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F 000	INITIAL COMMENTS The following deficiencies represent the findings of Health Resurvey and investigation of complaints #KS00185876, #KS00184941, KS00184360, and #1S0084211. This 2567 was electronically sent to the facility on 04/03/24.	F 000		
F 550 SS=E	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 04/03/2024

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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§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:
- Review of Resident (R) 37's medical record revealed diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear, chronic kidney disease, congestive heart failure (a condition with low heart output and the body becomes congested with fluid), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The "Admission Minimum Data Set" (MDS), dated 07/25/23, assessed the resident with a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The resident required extensive assistance of staff for dressing and personal hygiene.

The "Cognitive Loss Care Area Assessment" (CAA), dated 07/25/23, assessed the resident's risk factors of skin breakdown, weight loss and fluid imbalance.

The ADL (Activity of Daily Living)

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Functional/Rehabilitation CAA" dated 07/25/23 did not trigger.

The "Care Plan" reviewed 03/20/24, instructed staff the resident had a functional deficit with ADLs due to dementia(progressive mental deterioration characterized by confusion and memory failure),

The resident required moderate assistance with dressing. The care plan instructed staff to ensure the resident wore appropriate footwear, as she preferred tennis shoes.

Interview, on 03/25/24 at 02:10 PM, with a family member revealed R37 preferred to wear support hose and had multiple pairs of them in her drawers. The family member stated the resident often does not have them on and she assists R37 in putting them on when visiting the resident.

Observation, on 03/26/24 at 11:38 AM, revealed Certified Medication Aide (CMA) M ambulated with the resident to the bathroom. The resident lacked support hose. Interview with CMA M at that time revealed the night shift washed the support hose and dried them on the towel rack in the bathroom, and they were wet this morning, but dry at this time. CMA M did not know the resident had several pairs of the compression hose in her drawers. Observation revealed several pairs of support hose in her drawer beneath the closet.

Interview, on 03/28/24 at 10:00 AM, with Administrative Nurse D, revealed the resident did not have a physician order for the support hose, but could wear them as her preference and this should be indicated on the care plan.

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The facility policy for "Resident Rights", undated, included: The facility places a strong emphasis on individual dignity and self-determination for all residents. The policy instructed staff to encourage residents to dress per their individual preferences.

The facility failed to ensure staff dressed R37 in support hose as her preference to promote her sense of well-being.

- R60's physician orders revealed the following diagnoses that included diabetes mellitus type two (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), and history of urinary tract infection (infection of any part of the urinary system).

The "Admission Minimum Data Set" (MDS) dated 11/03/23, revealed a "Brief Interview for Mental Status" (BIMS) score of eight, indicating moderate cognitive impairment. The resident was dependent on staff for all activities of daily living (ADLs) and used a wheelchair for mobility. The resident had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) and was incontinent of bowel. The resident had a diagnosis of neurogenic bladder and chronic urinary tract infection and received an antibiotic.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 11/03/23, R60 required assistance for ADLs to

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keep clean and dry with bowel needs. R60 had a urinary catheter due to urinary retention.

R60's "Care Plan" dated 10/31/23 revealed the resident had an 18 French, five cubic centimeter (cc) balloon indwelling catheter for neurogenic bladder. Staff were to position the catheter bag and tubing below the level of the bladder and attach the leg bag when out of bed.

The resident has bowel incontinence related to immobility and required routine check and change incontinent care, dated 12/04/23.

Observation, on 03/25/24 at 12:10 PM, revealed Certified Nursing Aides (CNA) V and CNA UU transferred R60 to the bed with the use of a total body lift. The resident had a bowel movement, and staff removed the brief. At 12:24 PM, CNA VV walked into R60's room without knocking on the door when the resident was fully exposed during incontinent care and did not excuse herself. She stayed to collect pizza orders from staff in the room. The resident remained exposed during the conversation.

On 03/25/24 at 12:30 PM, CMA VV reported she reported she knew better and was not thinking and knew she should have knocked before entering as well as she should have left the room as soon as she entered and saw the resident's genitals exposed.

On 03/28/24 at 08:00 AM, Administrative Nurse D reported all staff whether nursing or not, should knock on the resident's door and wait for permission to enter. At no time would it be appropriate to enter a resident's room unannounced during resident care, much less to

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take a staff member's pizza order.

