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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically went to the facility on 03/10/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

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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resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents. Based on observation, record review and interview the facility failed to provide a dignified dining experience for Resident 142, who was left unattended and unassisted while dropping food down on the front of his shirt. This placed R142 at risk for impaired dignity and decreased psychosocial wellbeing.

Findings included:

- R142's Electronic Medical Record (EMR) recorded he admitted to the facility on 02/06/23 with the only diagnosis of Huntington's (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder) disease. R142 had an admission weight of 157.2 pounds (lbs.).

The "Admission Minimum Data Set" (MDS), with an Assessment Reference Date (ADR) of 02/14/23, was not completed and remained in progress.

The Care Area Assessment (CAA) also remained

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in progress.

R142's "Baseline Care Plan," dated 02/06/23, documented to promote/maintain adequate gastrointestinal habits, monitor for signs and symptoms and monitor meal intake per protocol.

On 02/15/23 R142's "Care Plan" addition documented R142 was at risk for altered nutritional/hydration status related to Huntington's disease. The care plan directed staff to encourage consumption of fluids provided, provide adaptive equipment of weighted silverware, Kennedy (designed to be spill proof) cups with a straw, and a divided plate. It directed staff to provide and serve a regular diet, regular texture, and thin liquids as ordered, and monitor and record meal intake. Monitor/record/report to the Medical Doctor as needed for signs and symptoms of malnutrition: loss of three lbs. in one week or greater than five percent (%) in one month. The care plan directed staff to honor R142's food preferences and update as needed; R142 loved cottage cheese, Dr. Pepper (soda drink), cheese, and sandwiches. Provide set-up and assistance with meals/snacks. The care plan further documented the Registered Dietician (RD) to evaluate and make recommendations as needed and physical, occupational, and speech therapy to evaluate and treat as needed.

R142's "Comprehensive Care Plan" had not been completed.

On 02/22/23 at 12:30 PM observation revealed R142 sat in the dining room wearing a clothing protector. The meal served to R142 consisted of thin soup in a bowl, a biscuit, and mixed fruit. R142 used a weighted spoon and his fingers to

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eat chunks of vegetables and meat from soup. R142 had extensive continual involuntary movements in his arms, trunk, hands, neck, and head. After obtaining the biscuit and attempting to split it in half, R142 unintentionally flung the biscuit across the table, and it landed on the floor. R142 then placed the other half of the biscuit in the soup then did not eat it. During the process of eating, he continually tried to keep his clothing protector in place. R142 then placed the weighted spoon into the ice cream and withdrew over half the ice cream on the spoon and placed all of it into his mouth. Staff seated at the table offered no assistance to the resident with cueing, or meal intake, or placement/adjustment of his clothing protector.

On 02/23/23 at 08:11 AM observation revealed R142 received a breakfast of French toast, hot cereal with brown sugar and bacon. R142 had continual involuntary movements. He poured syrup onto the hot cereal, picked up the whole slice of French toast and ate it with his fingers, and then picked up the bacon. He placed the bacon in his mouth and tore off large pieces to chew then, using the weighted spoon started, eating the hot cereal. While eating R142's clothing protector continually slipped to his lap, and he attempted numerous times to keep it over his chest area to protect his clothing. R142 was not successful and dropped cereal on his shirt. Staff seated at the table did not assist the resident with his clothing protector or help with eating.

On 02/23/23 at 12:22 PM observation revealed R142 received a meal of whole boneless, barbecue chicken breast, peas in a bowl, and macaroni and cheese. R142 managed to cut the

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chicken breast in half despite the involuntary movements of his body. R142 took one half of the chicken breast into his mouth (resident has not teeth or dentures) and worked at chewing it to swallow. R142 then used his hands to cup the macaroni and cheese in his right hand to eat. R142 worked at eating all his macaroni and cheese and the other half of the chicken breast. Again, R142 was not able to keep clothing protector in place and dropped a great deal of food on his shirt. Staff present at the table did not assist R142 with eating or his clothing protector.

On 02/23/23 at 01:12 PM Certified Nurse Aide (CNA) P stated R142 was new to the facility and ate almost anything put in front of him. CNA P reported R142 used of weighted silverware but was messy during meals. CNA P reported R142 had snacks and Dr. Pepper in his room, and since the resident was mostly independent, and he did not need assistance with snacks and drinks in the room.

On 02/27/23 at 07:44 AM, Dietary Staff (DS) BB stated R142 received nutritional supplement two times a day. DS BB said Huntington's disease was new to her and was aware of constant flailing of arms and that she provided the resident with weighted silverware. DS BB verified she did the diet history and preference and R142's soup should have been in a cup. She also verified the resident was at risk for choking by placing half a chicken breast in his mouth and should have foods cut up. She reported dietary and nursing department could referred to therapy services. CDM also reported she had not observed resident's eating.

On 02/27/23 08:45 AM Administrative Nurse D

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F 550	Continued From page 5 reported she had not observed meals for R142, she stated he was mostly independent. She verified staff should be mindful of the resident's struggle with clothing protector and assistance with cutting up food to prevent choking and involving therapy as an intervention due to R142 weight loss. Administrative Nurse D verified staff should assist the resident at meals to enhance dignity and prevent further weight loss. The facility's "Quality of Life-Activities of Daily Living" policy dated 11/2017, documented the community environment and staff behaviors are directed toward assisting the resident in maintain and/or achieving independent functioning, dignity, and well-being. Residents whom are unable to carry out activities of daily living receive the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene. The facility failed to provide a dignified dining experience by not assisting R142 with eating and his clothing protector and as a result R142 dropped food down the front of his shirt. This placed R142 at risk for impaired dignity and decreased psychosocial well-being.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		

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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 requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The

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sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to develop a comprehensive care plan for Remeron (an antidepressant medication), Lasix (a diuretic medication), and Eliquis (an anticoagulant medication), which required a Black Box Warning for one sampled resident, Resident (R) 29. This placed the resident at risk for adverse side effects.

Findings included:

- The Electronic Medical Record (EMR) for R29 documented diagnoses of pulmonary hypertension (a type of high blood pressure that affects arteries in the lungs and in the heart), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), chronic kidney disease (disease of the kidney's leading to kidney failure), diabetes mellitus type 1 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), artherosclerotic heart disease (a buildup of fats cholesterol and other substances in and on the artery walls) and atrial fibrillation (rapid, irregular heart beat).

The "Admission Minimum Data Set" (MDS), dated 02/02/23, documented R29 had severely impaired cognition and required limited assistance of one staff for bed mobility, transfers, ambulation, dressing, and personal hygiene. The MDS further documented R29 received an antidepressant (a class of medications used to treat mood disorders and relieve symptoms of

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depression), diuretic (medication to promote the formation and excretion of urine, anticoagulant (medication to prevent and treat clots in blood vessels and the heart), and an antibiotic (a medication used to treat infections caused by bacteria and other microorganisms).

R29's EMR lacked documentation of a Black Box Warning (BBW-indiates that the drug carries a significant risk of serious or even life threatening adverse effects) care plan for the use of the Remeron, Lasix, and Eliquis medications.

The "Physician Order," dated 01/26/23, directed staff to administer Remeron, 7.5 milligrams (mg), by mouth,
daily for sleep disorder.

The "Physician Order," dated 01/26/23, directed staff to administer Eliquis, 5 mg, by mouth, twice daily, for artherosclerotic heart disease.

The "Physician Order," dated 01/27/23, directed staff to administer Lasix, 40 mg, by mouth, daily, for congestive heart failure.

On 02/21/23 at 03:03 PM, observation revealed R29 independently ambulating with her walker down the hall.

On 02/22/23 at 04:00 PM, Administrative Nurse E verified she had not developed a care plan for R29's medications that required a Black Box Warning.

On 02/27/23 at 10:26 AM, Administrative Nurse D stated there should be a care plan completed for R29's medications.

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F 656	Continued From page 9 The facility "Comprehensive Care Plans" policy, dated August 2022, documented an individualized comprehensive person centered care plan that included measurable objectives and time frames to meet the residents medical, nursing, mental, cultural, and psychological needs was developed for each resident. The residents comprehensive care plan was developed within seven days of the completion of the residents comprehensive assessment. The care plan team was responsible for periodic review and updating of care plans when there was a significant change in condition, or when the desired out come was not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly. The facility failed to develop a comprehensive care plan for R29's Black Box Warning medications, placing her at risk for adverse side effects.	F 656		
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).	F 657		

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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 had a census of 40 residents. The sample included 12 residents, with five reviewed for accidents. Based on observation, record review, and interview, the facility failed to revise the care plan with resident-centered interventions to prevent falls for two sampled residents, Resident (R) 7 and R18, and failed to notify and invite one sampled resident, R14 to her care plan meetings. This placed the affected residents at risk for uncommunicated and unmet care needs as well as decreased autonomy.

Findings included:

- The Electronic Medical Record (EMR) for R7 recorded diagnoses dementia with behavior disturbance (progressive mental disorder characterized by failing memory, confusion), unsteadiness on feet, cerebrovascular disease (conditions that affect blood flow and the blood vessels in the brain), muscle weakness, and dysphagia (swallowing difficulty).

R7's "Quarterly Minimum Data Set" (MDS), dated 01/22/22, documented R7 had long and

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short-term memory impairment and required extensive assistance of two staff for bed mobility, transfers, ambulation, dressing and toileting. The MDS further documented R7 had unsteady balance, no functional impairment and had one non-injury fall.

The "Significant Change MDS," dated 11/17/22, documented R7 had long and short- term memory impairment and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and limited assistance of one staff for ambulation. The MDS further documented R7 had unsteady balance, no functional impairment, and had no falls.

