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	17E589	A. BUILDING _____ B. WING _____	11/17/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. This 2567 was electronically sent to the facility on 11/22/22.	F 000		
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:	F 657		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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The facility reported a census of 34 residents with 16 selected for review. Based on observation, interview, and record review the facility failed to review and revise the plan of cares for two of the 16 sampled residents, including; Resident (R)6 and R13 with the lack of intervention to support the residents' legs during transport in wheelchairs to prevent accidents with potential foot/leg injury.

Findings included:

- Review of resident (R)6's electronic medical record, revealed diagnoses included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), dementia (progressive mental disorder characterized by failing memory and confusion), neuropathy (damage to nerves outside of the brain and spinal cord), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and chronic pain.

The "Annual Minimum Data Set" (MDS), dated 06/07/22, assessed the resident with severely impaired cognitive status. The resident required extensive assistance of one staff for transfer and locomotion on and off the unit. The resident had functional impairment in range on motion on one side of her upper and lower extremities. The resident used a wheelchair for mobility.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 06/07/22, assessed the resident had decline in cognition but was able to make needs known. The resident had a diagnosis of dementia.

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The "Falls CAA" dated 06/07/22, assessed the resident made poor choices and was wheelchair bound.

The "Quarterly MDS", dated 09/03/22, assessed the resident with severely impaired cognitive status. The resident required extensive assistance on one staff for transfers and required limited assistance of one person for locomotion on and off the unit. The resident had functional impairment in range on motion on one side of her upper and lower extremities. The resident used a wheelchair for mobility.

The "Care Plan," revised 09/11/22, instructed staff the resident required up to extensive assistance of one staff for locomotion on and off the unit. The resident propelled herself in the wheelchair for very short distances The "Care Plan" lacked interventions for use of foot pedals on her wheelchair.

Observation, on 11/14/22 at 08:00 AM, revealed Certified Nurse Aide (CNA) N, propelled the resident in her wheelchair from her room to the dining room. The wheelchair lacked foot pedals and her feet skimmed along directly on the floor. The resident intermittently raised her feet up but did not maintain her feet in an elevated position.

Observation, on 11/15/22 at 08:47 AM, revealed CNA Q, propelled the resident in her wheelchair from the dining room to her room. The wheelchair lacked foot pedals and the resident's feet skimmed along directly on the floor.

Interview, on 11/15/22 at 09:00 AM, with the resident revealed she often had pain in her legs

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and staff assisted her in her wheelchair. The resident stated she did not walk.

Observation, on 11/16/22 at 08:41 AM, revealed CNA NN propelled the resident seated in her wheelchair from the dining room to her room. The wheelchair lacked foot pedals and the resident's feet skimmed along directly on the floor. Interview, at that time, with CNA NN, revealed the resident did have foot pedals for the wheelchair, but did not know where they were. CNA NN stated the resident did propel herself in her room at times but could not self-propel long distances.

Interview, on 11/16/22 at 11:25 PM, with Administrative Nurse E, revealed the care plan included triggers from the MDS. Administrative Nurse E stated use of foot pedals on a wheelchair should be included on the care plan.

Interview, on 11/16/22 at 01:33 PM, with Licensed Nurse (LN) H, revealed the resident did have foot pedals, but did not know where they were. The resident informed LN H where the foot pedals were located, in her room at that time. LN H attempted to attach the foot pedals to the wheelchair and noted the left foot pedal did not attach completely and requested assistance from CNA MM. Interview with CNA MM, at that time, revealed she did not know why the foot pedals were not attached to the chair, and would notify maintenance to assist with attaching them.

Interview, on 11/16/22 at 02:53 PM, with Administrative Nurse D, revealed she would expect staff to propel the resident in her wheelchair slowly, as she thought the resident could hold her feet up off the floor. She expected

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staff to place one hand on the resident's shoulder in case the resident lurched forward unexpectedly. Administrative Nurse D stated staff should apply foot pedals when the resident could not hold their feet off the floor. Administrative Nurse D stated the resident often refused interventions and the care plan indicated her refusal but did not know if she refused foot pedals.

The facility policy for "Comprehensive Assessment Policy Including the MDS, CAAs and Care Planning", approved 01/11/21, included: Any changes in the resident's condition will require an immediate reassessment with changes in the plan of care reflecting the change in condition.