The facility's policy for "Resident Rights", undated, included the facility places a strong emphasis on individual dignity and self-determination for all residents.

The facility failed to maintain R60s dignity by staff entering the room unannounced during personal care, and remained in the room when the resident was exposed.

The facility reported a census of 92 residents with 22 residents sampled, including five residents reviewed for dignity. Based on observation, interview and record review, the facility failed to show respect and dignity to four Residents (R)31, regarding standing over the resident while feeding him and R 78, regarding the failure to use a dignity bag on the catheter collection bag, R 60, regarding not knocking on door before entering resident's room while cares were being given and R 37, regarding the facility not allowing the resident to wear compression stockings (specially made, snug-fitting, stretchy socks that gently squeeze the leg to promote circulation).

Findings included:

- Review of Resident (R)31's "Physician Order Sheet", dated 03/21/24, documented the resident had a diagnosis of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

The "Significant Change Minimum Data Set"

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(MDS), dated 02/06/24, lacked documentation of the resident's cognition. He was dependent on staff for all activities of daily living (ADL).

The "Nutritional Status Care Area Assessment" (CAA), dated 02/06/24, triggered but was not completed.

The "Modification of Admission/Medicare 5-Day MDS," dated 01/15/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. He was dependent on staff for all ADLs.

The care plan for ADLs, revised 01/02/24, instructed staff the resident required substantial assistance of one for eating.

On 03/26/24 at 11:49 AM, the staff served lunch to the resident in the dining room. Certified Nurse Aide (CNA) OO began to feed the resident his meal while standing over the resident, leaning in slightly toward and over the resident, as the resident was fed.

On 03/26/24 at 01:10 PM, CNA OO stated he did not sit down next to the resident while he fed him his lunch because he did not want to. He liked to stand while feeding the residents.

On 03/28/24 at 09:51 AM, Administrative Nurse D stated it was the expectation for staff to sit down next to a resident while assisting them with their meals and not to stand up over the residents.

The facility policy for "Resident Rights", undated, included: The facility places a strong emphasis on individual dignity and self-determination for all

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residents.

The facility failed to show respect and dignity to this dependent resident while feeding him his meal.

- Review of Resident (R)78's electronic medical record (EMR) revealed a diagnosis of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying).

The "Modification of Admission Minimum Data Set (MDS), dated 08/06/23, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She required extensive assistance of two staff for toileting and had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 08/06/23, documented the resident had an indwelling urinary catheter.

The "Quarterly MDS," dated 01/23/24, documented the staff assessment for cognition revealed the resident was independent with daily decision making. She was dependent on staff for all activities of daily living (ADLs) and had a urinary catheter.

The care plan for the urinary catheter, dated 08/01/23, instructed staff to keep the catheter bag and tubing below the level of the bladder.

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F 550	Continued From page 8 On 03/25/24 at 10:35 AM, the resident sat in her wheelchair in her room. The catheter bag hung below the seat of her wheelchair and lacked a dignity bag. On 03/26/24 at 08:14 AM, the resident rested in bed in her room with the door open. The resident's catheter bag hung from the bed frame and lacked a dignity bag. On 03/26/24 at 08:14 AM, Certified Nurse Aide (CNA) T stated the resident did not have a dignity bag for her catheter bag because they (CNA T) could not find one. CNA T stated catheter bags typically would be in a dignity bag. On 03/26/24 at 08:19 AM, Certified Medication Aide (CMA) MM stated the resident did not have a dignity bag for her catheter bag. CMA MM stated she was unsure as to why the resident did not have a dignity bag. On 03/27/24 at 01:38 PM, Administrative Nurse D stated it was the expectation for staff to always use a dignity bag for all residents who have a catheter bag. The facility policy for "Urinary Catheter Care", dated 02/2017, included: To protect the dignity of residents who need an indwelling catheter, drainage bags will be placed in a dignity bag. The facility failed to utilize a dignity bag to hold the catheter bag of this dependent resident with an indwelling urinary catheter.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		

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§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable

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sound levels.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 92 residents, which included 10 residents residing in one of the six "Green Houses." Based on observation, record review, and interview, the facility failed to provide unstained towels and washcloths to the residents in one Green House.

