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THE HEALTHCARE RESORT OF TOPEKA	6300 SW 6TH AVENUE TOPEKA, KS 66615

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation # KS00171593 AND KS00166873. The 2567 was sent electronically on 09/02/22.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: The facility identified a census of 63 residents. The sample included 18 residents with one resident reviewed for self-administration of medications. Based on observations, interviews, and record reviews, the facility failed to assess Resident (R)116 for the ability to safely self-administrator medications. This deficient practice placed R116 at risk for medication errors and unnecessary side effects. Findings Included: - A review of R116's Electronic Medical record (EMR) revealed that she was admitted to the facility on 08/27/22. The "Medical Diagnosis" section within R116's EMR included diagnoses of hypertension (high blood pressure), muscle weakness, type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), cholecystitis (inflammation of the gallbladder), heart failure,	F 554		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/02/2022

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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respiratory failure, and need for assistance with personal cares.

A review of R116's EMR indicated that her "Minimum Data Set" (MDS) information was not available for review.

A review of R116's "Assessments" revealed a Brief Interview for Mental Status (BIMS) score of 10 completed on 08/29/22 indicating moderate cognitive impairment.

A review of R116's EMR lacked evidence an assessment was completed related to self-administration of medication for R116.

R116's "Care Plan" created 08/27/22 noted that R116 was at risk for impaired cognitive thought processes related to impaired decision making. The plan instructed staff to keep her routine consistent and try to provide consistent care givers as much as possible to decrease confusion.

A review of R116's "Medication Administration Report (MAR)" indicated that her morning medications on 08/29/22 had been administered.

On 08/29/22 at 10:48 PM observation revealed a plastic medication cup with four white pills inside sat on R116's bedside table.

On 08/29/22 at 10:48 AM R116 reported that nursing staff left her medication on the bedside table but further said she would not take the medication because she did not know what it was or what the medication did. R116's representative reported that she was not sure why the medications were left in the room or if staff

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F 554	Continued From page 2 expected R116 to take the medication's herself. On 08/31/22 at 01:40 PM in interview with Licensed Nurse (LN) H, she stated that medications should never be left in the resident's room unsupervised. She stated that some residents could self-administer medications but required a risk assessment to be completed for their safety. On 08/31/22 at 03:40 PM in an interview with Administrative Nurse D, she stated that if a resident desired to self-administer medications, an assessment must be completed to ensure they were safe to administer the medications themselves. She stated that R116 was not safe for self-administration of medications and that the medications should not have been left in the room. A review of the facility's "Medication Administration Policy" revised 01/2022 stated that all medications given will be documented in the Medication Administration Report as the medications are given only by a licensed nurse or certified medication aide. The facility failed to assess R116 for the ability to self-administrator medications safely. This deficient practice placed R116 at risk for medication errors and unnecessary side effects.	F 554		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		

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representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement

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its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 63 residents. The sample included 18 residents with one resident reviewed for physician notification. Based on observations, interviews, and record reviews, the facility failed to notify Resident (R)18's physician of R18's face/head injuries obtained during an accident while being transferred with a Hoyer lift (total body mechanical lift used to transfer residents). This deficient practice placed R18 at risk for complications related to accidents and injuries.

Findings Included:

- The "Medical Diagnosis" section within R18's Electronic Medical Records (EMR) included diagnoses of hemiplegia (paralysis of one side of the body), major depressive disorder (major mood disorder), dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness, morbid obesity), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

R18's "Quarterly Minimum Data Set (MDS)" dated 06/17/22 noted a Brief Interview for Mental Status (BIMS) assessment could not be completed due to severe cognitive impairment. The MDS noted that she required extensive assistance from two staff for all transfers and bed mobility.

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A review of R18's "Dementia Care Area Assessment (CAA)" dated 12/17/21 noted a BIMS score of three at the time of assessment with a dementia diagnosis.

A review of R18's "Communication CAA" dated 12/17/21 she had an impaired ability to make herself understood and to express ideas and wants with others.

