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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey with the following complaints #KS00180080, #KS00179456. This 2567 was electronically sent to the facility on 05/24/23.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 561		

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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This REQUIREMENT is not met as evidenced by:
The facility reported a census of 56 residents with 14 sampled which included two residents reviewed for choices. Based on observation, interview, and record review, the facility failed to provide choices for Resident (R)39 related to her preferences for waking up in the morning.

Findings included:

- Review of Resident (R)39's "Physician Orders," dated 04/25/23, the resident had diagnoses that included hemiplegia (paralysis of one side of the body), and hemiparesis (muscular weakness of one half of the body) following a cerebral infarction (CVA/stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain affecting left non-dominant side, difficulty walking, muscle weakness, and need for assistance with personal care).

The "Admission Minimum Data Set," (MDS), dated 05/04/23, documentation revealed the "Brief Interview for Mental Status," (BIMS) score of 15, indicating intact cognition. She did not exhibit behaviors or rejection of care. The resident reported it was somewhat important to choose her own bedtime.

The "ADL (activities of daily living) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 05/16/23, documentation did not address the resident's choice related to preferences related to her wake time.

The resident's "Care Plan," dated 04/22/23,

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lacked documentation of the resident's choice of preferred time to wake up in the morning.

On 05/15/23 at 04:14 PM, the resident reported the staff made her get up in the morning before she wanted to. She reported staff would enter her room and awaken her prior to 07:00 AM, which was her preferred time to get up.

On 05/17/23 at 09:33 AM, the resident sat in her self-propelling about the room. She reported she was awakened before 07:00 AM again. She stated she could not sleep in until 07:00 AM, because that was when staff served breakfast and it takes her a while to get up and get dressed. She explained she required two staff to assist her with dressing and applying her brace in the morning.

On 05/18/23 at 08:37 AM, Administrative Nurse B stated the resident's preferences should be obtained on admission and included on the care plan to direct the staff in providing care in keeping with the resident's preferences/choices. Administrative Nurse B stated she was aware of the resident's preference to get up in the morning 07:00 AM, or after. Additionally, she stated staff failed to complete the documentation of the resident's preferences. Furthermore, she verified the "Care Plan" lacked care directives to the staff related to the resident's choice/preference for time of waking in the morning.

The undated policy titled "Resident Rights," documentation included the right to self-determination.

The facility failed to provide choices for the resident related to her preferences for waking up

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F 561	Continued From page 3 in the morning.	F 561		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623		

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(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy

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for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 56 residents with 14 sampled that included three for hospitalization. Based on observation, record review, and interview the facility failed to notify/ send a copy of the notice of facility-initiated hospitalization transfer/discharge to a representative of the Office of the State Long-Term Care Ombudsman of the reason for the transfers for Resident (R) 13, R14, and R47's required hospitalizations.

- Review of R13's "Minimum Data Set" (MDS) tracking form documented the resident discharged to the hospital on 09/04/22 and returned to the facility on 09/12/22. Furthermore, the resident discharged to the hospital again on 04/30/23 and returned to the facility on 05/04/23.

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Review of R13's "Medical Record" lacked evidence of a written notification of the facility-initiated hospitalizations transfer/discharges to the Office of the State Long-Term Care Ombudsman.

On 05/17/23 at 09:55 AM, Social Service staff D confirmed she did not send a notice to the Office of the State Long Term Care Ombudsman when this resident discharged to the hospital and had thought the Ombudsman's email had documented that she did not need the information.

Review of an email dated 02/20/23 from the Office of the State Long-Term Care Ombudsman, documented that staff should send notification of hospitalizations to the state office.

The facility lacked a policy for Ombudsman notification.

The facility failed to notify/ send a copy of the notice of facility-initiated hospitalization transfer/discharge to a representative of the Office of the State Long-Term Care Ombudsman of the reason for the transfer for R13's required hospitalizations.

- Review of R14's "Minimum Data Set" (MDS) tracking form documented the resident discharged to the hospital on 12/25/22 and returned to the facility on 01/03/23. Furthermore, the resident discharged to the hospital again on 02/26/23 and returned to the facility on 03/02/23.

Review of R14's "Medical Record" lacked evidence of a written notification of the facility-initiated hospitalizations

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transfer/discharges to the Office of the State Long-Term Care Ombudsman.

On 05/17/23 at 09:55 AM, Social Service staff D confirmed she did not send a notice to the Office of the State Long Term Care Ombudsman when this resident discharged to the hospital and had thought the Ombudsman's email had documented that she did not need the information.

Review of an email dated 02/20/23 from the Office of the State Long-Term Care Ombudsman, documented that staff should send notification of hospitalizations to the state office.

The facility lacked a policy related to Ombudsman notification.