Findings included:

- Interview, on 03/27/24 at 02:45 PM, with Resident (R)43 revealed certified staff does the laundry, and supplies towels and washcloths to the resident, however the towels are often stained, rough and/or worn. Observation at that time revealed a hand towel with a large gray stain over 3 percent of the towel.

Observation, on 03/28/24 at 09:06 AM, revealed eight hand towels and two washcloths with stains of varying sizes with rough coarse texture and several with areas of worn texture.

Interview, on 03/28/24 at 09:06 AM, with Certified Medication Aide/Certified Nurse Aide (CMA/CNA) AA, revealed all staff on all shift's complete laundry tasks and stained linen should be thrown away, and when the supply is low, more can be ordered.

Interview, on 03/28/24 at 10:45 AM, with Administrative Staff A, revealed she expected staff to throw out stained linen and order more linen when needed.

The facility policy Resident Rights revised 10/22, instructed staff to provide a safe, clean,

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F 584	Continued From page 11 comfortable, and homelike environment. The facility failed to ensure staff provided unstained, normal textured towels and washcloths to the residents in this Green House" to promote a sense of well-being.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F 636		

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(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 92 residents. Based on observation, interview, and record review, the facility failed to complete an accurate Minimum Data Set (MDS) for two residents, that included Resident (R)31, regarding the failure to complete the Care Area Assessments (CAA) for nutrition and pressure ulcers (PU) and R 33, regarding the failure to complete CAAs for psychotropic drugs, pain and mood state.

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Findings included:

- Review of Resident (R)31's electronic medical record (EMR) included the following diagnoses included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Significant Change Minimum Data Set (MDS)", dated 02/06/24, lacked documentation for cognition. The resident had a significant weight loss, without a prescribed weight loss regimen and was at risk for the development of pressure ulcers (PU) with one unhealed stage III (full thickness pressure injury extending through the skin into the tissue below) PU at the time of the assessment, present on admission.

The "Nutritional Status and Pressure Ulcer/Injury Care Area Assessments (CAA)", dated 02/06/24, triggered but lacked an analysis of findings.

The care plan for PUs, revised 02/07/24, instructed staff to turn and reposition the resident off his back and from side to side as often as possible. Weight loss was to be expected for the resident due to his terminal diagnosis.

On 03/27/24 at 04:30 PM, Administrative Staff A stated the facility was aware of the MDSs were not being completed properly. The facility had a new MDS coordinator who was currently learning the process to complete the MDSs and CAAs appropriately.

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The facility policy for "Expanded Assessment Areas", revised 05/20/17, included: The facility utilized the Resident Assessment Instrument (RAI) for accurate completion of the Minimum Data Set (MDS) and Care Area Assessment (CAA).

The facility failed to complete an accurate MDS for this dependent resident regarding the failure to complete the Nutrition and PU CAAs.

- Review of Resident (R)33's medical record revealed diagnoses that included heart failure, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) and major depressive disorder (major mood disorder).

The "Annual Minimum Data Set" (MDS), dated 05/06/23, assessed the resident with a Brief interview for Mental Status (BIMS) score of 15, which indicated normal cognitive function. The resident received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions), antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension), antidepressant, (class of medications used to treat mood disorders and relieve symptoms of depression), anticoagulant (medications used to treat the blood from forming clots), diuretic (medications to promote the formation and excretion of urine), opioid (narcotic pain medications) medications, and antibiotic (medication used to treat infections).

The "Psychotropic (medications that affect

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F 636	Continued From page 15 mood) Drug Use Care Area Assessment" (CAA), dated 05/06/23 was undeveloped. The "Pain CAA" dated 05/06/23, was not developed. The "Mood State CAA" dated 05/06/23, was not developed. Interview, on 03/27/24 at 02:20 PM, with Administrative Nurse F confirmed the CAAs were not developed for some residents. Interview, on 03/27/24 at 04:30 PM, with Administrative Staff A, confirmed the MDS and CAAs were lacking in completeness for some residents. The facility followed the "Resident Assessment Instrument" (RAI) manual when completing the CAAs. The facility failed to ensure staff completed the CAAs for this resident to develop a comprehensive care plan as required.	F 636		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		

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describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 92 residents with 22 selected for review. Based on observation, interview, and record review, the

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facility failed to develop comprehensive care plans for four of the 22 residents reviewed. Resident (R)37 for use of support hose, R35 for fluid restriction, R78 for type of music, TV shows and religious preferences and R242 for shaving preferences.