R18's "Care Plan" created 01/03/20 noted that she had a self-care deficit related to her activities of daily living (ADL's). The plan noted that she required two staff to transfer her with the Hoyer lift. The care plan noted that she had a risk for impaired skin integrity noted. The plan instructed staff to use caution during transfers and bed mobility to prevent injuries from sharp or hard surfaces. The care plan indicated that R18 was taking Plavix (medication used to prevent blood from clotting) and was at risk for hemophilia (disorder where blood does not clot leading to excessive bleeding).

A review of a "Witness Statement" completed on 08/25/22 by Certified Medication Aid (CMA) R indicated that R18 was struck on the left cheekbone by the sling attachment point (metal swivel bar) during a Hoyer transfer from R18's bed to her wheelchair on 08/25/22 at 08:00 AM. The statement noted Certified Nurse Aid (CNA) M notified the charge nurse immediately of the incident.

A review of a "Witness Statement" completed 08/25/22 by CNA M noted that while transferring R18, the Hoyer lift's arm struck R18 in the face.

R18's clinical record lacked evidence the

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F 580	Continued From page 6 physician was notified regarding the accident related injury. On 08/30/22 at 12:05PM R18 ate her lunch in the dining area. R18's left cheek had a circular quarter sized dark blue bruise under her left eye. R18 was unable to communicate how her injury happened. On 08/31/22 at 01:20 PM Licensed Nurse (LN) G stated that she notified the nurse practitioner and the family but did not document the notifications. LN G stated that the resident's representative was contacted about the accident. On 08/31/22 at 03:54 PM Administrative Nurse D stated that both the physician and the resident representative had been notified at the time, but LN G wasn't able to document the information. She stated that she also had intended to update the information but was out those days due to an illness. A review of the facility's "Notification to Physician and Responsible Party" policy revised 08/2022 noted that the facility is required to promptly notify the resident, attending physician, and resident representative of any change in conditions or status. The facility failed to ensure that R18's attending physician was notified of face/head injuries from an accident during a Hoyer lift transfer. This deficient practice placed R18 at risk for complications related to accidents and injuries.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the

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requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 63 residents. The sample included 18 residents with 18 residents reviewed for development of comprehensive care plans. Based on observation, record review, and interviews, the facility failed to develop a person-centered comprehensive care plans for Resident (R) 43, related to an individualized toileting program and/or bladder retraining. This deficient practice placed the resident at risk of not achieving and/or maintaining her highest practicable physical, mental, and psychosocial well-being due to unmet or uncommunicated care needs.

Findings included:

- R43's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), hypertension (elevated blood pressure), and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin).

The "Admission Minimum Data Set" (MDS) dated 08/06/22 documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented that R43 required extensive assistance of one staff member for toileting and bed mobility, limited assistance of one staff member for transfers and dressing and limited assistance of two staff members for personal hygiene.

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R43's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 08/12/22 documented R43 was incontinent of bladder and bowels and required assistance with toileting.

Review of the EMR under "Assessments" tab revealed a "Bowel and Bladder Evaluation" dated 08/09/22 which documented R43was a likely candidate for bowel and bladder retraining.

R43's "Care Plan" dated 08/10/22 documented staff was to offer restroom frequently. The "Care Plan" lacked resident -specific toileting schedule or interventions related to bladder retraining.

R43's clinical record lacked evidence a bladder retraining program was attempted or implemented.

On 08/30/22 at 12:21 PM R43 was assisted into the bathroom, R43 was not incontinent of urine. One staff member assisted her into the bathroom.

On 08/29/22 at 11:23 AM R43 stated she was aware of the urge to void and had a few episodes of incontinence when she was unable to get to the bathroom in time.

On 08/31/22 at 01:19 PM Licensed Nurse (LN) H stated the "Bowel and Bladder Evaluation" was completed by LN I and was not sure what information was reviewed for that evaluation. LN H stated she had access to the care plan and was able to make changes to the care plan if needed or would notify the director of nursing or the assistant director of nursing to make the changes to the care plan.

