

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

PRINTED: 05/29/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2023
NAME OF PROVIDER OR SUPPLIER MEDICALDORGES POST ACUTE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6500 GREELEY AVENUE KANSAS CITY, KS 66104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations are a result of an extended and health recertification survey. On 05/01/23 at 12:04 PM Administrative Staff A received a copy of the "IJ Checklist" and was informed of the immediate jeopardy for Resident (R) 38. On 05/01/23 at 07:55 AM Certified Nurse Aide (CNA) M brought R38 to the common area in a Broda (special wheelchair with tilt abilities) chair. CNA M then forcefully grabbed R38 by R38's right wrist/forearm multiple times while attempting to adjust R38's shirt and hair, despite the fact the resident raised her right arm in objection to the provision of cares. CNA M held R38's right arm tightly against R38's body and restricted R38's movement while R38 struggled against CNA M's grip. R38, who already had an older-appearing dime sized dark brown bruise on her inner right wrist, did not appear to have any physical injuries immediately after the interaction but became physically agitated with increased combativeness towards staff afterwards. The facility failure to prevent the incident of physical abuse placed R38 in immediate jeopardy. The facility implemented the following corrective actions to address the immediacy related to the abuse: 1. CNA M was suspended immediately and escorted out of the building. 2. R38 was assessed for injury immediately. 3. The facility provided staff education on prevention of abuse, neglect and exploitation. 4. R38's responsible party and physician were notified. 5. Law enforcement was notified.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

05/19/2023

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 000	Continued From page 1 6. Other Residents were interviewed to assess for others affected by abuse. The above corrections removing immediacy were verified on 05/02/23. The deficient practice remained at a scope and severity of a "G" to represent actual harm determined by the visual agitation of the resident after the event as well as using the "reasonable person" concept based on the fact R38 was unable to verbalize or express the psychosocial impact of the abuse. On 05/02/23 at 05:13 PM Administrative Staff A received a copy of the "IJ Checklist" and was informed of the immediate jeopardy for all residents in the facility. The facility identified 22 COVID-19 (an acute respiratory illness capable of producing severe symptoms and in some cases death) positive residents on 05/02/23. Based on observations, record review, and interviews, the facility failed to ensure staff exercised appropriate infection control techniques to prevent the transmission of COVID-19 within the facility. The facility failed to disinfect shared equipment used on COVID-19 positive negative residents. The facility failed to accurately identify COVID-19 positive resident rooms, inform staff of COVID-19 positive test results, and implement the required isolation, with the appropriate signage and personal protective equipment (PPE- gloves, gowns, face shields and/or eyeglasses/goggles) designation for those positive residents. The facility further failed to ensure positive COVID-19 residents did not share a room with residents who tested negative. The facility failed to ensure staff used the appropriate PPE required when caring for COVID-19 positive residents; failed to use standards of practice	F 000			

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F 000	Continued From page 2 related to the use of PPE including appropriate use of source control, respirators, gowns; and proper removal and disposal of soiled PPE when exiting the infectious room/area. The facility failed to post the appropriate signage announcing the COVID-19 outbreak status and ensuring all who entered the facility received education and information related to COVID-19 and related risks. The cumulation of these failures placed all residents in the facility in immediate jeopardy. The facility completed the following corrective actions to remove the immediacy: 1.Resident care equipment was disinfected immediately. 2.COVID-19 signage was posted at both entrance doors to the facility at 05:35 PM on 05/02/23. 3.Centers for Disease Control (CDC) "Actions to Protect Yourself and Others" was posted at all entrances to the facility at 06:00 PM on 05/02/23. 4.The facility cohorted residents who were positive for COVID-19 in the same room and away from COVID-19 negative residents on 05/02/23. 5.PPE was made available outside each COVID-19 positive room and each COVID-19 positive room received a droplet precaution posting on the door on 05/02/23. 6. Staff were educated on equipment disinfection between use on residents, donning and doffing of PPE when entering and exiting an isolation room and the appropriate PPE required for droplet precautions, and hand hygiene practices on 05/02/23 at 11:59 pm. The above corrective actions removing the immediacy were verified on 05/03/23 though the deficient practice remained at a scope and severity of "F."	F 000			

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F 000	Continued From page 3 The 2567 was sent electronically on 05/18/23. A revised 2567 was sent electronically on 05/30/23	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. This REQUIREMENT is not met as evidenced by:	F 561			

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F 561	Continued From page 4 The facility identified a census of 45 residents. The sample included 13 residents. Based on observation, record review, and interviews, the facility failed to assess and document resident-centered dietary and mealtime preferences for Resident (R) 18. This deficient practice had the risk for weight loss, and declines in psychosocial well-being and independence for R18. Findings included: - R18's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of major depressive disorder (major mood disorder), need for assistance with personal care, open wound to right foot, pressure ulcer of left heel, pressure ulcer of sacral region (large triangular bone between the two hip bones), stage four (full thickness tissue loss with exposed bone, tendon or muscle. Dead tissue may be present on some parts of the wound bed. Often includes undermining and tunneling), malnutrition, and quadriplegia (paralysis of the arms, legs and trunk of the body below the level of an associated injury to the spinal cord). The "Significant Change Minimum Data Set" (MDS) dated 01/02/23, documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R18 was dependent on two staff member assistance for activities of daily living (ADLs). The MDS documented R18 as at risk for development of pressure related injuries, R18 had one or more unhealed pressure ulcers, and R18 was totally dependent on one staff member for bathing during the look back period .	F 561			

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F 561	Continued From page 5 The "Quarterly MDS" dated 03/31/23 documented a BIMS score of 15, which indicated intact cognition. The MDS documented R18 was dependent on two staff member assistance for ADLs. The MDS documented R18 was at risk for development pressure related injuries and had one or more unhealed pressure ulcers. The MDS further documented R18 required extensive assistance of one staff member for personal hygiene and noted bathing did not occur during the look back period. The "ADL Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 01/02/23, documented R18 was triggered for ADL function related to staff support for cares and needs. The CAA further documented R18 as dependent on staff for transfers, bathing, dressing, and daily care needs related to quadriplegia. The CAA directed staff to continue to provide cares so that no needs went unmet. The "Nutritional Status CAA" dated 01/02/23, documented R18 was at risk for weight loss and pressure ulcers. The "Care Plan" dated 09/28/20, documented R15 had a desired weight of 165 to 175 pounds. The "Care Plan" updated 09/29/20, directed staff to honor R18's food preferences when available. The "Care Plan" updated 09/17/21, directed staff to honor R18's goal weight. The "Care Plan" documented R18 chooses not to consume meals that are served to him, he was not a breakfast eater, and he was inconsistent with taking meals and or substitutes. The "Care Plan" did not address what R18's food preferences or preferred mealtimes were.	F 561			

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F 561	Continued From page 6 R18's EMR lacked evidence that his preferences for mealtimes and food choices had been addressed. On 05/03/23 at 08:37 AM R18 was sleeping in his bed. On 05/03/23 at 11:49 AM R18 was observed to be in his room. He stated that he did not like the food he was being served by the facility and he was not eating very much as a result. He stated that most of the food was too salty and he did not typically eat his meals during the normal time they were served. R18 stated that none of the staff had discussed options for preferences for food or alternate mealtimes with him. He further stated he was being served the same foods every day. On 05/03/23 at approximately 10:00 AM, Dietary Staff BB stated she was training to become the certified dietary manager (CDM) and she oversaw the kitchen. She stated she was responsible for handling food preferences for the residents. On 05/04/23 at 03:31 PM Certified Nurse Aide (CNA) N stated she was unsure if R18 expressed his preferences for mealtimes or alternate foods but did state that she knew he would eat his lunch for dinner and he would eat his dinner for a midnight snack. On 05/04/23 at 04:25 PM Administrative Nurse D stated Dietary Staff BB and the CNAs reported a resident's preferences for food and mealtimes. She stated that preferences were documented on the resident's meal tickets or in the care plan. The facility did not provide a policy on resident-centered dietary and mealtime	F 561			

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F 561	Continued From page 7 preferences. The facility failed to assess and document resident-centered dietary and mealtime preferences for R18. This deficient practice had the risk for weight loss, and a decline in psychosocial well-being and independence for R18.	F 561			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 582			

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F 582	Continued From page 8 notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents. Based on interview and record review the facility failed to issue the Notification of Medicare Non-Coverage (NOMNC- the form used to notify Medicare A participants of their rights to appeal and the last covered date of service) form 10123, which contained the required information for Resident (R) 45. This failure placed the resident at risk for decreased autonomy and impaired right to appeal. Findings included:	F 582			

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F 582	Continued From page 9 - Review of R45's Electronic Medical Record (EMR) documented the resident had a Medicare Part A episode, which ended on 04/14/23. R45 did not remain in the facility and the facility did not issue a NOMNC 10123 to R45. On 05/04/23 at 03:15 PM Social Services X stated she was responsible for providing the NOMNC forms to the residents that discharged from Medicare Part A services. Social Services X stated she kept copies of the documents that were provided to the residents. The facility did not provide a policy on beneficiary notification. The facility failed to issue the NOMNC form 10123, which contained the required information for R45. This failure placed the resident at risk for decreased autonomy and impaired right to appeal.	F 582			
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600			

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F 600	Continued From page 10 involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents. Based on observation, record review, and interviews, the facility failed to ensure cognitively impaired, dependent Resident (R) 38 remained free from abuse when the facility failed to prevent an episode of staff to resident physical abuse. On 05/01/23 at 07:55 AM Certified Nurse Aide (CNA) M brought R38 to the common area in a Broda (special wheelchair with tilt abilities) chair. CNA M then forcefully grabbed R38 by R38's right wrist/forearm multiple times while attempting to adjust R38's shirt and hair, despite the fact the resident raised her right arm in objection to the provision of cares. CNA M held R38's right arm tightly against R38's body and restricted R38's movement while R38 struggled against CNA M's grip. R38, who already had an older-appearing dime sized dark brown bruise on her inner right wrist, did not appear to have any physical injuries immediately after the interaction but became physically agitated with increased combativeness towards staff afterwards. The facility failure to prevent the incident of physical abuse placed R38 in immediate jeopardy. Findings Included: - The "Medical Diagnosis" section within R38's Electronic Medical Records (EMR) included diagnoses of intracerebral hemorrhage (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), hemiplegia (paralysis of one side of the body), aphasia (condition with disordered or absent language	F 600			

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F 600	Continued From page 11 function), fracture of left humerus (broken bone of the left upper arm), need for assistance with personal cares, and dysphagia (swallowing difficulty). A review of R38's "Admission Minimum Data Set (MDS)" completed 12/15/22 indicated a Brief Interview for Mental Status (BIMS) was not completed. The MDS noted she had hearing and visual impairments with no speech. The MDS noted she usually would make herself understood if prompted or given time and would sometimes understand others. The MDS noted she required total assistance from one to two staff for transfers, locomotion, toileting, dressing, personal hygiene, and bathing. The MDS indicated no noted behaviors. A review of R38's "Quarterly MDS" completed 03/09/23 indicated a BIMS assessment could not be completed. The MDS indicated R38 had no behaviors. The MDS noted she required total assistance from one to two staff for transfers, locomotion, toileting, dressing, personal hygiene, and bathing. The MDS indicated she had function limitations of range of motion (ROM) to both upper and lower extremities and required extensive physical assistance from one staff for bed mobility. The MDS noted she had hearing and visual impairments with no speech. The MDS noted she usually would make herself understood if prompted or given time and would sometimes understand others. A review of R38's "Communication Care Area Assessment" completed 12/20/22 indicated she had communication deficit related to her hearing impairment, aphasia, difficulty understanding and communicating her needs. The CAA noted staff	F 600			

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F 600	Continued From page 12 should learn and be aware of R38's gestures and personal sign language to assist her. The CAA noted a BIMS assessment was not completed due to hearing and language barriers. R38's "Activities of Daily Living (ADLs) CAA" completed 12/20/22 indicated she required total staff assistance for all daily care needs. The CAA indicated she was at risk for skin breakdown related to her bowel and bladder incontinence, communication deficit, limited ROM, and medical diagnoses. A review of R38's "Care Plan" initiated 12/07/22 indicated she had a deficit in cognitive function characterized by deficits with memory, judgment, decision making, and thought processes related to cognitive changes. The plan noted she had aphasia and staff should encourage her to communicate her needs in a slow/calm manner. The plan indicated staff should explain to her before beginning care or tasks (12/07/22). The plan indicated R38 had hearing impaired and used gestures and personal sign language to make staff aware of her needs (12/20/22). The plan instructed staff to reach out to her family to learn about her specific gestures and sign language. The care plan lacked documentation related to refusal of cares provided and aggressive behaviors. The plan indicated she had limitation to her left side and staff should place all items on her right side (12/12/22). A review of R38's "Care Plan" indicated staff identified a yellowish bruise of unknown origin on her left upper arm on 03/26/23. The plan noted an x-ray was completed of her arm and revealed to be a humeral fracture. The plan noted the facility continued pain management, shoulder	F 600			

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F 600	Continued From page 13 immobilization, and scheduled orthopedic appointments. On 05/01/23 at 07:50AM observation revealed Certified Nurse Aided (CNA) M transported R38 from the 300 Hall to the dining area in her Broda chair. R38's left arm was immobilized, and she only had range of motion in her right arm. R38 was agitated during transport and began grabbing at CNA M with her right arm. R38 was positioned in front of the television. CNA M attempted to adjust R38's shirt with R38 still agitated. R38 pushed CNA M's hands away as CNA M attempted to adjust R38's shirt around her stomach. CNA M forcefully grabbed R38's right arm and continued to adjust her shirt. CNA M stepped back and directly behind the chair. R38 calmed down. CNA M brushed her hand through R38's hair. CNA M patted down R38's hair with her hands and R38 swung her right arm upward in protest. CNA M grabbed R38's right upper arm and forearm manipulating it against R38's body. CNA M did not communicate with R38 during this interaction. R38 remained agitated and was moved to the dining area for breakfast. R38 grabbed a fork and made stabbing motions with the fork as staff walked past her in the dining area. An inspection of R38's right arm revealed two older dime-sized brown bruised areas under her upper arm and lower forearm. These bruises were not documented in R38's EMR. In an interview of 05/01/23 at 08:35AM, CNA M reported she was trying to pull R38's shirt down as R38 was being combative towards staff. CNA M reported she had received some information related to R38's care needs but nothing about preventing behaviors or caring for her. CNA M stated that it was her first day working with R38	F 600			

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F 600	Continued From page 14 and she was just assisting another staff with moving R38 to the television area. She reported she was agency staff and had no previous training on abuse. She stated all staff had access to the Kardex (condensed document containing care planned information) and can ask the nurses if any question arise. On 05/01/23 at 08:45 AM, Licensed Nurse (LN) H reported most of the staff in the facility were agency with one to two days experience with the residents. She stated if a resident was agitated, or aggressive, staff should give that resident time and space to calm down and reapproach at another time. She stated R38 can be aggressive, but staff should not have grabbed the resident physically. She stated she felt staff had to "wing it" because staff received little direction from the facility's management. On 05/01/23 at 09:00 AM, Administrative Staff A stated CNA M would be removed from the facility immediately and the situation would be investigated. She stated all agency staff received training that include abuse, neglect, and exploitation. She reported the facility was in crisis staffing due to having a COVID-19 (highly contagious, potentially life-threatening viral infection) outbreak. She stated she was, at that time, unable to leave the 200 Hall (designated Covid area). A review of the facility's "Abuse, Neglect, and Exploitation" revised 10/2022 indicated all residents have the right to be free from verbal, sexual physical, and mental abuse. The policy indicated all employees will be trained during orientation and at least annually in the prevention of abuse. The policy indicated the facility will	F 600			

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F 600	Continued From page 15 identify and intervene potential abuse situations. The policy indicated the facility will ensure staff are knowledgeable of each individual's care needs. The facility failed to ensure cognitively impaired, dependent R38 remained free from abuse when the facility failed to prevent an episode of staff to resident physical abuse. The abuse and mistreatment of R38, who was totally dependent upon staff and nonverbal, placed R38 in immediate jeopardy. The facility implemented the following corrective actions to address the immediacy related to the abuse: 1. CNA M was suspended immediately and escorted out of the building. 2. R38 was assessed for injury immediately. 3. The facility provided staff education on prevention of abuse, neglect and exploitation. 4. R38's responsible party and physician were notified. 5. Law enforcement was notified. 6. Other Residents were interviewed to assess for others affected by abuse. The above corrections removing immediacy were verified on 05/02/23. The deficient practice remained at a scope and severity of a "G" to represent actual harm determined by the visual agitation of the resident after the event as well as using the "reasonable person" concept based on the fact R38 was unable to verbalize or express the psychosocial impact of the abuse.	F 600			
F 655 SS=D	Baseline Care Plan	F 655			