Findings included:

- Review of Resident (R) 37's medical record revealed diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear, chronic kidney disease, congestive heart failure (a condition with low heart output and the body becomes congested with fluid), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The "Admission Minimum Data Set" (MDS), dated 07/25/23, assessed the resident with a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The resident required extensive assistance of staff for dressing and personal hygiene.

The "Cognitive Loss Care Area Assessment" (CAA), dated 07/25/23, assessed the resident's risk factors of skin breakdown, weight loss and fluid imbalance.

The ADL (Activity of Daily Living) Functional/Rehabilitation CAA" dated 07/25/23 did not trigger.

The "Care Plan" reviewed 03/20/24, instructed staff the resident had a functional deficit with

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ADLs due to dementia(progressive mental deterioration characterized by confusion and memory failure).The resident required moderate assistance with dressing. The care plan instructed staff to ensure the resident wore appropriate footwear, as she preferred tennis shoes. The care plan lacked the resident's preference for wearing support hose.

Interview, on 03/25/24 at 02:10 PM, with a family member revealed R37 preferred to wear support hose and had multiple pairs of them in her drawers. The family member stated the resident often does not have them on and she assists R37 in putting them on when visiting the resident.

Observation, on 03/26/24 at 11:38 AM, revealed Certified Medication Aide (CMA) M ambulated with the resident to the bathroom. The resident lacked support hose. Interview with CMA M at that time revealed the night shift washed the support hose and dried them on the towel rack in the bathroom, and they were wet this morning, but dry at this time. CMA M did not know the resident had several pairs of the compression hose in her drawers. Observation revealed several pairs of support hose in her drawer beneath the closet.

Interview, on 03/28/24 at 10:00 AM, with Administrative Nurse D, confirmed the resident preference for support hose was not on the care plan, and not listed as a "Task "for certified staff to complete.

The facility policy "Standards of Care and Care Planning Practice" dated 04/01/23, instructed staff the care plan should reflect resident centered items that are unique to that resident's

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care.

The facility failed to include R37's preference for wearing support hose in her comprehensive care plan to promote a sense of well-being.

- Review of Resident (R)78's electronic medical record (EMR) included a diagnosis of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord).

The "Modification of the Admission Minimum Data Set" (MDS), dated 08/06/23, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. It was very important for her to listen to music she liked, participate in religious services and do her favorite activities. She required total staff assistance with transfers, locomotion on and off the unit, and she had impaired range of motion (ROM) on bilateral (both) upper and lower extremities.

The "Activities Care Area Assessment" (CAA), dated 08/06/23, documented the resident was at risk for decreased socialization and worsening depression. The facility would encourage active participation in facility functions to engage in sensory stimulation.

The "Quarterly MDS," dated 01/23/24, documented the staff assessment for cognition revealed the resident was independent with daily decision making. She was dependent on staff for all activities of daily living (ADL).

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The care plan for activities, revised 08/01/23, instructed staff the resident was dependent on staff for participation in activities. Her favorite activities included visiting, watching group activities, watching TV and listening to music. The care plan lacked the genre of music the resident enjoyed, TV shows she like to watch and lacked the resident's religion.

Review of the resident's "Activities Admission Data Collection", dated 08/01/23, documented it was very important for her to listen to the music she liked, participate in religious services and to do her favorite activities. The primary respondent for the assessment was the resident.

Review of the resident's "Activities Readmission Data Collection", 02/21/24, lacked activity preferences.

Review of the facility's activity calendar revealed an activity of morning music would occur every morning at 09:30 AM and religious services would occur each Sunday morning at 09:30 AM and 11:00 AM.

Review of the resident's EMR, from 03/01/24 through 03/27/24, revealed she participated in a social on three occasions and had visitors on two occasions. No other activities documented.

On 03/26/24 at 08:14 AM, Certified Nurse Aide (CNA) T and Certified Medication Aide (CMA) MM entered the resident's room to prepare the resident for the day. The resident's room lacked a device to listen to music and her TV was not turned to a music station.

On 03/27/24 at 09:48 AM, the resident sat in her

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wheelchair in the commons area facing the TV. The TV, which was tuned to a soap opera, had no volume.

