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	175550	A. BUILDING _____ B. WING _____	05/13/2021

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigations #162193 and #162382. The 2567 was electronically sent to the facility on 5/18/21.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility had census of 75 residents. The sample included 19 residents. Based on observation, record review, and interview, the facility failed to accommodate one of 19 sampled residents' needs, Resident (R) 60, who's audio device had dead batteries, making her unable to hear her scriptures that brought her comfort. Findings included: - R60's "Admission Minimum Data Set" (MDS), dated 04/16/21, documented the resident had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, dressing and personal hygiene. The assessment documented it was very important to the resident to take part in religious programs The "Mood Care Plan," dated 04/26/21, directed staff to assist the resident with a program of activities that were meaningful and of interest, and wanted scripture played on her audio device.	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/18/2021

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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On 05/11/21 11:45 AM, observation revealed the resident in a Broda chair (positioning chair), the resident's "Faith Comes by Hearing" bible audio device was not playing, and the red light was on.

On 05/11/21 at 12:00 PM, Licensed Nurse (LN) G stated the resident listened to bible podcasts but right now her audio device did not work because the batteries were dead. LN G stated the facility did not provide the batteries, the family did.

05/11/21 at 1:30 PM, observation revealed the resident's door was closed and the resident was hollering.

05/12/21 at 10:41 AM, observation revealed the resident's audio device sat on the resident's nightstand and was not turned on.

05/12/21 at 01:15 PM, observation revealed the resident's television was on and played an old western show. The resident was lying in bed and hollered, "hey, hey" continuously. Continued observation revealed the resident's audio device sat on her nightstand and a faint static sound could be heard.

On 05/13/21 at 08:30 AM, observation revealed the resident lying in bed, not hollering, and the audio device played bible scripture.

On 05/12/21 at 01:20 PM, LN G stated the device was staticky because the batteries were going dead and was not sure when family would be in to visit and replace the batteries.

On 05/12/21 at 01:45 PM, Administrative Nurse D stated the family brought in the device because

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F 558	Continued From page 2 the resident was very religious, and she liked to listen to hymns. Administrative Nurse D further stated the resident hollered, the family did not want the resident over sedated with medication, and the facility provided batteries for the device if the family did not bring batteries when visiting. Upon request, the facility did not provide a policy for accommodation of needs. The facility failed to provide R60 an audio device with working batteries, placing the resident at risk for anxiety and discomfort.	F 558		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing,	F 676		

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grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 75 residents. The sample included 19 residents with one resident reviewed for communication. Based on observation, record review, and interview, the facility failed to provide communication tools for a non-English speaking resident, Resident (4).

Findings included:

- R4's "Physician Order Sheet" (POS), dated 03/16/21, documented diagnoses of type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), peripheral vascular disease (abnormal condition affecting the blood vessels), hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (CVA (stroke) - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting left non-dominant side, dysphagia (swallowing

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difficulty) hypertension, history of sudden cardiac arrest, and major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

The "Annual Minimum Data Set" (MDS), dated 08/07/20, documented the resident was Asian, needed or wanted an interpreter to communicate with a doctor or health care staff, preferred language of Vietnamese, had unclear speech, sometimes understood, and sometimes understands. Staff assessed the resident with severe cognitive impairment, he required extensive assistance with activities of daily living, had physical and verbal behaviors directed toward others, had an indwelling urinary catheter and feeding tube.

The "Communication Care Area Assessment" (CAA), dated 08/06/20, documented the resident as sometimes understood, not able to speak clearly, had difficulty understanding what is said to him, had a cerebral vascular accident (CVA) with dysphagia with left sided weakness, and these factors impeded his ability to verbally communicate as well as to understand complex ideas.

The "Quarterly MDS" dated 04/24/21, documented the resident as Asian, needed or wanted an interpreter to communicate with a doctor or health care staff, preferred language was Vietnamese, had unclear speech, sometimes understood, and understands, had severe cognitive impairment. The MDS further documented R4 required extensive assistance with activities of daily living, an indwelling urinary catheter, feeding tube, received occupational and

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physical therapy.

The "Communication Care Plan," dated 04/04/21, directed staff to provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out a staff member when agitated. The care plan further directed staff to make sure the resident was safe when overly agitated and attempt approaching the resident at a later time, if appropriate.

