

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/11/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/26/2023
NAME OF PROVIDER OR SUPPLIER MERRIAM GARDENS HEALTHCARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 9700 W 62ND STREET MERRIAM, KS 66203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 550 SS=E	The following citations represent the findings of a partial extended, abbreviated survey for complaint investigations KS00179442, KS00179702, KS00179358, and KS00178680. 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 resident can exercise his or her rights without	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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F 550	Continued From page 1 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 identified a census of 90 residents. The sample included 16 residents. Based on record review, interview, and observation, the facility failed to provide dignity to Resident (R)9, R3, R16, R5, R6, and R15 when R3, R5, and R6 lacked the appropriate utensils to eat their meal, R14 was served cold meals, R16 sat across from table mates that were eating while R16 had not been served, and R15 was served food that was to hot and not offered a drink to help cool the hot food R15 was served. This placed R9, R3, R16, R5, R6, and R15 at risk for impaired psychosocial well-being due to not being served with the appropriate utensils, being served the same times as tablemates, being served warm food, or being assisted to prevent a negative dining experience. Findings included: - On 04/25/23 at 11:41 AM R9, who had a Brief Interview for Mental Status (BIMS) of 14, which indicated intact cognition, stated that meals were changed from the menu a lot and were always cold when the meal trays were brought to her room. R9 further stated that sometimes she was able to get a staff member to heat her meal tray up if a staff member responded to her call light	F 550			

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F 550	Continued From page 2 during meals. On 04/26/23 at 08:43 AM R3, who had a BIMS of 11, which indicated moderately intact cognition, stated that breakfast was awful. R3 further stated that he had to beg for a spoon just to eat the warm cereal that was served to him. R3 stated the dining room service in the facility made him feel inhuman because he had to ask for a spoon and then waited for staff to go and get him one, which took a few minutes. On 04/26/23 at 08:50 AM R16, who had a BIMS of 15, which indicated intact cognition, stated that he was in the dining room since 07:30 AM. He was provided coffee, but no one had brought him breakfast. R16 waved his hand towards to other side of the table he was seated at and stated that the residents seated across from R16 were eating for a while. R16 further stated that he had ordered what he wanted for breakfast the night before, but still had to wait for over an hour for food, which still had not arrived. On 04/26/23 at 09:23 AM R5, who had a BIMS of 15, which indicated intact cognition, asked how he was expected to eat a rock-hard waffle. R5 took the waffle and banged it on his glass plate, and it was noted to clank loudly. R5 asked how he was supposed to cut this hard waffle when no resident was set up with a knife. On 04/26/23 at 09:24 AM R6, who had a BIMS of 15, which indicated intact cognition, stated he waited for over ten minutes for a knife to cut his waffle. R6 further stated the waffles were too hard to eat with a fork. R6 tapped the waffle on the table, which made a knocking sound, and then asked R16 if they wanted to play catch with his	F 550			

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F 550	Continued From page 3 waffle Frisbee. R6 gestured throwing the waffle as a Frisbee to R16 but did not release the waffle. R6 sat on one side of the dining room near the wall and R16 sat across the dining room near the opposite wall. On 04/26/23 at 09:36 AM R15, who had a BIMS of 15, which indicated intact cognition was assisted with eating warm cereal. Certified Nurse Aide (CNA) M spooned the warm cereal into R15s mouth without checking to see if the food temperature was appropriate. Staff scooped a full spoonful of warm cereal into R15's mouth, at which time R15 immediately turned his head to the left, proceeded to spit out the warm cereal and attempted to rub his tongue on the clothing protector that wore. R15 stated the warm cereal was "really hot." CNA M asked R15 if it was too hot, to which R15 shook his head yes. CNA M stated "Oh," and proceeded to give R15 other food from his breakfast tray without offering a drink of fluid to aide in cooling R15's mouth. On 04/26/23 at 09:40 AM Administrative Nurse E stated staff needed to check the temperature of the food before staff just feed it to assisted residents. Administrative Nurse E further stated that when staff served the residents, all of the residents at a table needed to be fed before moving to a different table, half of a table should not be left unserved and sit to watch the other half at the same table enjoy their meal. The facility's "Dining Room Service" policy date 2017 documented adequate staff would be available in the dining areas to help individuals who needed assistance and to handle any situation that may arise.	F 550			

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F 550	Continued From page 4 The facility's "In-Room Dining (Room Service)" policy dated 2017 documented that food preferences and choices would be honored as appropriate. Flatware would be clean, without spots, neatly placed, and in good condition. All meals served must include a minimum, fork, and spoon (and a knife when appropriate). The facility failed to ensure R9, R3, R16, R5, R6, and R15 had a positive dining experience when R3, R5, and R6 lacked the appropriate utensils to eat their meal, R14 was served cold meals, R16 sat across from table mates that were eating while R16 had not been served, and R15 was served food that was too hot and not offered a drink to help cool the hot food R15 was served. This placed R9, R3, R16, R5, R6, and R15 at risk for impaired psychosocial well-being due to staff not provided the appropriate utensils, staff not serving at the same times as tablemates, staff not checking temperature of food when assisting to eat to ensure food was not too hot to eat safely, , or being assisted to prevent a negative dining experience.	F 550			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580			

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F 580	Continued From page 5 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: The facility identified a census of 90 residents.	F 580			

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F 580	Continued From page 6 The sample included 17 residents. Based on interview and record review the facility failed to inform Resident (R) 17's physician of abnormal lab values. This placed R17 at risk for health complications due to delayed physician involvement or uncommunicated care needs. Findings included: - R17's electronic medical record (EMR) documented diagnoses of hemiplegia (paralysis of one side of the body) left side dominant, muscle weakness, dysphagia (trouble swallowing), and cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area). The "Significant Change Minimum Data Set" (MDS) dated 08/19/22 documented a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. R17 required extensive assistance of two staff members for bed mobility, transfers, and toilet use. R17 required extensive assistance of one staff member for personal hygiene, eating, dressing, and locomotion on and off the unit. R17 had not received any intravenous (IV, administration directly into a vein) medications. The "Quarterly MDS" dated 04/04/23 documented a BIMS score of nine, which indicated moderately impaired cognition. R17 required extensive assistance of two staff members for bed mobility, transfers, walk in room, walk in corridor, dressing, toilet use, and personal hygiene. R17 required extensive assistance of one staff member for locomotion on and off the unit, and limited assistance of one staff member with eating. R17 had received IV medications both while not in the	F 580			