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On 08/31/22 at 01:30 PM Certified Medication Aide (CMA) R stated R43 was continent of urine most of the times she had assisted her to the bathroom. CMA R stated she was not aware of an individualized toileting schedule for R43. CMA R stated she would check R43 every two hours. CMA R stated she had access to review the resident's care plan and care information was found on the Kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change).

On 08/31/22 at 02:47 PM Administrative Nurse D stated LN I completed the "Bowel and Bladder Evaluation" three days after a resident's admission to the facility. Administrative Nurse D stated LN I reviewed the documentation under the "Tasks" tab in the EMR for bowel and bladder. Administrative Nurse D stated that LN I would make a note in the progress notes and update the resident's care plan. Administrative Nurse D stated she was unable to located LN I progress note for the current evaluation for R43.

The facility "Comprehensive Person-Centered Care Plan" policy, last revised January 2022 documented the resident's comprehensive care plan would be review and revised after each assessment.

The facility failed to develop a person-centered comprehensive care plans for R43 related to an individualized toileting program and/or bladder retraining. This deficient practice placed the resident at risk of unmet or uncommunicated care needs.

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F 657 SS=D	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 by: The facility identified a census of 63 residents. The sample included 18 residents with two residents sampled for respiratory care. Based on observation, record review and interview, the facility failed to ensure that a comprehensive person-centered care plan was implemented for R58's oxygen (O2) therapy/use. This deficient practice placed R58 at risk uncommunicated care	F 657		

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needs related to O2 therapy.

Findings included:

- The electronic medical record (EMR) for R58 documented diagnoses of hypertension (elevated blood pressure), and chronic obstructive pulmonary disease (COPD-a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Significant Change Minimum Data Set" (MDS) dated 08/08/22 documented R58 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R58 required extensive assistance of two staff for all her activities of daily living (ADLs). R58 required O2 therapy.

The "ADL Care Area Assessment" (CAA) dated 08/22/22 documented R58 admitted for COPD and was on hospice. R58 needed staff assistance with ADLs. R58 was noted with O2 use.

R58's "Care Plan" lacked directives or intervention related to O2 use/care.

Under the "Orders" tab, R58 had an order dated 07/22/22 to titrate (to continuously measure and adjust the balance of) O2 to keep saturation level between 88 to 92 percent (%).

Under the "Orders" tab R58 had an order dated 07/22/22 to change O2 tubing and humidifier bottle weekly every Wednesday night shift.

An initial observation on 08/29/22 at 01:56 PM revealed R58 had O2 on per nasal cannula

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(NC-tube which delivers oxygen through the nostrils). The tubing lacked a date to indicate when the tubing was last changed.

On 08/31/22 at 10:46 AM R58 laid in bed with her O2 on.

On 08/31/22 at 01:00 PM Certified Nurse Aide (CNA) M stated that the care plan for the residents should show the cares needed for the O2 therapy. The care plan was updated by the nurses.

On 08/31/22 at 01:08 PM Licensed Nurse (LN) G stated that the care plan was initiated at admission and the interdisciplinary team (IDT) would update the care plan as needed. LN G was not aware that R58 lacked a care plan area for her O2.

On 08/31/22 at 02:47 PM Administrative Nurse D stated that the initial care plan was completed by herself or Administrative Nurse E and was updated as needed by nursing staff. Administrative Nurse D said R58 should have a care area in her care plan for the O2 therapy but it appeared that it had been omitted.

The facility policy "Comprehensive Person-Centered Care Planning" revised 01/22 documented: the facility interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, mental and psychological needs that were identified in the comprehensive assessment.

