

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

PRINTED: 02/02/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175557	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2024
NAME OF PROVIDER OR SUPPLIER AZRIA HEALTH OLATHE			STREET ADDRESS, CITY, STATE, ZIP CODE 201 E FLAMING ROAD OLATHE, KS 66061		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00184774, KS00182987, KS0000185029, KS00182181, KS00185238 and KS00181681.	F 000			
F 550 SS=E	The 2567 was sent electronically on 02/02/24. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550			

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

TITLE

(X6) DATE

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

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 102 residents. The sample included 22 residents with six residents reviewed for dignity. Based on observation, interview, and record review, the facility failed to ensure a dignified care environment for Resident (R)33, R62, R75, R88, and R89. The facility additionally failed to provide dignity while dining when the facility used disposable silverware and dishware during meals. This deficient practice placed the residents at risk of unnecessary embarrassment and decreased psychosocial well-being. Findings Included: - The "Facility Reported Incident 2181" documented that on 08/13/23, R33 assisted emergency medical services (EMS) by holding open a door so EMS could enter the facility. The report indicated Administrative Staff B approached R33 and told R33 to move out of the way. The report indicated R33 refused to move, and Administrative Staff B used profanity towards R33. On 01/17/24 at 08:05 AM an inspection of the	F 550			

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F 550	Continued From page 2 main dining area revealed residents ate breakfast with Styrofoam plates/cups and disposable plastic silverware. At 08:05 AM Dietary Staff BB stated the facility had enough silverware for all three meal services, but staff did not return the silverware to the kitchen in time for the next service. On 01/17/24 at 08:30 AM an inspection of the "Abbey Hall" dining service revealed residents ate breakfast with Styrofoam plates/cups and disposable plastic silverware. On 01/17/24 at 12:14 PM R75 (a severely cognitively impaired resident) rested in the dining area in her Broda chair (specialized wheelchair with the ability to tilt and recline). R75 sat at the table with her head and arms resting on the table. An unidentified staff member walked up to R75 and informed her it was lunchtime. R75 stated she preferred to rest with her head on the table. Staff then repositioned her upright in her wheelchair without notifying her or asking her if she wanted to sit up. R75 agreed to eat lunch. The unidentified staff member yelled out "I'll feed her" to another staff across the room. On 01/22/24 at 09:56 AM Licensed Nurse (LN) G administered R88's morning medications through her gastrotomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) and completed a dressing change. LN G failed to close the door or pull the privacy curtain during the provided care with multiple people walking past the room within sight of the provided care. During the dressing change, Administrative Nurse D walked by R88's room, then stopped and closed the door. LN G stated she usually would close the door when she	F 550			

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F 550	Continued From page 3 provided wound care but not while working with G-tubes. On 01/22/24 at 11:50 AM R89 (a severely cognitively impaired resident) sat at the dining table closest to the television and awaited her lunch. Certified Nurses Aid (CNA) NN brought R89's meal to her and prepped her for lunch. CNA NN provided assistive feeding for R89 while standing next to the resident. At 11:56 AM, LN J approached CNA NN and instructed her to sit down next to R89 while providing assisted feeding. CNA NN sat down and remained seated during the meal assist. On 01/22/24 at 11:58 AM R62 was assisted to the dining room by CNA LL. R62 sat at the table next to the window and CNA LL adjusted her seat. CNA LL completed hand hygiene and retrieved R62's meal and drink from the food cart. CNA LL stood next to R62 and began spoon-feeding her mechanically soft beef and mashed potatoes. At 12:01 PM CNA LL continued to provide assistive feeding to R62 without offering or alternating drinks with her solid food. At 12:09 PM CNA LL picked up R62's red beverage and offered it to her. R62 took a large drink and continued her meal while CNA LL stood next to her to assist. On 01/23/24 at 11:20 AM CNA M stated staff were expected to always be seated with the residents during assistive feedings. She stated it would be disrespectful to stand over someone else while trying to feed them. On 01/23/24 at 11:55 AM LN I stated staff should always communicate before repositioning residents and always sit with them while assisting them with meals. She stated staff should always	F 550			

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F 550	Continued From page 4 ensure privacy while providing personal care assistance and dressing changes. On 01/23/24 at 12:50 PM Administrative Nurse D stated staff was expected to ensure the residents had privacy during care. He stated staff should always sit while providing assisted meals and be at eye level to ensure effective communication. He stated staff should always communicate with the residents before repositioning them and ask for their opinion or input. A review of the facility's "Resident Rights" policy revised 12/2016 indicated all residents had the right to be treated with dignity, respect, and kindness. The policy indicated the facility would provide care in a manner that communicates understanding and preferred choices related to each resident's needs, wants, and preferences. The facility failed to ensure a dignified care environment for R33, R62, R75, R88, and R89. The facility additionally failed to provide dignity while dining related to using disposable silverware and dishware during meals. This deficient practice placed the residents at risk of unnecessary embarrassment and decreased psychosocial well-being.	F 550			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and	F 582			

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F 582	Continued From page 5 for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's	F 582			

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F 582	Continued From page 6 date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: The facility identified a census of 102 residents with 22 residents included in the sample. The facility identified two residents who were discharged from Medicare Part A services. Based on interview and record review the facility failed to issue CMS (Center for Medicare/Medicaid Services) Skilled Nursing Facility Advance Beneficiary Notification (SNF ABN) form 10055 (the form used to notify Medicare A participants of potential financial liability when a Medicare Part A episode ends) with the required information for Resident (R) 81 and R 28. This failure placed the residents at risk for impaired decision-making. Findings included: - A review of R81's Electronic Medical Record (EMR) documented that the Medicare Part A episode began on 08/17/23 and ended on 08/21/23. R81 remained in the facility for custodial care. The facility-issued SNF ABN 10055 lacked an estimated cost for continued services. A review of R28's Electronic Medical Record (EMR) documented that the Medicare Part A episode began on 07/12/23 and ended on 09/01/23. R28 remained in the facility for custodial care. The facility-issued SNF ABN 10055 lacked an estimated cost for continued services.	F 582			