The facility failed to notify/ send a copy of the notice of facility-initiated hospitalization transfer/discharge to a representative of the Office of the State Long-Term Care Ombudsman of the reason for the transfer for R14's required hospitalizations.

- Review of the "Electronic Medical Records" revealed on 05/07/23, R47 transferred to the hospital for severe back pain for a diagnosis of osteomyelitis (local or general infection of the bone).

Interview with Social Service D on 05/17/23 revealed the facility did not send the notification of hospitalization to the state long-term care Ombudsman. The facility only gave notification for the residents that discharged from the facility monthly.

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F 623	Continued From page 8 The facility was unable to provide a policy regarding "Ombudsman Notification". The facility failed to notify the long-term care Ombudsman of this resident's transfer to the hospital.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625		

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This REQUIREMENT is not met as evidenced by:
The facility reported a census of 56 residents with 14 residents included in the sample. Based on interview and record review, the facility failed to provide a written notice specifying the duration and cost of the bed hold policy at the time of the residents' transfers to the hospital. This included Resident (R) 14, R 13, R 47, R 164.

Findings included:

- Review of R47's "Electronic Medical Record" dated 04/24/23, revealed the facility lacked a signed bed hold with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's transfer to the hospital on 05/04/23.

On 05/17/23 at 09:55 AM, Social Service staff D stated the charge nurse would send a copy of the bed-hold policy with the resident upon the discharge to the hospital.

Interview with Administrative Nurse B on 05/17/23 at 10:01 AM revealed it was the expectation of the nursing staff that with each hospitalization the bed hold policy should be sent with the resident and scanned into the resident's chart.

On 05/17/23 at 10:25 AM, Licensed Nurse (LN) E stated she did not send a bed-hold policy with the residents when they discharged to the hospital.

The "Bed Hold Policy and Agreement" dated February 2014, indicated the purpose of the policy was to establish policy and procedures for the facility to notify the resident/responsible part of the bed hold policy and agreement the bed

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hold agreement is to be obtained for each occurrence-hospital or therapeutic home leave.

The facility failed to provide this resident and/or their representative, with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's transfer to the hospital.

- Review of R 164's "Minimum Data Set" (MDS) tracking form documented the resident discharged to the hospital on 04/18/23.

Review of the resident's record lacked evidence of the bed-hold policy given to the resident/resident representative at the time of the facility-initiated transfer to the hospital.

On 05/17/23 at 09:55 AM, Social Service staff D stated the charge nurse would send a copy of the bed-hold policy with the resident upon the discharge to the hospital.

Interview with Administrative Nurse B on 05/17/23 at 10:01 AM revealed it was the expectation of the nursing staff that with each hospitalization the bed hold policy should be sent with the resident and scanned into the resident's chart.

On 05/17/23 at 10:25 AM, Licensed Nurse (LN) E stated she did not send a bed-hold policy with the residents when they discharged to the hospital.

The "Bed Hold Policy and Agreement" dated February 2014, indicated the purpose of the policy was to establish policy and procedures for the facility to notify the resident/responsible part of the bed hold policy and agreement the bed

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hold agreement is to be obtained for each occurrence-hospital or therapeutic home leave.

The facility failed to provide this resident and/or their representative, with a written notice specifying the duration and cost of the bed hold policy, at the time of the resident's transfer to the hospital.

- Review of R13's "Minimum Data Set" (MDS) tracking form documented the resident discharged to the hospital on 09/04/22 and returned to the facility on 09/12/22. Furthermore, the resident discharged to the hospital again on 04/30/23 and returned to the facility on 05/04/23.

Review of R13's "Medical Record" lacked evidence of the bed-hold policy given to R13 or her representative at the time of the facility-initiated transfers to the hospital.

On 05/17/23 at 04:39 PM, R13 sat in her bed in her room, with all needed items within reach.

On 05/17/23 at 09:55 AM, Social Service staff D stated the charge nurse would send a copy of the bed-hold policy with the resident upon the discharge to the hospital.

On 05/17/23 at 10:25 AM, Licensed Nurse (LN) E stated she did not send a bed-hold policy with the residents when they discharged to the hospital.

On 05/17/23 at 11:50 AM, Administrative Nurse B stated staff should send the bed-hold policy with a resident when transferred to the hospital.

The facility's "Bed Hold Policy and Agreement

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Form" revised February 2014 documented that the bed hold agreement is to be obtained for each occurrence-hospital or therapeutic home leave.

The facility failed to provide the resident and/or the resident representative with a written notice specifying the duration and cost of the bed hold, at the time of the resident's transfer to the hospital.

- Review of R14's "Minimum Data Set" (MDS) tracking form documented the resident discharged to the hospital on 12/25/22 and returned to the facility on 01/03/23. Furthermore, the resident discharged to the hospital again on 02/26/23 and returned to the facility on 03/02/23.