The facility failed to ensure that R58's

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F 657	Continued From page 14 comprehensive care plan included interventions and directives for O2 therapy/care. This deficient practiced placed R58 at risk for unmet care needs related to O2 therapy.	F 657		
F 689 SS=D	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 identified a census of 63 residents. The sample included 18 residents with three residents reviewed for accidents. Based on observations, interviews, and record reviews, the facility failed to ensure a safe environment free from preventable accidents when staff hit Resident (R)18 in the face with the Hoyer lift (total body mechanical lift used to transfer residents) swivel bar during a transfer. This deficient practice placed R18 at risk for complications related to accidents and injuries. Findings Included: -The "Medical Diagnosis" section within R18's Electronic Medical Records (EMR) included diagnoses of hemiplegia (paralysis of one side of the body), major depressive disorder(major mood disorder), dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness, morbid obesity (severely	F 689		

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overweight), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

R18's "Quarterly Minimum Data Set (MDS)" dated 06/17/22 noted a Brief Interview for Mental Status (BIMS) assessment could not be completed due to severe cognitive impairment. The MDS noted that she required extensive assistance from two staff for all transfers and bed mobility.

A review of R18's "Dementia Care Area Assessment (CAA)" dated 12/17/21 noted a BIMS score of three at the time of assessment with a dementia diagnosis.

A review of R18's "Communication CAA" dated 12/17/21 she had an impaired ability to make herself understood and to express ideas and wants with others.

R18's "Care Plan" created 01/03/20 noted that she had a self-care deficit related to her activities of daily living (ADL's). The plan noted that she required two staff to transfer her with the Hoyer lift. The care plan noted that she had a risk for impaired skin integrity noted. The plan instructed staff to use caution during transfers and bed mobility to prevent injuries from sharp or hard surfaces. The care plan indicated that R18 was taking Plavix (medication used to prevent blood from clotting) and was at risk for hemophilia (disorder where blood does not clot leading to excessive bleeding.)

A review of a "Witness Statement" completed on 08/25/22 by Certified Medication Aid (CMA) R indicated that R18 was struck on the left cheekbone by the sling attachment point (metal

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swivel bar) during a Hoyer transfer from R18's bed to her wheelchair on 08/25/22 at 08:00 AM. The statement noted Certified Nurse Aid (CNA) M notified the charge nurse immediately of the incident.

A review of a "Witness Statement" completed 08/25/22 by CNA M noted that while transferring R18, the Hoyer lift's arm struck R18 in the face.

A review of the facility's "In-Service" training logs revealed that the facility recently held a "Skills Fair" held in 04/17/22 that included resident accidents, lifting transfers, and resident injuries. The review revealed staff involved completed the skills check-off training and received monthly online training on topics related to accident prevention, transfers, and basic care skills.

On 08/30/22 at 12:05 PM R18 was observed eating her lunch in the dining area. R18's left cheek had a circular quarter sized dark blue bruise under her eye. R18 was unable to communicate how her injury happened.

On 08/30/22 at 02:00 PM Certified Nurses Aide (CNA) M stated that she assisted Certified Medication Aide (CMA) R with transferring R18 to her wheelchair when the metal sling arm came forward and struck R18 in the left cheek. She stated neither staff held the sling arm while moving the machine and the arm where the sling connected struck R18 in the face while the lift was moved backwards.

On 08/30/22 at 02:45 PM CMA R stated that the momentum of the sling being unhooked caused the Hoyer lift arm to swivel forward and strike R18 in the face. She stated that it was an accident and

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the nurse was immediately notified. She stated that staff offered a cold compress pack (ice pack) but R18 would not allow them to assist her.

On 08/31/22 at 01:20 PM Licensed Nurse (LN) G stated when she arrived in R18's room the accident had already occurred and R18 was crying and refusing cares from the staff. She stated that she assessed R18 and notified Administrative Nurse D, the nurse practitioner, and R18's representative. She stated that she did enter note to monitor R18's left cheek but no documentation was completed related to R18's assessment, physician/guardian notification, or injury documentation. LN G stated that she had left work early due to being stressed out from the incident and was not able to complete the documentation.

On 08/31/22 at 02:00 LN H stated that all Hoyer lift transfers required two staff members to safely move a resident between positions. She stated that if an injury occurred, she would immediately assess the resident's health and safety, notify the physician, administrative nurses, and the resident's representative. She stated that the assessments should have been documented in the EMR and an incident note created to show what happened.