The "Fall Risk Assessments," dated 04/10/22, 07/10/22, 08/06/22, and 11/07/22 documented the resident was a high risk for falls.

The "Fall Care Plan," dated 01/10/23, originally dated 09/17/19, directed staff to ensure R7 wore appropriate footwear when ambulating, check and change upon rising in the morning, before and after meals, and prior to bedtime, and ensure R7 wore nonskid socks at night. The update, dated 05/01/21, directed staff to sit with the resident while in the dining room and redirect him as needed to stay seated. The update dated 08/20/22 directed staff to check alarm placement every two hours for correct positioning. The update, dated 01/26/23, directed staff to have resident in full view when not in bed and be aware of R7 when he wandered outside of the 200 hall and commons area to determine if the resident had any needs.

The "Fall Investigation," dated 02/15/22 at 05:42 PM, documented R7 stood from his wheelchair,

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appeared to be off balance, went to sit down and missed the seat of the wheelchair. The investigation further documented the fall was witnessed and the resident did not obtain any injuries.

The "Fall Investigation," dated 05/31/22 at 04:40 PM, documented R7 was observed on the floor in his room, lying on his back. The investigation further documented the fall was unwitnessed and the resident could not describe what he was doing at the time of the fall.

The "Fall Investigation," dated 08/06/22 at 06:35 PM, documented R7 slid out of his wheelchair on to the floor. The investigation further documented R7 tried to get up unassisted and was not wearing shoes or gripper socks. The investigation directed staff to make sure R7 wore shoes or gripper socks.

The "Fall Investigation," dated 08/20/22 at 03:00 PM, documented R7 was found on the floor in the activity room. The investigation further documented R7's chair alarm was not on, and education was given to staff to always keep the alarm on.

The "Fall Investigation," dated 01/20/23 at 07:30 PM, documented R7 was found in another resident's room on the floor. The investigation further documented staff were notified by another resident that R7 had fallen in his room. The investigation documented R7's alarm was not on and staff were educated to make sure the alarm was turned on after transfers and throughout the day.

On 02/22/23 at 10:15 AM, observation revealed

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Certified Nurse Aide (CNA) M transferred the resident from his wheelchair to his bed without a gaitbelt. Further observation revealed R7 spoke to CNA M in Arabic, and she stated she did not know what he was saying. CNA M checked his incontinence brief and verified his buttocks were red and stated she would apply barrier cream after peri care. Observation revealed, CNA M could not find barrier cream and put a clean incontinence brief on R7, took his shoes off, and covered him up.

On 02/22/23 at 10:15 AM, CNA M stated a lot of the time she did not know what the resident was saying as he spoke in Arabic and did not have any means to find out what he was saying. CNA M further stated staff made sure his bed was lowered, a bed alarm, and a fall mat was placed next to the bed to prevent further falls.

On 02/27/23 at 07:49 AM, Licensed Nurse (LN) G stated R7 got restless when he required toileting and had received therapy in the past for his falls.

On 02/27/23 at 10:26 AM, Administrative Nurse D stated staff checked his alarm every two hours to make sure it is on and verified there should be interventions in place after a resident fell.

The facility "Comprehensive Care Plans" policy, dated August 2022, documented an individualized comprehensive person centered care plan that included measurable objectives and time frames to meet the residents medical, nursing, mental, cultural, and psychological needs was developed for each resident. The residents comprehensive care plan was developed within seven days of the completion of the residents comprehensive assessment. The care plan team was responsible

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for periodic review and updating of care plans when there was a significant change in condition, or when the desired out come was not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly.

The facility failed to provide identify and implement resident centered interventions to the care plan to prevent falls for cognitively impaired R7, placing him at risk for further falls and injury.

- The Electronic Medical Record (EMR) for R18 documented the resident had diagnoses of bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods), cognitive communication deficit (may occur after a stroke, tumor, brain injury, or other neurological damage), traumatic brain injury (brain dysfunction caused by an outside force, usually a blow to the head), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

R18's "Admission Minimum Data Set" (MDS), dated 09/06/22, documented R18 was admitted to the facility 08/30/22 and had moderately impaired cognition and required extensive assistance of two staff for transfers, and extensive assistance of one staff for bed mobility, ambulation, toileting, and personal hygiene. The assessment further documented R18 had unsteady balance, no functioning impairment, and had one fall since admission.

The "Quarterly MDS," dated 01/10/23, documented R18 had moderately impaired cognition and was dependent upon two staff for transfers, toileting, and extensive assistance of

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two staff for bed mobility, and toileting. The assessment further documented R18 did not ambulate, had unsteady balance, no functional impairment and had one non-injury fall.

The "Fall Assessments," dated 08/31/22, 11/07/22, and 02/09/23, documented R18 was a high risk for falls.

The "Nursing Evaluation," dated 08/30/22, documented R18 used a walker when ambulating with staff assistance, had full range of motion, and did not require the use of a mechanical lift for transfers.

Review of the EMR lacked documentation a fall care plan was completed until 12/18/22.

The "Nurse's Note," dated 09/03/22 at 02:09 PM, documented R18 was lowered to the floor with two staff assistance and a gait belt. The note further documented R18 did not receive any injuries.

Review of the EMR lacked further documentation regarding the fall.

On 02/23/23 at 08:58 AM, observation revealed Licensed Nurse (LN) H and Certified Nurse Aide N attached the sling to the mechanical lift and lifted R18 up and lowered her onto the bed.

On 02/23/23 at 09:00 AM, CNA N stated she was not aware of any falls prior to the most recent fall the resident had. CNA N laughed and stated the most recent fall happened as a CNA rolled the resident, and the resident kept rolling and fell out of bed. CNA N further stated R18 was not hurt and that she should not laugh about it, but it was

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funny. CNA N stated staff use a mechanical lift and two staff for her transfers.

On 02/27/23 at 09:17 AM, LN G stated R18 was lowered to the ground by two staff, and the facility considered that a fall, but LN G was unable to find an incident report.

On 02/27/23 at 10:26 AM, Administrative Nurse D verified she was unable to find any incident report related to staff lowering R18 to the floor and stated an incident report should have been completed as well as fall interventions for the resident

The facility "Comprehensive Care Plans" policy, dated August 2022, documented an individualized comprehensive person centered care plan that included measurable objectives and time frames to meet the residents medical, nursing, mental, cultural, and psychological needs was developed for each resident. The residents comprehensive care plan was developed within seven days of the completion of the residents comprehensive assessment. The care plan team was responsible for periodic review and updating of care plans when there was a significant change in condition, or when the desired out come was not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly.

The facility failed to identify and implement resident centered interventions for falls for R18, after staff lowered her to the ground, placing her at risk for further falls and injury.

-R14's Electronic Medical Record (EMR) recorded diagnoses of acute and chronic respiratory failure, atrial fibrillation (rapid, irregular heart beat), anxiety (mental or emotional reaction

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characterized by apprehension, uncertainty and irrational fear) disorder, cerebral infarction (stoke), hemiplegia (paralysis of one side of the body), morbid (severe) obesity, and angina pectoris (chest pain).

The "Annual Minimum Data Set" (MDS), dated 12/25/22, documented R14 had intact cognition, no delirium or exhibited behaviors. R14 required extensive assistance of two staff for activities of daily living with the exception of eating which required limited assistance of one staff member. R14 had pain and pain treatment, shortness or trouble breathing with exertion and when lying flat. The MDS further documented R14 received oxygen and required non-invasive mechanical ventilator.

The EMR "Care Plan" reviews were dated 03/17/22, 06/21/22, 09/20/22, and 12/20/22.

Review of R14's "Care Plan Invitation" for 03/17/22 and 06/21/22 revealed the resident had been invited and signatures of the interdisciplinary team in attendance along with R14's signature. The 09/20/22 and 12/20/22 invitation did not include R14 had attended nor had R14's signature for attendance.

On 02/21/23 during initial tour and resident interview, R14 reported she had not been invited or participated in the care planning process.

On 02/23/23 at 04:29 PM Administrative Nurse E reported she was responsible for the care plan invitation, and she keeps the care plan conference invitation. The information sheet documented the letter was to inform that the resident or representative it was time for the care

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F 657	Continued From page 18 plan conference, and the interdisciplinary team would like to invite them to discuss the resident's care. Administrative Nurse E stated the goal at the facility was to work as a team with the residents and families to provide the best possible care. She said the form included a question as to whether the resident had been invited and signature lines for attendance. The facility's "Comprehensive Care Plan" policy, dated 08/2022, documented an individualized comprehensive person-centered care plan that includes measurable objectives and time frames to meet the resident's medical, nursing, cultural and psychological needs is developed for each resident. The facility's care planning/interdisciplinary team in coordination with the resident, his/her family or representative, develop and maintains a comprehensive care plan for each resident that identifies the highest level of function the resident may be expected to attain. The facility failed to invite R14 to participate in two of the last four care plan conferences, which placed the resident at risk for decreased autonomy.	F 657		
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	F 676		

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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, 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 40 residents. The sample included 12 residents, with one reviewed for communication. Based on observation, record review, and interview, the facility failed to identify and implement alternative communication methods for one sampled resident, Resident (R) 17, who had a diagnosis of cognitive communication deficit (difficulty with any aspect of communication that was affected by disruption

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of cognition) and spoke in Arabic. This placed the resident at risk for unmet needs, frustration, and loneliness.