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F 580	Continued From page 7 facility and while in the facility. The "Activities of Daily Living (ADL) Care Area Assessment" (CAA) dated 08/19/22 documented R17 had a self-care performance deficit related to a history of cerebral infarction with hemiplegia, left sided dominant. R17 required extensive assistance of one to two staff members with care needs. The "Black Box Warning Care Plan" intervention dated 03/16/21 directed staff to monitor labs and report findings to the nurse practitioner or physician as indicated. The "Nutrition Care Plan" intervention dated 03/17/21 directed staff to obtain and monitor lab/diagnostic work as ordered, report results to the physician and follow up as indicated. The "Physician Orders" noted the following orders: Complete blood count (CBC) with differential (laboratory blood test), comprehensive metabolic panel (CMP-laboratory blood test), magnesium (Mag - laboratory blood test to check magnesium levels), and C-reactive protein (CRP - laboratory blood test to measure protein in the blood) STAT (immediately), dated 04/05/23. Review of the "Lab" results for the CBC with differential dated 04/05/23 documented R17's white blood cell (WBC) count was 17.1 times 10 (3)/uL, which was noted as high. The reference range was 4.5 - 10.5 times 10(3)/uL. The "Transfer to Hospital Summary" dated 04/06/23 at 04:00 PM documented R17 was on IV antibiotics, which were evaluated to be less	F 580			

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F 580	Continued From page 8 effective than needed. It was determined R17 needed to be sent back to the hospital for further evaluation of the left leg amputation and correlated infection. The "Progress Notes" lacked physician notification related to the abnormal labs on 04/05/23. On 04/26/23 at 02:50 PM Administrative Nurse E stated the staff should notify the physician of abnormal lab values. The facility's "Notification of Changes" policy dated 01/01/20 documented the purpose of this policy was to ensure the facility promptly informed the resident, consulted with the resident's physician, and notified resident's representative when there was a change that required notification. The facility failed to ensure staff notified the physician when R17 had elevated WBC count, noted as high on 04/05/23. This placed R17 at risk for health complications due to delayed physician involvement or uncommunicated care needs.	F 580			
F 584 SS=F	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584			

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F 584	Continued From page 9 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: The facility identified a census of 90 residents. The sample included 17 residents. Based on observation, record review, and interviews the facility failed to provide a clean, safe, comfortable, and sanitary homelike environment for residents housed in the facility throughout the	F 584			

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F 584	Continued From page 10 building. Findings included: - On 04/25/23 at 11:25 AM observation of R7's room noted dirty linens laid on the floor below the window. The linen was noted to have a tan spill on the sheet. The room smelled of urine and there was also a soiled chuck (cloth bed pad) laying under the window. Near the room's bathroom were a used pair of rubber gloves, pulled into each other, and thrown on the floor at the bathroom doorway and with a pillowcase. The IV pole next to the bed by the window was noted to have a dirty base, with what appeared to be dried tube feeding residue, spilled on the feet of the pole. The low air loss mattress on the bed by the window was noted to be dirty and have particles on the mattress. On 04/25/23 at 11:26 AM in R18's room there was a ripped incontinence brief laying in the middle of the floor. On 04/25/23 at 11:27 AM R2's room noted used gloves lying on the floor, and a kidney shaped brown stain by the wall behind the doorway, approximately two inches in length at the longest part. There was also a raised brown stain, diamond shaped, by the foot of the resident's bed to the right side, upon entering the room. There is also an untouched pureed breakfast tray set on the over the bedside table. It was also noted that there was oxygen tubing attached to an oxygen concentrator, undated. On 04/25/23 at 11:48 AM R15's room was noted to have mouse droppings on the floor by R15's dresser and his shoes set underneath the	F 584			

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F 584	Continued From page 11 window. Mouse droppings noted by the room divider curtain and R15 stated he had seen a mouse in his room recently but could not recall the date. There was also various debris noted on the floor. On 04/25/23 at 11:52 AM R11's room with the bed by the window was noted to have approximately eight drops of dried blood from pea shaped size, up to dime size on the side of the bed, beside the window. The pillowcase that laid on the bed was noted to have various amounts of what looked like blood stained drops that had dried on the same side as the sheet. There was a large amount of debris located on the floor. The closet on the window side of the room was noted to bulge out approximately one foot with a large curtain covering it, underneath the curtain there was a spider web and debris noted to be on the floor next to the boxes behind the curtain. On 04/25/23 at 11:41 AM R9's room was noted to have a catheter laying on the floor, there was debris noted on the floor by the dresser in the corner opposite the doorway. R9 reported that housekeeping hardly came to the room to clean the floor or pick up. On 04/25/23 at 11:50 AM R12's room noted that there was trash on the floor, there was an oxygen tubing attached to the concentrator that lacked a date, and a nebulizer machine laying on the floor at the head of the bed by the window. The over the bedside table next to the bathroom was noted to have an untouched pureed lunch dated 04/24/23 (the day before). On 04/25/23 at 11:54 AM R14 and R13's room had eight mouse droppings between R14's fridge	F 584			

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F 584	Continued From page 12 beside the door and a dresser. Along the wall underneath R14's small table by the bed there were two mouse droppings mixed in with R14's shoes. R13, who shared a room with R14, was noted to have a box with the top open sitting on the floor. Inside the box there were four bags of crackers with two of the bags had gnawed on areas, with one bag with the top cracker nibbed on and the second bag noted to only have three full crackers left with only the chewed area noted to have opened the bag. A single serving container of peanut butter that had a foil seal was noted to have chewed areas into the foil and all the peanut butter had been cleaned out. The box also contained a box of rice Krispie's, unopened or gnawed on; a bag of plain lay chips, unopened or gnawed on; a zip lock bag of Cheeto puffs, unopened or gnawed on, and a gift bag that appeared untouched. The box was noted to have multiple mouse droppings in the bottom when the crackers were moved to the side. There were mouse droppings noted at the base of R13's furnace. Also at the base of the furnace were two empty sticky traps. When R13 was asked about mouse activity, R13 revealed he had poor eyesight and would not have seen them even if they were running in the room. R13 further revealed no staff member told him about a concern with mice. When asked about the mouse activity in R13's box, R13 stated he did not know and asked if a staff member planned on cleaning the area. On 04/25/23 at 12:03 PM R1's room was noted to have 43 mouse droppings in the second drawer from the top of R1's dresser throughout his clothing. R1's bottom drawer of the dresser had numerous Hersey kisses in it with the silver foil shredded. R1 stated that approximately four days	F 584			

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F 584	Continued From page 13 ago a mouse was on his bed. R1 stated that normally if he could move, he would not have had a problem with a mouse on his bed, but since R1 is a quadriplegic (paralysis of the arms, legs and trunk of the body below the level of an associated injury to the spinal cord) and is unable to move, the mouse on his bed scared him the "hell out" of R1. R1 revealed he called for staff. An unidentified staff member came and shook R1's bed to get the mouse off of it. The side of the low air loss mattress on the side facing the window was noted to have TWOCAL (nutritional supplement drink) spilled down the sides, the foot pedals to the IV pole was noted to have spilled TWOCAL spilled and dried on the four legs of the pole. R1 revealed no one hardly came in to help clean his room or organize his closet. On 04/25/23 at 12:40 PM Administrative Staff A stated when reviewing R13's room, it appeared not that messy, that the mess was on R13's over the bed side table and underneath the table near the open box. Administrative Staff A stated she would not feel comfortable living or sleeping in a room with mice. Administrative Staff A confirmed that the room tray in R13's room was dated 04/24/23 dinner and that the tray should have been removed by staff. Administrative Staff A further stated the residents in the facility were not expected to remove the trays when a resident was done eating. On 04/25/23 at 12:43 PM Administrative Nurse E stated there appeared to be mouse droppings between R14's fridge and dresser. Administrative Nurse E looked at R13's side of the room and confirmed the cracker packages had been gnawed on, there were mouse dropping in the resident's box, and on the floor by the furnace.	F 584			