On 03/28/24 at 09:01 AM, the resident sat in her wheelchair in her room with CNA X. The TV was turned off and no music played in the resident's room.

On 03/28/24 at 09:01 AM, the resident stated she prefers to listen to rap music. She stated she was a Baptist but had not been able to participate in a Baptist service for a long time.

On 03/26/24 at 03:09 AM, CNA PP stated she was unsure of what the resident liked to watch on TV but staff would put her in the commons area in front of the TV so she was able to watch whatever was on at that time.

On 03/27/24 at 08:14 AM, CNA T stated the resident's family would turn the TV on to a music station when they visited, but CNA T was unsure of what music the resident preferred.

On 03/28/24 at 07:38 AM, Activity Staff Z stated the staff were responsible for activities in the green houses.

On 03/28/24 at 09:01 AM, CNA X stated she was unsure of what music the resident preferred.

On 03/28/24 at 09:51 AM, Administrative Nurse D stated it was important for the care plan to include the types of music and TV shows the resident enjoyed and should also include her religion.

The facility policy for "Standards of Care and Care Planning Practice", dated 04/01/23,

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included: Care plans should reflect resident-centered items that are unique to that resident's care.

The facility failed to complete a person-centered comprehensive care plan to meet this dependent resident's activity preferences.

- The "Physician's Order Sheet" (POS), dated 03/21/24, documented Resident (R)242 had a diagnosis of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

The "Annual Minimum Data Set" (MDS), dated 01/15/24, documented the staff assessment for cognition revealed severe impairment. The resident was dependent on staff for all activities of daily living (ADL).

The "Functional Abilities Care Area Assessment" (CAA), dated 01/15/24, did not trigger.

The "Medicare 5-day MDS," dated 03/16/24, documented the staff assessment for cognition revealed severe impairment. He was dependent on staff for all ADLs.

The care plan for ADLs, revised 01/30/24, instructed staff the resident was dependent on staff for all ADLs. The care plan lacked staff instruction on facial shaving.

Review of the resident's electronic medical record (EMR), from 02/27/24 through 03/26/24, revealed the resident was dependent on staff for personal

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hygiene, including shaving.

On 03/25/24 at 01:50 PM, the resident sat in his room in his wheelchair. He was unshaven with scraggly overgrowth of facial hair.

On 03/26/24 at 09:55 AM, the resident sat in his wheelchair in the dining room. He remained unshaven with scraggly overgrowth of facial hair.

On 03/27/24 at 08:29 AM, the resident sat in his wheelchair in the commons area. He remained unshaven with scraggly overgrowth of facial hair.

On 03/26/24 at 01:15 PM, Certified Medication Aide (CMA) NN stated residents were to be shaved on their shower days.

On 03/27/24 at 11:13 AM, Certified Nurse Aide (CNA) RR stated residents were to be shaved on their shower days.

On 03/26/24 at 12:26 PM, Licensed Nurse (LN) H stated the staff were to shave the residents on their shower days and whenever they wanted to be shaven.

On 03/27/24 at 01:38 PM, Administrative Nurse D stated staff instruction for the resident's facial shaving should be included on the care plan.

The facility policy for "Standards of Care and Care Planning Practice", dated 04/01/23, included: Care plans should reflect resident-centered items that are unique to that resident's care.

The facility failed to complete a person-centered comprehensive care plan to meet this dependent

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resident's preferences for facial shaving.

- R35's physician orders revealed the following diagnoses included orthostatic hypotension (blood pressure dropping with change of position), essential (primary) hypertension (elevated blood pressure), viral hepatitis C (inflammatory condition of the liver), chronic obstructive pulmonary disease (COPD, a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), chronic kidney disease, and fluid overload (increase in the volume of extracellular and/or intravascular fluids).

The "Annual Minimum Data Set" (MDS) dated 10/12/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 09, indicating moderate cognitive impairment. The resident used a wheelchair or walker for mobility.

The quarterly MDS dated 01/10/24, revealed no significant changes in status.

The " Dehydration/ Fluid Maintenance Care Area Assessment" (CAA), dated 10/12/23, revealed R35 was on a fluid restriction, and nursing staff were to monitor the resident was drinking fluids.

Review of the care plan dated 01/23/24, lacked guidance related to the resident's fluid restriction.