Findings Included:

- The Electronic Medical Record (EMR) for R7 recorded diagnoses dementia with behavior disturbance (progressive mental disorder characterized by failing memory, confusion), unsteadiness on feet, cerebrovascular disease, conditions that affect blood flow and the blood vessels in the brain), muscle weakness, dysphasia (swallowing difficulty, colon cancer (a cancer of the colon or rectum, located at the digestive tract's lower end).

The "Significant Change Minimum Data Set" (MDS), dated 11/17/22, documented R7 had long and short- term memory impairment and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and limited assistance of one staff for ambulation. The MDS documented R7 sometimes made self-understood, had unclear speech. The MDS further documented R7 was on hospice services.

The "Care Area Assessment" (CAA), dated 11/17/22, documented R7 was at risk for communication deficits related to his unclear speech. The CAA further documented staff anticipate and meet his needs as needed and he was able to communicate with body language and gestures most of the time.

The "Care Plan," dated 01/10/23, documented R7 was at risk for impaired communication related to being bilingual and inability to complete thoughts, observe his for nonverbal signs of distress to

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anticipate his needs, encourage R7 to speak in English, and documented a translation line was available should he need to speak in a foreign language.

The EMR documented R7 was admitted to Hospice on 11/12/22 for the diagnosis of senile degeneration of the brain (dementia) and colon cancer.

On 02/22/23 at 08:15 AM, observation revealed R7 in the small dining room, seated at the table with two other residents. Further observation revealed R7 speaking in his native language. Further observation revealed staff at the table did not acknowledge him or try to talk to him. Continued observation revealed R7 continued to talk in his native language throughout the meal without staff talking to him.

On 02/22/23 at 08:51 AM, observation revealed, after breakfast, R7 sat in the living room area in his wheelchair, which did not have a pressure relieving cushion. R7 was very vocal, saying "uh, uh, uh," and spoke in a different language than English. Further observation revealed R7 continued to say "uh, uh, uh," and rested his chin in his hands and closed his eyes. R7 stated "magahela, magahela, magahela, comarsh, comarsh." At 09:14 AM, R7 stated, "look at me", "look at me!" R7 continued speaking saying " ukahara, comarsh, comarsh, ummm, ummm, ya, ya." At 09:23 AM, R7 continued to holler out and would periodically close his eyes and at one point, his head dropped down causing him to wake up and then he began again saying "comarsh, comarsh, sokahara, sokahara." At 09:39 AM, as R7 stated "comarsh, comarsh" Certified Medication Aide (CMA) R went to the resident

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and said "what does that mean? I don't know what that means," and walked away. At 09:43 AM, R7 continued to repeat the same words over and over without staff offering assistance to see if they could provide care and reposition the resident as he had been in the wheelchair since before breakfast at 08:00 AM. At 10:06 AM, ongoing observation revealed R7 fell asleep in his wheelchair until 10:15 AM, when this surveyor asked CNA M to attend to the resident.

On 02/22/23 at 10:15 AM, observation revealed CNA M transferred the resident from his wheelchair to his bed without a gaitbelt. Further observation revealed R7 spoke to CNA M in Arabic, and she stated she did not know what he was saying and did not know of any type of communication book or anything to help to understand what he was saying. CNA M checked R7's incontinence brief and verified his buttocks were red and stated she would apply barrier cream after peri care. Observation revealed CNA M could not find barrier cream, so she put a clean incontinence brief on R7, took his shoes off, and covered him up. Observation revealed there was not any documentation or phone number for a translation line as stated in the resident's care plan.

On 02/22/23 at 12:12 PM, observation revealed R7 spoke his native language to CNA N, who was seated beside of him and she did not respond or try to speak to him.

On 02/23/23 at 07:46 AM, observation revealed R7 in the small dining room, seated at the table with two other residents. Further observation revealed R7 stated, "kolzar, kolzar, soblah," then laughed. Continued observation revealed CNA N

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did not talk with the resident during the meal.

On 02/23/23 at 07:49 AM, another staff member, CNA O stated she was unsure what the resident was saying because he was speaking Arabic. CNA O stated she had tried, in the past, to use an online translator but was unable to put in the right words. CNA O stated, "If only he could say it in English."

On 02/23/23 at 08:41 AM, observation revealed staff pushed R7 into the living room area and left him facing the wall with his back towards other residents. Further observation revealed R7 would sigh and rest his head in his left hand. Continued observation revealed R7 sat in his wheelchair, without a pressure relieving cushion or repositioning until 10:15 AM, when the surveyor asked staff to attend to the resident.

On 02/23/23 at 10:15 AM, observation revealed R7 held his hand out towards CNA N and she did not take his hand or acknowledge him. Further observation revealed CNA N placed a gaitbelt around R7's waist and she and CNA P transferred the resident into bed. CNA N stated she was going to break and said CNA P could finish with cares for R7. Observation revealed CNA P checked R7's incontinence brief and verified his buttocks were red, as R7 had had a bowel movement. CNA P stated he would put barrier cream on the resident. CNA P looked for the barrier cream and found a tube on the top shelf of the resident's closet in a basin (small plastic tub) and applied the cream after peri care. CNA P took off the resident's shoes and covered up the resident.

On 02/23/23 at 10:15 AM, CNA P stated that he

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worked at the facility three days a week and sometimes could understand the resident because he knew some classic Arabic and it did not always cross over to the Arabic R7 spoke.

On 02/27/23 at 07:52 AM, observation revealed R7 in the small dining room at the table with two other residents. Further observation revealed R7 started to eat his pureed food with his fingers and CNA sat down beside of him to mix up his food for him and handed him a spoon. R7 started talking in his native language, "asalumya, asalumya, agumeal, agumeal, ooh, ah, ooh, ah", and the CNA did not speak to him nor did she ask him to speak in English. Continued observation revealed CNA N did not interact or try to converse with R7 throughout the entire breakfast.

On 02/27/23 at 07:49 AM, Licensed Nurse (LN) N stated, that R7 spoke Hebrew or something, she was not quite sure but at times was able to speak in English. LN G further stated sometimes R7 spoke so fast, you were not able to understand and would ask him to please speak in English.

On 02/27/23 at 10:26 AM, Administrative Nurse D stated he does speak in his language and was difficult for staff to understand and know his language. Administrative Nurse D further stated, she was unsure if therapy had ever tried any type of picture book or assistive devices to help the resident and staff with the language barrier.

The facility "Culturally Competent Care" policy, dated October 2022, documented, if language assistance services was required, the interpreter or translator would be contacted. The resident's cultural beliefs, experiences, expectations, needs and values would be reviewed, documented, and

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F 676	Continued From page 25 added to the care plan so that they could be honored. If the resident was non-English speaking, staff identified how communication would occur with the resident, if indicated language assistance services would be arrange for the resident. The facility failed to effectively communicate with R7, placing the resident at risk for unmet needs, frustration and loneliness.	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 40 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed provide Resident (R) 5 assistance with toileting as requested and care planned and failed to provide R142 with meal assistance. This placed R5 and R142 at risk for unmet care needs. Findings included: - R5's Electronic Medical Record (EMR) recorded diagnosis of type two diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, mood disorder, obsessive-compulsive personality (OCD - anxiety	F 677		

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disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning) disorder, intellectual disabilities (characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, getting along in social situations and school activities), bipolar (major mental illness that caused people to have episodes of severe high and low moods) disorder, dementia (progressive mental disorder characterized by failing memory, confusion), secondary Parkinsonism (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and unsteady on feet.

The "Quarterly Minimum Data Set" (MDS), dated 11/25/22, documented R5 had moderately impaired cognition, had verbal behavioral symptoms directed toward others, rejections of cares and wandering behaviors which occurred daily. R5 required extensive assistance of one staff for activities of daily living (ADL), was not steady with surface transition and balance and was only able to stabilize with staff assistance. The MDS further documented R5 had no toileting program, was always incontinent of urine and occasionally incontinent of bowel. R5 experienced shortness of breath with exertion and had two or more falls with no injury. R5 received an antipsychotic (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment in reality

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testing) and other mental emotional conditions), antianxiety (class of medication used to treat anxiety) , antidepressant (class of medication to treat depression), received daily. R5 had occupational and physical therapy services.

The "Urinary Incontinence Care Area Assessment" (CAA), dated 06/02/22, documented R5 was incontinent of bowel and bladder, needed extensive assistance with toileting and hygiene, utilized adult pull ups during the day and adult briefs at night. The CAA further documented R5 was able to make staff aware when he has been incontinent.

On 06/13/22 R5's "Care Plan" was updated following a fall, with an incontinence episode. On 06/09/22 the documented intervention was to educate staff to the importance of (incontinence) check and changes at night and early morning.

On 07/21/22 the "Accident Investigations" root cause analysis documented R5 had decreased mobility and an intervention that staff were educated to offer toileting to R5.

On 07/25/22 R5's "Care Plan" directed staff to offer to assist R5 to the toilet, upon R5 rising from bed, before and after meals, and before bed to decrease R5's risk of falling.

The "Progress Note", dated 08/06/22 at 08:30 PM, documented R5 had been on skilled services for medication management. R5 ambulated with a walker with supervision and cueing, was assisted by one staff with toileting as needed, was incontinent of bladder at times, wore pullups and fed self. The note further documented R5 was difficult to redirect and R5 attempted to open

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other resident's doors for staff.

On 02/22/23 at 12:47 PM observation revealed R5 was assisted out of the dining room. At 02:15 PM R5 left the Bingo activity. Ongoing observation from the time R5 left the dining room to the Bingo activity revealed R5 was not offered toileting or check and changes.