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F 582	Continued From page 7 On 01/23/23 at 11:25 PM Social Services X stated that she was unaware the form CMS-10055 needed an estimated cost for continued services. The facility's "Advance Beneficiary Notices" policy, dated 04/2021, documented that the current CMS-approved version of the forms shall be used at the time of issuance to the beneficiary and the contents of the form shall comply with related instructions and regulations regarding the use of the form. The facility failed to ensure the forms provided at the end of skilled services contained the required information for the residents to make informed choices. This failure placed the residents at risk for impaired decision-making.	F 582			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened	F 583			

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F 583	Continued From page 8 mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: The facility identified a census of 102 residents. The sample included 22 residents. Based on observation, record review, and interview, the facility failed to ensure staff secured and protected the privacy and confidentiality of Resident (R) 47's medical record. This placed this resident's personal and confidential information at risk of being accessed by unauthorized individuals. Findings included: - Observation on 01/18/24 at 12:14 PM R47's "Medication Administration Record" (MAR) was left open, visible, and unattended on the medication cart outside of his room. On 01/18/24 at 12:16 PM Certified Medication Aide (CMA) R stated it was his mistake, he walked away from his medication cart and left the screen unlocked with R47's information visible.	F 583			

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F 583	Continued From page 9 CMA R stated normally he locked the laptop screen every time he walked away from the cart. On 01/18/24 at 03:09 PM Licensed Nurse (LN) H stated the laptop screen should be locked every time the medication aide or nurse walked away from the laptop area. On 01/23/24 at 01:00 PM Administrative Nurse D stated he expected nursing staff to lock the laptop screen any time staff left the direct area of their laptop when passing medications so resident privacy and personal information was protected. The "Protected Health Information (PHI), Safeguarding Electronic" policy revised February 2014 documented that electronic PHI was safeguarded by administrative, technical, and physical means to prevent unauthorized access to protected health information. Physical access to electronic information systems was limited to individuals who were authorized to access the system. All workstations are protected from unauthorized access by physical barriers that discourage attempts to tamper with or violate security rules including placing computer terminals and workstations away from high-traffic areas. Automatically locking computer screens after a specified number of incorrect password attempts. The facility failed to ensure that staff secured and protected the privacy and confidentiality of R47's medical record. This placed this resident's personal and confidential information at risk of being accessed by unauthorized individuals.	F 583			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609			

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F 609	Continued From page 10 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility identified a census of 102 residents. The sample included 22 residents with three reviewed for abuse and/or neglect. Based on record review, observations, and interviews, the facility failed to identify a preventable accident for Resident (R) 18, who was dependent on staff for transfers with a Hoyer (full body mechanical lift), as an allegation of potential neglect and failed to	F 609			

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F 609	Continued From page 11 report to the State Agency (SA) as required within the required timeframe. This placed the resident at risk for unidentified and ongoing neglect. Findings included: - The Electronic Medical Record (EMR) for R18 documented a diagnosis of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), and obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow that can be either structural or functional and allows urine to flow back into the kidneys). The "Admission Minimum Data Set (MDS)" dated 07/21/23, documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. The MDS documented R18 used a wheelchair and was dependent on staff for bathing, dressing, mobility, and transfers. The "Falls Care Area Assessment (CAA)" dated 07/21/23, documented R18 was at risk for falls related to cerebral palsy. The MDS further documented R18 had a history of falls, weakness, and physical performance limitations that affected his balance, gait, strength, and muscle endurance. R18's "Care Plan" with an initiated date of 07/24/23, documented R18 had an activity of daily living (ADL) self-care performance deficit and impaired mobility related to cerebral palsy. An intervention with an initiated date of 07/24/23 documented R18 required the use of a Hoyer lift	F 609			

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F 609	Continued From page 12 for transfers. An intervention with an initiated date of 07/24/23 documented R18 admitted to the facility with his wheelchair and that R18 was dependent on staff for locomotion. The intervention directed staff to assist as appropriate. A "Witnessed Fall 3110" report dated 01/04/24, documented Licensed Nurse (LN) H was called to R18's room and found him on the floor facing up with a pillow under his head. The document further recorded the staff present at the time of the incident reported they transferred R18 from a chair to his bed with a Hoyer lift when one of the loops on the right side "came loose" and caused R18 to fall. The document further recorded R18 had a hard bump to the back of his head. The document recorded R18 was assessed by the advanced practice registered nurse (APRN) who was in the facility and sent to a local emergency room for evaluation and treatment. Certified Nurse Aide (CNA) M's undated "Witness Statement" documented CNA M and CNA N took R18 to his room. CNA N hooked the Hoyer pad to the Hoyer lift. The witness statement documented CNA M walked behind R18's wheelchair to move it as CNA N began lifting R18 with the Hoyer lift. The witness statement further documented CNA N yelled as CNA M came around the wheelchair to move it, and R18 fell on the floor. CNA N's undated "Witness Statement" documented CNA M and CNA N took R18 into his room so he could go to bed. The witness statement documented CNA N hooked the R18's sling to the Hoyer lift while CNA M unhooked R18's urine collection bag from the bottom of his wheelchair. The statement further documented CNA N raised R18 in the Hoyer sling and CNA M	F 609			

