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	175468	A. BUILDING _____ B. WING _____	06/21/2023

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. This 2567 was electronically sent to the facility on 6/26/23.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: The facility reported a census of 24 residents with 14 sampled. Based on observation, interview, and record review the facility failed to complete multiple triggered "Care Area Assessment" (CAA), for one sampled Resident (R)5. Findings included: - Review of Resident (R)5's electronic medical record (EMR), revealed a diagnosis of pain, spondylolisthesis (spinal condition that affects the lower vertebrae), dissociative identity disorder (mental disorders that involve experiencing a	F 637		

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

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

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disconnection and lack of continuity between thoughts, memories, surroundings, actions and identity), major depressive disorder (major mood disorder), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and panic disorder (sudden feelings or terror when there is no real danger).

The significant change "Minimum Data Set" (MDS), dated 10/11/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. She had disorganized thinking continuously with hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality). She had verbal and physical behaviors which placed the resident at risk for illness or injury and significantly interfered with her care and social interactions. She required extensive assistance of two staff for bed mobility, transfers, walking in her room, dressing and toilet use. She had limited range of motion (ROM) on one side of her lower extremity (LE) and used a wheelchair for locomotion on and off the unit. She received an antipsychotic (medication used to treat psychosis) six days, an antianxiety (medication used to treat anxiety), antidepressant (medication used to treat depression), a diuretic (medication which promotes diuresis) five days and an opioid (medication used to reduce pain) seven days of the seven-day assessment period.

The "Cognitive Loss/Dementia, Urinary Incontinence and Indwelling Catheter, Activities, Falls, Dental Care, Behavioral Symptoms,

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Psychosocial Well-Being, Psychotropic Drug Use, Nutritional Status, Mood State and Pressure Ulcer/Injury Care Area Assessments" (CAA)s all triggered but lacked an analysis of findings.

The quarterly "MDS," dated 03/23/23, documented the resident had a BIMS score of 14, indicating intact cognition. The resident had no delirium or psychosis and no behavioral symptoms. She required extensive assistance of two staff for bed mobility, transfers, dressing, and toilet use and extensive assistance of one staff for locomotion on and off the unit with her wheelchair. She had limited ROM on one side of her LE. She received an antidepressant, anticoagulant (medication used to thin the blood) seven of the seven days of the assessment period.

The mental wellness and trauma care plan, revised 04/13/23, instructed staff the resident had no issues with being depressed but could get paranoid (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking) or angry at times. Staff were to notify the nurse if the resident had a change in mood.

On 06/21/23 at 09:40 AM, Administrative Nurse D stated the staff did not complete the analysis of findings in the triggered CAAs for this resident's significant change MDS, dated 10/11/22, as required. Administrative Nurse D stated staff needed to complete the analysis of findings for all comprehensive MDS assessments.

The facility utilized the "Resident Assessment Instrument" (RAI) for the completion of the CAAs.

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F 637	Continued From page 3 The facility failed to complete the triggered CAAs for multiple areas of the significant change MDS for this dependent resident who experienced a change in behaviors.	F 637		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 24 residents with 14 residents sampled, including two residents reviewed for accidents. Based on observation, interview and record review, the facility failed to provide one of the two sampled, Resident (R)17 adequate supervision to prevent a non-injury fall. Findings included: - Review of Resident (R)17's "Physician Order Sheet" (POS), dated 06/01/23, documented the resident had a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The annual "Minimum Data Set" (MDS), dated 11/25/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. She required limited assistance of two staff for	F 689		

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ambulation in her room and extensive assistance of two staff for toileting and dressing. Her balance was not steady, and she was only able to stabilize with staff assistance. She had not had any falls since the prior assessment.

The "Fall Care Area Assessment" (CAA), dated 11/25/22, documented the resident had poor balance, weakness, and poor coordination.

The quarterly "MDS," dated 05/11/23, documented the staff assessment for cognition revealed severe impairment. She required extensive assistance of one staff for walking in her room and extensive assistance of two staff for dressing and toileting.

The care plan for bowel and bladder, revised 05/16/23, instructed staff the resident required assistance to toilet.

The care plan for safety, revised 05/16/23, instructed staff the resident was impulsive and had poor safety awareness due to severe cognitive impairment.

Review of the resident's electronic medical record "EMR", revealed fall assessments, dated 06/15/23, 06/03/23, 04/18/23, 12/20/22 and 12/04/22, which placed the resident at a high risk for falls.

Review of the resident's "Incident Report Check Sheet", dated 06/15/23, provided by the facility, documented on 06/15/23 at 05:30 PM, Certified Nurse Aide (CNA) M walked with resident to her room to get ready for bed. CNA M walked with the resident into her bathroom when CNA M noticed she had forgotten the resident's pajamas.

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CNA M instructed the resident to stay in the bathroom, standing by the door, while she got the resident's pajamas. CNA M turned her back on the resident to get her pajamas from her dresser when the resident attempted to sit down and fell to the floor on her buttocks. The resident did not receive an injury from the fall.

Observation on 06/20/23 at 10:22 AM, revealed CNA Q and CNA N assisted the resident to toilet. Staff walked with the resident from the side of the resident's bed to the toilet. The resident required prompting and cueing from staff to stay sitting on the toilet during the task as the resident attempted twice to stand up, unattended, from the toilet. The resident cooperated with the staff without difficulty. Following toileting, staff assisted the resident to ambulate to the dining room, with staff assist of two, for lunch.

On 06/20/23 at 10:22 AM, CNA N stated the resident required extensive assistance to complete activities of daily living (ADL). CNA N stated the resident should not be left alone while in the bathroom as the resident had issues with safety awareness.