On 02/23/23 at 07:55 AM observation revealed R5 was pushed in a wheelchair by staff into the dining room. At 09:03 AM R5 was in the hallway trying to open a conference room door, staff within the room informed R5 could not enter due to a meeting. At 09:56 AM continued observation revealed R5 slept in his wheelchair in the commons area, when Certified Nurse Aide (CNA) P asked R5 if he wanted to rest in his recliner in his room. R5 was agreeable. CNA P assisted R5 into his recliner. During the ongoing observation from 07:55 AM to 09:56 AM, R5 had not been offered toileting or check and change by staff.

On 02/27/23 at 07:28 AM, Certified Medication Aide (CMA) S reported R5 used his wheelchair mostly for mobility, and had a room move closer to where staff was. CMA S said staff were to make sure R5 had a call light, and R5 used a night light and keep door partially open for observation to prevent falls.

On 02/27/23 at 08:43 AM Administrative Nurse G verified and expected staff to toilet R5 as care planned, to prevent falls and maintain skin integrity.

The facility's "Quality of Life-Activities of Daily Living" policy dated 11/2017, documented the community environment and staff behaviors are

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directed toward assisting the resident in maintain and/or achieving independent functioning, dignity, and well-being. Residents whom are unable to carry out activities of daily living receive the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene.

The facility failed to follow R5's specific care plan assistance with toileting which placed R5 at risk for unmet care needs.

- R142's Electronic Medical Record (EMR) recorded he admitted to the facility on 02/06/23 with the only diagnosis of Huntington's (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder) disease. R142 had an admission weight of 157.2 pounds (lbs.).

The "Admission Minimum Data Set" (MDS), with an Assessment Reference Date (ADR) of 02/14/23, was not completed and remained in progress.

The Care Area Assessment (CAA) also remained in progress.

R142's "Baseline Care Plan," dated 02/06/23, documented to promote/maintain adequate gastrointestinal habits, monitor for signs and symptoms and monitor meal intake per protocol.

On 02/15/23 R142's "Care Plan" addition documented R142 was at risk for altered nutritional/hydration status related to Huntington's disease. The care plan directed staff to

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encourage consumption of fluids provided, provide adaptive equipment of weighted silverware, Kennedy (designed to be spill proof) cups with a straw, and a divided plate. It directed staff to provide and serve a regular diet, regular texture, and thin liquids as ordered, and monitor and record meal intake. Monitor/record/report to the Medical Doctor as needed for signs and symptoms of malnutrition: loss of three lbs. in one week or greater than five percent (%) in one month. The care plan directed staff to honor R142's food preferences and update as needed; R142 loved cottage cheese, Dr. Pepper (soda drink), cheese, and sandwiches. Provide set-up and assistance with meals/snacks. The care plan further documented the Registered Dietician (RD) to evaluate and make recommendations as needed and physical, occupational, and speech therapy to evaluate and treat as needed.

R142's "Comprehensive Care Plan" had not been completed.

The "Physician Order" dated 02/06/23, documented dietary supplements may be used when determined appropriate by Interdisciplinary Team (IDT) or RD, and physical, occupational, and speech therapy to evaluate and treat.

The "Physician Order" dated 02/07/23, directed staff to provide a regular diet, regular texture and thin consistency liquids.

The "Nutrition: RD Admission Assessment" dated 02/07/23, documented R142's nutrition information, from the EMR, documented R142 was 71 inches tall and weighed 157.2 lbs. The assessment recorded the nursing admission note reported R142 had a recent weight loss and the

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RD was unsure of details; per progress notes R142's diet was regular, but there was no physician ordered diet ordered yet. R412's meal intake was good at 76-100%, no special items were utilized. R142 independently fed himself and was ambulatory.

The "Task" section of R142's EMR documented he received limited assistance of one-person physical assist with eating on 02/12/23 and 02/13/23 only.

The "Nutrition: Dietary Manager Initial (Admission) Evaluation", dated 02/14/23, recorded the source of the nutrition information evaluated as R142. R142's desired weight range was 150-160 lbs., he had a regular diet and thin liquids, and no specialized items utilized. R142's beverage preferences were water, coffee, milk, juice and Dr. Pepper. R142 stated his appetite was good, his usual eating pattern was all three meals. He liked to snack between meals. The note recorded R142's self-feeding ability as he required supervision, oversight and cueing. Family brought in snacks and drinks. R142 was not a picky eater, and before coming to facility would occasionally skip a meal and would eat snacks. The evaluation further documented R142 had Huntington's disease; he may burn extra calories due to body movements, he used weighted silverware and on occasion nursing would assist with feeding.

The "Dietary Admission Welcome and Interview Sheet", dated 02/14/23, documented R142 had a usual weight of 155 lbs. and a desired body weight of 150-160 lbs. R142 liked cottage cheese, cheese, Dr. Pepper, and sandwiches. He disliked broccoli. R142 was not picky, and he fed

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himself with weighted silverware. R142 had no difficulty with swallowing, chewing, or feeding himself with weighted silverware and some assistance from staff.

On 02/20/23 the "Weight Variance Note" recorded R142 weighed 148.8 lbs. (5.34% loss in two weeks), and a nutritional supplement twice a day was initiated. The medical provider was notified of the weight loss. The goal for R142 was to encourage and or assist him at meals; R142 had snacks and drinks in his room and used weighted silverware.

The EMR dated 02/27/23 recorded R142's weighed 147.2 lbs., a continued loss of greater than 5%

On 02/22/23 at 12:30 PM observation revealed R142 sat in the dining room wearing a clothing protector. The meal served to R142 consisted of thin soup in a bowl, a biscuit, and mixed fruit. R142 used a weighted spoon and his fingers to eat chunks of vegetables and meat from soup. R142 had extensive continual involuntary movements in his arms, trunk, hands, neck, and head. After obtaining the biscuit and attempting to split it in half, R142 unintentionally flung the biscuit across the table, and it landed on the floor. R142 then placed the other half of the biscuit in the soup then did not eat it. During the process of eating, he continually tried to keep his clothing protector in place. R142 then placed the weighted spoon into the ice cream and withdrew over half the ice cream on the spoon and placed all of it into his mouth. Staff seated at the table offered no assistance to the resident with cueing, or meal intake, or placement/adjustment of his clothing protector.

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On 02/23/23 at 08:11 AM observation revealed R142 received a breakfast of French toast, hot cereal with brown sugar and bacon. R142 had continual involuntary movements. He poured syrup onto the hot cereal, picked up the whole slice of French toast and ate it with his fingers, and then picked up the bacon. He placed the bacon in his mouth and tore off large pieces to chew then, using the weighted spoon started, eating the hot cereal. While eating R142's clothing protector continually slipped to his lap, and he attempted numerous times to keep it over his chest area to protect his clothing. R142 was not successful and dropped cereal on his shirt. Staff seated at the table did not assist the resident with his clothing protector or help with eating.

On 02/23/23 at 12:22 PM observation revealed R142 received a meal of whole boneless, barbecue chicken breast, peas in a bowl, and macaroni and cheese. R142 managed to cut the chicken breast in half despite the involuntary movements of his body. R142 took one half of the chicken breast into his mouth (resident has not teeth or dentures) and worked at chewing it to swallow. R142 then used his hands to cup the macaroni and cheese in his right hand to eat. R142 worked at eating all his macaroni and cheese and the other half of the chicken breast. Again, R142 was not able to keep clothing protector in place and dropped a great deal of food on his shirt. Staff present at the table did not assist R142 with eating or his clothing protector.

On 02/23/23 at 01:12 PM Certified Nurse Aide (CNA) P stated R142 was new to the facility and ate almost anything put in front of him. CNA P

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reported R142 used of weighted silverware but was messy during meals. CNA P reported R142 had snacks and Dr. Pepper in his room, and since the resident was mostly independent, and he did not need assistance with snacks and drinks in the room.

On 02/27/23 at 07:44 AM, Dietary Staff (DS) BB stated R142 received nutritional supplement two times a day. DS BB said Huntington's disease was new to her and was aware of constant flailing of arms and that she provided the resident with weighted silverware. DS BB verified she did the diet history and preference and R142's soup should have been in a cup. She also verified the resident was at risk for choking by placing half a chicken breast in his mouth and should have foods cut up. She reported dietary and nursing department could referred to therapy services. CDM also reported she had not observed resident's eating.

On 02/27/23 08:45 AM Administrative Nurse D reported she had not observed meals for R142, she stated he was mostly independent. She verified staff should be mindful of the resident's struggle with clothing protector and assistance with cutting up food to prevent choking and involving therapy as an intervention due to R142 weight loss. Administrative Nurse D verified staff should assist the resident at meals to enhance dignity and no further weight loss.

The facility's "Quality of Life-Activities of Daily Living" policy dated 11/2017, documented the community environment and staff behaviors are directed toward assisting the resident in maintain and/or achieving independent functioning, dignity, and well-being. Residents whom are unable to

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F 677	Continued From page 35 carry out activities of daily living receive the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene. The facility failed to provide R142 assistance during meals which placed the resident at risk for unmet care needs.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The sample included 12 residents, with one reviewed for Hospice (end of life) cares. Based on observation, record review, and interview, the facility failed to provide adequate end-of-life Hospice treatment and care for one resident, Resident (R)7, who was restless, hollering, and had the potential for skin breakdown. This placed the resident at risk for unmet needs and skin breakdown. Findings included: - The Electronic Medical Record (EMR) for R7 recorded diagnoses dementia with behavior disturbance (progressive mental disorder	F 684		

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characterized by failing memory, confusion), unsteadiness on feet, cerebrovascular disease, conditions that affect blood flow and the blood vessels in the brain), muscle weakness, dysphasia (swallowing difficulty, colon cancer (a cancer of the colon or rectum, located at the digestive tract's lower end).