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F 609	Continued From page 13 went to move R18's wheelchair. CNA N documented as R18 was raised in the sling, the back, left hoop on the Hoyer sling came off and R18 fell backward out of the sling onto the floor. On 01/22/24 at 09:22 AM CNA M and CNA O used a Hoyer lift to transfer R18 from a wheelchair to his bed. On 01/23/24 at 12:55 PM Administrative Nurse D stated the expected staff to ensure sling hoops were correctly placed on the Hoyer lift before transfers. Administrative Nurse D stated it was not a normal occurrence for a Hoyer sling to come off a Hoyer lift unless the equipment was faulty. Administrative Nurse D further stated the fall was most likely a result of human error as the lift and sling used to transfer R18 were inspected and found to be functioning correctly. Administrative Nurse D stated the fall was not reported to the SA as it was his understanding that a fall from a Hoyer was only reportable if the resident sustained a significant injury, since the facility did not report every resident that was sent to the emergency room due to a fall. Administrative Nurse D verified the facility reported outright allegations of abuse but went on to say there was not a suspicion of neglect and the facility believed it was premature to assume there was until after an investigation was conducted. Administrative Nurse D stated the fall would have been reported immediately if R18 had a significant injury or if the investigation showed abuse. Administrative Nurse D stated he did see human error as a potential neglect situation. The facility provided the "Abuse, Neglect, Exploitation, and Misappropriation Preventions Program" policy with a revised date of April 2021	F 609			

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F 609	Continued From page 14 documented that residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy further documented that the program supported identifying and investigating all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property and investigating and reporting allegations within the timeframes required by federal requirements. The facility failed to identify a preventable accident for R18, who was totally dependent on staff for transfers with a Hoyer, as an allegation of potential neglect and failed to report to the SA as required within the required timeframe. This placed R18 at risk for unidentified and ongoing neglect.	F 609			
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.	F 623			

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F 623	Continued From page 15 (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (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	F 623			

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F 623	Continued From page 16 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy 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 identified a census of 102 residents. The sample included 22 residents. Based on			F 623			

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F 623	Continued From page 17 record review and interview, the facility failed to provide written notification as soon as practicable to Resident (R) 58. This deficient practice had the risk of miscommunication between the facility and the resident. Findings included: - The electronic medical record (EMR) for R58 documented diagnosis of quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), and neuralgia (intense pain along a nerve). The "Significant Change Minimum Data Set (MDS)" dated 11/30/23 documented R58 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R58 had impairment on both sides of his body and was dependent on staff for all functional activities. The "Functional Abilities Care Area Assessment (CAA)" dated 12/07/23 documented R58 was dependent on staff for activities of daily living (ADLs) care needs including eating, oral and personal hygiene, toileting, and mobility issues. R58's "Psychosocial Well-Being Care Plan" revised 12/29/23 directed staff to allow R58 the opportunity to communicate his feelings. R58 was to meet with social services weekly to discuss feelings and develop coping strategies. A "Bed Hold Authorization" dated 09/21/23 with a transfer date of 09/20/23 was completed and verbally authorized by R58's representative. A "Bed Hold Authorization" dated 10/20/23 with a transfer date of 10/19/23 was completed and	F 623			

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F 623	Continued From page 18 verbally authorized by R58's representative. A "Bed Hold Authorization" dated 12/01/23 with a transfer date of 12/01/23 was completed and verbally authorized by R58's representative. A "Bed Hold Authorization" dated 12/15/23 with a transfer date of 12/14/22 was completed and verbally authorized by R58's representative. R58's clinical record lacked evidence a written notification of transfer was provided to R58 and/or their representative for the facility-initiated transfer dates noted above (09/21/23, 10/19/23, 12/01/23, and 12/14/23). On 01/22/24 at 01:05 PM Administrative Staff A stated that staff notified the family representative by phone of the transfer. Administrative Staff A said she was not aware if written notification was provided to R58 or his representative. The "Transfer or Discharge, Facility-Initiated" policy dated October 2022 documented facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification, orientation, and documentation as specified in this policy. The resident and representative were to be notified in writing of a specific reason for the transfer or discharge. The effective date of the transfer or discharge. The specific location to which the resident was being transferred or discharged. An explanation of the resident's rights to appeal the transfer or discharge to the state. The facility failed to provide written notification of facility-initiated transfers with the required information to R58 and/or his representative in a	F 623			

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F 623	Continued From page 19 practicable amount of time. This deficient practice had the risk of miscommunication between the facility and R58.	F 623			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility identified a census of 102 residents. The sample included 22 residents with three residents reviewed for activities of daily living (ADLs). Based on record review, interviews, and observations, the facility failed to provide the necessary assistance to Resident (R)62 for eating and drinking. These deficient practices placed R62 at risk of increased complications due to impaired ADL ability. Findings included: - The "Medical Diagnosis" section within R62's Electronic Medical Records (EMR) included diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion), aphasia (condition with disordered or absent language function), major depressive disorder (major mood disorder), and type two diabetes mellitus (when the body cannot use glucose, not enough insulin or the body cannot respond to the insulin). R62's "Quarterly Minimum Data Set (MDS)" completed 01/03/24 indicated a Brief Interview for Mental Status (BIMS) score of zero indicating	F 677			

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F 677	Continued From page 20 severe cognitive impairment. The MDS indicated she was dependent on staff assistance for eating, oral hygiene, toileting, dressing, bed mobility, transfers, and bathing. The MDS indicated no dental or oral issues. R62's "Nutrition Care Area Assessment (CAA)" completed 04/14/23 indicated she was at risk for impaired nutrition related to her advanced dementia. The CAA noted she required a mechanically soft diet and had forgotten how to use eating utensils for self-feeding. The CAA noted she required assistance with eating. The CAA noted she was unable to eat meals without extensive physical assistance. The CAA indicated she had issues with swallowing her meals. R62's "Care Plan" initiated 06/09/22 indicated she had nutritional deficits related to her medical diagnoses. The plan indicated she required extensive to total assistance with meals. The plan instructed staff to provide her meals as ordered and monitor her intake. The plan instructed staff to offer meal substitutions and snacks as appropriate. The plan indicated she had dementia-focused nutritional interventions due to R62's inability to use utensils. The plan implemented safe swallow strategies instructing staff to alternate between two bites of solid food to one drink ratio. On 01/22/24 at 11:58 PM, R62 was assisted to the dining room by Certified Nurses Aid (CNA) LL. R62 sat at the table next to the window and CNA LL adjusted her seat. CNA LL completed hand hygiene and retrieved R62's meal and drink from the food cart. CNA LL stood next to her R62 and began spoon-feeding her mechanically soft beef and mashed potatoes. At 12:01 PM CNA LL	F 677			