On 08/31/22 at 03:54PM Administrative Nurse D reported that all injuries were to be assessed and documented. She stated that all transfer with the Hoyer lift required two staff members present to ensure the resident was safely moved. She stated that all staff had recently received in-services related to transfers, accident management, and patient safety.

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F 689	Continued From page 18 A review of the facility's "Hoyer Lift" 03/2022 stated that it is the facility's responsibility to ensure all resident's that required transfers using a mechanical device by safely transferred. The policy indicated that two staff members are required to be assisting for the safety of the resident in the event of a device failure or emergency. The facility failed to safely transfer R18 from her bed to her wheelchair resulting in an injury during a Hoyer lift transfer. This deficient practice placed R18 at risk for complications related to accidents and injuries.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		

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and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 63 residents. The sample included 18 residents. Based on observation, record review, and interviews, the facility failed to provide an individualized toileting program for Resident (R) 43 to promote continence. This placed her at risk for increased incontinence and impaired dignity and well-being.

Findings included:

- R43's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (elevated blood pressure), and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin).

The "Admission Minimum Data Set" (MDS) dated 08/06/22 documented a Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented that R43 required extensive assistance of one staff

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member for toileting and bed mobility, limited assistance of one staff member for transfers and dressing and limited assistance of two staff members for personal hygiene.

R43's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 08/12/22 documented R43 was incontinent of bladder and bowels and required assistance with toileting.

Review of the EMR under "Assessments" tab revealed a "Bowel and Bladder Evaluation" dated 08/09/22 which documented R43 was a likely candidate for bowel and bladder retraining.

R43's "Care Plan" dated 08/10/22 documented staff was to offer restroom frequently. The "Care Plan" lacked resident -specific toileting schedule or interventions related to bladder retraining.

R43's clinical record lacked evidence a bladder retraining program was attempted or implemented.

On 08/30/22 at 12:21 PM R43 was assisted into the bathroom, R43 was not incontinent of urine. One staff member assisted her into the bathroom.

On 08/29/22 at 11:23 AM R43 stated she was aware of the urge to void and had a few episodes of incontinence when she was unable to get to the bathroom in time.

On 08/31/22 at 01:19 PM Licensed Nurse (LN) H stated the "Bowel and Bladder Evaluation" was completed by LN I and she was not sure what information was reviewed for that evaluation. LN

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H stated she had access to the care plan and was able to make changes to the care plan if needed or would notify the director of nursing or the assistant director of nursing to make the changes to the care plan.

On 08/31/22 at 01:30 PM Certified Medication Aide (CMA) R stated R43 was continent of urine most of the times she had assisted her to the bathroom. CMA R stated she was not aware of an individualized toileting schedule for R43. CMA R stated she would check R43 every two hours. CMA R stated she had access to review the resident's care plan and care information was found on the Kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change).

On 08/31/22 at 02:47 PM Administrative Nurse D stated LN I completed the "Bowel and Bladder Evaluation" three days after a resident's admission to the facility. Administrative Nurse D stated LN I reviewed the documentation under the "Tasks" tab in the EMR for bowel and bladder. Administrative Nurse D stated that LN I would make a note in the progress notes and update the resident's care plan. Administrative Nurse D stated she was unable to locate LN I's progress note for the current evaluation for R43.

The facility "Bladder and Bowel Assessment and Policy" policy dated February 2022 documented the assessment would be completed quarterly, and with significant change and annually with each MDS. The care plan would be updated to reflect toileting schedule or other measures employed to reduce/prevent incontinence.

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F 690	Continued From page 22 The facility failed to provide an individualized toileting program and/or bladder retraining for R43 to promote continence. This placed her at risk for increased incontinence and impaired dignity and well-being.	F 690		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident	F 726		

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assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:
The facility identified a census of 63 residents. The sample included 18 residents with 18 residents reviewed for competent nurse staffing. Based on observations, interviews, and record reviews, the facility failed to ensure that staff possessed the knowledge and skills necessary to ensure Resident (R)18 was assessed after an accident with a Hoyer lift (total body mechanical lift used to transfer residents) transfer. The facility additionally failed to complete follow-up assessments for R18's injury. This deficient practice placed R18 at risk for complications from accident related injuries.