The facility failed to review and revise the care plan to include interventions for the use of foot pedals on this resident's wheelchair to ensure resident safety when staff propelled the resident.

- Review of Resident (R)13's electronic medical record (EMR) included a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The annual "Minimum Data Set" (MDS), dated 01/25/22, documented the staff assessment for pain revealed severe cognitive impairment. She required extensive assistance of one staff for locomotion with her wheelchair.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 01/25/22, did not trigger for further review.

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The quarterly "MDS," dated 10/21/22, documented the staff assessment for cognition revealed severe cognitive impairment. She required extensive assistance of one staff for locomotion with her wheelchair.

The care plan for ADLs, revised 10/25/22, instructed staff the resident required total assistance of one staff for propelling her wheelchair as the resident was non-ambulatory. The care plan lacked interventions to support the resident's feet/legs when unable to hold them above the floor while being transported in the wheelchair, to prevent accidents.

Review of the resident's EMR, revealed from 10/17/22 through 11/14/22, the resident required limited to total assistance of one staff for locomotion on the unit with her wheelchair.

On 11/14/22 at 11:53 AM, Licensed Nurse (LN) H propelled the resident into the dining room for lunch. The resident's shoed feet bounced on the floor multiple times during transport. The resident's wheelchair lacked foot pedals.

On 11/15/22 at 11:43 AM, Certified Nurse Aide (CNA) N propelled the resident to the dining room for lunch. The resident's shoed feet skimmed the floor during transport. The resident's wheelchair lacked foot pedals.

On 11/15/22 at 11:43 AM, CNA N stated staff do not use foot pedals on the resident's wheelchair due to she will propel herself at times.

On 11/14/22 at 11:53 AM, LN H stated the resident did not have footpedals on her

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F 657	Continued From page 6 wheelchair because she would propel herself at times using her feet. On 11/15/22 at 03:34 PM, LN G stated the resident would propel herself at times in her wheelchair. Staff should probably place foot pedals on the wheelchair when they propelled her. On 11/16/22 at 11:25 PM, Administrative Nurse E, stated she was responsible for updating the care plans. Anything that triggers on a MDS should be included on the care plan. If a resident uses foot pedals on a wheelchair, it would need to be included on the care plan. On 11/16/22 at 02:53 PM, Administrative Nurse D stated the staff will transport the residents in the wheelchairs slowly without foot pedals in place. Many residents will propel themselves and foot pedals would act as a restraint. The facility policy for "Comprehensive Assessment Policy Including the MDS, CAAs and Care Planning", approved 01/11/21, included: Any changes in the resident's condition will require an immediate reassessment with changes in the plan of care reflecting the change in condition. The facility failed to review and revise the care plan to include interventions for the use of foot pedals on this resident's wheelchair to ensure resident safety when staff propelled the resident.	F 657		
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	F 677		

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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 reported a census of 34 residents, with 16 residents sampled, including two residents reviewed for "Activities of Daily Living" (ADL). Based on observation, interview, and record review, the facility failed to provide adequate care for the two dependent Residents (R) 32 and R25 regarding oral hygiene cares.

Findings included:

- Review of Resident (R) 32's electronic medical record (EMR), including a diagnosis of Dementia (a progressive mental disorder characterized by failing memory and confusion).

The annual "Minimum Data Set" (MDS), dated 7/29/22, documented the staff assessment for cognition revealed moderately impaired cognition with disorganized thinking and delirium (sudden severe confusion, disorientation, and restlessness).

The "Activities of Daily Living (ADL) Function/Rehabilitation Potential Care Area Assessment" (CAA) dated 7/29/22 stated the resident was dependent on staff to anticipate needs and assistance with all ADLs.

The care plan, revised on 10/26/22, reports "has own teeth. Staff to assist with oral cares at least twice daily and as needed."

A review of the resident's EMR, from 10/20/22 through 11/17/22, reveals the resident's hygiene

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performance, including brushing teeth, ranging from: requires supervision (oversight, encouragement, or cueing), extensive assistance (resident involved in activity) and total dependence (full staff performance).