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F 677	Continued From page 21 continued to provide assistive feeding to R62 without offering or alternating drinks with her solid food. At 12:09 PM CNA LL picked up R62's red beverage and offered it to her. R62 took a large drink and continued her meal. R62's solid-to-liquid meal intake was not alternated throughout the meal per her care plan. On 01/23/24 at 11:20 AM Certified Nurse's Aide (CNA) M stated each resident's diet and care requirements were reflected on the Kardex. She stated staff should actively engage with the residents while feeding them and anticipate their needs if a resident could not communicate with them. She stated staff should offer drinks to residents frequently who were unable to get a drink on their own. On 01/23/24 at 11:55 AM Licensed Nurse (LN) I stated direct staff were expected to review each Kardex to ensure the correct level of care was given to each resident. She stated staff were expected to sit next to each resident while assisting them and ask the resident frequently if they required drinks. She stated R62 required total assistance during meals due to her dementia and difficulty communicating her needs. On 01/23/24 at 12:54 PM Administrative Nurse D stated all staff had access to review the care plans and Kardex information for each resident. He stated staff were expected to sit next to the residents during meals and provide the level of assistance identified in the care plan. The facility's provided "Activities of Daily Living" 03/2018 indicated residents unable to carry out activities of facility living independently will receive the services necessary to maintain good	F 677			

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F 677	Continued From page 22 nutrition, grooming, and personal care. The facility failed to provide R62 with the necessary assistance during staff-assisted meals. These deficient practices placed R62 at risk for complications.	F 677			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility identified a census of 102 residents. The sample included 22 residents with one resident reviewed for hydration. Based on observation, record review, and interviews, the facility failed to follow a physician's order for daily weights to monitor for fluid overload for Resident (R) 38. This deficient practice placed R38 at risk for delay in treatment related to fluid overload and untreated illness. Findings included: - R38's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), edema (swelling resulting from an excessive accumulation of fluid in the body	F 684			

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F 684	Continued From page 23 tissues), and paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk). The "Annual Minimum Data Set" (MDS) dated 12/15/23 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R38 was dependent on staff assistance for transfers. The MDS documented R38 received diuretic (medication to promote the formation and excretion of urine) medication during the observation period. R38's "Functional Abilities Care Area Assessment" (CAA) dated 12/28/23 documented R38 preferred to stay in bed. R38's "Care Plan" dated 05/26/22 documented that a daily weight would be obtained as ordered by the physician and staff would notify the physician of a weight gain greater than three pounds. A review of the EMR under the "Orders" tab revealed the following physician orders: Lasix (diuretic) oral tablet 20 milligrams (mg) give 60 mg by mouth two times a day for CHF dated 05/23/23. Daily weight in the morning, notify physician of weight gain of three pounds or greater related to edema dated 05/23/23. Review of R38's "Treatment Administration Record" (TAR) from 10/01/23 to 01/21/24 (113 days) lacked evidence staff measured and recorded R38's weight) on following dates 10/28/23, 10/31/23, 11/04/23, 11/11/23, 11/13/23,	F 684			

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F 684	Continued From page 24 11/16/23, 11/28/23, 12/08/23, 12/14/23, 12/17/23, 01/03/24, and 01/15/24. The clinical record lacked evidence of physician notification the daily weight was not obtained. Observation on 01/22/24 at 12:16 PM R38 reclined in his Broda chair (specialized wheelchair with the ability to tilt and recline). He wore foam boots on both lower extremities as he watched TV in his room. On 01/23/24 at 11:55 AM Certified Nurse Aide (CNA) M stated the CNAs obtained the daily weights as assigned by the charge nurse. CNA M stated R38's weight was obtained early each morning per his preference. CNA M stated R38 always wanted to know what his weight was to ensure he had not gained any weight. CNA M stated that per her knowledge, R38 had never refused to be weighed. On 01/23/24 at 12:20 PM Licensed Nurse (LN) H stated R38 wanted to be weighed at 06:00 AM every day. LN H stated R38 refused to be weighed occasionally and the refusal would be documented on the TAR. LN H said the physician should have been notified of any refusals and documented in the clinical record. On 01/23/24 at 12:54 PM Administrative Nurse D stated R38's daily weight should be obtained as ordered by the physician and the physician should be notified of any changes and refusals. Administrative Nurse D stated communication with the physician should be documented in the clinical record. The facility's "Accommodation of Needs" policy last revised 03/2021 documented the resident's	F 684			

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F 684	Continued From page 25 individual needs and preferences were accommodated to the extent possible. The facility failed to follow the physician's order for daily weights to monitor weight gain for fluid overload for R38, who had CHF. This deficient practice placed R38 at risk of adverse side effects from unnecessary medication or complications related to fluid overload.	F 684			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility documented a census of 102 residents. The sample included 22 residents, with 10 reviewed for falls. Based on observation, record review, and interview, the facility failed to ensure an environment free from preventable accidents when staff failed to correctly place the loop of the sling during a Hoyer lift (total body mechanical lift used to transfer residents) transfer which resulted in resident (R)18's fall to the floor from the lift. The facility further failed to ensure Dycem (non-slip mat used for stabilization and gripping to prevent slipping) was placed correctly in R75's wheelchair. These deficient practices placed R18 and R75 at risk for avoidable injuries. Findings included:	F 689			