Review of R14's "Medical Record" lacked evidence of the bed-hold policy given to R14 or her representative at the time of the facility-initiated transfers to the hospital.

On 05/17/23 at 09:55 AM, Social Service staff D stated the charge nurse should send a copy of the bed-hold policy with the resident upon the discharge to the hospital.

On 05/17/23 at 10:25 AM, Licensed Nurse (LN) E verified she did not send a bed-hold policy with the residents when they discharged to the hospital.

On 05/17/23 at 11:50 AM, Administrative Nurse B stated the bed-hold policy should be sent with a resident when they transferred to the hospital.

The facility's "Bed Hold Policy and Agreement Form" revised February 2014 documented that

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F 625	Continued From page 13 the bed hold agreement was to be obtained for each occurrence-hospital or therapeutic home leave. The facility failed to provide this resident and/or the resident representative with a written notice specifying the duration and cost of the bed hold, at the time of the resident's transfer to the hospital.	F 625		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: The facility reported a census of 56 residents, with 14 sampled including two residents sampled for Preadmission Screening and Resident Review (PASARR). Based on interview and record review the facility failed to coordinate an assessment	F 644		

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with the PASARR program for a level II screening as recommended for Resident (R) 22.

Findings Included:

- The "Electronic Health Record" (EHR) for R22 revealed the following diagnoses included anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and schizoaffective disorder (mental health disorder characterized by a combination of symptoms of schizophrenia).

The 11/13/19 "Preadmission Screening and Resident Review" (PASARR) Determination Letter indicated a need for further evaluation and would be referred for a Level II screening.

The 05/09/23 "Care Plan" lacked documentation of PASARR Level II requirements.

The 05/17/23 EHR for R22 lacked documentation of a PASARR Level II assessment.

On 05/17/23 at 10:25 AM, Licensed Nurse E stated R22 could make her needs known and was able to do most things for herself. She confirmed she had nothing to do with obtaining the PASARR.

On 05/17/23 at 03:30 PM, Administrative Nurse B revealed she did not know that the Level II PASARR assessment was needed or had not been obtained for R22. Administrative Nurse B confirmed she expected her staff to follow the recommendations of obtaining the assessments.

On 05/18/23, Administrative Staff A stated they had no policy in regard to the PASARR, however

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F 644	Continued From page 15 staff should follow the state guidelines. The facility failed to obtain the recommendations from the PASARR level I evaluation report by not obtaining a PASARR level II assessment, to ensure optimal mental health services provided.	F 644		
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 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	F 656		

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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 reported a census of 56 residents, with 14 residents sampled for review. Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for Resident (R) 13 and R15 which included oxygen use and care.

Findings included:

- R13's pertinent diagnoses from the "Electronic Health Record" (EHR) included anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), asthma (disorder of narrowed airways that caused wheezing and shortness of breath), and dementia (progressive mental disorder characterized by failing memory, confusion).

The 05/12/22 "Admission Minimum Data Set" (MDS) documented R13 had a Brief Interview for Mental Status (BIMS) score of 14, indicating

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intact cognition. The assessment documented no oxygen use.

The 02/10/23 "Quarterly MDS" documented a BIMS of 15, indicating intact cognition and documented R13 had not used oxygen.

The 05/15/23 "Care Plan" lacked documentation of nebulizer medication or oxygen use or the care of the equipment.

The "Physicians Orders" documented an order on 05/04/23 for R13 for the use of oxygen at one to two liters per minute (LPM) to keep R13's oxygen saturation (measure of how much oxygen the blood carried as a percentage of the maximum it could carry) above 90 percent (%) and ipratropium-albuterol (medication used to control the symptoms of lung diseases such as asthma) 0.5/2.5 (3) milligrams per milliliter (mg/ml) by nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) inhaled every eight hours as needed for shortness of air. The "Physicians Orders" documented an order on 05/12/23 for R13 for ipratropium-albuterol 0.5/2.5 (3) mg/3 ml four times a day by nebulizer for wheezes.

Observation on 05/17/23 at 04:39 PM, R13 sat in her bed in her room, with the nebulizer mask sitting on her "craft rack" with no barrier noted under it.

On 05/17/23 at 10:25 AM, Licensed Nurse (LN) E revealed R13 used the nebulizer four times a day, that she washed it out before and after the use of it. She stated she thought maybe there should be a barrier under it and that there should probably have a plastic bag to store it in.

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On 07/17/23 at 11:50 AM Administrative Nurse B stated the care plans would be updated with each change in the resident care. Administrative Nurse B confirmed the care plan had not been updated and that she would expect them to be updated at least weekly.