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F 655	Continued From page 16 CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and	F 655			

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F 655	Continued From page 17 dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with six residents reviewed for activities of daily living (ADL) cares. Based on observation, record review, and interviews, the facility failed to complete a baseline care plan for R103, which placed him at risk of impaired care related to unidentified or uncommunicated care needs. Findings included: - R103's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of failure to thrive and major depressive disorder (major mood disorder). The "Admission Minimum Data Set" (MDS) dated 02/10/23 documented a Brief Interview of Mental Status (BIMS) score of 99, with a staff interview which revealed R103 had modified independence with cognitive skills, with some difficulty in new situations. The MDS documented R103 was independent with set up assistance for ADLs. The MDS documented bathing activity did not occur for R103 during the look back period. R103's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 02/15/23 documented he required supervision to limited assistance from staff depending on ADL.	F 655			

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F 655	Continued From page 18 R103's "Baseline Care Plan" lacked documentation of ADL care. Review of the EMR under "Reports: Documentation Survey Report" under daily charting look back report for R103 reviewed from 02/02/23 to 03/10/23 (37 days) and from 04/26/23 to 05/02/23 (7 days) revealed no documentation of bathing. The clinical record lacked documentation that R103 refused a shower/bath. On 05/03/23 at 02:34 PM, R103 stood at the nurse's station, and stated he had scheduled a shower for today. An unidentified staff was overheard telling R103 today was not his shower/bath day. R103 stated he had not had a bath for two weeks. R103 had a foul body odor and food in his beard. Another unidentified staff member approached R103 and offered a shower. On 05/04/23 at 12:34 PM, R103 walked with a front wheeled walker into the 100 hallways, with no shoes, only socks. R103 stated he felt better after his shower yesterday; there was no evidence of body odor. On 05/04/23 at 03:32 PM, Certified Nurse Aide (CNA) N stated at the time of admission a resident was offered the morning or evening for their bath. CNA N stated staff checked the Kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change) daily for the residents due for a bath/shower that day. On 05/04/23 at 04:09 PM, Agency Licensed Nurse (LN) G stated a baseline care plan was	F 655			

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F 655	Continued From page 19 completed at the time of admission. LN G stated everyone had access to the care plan or Kardex for to review for the care of each resident. On 05/04/23 at 04:26 PM, Administrative Nurse D stated at the time of admission each resident was asked their preference of days or evenings and frequency of bath/shower. Administrative Nurse D stated the dayshift nurse or her would update the Kardex with the residents' preferences. Administrative Nurse D stated everyone had access to the care plan and Kardex to know how to care for each resident. The facility was unable to provide a policy related baseline care planning and stated the facility followed the "Resident Assessment Instrument" (RAI) manual. The facility failed to formulate and develop a baseline care plan for R103, which placed him at risk of impaired cares related to unidentified or uncommunicated care needs.	F 655			
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the	F 660			

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F 660	Continued From page 20 development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident	F 660			

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F 660	Continued From page 21 representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with one resident reviewed for discharge. Based on record review and interviews, the facility failed to ensure active discharge planning occurred for Resident (R) 51. This deficient practice had the risk for miscommunication of discharge goals and missed services for R51. Findings included: - R51 admitted to facility on 12/02/22 and discharged on 03/11/23. The "Diagnoses" tab of R43's Electronic Medical Record (EMR) documented diagnoses of			F 660			

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F 660	Continued From page 22 pulmonary cryptococcosis (fungal lung infection), malnutrition, hereditary ataxia (impaired ability to coordinate movement). The "Admission Minimum Data Set" (MDS) dated 12/12/22, documented R51 had a Brief Interview for Mental Status (BIMS) score of 14, which indicates R51 was cognitively intact. The MDS further documented R51 required limited assistance with activities of daily living (ADLs), he was expected to remain in the facility, and no active discharge planning had occurred. The "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 12/15/23, documented R51 triggered for risk due to need for assistance with ADLs. The "Care Plan," dated 12/07/22, documented R51 did not have plans to discharge from the facility. The "Care Plan" directed the treatment team to review and update R51's discharge status as indicated/requested in the future. It directed social services to continue to assist R51 as appropriate with any discharge plans in the future, to review quarterly if R51's wishes to discharge changed and to offer support and assistance as needed. A "Nurse's Note," dated 03/11/23, revealed R51 left the facility with his family. The "Nurse's Note" documented R51 left without any medical, medication, or treatment orders. It further revealed that R51 reported his family was unable to come get him on Monday as was planned. R51's EMR lacked evidence of active discharge planning prior to his discharge on 03/11/23.	F 660			

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F 660	Continued From page 23 On 05/04/23 at 03:15 PM Social Services X stated she assisted with discharge preparation and helped to ensure discharged residents were set up for any services or appointments that they had once they left the facility. Social Services X stated R51 did not have a completed discharge summary, which included a recapitulation of stay. On 05/04/23 at 04:25 PM Administrative Nurse D stated discharge planning was a team effort that included social services, medical records staff, and the director of nursing. The facility did not provide a policy related to discharges. The facility failed to ensure active discharge planning occurred for R51. This deficient practice had the risk for miscommunication of discharge goals and missed services for R51.	F 660			
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.	F 661			

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F 661	Continued From page 24 (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents, with one resident reviewed for discharge. Based on record review and interviews, the facility failed to complete a discharge summary including a recapitulation of stay for Resident (R) 51. This deficient practice placed the resident risk for miscommunication of services received during a stay in the facility and of post discharge care needs. Findings included: - R51 admitted to facility on 12/02/22 and discharged on 03/11/23. The "Diagnoses" tab of R43's Electronic Medical Record (EMR) documented diagnoses of pulmonary cryptococcosis (fungal lung infection), malnutrition, hereditary ataxia (impaired ability to coordinate movement). The "Admission Minimum Data Set" (MDS) dated	F 661			

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F 661	Continued From page 25 12/12/22, documented R51 had a Brief Interview for Mental Status (BIMS) score of 14, which indicates R51 was cognitively intact. The MDS further documented R51 required limited assistance with activities of daily living (ADLs), he was expected to remain in the facility, and no active discharge planning had occurred. The "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 12/15/23, documented R51 triggered for risk due to need for assistance with ADLs. The "Care Plan," dated 12/07/22, documented R51 did not have plans to discharge from the facility. The "Care Plan" directed the treatment team to review and update R51's discharge status as indicated/requested in the future. It directed social services to continue to assist R51 as appropriate with any discharge plans in the future, to review quarterly if R51's wishes to discharge changed and to offer support and assistance as needed. A "Nurse's Note," dated 03/11/23, revealed R51 left the facility with his family. The "Nurse's Note" documented R51 left without any medical, medication, or treatment orders. It further revealed that R51 reported his family was unable to come get him on Monday as was planned. R51's EMR lacked evidence of a discharge summary including a recapitulation of stay. The facility failed to provide a discharge summary including a recapitulation of stay upon request. On 05/04/23 at 03:15 PM Social Services X stated she assisted with discharge preparation	F 661			

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F 661	Continued From page 26 and helped to ensure discharged residents were set up for any services or appointments that they had once they left the facility. Social Services X stated R51 did not have a completed discharge summary, which included a recapitulation of stay. On 05/04/23 at 04:25 PM Administrative Nurse D stated discharge planning was a team effort that included social services, medical records staff, and the director of nursing. The facility did not provide a policy related to discharges. The facility failed to complete a discharge summary including a recapitulation of stay for R51. This deficient practice had the risk for miscommunication of services received during stay in facility and of post discharge care needs.	F 661			
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...	F 676			

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F 676	Continued From page 27 §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: The facility reported a census of 45 residents. The sample included 13 residents with four reviewed for maintaining activities of daily living (ADLs). Based on record review, interviews, and observations, the facility failed to ensure staff effectively communicated with R38 during ADL care. This deficient practice placed R38 at risk for a decline in her ADLs and decreased psycho-social wellbeing. Findings Included: -The "Medical Diagnosis" section within R38's Electronic Medical Records (EMR) included diagnoses of intracerebral hemorrhage (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or	F 676			

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F 676	Continued From page 28 rupture of an artery to the brain), hemiplegia (paralysis of one side of the body), aphasia (condition with disordered or absent language function), fracture of left humerus (broken bone of the left upper arm), need for assistance with personal hygiene, and dysphagia (swallowing difficulty). A review of R38's "Quarterly Minimum Data Set (MDS)" completed 03/09/23 indicated a Brief Interview for Mental Status (BIMS) assessment could not be completed. The MDS indicated R38 had no behaviors. The MDS noted she required total assistance from one to two staff for transfers, locomotion, toileting, dressing, personal hygiene, and bathing. The MDS indicated she had function limitations of range of motion (ROM) to both upper and lower extremities and required extensive physical assistance from one staff for bed mobility. The MDS noted she had hearing and visual impairments with no speech. The MDS noted she usually made herself understood if prompted or given time and would sometimes understand others. A review of R38's "Communication Care Area Assessment" completed 12/20/22 indicated she had communication deficit related to her hearing impairment, aphasia, difficulty understanding and communicating her needs. The CAA noted staff should learn and be aware of R38's gestures and personal sign language to assist her. The CAA noted a BIMS assessment was not completed due to hearing and language barriers. R38's "Activities of Daily Living (ADLs) CAA" completed 12/20/22 indicated she required total staff assistance for all daily care needs. The CAA indicated she was at risk for skin breakdown	F 676			

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F 676	Continued From page 29 related to her bowel and bladder incontinence, communication deficit, limited ROM, and medical diagnoses. A review of R38's "Care Plan" initiated 12/07/22 indicated she had a deficit in cognitive function characterized by deficits with memory, judgment, decision making, and thought processes related to cognitive changes. The plan noted she had aphasia and staff should encourage her to communicate her needs in a slow/calm manner. The plan indicated staff should explain to her before beginning care or tasks (12/07/22). The plan indicated R38 had hearing impaired and used gestures as personal sign language to make staff aware of her needs (12/20/22). The plan instructed staff to reach out to her family to learn about her specific gestures and sign language. The care plan lacked documentation related to refusal of cares provided and aggressive behaviors. The plan indicated she had limitation to her left side and staff should place all items on her right side (12/12/22). A "Nurse's Note" on 01/03/23 indicated R38 refused her medications and attempted to hit her nurse. The note indicated R38 hit the medications out of the nurse's hands. The note indicated R38's representative had to be contacted to talk with the resident due to the language/communication barrier. A "Nurse's Note" on 02/07/23 indicated R38 attempted to hit and scratched staff during personal cares. The note indicated R38 grabbed items and threw them at staff. The note indicated staff were unable to redirect her due to language/communication barriers.	F 676			

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F 676	Continued From page 30 On 05/01/23 at 07:50 AM Certified Nurse Aided (CNA) M transported R38 to the dining room's television area. CNA M attempted to adjust R38's shirt by standing off to her right side and slightly behind her. CNA M did not explain to R38 her intentions or use hand gesture as indicated by R38's care plan. R38 became agitated and physically aggressive. CNA M continued to pull at R38's shirt and grabbed her arms without talking to her or explaining what she was doing. CNA M backed up directly behind R38 and matted R38's hair down. R38 threw her right arm up in protest and CNA M continued grabbing R38's right arm from behind her. (See Citation F600) In an interview of 05/01/23 at 08:35 AM, CNA M reported she was trying to pull R38's shirt down as she was being combative towards staff. CNA M reported she had received some information related to R38's care needs but not about preventing behaviors or caring for her. CNA M stated it was her first day working with R38 and she was just assisting another staff with moving her to the television area. She reported she was agency staff and had no previous training on abuse. She stated all staff have access to the Kardex (condensed document containing care planned information) and can ask the nurses if any question arise. On 05/04/23 at 04:01 PM Administrative Nurse D stated all direct care had access to the care plan and are expected to review the Kardex (condensed report pulled from care plan information) for the residents cared for. She reported staff should calmly approach R38 and explain to her what they are doing before touching her or moving her. She stated staff should use simple hand gestures to communicate	F 676			

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F 676	Continued From page 31 with her as well. She stated staff should never move a resident or perform cares before explaining to them what was going on. On 05/09/2023 at 10:30AM Consultant HH stated R38 was difficult to prevent weight loss due to the language barrier and not knowing what foods she really preferred. She stated R38 was placed on puree diet due to issues swallowing but seemed to respond better to non-pureed foods brought in by her daughter. She stated due to R38 using her own variation of sign language staff may not be able to effectively know her needs and could cause behavioral episodes and refusal of meals. She stated the language barrier made it difficult to know how to address R38's weight loss. (See Citation F692) A review of the facility's "Resident's Rights" policy indicated all residents will be treated with respect and dignity. The policy indicated the facility will accommodate each resident's choices, preferences, cultural, and dignity. The policy indicated staff will address each resident by their preferred names and ensure the plan of care is followed related to the resident's needs. The facility failed to ensure staff effectively communicated with R38 during ADL care. This deficient practice placed R38 at risk for a decline in her ADL and decreased psychosocial wellbeing.	F 676			
F 677 SS=E	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	F 677			

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F 677	Continued From page 32 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with six residents reviewed for activities of daily living (ADL) cares. Based on observation, record review, and interviews, the facility failed to ensure bathing was provided for four residents who required assistance from staff to complete the care. This deficient practice placed resident (R)103, R29, R4 and R18 at risk for potential skin breakdown and/or skin complications from not maintaining good personal hygiene and bathing practices. Findings included: - R103's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of failure to thrive and major depressive disorder (major mood disorder). The "Admission Minimum Data Set" (MDS) dated 02/10/23 documented a Brief Interview of Mental Status (BIMS) score of 99, with a staff interview which revealed R103 had modified independence with cognitive skills, with some difficulty in new situations. The MDS documented R103 was independent with set up assistance for ADL. The MDS documented bathing activity did not occur for R103 during the look back period. R103's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 02/15/23 documented he required supervision to limited assistance from staff depending on ADL. R103's "Baseline Care Plan" lacked	F 677			

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F 677	Continued From page 33 documentation of ADL care. Review of the EMR under "Reports: Documentation Survey Report" (POC) under daily charting look back report for R103 reviewed from 02/02/23 to 03/10/23 (37 days) and from 04/26/23 to 05/02/23 (7 days) revealed no documentation of bathing. The clinical record lacked documentation of R103 refused a shower/bath. On 05/03/23 at 02:34 PM R103 stood at the nurse's station, stated he had scheduled a shower for today, an unidentified staff was overheard telling R103 today was not his shower/bath day. R103 stated he had not had a bath for two weeks he had a foul body odor and food in his beard. Another nursing staff had approached R103 and offered a shower. On 05/04/23 at 12:34 PM R103 walked with a front wheeled walker into the 100 hallways, with no shoes only socks. R103 stated he felt better after his shower yesterday, no body odor. On 05/04/23 at 03:32 PM Certified Nurse Aide (CNA) N stated at the time of admission a resident was offered the morning or evening for their bath. CNA N stated staff check the Kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change) daily for the residents due for a bath/shower that day. CNA N stated if a resident would refuse a shower/bath, staff would offer several more times and report refusal to the nurse. CNA N stated document in POC the bathing or refusals.	F 677			

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F 677	Continued From page 34 On 05/04/23 at 04:09 PM Agency Licensed Nurse (LN) G stated if a resident was to refuse their bath/shower, the CNAs would offer several more times and offer alternative bathing, then report the refusal to the nurse. LN G stated the nurse would approach the resident and if continued to refuse the nurse would notify the director of nursing and the resident's family. LN G stated the refusal would be charted in the POC. On 05/04/23 at 04:26 PM Administrative Nurse D stated at the time of admission each resident was asked their preference of days or evenings and frequency. Administrative Nurse D stated the dayshift nurse or her would update the Kardex with the residents' preferences. Administrative Nurse D stated alternative bathing was offered, along with a as needed bathing would be offered, and refusals are documented in the POC. The facility was unable to provide a policy related to bathing. The facility failed to ensure a shower/bath was provided for R103, who required assistance with ADL's, which had the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial wellbeing. - R29's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin) and major depressive disorder (major mood disorder). The "Annual Minimum Data Set" (MDS) dated 02/16/23 documented a Brief Interview of Mental	F 677			