The physician's order dated 04/23/23 revealed the following:

The resident has a daily 2000 milliliter (ml) fluid restriction. Fluids include anything that is liquid at room temperature.

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During the day shift, the resident may have 480 ml at breakfast and 360 ml at lunch from dietary. The resident may have 360 ml during the shift from Nursing. A total for dayshift would be 1200 ml.

During the evening shift, the resident may have 360 ml at supper from dietary. The resident may have 240 ml during the shift from nursing. A total for evening shift would be 600 ml.

During the night shift, the resident may have 180 ml from nursing. A total for night shift would be 180 ml.

Observation on 03/25/24 at 01:40 PM revealed the resident sat in his chair in his room with feet elevated.

On 03/25/24 at 01:40 PM, the resident reported he was on an 1800 ml fluid restriction, but the staff did not bother him a whole lot because he has been on it a long time and just knows what he can drink and if he wants extra, he will just get it.

On 03/26/24 at 11:55 AM, Certified Nursing Assistant (CNA) SS reported she did not know how staff monitored the resident's fluid restriction. She thought it was probably up to dietary to restrict his fluids and thought he usually had a coffee cup and a glass of fluid at each meal. She was unable to determine the amount of fluid would total for a cup of coffee and a glass of fluid. She reported there was no intake sheet to chart his fluids, but as long as he had no fluid in his room, nursing did not need to monitor his fluid intake.

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F 656	Continued From page 26 On 03/26/24 at 12:10 PM, Licensed nurse (LN) I reported she was not sure what the fluid restriction was. She knew they have a chart in the kitchen to tell how much each size glass held. There was no intake sheet that she was aware of and thought dietary measured the fluids. She reported staff did not monitor the resident's fluid intake. On 03/27/24 at 10:30 AM, Administrative Nurse F reported she would expect the resident's fluid restriction to be included on the care plan. On 03/27/24 at 04:30 PM, Administrative Staff A reported the facility had a new MDS staff but had to learn the process to get the assessments to reflect the resident's status. they know the MDS, care plan piece is not where it needs to be. On 03/25/24 a policy for Care Plans was requested and was referred to the MDS manual for instruction. The facility failed to include R35's fluid restriction for staff guidance on the comprehensive care plan.	F 656		
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.	F 657		

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(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) 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 census totaled 92 residents with 22 residents included in the sample. Based on observation, interview, and record review, the facility failed to revise care plans for two residents. Resident (R)9, related to the failure to care plan a fall with a fractured foot that required a special walking boot, and R9, related to skin care for a pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction).

Findings included:

- R9's physician orders revealed the following diagnoses: diabetes mellitus (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and

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right great toe fracture (broken toe).

The "Annual Minimum Data Set" (MDS) dated 01/04/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, indicating intact cognition. The resident was dependent on a walker or wheelchair for mobility. The resident had no recent falls.

Review of the Quarterly MDS dated 03/01/24 revealed a BIMS score of 15. The resident used a walker and wheelchair for mobility. The resident had a fall with major injury since last MDS. The resident received Physical Therapy and Occupational Therapy (PT, OT) for rehabilitation.

The "Activities of daily living (ADL) Functional/ Rehabilitation Care Area Assessment" (CAA) dated 01/04/24 revealed the resident had impaired balance and transition during transfers, and functional impairment in activity.

The care plan failed to resvise the care plan to include the fall on 01/28/24 which resulted in a fractured right great toe and use of a walking boot.

The physician orders dated 01/29/24 revealed the resident was to wear a surgical boot on the right foot when getting out of bed and off at bedtime, for a fracture of the right great toe.

Review of the "Reported Incident" revealed on 01/28/24 at 03:15 AM, R9 fell from her bed. The fall resulted in a skin tear to her right elbow and a fractured right great toe. R9 was to wear a walking shoe until the fracture healed.

Observation on 03/25/24 at 11:45 AM, revealed

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Certified Nurse Aide (CNA) UU assisted R9 to the dining room. R9 wore the walking boot.

On 03/25/24 at 11:50 AM, the resident reported she fell out of bed "about 5 weeks ago" and had to wear the fracture boot until her fractured toe healed.

On 03/27/24 at 10:30 AM Administrative Nurse F reported the care plan should have been revised to include her fall with a fracture and interventions.

