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F 000	INITIAL COMMENTS The following citations are the result of a health recertification survey and complaint investigation KS00179909. The 2567 was sent electronically on 01/02/24.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's	F 553		

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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strengths and needs.
(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to include two sampled residents, Resident (R) 1 and R14, in the development and planning of the residents' care plan. This placed the residents at risk of impaired care and decreased autonomy.

Findings included:

- The Electronic Medical Record (EMR) for R1 documented diagnoses of diabetes mellitus type 2 (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia with other behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), auditory hallucinations (sensing things while awake that appear to be real, but the mind created), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), migraines (a recurrent, throbbing headache that typically affects one side of the head and is often accompanied by nausea and disturbed vision), psychosis (any major mental disorder characterized by a gross impairment in reality testing), acute kidney failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), and delirium due to known physiological condition (sudden severe confusion, disorientation and restlessness).

The "Annual Minimum Data Set" (MDS), dated

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10/20/23, document R1 had intact cognition and was independent with toileting, oral care, personal hygiene, and eating. R1 required supervision with bathing and ambulation. The MDS further documented it was very important to R1 to have her family involved in discussions about her care.

R1's "Care Plan," dated 10/26/23, directed staff to encourage R1 to do as much for herself as she could, and assist as needed. R1 slept in, late at times until noon, and her breakfast may be served in her room per choice. The plan further directed when she had migraine headaches, she may not come out of her room for several days, and she preferred medications in the dining room with meals.

R1's "Care Plan Conference Summary," dated 02/22/23, 05/17/23, and 11/01/23 documented family and resident not present.

On 12/13/23 at 04:40 PM, observation revealed R1 was in her room watching television. She wore pajamas as she laid in bed.

On 12/13/23 at 04:43 PM, R1 stated she knew what the care plan meeting was but had never been invited or participated in the care plan process. R1 stated she would attend if invited.

On 12/18/23 at 01:28 PM, Social Service X stated she gave the residents care plan letters and reminded them about the meetings during her MDS interviews. Social Service X stated R1 did not attend the meetings and her family was not able to come to them as they worked during the time the meetings were held. Social Service X further stated she did not document in the EMR

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when she invited the resident or family to the meetings.

On 12/19/23 at 09:58 AM, Administrative Nurse D verified the facility did not document in the EMR if a resident was invited, only if they attended.

The facility's "Care Plans, Comprehensive Person Centered" policy, dated 03/22, documented the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident and had the right to participate in the planning process, request meetings, request revisions to the plan of care, and see the car plan and sign it after significant changes are made. The resident was informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences.

The facility failed to include R1 in the development and planning of the resident's care plan placing her at risk for impaired care and autonomy.

- The Electronic Medical Record (EMR) for R14 documented diagnoses of dysphagia (swallowing difficulty), hypertension (high blood pressure), flaccid hemiplegia affecting right dominant side (paralysis of one side of the body), and diabetes mellitus type 2 (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin).

The "Quarterly Minimum Data Set" (MDS), dated 09/08/23, documented R14 had moderately impaired cognition, and required extensive assistance of two staff for bed mobility, transfers,

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dressing and toileting; R14 did not ambulate. The MDS further documented it was very important to R14 to have his family involved in discussions about his care.

R14's "Care Plan," dated 09/11/23, directed staff to cue R14 to gather items to brush his teeth, allow him to pick out his clothing, cue through the process of dressing, and assist with a gait belt and one staff for transfers.

R14's "Care Plan Conference Summary," dated 03/22/23, documented family and resident were not present.

On 12/13/23 at 09:38 AM, R14 reported he had lived at the facility for four years and had never participated in a care plan meeting. R14 reported he did not know what the meeting was for.

On 12/18/23 at 01:28 PM, Social Service X stated she gave the residents care plan letters and reminded them about the meetings during her MDS interviews. Social Service X stated R14 did not attend the meetings. She also stated she did not document in the EMR when she invited the resident or family to the meetings.

On 12/19/23 at 09:58 AM, Administrative Nurse D verified the facility did not document in the EMR if a resident was invited, only if they attended.

The facility's "Care Plans, Comprehensive Person Centered" policy, dated 03/22, documented the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident and had the right to participate in

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F 553	Continued From page 5 the planning process, request meetings, request revisions to the plan of care, and see the car plan and sign it after significant changes are made. The resident was informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences. The facility failed to include R14 in the development and planning of the resident's care plan placing him at risk for impaired care and autonomy.	F 553		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 1 had a physician's order and was assessed for the ability to safely self-administer medications left at the bed side. This placed R1 at risk for improper use of medication and related side effects. Findings included: - The Electronic Medical Record (EMR) for R1 documented diagnoses of diabetes mellitus type 2 (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia with other behavioral disturbance (progressive mental disorder characterized by failing memory, confusion),	F 554		

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auditory hallucinations (sensing things while awake that appear to be real, but the mind created) , anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), migraines (a recurrent, throbbing headache that typically affects one side of the head and is often accompanied by nausea and disturbed vision), psychosis (any major mental disorder characterized by a gross impairment in reality testing), acute kidney failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), gastro esophageal reflux (GERD-backflow of stomach contents to the esophagus), and delirium due to known physiological condition (sudden severe confusion, disorientation and restlessness.

The "Annual Minimum Data Set" (MDS), dated 10/20/23, document R1 had intact cognition and was independent with toileting, oral care, personal hygiene, and eating. R1 required supervision with bathing and ambulation. The MDS further documented R1 received antipsychotic (medications used to treat psychosis and other mental emotional conditions), antidepressant (medications used to treat mood disorders and relieve symptoms of depression), antiplatelet (medication that prevent blood clots from forming), and a hypoglycemic (medication used to help reduce the amount of sugar present in the blood).

R1's "Care Plan," dated 10/26/23, initiated on 02/14/20, documented R1 was at risk for complications from medications with Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration), and directed staff to administer medications as ordered by the

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physician, monitor for side effects and effectiveness, and report as needed any adverse reactions to the physician.

The "Physician's Orders," dated 01/14/20, directed staff to administer, lisinopril (blood pressure medication), 40 milligrams (mg), one by mouth, daily for hypertension (high blood pressure), amlodipine (blood pressure medication), 5 mg, one by mouth, daily, for hypertension, and magnesium oxide, one 400 mg, by mouth twice per day, for nutritional supplement.