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F 584	Continued From page 14 Administrative Nurse E revealed it would be uncomfortable to live with mice. Administrative Nurse E revealed that catheters should not be laid on the floor but be up on the railing of the bed. Administrative Nurse E further revealed that it was not sanitary. Administrative Nurse E confirmed that the tray in room 107 was from lunch on 04/24/23 and needed to be removed from the room promptly. On 04/25/23 at 02:08 PM Maintenance V stated he was called into R9's room related to a mouse being stuck in the furnace. Maintenance V stated the mouse tail was hung up in the furnace on something. Maintenance V revealed that the mouse was alive and appeared to be a young tiny mouse. Maintenance V further revealed it looked like a baby. Maintenance V stated that when he entered rooms to check on the sticky traps for mouse activity, resident rooms appeared to still be dirty, and the floors were sticky with debris on them. Maintenance V further stated now that it was getting warmer outside, the mice would hopefully stay outside and not be a problem any longer. The facility's "Safe and Homelike Environment" policy dated 10/25/19 documented the facility would provide sufficient individual closet space in each residents' room. The facility would provide and maintain bed and bath linens that are clean and in good condition. Housekeeping and maintenance services would be provided as necessary to maintain a sanitary, orderly, and comfortable environment. The policy further documented the facility would minimize odors by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to the housekeeping department.	F 584			

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F 584	Continued From page 15			F 584			
F 677 SS=D	The facility failed to provide a clean, safe, comfortable, and sanitary homelike environment to residents who resided in the facility. This placed those residents at risk for impaired health and well-being. 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 reported a census of 90 residents. The sample included five residents. Based on observation, record review, and interview the facility failed to ensure Resident (R)1 and R9 received assistance to maintain the residents physical and psychosocial wellbeing, when the facility failed to ensure staff offered and provided the residents a shower based on their individual preferences. This placed the residents at risk for poor hygiene and impaired psychosocial wellbeing. Findings included: - R1's electronic medical record (EMR) documented diagnoses of quadriplegia (paralysis of the arms, legs and trunk of the body below the level of an associated injury to the spinal cord), severe protein-calorie malnutrition, muscle weakness, abnormal posture, neuromuscular dysfunction of bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), and muscle spasms.			F 677			

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F 677	Continued From page 16 The "Quarterly Minimum Data Set" (MDS) dated 01/07/23 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 required total dependence on two staff members for bed mobility and transfers. R1 required extensive assistance of two staff members for personal hygiene, toilet use, dressing, and locomotion on and off of the unit. R1 required extensive assistance of one staff member with eating. R1 had no behaviors noted. The "Annual MDS" dated 04/02/23 documented a BIMS score of 15 which indicated intact cognition. The "Activities of Daily Living (ADL) Care Area Assessment" (CAA) dated 04/07/23 documented R1 was dependent on staff for assistance with ADL related to quadriplegia. The "ADL Care Plan" interventions dated 04/03/22 directed R1 preferred showers and required total assistance of one staff member for shower, using the reclining shower chair. Staff were directed to apply lotion to R1's upper and lower extremities after bathing, and as needed, to help keep R1's skin soft and supple and decrease risk of dry, itchy skin and skin injury. It further directed staff to apply moisture barrier cream to R1's buttocks and peri area as needed to protect R1's skin. R1 was dependent on one staff member for personal hygiene tasks. R1 preferred to be clean shaved and had an electric razor for R1's shaving needs. The "Progress Notes" 02/01/23 through 04/24/23 lacked any documentation regarding R1's bathing or bathing refusals.	F 677			

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F 677	Continued From page 17 Review of February "Bathing/Showers" revealed R1 received two showers and four bed baths: 02/01/23 Bed Bath 02/05/23 Bed Bath 02/08/23 Refused 02/12/23 (seven days since prior bed bath), Bed Bath 02/15/23 documented yes a shower occurred but the self performance, support provided, and mode of bath was marked as not applicable (NA) 02/16/23 Shower 02/19/23 Refused 02/22/23 (six days since prior shower) Bed Bath 02/26/23 Refused Review of March "Bathing/Showers" revealed R1 received two showers and six bed baths: 03/01/23 Bed Bath 03/05/23 Bed Bath 03/08/23 Bed Bath 03/12/23 lacked documentation 03/15/23 (seven days since prior bed bath and 27 days since prior shower) documented yes a shower occurred but the self-performance, support provided, and mode of bath were marked NA 03/19/23 Bed Bath 03/22/23 Bed Bath 03/26/23 Bed Bath 03/29/23 Shower Review of April "Bathing/Showers" revealed R1 received no showers and four bed baths: 04/02/23 Bed Bath 04/05/23 Marked NA 04/09/23 Marked NA 04/12/23 (10 days since prior bed bath) Bed Bath 04/16/23 Bed Bath 04/19/23 Bed Bath	F 677			

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F 677	Continued From page 18 04/23/23 Marked NA On 04/25/23 at 12:03 PM R1 laid in his bed on his back with his knees pulled up to his right side. R1 was covered with a blanket up to his chin. R1 appeared to have flaky white particles in his hair. R1's hair appeared unkempt and greasy in appearance. R1's face was noted to have dry skin in his grown-out beard on both sides of his face; his nose was ashy in appearance. R1 stated he could not recall the last time his hair was cleansed. R1 stated the staff hardly ever got him up into the shower. R1 revealed he preferred a close shave, to a beard on his face, but staff never cut it when R1 asked. R1 further revealed at times his face itched intensely and it embarrassed him to have a dry flaky face. R1 stated, at times he felt sorry for himself when he was not taken to the shower to get washed up and clean shaved. R1 further stated he had stopped asking staff for "too much" help because staff body language made him feel like a burden and a bother. On 04/26/23 at 01:50 PM R1 was returning to his room. R1 stated he received a shower and he felt so good. R1 had no flaky white particles in his hair and was clean shaved. R1 further stated he felt he received a shower as a result of the survey, and said he was thankful. (Per record review 28 days lapsed between R1's last shower, which occurred on 03/29/23, to the shower on 04/26/23). On 04/26/23 at 01:45 PM Certified Nurse Aide (CNA) M stated she could get to the showers assigned to her on her shift. On 04/26/23 at 01:10 PM Licensed Nurse (LN) G	F 677			