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F 677	Continued From page 35 Status (BIMS) score of 99, a staff interview documented a severely impaired cognition. The MDS documented that R29 required limited assistance of one staff member for activities of daily living (ADLs). The MDS documented R29 required limited assistance of one staff member for transfer only for bathing activity during the look back period. The "Quarterly MDS" dated 04/27/23 documented a BIMS score of 99, a staff interview documented a moderately impaired cognition. The MDS documented that R29 required limited assistance of one staff member for ADLs. The MDS documented R29 was dependent on one staff member for bathing during the look back period. R29's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 02/21/23 documented the care plan would be reviewed to maintain current ADL status and reduce risk for falls and pressure ulcer risk. R29's "Care Plan" dated 11/04/22 documented R29 preferred a bath/shower two times a week and at times would choose to only bath one time a week. Review of the EMR under "Report: Documentation Survey Report" tab (POC) under daily charting looks back report for R29 reviewed from 02/01/23 to 05/02/23 (91 days) revealed shower/bath were given on the following (7) dates 02/07/23, 02/14/23, 02/24/23, 03/03/23, 03/07/23, 04/11/23, and 04/25/23. Resident was not available (RA) on 04/21/23. Resident refused (RR) one time on 03/31/23. On 05/01/23 at 02:50 PM R29 slept on his bed.	F 677			

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F 677	Continued From page 36 On 05/04/23 at 03:32 PM, Certified Nurse Aide (CNA) N stated at the time of admission a resident was offered the morning or evening for their bath. CNA N stated staff checked the Kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change) daily for the residents due for a bath/shower that day. CNA N stated if a resident would refuse a shower/bath, staff would offer several more times and report refusals to the nurse. CNA N stated they document in POC the bathing or refusals. CNA N stated R29 did not refuse very often to take his bath/shower. On 05/04/23 at 04:09 PM, Licensed Nurse (LN) G stated if a resident was to refuse their bath/shower, the CNAs would offer several more times and offer alternative bathing, then report the refusal to the nurse. LN G stated the nurse would approach the resident and if continued to refuse the nurse would notify the director of nursing and the resident's family. LN G stated the refusal would be charted in the POC. On 05/04/23 at 04:26 PM, Administrative Nurse D stated at the time of admission each resident was asked their preference of days or evenings and frequency. Administrative Nurse D stated the dayshift nurse or her would update the Kardex with the residents' preferences. Administrative Nurse D stated alternative bathing was offered, along with a as needed bathing would be offered, and refusals are documented in the POC. The facility was unable to provide a policy related	F 677			

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F 677	Continued From page 37 to bathing. The facility failed to ensure a shower/bath was provided for R29, who required assistance with ADL's, this had the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial wellbeing. - R4's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (elevated blood pressure), major depressive disorder (major mood disorder), and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The "Annual Minimum Data Set" (MDS) dated 12/29/22 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented that R4 required extensive assistance of one staff member for activities of daily living (ADLs). The MDS documented R4 required physical assistance of one staff member for bathing during look back period. The "Quarterly MDS" dated 03/27/23 documented a BIMS score of four which indicated severely impaired cognition. The MDS documented that R4 required extensive assistance of one staff member for ADLs. The MDS documented bathing did not occur during the look back period for R4. R4's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 01/06/23 documented R4 was at risk of ADL decline related to the need for assistance with ADLs.	F 677			

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F 677	Continued From page 38 R4's "Care Plan" dated 04/24/19 documented staff would provide supervision and set up assistance for bath/shower. The "Care Plan" dated 08/26/21 R4 would refuse at times to take a shower, but staff would attempt to redirect R4 into the bath/shower. Review of the EMR under "Report: Documentation Survey Report" tab (POC) under daily charting looks back report for R4 reviewed from 02/01/23 to 05/04/23 (93 days) revealed shower/bath were given on the following dates 02/17/23, 04/28/23, and 05/03/23. Two partial baths documented on following dates 02/03/23 and 03/06/23. Resident refused five times on the following dates 03/08/23, 03/15/23, 03/22/23, 03/24/23, and 03/29/23. Not applicable was documented on 03/10/23 and 03/27/23. On 05/02/23 at 01:42 PM, R4 laid on right side on the bed asleep, covered with a blanket. On 05/04/23 at 03:32 PM, Certified Nurse Aide (CNA) N stated at the time of admission a resident was offered the morning or evening for their bath. CNA N stated staff check the Kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change) daily for the residents due for a bath/shower that day. CNA N stated if a resident would refuse a shower/bath, staff would offer several more times and report refusal to the nurse. CNA N stated document in POC the bathing or refusals. CNA N stated R4 did not refuse very often to take his bath/shower. On 05/04/23 at 04:09 PM, Licensed Nurse (LN) G	F 677			

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F 677	Continued From page 39 stated if a resident was to refuse their bath/shower, the CNAs would offer several more times and offer alternative bathing, then report the refusal to the nurse. LN G stated the nurse would approach the resident and if continued to refuse the nurse would notify the director of nursing and the resident's family. LN G stated the refusal would be charted in the POC. On 05/04/23 at 04:26 PM, Administrative Nurse D stated at the time of admission each resident was asked their preference of days or evenings and frequency. Administrative Nurse D stated the dayshift nurse or her would update the Kardex with the residents' preferences. Administrative Nurse D stated alternative bathing was offered, along with a as needed bathing would be offered, and refusals are documented in the POC. The facility was unable to provide a policy related to bathing. The facility failed to ensure a shower/bath was provided for R4, who required assistance with ADLs, this had the potential to cause skin breakdown and/or skin complications due to poor personal hygiene and impaired psychosocial wellbeing. - R18's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of major depressive disorder (major mood disorder), need for assistance with personal care, open wound to right foot, pressure ulcer of left heel, pressure ulcer of sacral region (large triangular	F 677			

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F 677	Continued From page 40 bone between the two hip bones), stage four (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling), malnutrition, and quadriplegia (paralysis of the arms, legs and trunk of the body below the level of an associated injury to the spinal cord). The "Significant Change Minimum Data Set" (MDS) dated 01/02/23 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R18 was dependent on two staff members assistance for activities of daily living (ADLs). The MDS documented R18 as at risk for development of pressure related injuries, R18 had one or more unhealed pressure ulcers, and R18 was totally dependent on one staff member for bathing during the look back period. The "Quarterly MDS" dated 03/31/23 documented a BIMS score of 15, which indicated intact cognition. The MDS documented R18 was dependent on two staff members assistance for ADLs. The MDS documented R18 was at risk for development pressure related injuries and had one or more unhealed pressure ulcers. The MDS further documented R18 required extensive assistance of one staff member for personal hygiene and noted bathing did not occur during the look back period. The "ADL Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 01/02/23, documented R18 was triggered for ADL function related to staff support for cares and needs. The CAA further documented R18 as dependent on staff for transfers, bathing, dressing, and daily	F 677			

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F 677	Continued From page 41 care needs related to quadriplegia. The CAA directed staff to continue to provide cares so that no needs went unmet. The "Care Plan" dated 09/28/20, documented R18 required staff assistance with ADLs related to physical limitations. The "Care Plan" updated on 11/08/22, documented R18 preferred to be showered twice a week and there was a bathing cot available for that process. Review of the EMR under "Report: Documentation Survey Report" tab (POC) under the daily charting look back report for R18 reviewed from 02/01/23 to 05/02/23 (91 days) revealed shower/bath were given on the following (3) dates 03/02/23, 03/15/23, and 04/26/23. It documented R18 refused (RR) one time on 03/29/23. On 05/03/23 at 08:37 AM R18 was sleeping in his bed. On 05/04/23 at 11:40 AM R18 was laying in bed in his room. R18 stated he did not get showers very often. He stated staff often told him they would see about it or try to give him a shower when he would ask; however, he stated they rarely gave him one. He stated that it made him feel like staff did not care. Observations revealed R18's beard and hair were unkept, and his fingernails were approximately half of an inch to one inch long and dirty. R18 stated that staff would not help him trim his fingernails or shave/trim his hair or beard. On 05/04/23 at 03:32 PM Certified Nurse Aide (CNA) N stated at the time of admission a resident was offered the morning or evening for	F 677			

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F 677	Continued From page 42 their bath. CNA N stated staff checked the Kardex (a medical information system used by nursing staff to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change) daily for the residents due for a bath/shower that day. CNA N stated if a resident would refuse a shower/bath, staff would offer several more times and report refusal to the nurse. CNA N stated document in POC the bathing or refusals. On 05/04/23 at 04:09 PM Agency Licensed Nurse (LN) G stated if a resident was to refuse their bath/shower, the CNAs would offer several more times and offer alternative bathing, then report the refusal to the nurse. LN G stated the nurse would approach the resident and if the resident continued to refuse the nurse would notify the director of nursing and the resident's family. LN G stated the refusal would be charted in the POC. On 05/04/23 at 04:26 PM Administrative Nurse D stated at the time of admission each resident was asked their preference of days or evenings and frequency. Administrative Nurse D stated the dayshift nurse or her would update the Kardex with the residents' preferences. Administrative Nurse D stated alternative bathing was offered, along with a as needed bathing would be offered, and refusals were documented in the POC. The facility was unable to provide a policy related to bathing. The facility failed to ensure a shower/bath was provided for R18, who required assistance with ADLs, which had the potential to cause skin breakdown and/or skin complications due to poor	F 677			

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F 677	Continued From page 43	F 677			
F 679 SS=E	personal hygiene and impaired psychosocial wellbeing. Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample include 13 residents. Based on observation, record review, and interviews, the facility failed to provide activities for the residents during weekends and failed to provide activities for residents in isolation. This deficient practice placed 45 residents at risk for decreased psychosocial wellbeing. Findings Included: - The facility's "Activity Calendar" for February, March, and April of 2023 revealed the activities schedule for Saturdays and Sundays lacked activities listed on the activity calendar. On 05/01/23 at 08:45 AM Resident (R)46 reported she just got out of isolation due to COVID-19 (highly contagious, potentially life-threatening respiratory virus). She stated she	F 679			

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F 679	Continued From page 44 is grateful for being out of isolation because she was bored in her room. She stated she was not provided activities or entertainment for over ten days in isolation. She stated she got bored of watching television but could not be around other residents. She stated the facility did not provide her with any type of human interaction or companionship while in isolation. On 05/02/23 at 11:18 AM, Resident Council members reported the facility did not provide weekend activities. The council reported the facility left some games out but did not have staff led activities for the residents on weekends. The council reported residents in isolation complained about having no activities or entertainment. On 05/02/23 at 02:25 PM Activities Coordinator (AC) Z reported handle the facility activities Monday through Friday but left out games and puzzles for the residents over the weekend. AC Z reported the residents in isolation were provided coloring pages and puzzles, but were not provided any other activities, aside from television. On 05/04/23 at 02:00 PM AC Z held a staff led Bingo game in the dining room. The game consisted of non-isolated resident, and had prizes. A review of the facility's "Activity" policy (undated) indicated the activities staff will provide opportunities for residents to perform at their maximum level of function. The policy indicated the resident council is to be promoted and used as a way for soliciting new ideas and suggestions for programs.	F 679			

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F 679	Continued From page 45 The facility failed to provide activities for the residents on weekends and for isolated residents. This deficient practice placed 45 residents at risk for decreased psychosocial wellbeing.	F 679			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with one resident reviewed for treatment of pressure injuries. Based on observation, record review, and interviews, the facility failed to ensure staff implemented appropriate infection control practices during wound care for Resident (R) 18, who was on an antibiotic (medication used to treat bacterial infections) for a wound infection. This deficient practice placed R18 at risk of wound worsening and complications related to infections. Findings included:	F 686			

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F 686	Continued From page 46 - R18's Electronic Medical Record (EMR) documented diagnoses of major depressive disorder (major mood disorder), need for assistance with personal care, open wound to right foot, pressure wound of left heel, pressure injuries of sacral region (large triangular bone between the two hip bones), stage four (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling), malnutrition, and quadriplegia (paralysis of the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord). The "Significant Change Minimum Data Set" (MDS) dated 01/02/23 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R18 was dependent on two staff members assistance for activities of daily living (ADL). The MDS documented R18 was at risk for development of pressure related injuries and had one or more unhealed pressure injuries. The "Quarterly MDS" dated 03/31/23 documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R18 was dependent on two staff members assistance for ADLs.). The MDS documented R18 was at risk for development pressure related injuries and had one or more unhealed pressure injuries. R18's "Pressure Ulcer Care Area Assessment" (CAA) dated 01/02/23 documented R18 was dependent on staff for bed mobility and transfers. Licensed Nurses completed daily wound care and daily wound assessments.	F 686			

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F 686	Continued From page 47 R18's "Care Plan" dated 09/28/20 documented the physician would be notified of any changes of wound status and staff would use pressure reducing devices as indicated. The "Care Plan" dated 03/21/23 documented R18 was in standard precautions for the duration of the wound infection. Review of the EMR under "Orders" tab revealed the following seven "Physician Orders": 1. Santyl ointment (a sterile enzymatic debriding ointment) 250 unit/gram (gm) apply to all wounds topically one time a day related to pressure ulcer of sacral region, stage four, open wound right foot, left outer ankle, top right foot, right buttock, left ischium (part of the hip bone), coccyx. Cleanse with normal saline, apply skin prep to peri-wound, then apply saintly/gentamycin ointment (a broad-spectrum antibiotic used chiefly for severe systemic infections) then cover with border gauze daily dated 07/06/22. 2. Coccyx (small triangular bone at the base of the spine) wound treatment, to cleanse with normal saline, use a trip to cleanse inside of wound, removing any bio-film (a thin usually resistant layer of microorganisms (as bacteria) that form on and coat various surfaces (as of catheters), apply skin prep to peri-wound, then apply santly to wound bed and cover with border dressing daily related to pressure ulcer of sacral region stage four, coccyx wound treatment - cleanse with normal saline with a tip to clean wound bed removing bio-film, apply skin prep to peri-wound, apply santly to wound bed and then apply collagen powder (a supplement made from very small pieces of protein) sprinkled on top of wound cover with border dressing, dated	F 686			

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F 686	Continued From page 48 01/17/23. 2. Clean scrotum and penis with normal saline and apply zinc ointment to open areas daily, dated 02/02/23. 3. Gentamycin sulfate ointment 0.1%, apply topically to right buttocks daily related to pressure ulcer on right foot and right buttock, dated 02/22/23. 4. Right inner foot wound treatment to cleanse with normal saline, apply santly/gentamycin ointment to wound bed and cover with border gauze dressing daily related open wound on right foot, dated 03/11/23. 5. Right inner buttock treatment to cleanse with normal saline and apply skin prep to peri-wound, apply santly/gentamycin ointment and cover with border gauze daily related to pressure ulcer of right buttock, dated 03/11/23. 6. Right inner foot treatment, to apply ABD pad (highly absorbent dressing that provides padding and protection for large wounds) daily for accumulated drainage during dressing change for wound, dated 03/24/23. 7. Linezolid oral (antibiotic) tablet 600 milligram (mg) give one tablet by mouth two times a day for 14 days, related pressure and vascular wounds, dated 04/28/23. On 05/04/23 at 10:50 AM R18 laid on his back on the bed. Licensed Nurse (LN) I and Administrative Nurse E used hand sanitizer and doffed gloves to provide wound care for R18. Wound care items place on a barrier. Administrative Nurse E	F 686			

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F 686	Continued From page 49 removed R18's soiled dressings from his buttocks. Administrative Nurse E then placed a barrier between R18's buttocks and the bed. R18 was incontinent of stool, Administrative Nurse E removed disposable wipes from R18's dresser and provided peri care. Administrative Nurse E doffed her gloves and did not perform hand hygiene prior to donning new gloves. Administrative Nurse E asked LN I if she was to remove the three soiled dressing from R18's left foot. Administrative Nurse E pulled on the trash bag and then returned to assist holding R18's left leg. LN I doffed soiled gloves, hand sanitized and donned new gloves. LN I used a new dry gauze dressing to dry to wound bed, then applied skin prep to peri-wound, then used the tip to apply Santyl (autolytic debriding ointment) to wound bed. LN I applied gentamicin (antibiotic) ointment to island dressing before she applied the dressing to pressure ulcer. LN I doffed soiled gloves, hand sanitized and donned new pair of gloves. Administrative Nurse E touched her facial mask with her gloved hand, then placed the same gloved hand onto R18's bed. Administrative Nurse E with the same gloves she placed gauze dressing into plastic medication cup with normal saline, opened border dressing and placed Santyl ointment into plastic medication cup. LN I cleansed third pressure wound on R18's left foot. LN I doffed soiled gloves, failed to hand sanitize prior to donning new gloves. LN I doffed soiled gloves; hand sanitized prior to donning a new pair of gloves. Administrative Nurse E removed the treatment barrier and placed onto the overflowing trash bag, then placed soiled incontinence brief into the trash can. Administrative Nurse E doffed soiled gloves hand sanitized prior to donning a new pair of gloves, removed soiled dressing from left ankle.	F 686			