The facilities 01/2017 "Care Planning-Interdisciplinary Team" policy directed staff to use the assessments to develop a comprehensive plan of care for each resident that would assist the resident in achieving and maintaining the highest practical level of mental functioning, physical functioning, and wellbeing as possible.

The facility failed to develop an individualized comprehensive plan of care for this resident that required a nebulizer.

- R15's pertinent diagnoses from the "Electronic Health Record" (EHR) included major depressive disorder (major mood disorder) and hypertension (elevated blood pressure).

The 08/04/22 "Admission Minimum Data Set" (MDS) documented R15 had a Brief Interview for Mental Status (BIMS) score of eight, indicating moderately impaired cognition. The assessment documented no oxygen use.

The 02/28/23 "Quarterly MDS" documented a BIMS of 15, indicating intact cognition and documented R15 had used oxygen.

The 05/09/23 Care Plan lacked documentation or staff guidance related to use of nebulizer medication, oxygen use, or the care of the

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equipment.

The Physicians Orders documented an order on 01/26/23 for R15 for ipratropium-albuterol (medication used to control the symptoms of lung diseases such as asthma) 0.5/2.5 (3) milligrams per milliliter (mg/ml), four times a day, by nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) for chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) exacerbation for seven days and every four hours as needed for shortness of air. The Physicians Orders documented an order on 05/11/23 for R15 for budesonide (medication used to treat swelling in the lungs) 0.25 mg/2 ml by nebulizer inhaled two times a day for shortness of air and ipratropium-albuterol 0.5/2.5 (3) mg/ml by nebulizer inhaled every six hours as needed for shortness of air.

Observation on 05/16/23 at 10:07 AM, revealed R15 sat in her recliner in her room, with the nebulizer mask sitting on her bedside table with no barrier under it.

On 05/17/23 at 10:25 AM, Licensed Nurse (LN) E revealed R15 just started using the nebulizer four times a day, that she washed it out before and after the use of it.

On 05/17/23 at 11:50 AM, Administrative Nurse B stated care plans should be updated with each change in the resident care. Administrative Nurse B confirmed the care plan had not been updated and that she would expect them to be updated at least weekly.

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F 656	Continued From page 20 The facilities policy dated 01/2017 for "Care Planning- Interdisciplinary Team" directed staff to use the assessments to develop a comprehensive plan of care for each resident that would assist the resident in achieving and maintaining the highest practical level of mental functioning, physical functioning, and wellbeing as possible. The facility failed to develop an individualized comprehensive plan of care for this resident that required a nebulizer.	F 656		
F 692 SS=D	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	F 692		

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by:
The facility reported a census of 56 residents with 14 residents sampled which included two residents reviewed for nutrition. Based on observation, interview, and record review the facility failed to accurately obtain weight and verify weights as needed to monitor and address Resident (R)23's nutritional status/weight loss.

Findings included:

- Review of Resident (R)23's Physician Orders, (POS) dated 03/21/23, documentation included diagnoses of major depression disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), dementia (progressive mental disorder characterized by failing memory, confusion), with behavioral disturbances, acquired absence of limb, hypertension (high blood pressure), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), encephalopathy (condition of the brain), cerebral infarct (stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), acute kidney failure, mild cognitive impairment, and hyperkalemia (elevate potassium in the blood).

Review of the "Admission Minimum Data Set," (MDS), dated 03/10/23, documentation revealed a "Brief Interview for Mental Status," (BIMS)score of five, indicating severe cognitive impairment. He exhibited continuous behaviors which included inattention and disorganized thinking. He ate independently. He had no limitation in functional range of motion of his upper extremities. His

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height was 70 inches, and his weight (wt.) was 140 pounds (lbs.). The resident had no known significant weight loss or gain.

The "Nutritional Status CAA," did not trigger. The "ADL/Functional Rehabilitation Potential Care Area Assessment" (CAA) dated 03/18/23, documented the resident required extensive assistance of two staff with use of a mechanical lift for transfers due to amputation to both lower extremities.

The "Care Plan," (CP), dated 03/21/23, directed staff the resident had nutritional problem or potential for nutritional problem. Additional intervention dated 05/10/23, directed staff to assist the resident with developing a support system to aid in weight loss efforts to include friends, family, other residents, and volunteers. The resident's identified favorite foods included chicken strips, fries, or cheeseburger.

Review of the electronic medical record (EMR) "Weight/ VS (vital signs)," documentation revealed significant weight changes ranging from three to 39 lbs. as noted below:

1. On 02/25/2023, revealed the resident weighed 141.2 lbs.

2. On 03/03/2023, revealed the resident weighed 141.2 lbs.

3. On 03/10/2023, revealed the resident weighed 140.0 lbs.

4. On 03/15/2023, revealed the resident weighed 136.0 lbs.

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5. On 03/17/2023, revealed the resident weighed 177.4 lbs.