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F 689	Continued From page 26 - The Electronic Medical Record (EMR) for R18 documented a diagnosis of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), and obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow that can be either structural or functional and allows urine to flow back into the kidneys). The "Admission Minimum Data Set (MDS)" dated 07/21/23, documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. The MDS documented R18 used a wheelchair and was dependent on staff for bathing, dressing, mobility, and transfers. The "Falls Care Area Assessment (CAA)" dated 07/21/23, documented R18 was at risk for falls related to cerebral palsy. The MDS further documented R18 had a history of falls, weakness, and physical performance limitations that affected his balance, gait, strength, and muscle endurance. R18's "Care Plan" with an initiated date of 07/24/23, documented R18 had an activity of daily living (ADL) self-care performance deficit and impaired mobility related to cerebral palsy. An intervention with an initiated date of 07/24/23 documented R18 required the use of a Hoyer lift for transfers. An intervention with an initiated date of 07/24/23 documented R18 admitted to the facility with his wheelchair and that R18 was dependent on staff for locomotion. The intervention directed staff to assist as appropriate.	F 689			

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F 689	Continued From page 27 A "Witnessed Fall 3110" report dated 01/04/24, documented Licensed Nurse (LN) H was called to R18's room and found him on the floor facing up with a pillow under his head. The document further recorded the staff present at the time of the incident reported they transferred R18 from a chair to his bed with a Hoyer lift when one of the loops on the right side "came loose" and caused R18 to fall. The document further recorded R18 had a hard bump to the back of his head. The document recorded R18 was assessed by the advanced practice registered nurse (APRN) who was in the facility and sent to a local emergency room for evaluation and treatment. Certified Nurse Aide (CNA) M's undated "Witness Statement" documented CNA M and CNA N took R18 to his room. CNA N hooked the Hoyer pad to the Hoyer lift. The witness statement documented CNA M walked behind R18's wheelchair to move it as CNA N began lifting R18 with the Hoyer lift. The witness statement further documented CNA N yelled as CNA M came around the wheelchair to move it, and R18 fell on the floor. CNA N's undated "Witness Statement" documented CNA M and CNA N took R18 into his room so he could go to bed. The witness statement documented CNA N hooked the R18's sling to the Hoyer lift while CNA M unhooked R18's urine collection bag from the bottom of his wheelchair. The statement further documented CNA N raised R18 in the Hoyer sling and CNA M went to move R18's wheelchair. CNA N documented as R18 was raised in the sling, the back, left hoop on the Hoyer sling came off and R18 fell backward out of the sling onto the floor.	F 689			

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F 689	Continued From page 28 On 01/22/24 at 09:22 AM CNA M and CNA O used a Hoyer lift to transfer R18 from a wheelchair to his bed. On 01/23/24 at 11:55 AM, CNA M stated she would check the size of the sling and ensure the sling hoops were the correct size for the Hoyer being used before attempting to transfer a resident. CNA M stated once the sling hoops were attached, many of the Hoyer lifts would have an arm or lever to keep the hoops from coming off during a transfer. CNA M stated if the hoops were placed properly, they should not come off the Hoyer lift, and if the hoops were to come off of the Hoyer lift during a transfer, it would likely be due to the hoops not being placed properly. On 01/23/24 at 12:20 PM, LN H stated staff should correctly secure the Hoyer sling to the lift and double check the sling hoops to ensure they were securely in place before transferring a resident with the Hoyer lift. LN H stated if the sling hoops were correctly placed, and the Hoyer was not broken, then there was no way for them to fall off of the Hoyer lift during a transfer. On 01/23/24 at 12:55 PM Administrative Nurse D stated he expected staff to ensure sling hoops were correctly placed on the Hoyer lift before transfers. Administrative Nurse D stated it was not a normal occurrence for a Hoyer sling to come off a Hoyer lift unless the equipment was faulty. Administrative Nurse D further stated the fall was most likely a result of human error as the lift and sling used to transfer R18 were inspected and found to be functioning correctly. The facility provided a "Lifting Machine, Using a Mechanical Lift" policy with a revised date of July	F 689			

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F 689	Continued From page 29 2017, documented in the steps in the procedure section ensure the resident is utilizing the proper sling size and purpose according to the manufacturer's instructions, select a sling bar that is appropriate for the residents' size and the task, make sure the lift is stable and locked, make sure that all necessary equipment (slings, hooks, chains, straps and supports) are on hand and in good condition. The facility failed to ensure an environment free from preventable accidents when staff failed to correctly place the loop of the sling during a Hoyer lift transfer which resulted in R18 falling to the floor from the lift. This deficient practice placed R18 at risk for avoidable injuries. - The "Medical Diagnosis" section within R75's Electronic Medical Records (EMR) included diagnoses of Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), visual loss, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and repeated falls. R75's "Quarterly Minimum Data Set (MDS)" completed 12/28/23 indicated a Brief Interview for Mental Status (BIMS) was not completed due to severe impairment. The MDS indicated she was dependent on staff assistance for eating, oral hygiene, toileting, dressing, bed mobility, transfers, and bathing. The MDS indicated she had two non-injury falls since her admission. R75's "Fall Care Area Assessment (CAA)" completed 04/27/23 indicated she was at risk for falls related to her medical diagnoses. The CAA indicated she had difficulty with balance and	F 689			