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F 677	Continued From page 19 stated showers should just be done. LN G revealed showers in the shower should be the first option for residents. LN G stated it was good for the residents to get up and into the shower to be bathed, if a resident refused or was not able to get up, then another type of bath needed to be offered for that day. LN G further stated if staff were not able to complete all of the showers scheduled on that shift, it needed to be reported to the oncoming shift to attempt to get it completed, and if that failed then the shower needed to be offered the following day. LN G stated when that happened, it would need to be documented in the chart. On 04/26/23 at 02:45 PM Administrative Nurse E stated showers should be done per the schedule and if a resident wanted a shower verses a bed bath, the resident could get that. The facility's "Activities of Daily Living (ADLs)" policy dated 08/01/19 documented a resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility failed to ensure R1 received a shower and/or bath twice a week. This deficient practice placed R1 for decreased quality of life and negative psychosocial impact due to not getting bathed or shaved regularly. - R9's electronic medical record (EMR) documented diagnoses of muscle weakness, lack of coordination, dysphagia (swallowing difficulty), and severe protein-calorie malnutrition. The "Quarterly Minimum Data Set" (MDS) dated	F 677			

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F 677	Continued From page 20 01/29/23 documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R9 required total dependence of two staff members for transfers. R9 required extensive assistance of two staff members for bed mobility, dressing, toilet use, and personal hygiene. R9 required extensive assistance of one staff member for mobility on and off the unit. R9 required limited assistance of one staff member for eating. The "Activities of Daily Living (ADL) Care Area Assessment" (CAA) dated 10/29/22 documented R9 required one to two staff extensive to total assistance with R9's daily ADL. The "ADL Care Plan" interventions dated 10/21/21 directed staff R9 preferred showers. Staff were directed to apply lotion to R9's upper and lower extremities after bathing and as needed to keep R9's skin soft and supple and to decrease the risk of dry itchy skin and skin injury; also apply moisture barrier cream to my buttocks and peri area as need to protect R9's skin. The "Progress Notes" 02/01/23 through 04/24/23 lacked any documentation that R9 had received or refused to take a shower. Review of February "Bathing/Showers" noted R9 received two showers and four bed baths: 02/03/23 lacked documentation 02/07/23 Bed Bath 02/08/23 Not Applicable (NA) 02/10/23 Bed Bath 02/13/23 documented yes a shower occurred but the self-performance, support provided, and mode of bath was NA 02/14/23 NA	F 677			

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F 677	Continued From page 21 02/17/23 Bed Bath 02/21/23 documented yes a shower occurred but the self-performance, support provided, and mode of bath was NA 02/24/23 lacked documentation 02/28/23 Refused Review of March "Bathing/showers" revealed R9 received two showers and two bed baths: 03/01/23 NA 03/03/23 (10 days since prior shower) Bed Bath 03/07/23 Bed Bath 03/08/23 NA 03/10/23 documented yes a shower occurred but the self-performance, support provided, and mode of bath was NA 03/14/23 documented yes a shower occurred but the self-performance, support provided, and mode of bath was NA 03/17/23 lacked documentation 03/18/23 NA 03/19/23 NA 03/21/23 lacked documentation 03/21/23 NA 03/22/23 NA 03/24/23 lacked documentation 03/28/23 lacked documentation 03/31/23 NA Review of April "Bathing/showers" revealed R9 received no showers and four bed baths: 04/04/23 (21 days since prior bathing activity) Bed Bath 04/05/23 NA 04/07/23 NA x 2 04/11/23 (seven days since prior bed bath) Bed Bath 04/13/23 NA 04/14/23 Bed Bath			F 677			

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F 677	Continued From page 22 04/18/23 Bed Bath 04/21/23 lacked documentation On 04/25/23 at 11:41 AM R9 stated that she felt terrible and not clean. R9 stated she only got a bed bath but preferred to get up and get a shower. R9 revealed to get a bed bath she had to ask repeatedly, over and over, just to get staff to finally give her one. R9 laid in her bed on her back with her hair underneath a hair bonnet and bedding pulled up to her chest. R9 appeared to have dry skin on both arms. R9 revealed she would love to get up during the day, not all of the time, but at least sometimes but even that did not happen. On 04/26/23 at 01:45 PM Certified Nurse Aide (CNA) M stated she could get to the showers assigned to her on her shift. On 04/26/23 at 01:10 PM Licensed Nurse (LN) G stated showers should just be done. LN G revealed showers in the shower should be the first option for residents. LN G stated it was good for the residents to get up and into the shower to be bathed, if a resident refused or was not able to get up, then another type of bath needed to be offered for that day. LN G further stated if staff were not able to complete all of the showers scheduled on that shift, it needed to be reported to the oncoming shift to attempt to get it completed, and if that failed then the shower needed to be offered the following day. LN G stated when that happened, it would need to be documented in the chart. On 04/26/23 at 02:45 PM Administrative Nurse E stated showers should be done per the schedule and if a resident wanted a shower verses a bed	F 677			

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F 677	Continued From page 23 bath, the resident could get that. The facility's "Activities of Daily Living (ADLs)" policy dated 08/01/19 documented a resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility failed to ensure R9 received a shower and/or bath twice a week, per R9's assessed and care planned preference. This deficient practice placed R9 for decreased quality of life and negative psychosocial impact due to not receiving bathing regularly.			F 677			
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: The facility identified a census of 90 residents. The sample included 17 residents with one resident reviewed for Intravenous (IV, administration directly into a vein) antibiotic (used in the prevention and treatment of infectious diseases) therapy. Based on interview and record review the facility failed to ensure R17 received the appropriate orders, treatment, maintenance, and services related to IV administrations. This placed R17 at risk for increased risk of infection, clotting, and IV related complications.			F 694			

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F 694	Continued From page 24 Findings included: - R17's electronic medical record (EMR) under the "Diagnosis" tab documented diagnoses of hemiplegia (paralysis of one side of the body) left side dominant, muscle weakness, dysphagia (trouble swallowing), and cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area). The "Significant Change Minimum Data Set" (MDS) dated 08/19/22 documented a Brief Interview for Mental Status (BIMS) score of six which indicated severely impaired cognition. R17 required extensive assistance of two staff members for bed mobility, transfers, and toilet use. R17 required extensive assistance of one staff member for personal hygiene, eating, dressing, locomotion on and off the unit. R17 had not received any IV medications. The "Quarterly MDS" dated 04/04/23 documented a BIMS score of nine, which indicated moderately impaired cognition. R17 required extensive assistance of two staff members for bed mobility, transfers, walk in room, walk in corridor, dressing, toilet use, and personal hygiene. R17 required extensive assistance of one staff member for locomotion on and off the unit, and limited assistance of one staff member with eating. R17 had received IV medications both while not in the facility and while in the facility. The "Activities of Daily Living (ADL) Care Area Assessment" (CAA) dated 08/19/22 documented R17 had a self-care performance deficit related to a history of cerebral infarction with hemiplegia left sided dominant. R17 required extensive assistance of one to two staff member with care			F 694			