The "Significant Change Minimum Data Set" (MDS), dated 11/17/22, documented R7 had long and short- term memory impairment and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and limited assistance of one staff for ambulation. The MDS documented R7 sometimes made self-understood, had unclear speech, and risk for skin breakdown. The MDS further documented R7 was on hospice services.

The "Care Area Assessment" (CAA), dated 11/17/22, documented R7 was at risk for communication deficits related to his unclear speech. The CAA further documented staff anticipate and meet his needs as needed and he was able to communicate with body language and gestures most of the time.

The Care Plan," dated 01/10/23, documented R7 received hospice services and directed staff to work with the hospice team to ensure his spiritual, emotional, intellectual, physical, and social needs were met, and work with nursing staff to provide maximum comfort for the resident. The care plan further directed staff to observe R7 for non-verbal signs of distress, and staff should anticipate R7's needs,

The EMR documented R7 was admitted to Hospice on 11/12/22 for the diagnosis of senile

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degeneration of the brain (dementia) and colon cancer.

On 02/22/23 at 08:51 AM, observation revealed, after breakfast, R7 sat in the living room area in his wheelchair, which did not have a pressure relieving cushion. R7 was very vocal, saying "uh, uh, uh," and spoke in a different language than English. Further observation revealed R7 continued to say "uh, uh, uh," and rested his chin in his hands and closed his eyes. R7 stated "magahela, magahela, magahela, comarsh, comarsh." At 09:14 AM, R7 stated, "look at me", "look at me!" R7 continued speaking saying " ukahara, comarsh, comarsh, ummm, ummm, ya, ya." At 09:23 AM, R7 continued to holler out and would periodically close his eyes and at one point, his head dropped down causing him to wake up andthen he began again saying "comarsh, comarsh, sokahara, sokahara." At 09:39 AM, as R7 stated "comarsh, comarsh" Certified Medication Aide (CMA) R went to the resident and said "what does that mean? I don't know what that means," and walked away. At 09:43 AM, R7 continued to repeat the same words over and over without staff offering assistance to see if they could provide care and reposition the resident as he had been in the wheelchair since before breakfast at 08:00 AM. At 10:06 AM, ongoing observation revealed R7 fell asleep in his wheelchair until 10:15 AM, when this surveyor asked Certified Nurse Aide (CNA) M to attend to the resident.

On 02/22/23 at 10:15 AM, observation revealed CNA M transferred the resident from his wheelchair to his bed without a gaitbelt. Further observation revealed R7 spoke to CNA M in Arabic, and she stated she did not know what he

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was saying. CNA M checked R7's incontinence brief and verified his buttocks were red and stated she would apply barrier cream after peri care. Observation revealed CNA M could not find barrier cream, so she put a clean incontinence brief on R7, took his shoes off, and covered him up.

On 02/23/23 at 08:41AM, observation revealed staff pushed R7 into the living room area and left him facing the wall with his back towards other residents. Further observation revealed R7 would sigh and rest his head in his left hand. Continued observation revealed R7 sat in his wheelchair, without a pressure relieving cushion or repositioning until 10:15 AM, when the surveyor asked staff to attend to the resident.

On 02/23/23 at 10:15 AM, observation revealed R7 held his hand out towards CNA N and she did not take his hand or acknowledge him. Further observation revealed CNA N placed a gaitbelt around R7's waist and she and CNA P transferred the resident into bed. CNA N stated she was going to break and said CNA P could finish with cares for R7. Observation revealed CNA P checked R7's incontinence brief and verified his buttocks were red, as R7 had had a bowel movement. CNA P stated he would put barrier cream on the resident. CNA P looked for the barrier cream and found a tube on the top shelf of the resident's closet in a basin (small plastic tub) and applied the cream after peri care. CNA P took off the resident's shoes and covered up the resident.

On 02/23/23 at 10:15 AM, CNA P stated R7 sometimes propelled himself around the facility after breakfast and did not want to lay down. CNA

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F 684	Continued From page 39 P said R7 should be repositioned every two hours and he did not know why R7 did not have a pressure reducing cushion in his wheelchair. On 02/27/23 at 07:49 AM, Licensed Nurse (LN) G stated, when R7 got restless, it would usually mean he needed toileted and should have been repositioned, either by lying down in bed or placed in the recliner. On 02/2723 at 10/26 AM, Administrative Nurse D stated R7 should be repositioned and checked to make sure he had not been incontinent. Administrative Nurse D stated staff should be more aware of R7's needs and not to sit in the wheelchair without a cushion for so long and said would contact Hospice for one to be sent for him. The facility "Hospice Program" policy, dated June 2021, documented the community retained the ultimate responsibility for the care plan and coordinates the plan of care with the hospice provider, community staff, the resident and family. The policy further documented the care plan should discuss the need for oral care, skin integrity, medical diagnostics treatment, symptom management, nutrition and hydration, activities, psychosocial needs, and interventions to manage pain and other symptoms of discomfort. The facility failed to provide adequate end of life care for R7 who was restless and sat in his wheelchair for an extended period of time without staff attention to his needs or intervention. This placed the resident at risk for unmet needs.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		

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F 686	Continued From page 40 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The sample included 12 residents, with two reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interview the facility failed to reposition one sampled resident in a manner consistent with the standards of care and failed to provide a pressure reducing cushion for Resident (R) 7, who was at risk for impaired skin integrity. This placed the resident at risk for skin breakdown. Findings included: - The Electronic Medical Record (EMR) for R7 recorded diagnoses dementia with behavior disturbance (progressive mental disorder characterized by failing memory, confusion), unsteadiness on feet, cerebrovascular disease, conditions that affect blood flow and the blood vessels in the brain), muscle weakness,	F 686		

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dysphasia (swallowing difficulty, colon cancer (a cancer of the colon or rectum, located at the digestive tract's lower end).

The "Significant Change Minimum Data Set" (MDS), dated 11/17/22, documented R7 had long and short- term memory impairment and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and limited assistance of one staff for ambulation. The MDS documented R7 was at risk for pressure ulcers, had a pressure ulcer device in his bed and chair, and had ointment other that to his feet.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 11/17/22, documented R7 was at risk for impaired skin integrity related to impaired activities of daily living function and incontinence. The CAA further documented R7 had a pressure reducing mattress and pressure reducing wheelchair cushion to help with skin integrity and required extensive assist with bed mobility and repositioning, was incontinent of bowel/bladder. The CAA documented staff would monitor for skin breakdown during showers and report changes to charge nurse, the charge nurse would complete weekly skin and Braden assessments quarterly and as needed.

The Care Plan," dated 01/10/23, R7 had a potential for altered skin integrity related to impaired immobility and incontinence and directed staff to apply barrier cream as needed to assist with skin integrity, complete weekly head to toe skin assessments, educate care givers to the causes of skin breakdown, including transfer and positioning requirement, to follow facility policies and procedures for the prevention and treatment of skin breakdown, pressure reducing mattress

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on his bed, extensive assistance of 1-2 staff for repositioning in bed to avoid shearing during positioning, transferring and turning, check and change the resident upon rising in the morning, before and after meals, and prior to bedtime.

The "Braden Scale Assessment," (assessment for predicting pressure ulcer risk) dated 01/10/23, documented a score of 15, which indicated low risk.

The EMR documented R7 was admitted to Hospice on 11/12/22 for the diagnosis of senile degeneration of the brain (dementia) and colon cancer.

On 02/22/23 at 07:45 AM, observation revealed R7, in his wheelchair in the living room area waiting for breakfast. Further observation revealed R7's wheelchair did not have a pressure relieving cushion.

On 02/22/23 at 08:51 AM, observation revealed, after breakfast, R7 sat in the living room area in his wheelchair, which did not have a pressure relieving cushion. R7 was very vocal, saying "uh, uh, uh," and spoke in a different language than English. Further observation revealed R7 continued to say "uh, uh, uh," and rested his chin in his hands and closed his eyes. R7 stated "magahela, magahela, magahela, comarsh, comarsh." At 09:14 AM, R7 stated, "look at me", "look at me!" R7 continued speaking saying " ukahara, comarsh, comarsh, ummm, ummm, ya, ya." At 09:23 AM, R7 continued to holler out and would periodically close his eyes and at one point, his head dropped down causing him to wake up andthen he began again saying "comarsh, comarsh, sokahara, sokahara." At 09:39 AM, as

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R7 stated "comarsh, comarsh" Certified Medication Aide (CMA) R went to the resident and said "what does that mean? I don't know what that means," and walked away. At 09:43 AM, R7 continued to repeat the same words over and over without staff offering assistance to see if they could provide care and reposition the resident as he had been in the wheelchair since before breakfast at 08:00 AM. At 10:06 AM, ongoing observation revealed R7 fell asleep in his wheelchair until 10:15 AM, when this surveyor asked Certified Nurse Aide (CNA) M to attend to the resident.

On 02/22/23 at 10:15 AM, observation revealed CNA M transferred the resident from his wheelchair to his bed without a gaitbelt. Further observation revealed R7 spoke to CNA M in Arabic, and she stated she did not know what he was saying. CNA M checked R7's incontinence brief and verified his buttocks were red and stated she would apply barrier cream after peri care. Observation revealed CNA M could not find barrier cream, so she put a clean incontinence brief on R7, took his shoes off, and covered him up.

On 02/23/23 at 07:46 AM, observation revealed R7, in his wheelchair in the living room area waiting for breakfast. Further observation revealed R7's wheelchair did not have a pressure relieving cushion.