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F 686	Continued From page 50 On 05/04/23 at 11:35 AM Licensed Nurse (LN) I stated she should have hand sanitized between doffing and donning new gloves. LN I stated she realized she forgot to hand sanitize when she applied the border dressing. On 05/04/23 at 11:36 AM Administrative Nurse E stated hand hygiene should be preformed between donning and doffing gloves. Administrative Nurse E stated she should have changed her gloves and hand sanitized after touching the trash can and before she touched R18 again. Administrative Nurse E stated she had only touched the outside of the trash can. On 05/04/23 at 03:32 PM Certified Nurse Aide (CNA) N stated staff should wash hands or hands sanitize between donning and doffing gloves when providing resident care. On 05/04/23 at 04:26 PM Administrative Nurse D stated staff should wash, or hand sanitize hands between donning and doffing of gloves when providing care or treatments. The facility's "Hand Hygiene" policy dated 05/2017 documented hand hygiene would be completed by staff between glove changes during care or procedures. The facility failed to ensure staff implemented appropriate infection control practices during wound care for R18, who was on antibiotic for a wound infection. This deficient practice placed R18 at risk of wound worsening and complications related to infections.	F 686			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices	F 689			

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F 689	Continued From page 51 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with three residents reviewed for falls. Based on observation, record review, and interviews, facility failed to identify toileting as a causal factor for falls and implement toileting interventions after R40 experienced falls related to incontinence which resulted in an orbital socket (set of bones that surround the eye) injury. As a result, R40 had another toileting related fall in which she sustained a femur (large bone of upper leg) fracture. Findings Included: - The "Medical Diagnosis" section within R40's Electronic Medical Records (EMR) included diagnoses of muscle weakness, history of falls, dementia (progressive mental disorder characterized by failing memory, confusion), reduced mobility, cognitive communication deficit, anxiety (progressive mental disorder characterized by failing memory, confusion), and left femur fracture (broken bone in left upper leg). Review of R40's "Discharge Minimum Data Set (MDS)" completed 05/08/22 revealed a Brief	F 689			

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F 689	Continued From page 52 Interview for Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. She required extensive assistance for transfers and limited assistance with toileting. The MDS further indicated she had one injury fall since her admission. The MDS documented R40 as frequently incontinent of bowel and bladder and was not on a toileting program. A review of R40's "Significant Change MDS" completed 02/16/23 revealed a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. The MDS documented she required limited assistance from staff for transfers, bed mobility, dressing, toileting, personal hygiene, and bathing. R40 was frequently incontinent of bladder and occasionally incontinent of bowel and a trial toileting program was not attempted. A review of R40's "Urinary Incontinence Care Area Assessment (CAA)" completed 02/20/23 indicated she was frequently incontinent. The CAA instructed staff to encourage her for toileting and assist as needed. The CAA noted she was at risk for urinary tract infections and skin breakdown. The CAA instructed staff to encourage resident participation during cares to promote independence. A review of R40's "Fall CAA" completed 02/20/23 revealed she was at risk for falls related to her fall history, cognitive impairment, and medical diagnoses. The CAA instructed staff to remind her to call for assistance for bathroom use. A review of R40's "Care Plan" (initiated 04/12/22) revealed she required assistance from one staff for transfers. The care plan indicated once R40	F 689			

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F 689	Continued From page 53 transferred to her wheelchair she could independently propel herself throughout the facility. R40's care plan lacked documentation of interventions related to her bowel and bladder incontinence, assistance needed for toileting, and skin care after incontinence episodes. R40's "Care Plan" revealed she was at risk for falls. The care plan instructed staff to keep all commonly used items within reach (04/12/22), wear appropriate footwear (04/12/22), encourage position changes slowly (04/12/22), apply nonskid strips to her floor at bed side (11/04/22), and nonskid strips in front of her bathroom sink (02/03/23). R40's "Care Plan" noted she fell on 05/08/22 attempting to go to the bathroom. The plan documented she injured her left orbital (eye) socket resulting in a minor injury. The entry noted she was sent to an acute care facility and later returned. A review of the "Fall Investigation" dated 05/08/22 indicated toileting as an identified predisposing factor. The care plan and fall investigation lacked documented interventions for the fall. The fall investigation lacked identification of causal factor for the fall. R40's "Care Plan" revealed she had a major injury fall on 02/03/23 resulting in a left femur fracture. A review of the "Fall Investigation" for the 02/03/23 fall indicated R40 attempted to leave her bathroom and fell out of her wheelchair. The report indicated R40 had a skin tear on her left arm but no signs of other injuries. The report	F 689			

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F 689	Continued From page 54 documented predisposing factors for the fall included confusion, impaired memory, and needing assistance with ambulation. The investigation lacked identification of causal factor for the fall. A review of R40's "Progress Note" dated 02/03/23 indicated R40 complained about discomfort in her left leg. The note indicated a completed x-ray revealed a left femur fracture. The note indicated she was sent out to an acute care facility for treatment. R40's EMR indicated she was hospitalized from 02/03/23 through 02/07/23 for a left femur fracture. A review of R40's EMR revealed no "Bowel and Bladder" assessments since she admitted on 04/08/22. (Refer to F690) On 05/02/23 at 09:15 AM R40 reported she was not sure if the facility provided a toileting program but did report she had incontinence, and falls related to her incontinence. She stated staff came around and asked her for bathroom assistance, but she was not sure how often. She reported she fell before going to the bathroom and broke her hip in the facility. On 05/04/23 at 03:30 PM Certified Nurse Aide (CNA) N stated R40 could independently wander the facility safely but still needed assistance with transfers, cares, and toileting. She stated R40 was incontinent but not sure if she recently had a bowel and bladder assessment or toileting program. She stated she did not know if R40 had any recent falls but R40 had fall strips in her room and bathroom. She stated all CNA staff had access to view the care plans on the residents. She stated R40 often attempted to transfer	F 689			

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F 689	Continued From page 55 without alerting staff. She stated R40 was not currently being assisted for restorative cares related to toileting. On 05/04/23 at 04:01 PM Administrative Nurse D stated all residents in the facility would receive bowel and bladder assessments upon admission, quarterly, annually, and with significant changes. She stated every time an accident or fall occurred the facility investigated and provided interventions to prevent further occurrences. A review of the facility's "Fall Management" policy revised 12/2017 indicated the facility will identify risk related to falls/accidents to allow interventions to be implemented. The policy noted a plan of care will address the individualized focus, goal, and interventions directed towards reducing the resident's risk of injury and potential reoccurrences of falls. The facility failed to identify toileting as a causal factor for falls and implement toileting interventions after R40 experienced falls related to incontinence which resulted in an orbital socket injury. As a result, R40 had another toileting related fall in which she sustained a femur fracture.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690			

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F 690	Continued From page 56 §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with three reviewed for bowel and bladder management. Based on observation, record review, and interviews, the facility failed to implement individualized toileting interventions related to bowel and bladder incontinence for Residents (R)40, and R6. This deficient practice placed the residents at risk for complications related to incontinence.	F 690			

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F 690	Continued From page 57 Findings Included: -The "Medical Diagnosis" section within R40's Electronic Medical Records (EMR) included diagnoses muscle weakness, history of falls, dementia (progressive mental disorder characterized by failing memory, confusion), reduced mobility, cognitive communication deficit, anxiety (progressive mental disorder characterized by failing memory, confusion), and left femur fracture (broken bone in left upper leg). A review of R40's "Significant Change Minimum Data Set (MDS)" completed 02/16/23 indicated a brief Interview for Mental Status (BIMS) score of eight noting moderate cognitive impairment. The MDS indicated she required limited assistance from staff for transfers, bed mobility, dressing, toileting, personal hygiene, and bathing. The MDS indicated she was frequently incontinent of bladder and occasionally incontinent of bowel. The MDS noted a trial toileting program was not attempted. A review of R40's "Urinary Incontinence Care Area Assessment (CAA)" completed 02/20/23 indicated she was frequently incontinent. The CAA instructed staff to encourage her for toileting and assist as needed. The CAA noted she was at risk for urinary tract infections and skin breakdown. The CAA instructed staff to encourage resident participation during cares to promote independence. A review of R40's "Fall CAA" completed 02/20/23 indicated she was at risk for falls related to her fall history, cognitive impairment, and medical diagnoses. The CAA instructed staff to remind			F 690			

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F 690	Continued From page 58 her to call for assistance for bathroom use. A review of R40's "Care Plan" (initiated 04/12/22) indicated she required assistance from one staff transfer. The care plan indicated once R40 transferred to her wheelchair she could independently propel herself throughout the facility. R40's plan lacked documented interventions related to her bowel and bladder incontinence, assistance needed for toileting, and skin care after incontinence episodes. R40's "Care Plan" indicated she had a fall on 05/08/22 attempting to go to the bathroom. The plan indicated she injured her left orbital (eye) socket resulting in bleeding with a minor injury. The entry noted she was sent to an acute care facility and later returned. A review of the "Fall" report indicated toileting as an identified predisposing factor. R40's "Care Plan" indicated she had a major injury fall on 02/03/23 resulting in a left femur fracture. A review of the fall report indicated R40 was attempting to leave her bathroom and fell out of her wheelchair. A review of R40's EMR revealed no "Bowel and Bladder" assessments since she admitted on 04/08/22. On 05/02/23 at 09:15AM R40 reported she was not sure if the facility provided toileting programs, but did report she had incontinence and falls related to her incontinence. She stated staff come around and ask her for bathroom assistance, but not sure how often. She reported she had fallen before going to the bathroom.	F 690			

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F 690	Continued From page 59 On 05/04/23 at 03:30PM Certified Nurse Aide (CNA) N said that R40 was not currently being assisted for restorative cares related to toileting. She stated R40 had incontinence and would often attempt to toilet herself without calling for help due to her memory issues. She stated staff would go around every two hours for assistance. She stated all the impaired incontinent residents were on two-hour check and change. On 05/04/23 at 04:01PM Administrative Nurse D stated all residents in the facility will receive bowel and bladder assessments upon admission, quarterly, annually, and with significant changes. She stated residents with incontinence will have intervention listed in the care plan. She stated all direct care staff have access to the Kardex (condensed report created from care planned information) that should show each resident's required level of assistance needed. A review of the facility's "Incontinence Management" policy revised 12/2017 indicated all residents will be assessed to identify history and incontinence. The policy noted resident's will be monitored for changes in incontinence and reassessed with significant changes. The policy indicated interventions will be implemented to maintain each resident's highest practicable level of incontinence. The facility failed to implement individualized toileting interventions related to bowel and bladder incontinence for R40. This deficient practice placed R40 at risk for complications related to incontinence. - The "Diagnoses" tab of R6's Electronic Medical	F 690			

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F 690	Continued From page 60 Record (EMR) documented diagnoses of age-related cognitive decline, generalized muscle weakness, history of falling, difficulty in walking, and dependence on wheelchair. The "Annual Minimum Data Set (MDS)" dated 09/19/22, documented R6 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated R6 was cognitively intact. The resident required extensive assistance of one staff member for toileting and personal hygiene, limited assistance of one staff member for dressing, and R6 was independent for eating, locomotion, bed mobility, and transfers. R6 was always incontinent of urine, always incontinent of bowel, and a toileting program had not been attempted at the time of the assessment. The "Quarterly MDS" dated 02/23/23, documented R6 had a BIMS score of eight, which indicated moderately impaired cognition. The resident required limited assistance of one staff member for toileting, personal hygiene, dressing, and R6 was independent for eating, locomotion, bed mobility, and transfers. R6 was frequently incontinent of urine, frequently incontinent of bowel, and a toileting program had not been attempted. The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 09/19/22, documented R6 triggered for need for assistance with personal cares. The CAA further documented for R6 to maintain ADL status, continence, and functional status and that R6 was able to make needs known. The CAA directed staff to continue helping as needed.	F 690			

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F 690	Continued From page 61 The "Urinary Incontinence/Indwelling Catheter CAA" dated 09/19/22, documented R6 triggered for urinary incontinence. The CAA further documented R6 had periods of incontinence and required extensive assistance from staff to maintain peri care and changing clothes/briefs. Staff encouraged the resident to maintain current level of function. The CAA directed staff to assist as needed. The "Care Plan" dated 06/17/13 , documented R6 was at risk for falls due to a history of falls, impaired balance, and confusion. The "Care Plan" updated 06/10/15 directed staff to encourage R6 to use the call light for assistance when wishing to access and use the restroom; encourage R6 to use an incontinence brief at night and encourage R6 to call for assist with movement and transitions. The "Care Plan" updated 02/17/20, documented that R6 had an unwitnessed, non-injury fall and directed staff to check and change/toilet with rounds. The "Care Plan" updated 08/11/20 directed staff to toilet R6 throughout the night even if R6 stated that he did not have to go. The "Care Plan" updated 09/02/20, direct staff to assist R6 to the bathroom upon waking, after breakfast, before lunch, between 1-2pm, before dinner, prior to going to bed at night, and continue to offer to assist to the bathroom with rounds during the night. The "Assessment" tab of R6's EMR revealed a bowel and bladder assessment on 12/10/21 that documented he was continent of bowel and bladder. R6's clinical record lacked evidence of a bowel and bladder assessment completed after 12/10/21. A "Bowel and Bladder Elimination Report" dated	F 690			

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F 690	Continued From page 62 from 04/03/23 through 05/02/23, documented that R6 had 27 incontinent episodes during the 30 day look back period. On 05/01/23 at 08:10 AM revealed R6 in his room, sitting in his wheelchair. R6's bed was wet and there was a strong urine odor noted in his room. On 05/03/23 at 08:05 AM revealed R6 in his room, sitting in wheelchair, with strong urine odor noted in room. On 05/03/23 at 11:55 AM R6 in his room and housekeeping was cleaning his room and mopping the floor. Certified Nurse Aide (CNA) O went into R6's room shortly after housekeeping finished cleaning R6's room. No odor noted after housekeeping finished cleaning room. On 05/04/23 at 07:22 AM R6 was in his room sitting on edge of his bed. Strong urine odor noted in his room. On 05/03/23 at 12:00 PM interviewed CNA O as she came out of R6's room. CNA O stated she went into R6's room to change him as he had been incontinent. She stated R6 was not good at letting staff know when he needed to use the restroom, so they checked him and changed him when he was incontinent. She stated that R6 was frequently incontinent. On 05/04/23 at 04:09 PM Licensed Nurse (LN) G stated she has not seen any residents on a toileting program in the facility. LN G stated that residents were usually changed after they were found to have had an incontinent episode.	F 690			

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F 690	Continued From page 63 On 05/04/23 at 04:25 PM Administrative Nurse D stated there were residents that would be toileted daily, but they were not on scheduled times. She stated that staff typically check on residents every two to four hours depending on the resident, or some residents would alert staff when they needed to use to bathroom. Administrative Nurse D stated bowel and bladder assessments could be completed quarterly or annually along with the MDS assessments and that they could be found under the assessments tab in the EMR. She stated she was unsure if R6 had received a more recent bowel and bladder assessment as the last one documented had a date of 12/10/21. The facility's "Incontinence Management Policy" revised on 12/2017, documented that residents are to be assessed to identify a history and pattern of bowel and bladder function. It further documents that residents are to complete a three-day toileting diary upon admission, annually and with a significant change. The facility failed to provide the necessary care and services related to incontinence care for R6. This deficient practice had the risk for skin breakdown, loss of dignity, and physical complications for R6.	F 690			
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692			

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F 692	Continued From page 64 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with three reviewed for nutrition. Based on observation, record review, and interviews, the facility failed to identify and implement appropriate, culturally aware, resident-centered interventions to address decreased intake for cognitively impaired Resident (R) 38, who was at risk for weight loss. This deficient practice resulted in a significant, unintended loss of 21.74 percent (%) in four months (between 01/01/23 through 05/04/23) . Findings Included: - The "Medical Diagnosis" section within R38's Electronic Medical Records (EMR) included diagnoses of intracerebral hemorrhage (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), hemiplegia (paralysis of one side of the body), aphasia (condition with disordered or absent language function), fracture of left humerus (broken bone of	F 692			