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F 694	Continued From page 25 needs. The "Care Plan" lacked any interventions related to IV antibiotic administration, monitoring the peripherally inserted central catheter (PICC - a form of intravenous access that can be used for a prolonged period of time) line site, monitoring R17s above the knee amputation (AKA) surgical site, or pain related to post-surgical AKA. The "Physician Orders" revealed the following orders: Order dated 03/29/23 for Meropenem Solution (antibiotic) reconstituted one gram (GM) intravenously every eight hours for infection until 04/15/23. Order dated 03/30/23 for Meropenem Solution reconstituted one GM intravenously every eight hours for infection until 04/06/23. Order dated 03/30/23 for Daptomycin (antibiotic) intravenous solution reconstituted 350 milligrams (mg) use one application intravenously one time a day for infection until 04/06/23. Order dated 03/31/23 instructing staff to change transparent dressing and needleless connector to midline or PICC site, and to measure external catheter length with each dressing change, as needed for wet, soiled, loose, or otherwise compromised dressing. The orders lacked orders for, or any directions related to normal saline flushes in conjunction with the IV antibiotics and/or flushes to maintain the line patency (unobstructed). Review of the March "Medication Administration Record" (MAR) noted two out of seven opportunities to administer Meropenem were documented as "Other / See Progress Notes" on	F 694			

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F 694	Continued From page 26 03/29/23 at 11:00 PM and 03/31/23 at 07:00 AM. Review of the "Lab" results for the complete blood count (CBC) with differential (laboratory blood test) dated 04/05/23 documented R17's white blood cell count was 17.1 times 10(3)/uL which was noted as high. The reference range was 4.5 - 10.5 times 10(3)/uL. Review of the April MAR noted that one out of six opportunities lacked evidence of administration for the Daptomycin at bedtime. The Meropenem noted that out of 17 opportunities, one lacked evidence of administration on 04/03/23 at 03:00 PM, two were documented as "Other/ See Progress Notes" (04/03/23 at 07:00 AM and 04/06/23 at 03:00 PM) and the last was documented as "Hold / See Progress Notes" 04/01/23 at 11:00 PM . The "Activity Participation Note" dated 03/29/23 at 07:07 PM documented R17 arrived at the facility and had an IV in the right arm. The "Orders Administration Note" dated 04/01/23 at 10:14 PM documented medication on order. The "Orders Administration Note" dated 04/03/23 at 01:03 PM documented medication not available. The "Orders Administration Note" dated 04/06/23 03:14 PM documented R17 was being sent out to the hospital and not to administer. The "Transfer to Hospital Summary" dated 04/06/23 at 04:00 PM documented R17 was on IV antibiotics, which were evaluated to be less effective then needed. It was determined that R17	F 694			

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F 694	Continued From page 27 needed to be sent back to the hospital for further evaluation of the left leg amputation and correlated infection. The "Progress Notes" lacked a description of the PICC access site, measurements of the PICC line, evidence the site was assessed for signs of infection or indications that a saline flush was utilized prior or post antibiotic administration. On 04/26/23 at 01:10 PM Licensed Nurse (LN) G stated when administering IV medications, orders would need to be checked first to make sure all supplies were gathered. LN G further stated when going to administer the medication, first wash your hands, and cleanse the IV port with alcohol swab wiping it for 15 seconds. Once completed the hub and insertion site were assessed and then the line was flushed with normal saline or whatever the physician ordered, the IV medication was ran, then the IV would be flushed at the end and then clamped. LN G revealed that all IV lines should be flushed, and all flushes needed a physician order. LN G further stated if the MAR had a blank area, the treatment or medication was not completed as ordered. On 04/26/23 at 02:19 PM Administrative Nurse E stated that if a resident had an IV site there needed to be a physician order to flush the line, the site should be monitored, and if the MAR had a blank it was not completed. The facility's "Medication Ordering, Receiving and Storage" policy dated 10/01/15 documented that orders for flushing protocols would also be written at the time of the IV medication order being written if not already present in the residents medical record.	F 694			

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F 694	Continued From page 28	F 694			
F 730 SS=F	The facility failed to ensure R17 received appropriate cares and services in accordance with the standards of care and the facility policy for a PICC line. This placed R17 at increased risk for infections and PICC related complications. Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility reported a census of 90 residents. Based on interview and record review the facility failed to complete an annual performance review at least once every 12 months for seven of seven Certified Nurses Aides (CNA) reviewed, CNA N, CNA O, CNA P, CNA Q, CNA GG, CNA HH, and CNA II, to identify further education needs, to provide cares to the residents of the facility. Findings included: - The facility identified seven staff as employees who worked over a year in the facility. Review of these seven employee files, revealed the following concerns: 1. Certified Nurse Aide (CNA) N, hired 08/03/21, lacked an annual performance review in her personnel file.	F 730			

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F 730	Continued From page 29 2. CNA O, hired 09/02/2014, lacked an annual performance review in her personnel file. 3. CNA P, hired 01/13/22, lacked an annual performance review in her personnel file. 4. CNA Q, hired 01/12/05, lacked an annual performance review in her personnel file. 5. CNA GG, hired 07/07/20, lacked an annual performance review in her personnel file. 6. CNA HH, hired 12/22/21, lacked an annual performance review in her personnel file. 7. CNA II, hired 09/26/06, lacked an annual performance review in her personnel file. On 04/26/23 at 01:50 PM Administrative Staff A revealed no performance evaluations could be located in any CNAs personnel file who had worked for the facility for over a year. The facility lacked a policy for the completion of the required employees' annual evaluations. The facility failed to complete annual performance reviews for staff CNAs, who had been an employee for over one year, to identify further areas of education needs, to provide cares to the residents of the facility.	F 730			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761			

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F 761	Continued From page 30 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility identified a census 90 residents with a sample of 25 residents. Based on observation, interview, and record review the facility failed to ensure medications were labeled and stored properly when staff left Resident (R)12's cup of morning medications unsupervised and unmarked in his room. This placed residents at risk for accidental ingestion of medication and related complications Findings included: - On 04/25/23 at 11:50 AM a medication cup with 15 unlabeled, various shapes and color pills were noted in the cup and left unattended in R12's room, on top of his dresser. R12 was not located			F 761			

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F 761	Continued From page 31 in his room, at that time. On 04/25/23 at 11:58 AM Certified Medication Aide (CMA) R verified the medication cup held 15 pills and was left unattended in R12's room. CMA R revealed the medications should not be left out unsupervised and that CMA R had walked away from R12 when R12 became upset and refused to take his medication. CMA R stated the medication was left to give R12 time to take the medications. CMA R further stated the medications should not have been left unattended and CMA R had actually forgotten CMA R had left them there. On 04/25/23 at 12:50 PM Administrative Nurse E confirmed medications were not to be left in a resident's room unattended. Administrative Nurse E revealed the staff were to witness residents taking medications. The facility's "Preventing Medication Errors" policy dated 01/01/20 documented staff were to observe resident consumption of medication. The facility failed to ensure medications were labeled and stored properly when staff left R12's cup of morning medications unsupervised and unmarked in his room. This placed residents at risk for accidental ingestion of medication and related complications.	F 761			
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that	F 804			