On 02/23/23 at 08:41 AM, observation revealed staff pushed R7 into the living room area and left him facing the wall with his back towards other residents. Further observation revealed R7 would sigh and rest his head in his left hand. Continued observation revealed R7 sat in his wheelchair,

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without a pressure relieving cushion or repositioning until 10:15 AM, when the surveyor asked staff to attend to the resident.

On 02/23/23 at 10:15 AM, observation revealed R7 held his hand out towards CNA N and she did not take his hand or acknowledge him. Further observation revealed CNA N placed a gaitbelt around R7's waist and she and CNA P transferred the resident into bed. CNA N stated she was going to break and said CNA P could finish with cares for R7. Observation revealed CNA P checked R7's incontinence brief and verified his buttocks were red, as R7 had had a bowel movement. CNA P stated he would put barrier cream on the resident. CNA P looked for the barrier cream and found a tube on the top shelf of the resident's closet in a basin (small plastic tub) and applied the cream after peri care. CNA P took off the resident's shoes and covered up the resident.

On 02/23/23 at 10:15 AM, CNA P stated R7 sometimes propelled himself around the facility after breakfast and did not want to lay down. CNA P said R7 should be repositioned every two hours and he did not know why R7 did not have a pressure reducing cushion in his wheelchair.

On 02/27/23 at 07:49 AM, Licensed Nurse (LN) G stated, when R7 got restless, it would usually mean he needed toileted and should have been repositioned, either by lying down in bed or placed in the recliner.

On 02/2723 at 10/26 AM, Administrative Nurse D stated R7 should be repositioned and checked to make sure he had not been incontinent. Administrative Nurse D stated staff should be

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F 686	Continued From page 45 more aware of R7's needs and not to sit in the wheelchair without a cushion for so long and said would contact Hospice for one to be sent for him. The facility "Skin Integrity, Pressure Injuries Nursing Protocol" policy, dated May 2021, documented the resident would receive care consistent with professional standards of practice to prevent pressure injuries and would not develop pressure injuries unless the individuals clinical condition demonstrated that they were unavoidable. The facility would implement and modify interventions to attempt to stabilize, reduce or remove underlying risk factors and use the Braden scale. The policy documented, based on the assessment and the residents clinical condition, choices and identification needs, basic or routine care could include but not limited to provide appropriate pressure redistribution support surfaces, redistribute pressure, minimize exposure to moisture and keep skin clean. The facility failed to reposition R7, who had the potential for skin breakdown, for over two hours. The facility further failed to ensure a pressure reducing cushion was used for R7 This place the resident at risk for skin breakdown.	F 686		
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.	F 689		

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents and the sample included 14 residents. Based on observation, record review, and interview, the facility failed to implement care planned interventions for Resident (R)5 for toileting, and failed to identify and implement resident-centered interventions to prevent falls for R7 and R18 This palced the resident at risk for further falls and/or avoidable injuries.

Findings included:

- R5's Electronic Medical Record (EMR) recorded diagnosis of type two diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, mood disorder, obsessive-compulsive personality (OCD - anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning) disorder, intellectual disabilities (characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, getting along in social situations and school activities), bipolar (major mental illness that caused people to have episodes of severe high and low moods) disorder, dementia (progressive mental disorder characterized by failing memory, confusion), secondary Parkinsonism (slowly progressive

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neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and unsteady on feet.

The "Quarterly Minimum Data Set" (MDS), dated 11/25/22, documented R5 had moderately impaired cognition, had verbal behavioral symptoms directed toward others, rejections of cares and wandering behaviors which occurred daily. R5 required extensive assistance of one staff for activities of daily living (ADL), was not steady with surface transition and balance and was only able to stabilize with staff assistance. The MDS further documented R5 had no toileting program, was always incontinent of urine and occasionally incontinent of bowel. R5 experienced shortness of breath with exertion and had two or more falls with no injury. R5 received an antipsychotic (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment in reality testing) and other mental emotional conditions), antianxiety (class of medication used to treat anxiety) , antidepressant (class of medication to treat depression), received daily. R5 had occupational and physical therapy services.

The "Urinary Incontinence Care Area Assessment" (CAA), dated 06/02/22, documented R5 was incontinent of bowel and bladder, needed extensive assistance with toileting and hygiene, utilized adult pull ups during the day and adult briefs at night. The CAA further documented R5 was able to make staff aware when he has been incontinent.

The "Fall Care Plan" dated 05/13/22 documented R5 was at risk for falls related to an unsteady and

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shuffling gait.

On 06/13/22 R5's "Care Plan" was updated following a fall, with an incontinence episode. On 06/09/22 the documented intervention was to educate staff to the importance of (incontinence) check and changes at night and early morning.

On 07/21/22 the "Accident Investigations" root cause analysis documented R5 had decreased mobility and an intervention that staff were educated to offer toileting to R5.

On 07/25/22 R5's "Care Plan" directed staff to offer to assist R5 to the toilet, upon R5 rising from bed, before and after meals, and before bed to decrease R5's risk of falling.

The "Progress Note", dated 08/06/22 at 08:30 PM, documented R5 had been on skilled services for medication management. R5 ambulated with a walker with supervision and cueing, was assisted by one staff with toileting as needed, was incontinent of bladder at times, wore pullups and fed self. The note further documented R5 was difficult to redirect and R5 attempted to open other resident's doors for staff.

On 02/22/23 at 12:47 PM observation revealed R5 was assisted out of the dining room. At 02:15 PM R5 left the BINGO activity. Ongoing observation from the time R5 left the dining room to the Bingo activity revealed R5 was not offered toileting or check and changes.

On 02/23/23 at 07:55 AM observation revealed R5 was pushed in a wheelchair by staff into the dining room. At 09:03 AM R5 was in the hallway trying to open a conference room door, staff

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within the room informed R5 could not enter due to a meeting. At 09:56 AM continued observation revealed R5 slept in his wheelchair in the commons area, when Certified Nurse Aide (CNA) P asked R5 if he wanted to rest in his recliner in his room. R5 was agreeable. CNA P assisted R5 into his recliner. During the ongoing observation from 07:55 AM to 09:56 AM, R5 had not been offered toileting or check and change by staff.

On 02/27/23 at 07:28 AM, Certified Medication Aide (CMA) S reported R5 used his wheelchair mostly for mobility, and had a room move closer to where staff was. CMA S said staff were to make sure R5 had a call light, and R5 used a night light and keep door partially open for observation to prevent falls.

On 02/27/23 at 08:43 AM Administrative Nurse G verified and expected staff to toilet R5 as care planned, to prevent falls and maintain skin integrity.

The facility's "Managing Falls and Fall Risk" policy, dated 10/2022, documented based on previous evaluation and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The Interdisciplinary Team (IDT) will attempt to identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. The IDT will identify and implement relevant interventions to try to minimize serious consequences of falling.

The facility failed to follow R5's specific

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interventions in place to prevent falls which placed the resident at risk for continued falls and possible injuries.

- The Electronic Medical Record (EMR) for R7 recorded diagnoses dementia with behavior disturbance (progressive mental disorder characterized by failing memory, confusion), unsteadiness on feet, cerebrovascular disease (conditions that affect blood flow and the blood vessels in the brain), muscle weakness, and dysphagia (swallowing difficulty).

R7's "Quarterly Minimum Data Set" (MDS), dated 01/22/22, documented R7 had long and short-term memory impairment and required extensive assistance of two staff for bed mobility, transfers, ambulation, dressing and toileting. The MDS further documented R7 had unsteady balance, no functional impairment and had one non-injury fall.

The "Significant Change MDS," dated 11/17/22, documented R7 had long and short- term memory impairment and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and limited assistance of one staff for ambulation. The MDS further documented R7 had unsteady balance, no functional impairment, and had no falls.

The "Fall Risk Assessments," dated 04/10/22, 07/10/22, 08/06/22, and 11/07/22 documented the resident was a high risk for falls.

The "Fall Care Plan," dated 01/10/23, originally dated 09/17/19, directed staff to ensure R7 wore appropriate footwear when ambulating, check and change upon rising in the morning, before

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and after meals, and prior to bedtime, and ensure R7 wore nonskid socks at night. The update, dated 05/01/21, directed staff to sit with the resident while in the dining room and redirect him as needed to stay seated. The update dated 08/20/22 directed staff to check alarm placement every two hours for correct positioning. The update, dated 01/26/23, directed staff to have resident in full view when not in bed and be aware of R7 when he wandered outside of the 200 hall and commons area to determine if the resident had any needs.

The "Fall Investigation," dated 02/15/22 at 05:42 PM, documented R7 stood from his wheelchair, appeared to be off balance, went to sit down and missed the seat of the wheelchair. The investigation further documented the fall was witnessed and the resident did not obtain any injuries.

The "Fall Investigation," dated 05/31/22 at 04:40 PM, documented R7 was observed on the floor in his room, lying on his back. The investigation further documented the fall was unwitnessed and the resident could not describe what he was doing at the time of the fall.

The "Fall Investigation," dated 08/06/22 at 06:35 PM, documented R7 slid out of his wheelchair on to the floor. The investigation further documented R7 tried to get up unassisted and was not wearing shoes or gripper socks. The investigation directed staff to make sure R7 wore shoes or gripper socks.

The "Fall Investigation," dated 08/20/22 at 03:00 PM, documented R7 was found on the floor in the activity room. The investigation further

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documented R7's chair alarm was not on, and education was given to staff to always keep the alarm on.

The "Fall Investigation," dated 01/20/23 at 07:30 PM, documented R7 was found in another resident's room on the floor. The investigation further documented staff were notified by another resident that R7 had fallen in his room. The investigation documented R7's alarm was not on and staff were educated to make sure the alarm was turned on after transfers and throughout the day.