The "Physician's Order," dated 03/23/20, directed staff to administer Cymbalta DR (an antidepressant), 60 mg, one by mouth, daily, for depression (persistent feelings of sadness).

The "Physician's Order," dated 12/11/20, directed staff to administer metformin HCl extended release (ER) (anti-diabetic), 500 mg, one by mouth twice per day for diabetes.

The "Physician's Order," dated 04/20/21, directed staff to administer pantoprazole sodium (acid reducer), 40 mg, one by mouth daily for GERD.

The "Physician's Order, " dated 07/29/21, directed staff to administer Ultram (pain medication), 50 mg, every six hours as needed for pain.

The "Physician's Order," dated 12/14/21, directed staff to administer aspirin (anti-inflammatory), 81 mg, two by mouth daily for a healed fracture.

The "Physician's Order," dated 09/09/22, directed staff to administer Colace caplet (stool softener),

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100 mg, one by mouth daily in the morning for hard stools.

The "Physician's Order," dated 02/22/23, directed staff to administer Ritalin (stimulant), 5 mg, one by mouth in the morning for energy.

R1's EMR lacked a physician's order which allowed R1 to keep medications at her bedside and self-administer.

R1's EMR lacked evidence the facility assessed R1 for the ability to safely self-administer medication.

On 12/14/23 at 09:15 AM, observation revealed Licensed Nurse (LN) G asked R1 several times to sit up in bed so she could take her medication. R1 stated she did not want to take her pills right then, so LN G placed the pills on her bedside table and left R1's room. LN G stated she would return later to make sure the resident took the medication. LN G said she often left the medication on R1's bedside table to take later. At 09:30 AM, observation revealed R1 sat on the side of her bed and took her medication.

On 12/19/23 at 09:58 AM, Administrative Nurse D stated R1 probably had a self-administration assessment somewhere down in a box in the basement but verified R1 had not been assessed recently.

The facility's "Self-Administration of Medications" policy, dated 02/21, documented the residents have the right to self-administer medications if the interdisciplinary team (IDT) had determined that it was clinically appropriate and safe for the resident to do so. The policy further documented,

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F 554	Continued From page 9 as part of the evaluation comprehensive assessment, the IDT assess each resident's cognitive and physical abilities to determine whether self-administering medications are safe and clinically appropriate for the resident. The facility failed to ensure R1 had a physician order and the ability to safely self-administer medications prior to leaving medications at the bedside. This placed the resident at risk for improper use of medication and related side effects.	F 554		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		

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(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for

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the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
The facility had census of 32 residents. The sample included 14 residents with one reviewed for hospitalization. Based on observation, record review, and interview, the facility failed to provide a written notice for a facility-initiated transfer to Resident (R32) or her representative within a practicable time when R32 was transferred to the

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hospital. This placed the resident at risk for uninformed care choices.

Findings included:

- R32's Electronic Medical Record (EMR) documented R32 had diagnoses of heart failure, hypoxemia (abnormal deficiency in the concentration of oxygen in arterial blood) and edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

R32's "Admission Minimum Data Set" (MDS), dated 09/18/23, documented R32's Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R32 required extensive staff assistance with most activities of daily living (ADLs).

R32's "Care Area Assessment "(CAA) did not trigger for hydration/fluid maintenance.

R32's "Care Plan," revised 09/13/23, documented R32 required limited staff assistance with most ADLs.

The "Progress Note," dated 10/24/2023 at 01:34 PM documented R32 was admitted to the hospital.

Review of R32's clinical record lacked evidence the resident or representative was provided written notice.

On 12/14/23 at 10:35 AM, observation revealed R32 sat in a wheelchair in her room.

On 12/19/23 at 09:28 AM, Social Service X stated

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F 623	Continued From page 13 she was responsible for providing R32 or her representative with written notice of R32's transfer to hospital. Social Service X stated she mailed the transfer information to R32's representative but had not received it back and lacked documentation regarding when she mailed the form. On 12/19/23 at 10:10 AM, Administrative Nurse D stated social service staff was responsible for providing transfer information to R32 or her representative when R32 was transferred to the hospital. Administrative Nurse D stated she expected staff to follow up in two to three days if they had not received the signed form back. Upon request the facility did not provide a policy regarding written notification of resident transfers to hospital. The facility failed to provide R32 or her representative written notice regarding R32's transfer to the hospital. This placed the resident and/or her representative at risk of uninformed care choices.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to	F 625		

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return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included 14 residents. Based on record review and interview, the facility failed to provide Resident (R)32 or his representative with written information regarding the facility bed hold policy when R32 was transferred to the hospital. This placed R32 at risk for not being permitted to return and resume residence in the nursing facility.

Findings included:

- R32's Electronic Medical Record (EMR) documented R32 had diagnoses of heart failure, hypoxemia (abnormal deficiency in the concentration of oxygen in arterial blood) and edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

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R32's "Admission Minimum Data Set" (MDS), dated 09/18/23, documented R32's Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R32 required extensive staff assistance with most activities of daily living (ADLs).

R32's "Care Area Assessment "(CAA) did not trigger for hydration/fluid maintenance.

R32's "Care Plan," revised 09/13/23, documented R32 required limited staff assistance with most ADLs.

The "Progress Note," dated 10/24/2023 at 01:34 PM documented R32 was admitted to the hospital.

Review of R32's clinical record lacked evidence the resident or representative was provided the facility bed hold policy.

On 12/19/23 at 09:28 AM, Social Service X stated she was responsible for providing R32 or her representative with the bed hold policy when R32 was transferred to the hospital. Social Service X stated she mailed the bed hold policy to R32's representative but had not received it back and lacked documentation regarding when she mailed the form.

On 12/19/23 at 10:10 AM, Administrative Nurse D stated social service staff was responsible for providing the bed hold policy to R32 or her representative when R32 was transferred to the hospital. Administrative Nurse D stated she expected staff to follow up in two to three days if they had not received the signed bed hold policy

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F 625	Continued From page 16 back. The facility's "Bed-Holds and Returns Policy," revised March of 2022, documented all residents/representatives would be provided written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). The facility failed to provide R32 or his representative with the bed hold policy when R32 was transferred to the hospital. This placed the resident at risk for not being permitted to return and resume residence in the nursing facility.	F 625		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		

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(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to revise the care plan for Resident (R) 30 to include the Black Box Warning (BBW-highest safety-related warning that medications can have assigned by the Food and Drug Administration) for risperidone (antipsychotic medication) for staff direction to monitor for side effects from the antipsychotic medication. This placed the residents at risk due to uncommunicated care needs and adverse side effects.