6. On 03/24/2023, revealed the resident weighed 177.0 lbs.

7. On 04/04/2023, revealed the resident weighed 175.6 lbs.

8. On 04/11/2023, revealed the resident weighed 136.6 lbs.

9. No further weights documented in the resident's EMR as of 5/16/23.

The "Nutritional/Dietary Note," dated 04/10/23, in the electronic medical record, documentation included the questionable weights as noted above and identified the resident triggered for a significant weight increase of 34.4 lbs. resulting in a 24.4% weight increase of 175.6 lbs. on 04/04/23. Additionally, documentation noted it was not clear which weights were correct and requested clarification of weekly weights for monitoring the resident's nutritional status.

The "Dietary Note," dated 04/11/2023, documentation included the resident's weight was 175.6 lbs. due to not subtracting the weight of the w/c. The resident was reweighed, and the wheelchair weight was subtracted, that resulted in the resident's weight of 136.6 lbs.

On 05/17/23 at 12:39 PM, Certified Nurse Aide (CNA) L, weighed the resident in his wheelchair. The weight while in the wheelchair was 175 lbs. She reported the wheelchair weighed 46.8 lbs and the resident's weight after subtracting the weight of the wheelchair was 128.2 lbs which

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F 692	Continued From page 24 reflected a further weight loss 6.15% in 36 days, in which no weights had been documented. Additionally, the resident wt. loss totaled 9.2% lbs. in three months. On 05/18/23 at 11:29 AM, Administrative Nurse B, verified the above findings. She stated the facility staff should identify and address weight loss when it occurs. In situations where the weight is questionable, the staff should reweigh the resident and report the findings. The staff should perform an accurate assessment of the resident to determine actual concerns. She stated the facility did not have a policy regarding obtaining weights. Additionally, she reported the facility did not have a skills checklist to ensure the staff were knowledgeable in obtaining correct weights. The facility policy "Weight Assessment and Intervention," dated 01/2017, documentation included, weight will be recorded in the individual's medical record. The threshold for significant unplanned and undesired weight loss will be based on the following criteria 5% weight loss in one month, 7.5% weight loss in three months, and 10% weight loss in six months. The facility failed to accurately obtain this resident's weight and verify weights as needed to monitor and address his weight loss.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the	F 698		

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comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
The facility reported a census 56 residents with 14 residents sampled which included one resident reviewed for dialysis (a process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, interview, and record review, the facility failed to ensure that Resident (R) 55, who required dialysis, receive services, consistent with professional standards of practice, to monitor for the effectiveness and adverse reactions related to dialysis.

Findings included:

- Review of Resident (R)55's "Physician Orders," (POS) dated 02/24/23, documented diagnoses which included malignant neoplasm (terminal cancer), end stage renal disease, muscle weakness, reduced mobility, and presence of urogenital implant (suprapubic catheter-a surgically place tube through the abdominal wall which drains the bladder.

The "Admission Minimum Data Set," (MDS), dated 12/05/22, documentation included the resident's "Brief Interview for Mental Status," (BIMS) score of seven, which indicated severe cognitive impairment. He required limited assistance of staff with his activities of daily living and was independent with eating. He had an indwelling catheter. He received dialysis.

The "ADL (activity of daily living) Functional/Rehabilitation Potential Care Area

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Assessment," (CAA), dated 12/28/22, documented the resident needed assistance of staff with some of his ADL's.

The "Care Plan," dated 03/08/23, directed staff to obtain vital signs and weight before and after dialysis per protocol and report significant changes.

The physician's orders, dated 02/24/23, lacked an order for dialysis.

Review of the resident's weights in the "Wt.'s/Vitals" section of the electronic medical record (EMR)s dated 04/14/23 through 05/17/23, revealed the resident lacked weights pre and post dialysis on 04/21/23, 04/26/23, 04/28/23, 05/08/23, 05/10/23, 05/15/23, a total of 6 occasions. The weight recorded during that same time frame revealed weight fluctuation not consistent with dialysis treatment. As exhibited by an overall weight range of 135.4 pounds (lbs.) to 146 lbs. Additionally, the post dialysis weight was noted to exceed the pre dialysis weight on 04/17/23, 05/01/23, and 05/03/23, exhibited by the following weights, which reflect two to ten lbs. weight gain after dialysis as follows:

1. Pre dialysis weight on 04/17/2023 at 09:32AM, the resident weighed 136.8 lbs.
Post dialysis weight on 4/17/2023 at 4:41PM, the resident weighed 146.2 lbs., a total of 9.4 lbs. weight gain.