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F 689	Continued From page 30 transitions. The CAA noted she had a history of falls prior to her admission. The CAA noted a care plan would be completed to provide interventions to prevent further accidents/injuries. R75's "Care Plan" initiated 06/03/22 indicated she had deficits with her activities of daily living (ADLs). The plan indicated she required extensive staff assistance for toileting, bed mobility, transfers, dressing, meals, personal hygiene, and bathing. The plan noted she was at risk for falls related to her visual impairment, ataxia (loss of coordination with muscle movements), and medical diagnoses. The plan indicated R75 had a non-injury fall on 12/01/23. The plan indicated R75's Dycem (non-skid mat) pad was not appropriately placed in her chair during repositioning resulting in her fall. The plan indicated she used a Broda chair (specialized wheelchair with the ability to tilt and recline) and required staff for mobility. A "Fall Investigation" dated 12/01/23 indicated R75 had a non-injury fall while awaiting lunch. The report noted R60 slid out of her wheelchair and landed on the floor. The report indicated the responding nurse found R75's Dycem pad was bunched up in the back of the wheelchair and was not properly placed when staff repositioned her prior to her fall. The report indicated R75 was assessed and returned to her wheelchair for lunch. On 01/18/24 at 08:25AM R75 sat reclined in her Broda chair. R75 had a skid-proof pad and Dycem in place. An inspection of R75's room revealed her bed was in the lowest position. Her call light rested on her bed and a fall mat was on the floor to the right of her bed.	F 689			

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F 689	Continued From page 31 On 01/23/24 at 11:20AM Certified Nurse's Aide (CNA) M stated staff reviewed each resident's fall interventions before care was provided. She stated staff had frequent training related to completing lift transfers, repositioning, and safely moving residents. She stated staff should ensure placement of the residents in bed and chairs to prevent accidents and falls during transferring and repositioning. She stated direct care staff had access to each resident's Kardex (nursing tool that gives a brief overview of the care needs of each resident) to see safety interventions and transfer requirements. On 01/23/24 at 11:55AM Licensed Nurse (LN) I stated R75 had two non-injury falls. She stated staff were to ensure her non-slip pads were in place after moving or repositioning her. She stated all staff had access to the care plans or the Kardex. On 01/23/24 at 01:20PM Administrative Nurse D staff received frequent training related to positioning, transfers, and lifts. He stated all staff had access to review each resident's care interventions and he expected staff to ensure the proper care was provided. The facility's provided "Activities of Daily Living (ADLs)" policy revised 03/2018 indicated the facility will ensure each resident will be provided with the appropriate care, treatment, and services to maintain or improve their ADLs. The policy noted resident's dependent on staff for assistance will be provide care, treatment, and services in a manner that is supportive, safe, and therapeutic towards the resident's treatment goals.	F 689			

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F 689	Continued From page 32 The facility failed to ensure proper placement of R75's Dycem in her wheelchair resulting in a non-injury fall. This deficient practice placed R75 at risk for preventable accidents and injuries.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690			

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F 690	Continued From page 33 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 102 residents. The sample included 22 residents with four reviewed for catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care. Based on record review, observations, and interviews, the facility failed to ensure Resident (R) 18's catheter bag (urine collection bag) was kept below his bladder during a Hoyer (full body mechanical lift) transfer. This deficient practice placed R18 at increased risk for infection and other catheter-associated complications. Findings included: - The Electronic Medical Record (EMR) for R18 documented a diagnosis of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), and obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow that can be either structural or functional and allows urine to flow back into the kidneys). The "Admission Minimum Data Set (MDS)" dated 07/21/23, documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. The MDS documented R18 used a wheelchair and was dependent on staff for bathing, dressing, mobility, and transfers.	F 690			

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F 690	Continued From page 34 The "Falls Care Area Assessment (CAA)" dated 07/21/23, documented R18 was at risk for falls related to cerebral palsy. The MDS further documented R18 had a history of falls, weakness, and physical performance limitations that affected his balance, gait, strength, and muscle endurance. The "Urinary Incontinence and Indwelling Catheter CAA" dated 07/21/23, documented R18 was at risk for impaired urinary elimination pattern related to his medical condition which resulted in a need for a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder). R18's "Care Plan" with an initiated date of 07/17/23, documented R18 had a suprapubic catheter related to obstructive uropathy. An intervention with an initiated date of 07/17/23 directed staff to position R18's catheter bag and tubing below the level of his bladder. R18's "Care Plan" with an initiated date of 07/24/23, documented R18 had an Activities of Daily Living (ADL) self-care performance deficit and impaired mobility related to cerebral palsy. An intervention with an initiated date of 07/24/23 documented R18 required the use of a Hoyer lift for transfers. The intervention directed staff to assist as appropriate. On 01/22/24 at 09:22 AM R18 Certified Nurse Aide (CNA) M and CNA O transferred R18 from a wheelchair to his bed with a Hoyer lift. During the transfer, CNA M removed R18's catheter bag from the side of his wheelchair and hung it on the Hoyer lift, near where the sling attached to the lift, above R18's bladder. There was urine observed	F 690			

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F 690	Continued From page 35 in R18's catheter tubing during the transfer. On 01/23/24 at 11:55 AM CNA M stated she would hang the catheter bag on the side of the sling during a Hoyer transfer on a lower loop. CNA M stated the catheter bag should not be hung on the bar of the lift or above the resident's bladder. On 01/23/24 at 12:20 PM Licensed Nurse (LN) H stated catheter bags should not be hung on the Hoyer lift or in a position that would be above the resident's bladder. LN H stated the catheter bag should always be hung in a position that is below a resident's bladder. On 01/23/24 at 12:55 PM Administrative Nurse D stated a resident's catheter bag should be placed by their hip or in another area that is below the resident's bladder. Administrative Nurse D stated catheter bags should not be hung on the sling arm/bar of a Hoyer lift as it is above the resident's bladder. The facility provided a "Catheter Care, Urinary" policy revised in August 2022, documented purpose of the procedure was to prevent urinary catheter-associated complications, including urinary tract infections. The facility failed to ensure R18's catheter bag was kept below his bladder during a Hoyer transfer. This deficient practice placed R18 at increased risk for infection and other catheter-associated complications.	F 690			
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F 744			