Findings included:

- The Electronic Medical Record (EMR) for R30 documented diagnoses of frontotemporal neurocognitive disorder (occurs when nerve cells in the frontal and temporal lobes of the brain are lost), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), expressive language disorder (caused by brain damage sustained from neurological conditions), and abnormalities of gait and mobility.

The "Significant Change-5 Day Minimum Data Set" (MDS), dated 06/07/23, documented R30 had moderately impaired cognition and required extensive assistance of two staff for bed mobility,

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dressing, and toileting. R30 required extensive assistance of one staff for transfers and personal hygiene. The MDS further documented R30 received antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) and opioid (narcotic pain medication) medication. R30 had no behaviors.

The "Quarterly MDS," dated 11/17/23, documented R30 had severely impaired cognition and required substantial assistance for toileting. personal hygiene, dressing, and ambulation. R30 had had physical, verbal, and other behaviors 1-3 days, and received anxiety and depression medication.

R30's "Care Plan," dated 12/04/23, initiated on 03/15/23, documented R30 received medications with a BBW but failed to have risperidone medication on the care plan and what BBW signs and symptoms to monitor for.

The "Physician's Order," dated 11/21/23, directed staff to administer risperidone, 0.25 mg, one by mouth, twice per day for frontotemporal neurocognitive disorder, anxiety, and depression.

On 12/13/23 at 02:37 PM, observation revealed R30 ambulated down the hall with staff and required verbal cues to make sure R30 held on to her walker when she ambulated. Further observation revealed, R30 very pleasant and acknowledged other staff.

On 12/18/23 at 11:04 AM, Certified Nurse Aide (CNA) O stated there have been designated staff to be one on one with the resident due to her anxiety, and her impaired vision. CNA O stated

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F 657	Continued From page 19 R30 and times she tried to hit staff but otherwise very pleasant. On 12/19/23 at 10:00 AM, Licensed Nurse (LN) G stated R30 had periods of anxiety and agitation and felt the medication had help with some of her anxiety. On 12/19/23 at 10:32 AM, Administrative Nurse D verified there were not interventions placed on the care plan for the risperidone and the black box warnings. The facility's "Care Plans, Comprehensive Person-Centered" policy, dated 03/22, documented a comprehensive, person-centered care plan that included measurable objectives and timetables to meet a resident's physical, psychosocial and functional needs was developed and implemented for each resident and are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The facility failed revise the care plan for adverse side effects for R30's risperidone medication. This placed the resident at risk for possible side effects and decline due to uncommunicated care needs.	F 657		
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	F 689		

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supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included 14 residents, with five reviewed for falls, Based on observation, record review, and interview, the facility failed to evaluate effectiveness of fall interventions and change or modify the interventions which were ineffective at preventing falls for Resident (R) 19. This placed the resident at risk for further falls and injury.

Findings included:

- The Electronic Medical Record (EMR) for R19 documented diagnoses of weakness, epilepsy (a brain disorder characterized by repeated seizures), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and pain.

The "Quarterly- 5 Day Medicare Minimum Data Set" (MD, dated 12/29/23, documented R19 had intact cognition and required supervision and one staff assistance for dressing, toileting, and personal hygiene. R19 required supervision and one staff assistance for bed mobility, transfers, ambulation, and eating. R19 had unsteady balance, no functional impairment, and had no falls.

The Quarterly MDS," dated 10/06/23, documented R19 had intact cognition and

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required supervision with transfers. R19 was independent with eating, oral hygiene, personal hygiene, and had no functional impairment. The MDS recorded R19 had no falls.

The "Fall Risk Assessments," dated 12/27/22, 01/03/23, 01/10/23, 01/11/23, 01/21/23, 02/20/23, 03/05/23, 04/07/23, 05/09/23, 06/02/23, 07/02/23, 10/02/23, and11/12/23, documented R19 was a high risk for falls.

R19's "Care Plan," dated 10/12/23, initiated on 08/14/20, directed staff to keep items frequently used by R19 within reaching distance. The update on 08/28/20, directed staff to move her phone closer to her. The update, dated 12/23/21, directed staff to put gripper socks on the resident when in bed. The update, dated 01/03/23, directed staff to remind R19 that staff need to be present when she transferred. The update, dated 01/10/23, directed staff to ensure R19's call light was within reach and encourage the resident to use it for assistance. The update, dated 01/11/23, directed staff to place nonskid strips in front of her recliner. The update, dated 02/20/23, directed staff to place nonskid strips in front of her sofa. The update, dated 03/05/23, documented staff reeducated R19 on the importance of using her call light for assistance. The update, dated 03/29/23, directed staff to move her phone next to her couch or chair. The update, dated, 04/07/23, directed staff to place signs in her room to remind her to call for assistance when getting up. The update, dated 05/09/23, directed staff to remind the resident to call for assistance when she transferred. The update, dated 06/02/23, directed staff to have gripper socks or shoes on at all times while resident was in her recliner or wheelchair. The

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update, dated, 11/10/23, directed staff to explain and assist R19 when transferred to make sure she was ready to move and stable when staff is. The update, dated 11/15/23, directed staff to place gripper socks on R19 at night. The update, dated 12/01/23, directed staff to place a fall mat beside R19's bed.

The "Fall Investigation," dated 01/10/23 at 06:24 PM, documented staff heard a soft thud and found R19 in her room, on her right side, with her feet between the walker wheels, able to move all extremities, and had no injuries. The note further documented R19 was assisted up by three staff members and a gait belt.

The "Fall Investigation, " dated 02/20/23 at 07:44 PM, documented R19 yelled for help and staff found her on the floor leaning next to her sofa. R19 stated she got tired of sitting in the chair and had transferred herself from her wheelchair to her sofa. The noted further documented R19 had been educated several times to ask for assistance and to wait until someone came to transfer her. The resident did not sustain any injuries and was assisted by two staff and gait belt to her wheelchair.