On 11/14/22 at 08:23 AM, the resident was resting in her bed on her left side. She was alert and confused at times. She reported being concerned she was not getting any oral care, explicitly brushing her teeth. She stated, "If they would take 2 minutes to stand me up, I can brush my teeth." The resident's teeth contained a large amount of off-white, thick buildup between her bottom teeth and redness at her bottom gumline. She denied any mouth or tooth pain.

On 11/1/22 at 10:49 AM, the resident was sitting up in her recliner. She denied having her teeth brushed today. She still has a thick buildup between and on her bottom teeth, and her bottom gumline is red. Her toothbrush was dry and in an emesis basin on her bathroom sink countertop.

On 11/15/22 at 09:15 AM, Certified Nurse Aid (CNA) N and (CNA) P assisted the resident in returning to her bed from her wheelchair. When questioning of (CNA) N when the resident got her teeth brushed, he stated, "once on first shift, but I don't know about second and third shift." At that point, (CNA) N asked the resident if she wanted to brush her teeth. She stated, "yes." (CNA) N gathered supplies and asked the resident if she wanted to brush her own teeth or if she wanted him to do it for her. She stated, "I want you to." (CNA) N brushed the resident's teeth. Dental floss was lying on the resident's bathroom counter, which staff failed to use.

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On 11/16/22 at 08:17 AM, the resident was in the dining room in her wheelchair, drinking her nutrition shake. She had a significant buildup of debris between and on her bottom teeth, and the bottom gumline was red and inflamed.

On 11/16/23 at 08:26 AM, (LN) N asked when the resident received oral care. She stated, "for the most part, everyone gets their teeth brushed twice a day."

On 11/17/22 at 08:23 AM, the resident was sitting in the dining room in her wheelchair, waiting on breakfast. She had an excessive buildup of debris between and around her bottom teeth, and her bottom gumline was red and inflamed.

On 11/17/22 at 10:28 AM, the resident was asleep in her bed on her left side. Her toothbrush, emesis basin, and cup used to rinse her mouth after brushing her teeth on her bathroom countertop are all dry.

The facility policy for "Oral Care" includes: routinely assess oral health status; staff will assess thorough and consistent monitoring of each resident's oral status time at the time of admission, quarterly, if a resident experiences unintended weight loss, and with any significant change in the residents' health status including, but not limited to: lips, tongue, gums and tissue, saliva, natural teeth condition including decay or broken teeth, dentures, oral cleanliness, and dental pain.

The facility failed to provide adequate oral hygiene care for this dependent resident.

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- Review of Resident (R) 25's electronic medical record (EMR), including a diagnosis of Cerebrovascular accident (CVA) (stroke) - (the 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).

The annual"Minimum Data Set" (MDS), dated 8/20/22, documented the staff assessment for cognition and revealed cognitive loss and dementia (a progressive mental disorder characterized by failing memory and confusion). In addition, the resident required the total assistance of one staff for personal hygiene and had no dental issues.

The "Care Areas Assessment" (CAA) dated 8/20/22, revealed the resident had no teeth and was NPO (nothing to eat or drink by mouth). He was totally dependent on staff to complete oral care twice a day and had recurrent thrush (an infection of the mouth and throat, producing whitish patches) on his tongue.

The care plan, dated 8/29/22, reported the resident had no teeth and refused to wear dentures. Per his spouse, "He does not like them at all and has not worn them for years." In addition, the care plan lacked any instruction for oral care. There was a resident care information sheet on the back of the resident's bathroom door that documented, "Staff will assist with oral care at least twice a day."

A review of the resident's EMR, from 10/20/22 through 11/17/22, reveals the resident requires limited assistance (resident needs guided maneuvering of limbs from staff) to total dependence (full staff performance) for personal

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hygiene, including brushing his teeth.

On 11/14/22 at 9:20 AM, the resident rested on his back in bed. His mouth had a white, thick filmy buildup coating his tongue. He denied any pain or discomfort in his mouth.

On 11/14/22 at 11:17 AM, the resident was sitting up in his recliner. Licensed Nurse (LN) H was in the resident's room. She reported that the nurses perform oral care for the resident when they administer the resident's gastrostomy feeding (G-tube) (introducing a nutrient solution through a surgically inserted tube into the stomach through the abdominal wall) twice a day. Because of the resident's g-tube, he may have nothing to eat or drink by mouth (NPO).