2. Pre dialysis weight on 05/01/2023 at 10:36AM, the resident weighed 141.4 lbs.
Post dialysis weight on 05/01/2023at 04:23 PM. the resident weighed 143.6 lbs., a total of 2.2 lbs. weight gain.

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3. Pre dialysis weight on 05/03/2023 at 08:24 AM, the resident weighed 138.6 Lbs.
Post dialysis weight on 05/03/2023 at 04:57 PM, the resident weighed 144.8 Lbs., a total of 6.2 lbs. weight gain.

On 05/15/2023 at 10:12 AM the resident's pre dialysis weight was 138.7 Lbs.

On 05/17/23 at 10:14 AM, Licensed Nurse (LN) E, reported the resident was going to dialysis and he received dialysis three times a week. She stated she completed a pre and post dialysis assessment which included the resident's weight. LN E assisted the resident from his bed to his wheelchair. She positioned the resident's full urine collection bag on the wheelchair and proceeded to take him to the weight scale. She rolled the resident in the wheelchair onto the scale ramp and reported the resident's weight as 184 lbs. She stated the resident's wheelchair weighed 45 lbs., she stated his actual weight would be 184 lbs. minus the 45 lb. for the weight of the wheelchair, that resulted in a weight of 140 lbs. Upon inquiry, she reported the urine collection bag contained 1000 milliliters (mls) of urine and the collection bag should have been emptied prior to weighing the resident in order to get an accurate weight. LN E agreed the weight of 140 lbs. was not an accurate weight and did not reflect the resident's status. Upon review of the resident's POS., she agreed the resident lacked an order for dialysis.

On 05/17/23 at 01:54PM, Administrative Nurse B stated the staff should empty the resident's urine collection bag prior to weighing him in order to ensure an accurate assessment reflective of the

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F 698	Continued From page 28 resident's status and effectiveness of his dialysis treatment. She stated the resident should have an order for dialysis which should include the scheduled times, days of the week, and location with contact information. Upon review of the resident's POS, Administrative Nurse B agreed the resident lacked an order for dialysis. Additionally, she stated the facility lacked a policy for obtaining pre and post weights for dialysis residents. Furthermore, the facility lacked skills check list for staff to obtain weight. The undated facility policy titled "Weight Assessment and Intervention," lacked address of procedure to weigh residents pre and post dialysis or with a urine collection bag. The facility failed to ensure that the resident received services, consistent with professional standards of practice, to monitor for the effectiveness and adverse reactions related to dialysis.	F 698		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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.	F 812		

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(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 reported a census of 56 residents. The facility had one main kitchen. The kitchen served food to one main dining area. Based on observation, interview, and record review, the facility failed to properly store food in the main kitchen refrigerators due to foods left uncovered, boxes placed directly on the floor in the kitchen area, and staff failed to discard expired foods in accordance with professional standards for food service safety, to prevent food borne illness to the residents.

Findings included:

- During the brief initial tour of the kitchen, on 05/15/23 at 07:46 AM, observation revealed the following concerns:

1. The walk-in refrigerator had one large bowl of undated green jello with fruit in it, with the plastic wrap falling into the jello.

2. The kitchen dry storage area had one 500-piece box of foam cups, one box of lids for the cups, one large bag of potatoes, and five boxes of oil stored directly on the floor. Also, one undated 10-pound (lbs.) bag of dry spaghetti noodles stored on the shelf. Furthermore, 24 four ounce containers of prune juice with a use by date of 05/09/23.

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F 812	Continued From page 30 3. The refrigerator had an undated case of mighty shakes, that are to be stored frozen and used quickly once thawed. Furthermore, four two lbs. containers of yogurt with a use by date of 05/07/23. 4. The kitchen had five mixing bowls, 12 baking sheets, and three baking pans stacked upright on a lower shelf. On 05/16/23 at 08:22 AM, Dietary staff C confirmed staff should not store boxes directly on the floor, and that she was waiting for maintenance to obtain her something to sit them on. Dietary staff C confirmed staff should discard expired foods. The facility's policy undated "Food Storage (Dry Refrigerated, and Frozen)" documented all food items would be stored on shelves. All packaged food items would be properly labeled, dated, and sealed. Refrigerated items should follow a rotation procedure to ensure oldest would be used first. The facility failed to properly store food in the main kitchen refrigerators due to the boxes being directly on the floor and the open food items, also the expired food items for food service to the residents of this facility, This placed the 56 residents, who resided at the facility, at risk for receiving foodborne illness.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		

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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 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

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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 56 residents. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program related to Resident (R) 26's urinary catheter, and R13 and R15, related to nubulizer storage.

Findings included:

- Review of Resident (R) 26 "Physician Orders" dated 03/09/23 revealed diagnosis that included neurogenic bladder (dysfunction of urinary bladder caused by a lesion of the nervous system) requiring indwelling catheter (a tube placed in the bladder to drain urine into a

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collection bag).