The "Fall Investigation," dated 03/05/23 at 06:31 PM, documented staff heard R19 scream for assistance and found her seated on the floor between her recliner and wheelchair. R19 stated she fell while she transferred herself to her wheelchair. R19 was assisted by two staff and gait belt to her recliner and did not sustain any injuries.

The "Fall Investigation," dated 04/07/23 at 06:20 PM, documented R19 tried to transfer herself to

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her wheelchair, fell and hit her head. The investigation further documented R19 had a hematoma (solid swelling of clotted blood within the tissues) on the back of her head and a skin tear on her right forearm and was assisted up by staff and placed in her recliner.

The "Fall Investigation," dated 05/09/23 at 09:00 AM, documented staff found R19 in her room on the floor in front of her recliner. R19 had the wheelchair within reach in front of her and stated she tried to sit in her recliner and missed the chair. R19 did not sustain any injuries and was able to move all extremities as previous.

The "Fall Investigation," dated 06/02/23 at 02:10 PM, documented staff found R19 on the floor, on her right side, in front of her recliner. The fall was unwitnessed; R19 had no injury and stated she had tried to take herself to the bathroom. The investigation further documented two staff assisted R19 up with a gait belt and placed her in her wheelchair.

The "Fall Investigation," dated 11/10/23, documented staff assisted R19 to transfer from her wheelchair to her bed, and her hand slipped off the bed rail and she fell to the floor.

The "Fall Investigation," dated 12/01/23 at 10:06 AM, documented staff found R19 on the floor between her bed and wheelchair with both legs extended outward towards her end table with her right arm resting on her bed. The investigation further documented R19 did not sustain any injury; she had her call light within reach, but it was not activated. R19 was able to move all extremities and assisted up by staff.

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On 12/19/23 at 10:17 AM, observation revealed Certified Nurse Aide (CNA) N placed a gait belt around R19's waist, used her left hand under the gait belt to try to lift R19 from her wheelchair to her recliner. Further observation revealed R19 needed cueing during the transfer to stand up and pivot into the recliner as R19's legs were bent, and CNA N had to use extensive assistance to transfer her.

On 12/19/23 at 09:54 AM, Licensed Nurse (LN) G stated R19 was supposed to call for assistance when she wanted to transfer but did not remember to use her call light. LN G said R19 got "antsy" and did it herself which usually resulted in a fall. LN G further stated staff had placed three signs in R19's room for reminders, and the resident had a low bed, and had been reeducated multiples to call for assistance.

On 12/19/23 at 10:20 AM, CNA N stated R19 received therapy for transfers and strengthening and required a lot of reeducation not to transfer alone as she did not remember to call for assistance.

On 12/19/23 at 10:32 AM, Administrative Nurse D stated she had run out of interventions to prevent falls for R19 and verified there were repetitive interventions on R19's "Care Plan."

The facility's "Falls and Fall Risk, Managing" policy, dated 03/18, documented staff identified interventions related to the residents specific risks and causes to try to prevent the resident from falls and to minimize complications from falls. Care plan interventions were chosen only after data gathered, proper sequencing of events, careful consideration of the relationship between

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F 689	Continued From page 25 the resident's problem areas ad their causes, and relevant clinical decision making. The staff, with the input of the attending physician, would implement a resident-centered fall prevention plan to reduce the specific risk factors for each resident at risk or with a history of falls. The facility failed to evaluate effectiveness of fall interventions and change or modify the interventions which were ineffective at preventing falls for R19. This placed the resident at risk for further falls and injury.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 692		

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The facility had a census of 32 residents. The sample included 14 residents with one reviewed for hydration. Based on observation, record review, and interview, the facility nursing staff failed to consistently monitor Resident (R) 32's fluid intake related to a physician-ordered fluid restriction. This placed R32 at risk for fluid overload.

Findings included:

- R32's Electronic Medical Record (EMR) documented R32 had diagnoses of heart failure, hypoxemia (abnormal deficiency in the concentration of oxygen in arterial blood) and edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

R32's "Admission Minimum Data Set" (MDS), dated 09/18/23, documented R32's Brief Interview of Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented R32 required extensive staff assistance with most activities of daily living (ADLs).

R32's "Care Plan," revised on 09/13/23, documented R32 received a 2000 cubic centimeter (cc) fluid restriction and instructed dietary to provide R32 with 360 cc of fluid at breakfast, 480 cc at lunch and 480 cc at supper. The care plan instructed nursing staff to provide R32 270 cc from 06:00AM - 02:00PM, 270 cc from 02:00PM-10:00PM, and 140 cc from 10:00PM-06:00AM.

The "Progress Note," dated 10/24/23, documented R32 admitted to the hospital due to weight gain and hospital staff removed fluid from

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R32's body.

The "Physician Order," dated 12/04/23, instructed staff to provide R32 with a 2000 cc fluid restriction.

The "Progress note," dated 12/06/23 at 11:02 AM, documented R32 readmitted from the hospital on 12/04/23 due to fluid overload and instructed staff to continue to provide R32 with a 2000 cc fluid restriction.

R32's December 2023 "Medication Administration Record/Treatment Administration Record" (MAR/TAR) lacked documentation on R32's fluid intake on the following days:
Day shift December 05, 11,12, and 17.
Evening shift December 07,09, and 15.
Night shift 12/09/23

On 12/14/23 at 04:00 PM, observation revealed R32's bedside table had a pitcher on it with 200 cc of uniced water.

On 12/19/23 at 10:46 AM, Dietary Staff (DS) BB stated she kept track of R32's fluid intake with meals then reported the intake to nursing and the nurses were responsible for recording it in R32's clinical record.

On 12/19/23 at 10:58 AM, Administrative Nurse D verified the lack of fluid intake documentation on the above listed dates and stated nursing staff should document R32's fluid intake every shift.

The facility's " Encouraging and Restricting Fluids Policy, revised October 2010, instructed staff to follow specific instructions concerning fluid intake or restrictions, be accurate when recording fluid

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F 692	Continued From page 28 intake and record fluid intake on the intake side of the intake and output record. Record fluid intake in milters (ml) The facility failed to consistently monitor and record R32's physician ordered fluid restriction. This placed the resident at risk for fluid overload.	F 692		
F 756 SS=D	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	F 756		

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the resident's medical record.