On 11/14/22 at 11:28 AM, LN N gave the resident Biotene 5 millimeters of oral mouth rinse. The resident swished and spit out the mouth rinse. (LN) N obtained the resident's tongue brush from an emesis basin on the resident's bathroom countertop, gave it to him in his left hand, and assisted him in brushing his tongue. LN N then rinsed the tongue brush in the bathroom sink and replaced it in the emesis basin. The resident still had a white, thick, filmy coating on his tongue. However, LN N reported the appearance of his tongue was "normal because of his dry mouth."

On 11/15/22 at 08:06 AM, the resident was sitting up in his recliner. He still had a white, thick, filmy coating on his tongue which appeared unchanged since yesterday.

On 11/15/22 at 08:11 AM, the resident's tongue brush was dry in the emesis basin on his countertop.

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On 11/15/22 at 02:58 PM, (LN) G was in the resident's room preparing to administer water into his G-tube. She reported the resident gets oral care "once or twice on this shift." When asked what times, she stated, "I try to do it when I'm doing his g-tube." LN G finished administering the water to the resident through his g-tube and left the room without offering or providing any oral hygiene care to the resident. The resident's tongue remained unchanged since this morning, with a white, thick, filmy coating.

On 11/16/22 at 08:05 AM, the resident was sitting in his recliner. He still had a white, thick, filmy coating on his tongue. The resident's tongue brush was dry in the emesis basin on his bathroom countertop. According to the Medication Administration Record (MAR) in the EMR, nutrition and water were administered to the resident into his g-tube at 6:00 AM, and Biotene moisturizing (mouth) rinse was given at 8:00 AM.

On 11/16/22 at 08:21 AM, LN N reported she administered his Biotene moisturizing rinse this morning and explained he gets oral care three times a day with his (g-tube) flushes and feedings. Then LN N reported, the resident had a history of thrush (an infection of the mouth and throat, producing whitish patches). She noted that she had seen the white, thick, filmy buildup on his tongue and said it was "from his mouth being dry." She reported the resident would have his tongue brushed again at 12:00 PM by either LN J or LN I.

On 11/16/22 at 12:45 PM, the resident was sitting up in his recliner. The resident still had a white,

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thick, filmy buildup on his tongue and said he has no pain in his mouth. His lips and mouth were moist. The resident's tongue brush in the emesis basin on his bathroom countertop was wet, and the medication cup used for administering the Biotene moisturizing mouth rinse was in the trashcan.

On 11/16/22 at 01:03 PM, LN I reported she did the resident's 12:00 PM Biotene moisturizing oral rinse and assisted the resident in brushing his tongue with the tongue brush in the emesis basin on the resident's bathroom countertop.

On 11/16/22 at 01:39 PM, Administrative Nurse D reported that she expects oral care to be done twice daily and as needed for every resident.

On 11/17/22 at 08:30 AM, Administrative Nurse D said she looked in the resident's mouth and spoke with (LN) N, who takes care of the resident a lot. She said, "LN N told me that is his normal, and I trust her." She could not say when the doctor saw the resident's tongue and mouth the last time. She reported she would speak with the dietary manager about the resident's formula and see if that has any effect. She also noted he had this "since he got here," and they had tried Nystatin (an antifungal medication used to treat thrush) multiple times in the past. She acknowledged recontamination could occur from the resident's tongue brush not being cleaned or stored correctly.

On 11/17/22 at 08:35 AM, the resident was sitting up in his recliner. There was less white, thick film on his tongue. He still denied any pain in his mouth. His tongue brush in the emesis basin on his bathroom countertop was wet.

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F 677	Continued From page 14 The facility policy for "Oral Care" includes: routinely assess oral health status; staff will assess thorough and consistent monitoring of each resident's oral status time at the time of admission, quarterly, if a resident experiences unintended weight loss, and with any significant change in the resident's health status including, but not limited to: lips, tongue, gums and tissue, saliva, natural teeth condition including decay or broken teeth, dentures, oral cleanliness, and dental pain. The facility failed to provide adequate oral hygiene care for this dependent resident.	F 677		
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 reported a census of 34 residents with 16 selected for review which included five residents reviewed for accidents. Based on observation, interview, and record review the facility failed to ensure staff provided foot pedals on wheelchairs to prevent accidents, while propelling three of the five residents (R)6, R13 and R28, reviewed for accident hazards. Findings included:	F 689		

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- Review of resident (R)6's electronic medical record, revealed diagnoses included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), dementia (progressive mental disorder characterized by failing memory and confusion), neuropathy (damage to nerves outside of the brain and spinal cord), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and chronic pain.