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F 804	Continued From page 32 conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: The facility identified a census of 90 residents. The sample included 17 residents. Based on observation, record review, and interviews, the facility failed to ensure safe and palatable food temperatures for Resident (R)9, R3, R16, R5, R6, and R15. This deficient practice placed the residents at risk for malnutrition and decreased psychosocial wellbeing. Findings included: - On 04/25/23 at 11:41 AM R9, who had a Brief Interview for Mental Status (BIMS) of 14 which indicated intact cognition, stated that meals were changed from the menu a lot and were always cold when the meal trays were brought to her room. R9 further stated that sometimes she was able to get a staff member to heat her meal tray up if a staff member responded to her call light during meals. On 04/26/23 at 08:27 AM Dietary CC stated that the trays were prepared and then the staff took them out to be served to the residents. Dietary CC stated he was not sure if they were left on the cart a long time or not, but the residents should get warm food. On 04/26/23 at 08:43 AM R3, who had a BIMS of 11 which indicated moderately intact cognition, stated that breakfast was awful. R3 further stated that he had to beg for a spoon just to eat the	F 804			

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F 804	Continued From page 33 warm cereal that was served to him. R3 stated the dining room service in the facility made him feel like less than a person because he had to ask for a spoon and then waited for staff to go and get him one, which took a while. On 04/26/23 at 08:50 AM R16, who had a BIMS of 15 which indicated intact cognition, stated that he was in the dining room since 07:30 AM. He said in that time, he received coffee, but no one brought him breakfast. R16 waved his hand towards to other side of the table where he sat and stated the residents seated across from him were eating for a while. R16 further stated that he ordered what he wanted for breakfast last night but still had to wait over an hour for his food, which still had not arrived. On 04/26/23 at 09:23 AM R5, who had a BIMS of 15, asked how he was expected to eat a rock-hard waffle. R5 took the waffle and banged it on his glass plate, and it was noted to clank loudly. R5 asked how he was supposed to cut the hard waffle when no resident had received a knife. On 04/26/23 at 09:24 AM R6, who had a BIMS of 15, stated he had waited for over ten minutes for a knife to cut his waffle. R6 further stated the waffles were too hard to eat. R6 was noted to tap the waffle on the table, to which a knocking sound was heard, and then asked R16 if R16 wanted to play catch with the waffle calling it a Frisbee. R6 made a throwing motion with his arm but did not release the waffle. R6 sat on one side of the dining room near the wall and R16 sat across the dining room near the opposite wall. On 04/26/23 at 09:36 AM R15, who had a BIMS	F 804			

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F 804	Continued From page 34 of 15, was assisted with cooked cereal. Certified Nurse Aide (CNA) M spooned the cooked cereal into R15s mouth with out checking to see if the temperature was appropriate. R15 got a full spoonful of the cooked cereal scooped into his mouth, and R15 immediately turned his head to the left, spit out the cereal and attempted to rub his tongue on his clothing protector. R15 stated the cereal was "really hot." CNA M asked R15 if it was too hot, to which R15 shook his head yes. CNA M stated "Oh," and proceeded to give R15 other food from his breakfast tray without offering a drink of fluid to aide in cooling R15's mouth. On 04/26/23 at 09:40 AM Administrative Nurse E stated that staff needed to check the temperature of the food before staff fed it to residents. The facility's "Dining Room Service" dated 2017 documented effective equipment would be provided and guidelines established to maintain food at appropriate and palatable temperatures during meal services. Food would be delivered promptly to assure quality. It further documented meals would be served promptly to maintain adequate temperature and appearance. The facility's "In-Room Dining (Room Service)" policy dated 2017 documented hot food must be hot and cold food must be cold (as acceptable to the individual being served). The facility failed to ensure safe and palatable food during meal services. This deficient practice placed the residents at risk for malnutrition and decreased psycho-social wellbeing.	F 804			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812			

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F 812	Continued From page 35 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 90 residents. The facility had one kitchen. Based on observation, interview, and record review the facility failed to store, prepare, and serve meals in a sanitary manner for all the residents at the facility that received food from the kitchen. This deficient practice placed the affected residents at risk for food borne illness. Findings included: - On 04/26/23 at 08:15 AM the dry food storage area in the kitchen had two mouse sticky traps underneath two different shelving units. There were dark brown rice shaped objects on the floor that appeared to be mouse droppings. The floor was also noted to have various debris spread out	F 812			

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F 812	Continued From page 36 through the entire dry food storage area. On 04/26/23 at 08:20 AM Dietary BB confirmed that the dark brown rice shaped objects on the floor were mouse droppings. On 04/26/23 at 08:27 AM Dietary CC stated that he would sweep out the dry food storage area when he had time. Dietary CC revealed it had been a long time since it had been swept out. On 04/26/23 at 11:55 AM Dietary DD checked the temperature of the uncovered chicken breasts on the hot table and the initial temperature was 132.0 degrees Fahrenheit (F) with one thermometer and 159.0 degrees F on a second thermometer. Dietary BB covered the chicken breasts with tin foil. Dietary DD proceeded to check the temperature of the mashed potatoes, which were 198.0 degrees F. Dietary DD moved to check the temperature of the mechanical chicken breasts which measured 150.4 degrees F. The buttered noodles were 180.0 degrees F. Dietary DD rechecked the chicken breasts that had been underneath the tin foil and they were now 160.2 degrees F. On 04/26/23 at 11:58 AM Dietary DD stated that the temperatures were not where they needed to be to be safe to serve. The facilities "Dining Room Service Policy" dated 2017 directed that effective equipment would be provided and guidelines established to maintain food at appropriate and palatable temperatures during meal service. The facility failed to store, prepare, and serve meals in a sanitary manner for the residents at	F 812			

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F 812	Continued From page 37	F 812			
F 880	the facility. This deficient practice placed the affected residents who receive meals from the kitchen at risk for food borne illness.				
SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880			
	§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be				

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F 880	Continued From page 38 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility reported a census of 90 residents. The sample included 17 residents. Based on observation, interviews, and record reviews, the facility failed to provide ensure appropriate infection control measures regarding care for an indwelling catheter (a flexible tube inserted	F 880			

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F 880	Continued From page 39 through a narrow opening into a body cavity, particularly the bladder, for removing fluid) for Resident (R)9 and failed to store oxygen tubing in a sanitary manner for R12. The facility failed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmissions of communicable diseases and infections. Findings included: - On 04/25/23 at 11:25 AM R7's room had dirty linens on the floor below the window. The linen had a tan stain on the sheet. There was a urine smell in the room and there was also a soiled chuck (cloth bed pad) on the floor under the window. Near the bathroom, a used pair of rubber gloves, pulled into each other was on the floor at the bathroom doorway as well as a pillowcase. The tube feeding pole (a pole used to hold tube feeding bags while being administered) next to the bed by the window was noted to have a dirty base, with what appeared to be dried tube feeding formula spilled on the feet of the pole. The low air loss mattress on the bed by the window was dirty and had particles on the mattress. - On 04/25/23 at 11:26 AM in R18's room there was a ripped incontinence brief laying in the middle of the floor. - On 04/25/23 at 11:27 AM R2's room had used gloves lying on the floor, and a kidney shaped brown stain by the wall behind the doorway approximately two inches in length at the longest part. There was also a raised brown stain, diamond shaped, by the foot of the resident's bed to the right side upon entering the room. There	F 880			