§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 had a census of 32 residents. The sample included 14 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist identified and reported that Resident (R) 26's as needed (PRN) Xanax (a sedative used for anxiety and panic disorder) lacked a 14-day stop date or specified duration which included a physician rationale. This placed the resident at risk for inappropriate use of medications.

Findings included:

- The Electronic Medical Record (EMR) for R26 recorded diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and restlessness and agitation.

The "Significant Change Minimum Data Set" (MDS), dated 12/06/23, documented R26 had severely impaired cognition and was independent with dressing, toileting, eating, and oral care. The MDS further documented R26 received antianxiety (class of medications that calm and

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relax people), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), anticoagulant (medication that inhibits the coagulation of the blood), and diuretic medication (medication to promote the formation and excretion of urine) and had no behaviors.

R26's "Care Plan," dated 10/05/23 documented R26 was at risk for medication adverse reactions related to Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) for Xanax and directed staff to monitor for side effects from medications.

The "Physician's Order," dated 10/11/23, directed staff to administer Xanax, 25 milligrams (mg), one by mouth, every eight hours, PRN, for anxiety. The order lacked a stop date.

The "Medication Regimen Review," dated 11/07/23, documented the pharmacist had no recommendations.

On 12/14/23 at 07:40 AM, observation revealed R26 laid in bed on her right side, on top of the covers.

On 12/14/23 at 08:00 AM, Licensed Nurse G stated R26 had some behaviors of yelling at staff and had PRN medication for anxiety.

On 12/18/23 at 10:57 AM, Certified Nurse Aide (CNA) O stated R26 yelled at staff a lot but was always easily redirectable and had never been aggressive towards other residents.

On 12/19/23 at 10:32 AM, Administrative Nurse D

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F 756	Continued From page 31 stated R26's PRN Xanax should have a stop date or a rationale as to why she received the medication, and the pharmacist should have let the facility know. The "Antipsychotic Medication Use" policy, dated 12/16, documented residents would not receive PRN does of psychotropic medications unless that medication was necessary to treat a specific condition that was documented in the clinical record and the need to continue PRN orders beyond 14 days required that the practitioner document the rationale for the extended order. The duration of the PRN order would be indicated on the order and would not be renewed beyond 14 days unless the healthcare practitioner had evaluated the resident for the appropriateness of that medication. The facility failed to ensure the Consultant Pharmacist identified and reported that R26's PRN Xanax lacked a 14-day stop date. This placed the resident at risk for inappropriate use of medications.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		

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F 758	Continued From page 32 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample included 14 residents, with six reviewed	F 758		

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for unnecessary medications. Based on observation, record review, and interview, the facility failed to identify Resident (R) 30's allergy medication, Benadryl, with psychotropic (alters mood or thoughts) properties being used to treat anxiety and failed to apply the required 14-day stop date or obtain a specified duration for use with a physician rationale as required for as needed (PRN) psychotropic medications. The facility further failed to ensure an appropriate indication for R30's risperidone (an antipsychotic) or the required physician documentation and failed to ensure R30's PRN lorazepam (an antianxiety medication) had a physician's rationale for the extended use. The facility also failed to ensure R26's PRN Xanax (a sedative used for anxiety and panic disorder) had a 14-day stop date as required. This placed the residents at risk for unnecessary psychotropic medications and related complications.

Findings included:

- The Electronic Medical Record (EMR) for R30 documented diagnoses of frontotemporal neurocognitive disorder (occurs when nerve cells in the frontal and temporal lobes of the brain are lost), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), expressive language disorder (caused by brain damage sustained from neurological conditions), and abnormalities of gait and mobility.

The "Significant Change-5 Day Minimum Data Set" (MDS), dated 06/07/23, documented R30 had moderately impaired cognition and required extensive assistance of two staff for bed mobility, dressing, and toileting. R30 required extensive assistance of one staff for transfers and personal

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hygiene. The MDS further documented R30 received antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) and opioid (narcotic pain medication) medication. R30 had no behaviors.

The "Quarterly MDS," dated 11/17/23, documented R30 had severely impaired cognition and required substantial assistance for toileting. personal hygiene, dressing, and ambulation. R30 had had physical, verbal, and other behaviors 1-3 days, and received anxiety and depression medication.

R30's "Care Plan," dated 12/04/23, initiated on 03/15/23, documented R30 received Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) but failed to have risperidone medication on the care plan and what signs and symptoms to monitor for.

A "Physician's Order," dated 07/12/23, directed staff to administer alprazolam (Xanax), 0.5 milligrams (mg), one by mouth, PRN for anxiety. This medication was discontinued on 09/05/23.

A "Physician's Order," dated 09/05/23, directed staff to administer alprazolam 0.5 mg, one by mouth, every 24 hours, PRN for anxiety. This medication was discontinued on 10/06/23.

A "Physician's Order," dated 10/06/23, directed staff to administer Xanax, 0.5 mg, one by mouth, every 12 hours PRN for anxiety. This medication was discontinued on 11/09/03.

A "Physician's Order," dated 11/09/23, directed

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staff to administer Ativan (anxiety medication), 1 mg, one by mouth, every 6 hours PRN for agitation. This medication was discontinued on 11/14/23.

A "Physician's Order," dated 11/14/23, directed staff to administer lorazepam (Ativan), 1 milligram (mg), one by mouth, every five hours PRN for agitation. The order lacked a stop date.

A "Physician's Order," dated 11/19/23, directed staff to administer ziprasidone (antipsychotic medication), 20 mg, one by mouth, every 12 hours PRN. This medication was discontinued on 11/21/23.

A "Physician's Order," dated 11/21/23, directed staff to administer risperidone, 0.25 mg, one by mouth, twice per day for frontotemporal neurocognitive disorder, anxiety, and depression.

A "Physician's Order," dated 11/24/23, directed staff to administer Benadryl, 25 mg, one by mouth every eight hours PRN for anxiety, and may administer Benadryl 50 mg, one by mouth every eight hours PRN for anxiety. The order lacked a stop date.

The "December MAR" documented R30 received seven doses of the PRN Benadryl 25 mg and seven doses of the 50 mg.

R30's clinical record lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic. The record further lacked a specified duration with physician rationale for the

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extended PRN lorazepam and Benadryl being used for anxiety without stop dates.

On 12/13/23 at 02:37 PM, observation revealed R30 ambulated down the hall with staff and required verbal cues to make sure R30 held on to her walker when she ambulated. Further observation revealed R30 was pleasant and acknowledged staff.