The annual "Minimal Data Set" (MDS) dated 12/08/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 02, indicating severely impaired cognition. The "Activities of Daily Living" documented the resident required two-person physical assist with toileting and required an indwelling catheter.

Review of the "Care Plan" dated 12/20/22, guided staff to position the catheter bag and tubing below the bladder and away from the entrance room door.

Observation on 05/15/23 at 09:27 AM, revealed the urinary catheter bag hung off the recliner and lacked a dignity bag over the collection bag. The drainage emptying spout was not secured in the holder. Observation revealed a strong urine odor.

Observation on 05/17/23 at 04:35 PM, revealed Licensed Nurse (LN) F in the resident's room to flush the urinary catheter as ordered. When staff removed the covers, observation revealed the urinary catheter bag laid directly on the floor, without a barrier or cover.

On 05/18/23 at 09:50 AM, LN F, reported staff were to make sure the catheter bag does not touch the floor. Staff should clean the port (emptying spout) after emptying the collection bag and ensure the spout is returned to the holder. Staff should store the urinary collection bags in a privacy bag.

On 05/18/23 at 10:27 AM, Administrative Staff B reported staff were to keep the indwelling catheter bag off the floor and always placed in a

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privacy bag.

The undated facility policy "Catheter Care Urinary" revealed the purpose was to prevent catheter-associated urinary tract infection and be sure the catheter tubing and drainage bag were kept off the floor.

The facility failed to ensure this resident with an indwelling urinary catheter received appropriate treatment and services to prevent urinary tract infections to the extent possible, when staff failed to keep the collection bag off the floor and keep the urinary spout closed.

- Observations daily from 05/16/23 through 05/18/23 revealed R13's nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) mask laid directly on her "craft cart" with no barrier under it and no bag to store it in.

Observation on 05/17/23 at 04:39 PM, R13 sat in her bed in her room, with the nebulizer mask sitting on her "craft rack" with no barrier noted under it.

On 05/17/23 at 11:18 AM Certified Medication Aid (CMA) N confirmed she did nothing with the nebulizer masks or medications.

On 05/17/23 at 10:25 AM Licensed Nurse (LN) E stated she washed the mask before and after she used it. LN E stated she thought maybe there should be a barrier used for the mask and that maybe a plastic bag should be used for the storage of the tubing and the mask.

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On 05/17/23 at 11:50 AM Administrative Nurse B confirmed staff should store the nebulizer in a plastic bag and a barrier should be used when drying. Administrative Nurse B confirmed the nebulizer mask should not be stored on top of R13's "craft cart".

The facilities 01/2017 "Oxygen Administration" policy directed staff to obtain a physician's order for administration of oxygen, listed the steps to apply oxygen, and what should be documented. The policy lacked documentation on storage of, or care for oxygen equipment.

The facility failed to provide a safe, sanitary, and comfortable environment to help prevent the development or
transmission of communicable diseases and infections by not storing R13's nebulizer mask in a clean sanitary way.

- Observations daily from 05/16/23 through 05/18/23 revealed R15's nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) mask laid directly on her bedside table with no barrier under it and no bag to store it in.

Observation of 05/17/23 at 10:25 AM Licensed Nurse (LN) E provided a nebulizer treatment for R15. LN E used appropriate hand hygiene, disposal, and technique while administering the treatment. LN E washed out the nebulizer mask, dried it with a paper towel, and placed the mask directly on the bedside table.

On 05/17/23 at 11:18 AM Certified Medication Aid (CMA) N confirmed she did nothing with the

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F 880	Continued From page 36 nebulizer masks or medications. On 05/17/23 at 10:25 AM Licensed Nurse (LN) E stated she washed the mask before and after she used it. LN E stated she thought maybe there should be a barrier used for the mask and that maybe a plastic bag should be used for the storage of the tubing and the mask. LN E confirmed she should not dry the mask with a paper towel. On 05/17/23 at 11:50 AM Administrative Nurse B confirmed staff should store the nebulizer in a plastic bag and a barrier should be used when drying, not to dry, as particles could get into the lungs. Administrative Nurse B confirmed the nebulizer mask should not be stored on top of R15's bedside table. The facilities 01/2017 "Oxygen Administration" policy directed staff to obtain a physician's order for administration of oxygen, listed the steps to apply oxygen, and what should be documented. The policy lacked documentation on storage of, or care for oxygen equipment. The facility failed to provide a safe, sanitary, and comfortable environment to help prevent the development or transmission of communicable diseases and infections by not storing R15's nebulizer mask in a clean sanitary way.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-	F 883		

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F 883	Continued From page 37 (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		

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documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 56 residents with 14 residents sampled which included five residents selected for review of influenza, pneumococcal, and COVID vaccines. Based on interview and record review, the facility failed to ensure the resident/resident representative received information/education regarding the benefits, risks, or medical contraindications of influenza, pneumococcal, and/or COVID vaccines for Resident (R)39.