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F 880	Continued From page 40 was an untouched pureed breakfast tray on the bedside table. further observation revealed oxygen tubing attached to an oxygen concentrator; undated, uncovered, and draped across the concentrator. On 04/25/23 at 11:48 AM R15's room had mouse droppings on the floor by R15's dresser and his shoes laying underneath the window. Mouse droppings were observed by the room divider curtain. R15 stated he saw a mouse in his room recently but could not recall the date. There was also various debris noted on the floor. On 04/25/23 at 11:52 AM R11's room had approximately eight drops of dried blood from pea shaped size up to dime size on the side of the bed beside the window. The pillowcase that laid on the bed had various amounts of blood-stained drops that had dried on the same side as the sheet. There was a large amount of debris located on the floor. The closet on the window side of the room bulged out approximately one foot with a large curtain covering it; underneath the curtain there was a spider web and debris noted on the floor next to the boxes behind the curtain. On 04/25/23 at 11:41 AM R9's indwelling catheter tubing/bag touched the floor. There was debris on the floor by the dresser in the corner opposite the doorway. R9 reported that housekeeping hardly came to the room to clean the floor or pick up. R9 stated that she saw mice in her room. R9 further stated that her two daughters also saw mice in the room. R9 went on to say a therapist had even seen a mouse trapped in the heater in R9's room. R9 revealed that when the mouse was trapped in the heater, maintenance had to be called to get it	F 880			

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F 880	Continued From page 41 out of the heater. On 04/25/23 at 11:50 AM R12's room noted that there was trash on the floor, there was an oxygen tubing attached to the concentrator that lacked a date and was draped uncovered across R12's bed, and a nebulizer machine laying on the floor at the head of the bed by the window. The over the bedside table next to the bathroom was noted to have an untouched pureed lunch dated 04/24/23 (the day before). On 04/25/23 at 11:54 AM R14's room had eight mouse droppings between R14's fridge. Along the wall underneath R14's small table by the bed, there were two mouse droppings mixed in with R14's shoes. R13, who shared a room with R14, was noted to have a box with the top open sitting on the floor. Inside the box, there were four bags of crackers. Two of the bags had areas which appeared to be gnawed on; one bag had the top cracker nibbed on and the second bag had only three full crackers left though the bag had not been opened except the chewed area. A single serving container of peanut butter that had a foil seal had chewed areas into the foil and all the peanut butter had been cleaned out. The box also contained a box of rice cereal, unopened or gnawed on; a bag of plain potato chips, unopened or gnawed on; a zip lock bag of cheese puffs, unopened or gnawed on, and a gift bag that appeared untouched. The box had multiple mouse droppings in the bottom when the crackers were moved to the side. There were mouse droppings noted at the base of R13's furnace. Also at the base of the furnace were two empty sticky mouse traps. When asked, R13 revealed he had poor eyesight and would not have seen any mice even if they were running in	F 880			

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F 880	Continued From page 42 the room. R13 further revealed no staff member had informed him about a concern with mice or about the mouse activity in R13's snack box. R13 stated he did not know and asked if a staff member planned on cleaning the area. On 04/25/23 at 12:03 PM R1's room was noted to have 43 mouse droppings in the second drawer from the top of R1's dresser throughout his clothing. R1's bottom drawer of the dresser had numerous chocolate kisses in it with the silver foil shredded. R1 stated that approximately four days ago a mouse was on his bed. R1 stated that normally, if he could move, he would not have had a problem with a mouse on his bed, but since R1 is a quadriplegic (paralysis of the arms, legs and trunk of the body below the level of an associated injury to the spinal cord) and is unable to move, the mouse on his bed scared him. R1 revealed he called for staff. An unidentified staff member came and shook R1's bed to get the mouse off it. The side of the low air loss mattress on the side facing the window had a nutritional supplement drink spilled down the sides, the foot pedals to the medical pole was noted to have spilled, dried, tube feeding formula on the four legs of the pole. R1 revealed staff rarely came in to help clean his room or organize his closet. On 04/25/23 at 12:40 PM Administrative Staff A stated R13's room was not that messy. She said that the mess was on R13's bedside table and underneath the table near the open box. Administrative Staff A stated she would not feel comfortable living or sleeping in a room with mice. Administrative Staff A confirmed that the room tray in R13's room was dated 04/24/23 dinner and that the tray should have been removed by staff. Administrative Staff A further	F 880			

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F 880	Continued From page 43 stated the residents in the facility were not expected to remove the trays when a resident was done eating. On 04/25/23 at 12:45 PM Administrative Nurse E stated that the catheter bag/tubing should not be on the floor but attached to the bed rail below the mattress. On 04/25/23 at 12:43 PM Administrative Nurse E stated there appeared to be mouse droppings between R14's fridge and dresser. Administrative Nurse E looked at R13's side of the room and confirmed the cracker packages had been gnawed on, there were mouse dropping in the resident's box, and on the floor by the furnace. Administrative Nurse E revealed it would be uncomfortable and unsanitary to live with mice. Administrative Nurse E revealed that catheters should not be laid on the floor but be up on the railing of the bed. Administrative Nurse E confirmed that the tray in room 107 was from lunch on 04/24/23 and needed to be removed from the room promptly. On 04/25/23 at 02:08 PM Maintenance V stated he was called into R9's room related to a mouse being stuck in the furnace. Maintenance V stated the mouse tail was hung up in the furnace on something. Maintenance V revealed that the mouse was alive and appeared to be a tiny young mouse. Maintenance V further revealed it looked like a baby. Maintenance V stated that when he entered rooms to check on the sticky traps for mouse activity, resident rooms appeared to still be dirty, and the floors were sticky with debris on them. Maintenance V further stated now that it was getting warmer outside, the mice would hopefully stay outside and not be a problem any	F 880			

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F 880	Continued From page 44 longer. On 04/26/23 at 10:41 AM R1's room was noted to have numerous mouse droppings in the second drawer from the top of R1's dresser that was now located underneath R1's clothing. It appeared that the top layer of clothing in R1's dresser had been brushed off, but the droppings remained in the drawer. R1's bottom drawer of the dresser still contained numerous chocolate kisses in it with the silver foil shredded. R1 stated that he had asked that the candy be thrown away, but it had not yet been done. On 04/26/23 at 12:35 PM R11 stated that her bedding had not been changed in quite some time and she cleaned up the mouse droppings on her over the bedside table because staff had not entered her room to clean in a long time. R11 could not recall the last time her room was cleaned. On 04/26/23 at 02:25 PM Administrative Nurse E stated that oxygen tubing needed to be dated and was to be changed out weekly or when sooner if it was needed. The facility's "Catheter Care Policy" dated 10/01/19 documented to provide catheter care to all residents that had an indwelling catheter in an effort to reduce bladder and kidney infections. The facility's "Oxygen Administration" policy dated 01/01/20 documented that oxygen tubing and mask/cannula was changed weekly and as needed if it became soiled or contaminated. The policy lacked directions on dated tubing. The facility's "Infection Prevention and Control	F 880			