On 12/18/23 at 11:04 AM, Certified Nurse Aide (CNA) O stated there had been designated staff to be one on one with R30 due to her anxiety, and her impaired vision. CNA O stated R30 tried to hit staff at times but was otherwise very pleasant.

On 12/19/23 at 10:00 AM, Licensed Nurse (LN) G stated R30 had periods of anxiety and agitation and felt the medication had help with some of her anxiety.

On 12/19/23 at 10:32 AM, Administrative Nurse D stated she had felt the Benadryl was not appropriate for the resident due to her fall risk and that it should not be used for anxiety, but the doctor ordered it. Administrative Nurse D verified there were not interventions placed on the care plan for the risperidone and the black box warnings.

The "Antipsychotic Medication Use" policy, dated 12/16, documented antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed.

The facility failed to ensure an appropriate

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indication or the required physician documentation or the continued use of risperidone, lorazepam, and Benadryl. This placed R30 at risk for unnecessary adverse psychotropic medication side effects.

- The Electronic Medical Record (EMR) for R26 recorded diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and restlessness and agitation.

The "Significant Change Minimum Data Set" (MDS), dated 12/06/23, documented R26 had severely impaired cognition and was independent with dressing, toileting, eating, and oral care. The MDS further documented R26 received antianxiety (class of medications that calm and relax people), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), anticoagulant (medication that inhibits the coagulation of the blood), and diuretic medication (medication to promote the formation and excretion of urine) and had no behaviors.

R26's "Care Plan," dated 10/05/23 documented R26 was at risk for medication adverse reactions related to Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration) for Xanax and directed staff to monitor for side effects from medications.

A "Physician's Order," dated 10/11/23, directed staff to administer Xanax, 25 milligrams (mg), one by mouth, every eight hours, PRN, for

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anxiety. The order lacked a stop date.

The "Medication Regimen Review," dated 11/07/23, documented the pharmacist had no recommendations.

On 12/14/23 at 07:40 AM, observation revealed R26 laid in bed on her right side, on top of the covers.

On 12/14/23 at 08:00 AM, Licensed Nurse G stated R26 had some behaviors of yelling at staff and had PRN medication for anxiety.

On 12/18/23 at 10:57 AM, Certified Nurse Aide (CNA) O stated R26 yelled at staff a lot but was always easily redirectable and had never been aggressive towards other residents.

On 12/19/23 at 10:32 AM, Administrative Nurse D stated R26's PRN Xanax should have a stop date or a rationale as to why she received the medication.

The "Antipsychotic Medication Use" policy, dated 12/16, documented residents would not receive PRN doses of psychotropic medications unless that medication was necessary to treat a specific condition that was documented in the clinical record and the need to continue PRN orders beyond 14 days required that the practitioner document the rationale for the extended order. The duration of the PRN order would be indicated on the order and would not be renewed beyond 14 days unless the healthcare practitioner had evaluated the resident for the appropriateness of that medication.

The facility failed to obtain a stop date for R26's

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F 758	Continued From page 39 PRN Xanax. This placed the resident at risk for receiving unnecessary psychotropic medications and related adverse effects.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample had 14 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed ensure a medications error rate of less than five percent (%) when staff incorrectly administered medications to Resident (R)1. This placed the resident at risk for improper use of medication and related side effects and resulted in a medication error rate of 27 %. Findings included: - The Electronic Medical Record (EMR) for R1 documented diagnoses of diabetes mellitus type 2 (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia with other behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), auditory hallucinations (sensing things while awake that appear to be real, but the mind created) , anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), migraines (a recurrent, throbbing	F 759		

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headache that typically affects one side of the head and is often accompanied by nausea and disturbed vision), psychosis (any major mental disorder characterized by a gross impairment in reality testing), acute kidney failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes), gastro esophageal reflux (GERD-backflow of stomach contents to the esophagus), and delirium due to known physiological condition (sudden severe confusion, disorientation and restlessness.

The "Annual Minimum Data Set" (MDS), dated 10/20/23, document R1 had intact cognition and was independent with toileting, oral care, personal hygiene, and eating. R1 required supervision with bathing and ambulation. The MDS further documented R1 received antipsychotic (medications used to treat psychosis and other mental emotional conditions), antidepressant (medications used to treat mood disorders and relieve symptoms of depression), antiplatelet (medication that prevent blood clots from forming), and a hypoglycemic (medication used to help reduce the amount of sugar present in the blood).

R1's "Care Plan," dated 10/26/23, initiated on 02/14/20, documented R1 was at risk for complications from medications with Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration), and directed staff to administer medications as ordered by the physician, monitor for side effects and effectiveness, and report as needed any adverse reactions to the physician.

The "Physician's Orders," dated 01/14/20,

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directed staff to administer, lisinopril (blood pressure medication), 40 milligrams (mg), one by mouth, daily for hypertension (high blood pressure), amlodipine (blood pressure medication), 5 mg, one by mouth, daily, for hypertension, and magnesium oxide, one 400 mg, by mouth twice per day, for nutritional supplement.

The "Physician's Order," dated 03/23/20, directed staff to administer Cymbalta DR (an antidepressant), 60 mg, one by mouth, daily, for depression (persistent feelings of sadness).

The "Physician's Order," dated 12/11/20, directed staff to administer metformin HCl extended release (ER) (anti-diabetic), 500 mg, one by mouth twice per day for diabetes.

The "Physician's Order," dated 04/20/21, directed staff to administer pantoprazole sodium (acid reducer), 40 mg, one by mouth daily for GERD.

The "Physician's Order, " dated 07/29/21, directed staff to administer Ultram (pain medication), 50 mg, every six hours as needed for pain.

The "Physician's Order," dated 12/14/21, directed staff to administer aspirin (anti-inflammatory), 81 mg, two by mouth daily for a healed fracture.

The "Physician's Order," dated 09/09/22, directed staff to administer Colace caplet (stool softener), 100 mg, one by mouth daily in the morning for hard stools.

The "Physician's Order," dated 02/22/23, directed staff to administer Ritalin (stimulant), 5 mg, one

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by mouth in the morning for energy.

R1's EMR lacked a physician's order which allowed R1 to keep medications at her bedside and self-administer.