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F 744	Continued From page 36 §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility identified a census of 102 residents. The sample included 22 with three reviewed for dementia (a progressive mental disorder characterized by failing memory, and confusion) care. Based on interviews, record review, and observations, the facility failed to provide appropriate dementia care and services to address Resident (R)60's wandering behavior. This deficient practice placed R60 at risk for decreased quality of life due to the inability to maintain her highest practicable level of functioning. Findings included: - The "Medical Diagnosis" section within R60's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), insomnia, cognitive-communication disorder, dysphagia (difficulty swallowing), and major depressive disorder (major mood disorder). R60's "Annual Minimum Data Set (MDS)" completed 10/09/23 noted a Brief Interview for Mental Status (BIMS) score of two indicating severe cognitive impairment. The MDS indicated no wandering behaviors. R60's "Cognitive Loss Care Area Assessment (CAA)" completed 11/02/23 noted she was at risk	F 744			

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F 744	Continued From page 37 for impairment related to orientation, memory, and recall deficits related to her BIMS. The CAA indicated her care plan will be developed to maintain her current cognitive status, continence, mobility, activities of daily living (ADLs), and communication. R60's "Falls CAA" completed 11/02/23 indicated she was at risk for falls related to impaired gait and mobility, physical limitations, and weakness. The CAA indicated she required supervision while walking. R60's "Care Plan" initiated 10/16/20 noted she was at risk for alterations in self-care/mobility and required assistance with her ADLs. The plan noted she required touch assistance while walking. The plan instructed staff to provide consistency in care to promote comfort with ADLs. The plan indicated R60 had a history of sleeping in other resident's beds. The plan instructed staff to show her to her bed and provide activities. The plan instructed staff to monitor and record occurrences for behaviors related to pacing, wandering, and aggressive behaviors (01/06/22). The plan indicated she preferred one-to-one interaction with staff including walking, music, painting nails, and social events. On 01/17/24 at 12:02 PM R60 was found in R75's room asleep in R75's bed. At 12:10 PM R60 was awoken by staff and taken to the dining area for lunch. This occurrence was not documented in the EMR. R75's bedding was not changed after the occurrence. On 01/18/24 at 11:50 AM R60 slept in her roommate's (R101) bed. Staff awoke her and	F 744			

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F 744	Continued From page 38 escorted her to the dining room for lunch. This occurrence was not documented in the EMR. The bedding was not changed after this occurrence. On 01/23/24 at 11:20 AM Certified Nurse's Aide (CNA) M stated staff should walk and direct severely impaired residents to their rooms and ensure they were oriented with their environment. She stated the facility should place confused residents closer to the nurse's station to help with supervision and assistance. She stated residents should not be allowed to use other resident's beds due to the risk of spreading illnesses and infections. On 01/23/24 at 11:55 AM Licensed Nurse (LN) I stated R60 often roamed the halls looking for her room. She stated a large sign was placed on her door and the unit had memory boxes outside each resident's room to help familiarize them with the unit. She stated wandering occurrences should be reported to the unit nurse and documented. On 01/23/24 at 12:50 PM Administrative Nurse D stated the facility provided frequent training related to caring for residents with dementia or cognitive impairments. He stated staff were expected to closely monitor all residents in the dementia unit and intervene when needed. He stated residents should not be allowed to sleep in other residents' beds and that staff should redirect residents to their appropriate beds. The facility's provided "Dementia" police indicated staff will continue to provide supervision and supportive care to individuals with cognitive impairment. The policy indicated individualized interventions will be implemented and adjusted to	F 744			

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F 744	Continued From page 39 address changes in each resident's condition.	F 744			
F 804 SS=E	The facility failed to provide adequate supervision and activities to R60 to prevent her from wandering into other resident's rooms and beds. This deficient practice placed R60 at risk for unmet care needs to maintain her highest practicable level of functioning. Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: The facility identified a census of 102 residents with six residents on puree textured diets. Based on observations, interviews, and record review, the facility failed to follow nutritionally approved recipes during the preparation of the facility's pureed meals. This deficient practice placed six residents at risk for complications related to nutritional impairment. Findings Included- - On 01/22/23 at 10:15 AM Dietary Staff BB placed a tin of cooked beef and another of beef stock in the preparation area. The food processor machine had previously been used for food and had not been washed before puree use. Dietary	F 804			

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F 804	Continued From page 40 Staff BB placed the contents of the cooked beef in the food processor and started to puree the meat. Dietary Staff BB then added beef stock to the processor without measuring to amount of liquid stock to be added. Dietary Staff then prepared a tin serving pan with non-stick spray and removed the textured mixer from the processor to the serving tray. An inspection of the mixer revealed a wet pudding-like consistency for the prepared meat. Dietary Staff BB did not review the pureed beef recipe throughout the preparation of the pureed meal. Dietary Staff BB explained the recipes were available for review and pointed to the recipe book on a table. On 01/23/23 at 11:23 PM Dietary Staff BB stated recipes must be followed by staff during meal preparation and staff were to review them during preparation. The facility's provided "Food Preparation and Service" 04/2019 indicated food will be prepared and maintained to ensure proper nutritional values are maintained and to meet the dietary requirements of each resident. The facility failed to follow a nutritionally approved recipe during the preparation of the facility's pureed meals. This deficient practice placed six residents at risk for complications related to nutritional impairment.	F 804			
F 812 SS=D	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	F 812			