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F 692	Continued From page 65 the left upper arm), need for assistance with personal cares, and dysphagia (swallowing difficulty). A review of R38's "Admission Minimum Data Set (MDS)" completed 12/15/22 indicated a Brief Interview for Mental Status (BIMS) was not completed. The MDS identified R38 had short-term and long-term memory problems, no memory recall ability, and moderately impaired decision-making abilities. The MDS noted R38 weighed 140 pounds (lbs.) with no weight loss and R38 was not indicated to be on physician ordered program. The MDS indicated no swallowing concerns noted. The MDS noted she had hearing and visual impairments with no speech. The MDS noted she usually would make herself understood if prompted or given time and would sometimes understand others. The MDS noted she required limited assistance from one staff for meals. . A review of R38's "Quarterly MDS" completed 03/09/23 indicated a Brief Interview for Mental Status (BIMS) assessment could not be completed. The MDS identified R38 had short-term and long-term memory problems, no memory recall ability, and moderately impaired decision-making abilities. The MDS indicated R38 had no behaviors. The MDS noted she required extensive assistance for eating her meals. The MDS noted R38 weighed 118 pounds (lbs.) but noted she had no recent weight loss and was not on a physician ordered weight loss program. The MDS noted she had hearing and visual impairments with no speech. The MDS noted she usually would make herself understood if prompted or given time and would sometimes understand others.	F 692			

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F 692	Continued From page 66 A review of R38's "Communication Care Area Assessment" completed 12/20/22 indicated she had a communication deficit related to her hearing impairment, aphasia, and difficulty understanding and communicating her needs. The CAA noted staff should learn and be aware of R38's gestures and personal sign language to assist her. R38's "Activities of Daily Living (ADL) CAA" completed 12/20/22 indicated she required total staff assistance for all daily care needs. R38's "Nutrition CAA" completed 12/20/23 noted she was at risk for weight loss related to her dysphagia, communication deficit, and need for assistance related to meal intake. The CAA indicated staff were to provide assistance with meals and promote adequate hydration. A review of R38's "Physician's Order" revealed an order dated 12/05/22 indicating she admitted on a regular diet with mechanically soft texture. On 12/14/23 R38's diet changed to a regular diet with pureed textures. R38's "Care Plan," initiated 12/15/22, noted for staff to weigh her as ordered (12/15/22), provide her diet as ordered by physician (12/15/22), provide pureed diet (12/15/22), provide a dietary consult, and promote fluids to prevent dehydration (12/20/23). The plan failed to address refusals related to aggression and/or behaviors. A review of R38's "Dietary Assessment" completed 12/22/22 indicated R38 could feed herself but needed assistance and	F 692			

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F 692	Continued From page 67 encouragement during meal services. The note indicated nutritional intake varied during meals and R38 had a feeding tube (tube for introducing high calorie fluids into the stomach) removed before her admission to the facility. The assessment instructed staff to monitor her weight weekly and report changes On 12/27/22 a physician order was added to encourage R38 to consume fluids, due to low sodium levels. R38's "Weight History" revealed on 01/01/23 R38's weight was 139.6 lbs. On 01/18/23, R38's weight decreased to 127 lbs. R38's "Physician's Orders" indicated an order started 01/18/23 for her to receive Mighty Shakes with meals. An order for R38 to start Boost was added to her EMR on 01/18/23. On 02/13/23 R38's weight decreased to 122 lbs. On 02/20/23 R38's "Mighty Shake" the order was changed to be given three times daily for weight loss. . A "Dietician Note" dated 02/28/23 indicated R38's weight decreased to 125.5 lbs. (loss of 10%) within the last 30 days. The note indicated she was on a pureed with thin liquids. The note indicated she received mighty shakes (nutritional supplement shake) three times a day (TID) and had a Boost (nutritional supplement shake) at bedtime. The note indicated her oral intake was poor. The note indicated no new interventions would be added, due to her not eating and refusing her scheduled medications.	F 692			

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F 692	Continued From page 68 A review of R38's "Dietary" assessment completed 03/06/23 indicated she weighed 118 lbs. and noted a 10% weight change since 12/06/23. The assessment indicated she required extensive assistance with meals. The assessment noted she required a divided plate and a two handled sip cup for meals. The assessment did not address R38's ongoing refusals for medication, supplements, and meals. The assessment did not indicate R38's dietary or cultural preferences. A "Dietician Note" completed 03/12/23 indicated R38's weight was 118lbs. and the resident was on a pureed diet. The note indicated her oral intake was poor. The note indicated R38 refused cares and medications. The note indicated she received mighty shakes TID and a Boost supplement at bedtime. A review of R38's "Medication Administration Report" (MAR) for April 2023 revealed she refused her Boost supplement 18 out of the 30 days offered at bedtime. R38's MAR for April 2023 revealed she refused her Mighty Shake on 20 occasions. A "Progress Note" dated 03/05/23 indicated R38 continued to refuse her foods most of the time. A "Progress Note" dated 03/29/23 indicated R38 ate very little and continued to refuse her mighty shake. An "Dietician's Assessment" completed 04/13/23 indicated R38's weighed 109 lbs. The Registered Dietician (RD) recommended R38 receive fortified foods, multivitamins, and weekly weights, related to her continued weight loss. The	F 692			

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F 692	Continued From page 69 assessment did not indicate R38's dietary or cultural preferences. On 04/13/23 R38's "Care Plan" noted she recently was a weight loss concern due to eating less. The plan noted family had been bringing in food and assisting R38 with meals. On 04/17/23 R38's plan added recommendations for fortified foods, multivitamins, and continued observations of her weight. The plan indicated R38 could feed herself but may require staff assistance and was a nutritional risk. The plan failed to address refusals related to aggression and/or behaviors. The "Care Plan" lacked new nutrition related interventions between 12/20/22 through 04/13/23. R38's plan of care did not address R38's need for a divided plate and two handled sip cup per dietary assessment on 3/06/23. R38's EMR revealed an order was started for a multivitamin on 04/17/23. A "Progress Note" dated 05/01/23 indicated R38 became physically aggressive during dinner service. The note indicated staff attempted to feed her when R38 started throwing her drink everywhere and clawed her direct care staff's arm. The note indicated staff left her alone to calm down. R38's "Weight History" revealed on 05/04/22 R38 weighed 108 lbs. On 05/04/23 at 12:14 PM R38 sat in dining room. R38 had a divided plate with a pureed meal. R38 consumed some of the main portion with staff assistance. R38 had a two handled sip cup with water.	F 692			

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F 692	Continued From page 70 On 05/04/23 at 03:30 PM Certified Nurse Aide (CNA) N stated staff weighed the residents based on a list provide by the nurses. She stated if a resident had weight loss the charge nurse would be notified. She stated residents at risk for weight loss were tracked by the RD. She stated that RD comes in monthly to review each resident's changes. She stated she weighs all the residents and provided restorative services for the residents. She stated she was not aware of R38 having a significant weight loss. On 05/04/23 at 04:01 PM Administrative Nurse D stated the facility attempted to provide dietary supplements and shakes with noted weight loss beyond the last thirty days. Administrative Nurse D reported she was unaware of the cause of the weight loss but did report to the dietician. She reported R38's eating habits change from day to day, and sometimes the person assisting her. She reported it depended on the staff taking care of her. On 05/09/2023 at 10:30AM Consultant HH stated R38 was difficult to prevent weight loss due to the language barrier and not knowing what foods she really preferred. She stated R38 was placed on puree diet due to issues swallowing but seemed to respond better to non-pureed foods brought in by her daughter. She stated due to R38 using her own variation of sign language staff may not be able to effectively know her needs and could cause behavioral episodes and refusal of meals. She stated the language barrier made it difficult to know how to address R38's weight loss. A review of the Facility's "Nutrition Policy" (undated) indicated the facility will continually	F 692			

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F 692	Continued From page 71 assess and monitor each resident's weight, diet, and hydration levels to prevent avoidable weight loss and malnutrition. The policy noted the facility will provide an interdisciplinary approach with involvement of the registered dietician, nursing, and medical provider. The facility failed to identify and implement appropriate, culturally aware, resident-centered interventions to address decreased intake for cognitively impaired R38, who was at risk for weight loss. This deficient practice resulted in a significant, unintended loss of 21.74 percent (%) in four months (between 01/01/23 through 05/04/23).	F 692			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to store oxygen tubing and nasal cannula (device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help) in a sanitary manner for Resident (R) 33. This deficient practice placed	F 695			

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F 695	Continued From page 72 R33 at increased risk to develop a respiratory infection. Findings included: - R33's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide and the lungs are unable to carry the blood to the organs) with hypoxia (inadequate supply of oxygen), hypertension (elevated blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The "Annual Minimum Data Set" (MDS) dated 08/18/22 documented a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R33 was independent with set up assistance for activities of daily living (ADLs). The MDS documented R33 received oxygen therapy during the look back period. The "Quarterly MDS" dated 04/28/23 documented a BIMS score of six, which indicated severely impaired cognition. The MDS documented R33 required supervision with set up assistance for ADLs. The MDS documented R33 received oxygen therapy during the look back period. R33's "Cognitive Loss Care Area Assessment" (CAA) dated 08/31/22 documented R103 had long and short-term memory loss.	F 695			

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F 695	Continued From page 73 R33's "Care Plan" dated 11/11/21 directed staff to change and date oxygen tubing and humidifier per facility routine. The "Care Plan" dated 11/30/22 documented when R33's oxygen was not in use or if there was multiple tubing to devices and the tubing was not in use it would be placed in a plastic bag for cleanliness storage. Review of the EMR under "Orders" tab revealed physician orders: Continuous oxygen at three liters via nasal cannula every shift dated 02/11/21. On 05/01/23 at 04:50 PM R33 laid on his left side on the bed. Undated oxygen tubing and nasal cannula laid on the seat of the wheelchair pushed next the bed. No plastic was available to store the oxygen tubing and the nasal cannula when not in use. On 05/02/23 at 11:46 AM R33 laid on the bed, undated oxygen tubing and nasal cannula was hung over the back of wheelchair next to the bed. No plastic was available to store the oxygen tubing and the nasal cannula when not in use. On 05/04/23 at 03:32 PM Certified Nurse Aide (CNA) N stated when the oxygen tubing was not in use it was to be stored in a plastic bag and changed weekly by night shift. On 05/04/23 at 04:09 PM Agency Licensed Nurse (LN) G stated the oxygen tubing was changed weekly and documented on the "Treatment Administration Record" when it was completed. LN G stated the tubing was to be dated and stored in a plastic bag when not in use for	F 695			

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F 695	Continued From page 74 infection control. On 05/04/23 at 04:26 PM Administrative Nurse D stated the oxygen tubing had a specific day of the week on night shift it was changed. Administrative Nurse D stated the tubing was to be dated and stored in a plastic bag when not in use for cleanliness. The facility was unable to provide a policy related oxygen therapy and stated the facility follows and follows the physician's order. The facility failed to provide necessary respiratory care and services in accordance with professional standards of practice, which placed R33 at increased risk to develop a respiratory infection.	F 695			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F 732			

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F 732	Continued From page 75 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. Based on observation, record review, and interviews, the facility failed to post and provide daily nursing staff numbers and hours and failed to maintain the posted daily nurse staffing data for the required 18 months. This deficient practice had the risk for miscommunication regarding resident care and staffing. Findings included: Review of posted staffing from 02/01/23 to 04/30/23 revealed the following missing posted staffing dates: 02/11/23 - 02/13/23, 02/16/23 - 02/19/23, 02/22/23, 02/24/23 - 03/08/23, 03/10/23, 03/11/23, 03/15/23, 03/22/23, 03/24 - 03/28/23, 03/31/23 - 04/02/23, 04/04/23, 04/06/23, 04/08/23 - 04/30/23.	F 732			

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F 732	Continued From page 76 On 05/04/23 at 02:14 PM, Administrative Nurse D stated nursing staff were responsible for completing posted staffing. Posted staffing was completed by the night shift nurse. She stated staff should be posted daily and provided upon request. The facility did not provide a policy related to "Posted Staffing" as requested on 05/04/23. The facility failed to post and provide daily nursing staff numbers and hours and failed to maintain the posted daily nurse staffing data for the required 18 months. This deficient practice had the risk for miscommunication regarding resident care and staffing.	F 732			
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with one resident reviewed for dementia (progressive mental disorder characterized by failing memory, confusion) care services. Based on observation, record review, and interviews, the facility failed to provide adequate dementia care and services for Resident (R) 38 (a cognitively impaired resident displaying dementia related symptoms). This deficient practice placed R38 at risk for preventable injuries and accidents as well as impaired quality of life.	F 744			

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F 744	Continued From page 77 Findings Included: - The "Medical Diagnosis" section within R38's Electronic Medical Records (EMR) included diagnoses of intracerebral hemorrhage (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), hemiplegia (paralysis of one side of the body), aphasia (condition with disordered or absent language function), fracture of left humerus (broken bone of the left upper arm), need for assistance with personal cares, and dysphagia (swallowing difficulty). A review of R38's "Quarterly Minimum Data Set" (MDS) completed 03/09/23 indicated a BIMS assessment could not be completed. The MDS indicated R38 had no behaviors. The MDS noted she required total assistance from one to two staff for transfers, locomotion, toileting, dressing, personal hygiene, and bathing. The MDS indicated she had functional limitations of range of motion (ROM) to both upper and lower extremities and required extensive physical assistance from one staff for bed mobility. The MDS noted she had hearing and visual impairments with no speech. The MDS noted she usually would make herself understood if prompted or given time and would sometimes understand others. The MDS noted she had poor short-term and long-term memory recall with moderately impaired decision-making abilities for daily tasks. A review of R38's "Communication Care Area Assessment" completed 12/20/22 indicated she had communication deficit related to her hearing	F 744			

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F 744	Continued From page 78 impairment, aphasia, difficulty understanding and communicating her needs. The CAA noted staff should learn and be aware of R38's gestures and personal sign language to assist her. The CAA noted a BIMS assessment was not completed due to hearing and language barriers. R38's "Activities of Daily Living (ADLs) CAA" completed 12/20/22 indicated she required total staff assistance for all daily care needs. The CAA indicated she was at risk for skin breakdown related to her bowel and bladder incontinence, communication deficit, limited ROM, and medical diagnoses. A review of R38's "Care Plan" initiated 12/07/22 indicated she had a deficit in cognitive function characterized by deficits with memory, judgment, decision making, and thought processes related to cognitive changes. The plan noted she had aphasia and staff should encourage her to communicate her needs in a slow/calm manner. The plan indicated staff should explain to her before beginning care or tasks (12/07/22). The plan indicated R38 had hearing impairment and used gestures and personal sign language to make staff aware of her needs (12/20/22). The plan instructed staff to reach out to her family to learn about her specific gestures and sign language. The plan indicated she had limitation to her left side and staff should place all items on her right side (12/12/22) The care plan lacked documentation related to refusal of cares provided, medication, and ongoing aggressive behaviors. A "Nurse's Note" on 01/03/23 indicated R38 refused her medications and attempted to hit her nurse. The note indicated R38 hit the medications	F 744			

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F 744	Continued From page 79 out of the nurse's hands. The note indicated R38's Resident Representative had to be contacted to talk with the resident due to the language/communication barrier. A "Nurse's Note" on 02/07/23 indicated R38 attempted to hit and scratched staff during personal cares. The note indicated R38 grabbed items and threw them at staff. The note indicated staff were unable to redirect her due to language/communication barriers. A "Nurse's Note" on 02/13/23 indicated R38 attempted to hit and scratch staff during personal cares. The note indicated R38 continually "pounded" her hand on the edge of the table due to being upset and refusing cares. The note lacked documentation related to interventions provided or attempted. A "Nurse's Note" on 03/07/23 at 06:49PM indicated R38 refused her medication. The note indicated R38 became physically aggressive and slapped the medication out of staff's hand. The note indicated staff attempted to redirect R38, but no other intervention noted. A "Nurse's Note" on 04/16/23 at 06:55PM indicated R38 became physically aggressive with staff during cares and spit out her medication upon administration. The note lacked documentation related to the interventions attempted by staff. On 05/01/23 at 07:50AM Certified Nurse Aided (CNA) M transported R38 from the 300 Hall to the dining area in her Broda chair (specialized wheelchair with the ability to tilt and recline). R38's left arm was immobilized, and she only had	F 744			

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F 744	Continued From page 80 range of motion in her right arm. R38 was agitated during transport and began grabbing at CNA M with her right arm. R38 was positioned in front of the television. CNA M attempted to adjust R38's shirt with R38 still agitated. R38 pushed CNA M's hands away as she attempted to adjust R38's shirt around her stomach. CNA M forcefully grabbed R38's right arm and continued to adjust her shirt. CNA M stepped back and directly behind the chair. R38 calmed down. CNA M brushed her hand through R38's hair. CNA M matted down R38's hair with her hands and R38 swung her right arm upward in protest. CNA M grabbed R38's right upper arm and forearm manipulating it against her body. CNA M failed to communicate with R38 during this interaction. R38 remained agitated and was moved to the dining area for breakfast. R38 grabbed a fork and threatened to stab everyone walking past her in the dining area. An inspection of R38's right arm revealed two older dime-sized brown bruised areas under her upper arm and lower forearm. These bruises were not documented in R38's EMR. In an interview on 05/01/23 at 08:35AM, CNA M reported she was trying to pull R38's shirt down as she was being combative towards staff. CNA M reported she had received some information related to R38's care needs but not about preventing behaviors or caring for her. CNA M stated that it was her first day working with R38 and she was just assisting another staff with moving her to the television. She reported she was agency staff. She stated all staff have access to the Kardex (condensed document containing care planned information) and can ask the nurses if any question arise.	F 744			