R1's EMR lacked evidence the facility assessed R1 for the ability to safely self-administer medication.

On 12/14/23 at 09:15 AM, observation revealed Licensed Nurse (LN) G asked R1 several times to sit up in bed so she could take her medication. R1 stated she did not want to take her pills right then, so LN G placed the pills on her bedside table and left R1's room. LN G stated she would return later to make sure the resident took the medication. LN G said she often left the medication on R1's bedside table to take later. At 09:30 AM, observation revealed R1 sat on the side of her bed and took her medication.

On 12/19/23 at 09:58 AM, Administrative Nurse D stated R1 probably had a self-administration assessment somewhere down in a box in the basement but verified R1 had not been assessed recently.

The facility's "Adverse Consequences and Medication Errors" policy, dated 02/23, documented a "medication error" was defined as the preparation or administration of drugs or biological which was not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional (s) providing services.

The facility failed to ensure a medication error rate of less than 5% when staff incorrectly

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F 759	Continued From page 43 administered R1's medications. This placed the resident at risk for improper use of medication and related side effects and resulted in a medication error rate of 27%.	F 759		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual	F 801		

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will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and

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F 801	Continued From page 45 (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to employ a full time certified dietary manager for the 32 residents who resided in the facility and received meals form the facility kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 12/14/23, review of the noon meal consisted of enchiladas, refried beans, whole kernel corn, garlic bread, and apple pie. On 12/14/23 at 11:20AM, observation revealed Dietary Staff BB in the kitchen overseeing the preparation of the noon meal. On 12/13/23 at 08:1AM, Dietary Staff BB verified she was not a certified dietary manager. Dietary Staff BB stated she had not started the certified dietary manager classes. On 12/14/23 at 2:00PM, Administrative Staff A verified Dietary Staff BB had no dietary manager certification. Upon request the facility did not provide a policy regarding Certified Dietary management	F 801		

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F 801	Continued From page 46 requirements. The facility failed to employ a full time certified dietary manager for 32 residents who resided in the facility who received meals from the kitchen. This placed the residents at risk for inadequate nutrition.	F 801		
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 had a census of 32 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for the 32 residents who received their meals from the	F 812		

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facility's kitchens when staff stored uncovered hamburger in two freezers. Kitchen staff failed to defrost the chest freezer and clean the outside of a chest and upright freezer. Kitchen staff failed to ensure the dishwasher sanitizing test strips were still effective. This placed the 32 residents at risk for foodborne illness.

Findings included:

- On 12/13/23 at 08:15 AM, observation in the kitchen revealed the following:
The inside of the white chest freezer, located in the dry storage room, had approximately one-quarter inch ice buildup, 13 uncovered quarter-pound hamburger patties, and seven slider hamburgers in an unsealed zip-lock bag. The outside of the white chest freezer and upright freezer, located in the dry storage room, had numerous different size areas of black substance.

On 12/13/23 at 08:30 AM, Dietary Staff (DS) CC verified the above findings, removed and discarded the hamburger patties and stated the chest freezer needed defrosted. DS CC stated staff should make sure food was stored in a sealed container in the freezers.

On 12/14/23 at 12:00 PM, observation revealed DS BB attempted to check the dishwasher sanitization level by placing a sanitizing test strip in sanitizing cycle and the test strip failed to read on the strip. DS BB checked the expiration date on the test strips and the label read expiration date "06/22." DS BB verified the strips were expired and stated she would order some more.

On 12/14/23 at 12:00 PM, DS BB verified the peeling paint on the cupboards, the ice buildup

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F 812	Continued From page 48 inside the white chest freezer and the numerous different size areas on the two freezer doors, located in the dry storage room. DS BB stated food should be stored in a covered container or sealed bag when placed in the freezer. Upon request the facility did not provide a food storage policy. The facility's " Dietary Aides Weekly Cleaning Chart" documented tasks for the aides to do daily. The Cooks daily cleaning chart listed tasks for the cook to completed am/pm and weekly cleaning. The facility's "Sanitization Policy," revised November 2022 documented all kitchens, kitchen areas and dining areas are kept clean. The policy documented the chemical solution is maintained at the correct concentration, based on periodic testing, at least once per shift and for the effective contact time according to manufacturer's guidelines. The facility kitchen staff failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for the 32 residents who received their food from the kitchen. This placed the 32 residents at risk for food borne illness.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more	F 849		

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Medicare-certified hospices.
(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.

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(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving

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mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient

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as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included 14 residents, with one reviewed for hospice (a type of health care that focused on the terminally ill patient's pain and symptoms and attended to their emotional and spiritual needs at

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the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R) 26. This placed R26 at risk for inappropriate and/or unmet end of life cares.

Findings included:

- R26's Electronic Medical Record (EMR) recorded diagnoses of dementia without behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and restlessness and agitation.

The "Significant Change Minimum Data Set" (MDS), dated 12/06/23, documented R26 had severely impaired cognition and was independent with dressing, toileting, eating, and oral care. The MDS further documented R26 received hospice services.

R26's "Care Plan," dated 11/29/23, documented R26 received hospice services and the facility worked side by side with hospice if problems or issues arose and directed staff to use the hospice plan of care for reference.

R26's EMR documented R26 was admitted to hospice care of 11/29/23 and lacked a hospice care plan with hospice services.

On 12/14/23 at 07:40 AM, observation revealed R26 laid in bed on her right side, on top of the covers.