Findings included:

- Review of Resident (R)39's immunizations records provided by Administrative Nurse B revealed the records lacked documentation of vaccine information/education for influenza, pneumococcal, and COVID vaccines provided to the resident and/or their representatives to demonstrate the benefits verses risks of receiving the vaccines. The facility lacked documentation the resident had been offered or provided an opportunity to receive the vaccine.

- On 05/18/23 3:34 PM, Administrative Nurse B, confirmed the records noted above were all inclusive. She stated the provided documentation

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F 883	Continued From page 39 was all she was able to provide. The facility policy "Infection Prevention and Control Manual, Resident Immunization and Vaccinations," dated 09/2022, documentation included documentation in the resident's medical record and on the immunization record should education was provided. The facility failed to ensure this resident/resident representative received information/education regarding the benefits, risks, or medical contraindications of influenza, pneumococcal, and/or COVID vaccines for the resident.	F 883		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: The facility reported a census of 56 residents. Based on observation, interview, and record review, the facility failed to provide housekeeping and maintenance services to ensure a safe and sanitary environment for the residents and staff related to items/areas in the facility laundry. Findings included: - The laundry tour on 05/18/23 at 09:22 AM, with Housekeeping/Maintenance Staff V and W identified the following areas of concern: 1. A one foot section of cove base dislodged along an interior wall in the soiled linen area with	F 921		

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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 921	Continued From page 40	F 921		

dirt and debris present.

2. An approximate five-foot section of cove base missing on the back wall of the soiled laundry area.

3. A door with a metal plate protruding from the wooden door at the entrance of the washer room.

4. A washing machine with a white lime deposit build-up that covered the exterior of the machine.

5. A missing panel on the wall behind the washing machine.

6. The platform for the washing machine was made of unsealed concrete, which was not sanitizable.

7. The hopper with brown stain and build-up around the parameter of the bowl and hoses laying inside in water.

8. Peeling floor tile at the corner of the washing machine.

9. Overhead ceiling tile metal strips with rust throughout.

10. Air condition ductwork with rust throughout.

11. A heavy build-up of a yellow green substance on the wall by the fire extinguisher.

12. The folding area had missing laminate which exposed approximately 12 foot of particle board.

13. A folding counter with several missing drawers and peeling laminate on the remaining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175218	A. BUILDING _____ B. WING _____	05/18/2023

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F 921	Continued From page 41 drawers and doors. 14. Uncovered clean resident clothing hanging on a rack in the hallway adjacent to the laundry. 15. A linen cart used for clean linen with chipped and missing paint on the bottom shelf. On 05/18/23 at 09:22 AM, Housekeeping/Laundry Staff V confirmed the above findings and agreed the laundry needed housekeeping/maintenance services. On 05/18/23 at 12:24 PM, Administrative Staff A, verified the above findings indicated the laundry in need of maintenance and repair. The facility lacked a policy for the maintenance and housekeeping of the facility laundry. The facility failed to provide housekeeping and maintenance services to ensure a safe and sanitary environment for the residents and staff in the facility laundry areas.	F 921		
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training.	F 947		

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F 947	Continued From page 42 §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: The facility reported a census of 56 residents. Based on interview and record review, the facility failed to develop, implement and permanently maintain an in-service training program for nurses aides that is appropriate and effective as to ensure the continuing competence of nurse aides with no less than 12 hours per year. Five of five nurse aides also lacked dementia management training, resident abuse prevention training Findings included: - The following hour totaled for the last 12 months indicated the following concerns: 1. Certified Nurse's aide (CNA) I had a total of in-service hours of one and a half total hours. The training record lacked dementia or abuse training. 2. CNA J had a total of in-service hours of three hours The training record lacked dementia or abuse training. 3. CNA K had a total of in-service hours equaled nine hours and fifty minutes of training. The training record lacked dementia and abuse training.	F 947		

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F 947	Continued From page 43 4. CNA L had a total of in-service hours equaled three hours. The training record lacked dementia and abuse training. 5. CNA M lacked indication of any training for the last 12 months. Interview with Administrative Staff B on 05/18/23 at 09:58 AM, revealed the expectation is for staff to complete the in-service training each month by the 20th and I am responsible to make sure the training is competed . The facility failed to provide a policy regarding certified nurse aide in-service. The facility failed to provide 12 hours of in-service training for the last 12 months for five CNA's sampled to include dementia and abuse prevention training.	F 947		