The "Annual Minimum Data Set" (MDS), dated 06/07/22, assessed the resident with severely impaired cognitive status. The resident required extensive assistance of one staff for transfer and locomotion on and off the unit. The resident had functional impairment in range on motion on one side of her upper and lower extremities. The resident used a wheelchair for mobility.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 06/07/22, assessed the resident had decline in cognition but was able to make needs known. The resident had a diagnosis of dementia.

The "Falls CAA" dated 06/07/22, assessed the resident made poor choices and was wheelchair bound.

The "Quarterly MDS", dated 09/03/22, assessed the resident with severely impaired cognitive status. The resident required extensive assistance on one staff for transfers and required limited assistance of one person for locomotion on and off the unit. The resident had functional

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impairment in range on motion on one side of her upper and lower extremities. The resident used a wheelchair for mobility.

The "Care Plan," revised 09/11/22, instructed staff the resident required up to extensive assistance of one staff for locomotion on and off the unit. The resident propelled herself in the wheelchair for very short distances The "Care Plan" lacked interventions for use of foot pedals on her wheelchair.

Observation, on 11/14/22 at 08:00 AM, revealed Certified Nurse Aide (CNA) N, propelled the resident in her wheelchair from her room to the dining room. The wheelchair lacked foot pedals and her feet skimmed along directly on the floor. The resident intermittently raised her feet up but did not maintain her feet in an elevated position.

Observation, on 11/15/22 at 08:47 AM, revealed CNA Q, propelled the resident in her wheelchair from the dining room to her room. The wheelchair lacked foot pedals and the resident's feet skimmed along directly on the floor.

Interview, on 11/15/22 at 09:00 AM, with the resident revealed she often had pain in her legs and staff assisted her in her wheelchair. The resident stated she did not walk.

Observation, on 11/16/22 at 08:41 AM, revealed CNA NN propelled the resident seated in her wheelchair from the dining room to her room. The wheelchair lacked foot pedals and the resident's feet skimmed along directly on the floor. Interview, at that time, with CNA NN, revealed the resident did have foot pedals for the wheelchair, but did not know where they were.

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CNA NN stated the resident did propel herself in her room at times but could not self-propel long distances.

Interview, on 11/16/22 at 01:33 PM, with Licensed Nurse (LN) H, revealed the resident did have foot pedals, but did not know where they were. The resident informed LN H where the foot pedals were located, in her room at that time. LN H attempted to attach the foot pedals to the wheelchair and noted the left foot pedal did not attach completely and requested assistance from CNA MM. Interview with CNA MM, at that time, revealed she did not know why the foot pedals were not attached to the chair, and would notify maintenance to assist with attaching them.

Interview, on 11/16/22 at 02:53 PM, with Administrative Nurse D, revealed she would expect staff to propel the resident in her wheelchair slowly, as she thought the resident could hold her feet up off the floor. She expected staff to place one hand on the resident's shoulder in case the resident lurched forward unexpectedly. Administrative Nurse D stated staff should apply foot pedals when the resident could not hold their feet off the floor. Administrative Nurse D stated the resident often refused interventions and the care plan indicated her refusal but did not know if she refused foot pedals.

The facility policy for "Wheelchair Positioning", approved 07/19/2016, included: Staff should recognize that many frail residents cannot maintain proper wheelchair alignment due to age related physical changes, dementia, and generalized weakness. Resident's feet should rest firmly on the floor or the wheelchair

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footplates.

The facility failed to ensure staff provided foot pedals for the wheelchair of this dependent resident with dementia, neuropathy and lower extremity pain, when propelling the resident to prevent accidents to the lower extremity with injury.

- Review of Resident (R)13's electronic medical record (EMR) included a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The annual "Minimum Data Set" (MDS), dated 01/25/22, documented the staff assessment for pain revealed severe cognitive impairment. She required extensive assistance of one staff for locomotion with her wheelchair.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 01/25/22, did not trigger for further review.