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F 744	Continued From page 81 On 05/04/23 at 03:32PM CNA N stated all staff have access to the Kardex that explains each resident's care needs. She stated the Kardex would explain how each resident communicated and should list communication and behavior interventions. She stated R38 refused cares and could be aggressive, but usually will calm down. She stated R38's family came in to help and R38 usually enjoys the interaction with her family. She stated that R38 is deaf (hearing impaired) and uses her own hand gestures for communication. She stated staff should explain to her before giving cares to prevent frightening her. On 05/04/23 at 04:09PM Licensed Nurse (LN) G stated each staff should have access to the care plan for interventions related to refusals and behaviors. She stated if a resident refused cares the direct care staff should notify the nurse. She stated if R38 became agitated or aggressive staff should get her time to process and attempt a different approach. She stated the facility did not provide dementia or behavioral training to her before coming to the facility. On 05/04/23 at 04:20PM Administrative Nurse D stated all staff receive "Dementia and Behavioral Care" Relias (online training service). She stated staff should review the care plans and Kardex information of each resident. A review of the facility's "Behavior Management" policy revised 12/2022 noted that facility will monitor behaviors exhibited by the resident's and provide non-pharmacological interventions. The policy noted prolonged behaviors will be care planned and reviewed by the risk management team. The facility did not provide a policy related to "Dementia Care" as requested on 05/04/23.	F 744			

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F 744	Continued From page 82	F 744			
F 756 SS=D	The facility failed to provide adequate dementia care and services for R38. This deficient practice placed R38 at risk for preventable injuries and accidents and impaired quality of life. Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756			

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F 756	Continued From page 83 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) recommendations were followed up for Resident (R) 33 related to an antihypertensive medication (class of medication used to treat hypertension (high blood pressure) which was held, and the physician was not notified. The facility failed to follow CP recommendations for antihypertensive medication administered outside of physician ordered parameters for R33 and R4. The facility also failed to notify the physician of blood sugars outside of ordered parameters for R33. This deficient practice had the potential for unnecessary medication use and possible adverse consequences and side effects. Findings included: - R33's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide and the lungs are unable to carry the blood to the organs) with hypoxia (inadequate supply of oxygen), hypertension (elevated blood pressure), diabetes mellitus (when the body	F 756			

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F 756	Continued From page 84 cannot use glucose, not enough insulin made or the body cannot respond to the insulin), atrial fibrillation (rapid, irregular heart beat), and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The "Annual Minimum Data Set" (MDS) dated 08/18/22 documented a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R33 was independent with set up assistance for activities of daily living (ADLs). The MDS documented R33 received oxygen therapy during the look back period. The MDS documented R33 received insulin (medication to regulate blood sugar), diuretic (medication to promote the formation and excretion of urine), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), and antipsychotic (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment testing) and other mental emotional conditions) for seven days during the look back period. The "Quarterly MDS" dated 04/28/23 documented a BIMS score of six, which indicated severely impaired cognition. The MDS documented R33 required supervision with set up assistance for ADLs. The MDS documented R33 received oxygen therapy during the look back period. The MDS documented R33 received insulin, diuretic, antidepressant, and antipsychotic medications for seven days during the look back period. R33's " Psychotropic Drug Use Care Area	F 756			

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F 756	Continued From page 85 Assessment" (CAA) dated 08/31/22 documented licensed staff would monitor for medication effectiveness and for any adverse effects. Medications would be periodically reviewed by the pharmacist and as needed. R33's "Care Plan" dated 08/05/21 documented R33 refused to have his blood sugar checked and refused his insulin. Staff was to reapproach R33 later or have a different licensed nurse and staff would notify the physician of all R33's refusals. Review of the EMR under the "Orders" tab revealed physician orders: Dulaglutide solution (insulin) pen-injector 0.75 milligram (mg)/0.5 milliliter (ml), inject three mg subcutaneously (SQ) weekly on Friday related diabetes mellitus dated 04/08/22. Novolog flex pen (insulin)100 unit/ml inject SQ as per sliding scale: if blood sugar 131 - 180 = 4 units; 181 - 240 = 8 units; 241 - 300 = 10 units; 301 - 350 = 12 units; 351 - 400 = 16 units; 401+ = 20 units; 401 or greater (>) =20 UNITS and notify physician. Give Sq with meals for diabetes mellitus dated 04/15/22. Insulin detemir (insulin) solution pen-injector 100 units/ml Inject 47 units SQ at bedtime related diabetes mellitus, notify physician if blood sugar > 300 or less than (<) 70 dated 11/01/22. Novolog (insulin) flex pen solution pen-injector 100 unit/ml inject 18-unit SQ with meals related to diabetes mellitus, hold if patient is nothing by mouth, not eating or blood sugar was 110 or below, or > 400, notify the physician dated 04/01/23.	F 756			

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F 756	Continued From page 86 Metoprolol tartrate (antihypertensive) tablet 50 milligrams (mg) give one tablet two times a day related to atrial fibrillation. Hold for systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was < 110 or Heart rate < 60 beats per minute, notify the physician. Manual blood pressure cuff and manual heart rate dated 04/05/23. Review of EMR under "Orders" tab, "Medication Administration Record" (MAR) were reviewed from 02/01/23 to 05/02/23 revealed metoprolol was held (91 days) 19 times on the following dates: 02/04/23 (2 times that day), 02/07/23, 02/08/23, 02/15/23, 02/22/23 (2 times that day), 02/28/23, 03/01/23, 03/08/23, 03/09/23 (2 times that day), 03/16/23, 03/17/23, 04/05/23, 04/13/23, 04/14/23, 04/17/23 and 04/29/23. R33 had refused medication on 03/17/23. Metoprolol was administered outside the physician ordered parameter on following dates 03/02/23, 03/03/23, 04/25/23. The clinical lacked documentation the physician was notified medication was held 19 times and given outside physician ordered parameters on three times. Review of EMR under "Orders" tab, MAR was reviewed from 02/01/23 to 05/02/23 revealed blood sugar was > 300 on following dates 02/08/23, 02/17/23, 02/22/23, and 04/11/23. Blood sugar results < 110 on following dates 03/13/23, 03/14/23, and 04/22/23. The clinical record lacked documentation physician was notified of blood sugars outside the physician ordered parameters. Review of the "Monthly Medication Review"	F 756			

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F 756	Continued From page 87 (MMR) from April 2022 to March 2023 documented recommendations from June 2022 and August 2022, which noted vitals sign were not documented on the MAR prior to admission of antihypertensive medications. The October 2022, December 2022, January 2023, February 2023, and March 2023 recommendation noted irregularities of antihypertensive medication, which were not administered as physician ordered. January 2023 February 2023, and March 2023 MRR noted irregularities of physician ordered blood sugar parameters had not been followed. On 05/02/23 at 11:46 AM R33 laid on the bed, undated oxygen tubing and nasal cannula was hung over the back of wheelchair next to the bed. No plastic was available to store the oxygen tubing and the nasal cannula when not in use. On 05/04/23 at 04:09 PM Agency Licensed Nurse (LN) G stated she had not seen the pharmacy monthly reviews. On 05/04/23 at 04:26 PM Administrative Nurse D stated the MMR were emailed to her monthly. Administrative Nurse D stated she printed the reports off, then passed them out to the physicians to review and make changes and add new orders. Administrative Nurse D stated once the MMR were returned, they were reviewed and new orders or any changes were entered into the resident's clinical record. The facility's "Medication regimen review and Reporting" policy dated 01/2023 documented the nursing care center would follow up on the recommendations to verify that appropriate action would be taken. Recommendations would be	F 756			

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F 756	Continued From page 88 acted upon within 30 calendar days. For those issues that require physician intervention, the attending physician would either accepts and act upon the report and recommendations or rejects all or some of the report and would document his or her rationale of why the recommendation was rejected in the resident's medical record. If there was a potential for serious harm and the attending physician does not concur, or refuses to document an explanation, the director of nursing and the consultant pharmacist contact the medical director. If the attending physician is also the medical director, a meeting shall be arranged to discuss issues and come to an agreement to ensure that no actual harm occurred. For recommendations that do not require physician intervention, the director of nursing or licensed designee will address the recommendation. Should the consultant pharmacist detect a potentially clinically significant medication issue that required urgent action to protect the resident, he/she will promptly alert the direct care nurse for immediate action. If prescriber intervention was required, facility staff would ensure proper communication was provided to the attending physician, nurse practitioner or physician's assistant to ensure resolution by midnight of the next calendar day. Recommendations regarding implementation of nursing care center policies, procedures, and/or methods of medication administration are made by the consultant pharmacist when appropriate. These findings are presented to the nursing care center's Quality Assessment and Assurance Committee. The facility failed to ensure CP recommendations had been addressed and followed for R33's physician orders for hypertensive medication and parameters for blood sugars. This deficit practice	F 756			

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F 756	Continued From page 89 placed R33 at risk of adverse side effects and for unnecessary medications related diabetes mellitus and atrial fibrillation. - R4's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (elevated blood pressure), major depressive disorder (major mood disorder) and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The "Annual Minimum Data Set" (MDS) dated 12/29/22 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R4 required extensive assistance of one staff member for activities of daily living (ADLs). The MDS documented R4 required physical assistance of one staff member for bathing during the look back period. The MDS documented R4 received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) for seven days during the look back period. The "Quarterly MDS" dated 03/27/23 documented a BIMS score of four, which indicated severely impaired cognition. The MDS documented R4 required extensive assistance of one staff member for ADLs. The MDS documented bathing did not occur during the look back period for R4. The MDS documented R4 received antipsychotic medication and antidepressant medication for seven days during the look back period. R4's "ADL Functional/Rehabilitation Potential	F 756			

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F 756	Continued From page 90 Care Area Assessment" (CAA) dated 01/06/23 documented R4 was at risk of ADL decline related to the need for assistance with ADLs. R4's "Care Plan" dated 01/31/22 documented staff was to administer medication as per physician orders. Review of the EMR under "Orders" tab revealed physician orders: Amlodipine besylate tablet 10 milligrams (mg) give one tablet by mouth daily related to hypertension. Hold for systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was below (<) 110 or heart rate < 60 beats per minute and notify the physician dated 04/07/22. Review of EMR under "Orders" tab, "Medication Administration Record" (MAR) were reviewed from 02/01/23 to 05/02/23 revealed amlodipine was held on the following dates 02/09/23, 02/15/23, 03/11/23, 03/13/23, 03/15/23, 03/22/23, 03/31/23, 04/02/23, 04/04/23, 04/16/23, and 04/19/23. The clinical record lacked documentation the physician was notified the resident's hypertensive medication was held. Review of the "Monthly Medication Review" (MMR) from April 2022 to March 2023 documented recommendations from March 2023 to review antihypertensive medication orders for hold parameters and physician notification. On 05/02/23 at 01:42 PM, R4 laid on right side on the bed asleep, covered with a blanket.	F 756			

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F 756	Continued From page 91 On 05/04/23 at 04:09 PM Agency Licensed Nurse (LN) G stated she had not seen the pharmacy monthly reviews. On 05/04/23 at 04:26 PM Administrative Nurse D stated the MMR were emailed to her monthly. Administrative Nurse D stated she printed the reports off, then passed them out to the physicians to review and make changes and add new orders. Administrative Nurse D stated once the MMR were returned, they were reviewed and new orders or any changes were entered into the resident's clinical record. The facility's "Medication regimen review and Reporting" policy dated 01/2023 documented the nursing care center would follow up on the recommendations to verify that appropriate action would be taken. Recommendations would be acted upon within 30 calendar days. For those issues that require physician intervention, the attending physician would either accepts and act upon the report and recommendations or rejects all or some of the report and would document his or her rationale of why the recommendation was rejected in the resident's medical record. If there was a potential for serious harm and the attending physician does not concur, or refuses to document an explanation, the director of nursing and the consultant pharmacist contact the medical director. If the attending physician is also the medical director, a meeting shall be arranged to discuss issues and come to an agreement to ensure that no actual harm occurred. For recommendations that do not require physician intervention, the director of nursing or licensed designee will address the recommendation. Should the consultant pharmacist detect a potentially clinically significant medication issue	F 756			

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F 756	Continued From page 92 that required urgent action to protect the resident, he/she will promptly alert the direct care nurse for immediate action. If prescriber intervention was required, facility staff would ensure proper communication was provided to the attending physician, nurse practitioner or physician's assistant to ensure resolution by midnight of the next calendar day. Recommendations regarding implementation of nursing care center policies, procedures, and/or methods of medication administration are made by the consultant pharmacist when appropriate. These findings are presented to the nursing care center's Quality Assessment and Assurance Committee. The facility failed to ensure CP recommendations had been addressed and followed for R4's physician orders for hypertensive medication. This deficit practice placed R4 risk of adverse side effects and for unnecessary medications related hypertension.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757			

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F 757	Continued From page 93 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to follow physician orders for Resident (R) 33's antihypertensive medication (class of medication used to treat hypertension (high blood pressure)), when staff held the medication and did not notify the physician, as ordered.. The facility failed to follow the consultant pharmacist recommendations for antihypertensive medication administered outside of physician ordered parameters for R33 and R4. The facility also failed to notify the physician of blood sugars outside of ordered parameters for R33. This deficient practice had the potential for unnecessary medication use and possible adverse consequences and side effects. Findings included: - R33's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of respiratory failure (condition in which the blood does not have enough oxygen or has too much carbon dioxide and the lungs are unable to carry the blood to the organs) with hypoxia (inadequate supply of oxygen), hypertension (elevated blood pressure), diabetes mellitus (when the body	F 757			

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F 757	Continued From page 94 cannot use glucose, not enough insulin made or the body cannot respond to the insulin), atrial fibrillation (rapid, irregular heart beat), and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The "Annual Minimum Data Set" (MDS) dated 08/18/22 documented a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R33 was independent with set up assistance for activities of daily living (ADLs). The MDS documented R33 received oxygen therapy during the look back period. The MDS documented R33 received insulin (medication to regulate blood sugar), diuretic (medication to promote the formation and excretion of urine), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), and antipsychotic (class of medications used to treat psychosis (any major mental disorder characterized by a gross impairment testing) and other mental emotional conditions) for seven days during the look back period. The "Quarterly MDS" dated 04/28/23 documented a BIMS score of six, which indicated severely impaired cognition. The MDS documented R33 required supervision with set up assistance for ADL. The MDS documented R33 received oxygen therapy during the look back period. The MDS documented R33 received insulin, diuretic, antidepressant, and antipsychotic medications for seven days during the look back period. R33's "Psychotropic Drug Use Care Area	F 757			

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F 757	Continued From page 95 Assessment" (CAA) dated 08/31/22 documented licensed staff would monitor for medication effectiveness and for any adverse effects. R33's "Care Plan" dated 08/05/21 documented R33 refused to have his blood sugar checked and refused his insulin. Staff were to reapproach R33 later or have a different licensed nurse approach, and staff would notify the physician for all of R33's refusals. Review of the EMR under the "Orders" tab revealed the following five "Physician Orders": 1. Dulaglutide solution (insulin) pen-injector 0.75 milligram (mg)/0.5 milliliter (ml), inject three mg subcutaneously (SQ) weekly on Friday related diabetes mellitus dated 04/08/22. 2. Novolog flex pen (insulin)100 unit/ml inject SQ as per sliding scale: if blood sugar 131 - 180 = 4 units; 181 - 240 = 8 units; 241 - 300 = 10 units; 301 - 350 = 12 units; 351 - 400 = 16 units; 401+ = 20 units; 401 or greater (>) =20 UNITS and notify physician. Give Sq with meals for diabetes mellitus dated 04/15/22. 3. Insulin detemir (insulin) solution pen-injector 100 units/ml Inject 47 units SQ at bedtime related diabetes mellitus, notify physician if blood sugar > 300 or less than (<) 70 dated 11/01/22. 4. Novolog (insulin) flex pen solution pen-injector 100 unit/ml inject 18-unit SQ with meals related to diabetes mellitus, hold if patient is nothing by mouth, not eating or blood sugar was 110 or below, or > 400, notify the physician dated 04/01/23.	F 757			