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F 880	Continued From page 45 Program" policy dated 11/01/19 documented the facility had established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The policy further documented soiled linens were collected at the bedside and placed in a linen bag. When the task was completed, the bag was closed securely and placed in the soiled utility room. The policy further documented that soiled linens would not be kept in a resident's room or bathroom. The facility failed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmissions of communicable diseases and infections when the facility staff failed to keep R9's catheter bag off of the floor, R11's oxygen tubing dated and nebulizer machine off of the floor, keep rodents out of resident rooms and the kitchen dry storage, clean resident rooms and the kitchen dry storage area regularly to keep the rodent feces and debris particles cleaned up, and failed to update the Infection Prevention and Control Policy annually.	F 880			
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 90 residents with 54 residents on the west side of the facility. The sample included 11 residents. Based on	F 925			

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F 925	Continued From page 46 observation, record review, and interview, the facility failed to have an effective pest control program and ensure residents dressers, floors, and items were cleaned during an ongoing pest treatment for rodents in the facility. Findings included: - Review of the "Pest Log Issues" noted there was a mouse caught in the kitchen on 01/23/23, mouse droppings noted in rooms 208 and 200 on 02/07/23, a mouse noted in the dry storage on 02/08/23, mouse droppings noted in room 107 on 02/24/23, a mouse noted in room 200 on 03/08/23, a mouse in the furnace in room 209 B on 03/09/23, a mouse in room 108 on 03/15/23, a mouse caught in the vent in room 106 on 03/30/23, and a mouse in room 302 A on 04/12/23. Review of the pest control invoice dated 03/28/23 documented house mice activity found. Review of recommendations noted that cracks or damage to walls allowing pest access, please repair to prevent pest entry. Review also noted in the kitchen there was an accumulation of food product from damaged goods noted, please remove food product to prevent attraction by pests. General comments noted spoke with staff before service and staff expressed seeing mice and mouse droppings in the kitchen. Inspected the kitchen and placed out interior rodent traps and found one dead mouse in the trap in the pantry. Moved a couple of mechanical rodent traps into different locations. Also placed out containerized glue boards, serviced the exterior rodent bait stations and replenished bait as needed.	F 925			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 925	Continued From page 47 Review of the pest control invoice dated 04/03/23 documented house mice activity found in laundry, droppings found in rooms upon request, and house mice activity found in another area of the facility. Review of the pest control invoice dated 04/18/23 documented house mice activity found in the kitchen, and rooms upon request. The kitchen was noted to have 75% to 100 % infestation. Two other areas in the facility noted to have 75% to 100% infestations. General comments noted spoke with staff before service and staff stated they were still seeing the occasional mouse. Set traps for mice in rooms 103 and 302. Inspected interior mechanical rodent traps and found two dead mice in traps in the kitchen. Serviced the rodent bait stations and replenished bait as needed. On 04/25/23 at 11:41 AM room 106, R9 stated that she had seen mice in her room. R9 further stated that her two daughters had seen mice in the room, one of R9's daughters boyfriend, and a therapist had even seen a mouse trapped in the furnace to her room. R9 revealed that when the mouse was trapped in the furnace maintenance had to be called to get it out of the furnace. On 04/25/23 at 11:48 AM room 100 was noted to have mouse droppings on the floor by R15's dresser and his shoes laying underneath the window. Mouse droppings noted by the room divider curtain. R15 stated he had seen a mouse in his room recently but could not recall the date. On 04/25/23 at 11:54 AM room 109 had eight mouse droppings between R14's fridge beside the door and a dresser. Along the wall			F 925			

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F 925	Continued From page 48 underneath R14's small table by the bed there were two mouse droppings mixed in with R14's shoes. R13, who shared a room with R14, was noted to have a box with the top open sitting on the floor. Inside the box there were 4 bags of crackers with two of the bags had gnawed on areas, with one bag with the top cracker nibbled on and the second bag noted to only have three full crackers left with only the chewed area noted to have opened the bag. A single serving container of peanut butter that had a foil seal was noted to have chewed areas into the foil and all the peanut butter had been cleaned out. The box also contained a box of rice Krispie's, unopened or gnawed on; a bag of plain lay chips, unopened or gnawed on; a zip lock bag of Cheeto puffs, unopened or gnawed on, and a gift bag that appeared untouched. The box was noted to have multiple mouse droppings in the bottom when the crackers were moved to the side. There were mouse droppings noted at the base of R13's furnace. Also at the base of the furnace were two empty sticky traps. When R13 was asked about mouse activity, R13 revealed he had poor eyesight and would not have seen them even if they were running in the room. R13 further revealed no staff member told him about a concern with mice and when asked about the mouse activity in R13's box, R13 stated he did not know and asked if a staff member planned on cleaning the area. On 04/25/23 at 12:03 PM R1's room was noted to have 43 mouse droppings in the second drawer from the top of R1's dresser through out his clothing. R1's bottom drawer of the dresser had numerous Hershey kisses in it with the silver foil shredded. R1 stated that approximately four days ago a mouse was on his bed. R1 stated that	F 925			

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F 925	Continued From page 49 normally if he could move, he would not have had a problem with a mouse on his bed, but since R1 is a quadriplegic (paralysis of the arms, legs and trunk of the body below the level of an associated injury to the spinal cord) and is unable to move, the mouse on his bed scared him the "hell out" of R1. R1 revealed he called for staff. An unidentified staff member came and shook R1's bed to get the mouse off of it. On 04/25/23 at 12:40 PM Administrative Staff A stated when reviewing R13's room, it appeared not that messy, that the mess was on R13's over the bed side table and underneath the table near the open box. Administrative Staff A stated she would not feel comfortable living or sleeping in a room with mice. On 04/25/23 at 12:43 PM Administrative Nurse E stated there appeared to be mouse droppings between R14's fridge and dresser. Administrative Nurse E looked at R13's side of the room and confirmed the cracker packages had been gnawed on, there were mouse dropping in the resident's box, and on the floor by the furnace. Administrative Nurse E revealed it would be uncomfortable to live with mice. On 04/25/23 at 02:08 PM Maintenance V stated he was called into R9's room related to a mouse being stuck in the furnace. Maintenance V stated the mouse tail was hung up in the furnace on something. Maintenance V revealed that the mouse was alive and appeared to be a young tiny mouse. Maintenance V further revealed it looked like a baby. Maintenance V stated that when he entered rooms to check on the sticky traps for mouse activity, resident rooms appeared to still be dirty, and the floors were sticky with debris on	F 925			

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F 925	Continued From page 50 them. Maintenance V further stated now that it was getting warmer outside, the mice would hopefully stay outside and not be a problem any longer. The facility's "Safe and Homelike Environment" dated 10/25/19 documented sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. It further documented housekeeping and maintenance services would be provided as necessary to maintain a sanitary, orderly, and comfortable environment. The facility's "Pest Control Program" dated 10/25/19 documented the facility would maintain an effective pest control program that eradicates and contains common household pests and rodents. It further documented the facility would utilize a variety of methods in controlling certain seasonal pests. The facility failed to ensure an effective pest control program and provide the residents a safe and homelike environment when the facility failed to ensure that pests were cleaned up and areas were sanitized in the resident areas. It further failed to ensure that the area surrounding where residents received their dry food was cleaned up and sanitized when mouse droppings were discovered in the dry food storage area.			F 925			