Findings Included:

- The "Medical Diagnosis" section within R18's Electronic Medical Records (EMR) included diagnoses of hemiplegia (paralysis of one side of the body), major depressive disorder(major mood disorder), dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness, morbid obesity (severely overweight), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

R18's "Quarterly Minimum Data Set (MDS)" dated 06/17/22 noted a Brief Interview for Mental Status (BIMS) assessment could not be completed due to severe cognitive impairment. The MDS noted that she required extensive assistance from two staff for all transfers and bed mobility.

A review of R18's "Dementia Care Area Assessment (CAA)" dated 12/17/21 noted a

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BIMS score of three at the time of assessment with a dementia diagnosis.

A review of R18's "Communication CAA" dated 12/17/21 she had an impaired ability to make herself understood and to express ideas and wants with others.

R18's "Care Plan" created 01/03/20 noted that she had a self-care deficit related to her activities of daily living (ADL's). The plan noted that she required two staff to transfer her with the Hoyer lift. The care plan noted that she had a risk for impaired skin integrity noted. The plan instructed staff to use caution during transfers and bed mobility to prevent injuries from sharp or hard surfaces. The care plan indicated that R18 was taking Plavix (medication used to prevent blood from clotting) and was at risk for hemophilia (disorder where blood does not clot leading to excessive bleeding).

A review of a "Witness Statement" completed on 08/25/22 by Certified Medication Aid (CMA) R indicated that R18 was struck on the left cheekbone by the sling attachment point (metal swivel bar) during a Hoyer transfer from R18's bed to her wheelchair on 08/25/22 at 08:00 AM. The statement noted Certified Nurse Aid (CNA) M notified the charge nurse immediately of the incident.

A review of a "Witness Statement" completed 08/25/22 by CNA M noted that while transferring R18, the Hoyer lift's arm struck R18 in the face.

A review of R18's clinical record revealed the last nursing assessments completed were on 08/22/22. The record lacked evidence an

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assessment was completed immediately after R18 was hit in the face with the Hoyer. The record further lacked evidence nursing staff assessed and monitored R18 neurological status and skin for latent injury or adverse outcomes related to the accident.

R18's clinical record lacked evidence the physician was notified regarding the accident related injury.

On 08/30/22 at 12:05 PM R18 ate her lunch in the dining area. R18's left cheek had a circular quarter sized dark blue bruise under her left eye. R18 was unable to communicate how her injury happened.

On 08/31/22 at 01:20 PM Licensed Nurse (LN) G stated that when she arrived in R18's room the accident had already occurred and R18 was crying and refusing cares from the staff. She stated that she assessed R18 and notified Administrative Nurse D, the nurse practitioner, and R18's representative. She stated that she did enter note to monitor R18's left cheek but no documentation was completed related to R18's assessment, physician/guardian notification, or injury documentation. LN G stated that she had left work early due to being stressed out from the incident and was not able to complete the documentation.

On 08/31/22 at 12:54PM Administrative Nurse D reported that upon reviewing R18's EMR, she noted that no assessment or documentation had been completed since the incident occurred on 08/25/22 but stated that the physician had been notified and they monitored R18 closely for her injuries.

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F 726	Continued From page 26 A review of the facility's "Incident reporting and Investigations" policy revised 03/2022 reported that the facility must investigate all injuries and assess residents after accidents for safety and identify interventions to prevent future interventions for safety. The policy noted all injuries must be assessed by a licensed nurse and reported to the physician. The facility failed to ensure staff assessed for injuries from an accident during a Hoyer lift transfer. The facility additionally failed to staff monitored R18's injury. This deficient practice placed R18 at risk for complications related to accidents and injuries.	F 726		