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F 757	Continued From page 96 5. Metoprolol tartrate (antihypertensive) tablet 50 milligrams (mg) give one tablet two times a day related to atrial fibrillation. Hold for systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was < 110 or heart rate < 60 beats per minute and notify the physician. Manual blood pressure cuff and manual heart rate dated 04/05/23. The "Medication Administration Record" (MAR) were reviewed from 02/01/23 to 05/02/23 and revealed the staff held metoprolol (91 days) 19 times on the following dates: 02/04/23 (twice), 02/07/23, 02/08/23, 02/15/23, 02/22/23 (twice), 02/28/23, 03/01/23, 03/08/23, 03/09/23 (twice), 03/16/23, 03/17/23, 04/05/23, 04/13/23, 04/14/23, 04/17/23 and 04/29/23. R33 refused medication on 03/17/23. The staff administered R33's metoprolol outside the physician ordered parameter on following dates 03/02/23, 03/03/23, and 04/25/23. The clinical lacked documentation of physician notification the medication was held 19 times and given outside physician ordered parameters on three times. The MAR was reviewed from 02/01/23 to 05/02/23 and revealed blood sugar was > 300 on following dates 02/08/23, 02/17/23, 02/22/23, and 04/11/23. Blood sugar results < 110 on following dates 03/13/23, 03/14/23, and 04/22/23. The clinical record lacked documentation of physician notification of blood sugars outside the physician ordered parameters. On 05/02/23 at 11:46 AM R33 laid on the bed, with oxygen on and appeared. R33 rested quietly. On 05/04/23 at 04:09 PM Licensed Nurse (LN) G	F 757			

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F 757	Continued From page 97 stated if vital signs were outside the physician ordered parameters, she would hold the medication, notify the physician, and document the communication in the resident's clinical record, under the progress notes. On 05/04/23 at 04:26 PM Administrative Nurse D stated she expected the LN to follow the physician orders regarding administration of hypertensive medication and to notify the physician. Administrative Nurse D stated the LN would document the notification in the progress notes. The facility's "Medication Administration General Guidelines" policy dated 01/2023 documented prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. Apply a "direction change" sticker to label if directions have changed from the current label. The facility failed to ensure physician orders for R33's was followed for hypertensive medication and parameters for blood sugars. This deficient practice placed R33 at risk of adverse side effects and for unnecessary medications related to diabetes mellitus and hypertension. - R4's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of hypertension (elevated blood pressure), major	F 757			

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F 757	Continued From page 98 depressive disorder (major mood disorder) and diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). The "Annual Minimum Data Set" (MDS) dated 12/29/22 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R4 required extensive assistance of one staff member for activities of daily living (ADL). The MDS documented R4 received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) for seven days during the look back period. The "Quarterly MDS" dated 03/27/23 documented a BIMS score of four, which indicated severely impaired cognition. The MDS documented R4 required extensive assistance of one staff member for ADL. The MDS documented R4 received antipsychotic medication and antidepressant medication for seven days during the look back period. R4's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 01/06/23 documented R4 was at risk of ADL decline related to the need for assistance with ADL. R4's "Care Plan" dated 01/31/22 documented staff was to administer medication as per physician orders. Review of the EMR revealed the following "Physician Orders" for amlodipine besylate tablet	F 757			

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F 757	Continued From page 99 10 milligrams (mg) give one tablet by mouth daily related to hypertension. Hold for systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was below (<) 110 or heart rate < 60 beats per minute and notify the physician dated 04/07/22. Review of EMR "Medication Administration Record" (MAR) reviewed from 02/01/23 to 05/02/23 revealed amlodipine was held on the following dates 02/09/23, 02/15/23, 03/11/23, 03/13/23, 03/15/23, 03/22/23, 03/31/23, 04/02/23, 04/04/23, 04/16/23, and 04/19/23. The clinical record lacked documentation of physician notification for the resident's hypertensive medication being held. On 05/02/23 at 01:42 PM, R4 laid on right side on the bed asleep, covered with a blanket. On 05/04/23 at 04:09 PM Licensed Nurse (LN) G stated if vital signs were outside the physician ordered parameters, she would hold the medication, notify the physician, and document the communication in the resident's clinical record, under the progress notes. On 05/04/23 at 04:26 PM Administrative Nurse D stated she expected the LN to follow the physician orders regarding administration of hypertensive medication and to notify the physician. Administrative Nurse D stated the LN would document the notification in the progress notes. The facility's "Medication Administration General Guidelines" policy dated 01/2023 documented prior to administration, review and confirm	F 757			

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F 757	Continued From page 100 medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. Apply a "direction change" sticker to label if directions have changed from the current label.	F 757			
F 761 SS=E	The facility failed to ensure staff followed physician orders for R4's antihypertensive medication. This deficient practice placed R4 at risk of adverse side effects and for unnecessary medications related to hypertension. 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 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	F 761			

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F 761	Continued From page 101 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 reported a census of 45 residents. Based of observations, record review, and interviews, the facility failed to ensure safe storage and handling of the resident's medications. This deficient practice placed the residents at risk for unnecessary medication and administration errors. Findings Included: - On 05/02/23 at 07:38 AM an inspection of the medication cart in the 100 Hall revealed one Novolog Flexpen (injectable short-acting hormone which regulates blood sugar) left unsecured and one Lispro Flexpen (injectable long-acting hormone which regulates blood sugar) left unsecured on top of the medication storage cart. On 05/04/23 at 01:05 PM an inspection of the "Nurses" medication storage room was completed. The inspection revealed the medication storage refrigerator temperature log was not being completed. An open cup pudding labeled March 2023 was inside the refrigerator. Licensed Nurse (LN) G stated the refrigerator temperature and contents should be checked each shift. LN G immediately threw away the expired pudding. On 05/04/23 at 01:40 PM an inspection of the	F 761			

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F 761	Continued From page 102 facility's medication room revealed expired medication for the following residents: R22 had 17 amlodipine (medication used to treat high blood pressure) tablets expired in 03/2023 and 30 Metoprolol (medication used to treat high blood pressure) tablets expired in 04/2023 storage with active medications. R4 had 60 quetiapine (antipsychotic medication used to treat psychosis and other mental emotional conditions) tablets expired in 03/2023 mixed in with active medications. R3 had 120 hydralazine (medication used to treat high blood pressure) tablets with expirations from 12/2022 to 02/2023 mixed in with active medications. R7 had 150 hydralazine tablets with expirations from 11/2022 to 02/2023 mixed in with active medications. On 05/04/23 at 01:45PM Certified Medication Aid (CMA) R reported all expired medications would be thrown away and reordered for the residents. She stated the pharmacist should be coming out monthly to inspect the medication rooms and carts. On 05/04/23 at 03:55PM Administrative Nurse D stated medications should be securely stored and checked each shift by the licensed staff handling the meds. She stated expired medications should be discarded and reordered before the medication ran out or expired. A review of the facility's "Medication Administration" policy revised 01/2023 indicated	F 761			

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F 761	Continued From page 103 that all medications will be stored in a manner that is sanitary, temperature/moisture controlled, and secured. The policy indicated medication supply will be monitored and reordered before expiration or low supply. The facility failed to ensure safe storage and handling of the resident's medications. This deficient practice placed the residents at risk for unnecessary medication and administration errors.	F 761			
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. (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 45 residents. The facility had one main kitchen. Based on observations, record review, and interviews, the	F 812			

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F 812	Continued From page 104 facility failed to properly label and store food, failed to store clean dishes inverted, failed to prevent cross-contamination during puree (mechanically altered diet) and mechanical soft (mechanically altered diet) diet preparation, and failed to ensure staff wore hair nets appropriately in the kitchen. This deficient practice had the risk to spread foodborne illness to all affected residents. Findings included: - On 05/01/23 at 07:17 AM, the refrigerator revealed two uncovered pudding cups and an Italian dressing bottle with the lid partially on and dressing crusted around the opening. Plates were stored at the end of the steam table, not inverted, or covered to prevent contamination. On 05/01/23 at 07:19 AM, the freezers revealed a bag of strawberries that leaked to the shelf below it and a bag of unidentified meat patties, opened and not dated. On 05/01/23 at 07:19 AM, the dry storage revealed a bag of beans, opened and not dated; a bag of cake mixes, opened and not dated; a bag of macaroni noodles, opened and not dated; and a bag of flour tortilla shells, opened and not dated. On 05/02/23 at 11:07 AM, Dietary CC was preparing the puree diet lunch and used gloves when preparing the first batch. When she prepared the second batch, she touched the chicken without gloves and placed it in the food processor. Dietary CC then prepared the mechanical soft diet lunch and wore gloves. She touched the food processor lid then grabbed the	F 812			

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F 812	Continued From page 105 chicken with her gloved hands without using utensils. On 05/04/23 at 11:16 AM, plates were stored at the end of the steam table, not inverted or covered to prevent contamination. Dietary DD and Dietary EE wore their hairnets on top of their head with their hair hanging out of the bottom of the hair net. On 05/03/23 at approximately 10:00 AM, Dietary BB stated she was training to become the certified dietary manager (CDM) and stated that she oversaw the kitchen. She stated she was responsible for handling food preferences for the residents. On 05/03/23 at 04:30 PM, Dietary BB was unavailable for interview. On 05/09/23 at 10:37 AM, Consultant HH stated she did spot inspections and consulted with Dietary BB about the findings. She stated she noticed some expired foods and improperly kept items in storage. The facility's undated "Food Storage" policy documented that all foods held longer than 24 hours are to be labeled and that the label must include the name of the food and the date by which it should be sold, consumed, or discarded. The facility failed to properly label and store food, failed to store clean dishes inverted, failed to prevent cross-contamination during puree and mechanical soft diet preparation, and failed to ensure staff wore hair nets appropriately in the kitchen. This deficient practice had the risk to spread foodborne illness to all affected residents.	F 812			

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F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope.	F 865			

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F 865	Continued From page 107 A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;	F 865			

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F 865	Continued From page 108 §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. Based on observations, record reviews, and interviews, the facility failed to maintain an effective quality assessment and assurance (QAA) program to develop corrective actions plans and monitor them to correct identified quality deficiencies prior to survey. This deficient practice placed the residents at risk for ineffective care. Findings Included: The facility failed to ensure cognitively impaired,	F 865			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175135		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2023	
NAME OF PROVIDER OR SUPPLIER MEDICALODGES POST ACUTE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6500 GREELEY AVENUE KANSAS CITY, KS 66104			
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F 865	Continued From page 109 dependent R38 (moderately cognitively impaired resident) remained free from abuse when the facility failed to prevent an episode of staff to resident physical abuse. (Refer to F600) The facility failed to ensure staff effectively communicated with R38 (moderately cognitively impaired resident the uses gestures and sign language to communicate) during ADL care. (Refer to F676) The facility failed to ensure bathing was provided for four residents who required assistance from staff to complete the care. This deficient practice placed resident (R)103, R29, R4 and R18 at risk for potential skin breakdown and/or skin complications from not maintaining good personal hygiene and bathing practices. Refer to F677) The facility failed to provide activities for the residents on weekends and for isolated residents. (Refer to F679) The facility failed to ensure staff implemented appropriate infection control practices during wound care for Resident (R) 18, who was on an antibiotic (medication used to treat bacterial infections) for a wound infection. This deficient practice placed R18 at risk of wound worsening and complications related to infections. (Refer to F686) The facility failed to implement toileting interventions after R40 experienced falls related to incontinence, resulting in multiple falls and a hospitalization for a femur fracture. This deficient practice placed the residents at risk for preventable falls and injuries. (Refer to F689)			F 865			

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F 865	Continued From page 110 The facility failed to implement individualized toileting interventions related to bowel and bladder incontinence. (Refer to F690) The facility failed to maintain nutritional intake related to R38's continual refusal of food and dietary supplementation. This deficient practice resulted in R38's 21.74 percent (%) severe weight loss in four months. (Refer to F692) The facility failed to provide adequate dementia care and services for R38. This deficient practice placed R38 at risk for preventable injuries and accidents. (Refer to F744) The facility failed to maintain the posted daily nurse staffing data for the required 18 months. This deficient practice had the risk for miscommunication regarding resident care and staffing. (Refer to F732) The facility failed to ensure the Consultant Pharmacist (CP) recommendations were followed up for R33 related to an antihypertensive medication (class of medication used to treat hypertension (high blood pressure) which was held, and the physician was not notified. The facility failed to follow CP recommendations for antihypertensive medication administered outside of physician ordered parameters for R33 and R4. The facility also failed to notify the physician of blood sugars outside of ordered parameters for R33. This deficit practice had the potential for unnecessary medication use and possible adverse consequences and side effects. (Refer to F756) The facility failed to ensure staff exercised appropriate infection control techniques to	F 865			

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F 865	Continued From page 111 prevent the transmission of COVID-19 within the facility. The facility failed to disinfect shared equipment used on COVID-19 positive and COVID-19 negative residents. The facility failed to accurately identify COVID-19 positive resident rooms, inform staff of COVID-19 positive test results, and implement the required isolation, with the appropriate signage and PPE designation for those positive residents. The facility further failed to ensure positive COVID-19 residents did not share a room with residents who tested negative. The facility failed to ensure staff used the appropriate personal protective equipment (PPE) required when caring for COVID-19 positive residents and failed to use standards of practice related to the use of PPE including appropriate use of source control, respirators, gowns and proper removal and disposal of soiled PPE when exiting the infectious room/area. The facility failed to post the appropriate signage announcing the COVID-19 outbreak status and ensuring all who entered the facility received education and information related to COVID-19 and related risks. (Refer to F880) The facility failed to obtain pneumococcal (infection that inflames air sacs in one or both lungs which may fill with fluid) vaccination signed consents or declinations for R4, R41, and R44 and the facility failed to administer pneumococcal vaccination after signed consent was obtained for R29. This deficient practice had the risk for unwarranted physical complications and the risk to spread illness among residents, a high-risk population. (Refer to F883) The facility failed to obtain signed consents or declinations for COVID-19 vaccinations for R44. This deficient practice had the risk for	F 865			

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F 865	Continued From page 112 unwarranted physical complications and the risk to spread illness among residents, a high-risk population. (Refer to F887) On 05/04/23 at 04:34PM Administrative Staff A reported that the facility's Quality Assurance Performance Improvement Team (QAPI) team officially meets every quarter but discusses concerns and issues monthly. She stated identified issues can be reported to the leadership team by staff or residents. She stated each issue brought to the committee's attention is assessed. She stated the facility recently had performance improvement plans for weight loss, falls, and infection control. A review of the facility's "Quality Assurance Performance Improvement (QAPI)" policy (undated) noted that the facility will consistently develop and processes and systems to provide safe, effective, and optimal care and services to each resident residing in the facility. The QAPI process will address issues within clinical care, quality of life, resident choice, care transitions, services provided by the facility. The policy indicated that QAPI leadership was responsible for ensuring the staff training was completed to meet and sustain goals developed by the QAPI team. The policy stated that that QAPI team will monitor the effectiveness of the interventions.	F 865			
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880			

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F 880	Continued From page 113 §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 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:	F 880			

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F 880	Continued From page 114 (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 identified a census of 45 residents. The facility identified 22 COVID-19 (an acute respiratory illness capable of producing severe symptoms and in some cases death) positive residents on 05/02/23. Based on observations, record review, and interviews, the facility failed to ensure staff exercised appropriate infection control techniques to prevent the transmission of COVID-19 within the facility. The facility failed to disinfect shared equipment used on COVID-19 positive negative residents. The facility failed to	F 880			

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F 880	Continued From page 115 accurately identify COVID-19 positive resident rooms, inform staff of COVID-19 positive test results, and implement the required isolation, with the appropriate signage and personal protective equipment (PPE- gloves, gowns, face shields and/or eyeglasses/goggles) designation for those positive residents. The facility further failed to ensure positive COVID-19 residents did not share a room with residents who tested negative. The facility failed to ensure staff used the appropriate PPE required when caring for COVID-19 positive residents; failed to use standards of practice related to the use of PPE including appropriate use of source control, respirators, gowns; and proper removal and disposal of soiled PPE when exiting the infectious room/area. The facility failed to post the appropriate signage announcing the COVID-19 outbreak status and ensuring all who entered the facility received education and information related to COVID-19 and related risks. The cumulation of these failures placed all residents in the facility in immediate jeopardy. Findings included: - On 05/01/2023 at 07:00 AM an inspection of the facility's main entrance revealed no signage alerting employees, vendors, residents, and visitors of the COVID-19 exposure risk due to current outbreak, or education related to signs/symptoms associated with COVID-19 and guidance on visitation with known COVID-19 exposure, positive COVID-19 test results or symptoms. On 05/01/23 at 07:09 AM, observation revealed an uncovered trash barrel with used PPE in the 200 hallways where COVID-19 positive and	F 880			