The quarterly "MDS," dated 10/21/22, documented the staff assessment for cognition revealed severe cognitive impairment. She required extensive assistance of one staff for locomotion with her wheelchair.

The care plan for ADLs, revised 10/25/22, instructed staff the resident required total assistance of one staff for propelling her wheelchair as the resident was non-ambulatory.

Review of the resident's EMR, revealed from 10/17/22 through 11/14/22, the resident required

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limited to total assistance of one staff for locomotion on the unit with her wheelchair.

On 11/14/22 at 11:53 AM, Licensed Nurse (LN) H propelled the resident into the dining room for lunch. The resident's shoed feet bounced on the floor multiple times during transport. The resident's wheelchair lacked foot pedals.

On 11/15/22 at 11:43 AM, Certified Nurse Aide (CNA) N propelled the resident to the dining room for lunch. The resident's shoed feet skimmed the floor during transport. The resident's wheelchair lacked foot pedals.

On 11/15/22 at 11:43 AM, CNA N stated staff do not use foot pedals on the resident's wheelchair due to she will propel herself at times.

On 11/14/22 at 11:53 AM, LN H stated the resident did not have footpedals on her wheelchair because she would propel herself at times using her feet.

On 11/15/22 at 03:34 PM, LN G stated the resident would propel herself at times in her wheelchair. Staff should probably place foot pedals on the wheelchair when they propelled her.

On 11/16/22 at 02:53 PM, Administrative Nurse D stated the staff will transport the residents in the wheelchairs slowly without foot pedals in place. Many residents will propel themselves and foot pedals would act as a restraint.

The facility policy for "Wheelchair Positioning", approved 07/19/2016, included: Staff should recognize that many frail residents cannot

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maintain proper wheelchair alignment due to age related physical changes, dementia and generalized weakness. Resident's feet should rest firmly on the floor or the wheelchair footplates.

The facility failed to safely transport this dependent resident in her wheelchair by not ensuring foot pedals were in place.

- Review of Resident (R)28's electronic medical record (EMR) included a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The annual "Minimum Data Set" (MDS), dated 09/10/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She required limited assistance of one staff for locomotion on the unit with the use of a wheelchair.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 09/10/22, did not trigger.

The quarterly "MDS," dated 06/20/22, documented the resident had a BIMS score of three, indicating severe cognitive impairment. She required limited assistance of one staff for locomotion on the unit with the use of a wheelchair.

The care plan for ADLs, revised 02/17/22, instructed staff the resident used a wheelchair for mobility and was able to propel herself with

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directional assist from staff, at times.

Review of the resident's EMR from 10/18/22 through 11/15/22, revealed the resident required independent to total assistance of one staff for locomotion in her wheelchair.

On 11/15/22 at 03:10 PM, Certified Medication Aide (CMA) R propelled the resident in her wheelchair to her room. The resident's shoed feet bounced off of the floor during transport. The resident's wheelchair lacked foot pedals.

On 11/17/22 at 09:13 AM, Certified Nurse Aide (CNA) O propelled the resident from the commons area to the resident's room. The resident's shoed feed skimmed the floor during transport. The resident's wheelchair lacked foot pedals.

On 11/15/22 at 03:10 PM, CMA R stated the staff do not use foot pedals on the resident's wheelchair due to the resident being able to propel herself with her feet at times.

On 11/17/22 at 09:13 AM, CNA O stated the staff do not use foot pedals on the resident's wheelchair as she will propel herself at times.

On 11/15/22 at 03:34 PM, LN G stated the resident would propel herself at times in her wheelchair. Staff should probably place foot pedals on the wheelchair when they propelled her.

On 11/16/22 at 02:53 PM, Administrative Nurse D stated the staff will transport the residents in the wheelchairs slowly without foot pedals in place. Many residents will propel themselves and foot

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F 689	Continued From page 22 pedals would act as a restraint. The facility policy for "Wheelchair Positioning", approved 07/19/2016, included: Staff should recognize that many frail residents cannot maintain proper wheelchair alignment due to age related physical changes, dementia and generalized weakness. Resident's feet should rest firmly on the floor or the wheelchair footplates. The facility failed to safely transport this dependent resident in her wheelchair by not ensuring foot pedals were in place.	F 689		