The "Social Service Summary Progress Note," dated 04/24/21, documented staff assessments were completed by staff, due to R4 unable to participate, being non-English speaking, and noting he had some confusion. R4 could not effectively make his needs known, therefore staff tried to anticipate and provide his needs. He could be resistive to cares at times, call out, yell out, and spit at staff.

On 05/11/21 at 12:30 PM, observation revealed staff fed R4 his midday meal. The resident repeated the same non-English words. The resident stated "I'm full".

On 05/13/21 at 08:29 AM, observation revealed nursing staff in R4's room to flush his feeding tube, the resident began to holler out what sounded like "I don't want" and "hurt".

On 05/11/21 at 12:33 PM, Certified Nurse Aid (CNA) N stated she did not understand what R4 was trying to say as he yelled out.

On 05/12/21 at 08:26 PM, Certified Medication Aid (CMA) R stated the resident did not speak

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English and does not understand what the resident says or means.

On 05/12/21 at 08:40 AM, CNA O stated the resident did not speak English and when R4 began to yell she went to the room and tried to communicate by pointing at things, she adjusted pillows, and/or she repositioned, and moved things he may have needed to be near him.

On 05/13/21 at 08:29 AM, Licensed Nurse (LN) H stated the resident could say a few English phrases like "thank you" and "hello", and she could not always understand what he needed.

On 05/13/21 at 08:04 AM, Administrative Nurse E stated staff would call R4's family if they needed interpretation of language. The resident's wife did not speak much English, but his children were fluent in English. Administrative Nurse E verified the care plan lacked interventions the resident and staff could utilize for his language barrier.

The facility's "Quality of Life, Non-English Communication" policy, dated October 2007, stated that all residents who are non-English speaking will be able to communicate their needs as desired by the resident. The facility will identify the language or tool needed for interpreter services and contact appropriate agency who can interpret. The policy further stated the facility will supple resident, family, staff members with the use of a communication board/binder/signage that has universal known drawing, whenever desired.

The facility failed to provide the resident with necessary communication tools of R4's non-English speaking status, placing the resident

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F 676	Continued From page 7 at risk for lack of informed care and services.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 19 residents, with three reviewed for activities of daily living (ADLs). Based on observation, record review, and interview, the facility failed to provide bathing and nail care for one of three sampled residents, Resident (R) 60. Findings included: - R60's "Admission Minimum Data Set" (MDS), dated 04/16/21, documented the resident had severely impaired cognition and required extensive assistance of two staff for personal hygiene. The assessment documented bathing did not occur during the seven day look back period. The "ADL Care Plan," dated 04/26/21, documented the resident required total staff assistance for bathing and one staff assistance for personal hygiene. The "April 2021 Bathing Record" documented the resident received a bed bath on the following days: 04/12/21 04/27/21(14 days without a bath).	F 677		

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On 05/12/21 at 10:41 AM, observation revealed the resident's toenails were brown, jagged, and overgrown past the tip of the toes.

On 05/12/21 at 01:15 PM, observation revealed the resident's toenails continued to be long and jagged, and the resident's mattress contained had a large amount of dry skin flakes from the resident's feet because the resident's feet were dry and flaky.

On 0/5/12/21 at 10:41 AM, Certified Nurse Aide (CNA) P stated she did not know why the resident's toenails were not cut.

On 05/12/21 at 01:15 PM, Licensed Nurse (LN) G stated staff applied lotion to the resident's legs and feet often, but did not know anything about the resident's toenails.

On 05/12/21 at 01:45 PM, Administrative Nurse D stated staff applied lotion to the resident's legs and feet all the time and verified the resident's toenails needed clipped.

On 05/13/21 at 11:30 AM, Administrative Nurse D stated staff documented the resident's bed baths on paper and in the computer, and verified staff had not given R60 a bed bath for two weeks.

The facility's "ADL Services" policy, dated November 2007, documented the residents are given the appropriate treatment and services to maintain or improve his/her abilities and residents who are unable to carry out ADL's received services to maintain good nutrition, grooming, personal hygiene and oral hygiene.

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F 677	Continued From page 9 The facility's "Nail Care" policy, dated November 2007, documented the facility promoted cleanliness, the safety and neat appearance of residents, staff observe for ingrown nails, corns calluses or infections, trim nails straight across and even with end of finger or toe, round the edges with a nail file or emery board, and smooth the rough edges on toenails.. The facility failed to provide R60 bathing services and nail care as care planned, placing the resident at risk for poor hygiene.	F 677		