On 02/22/23 at 10:15 AM, observation revealed Certified Nurse Aide (CNA) M transferred the resident from his wheelchair to his bed without a gaitbelt. Further observation revealed R7 spoke to CNA M in Arabic, and she stated she did not know what he was saying. CNA M checked his incontinence brief and verified his buttocks were red and stated she would apply barrier cream after peri care. Observation revealed, CNA M could not find barrier cream and put a clean incontinence brief on R7, took his shoes off, and covered him up.

On 02/22/23 at 10:15 AM, CNA M stated a lot of the time she did not know what the resident was saying as he spoke in Arabic and did not have any means to find out what he was saying. CNA M further stated staff made sure his bed was lowered, a bed alarm, and a fall mat was placed next to the bed to prevent further falls.

On 02/27/23 at 07:49 AM, Licensed Nurse (LN) G stated R7 got restless when he required toileting and had received therapy in the past for his falls.

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On 02/27/23 at 10:26 AM, Administrative Nurse D stated staff checked his alarm every two hours to make sure it is on and verified there should be interventions in place after a resident fell.

The facility "Fall and Fall Risk, Managing" policy, dated October 2022, documented the definition of a fall was unintentionally coming to rest on the ground floor or other lower level but not as a result of an overwhelming external force. The policy further documented the team would attempt to identify appropriate interventions to reduce the risk of falls and if falling reoccurs, despite initial interventions, staff would implement additional or different interventions or indicate why the current approach remained relevant.

The facility failed to provide supervision, ensure R7's personal alarm was activated, and failed to implement interventions for cognitively impaired R7, placing him at risk for further falls and injury.

- The Electronic Medical Record (EMR) for R18 documented the resident had diagnoses of bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods), cognitive communication deficit (may occur after a stroke, tumor, brain injury, or other neurological damage), traumatic brain injury (brain dysfunction caused by an outside force, usually a blow to the head), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

R18's "Admission Minimum Data Set" (MDS), dated 09/06/22, documented R18 was admitted to the facility 08/30/22 and had moderately impaired cognition and required extensive

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assistance of two staff for transfers, and extensive assistance of one staff for bed mobility, ambulation, toileting, and personal hygiene. The assessment further documented R18 had unsteady balance, no functioning impairment, and had one fall since admission.

The "Quarterly MDS," dated 01/10/23, documented R18 had moderately impaired cognition and was dependent upon two staff for transfers, toileting, and extensive assistance of two staff for bed mobility, and toileting. The assessment further documented R18 did not ambulate, had unsteady balance, no functional impairment and had one non-injury fall.

The "Fall Assessments," dated 08/31/22, 11/07/22, and 02/09/23, documented R18 was a high risk for falls.

The "Nursing Evaluation," dated 08/30/22, documented R18 used a walker when ambulating with staff assistance, had full range of motion, and did not require the use of a mechanical lift for transfers.

Review of the EMR lacked documentation a fall care plan was completed until 12/18/22.

The "Nurse's Note," dated 09/03/22 at 02:09 PM, documented R18 was lowered to the floor with two staff assistance and a gait belt. The note further documented R18 did not receive any injuries.

Review of the EMR lacked further documentation regarding the fall.

On 02/23/23 at 08:58 AM, observation revealed

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Licensed Nurse (LN) H and Certified Nurse Aide N attached the sling to the mechanical lift and lifted R18 up and lowered her onto the bed.

On 02/23/23 at 09:00 AM, CNA N stated she was not aware of any falls prior to the most recent fall the resident had. CNA N laughed and stated the most recent fall happened as a CNA rolled the resident, and the resident kept rolling and fell out of bed. CNA N further stated R18 was not hurt and that she should not laugh about it, but it was funny. CNA N stated staff use a mechanical lift and two staff for her transfers.

On 02/27/23 at 09:17 AM, LN G stated R18 was lowered to the ground by two staff, and the facility considered that a fall, but LN G was unable to find an incident report.

On 02/27/23 at 10:26 AM, Administrative Nurse D verified she was unable to find any incident report related to staff lowering R18 to the floor and stated an incident report should have been completed.

The facility "Fall and Fall Risk, Managing" policy, dated October 2022, documented the definition of a fall was unintentionally coming to rest on the ground floor or other lower level but not as a result of an overwhelming external force. The policy further documented the team would attempt to identify appropriate interventions to reduce the risk of falls and if falling reoccurs, despite initial interventions, staff would implement additional or different interventions or indicate why the current approach remained relevant.

The facility failed to implement interventions for R18, who was lowered to the ground by staff.

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F 689	Continued From page 56 This placed the resident at risk for further falls and injury.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility had a census of 40 residents. The sample included 12 residents, with two reviewed for nutrition. Based on observation, record review, and interview, the facility failed to provide nutritional support to prevent a significant weight loss of 10 lbs. or 6.36 percent in 21 days for Resident (R) 142. This failure placed the resident at ongoing risk for malnutrition and continued weight loss.	F 692		

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Findings included:

- R142's Electronic Medical Record (EMR) recorded he admitted to the facility on 02/06/23 with the only diagnosis of Huntington's (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder) disease. R142 had an admission weight of 157.2 pounds (lbs.).

The "Admission Minimum Data Set" (MDS), with an Assessment Reference Date (ADR) of 02/14/23, was not completed and remained in progress.

The Care Area Assessment (CAA), associated with the 02/14/23 MDS, also remained in progress.

R142's "Baseline Care Plan," dated 02/06/23, documented to promote/maintain adequate gastrointestinal habits, monitor for signs and symptoms, and monitor meal intake per protocol.

On 02/15/23, R142's "Care Plan" documented R142 was at risk for altered nutritional/hydration status related to Huntington's disease. The care plan directed staff to encourage consumption of fluids provided, provide adaptive equipment of weighted silverware, Kennedy (designed to be spill proof) cups with a straw, and a divided plate. It directed staff to provide and serve a regular diet, regular texture, and thin liquids as ordered, and monitor and record meal intake. Monitor/record/report to the Medical Doctor as needed for signs and symptoms of malnutrition: loss of three lbs. in one week or greater than five percent (%) in one month. The care plan further

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directed staff to honor R142's food preferences and update as needed; R142 loved cottage cheese, Dr. Pepper (soda drink), cheese, and sandwiches. Provide set-up and assistance with meals/snacks. The care plan further documented the Registered Dietician (RD) to evaluate and make recommendations as needed and physical, occupational, and speech therapy to evaluate and treat as needed.

R142's "Comprehensive Care Plan" had not been completed.

The "Physician Order" dated 02/06/23, documented dietary supplements may be used when determined appropriate by Interdisciplinary Team (IDT) or RD, and physical, occupational, and speech therapy to evaluate and treat.

The "Physician Order" dated 02/07/23, directed staff to provide a regular diet, regular texture, and thin consistency liquids.

The "Nutrition: RD Admission Assessment" dated 02/07/23, documented R142's nutrition information, from the EMR, documented R142 was 71 inches tall and weighed 157.2 lbs. The assessment recorded the nursing admission note reported R142 had a recent weight loss, and the RD was unsure of details; per progress notes R142's diet was regular, but there was no physician ordered diet ordered yet. R412's meal intake was good at 76-100%, no special items were utilized. R142 independently fed himself and was ambulatory.

On 02/07/23 R142's EMR recorded he weighed 156.0 lbs. (a 7.2 lb. difference)

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The "Nutrition Progress Note," dated 02/07/23, documented R142's oral intake demonstrated he had a good appetite. He was edentulous (without teeth), no dentures, and had no nutrition recommendations at that time.

The "Progress Note" dated 02/09/23 at 10:44 AM, documented R142 received orders for therapy. The nurse spoke with R142's Durable Power of Attorney (DPOA) who verbalized the desire to put therapy on hold and said the DPOA would let facility know when the DPOA was ready for the therapy to resume.

The "Task" section of R142's EMR documented he received limited assistance of one-person physical assist with eating on 02/12/23 and 02/13/23 only.

The "Nutrition: Dietary Manager Initial (Admission) Evaluation", dated 02/14/23, recorded the source of the nutrition information evaluated as R142. R142's desired weight range was 150-160 lbs., he had a regular diet and thin liquids, and no specialized items utilized. R142's beverage preferences were water, coffee, milk, juice, and Dr. Pepper. R142 stated his appetite was good, his usual eating pattern was all three meals. He liked to snack between meals. The note recorded r142's self-feeding ability as he required supervision, oversight, and cueing. Family brought in snacks and drinks. R142 was not a picky eater, and before coming to facility would occasionally skip a meal and would eat snacks. The evaluation further documented R142 had Huntington's disease; he may burn extra calories due to body movements; he used weighted silverware and on occasion nursing would assist with feeding.

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The "Dietary Admission Welcome and Interview Sheet," dated 02/14/23, documented R142 had a usual weight of 155 lbs. and a desired body weight of 150-160 lbs. R142 liked cottage cheese, cheese, Dr. Pepper, and sandwiches. He disliked broccoli. R142 was not picky, and he fed himself with weighted silverware. R142 had no difficulty with swallowing, chewing, or feeding himself with weighted silverware and some assistance from staff.

On 02/20/23 the "Weight Variance Note" recorded R142 weighed 148.8 lbs. (5.34% loss in two weeks), and a nutritional supplement twice a day was initiated. The medical provider was notified of the weight loss. The goal for R142 was to encourage and or assist him at meals; R142 had snacks and drinks in his room and used weighted silverware.