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F 849	Continued From page 54 On 12/14/23 at 10:57 AM, Licensed Nurse (LN) G stated R26 received hospice services due to her decline and refusal of medications. LN G stated the hospice nurse came to see R26 twice per week. On 12/14/23 at 02:14 PM, Consultant GG stated she came to see R26 twice per week and would send the facility her visit paperwork weekly on Fridays. Consultant GG said the care plan should have been sent to the facility. On 12/18/23 at 10:57 AM, Certified Nurse Aide (CNA) O stated R26 received hospice services and the hospice aide was responsible for one of her three showers per week. On 12/19/23 at 10:32 AM Administrative Nurse D stated the hospice care plan should have been in the resident's medical record. The facility's "Nursing Facility Hospice Services Agreement," dated 01/19, documented hospice shall establish and maintain a coordinated plan of care for each resident who became a patient in accordance with applicable federal and state laws and regulations, and in conjunction with the nursing facility. The facility failed to coordinate care between themselves and hospice services for R26, who received hospice services, placing her at risk for inappropriate and/or unmet end of life care.	F 849		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing	F 851		

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information based on payroll data in a uniform format.
Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

§483.70(q)(1) Direct Care Staff.
Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

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F 851	Continued From page 56 §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. Based on observation, interview and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (YR) 2023 Quarter 2 and 3 indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on multiple days, (Quarter 2: 5 dates, Quarter 3: 6 dates) Review of the facility licensed nurse payroll data	F 851		

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F 851	Continued From page 57 for the dates listed on the PBJ revealed a licensed nurse on duty for 24 hours a day seven days a week. On 12/13/23 at 08:00 AM, observation revealed a licensed nurse on duty in the facility. On 12/14/23 at 12:30 PM, Administrative Staff B stated the facility's corporate office completed the PBJ report and would have access to the staff schedule from the computer. On 12/18/23 at 08:00 AM, Administrative Staff B stated the PBJ report completed by the corporate office did not show that the information sent to CMS was incorrect and that it did not show they were lacking licensed nurse coverage for the dates above. The facility's "Reporting Direct Care Staffing Information (Payroll-Based Journal)" policy, dated 08/22, documented complete and accurate direct care staffing information was reported electronically to CMS through the PBJ system in a uniform format specified by CMS. Staffing information was collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter. The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.	F 851		
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	F 880		

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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

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

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

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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 had a census of 32 residents. The sample included 14 residents with one reviewed for bladder and bowel incontinence. Based on observation, record review, and interview, the facility staff failed exercise appropriate hand hygiene when providing Resident (R)31 incontinent and catheter (tube inserted directly into the bladder to drain urine) cares. This placed the resident at risk for infection.

Findings included:

- R31's Electronic Medical Record (EMR) documented R31 had diagnoses reflux uropathy (condition when urine flows backwards into your kidneys (two bean-shaped organs found on the

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left and right sides of the body) and urine retention (lack of ability to urinate and empty the bladder).

R31's "Admission Minimum Data Set" (MDS) documented R31 had short term memory problems and modified independent cognitive skills for daily decision making. The MDS documented R31 required limited staff assistance with most activities of daily living (ADLs), had an indwelling urinary catheter (tube placed in the bladder to drain urine into a collection bag), and was frequently incontinent of bowel.

The "Care Area Assessment," (CAA), dated 09/26/23, documented R31 had an indwelling catheter. R31needed some assistance with bed mobility, limited assistance for transfer, ambulation, locomotion, dressing and toileting with frequent bowel incontinence.

R31's "Care Plan," revised 09/20/23, documented R31 required limited staff assistance with toileting. The care plan instructed staff to monitor and document if R31 had pain or discomfort due to catheter. The plan directed staff to report to physician if R31 had signs/symptoms of urinary tract infection (UTI).

On 12/18/23 at 2:15 PM, Certified Nurse Aide (CNA) M entered R31's room and assisted him with a walker and stand by assist to the bathroom. CNA M cued R31 to pivot turn and stand above the toilet. Observation revealed CNA M applied gloves, pulled down the resident's pants and incontinent brief to reveal a small amount of soft stool in the brief. CNA M verified the stool in the brief, then removed and discarded the incontinent brief into the trash can. CNA M

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cued R31 to sit on the toilet. CNA M, with the same soiled gloves, retrieved a new incontinent brief from a plastic container in the bathroom by sink. CNA M placed the new incontinent brief on the resident's left leg. Further observation revealed CNA M, wearing with the same soiled gloves, placed three paper towels on the floor in front of the resident's feet. CNA M took a urinal out of a plastic container touching the front of it to open it and placed the urinal on the paper towels. With the same soiled gloves, CNA M opened the port of the leg bag, drained clear yellow urine into the urinal from the leg bag urine container and closed the port. Still wearing the soiled gloves, CNA M then took an alcohol pad and wiped the spout drainage port, then reconnected the leg bag to the resident's leg with a strap. Further observation revealed CNA M, with the same soiled gloves, took a clean blue washcloth and wiped from the tip of R31's penis down the catheter tubing, then placed the cloth into a plastic bag. CNA M, with the same soiled gloves, attempted to place the new incontinent brief on R31's right leg, touched the bottom of R31's shoes with the brief and her gloved hands, then took off the brief and placed it in the trash can. With the same soiled gloves, CNA M took a new incontinent brief from the same plastic container, touching the door front when she opened it, and placed the new incontinent brief on the resident's legs. CNA M cued the resident to stand, and she provided perineal (private area) care to the resident's buttock area, then with the same soiled gloves, pulled up R31's incontinent brief and pants, and pulled the resident's shirt down in the back. CNA M poured urine into the toilet from the urinal, then removed and discarded the gloves, but did not wash hands. Observation revealed CNA M touched the resident's walker and gait belt

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while assisting him back to his bed, adjusted the resident's bed pad, removed his shoes, and placed them on the bedside table as resident had requested. CNA M, with unwashed hands, picked up R31's water pitcher and gave him a drink of water. CNA M returned to the bathroom, tied up the two trash bags but did not wash her hands. When asked, CNA M stated she did not get anything on the gloves, but common sense should have told her to change them. When asked, CNA M said she would wash her hands before leaving the room. CNA M then picked up the trash bags and without washing her hands, left the room, took the bags to shower room, touched the door handle, placed the trash bags into the trash can, then washed her hands.

On 12/19/23 at 10:10 AM, Administrative Nurse D stated she expected staff, when providing a resident incontinent care, to change gloves after taking off a dirty incontinent brief, after providing perineal care, and before they touch anything clean. Administrative Nurse D stated she expected staff to wash hands before they put on gloves, when taking off gloves, and anytime they met a resident's bodily fluids.

The facility's "Handwashing/Hand Hygiene Policy," revised August 2019, documented the use of gloves does not replace hand washing/hand hygiene. single use disposable gloves should be used before aseptic procedures, when anticipating contact with blood or body fluids, and when in contact with a resident, or the equipment or environment of a resident who is on contact precautions.

The facility staff failed to change gloves and wash hands when providing R31 incontinent and

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F 880	Continued From page 63 catheter cares and continued to provide care with the same soiled gloves. This placed the resident at risk for infection.	F 880		