Reports involving the highest level of risk to residents showed all residents in the facility were in danger multiple times based on SJEC's deficient care.
    - The immediate jeopardy findings involved deficiencies relating to abuse, reporting alleged violations, investigating/preventing/correcting alleged abuse, infection control, and outbreak response.

- DOH repeatedly cited SJEC for improper administration of medication.
    - Reports from 2019 and 2021 show that SJEC failed to provide medicine to residents on schedule and in accordance with doctor's orders.
    - In 2021, DOH reported that all four of the residents whose files they reviewed failed to receive their medicine on time. An LPN stated that at least half of all the medications she administered were late. Records showed medications were provided three to four hours later than ordered.
    - For a resident admitted in 2021 with End Stage Renal Disease, SJEC failed to provide her medication on time, which made it impossible for her to leave the facility to receive dialysis. The records also showed on 19 occasions in November and December 2021 that the nurses administered the medication at a time when the resident already left the facility for dialysis.
    - In 2021, DOH found that for 8 of 22 residents examined, SJEC had incorrect physician order forms for medicine on file.
    - DOH also found poor documentation of medicine being distributed: A 2021 audit revealed that of the 20 residents reviewed for whom medication should have been administered, SJEC did not possess any documentation for five of the residents. In total, SJEC failed to document as administered 13 medications and 2 supplements.

- DOH cited SJEC for violations involving abuse and neglect of residents.
    - Reports from 2020 and 2023 document violations that involve the abuse and neglect of residents at SJEC.
    - In 2020, DOH cited SJEC for failing to report allegations of abuse. Surveyors determined that the facility staff failed to ensure a resident was protected from actual abuse. Based on a review of a security camera recording, the surveyors found that a resident was "roughly handled when a staff member forcefully pulled back the resident's wheelchair causing the resident to fall forward out of the chair, subsequently fell to the floor, and sustained an abdominal injury. A second staff member then forcefully grabbed the resident by the upper arm, causing the resident to be held down in the wheelchair while the 1st staff member roughly pushed the resident backwards in the wheelchair returning the resident to their room." The resident was sent to the hospital complaining of chest pain and was

admitted on June 3, 2020, with a diagnosis of abdominal hematoma and anxiety. Surveyors found that residents were at risk for abuse in an immediate jeopardy situation.
    - In 2023, DOH cited SJEC for using physical restraints when it was determined that the facility failed to ensure that a resident's movement in and out of a room was not restricted. The Surveyors found that a CNA tied the resident's bedroom door handle with a plastic trash bag and attached the other end of the trash bag to the handrail located just outside the resident's room door, which resulted in the resident not being able to exit the bedroom into the hallway.

- DOH cited SJEC for improper documentation of resident care and failure to ensure proper care.

    - Reports from 2019, 2020, 2021, and 2023 found that the facility failed to prepare appropriate MDS and Care Plans for residents.
    - A June 2020 survey found that a Care Plan for a resident had not been reviewed since September 2019.
    - In 2021, a survey found that SJEC staff failed to accurately transcribe a physician's order and failed to communicate with a physician in a timely manner about a resident's refusal to comply with the physician's orders.
    - A survey found that SJEC failed to ensure timely physician visits when a resident was not seen by an Attending Physician or Nurse Practitioner for a more than a two-month period in 2021.
    - In 2023, two residents who should have been identified as having serious mental illnesses were wrongly identified as not having serious mental illnesses.

- DOH repeatedly cited SJEC for improper practices involving food.

    - Surveys in 2019, 2020, and 2023 documented problems with food at SJEC.
    - In 2019, an inspection revealed 3 expired pantry items and 14 different food products in undated bags out of original packaging, including chicken, English muffins, ground beef, and shrimp. An opened one-gallon container of salad dressing had an opened date of November 2022 with a manufacturer's "use by date" of August 13, 2018.
    - In 2020, a survey revealed opened bags of meat that were stored open and exposed; chocolate pudding was kept an additional three days past the period permitted; and food was stored on freezer floor. A fan attached to wall above standing mixer was covered in dust and unidentified debris.
    - In 2023, a resident with end stage renal disease and hyperkalemia (high potassium in blood) was provided potatoes when the resident was not supposed to have potatoes.
    - In 2023, six food items observed by surveyor were undated and two half-pound containers of spices were expired by three to four years. A surveyor found a refrigerator/freezer with hair, solid black particles, ice buildup at the bottom, and a dried, brown substance on the bottom shelf. The surveyor also found that the

kitchen staff improperly sanitized/washed pots and pans in the three-compartment sink via improper testing procedures, which could lead to poisoning, bacterial growth, and potential sickness. Kitchen personnel were also found to not employ proper hygiene in handwashing or paper towel usage.

- DOH repeatedly cited SJEC for failing to maintain a safe and clean facility.
    - Surveys during inspections and in response to complaints in 2019, 2020, 2021, and 2023 documented problems with the SJEC facility.
    - In 2019, a surveyor found a door to a hazardous part of the facility did not close automatically when released.
    - In 2020, SJEC was cited for allowing a leaking fire sprinkler system to remain from at least April until September 2019, which delayed required inspections of the system.
    - In 2021, surveyors found that SJEC failed to ensure resident hallways and resident rooms were maintained in a clean and sanitary condition, which had the potential to affect all residents. Surveyors documented 24 areas that included, for instance, “Brown liquid spatter” and “Brown and green liquid and dried on spatter” on walls and “Brown smears on . . . handrails.”
    - A 2023 survey documented a tube feeding pole in a room with caked, tan material imbedded on it and a privacy curtain with a large brown, circular stain on it that remained for at least three days. Also, in another room a privacy curtain that was between two residents had brown/tan-colored stains that were in place for at least three days. The report notes that the resident stated that they had informed staff about it, but it was not addressed.