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F 880	Continued From page 116 negative residents resided. On 05/01/23 at 07:49 AM, an unidentified female staff member walked down the 200-hallway with her shirt pulled up over her mouth; she did not wear a facemask. On 05/01/23 at 08:13 AM, an unidentified staff wore a face mask below her nose and frequently touched her mask without performing hand hygiene before or after touching their mask. On 05/01/23 at 08:52 AM, observation revealed Certified Nurse Aide (CNA) M had her face mask pulled down to her chin exposing her mouth and nose. On 05/02/23 at 07:20 AM, staff moved the full-body mechanical lift into Resident (R)44's room from the hallway. The lift was not disinfected before transferring R44 into his wheelchair using the lift and sling. After use, staff moved the lift to the hallway across from R44's room without disinfecting the lift. The lift was then moved to another area and positioned with the lift arm over a trashcan. The trash can lid was partially open. On 05/02/23 at 07:34 AM an inspection of the 300 Hall revealed an uncovered clean linen cart left unattended in the middle of 300 hall in front of R47's (who tested COVID-19 positive on 05/04/23) room. The cart contained unused bed linen and pillowcases. On 05/02/23 at 07:40 AM, the facility's sit-to-stand (mechanical assistive lift) was moved from the designated COVID-19 hallway and positioned outside R7's room, who was COVID-19 negative.	F 880			

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F 880	Continued From page 117 The lift was then moved into R7's room without being disinfected and positioned in front of R7's bed. Staff completed an assisted transfer of R7 using the lift. Staff moved the lift back out into the hall across from R7's room without cleaning it and continued to assist R7 with dressing. Staff then took the lift back to the COVID-19 unit and posted it next to the medication cart. On 05/02/23 at 08:11 AM Social Service X walked from R99's room (who tested positive for COVID-19 on 04/24/23) with an isolation gown on. Social Service X walked from the 200-hallway down the 300 hallways with the isolation gown on, and then down the 100 hallways to R99's previous room. Social Service X pushed a wheelchair retrieved from R99's previous room, down the 100 hallways as she wore the isolation gown. She stopped to talk to with an unidentified resident in the 100 hallway. Social Service X left the empty wheelchair from R99's previous room in the hallway and pushed an unidentified resident into the dining room as she wore the isolation gown. Social Service X returned to the 100 hallway and retrieved the empty wheelchair and pushed the wheelchair down the 200 hallways to R99's current room. Social Service X exited R99's isolation room still wearing the isolation gown and went down the hallway to the nurse's station. Social Service X then walked back down the 200 hallway and removed the isolation gown but did not perform hand hygiene afterwards. On 05/02/23 at 11:07 AM, an unidentified female staff wore her face mask below her nose. She pulled the mask down to her chin without performing hand hygiene before or after touching	F 880			

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F 880	Continued From page 118 the mask. On 05/02/23 at 02:45 PM, CNA P assisted R41 to walk across the television room and sit on the couch. R41 used a walker and CNA P walked right next to her. CNA P wore a KN-95 (higher level respirator mask) but wore it inappropriately, without it covering her nose. On 05/04/23 at 07:05 AM, an uncovered linen cart containing unused towels and bed linen was observed in the 100-hallway across from a COVID-19 positive isolation room. On 05/04/23 at 08:30 AM, CNA Q spoke to a resident in the resident's room on the 100-hallway. CNA Q opened the door, and doffed (removed) gloves and isolation booties then exited the room without performing hand hygiene. CNA Q entered the shower room and closed the door. On 05/04/23 at 08:42 AM, CNA MM adjusted her face mask multiple times but did not wash her hands before proceeding to the kitchen to wait for room trays. On 05/04/23 at 08:45 AM, Certified Medication Aide (CMA) R loaded breakfast room trays with her hair hanging down her back. She adjusted her face mask and did not wash her hands before continuing to get the room trays ready. On 05/04/23 at 08:47 AM, an unidentified dietary staff was noted to have her face mask hanging on her right ear with her mouth exposed while she prepared breakfast plates. On 05/04/23 at 08:49 AM, CNA PP entered a room on 100-hall and did not sanitize her hands	F 880			

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F 880	Continued From page 119 upon entering. CNA PP greeted residents, then exited the room to put on gloves without performing hand hygiene. On 05/04/23 at 09:04 AM, CNA NN donned (put on) gloves without performing hand hygiene. He donned an isolation gown, did not tie the gown, then proceeded into a COVID-19 positive room with room tray. CNA NN then exited the room, doffed gown, and gloves, did not perform hand hygiene, then donned new gloves and gown and entered another COVID-19 positive room. He exited that room, doffed gown, and gloves, but did not perform hand hygiene before he grabbed a room tray and entered another COVID-19 negative room. CNA NN exited the COVID-19 negative room and did not perform hand hygiene. He donned gloves and gown to enter a COVID-19 positive room to deliver a room tray, doffed gown, and gloves before exiting, but did not perform hand hygiene. CNA NN delivered a room tray to a COVID-19 negative room and did not perform hand hygiene. He donned gloves and gown to deliver a room tray to a COVID-19 positive room; he exited the room and doffed gloves and gown without performing hand hygiene afterwards. CNA NN donned gloves and gown and entered another COVID-19 positive room. On 05/02/23, R2's, R31's and R99 (who shared a room with R26)) were in isolation lacked signage outside the room to direct staff on the type of isolation and PPE required. The facility had five residents (R16, R29, R44, R30, and R49) who were negative for COVID-19 but shared a room with COVID-19 positive residents. On 05/04/23 at 10:50 AM R18 laid on his back on the bed. Licensed Nurse (LN) I and Administrative	F 880			

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F 880	Continued From page 120 Nurse E used hand sanitizer and doffed gloves to provide wound care for R18. Wound care items were placed on a barrier. Administrative Nurse E removed R18's soiled dressings from his buttocks and Administrative Nurse E then placed a barrier between R18's buttocks and the bed. R18 was incontinent of stool, Administrative Nurse E removed disposable wipes from R18's dresser and provided peri care. Administrative Nurse E doffed her gloves and did not perform hand hygiene prior to donning new gloves. Administrative Nurse E asked LN I if she was to remove the threes soiled dressing from R18's left foot. Administrative Nurse E pulled on the trash bag and then returned to assist with holding R18's left leg. LN I doffed soiled gloves, hand sanitized and donned new gloves. LN I used a new dry gauze dressing to dry to wound bed, applied skin prep to peri-wound, then used the tip to apply prescribed ointment to wound bed. LN I applied ointment to island dressing before she applied the dressing to pressure ulcer. LN I doffed soiled gloves, hand sanitized and donned new pair of gloves. Administrative Nurse E touched her facial mask with her gloved hand, then placed the same gloved hand onto R18's bed. Administrative Nurse E with the same gloves she placed gauze dressing into plastic medication cup with normal saline, opened border dressing and placed prescribed ointment into plastic medication cup. LN I cleansed third pressure wound on R18's left foot. LN I doffed soiled gloves, failed to hand sanitize prior to donning new gloves. LN I doffed soiled gloves; hand sanitized prior to donning a new pair of gloves. Administrative Nurse E removed the treatment barrier and placed onto the overflowing trash bag, then placed soiled incontinence brief into the trash can. Administrative Nurse E doffed	F 880			

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F 880	Continued From page 121 soiled gloves hand sanitized prior to donning a new pair of gloves, removed soiled dressing from left ankle. On 05/02/23 at 02:45 PM, Administrative Nurse D stated the facility was currently in outbreak testing for COVID-19 which started with an employee testing positive at work. She stated the facility immediately went into outbreak testing and started testing each resident. Administrative Nurse D stated the facility staff were wearing face masks before the outbreak but switched to N-95 masks (higher level respirator mask) once the outbreak occurred. She stated the facility put positive residents in isolation and signage was posted on the door to alert staff and visitors. She stated all visitors were encouraged to wear masks due to the outbreak but not sure why signage was not currently posted on the entry doors to alert entrants of the facility about the outbreak. She stated the facility was currently transitioning COVID-19 positive residents to the 200-Hall, but all COVID-19 positive residents should have transmission precaution signage posted outside their rooms to indicate the PPE requirements. At 02:45PM Administrative Nurse D stated all equipment should be disinfected before use in between residents. She stated equipment should not be shared between infected and non-infected residents but if required the equipment should be thoroughly disinfected before and after use. On 05/04/23 at 08:37 AM, CNA P stated she did not wash her hands when she exited the room. On 05/04/23 at 11:35 AM LN I stated she should have hand sanitized between doffing and donning new gloves. LN I stated she realized she forgot to	F 880			

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F 880	Continued From page 122 hand sanitize when she applied the border dressing. On 05/04/23 at 11:36 AM Administrative Nurse E stated hand hygiene should be performed between donning and doffing gloves. Administrative Nurse E stated she should have changed her gloves and hand sanitized after touching the trash can and before she touched R18 again. Administrative Nurse E stated she had only touched the outside of the trash can. On 05/04/23 at 03:32 PM CNA N stated staff should wash hands or hands sanitize between donning and doffing gloves when providing resident care. CNA N stated shared equipment should always be sanitized between each use and not shared between COVID-19 positive residents and non-positive residents. CNA N stated the facility just had an in-service this week to review hand hygiene and PPE use. On 05/04/23 at 04:26 PM Administrative Nurse D stated staff should wash, or hand sanitize hands between donning and doffing of gloves when providing care or treatments. Administrative Nurse D stated the last in-service for hand hygiene and PPE was in 08/2022 and again this week they had an in-service with the staff. The facility's "Hand Hygiene" policy dated 05/2017 documented hand hygiene would be completed by staff between glove changes during care or procedures. The facility's "Infection Management Process" policy dated 12/1019 documented staff would be educated on proper use of PPE when handling soiled clothing and linen s. PPE includes gowns,	F 880			

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F 880	Continued From page 123 gloves, mask, and eye shields. Posting to notify employees, visitors and volunteers would be implemented to identify isolation precautions to be utilized including the correct PPE to be used. Residents requiring room isolation may be cohorted with another resident with the same condition. The facility's "Checklist for Controlling COVID-19 in LTC [long term care] Facility" policy dated 05/21/20 documented dedicate equipment was to remain in the resident room for duration of isolation (blood pressure cuff, stethoscope, glucometer, mechanical lift, sling). It may become necessary to rent equipment. The facility failed to ensure staff exercised appropriate infection control techniques to prevent the transmission of COVID-19 within the facility. The cumulation of these failures placed all residents in the facility in immediate jeopardy. The facility completed the following corrective actions to remove the immediacy: 1. Resident care equipment was disinfected immediately. 2. COVID-19 signage was posted at both entrance doors to the facility at 05:35 PM on 05/02/23. 3. Centers for Disease Control (CDC) "Actions to Protect Yourself and Others" was posted at all entrances to the facility at 06:00 PM on 05/02/23. 4. The facility cohorted residents who were positive for COVID-19 in the same room and away from COVID-19 negative residents on 05/02/23. 5. PPE was made available outside each COVID-19 positive room and each COVID-19 positive room received a droplet precaution posting on the door on 05/02/23.	F 880			

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F 880	Continued From page 124 6. Staff were educated on equipment disinfection between use on residents, donning and doffing of PPE when entering and exiting an isolation room and the appropriate PPE required for droplet precautions, and hand hygiene practices on 05/02/23 at 11:59 pm. The above corrective actions removing the immediacy were verified on 05/03/23 though the deficient practice remained at a scope and severity of "F."	F 880			
F 883 SS=E	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- (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	F 883			

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F 883	Continued From page 125 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 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 identified a census of 45 residents. The sample included 13 residents with five residents sampled for immunization review. Based on record review and interviews, the facility failed to obtain pneumococcal (infection that inflames air sacs in one or both lungs which may fill with fluid) vaccination signed consents or declinations for Resident (R) 4, R41, and R44 and the facility failed to administer pneumococcal	F 883			

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F 883	Continued From page 126 vaccination after signed consent was obtained for R29. This deficient practice had the risk for physical complications and the risk to spread illness among residents, a high-risk population. Findings included: - R4 admitted to the facility on 04/06/22. He received Pneumovax on 02/26/18. R4's medical record lacked evidence a Pevnar vaccination was offered upon admission and/or evidence of a signed consent or declination for the Pevnar vaccination for R4. - R41 admitted to the facility on 08/03/22. R41's medical record lacked evidence a pneumococcal vaccination was offered upon admission and/or evidence of a signed consent or declination for the pneumococcal vaccination for R41. - R44 admitted to the facility on 09/14/22. R44's medical record lacked evidence a pneumococcal vaccination was offered upon admission and/or evidence of a signed consent or declination for the pneumococcal vaccination for R44. - R29 admitted to the facility on 09/10/19. R29's medical record revealed a pneumococcal vaccination consent signed on 09/17/19, but the resident's record lacked evidence it was administered. - On 05/04/23 at 02:14 PM, Administrative Nurse D stated when a resident admitted to the facility, she and medical records staff reviewed the resident's history for vaccination status and obtained consents. She stated she and medical records staff were responsible for administering any immunizations on admission. Administrative	F 883			

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F 883	Continued From page 127 Nurse D stated the facility gave the next step for pneumococcal vaccination if the resident wanted one. The facility's "Resident immunizations" policy, last revised 12/2018 documented adult immunization was essential to the health and well-being of residents. Every year tens of thousands of adults needlessly suffer, are hospitalized, and even die because of diseases that could be prevented by vaccines. Given the clinically complex conditions of many residents, it is especially important to have an established and effective resident immunization program. All residents would be offered the influenza vaccine annually during the influenza season. Pneumococcal vaccines would be offered to all eligible residents per CDC guidelines. All other adult immunizations shall be administered in accordance with the current CDC ACIP recommendations for adult immunizations upon request of the resident, responsible party, or resident's physician. Residents and responsible parties would be provided with education regarding benefits, potential risks and side effects of immunizations utilizing the current CDC Vaccine Information Statements (VIS). Residents and responsible parties had the right to refuse any offered or physician ordered immunizations. The facility failed to obtain vaccination consents or declinations for R4, R41, and R44 and the facility failed to administer pneumococcal vaccination after consent was obtained for R29. This deficient practice had the risk for unwarranted physical complications and the risk to spread illness among residents, a high-risk population.	F 883			
F 887 SS=D	COVID-19 Immunization	F 887			

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F 887	Continued From page 128 CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with	F 887			

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F 887	Continued From page 129 COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: The facility identified a census of 45 residents. The sample included 13 residents with five residents sampled for COVID-19 (an acute respiratory illness in humans caused by coronavirus, capable of producing severe symptoms and in some cases death) vaccinations. Based on record review and interviews, the facility failed to obtain signed consents or declinations for COVID-19 vaccinations for Resident (R) 44. This deficient practice had the risk for unwarranted physical complications and the risk to spread illness among residents, a high-risk population. Findings included: - R44 admitted to the facility on 09/14/22. His medical record lacked evidence a COVID-19 vaccination was offered upon admission. There	F 887			

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F 887	Continued From page 130 was a lack of evidence of a signed consent or declination for COVID-19 vaccination for R44. On 05/04/23 at 02:14 PM, Administrative Nurse D stated when a resident admitted to the facility, she and medical records reviewed the resident's history for vaccination status and obtained consents. She stated she and medical records were responsible for administering any immunizations on admission. Administrative Nurse D stated the facility had been transporting residents to the local pharmacy to receive the COVID-19 vaccination. The facility's "Resident immunizations" policy, last revised 12/2018 documented adult immunization was essential to the health and well-being of residents. Every year tens of thousands of adults needlessly suffer, are hospitalized, and even die because of diseases that could be prevented by vaccines. Given the clinically complex conditions of many residents, it is especially important to have an established and effective resident immunization program. All residents would be offered the influenza vaccine annually during the influenza season. Pneumococcal vaccines would be offered to all eligible residents per CDC guidelines. All other adult immunizations shall be administered in accordance with the current CDC ACIP recommendations for adult immunizations upon request of the resident, responsible party, or resident's physician. Residents and responsible parties would be provided with education regarding benefits, potential risks and side effects of immunizations utilizing the current CDC Vaccine Information Statements (VIS). Residents and responsible parties had the right to refuse any offered or physician ordered immunizations.	F 887			

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F 887	Continued From page 131 The facility failed to obtain signed consents or declinations for COVID-19 vaccinations for R44. This deficient practice had the risk for unwarranted physical complications and the risk to spread illness among residents, a high-risk population.	F 887			