On 06/20/23 at 03:21 PM, CNA O stated the resident had confusion and did not understand what was going on around her. CNA O stated the resident should not be left alone in the bathroom. Her balance was not stable.

On 06/20/23 at 03:25 PM, CNA P stated staff should never leave the resident alone in the bathroom.

On 06/20/23 at 03:55 PM, CNA M stated on 06/15/23, she had left the resident standing,

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F 689	Continued From page 6 unattended in the bathroom when she went to get the resident's pajamas. CNA M stated she did not know the resident would try to sit down when there was nothing there for her to sit down on. She saw the resident falling but was unable to get to the resident before she landed on her buttocks on the floor. CNA M stated she called for the nurse to come and assess the resident. The resident did not receive any injuries from the fall. On 06/21/23 at 10:00 AM, Licensed Nurse (LN) G stated the resident lacked safety awareness and should not be left unattended in the bathroom. On 06/21/23 at 09:40 AM, Administrative Nurse D stated staff should not leave the resident unattended in the bathroom. The staff should have all needed supplies with them before taking the resident into the bathroom. The facility policy for "Fall Prevention Protocol", approved 04/15/19, included: Each elder residing in the facility will receive adequate supervision to prevent accidents. The facility failed to provide adequate supervision to prevent a non-injury fall for this dependent resident.	F 689		
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	F 812		

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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 reported a census of 24 residents. Based on observation, interview and record review, the facility failed to store, prepare, and serve food under sanitary conditions to prevent the spread of food borne illnesses to the residents of the facility.

Findings included:

- An environmental tour of the kitchen on 06/19/23 at 08:37 AM, revealed the following concerns:

1. The dry storage room had a box of eight loaves of bread resting directly on the floor.

2. One reach-in refrigerator contained food debris across on the bottom shelf.

3. One reach-in freezer contained food debris across on the bottom shelf.

On 06/20/23 at 01:20 PM, Dietary staff BB confirmed the reach-in refrigerator and reach-in freezer contained food debris on the bottom

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F 812	Continued From page 8 shelves. Dietary staff BB stated staff were to clean the reach-ins on a weekly basis. Dietary staff BB stated no boxes should be stored directly on the floor. The facility policy for "Food Storage (Dry, Refrigerated, and Frozen", undated, included: Food shall be stored on shelves in a clean, dry area, free from contaminates. Store dry food six inches off the floor to allow for proper sanitation. The facility policy for "Cleaning Instructions: Reach-In Refrigerator and Freezer", undated, included: The reach-in refrigerator and freezer will be cleaned and sanitized on a regular basis. Staff will wipe out the refrigerator and freezer with a clean cloth and warm water with detergent then rinse with clean, warm water. The facility failed to store, prepare, and serve food under sanitary conditions to prevent the spread of food borne illnesses to the residents of the facility. The facility failed to store, prepare, and serve food under sanitary conditions to prevent the spread of food borne illnesses to the residents of the facility.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program 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	F 880		

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program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the 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

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contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 24 residents with 14 residents sampled, including one resident reviewed for Urinary Catheter/Urinary Tract Infection (UTI). Based on observation, interview and record review, the facility failed to maintain an effective infection control program when they failed to provide safe and sanitary care for the one Resident (R)16, regarding the suprapubic urinary catheter (urinary bladder catheter inserted through the skin).

Findings included:

- Review of Resident (R)16's electronic medical record (EMR) revealed a diagnosis of neuromuscular dysfunction of the bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system).

The admission "Minimum Data Set" (MDS), dated 04/06/23, documented the resident had a Brief

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Interview for Mental Status (BIMS) score of 14, indicating intact cognition. He required extensive assistance of two staff for toileting and had an indwelling urinary catheter (urinary bladder catheter inserted through the skin).

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 04/06/23, documented the resident had a suprapubic urinary catheter due to a diagnosis of neurogenic bladder.

The bowel and bladder care plan, dated 04/20/23, instructed staff the resident had an indwelling urinary catheter. Staff were to empty the catheter collection bag every shift.

Review of the resident's EMR revealed a physician's order which included:

Macrobid (an antibiotic) 100 milligrams (mg), by mouth (po), for a urinary tract infection (UTI), for 14 days, ordered 06/14/23.

On 06/20/23 at 11:10 AM, Certified Nurse Aide (CNA) N entered the resident's room to empty the catheter collection bag. CNA N donned a gown and gloves and drained 650 cubic centimeters (cc) clear yellow urine into a urinal from the drainage spout of the catheter bag. CNA N reattached the drainage spout to the catheter bag without cleansing the spout.

On 06/20/23 at 11:10 AM, CNA N stated she should have cleansed the drainage spout with an alcohol swab before reattaching the spout to the bag but verified she had not.

On 06/21/23 at 10:00 AM, Licensed Nurse (LN) G

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F 880	Continued From page 12 stated staff were to clean the drainage spout of the catheter after draining the urine from the bag. LN G stated the resident was currently on an antibiotic for a UTI. On 06/21/23 at 09:40 AM, Administrative Nurse D stated, staff were to use an alcohol swab to cleanse the drainage spout of the catheter before reconnecting the spout to the catheter bag. The facility policy for "Drain and Measuring Output from Urinary Drainage Bag", undated, included: The staff shall cleanse the drainage spout with an alcohol pad after any time the catheter connection had been handled. The facility failed to maintain an effective infection control program when they failed to provide safe and sanitary care for this dependent resident's suprapubic catheter.	F 880		