The "Task" section of R142's EMR documented he received limited assistance of one-person physical assist with eating on 02/12/23 and 02/13/23 only.

The EMR dated 02/27/23 recorded R142's weighed 147.2 lbs., a continued loss of greater than 5%.

On 02/22/23 at 12:30 PM observation revealed R142 sat in the dining room wearing a clothing protector. The meal served to R142 consisted of thin soup in a bowl, a biscuit, and mixed fruit. R142 used a weighted spoon and his fingers to eat chunks of vegetables and meat from soup. R142 had extensive continual involuntary movements in his arms, trunk, hands, neck, and head. After obtaining the biscuit and attempting

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to split it in half, R142 unintentionally flung the biscuit across the table, and it landed on the floor. R142 then placed the other half of the biscuit in the soup then did not eat it. During the process of eating, he continually tried to keep his clothing protector in place. R142 then placed the weighted spoon into the ice cream and withdrew over half the ice cream on the spoon and placed all of it into his mouth. Staff seated at the table offered no assistance to the resident with cueing, or meal intake, or placement/adjustment of his clothing protector.

On 02/23/23 at 08:11 AM observation revealed R142 received a breakfast of French toast, hot cereal with brown sugar and bacon. R142 had continual involuntary movements. He poured syrup onto the hot cereal, picked up the whole slice of French toast and ate it with his fingers, and then picked up the bacon. He placed the bacon in his mouth and tore off large pieces to chew then, using the weighted spoon started, eating the hot cereal. While eating R142's clothing protector continually slipped to his lap, and he attempted numerous times to keep it over his chest area to protect his clothing. R142 was not successful and dropped cereal on his shirt. Staff seated at the table did not assist the resident with his clothing protector or help with eating.

On 02/23/23 at 12:22 PM observation revealed R142 received a meal of whole boneless, barbecue chicken breast, peas in a bowl, and macaroni and cheese. R142 managed to cut the chicken breast in half despite the involuntary movements of his body. R142 took one half of the chicken breast into his mouth (resident has not teeth or dentures) and worked at chewing it to

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swallow. R142 then used his hands to cup the macaroni and cheese in his right hand to eat. R142 worked at eating all his macaroni and cheese and the other half of the chicken breast. Again, R142 was not able to keep clothing protector in place and dropped a great deal of food on his shirt. Staff present at the table did not assist R142 with eating or his clothing protector.

On 02/23/23 at 01:12 PM Certified Nurse Aide (CNA) P stated R142 was new to the facility and ate almost anything put in front of him. CNA P reported R142 used of weighted silverware but was messy during meals. CNA P reported R142 had snacks and Dr. Pepper in his room, and since the resident was mostly independent, and he did not need assistance with snacks and drinks in the room.

On 02/27/23 at 07:44 AM, Dietary Staff (DS) BB stated R142 received nutritional supplement two times a day. DS BB said Huntington's disease was new to her and was aware of constant flailing of arms and that she provided the resident with weighted silverware. DS BB verified she did the diet history and preference and R142's soup should have been in a cup. She also verified the resident was at risk for choking by placing half a chicken breast in his mouth and should have foods cut up. She reported dietary and nursing department could referred to therapy services. CDM also reported she had not observed resident's eating.

On 02/27/23 08:45 AM Administrative Nurse D reported she had not observed meals for R142, she stated he was mostly independent. She verified staff should be mindful of the resident's struggle with clothing protector and assistance

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F 692	Continued From page 63 with cutting up food to prevent choking and involving therapy as an intervention due to R142 weight loss. Administrative Nurse D verified staff should assist the resident at meals to enhance dignity and prevent further weight loss. The facility's "Nutrition(impaired)/Unplanned Weight Loss Clinical Protocol," dated 04/2021 documented assessment and recognition monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time. As part of the initial assessment the IDT through the various assessments will define the individuals with anorexia, recent weight loss and significant risk for impaired nutrition. The threshold for significant unplanned and undesired weight loss will be based on the following criteria of one-month five percent (%) weight loss is significant and greater than five % is severe. For individuals with recent or rapid weight loss the IDT should consider possible fluid and electrolyte imbalances as a cause. IDT should attempt to identify conditions and medications that may be causing anorexia, weight loss, or increased the risk of weight loss. Closely monitor residents who have been identified as having impaired or risk factors for developing impaired nutrition. Identify pertinent interventions based on cause-specific interventions as indicated with careful consideration. The facility failed to provide nutritional support for R142 resulting in a significant weight loss of 10 lbs. or 6.36 percent in 21 days. This failure also placed R142 at ongoing risk for malnutrition and weight loss.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		

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F 695	Continued From page 64 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility had a census 40 residents. The sample included 14 residents. Based on observation, record review and interview the facility failed to obtain and replace Resident (R) 14's oxygen mask as physician ordered placing R14 at risk for respiratory infection. Findings included: -R14's Electronic Medical Record (EMR) recorded diagnoses of acute and chronic respiratory failure, atrial fibrillation (rapid, irregular heart beat), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, cerebral infarction (stoke), hemiplegia (paralysis of one side of the body), morbid (severe) obesity, and angina pectoris (chest pain). The "Annual Minimum Data Set" (MDS), dated 12/25/22, documented R14 had intact cognition, no delirium or exhibited behaviors. R14 required extensive assistance of two staff for activities of daily living with the exception of eating which required limited assistance of one staff member. R14 had pain and pain treatment, shortness or	F 695		

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trouble breathing with exertion and when lying flat. The MDS further documented R14 received oxygen and required non-invasive mechanical ventilator.

R14's "Care Plan" documented R14 had difficulty breathing at times related to chronic respiratory failure and required the use of supplemental oxygen. The care plan directed staff to administer oxygen to home ventilation and nebulizer treatments, change oxygen mask daily and nurse to assess for respiratory distress.

The "Physician Order," dated 10/22/20, directed staff to administer oxygen at two to six liters (l) to maintain oxygen saturation range between 92 and 98 percent (%), and change oxygen mask daily every night shift.

Record review of R14's "Treatment Administration Record" (TAR) revealed dates of coded "3" which indicated a supply was not available and had been reordered for:
December 22, 23, 24, 25, 29, and 31, 2022. (six days)
January 1, 3, 4, 5, 6, 7, 8, 2023. (seven days)
February 13, 14, 15, 17, 18, 19, 20 and 22, 2023. (eight days)

The "Progress Note", dated 02/02/23 at 09:49 AM, documented R14 appeared in no apparent distress, alert with oxygen via mask.

On 02/21/23 during initial tour/interview observation revealed R14 was in her room in bed with a visibly soiled oxygen mask on her face.

On 02/27/23 at 09:03 AM Administrative Nurse D stated R14's mask should have been changed

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	175457	A. BUILDING _____ B. WING _____	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEABODY HEALTH AND REHAB	407 N LOCUST STREET PEABODY, KS 66866

(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 695	Continued From page 66 daily. Administrative Nurse D reported at times the masks had been back ordered, but the facility had two cases of mask in supply storage and the nursing staff needed to be educated where to find the oxygen masks and open the boxes for replacement. Administrative Nurse D stated the oxygen masked should have been cleaned when supply was not available but lacked documentation of cleansing the masks. The facility's "Oxygen Administration" policy, dated 06/2021, documented the purpose of this procedure is to provide guidelines for safe oxygen administration. The facility failed to replace R14's oxygen mask daily as ordered placing R14 at risk for respiratory infections.	F 695		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		

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F 867	Continued From page 67 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or	F 867		

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safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

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

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

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

§483.75(g) Quality assessment and assurance.

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§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 40 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility' Quality Assessment and Assurance (QAA) program failed to provide good faith efforts to identify multiple issues of concerns for the 40 residents, who reside in the facility.

Findings included:

-Based on observation, record review, and interview, the facility failed to provide Resident (R) 142 with dignified dining. Refer to F550.

Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan to include R29's Black Box Warning medications. Refer to F656.

Based on observation, record review, and interview, the facility failed to update care plans following falls for R7 and R8, and lacked care plan invitation and participation for R14. Refer to

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F 867	Continued From page 70 F657. Based on observation, record review, and interview, the facility failed to find ways to communicate R 7 language barrier for activities of daily living. Refer to F676. Based on observation, record review, and interview, the facility failed to provided care planned toileting for R5 and meal assistance for R142. Refer to F677. Based on observation, record review, and interview, the facility failed provide comforting care for R7 while resident moaned in the living room. Refer to F684. Based on observation, record review, and interview, the facility failed to provide pressure reducing device for R7 who was left in a wheelchair for over 2 hours two days in a row. Refer to F686. Based on observation, record review, and interview, the facility failed to place intervention for R7 and R18 from falling and had not followed care planned toileting to prevent falls for R 5. Refer to F689. Based on observation, record review, and interview, the facility failed to prevent significant weight loss for R142. Refer to F692. Based on observation, record review, and interview, the facility failed to change R14's oxygen mask daily, placing the R14 at risk for respiratory infections. Refer to F695. On 02/27/23 at 01:37 PM, Administrative Staff A	F 867		

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reported she collects data from the interdisciplinary team and other sources of information for the quality assessment and assurance program that meets on a monthly basis for formulate plans of improvement.

The facility's "QAPI Committee, Program Feedback, Data Systems and Monitoring" policy, dated 10/2022, documented this facility shall establish and maintain a Quality Assessment and Assurance Committee (QAPI) that oversees the identification and handling of quality issues. The facility shall establish a system for program feedback, data collection systems and monitoring, to include adverse event monitoring.

The facility failed identify multiple issues of concern for the 40 resident who reside in the facility placing the residents at risk for lack of quality care.