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F 812	Continued From page 41 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 102 residents with one kitchen and two dining areas. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to food preparation, service, and storage. The facility additionally failed to ensure sanitary cleaning of kitchen service areas and equipment. These deficient practices placed the residents at risk related to food-borne illnesses and food safety concerns. Finding Included: - On 01/17/24 at 08:03 AM an inspection of the facility's kitchen was completed. An inspection of the microwave oven revealed dried food residue on the top and back walls of the inside of the microwave. The kitchen's deep fryer contained dark brownish oil covered with old food debris all over the inside and outside the frying unit. A five-gallon bucket filled with used oil and old food debris under the kitchen's convection oven.	F 812			

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F 812	Continued From page 42 An inspection of the kitchen's clean equipment storage area revealed saucers and water pitchers stored upward and uncovered on the rack. An inspection of the kitchen's reach-in refrigerator revealed an unlabeled/undated ham sandwich and a container of juice. An inspection of the kitchen's walk-in freezer unit revealed unlabeled and updated opened bags of wedge fries and onion rings. The unit contained a broken-up cardboard box of corn dogs with no covering barrier. On 01/17/24 at 08:45A an inspection of the facility's "Abby Hall" small kitchenette area revealed an unlocked refrigerator. The refrigerator only had two days of temperature checks completed for January 2024. The refrigerator's top freezer had severe frost build-up. The lower refrigerator unit had unlabeled and undated biscuits and moldy cheese with salami. The kitchenette's heater unit had food wrappers and trash on the floor between the heater and the wall. At 08:50 AM Licensed Nurse (LN) I stated the kitchen was responsible for maintaining the fridge for de-frosting issues. She stated direct care staff should be labeling and removing old foods. She stated unit staff were to be completing the temperature checks each shift but acknowledged the daily check sheet was not filled out. On 01/17/24 at 12:01 PM unidentified staff member wheeled Resident (R)18 to the dining room and positioned him at a table. The staff member retrieved R18's meal tray and set up his food. The staff member repositioned the	F 812			

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F 812	Continued From page 43 resident's wheelchair and assisted in positioning another resident's chair. The staff member returned to R18's table and assisted him with eating his entire meal without completing hand hygiene. On 01/22/24 at 11:20 AM a follow-up inspection of the kitchen was completed. The inspection revealed old dried-up food residue on the inside and outside glass barrier of the steam table. The five-gallon bucket of used oil remained under the convection oven. On 01/22/24 at 11:25 AM Dietary Staff BB stated staff were expected to clean throughout the day and in between food services. He stated the food storage areas and unit should be checked daily for food labeling and expiration. He stated staff were expected to clean up areas before prepping food and wipe down surfaces that may be potentially soiled or contaminated. He stated the "Abbey Hall" refrigerator should be checked by staff each shift. He stated staff were expected to complete hand hygiene during meal services. He stated the bucket of oil should have been removed by staff and not left in the kitchen. The facility's provided "Food Preparation/Handling/Storage" policy revised in October 2017 indicated the kitchen staff will ensure all food shall be stored in a manner that complies with safe food handling practices. The policy noted staff will ensure food storage areas remain clean and temperature units will be closely monitored. The policy indicated all food products will be maintained and handled in a manner that prevents contamination and exposure to potentially unsafe conditions. The policy indicated all food products will be dated	F 812			

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F 812	Continued From page 44 and labeled to ensure freshness and safety. The policy indicated all kitchen areas will be cleaned and sanitized per safe practices. The facility failed to follow sanitary dietary standards related to food preparation, service, and storage. The facility additionally failed to ensure sanitary cleaning of kitchen service areas and equipment. These deficient practices placed the residents at risk related to food-borne illnesses and food safety concerns.	F 812			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control 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	F 880			

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F 880	Continued From page 45 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct 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	F 880			

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F 880	Continued From page 46 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 102 residents. The sample included 22 residents. Based on observation, record review, and interview, the facility failed to ensure staff followed appropriate infection control practices and procedures when Resident (R)88's oxygen tubing and nasal cannula (a hollow tube used to deliver supplemental oxygen) were left on the floor. The facility further failed to ensure nursing staff appropriately sanitized a community-used Hoyer (total body mechanical lift) after each use. This deficient practice placed the residents at risk related to infectious diseases. Findings included: - On 01/17/24 at 08:49 AM R88's portable oxygen tank was on the back of her wheelchair and the oxygen tubing and nasal cannula attached to the tank laid on the floor in R88's room, no bag was noted. 01/17/24 11:39 AM Certified Nurse Aide (CNA) P and Certified Medication Aide (CMA) R did not clean/sanitize the Hoyer lift after use in R51's room and CNA P then wheeled the lift into R63's room. On 01/23/24 at 11:55 AM CNA M stated lifts should be cleaned after each use and/or before entering a resident's room. CNA M stated oxygen tubing should be stored in a bag when it was not being used and should not be left on the floor. CNA M stated she would replace the tubing if she noticed the cannula was on the floor.	F 880			

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F 880	Continued From page 47 On 01/23/24 at 12:21 PM, Licensed Nurse (LN) H stated oxygen tubing/nasal cannula should never be on the floor and should be replaced if found on the floor. LN H stated the tubing should be stored in a bag when not in use. LN H stated staff should be sanitizing the lift with disinfectant wipes after each use with a resident. On 01/23/24 at 12:55 PM Administrative Nurse D stated oxygen tubing was supposed to be in a storage bag when not in use and should not be on the floor. Administrative Nurse D stated lifts and shared equipment should be sanitized with disinfectant wipes after use on each resident. The "Oxygen Administration" policy revised in October 2010 lacked direction for appropriate nasal cannula storage. The "Standard Precautions" policy revised in September 2022 documented that reusable equipment was not used for the care of more than one resident until it had been appropriately cleaned and reprocessed. The facility failed to ensure staff followed appropriate infection control practices and procedures when R88's oxygen tubing and nasal cannula were left on the floor. The facility further failed to ensure nursing staff appropriately sanitized a community-used Hoyer lift after each use. This deficient practice placed the residents at risk related to infectious diseases.	F 880			