On 03/25/24, a policy for Care Plans was requested and was referred to the MDS manual for instructions.

The facility failed to revise R9's care plan regarding this resident's fall/interventions to guide staff with cares.

- Review of Resident (R)20's medical record revealed diagnoses that included deep vein thrombosis (DVT blood clots) in the right and left leg, heart disease, diabetes (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), and unstageable pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction and the wound is covered by a layer of dead tissue).

The "Quarterly Minimum Data Set" (MDS), dated 11/24/23, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 12,

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which indicated moderate cognitive impairment. The resident had an unstageable pressure ulcer present upon admission/reentry. The resident had no impairment in function range of motion in her upper or lower extremities and was dependent on staff for Activities of Daily Living (ADL).

The "Significant Change Minimum Data Set" (MDS), dated 02/05/24, assessed the resident with a BIMS score of nine, which indicated moderate cognitive impairment. The resident had no impairment in her upper or lower extremities, was dependent on staff for ADL, and at risk for pressure ulcers with no current pressure ulcer injury.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 02/05/24, assessed the resident due to impairment with functional mobility, recent acute illness, and incontinence. Licensed staff were to assess R20's skin each week and initiate proper interventions to prevent skin breakdown, and caregivers assist with repositioning as needed.

The "Care Plan" reviewed 02/21/23, instructed staff the resident admitted to hospice. The resident had a potential for impairment of skin integrity related to fragile skin. An intervention added 11/21/23, instructed staff to avoid positioning the resident on her heals and use foam always off-loading boots when in bed due to a deep tissue injury (DTI) to the left heel following hospitalization (11/13-11/20/23). Staff instructed to apply skin prep (a solution when applied that forms a protective waterproof barrier on the skin) to bilateral (both) heels daily. The care plan failed to include the right heel pressure ulcer which

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developed on 02/09/24 and failed to include updated interventions for off loading devices.

On 02/29/24, the physician instructed staff to apply skin prep to bilateral heels daily.

A "Skin/Wound New Observation" note dated 02/09/24, indicated the resident developed a 1.5 by 1 centimeter (cm) deep tissue injury to her right heel. This note indicated staff to continue to utilize the off-loading boots.

A "Skin/Wound Weekly Observation" note, dated 02/13/24, indicated the DTI measured 3.3 cm by 4.5 cm and staff instructed to continue the use of off-loading boots.

A "Skin/Wound Weekly Observation" note, dated 02/20/24, indicated the DTI measured 4 cm by 6 cm, with a mushy feeling.

A "Skin/Wound Weekly Observation" note, dated 03/07/24, indicated the DTI measured 6 cm by 3.5 cm with a depth of 1 cm, with wound edges intact. The note indicated a treatment of skin prep to both heels and float the heel off the bed with pillows.

A "Skin/Wound Weekly Observation" note, dated 03/12/24, indicated the DTI measured 7 cm by 4 cm with no depth. This note indicated the area improved with softness decreased.

A "Skin/Wound Weekly Observation" note, dated 03/19/24, indicated the DTI measured 5.2 cm by 7.4 cm with a dark colored eschar (dead tissue) and no changes in treatment.

A "Skin/Wound Weekly Observation" note, dated

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03/26/23, indicated the DTI measured 4.5 cm by 6.3 with 100% eschar with no changes in treatment.

An Interdepartmental Team (IDT) Comprehensive Care Review dated 02/15/24, indicated the resident had a new DTI to her right heel with a wound treatment of offloading the heels by floating the heels.

An Interdepartmental Team (IDT) note, dated 02/22/24, indicated the right heel decreased in size.

An Interdepartmental Team (IDT) note, dated 03/01/24, indicated the right heel as mushy with the appearance of a blood blister.

An Interdepartmental Team (IDT) note, dated 03/14/24, indicated the resident had a DTI to the right heel with stable wound margins.

The resident had DVT's to both lower legs and was on hospice for end-of-life cares. The resident had a pressure redistributing mattress on her bed and used a pillow to float her heels off the surface.

Observation, on 03/26/24 at 09:45 AM, revealed the resident seated in her wheelchair in her room. Certified Medication Aide (CMA) XXX and CMA Y assisted R20 to pivot transfer into her bed. CMA Y placed a pillow under the resident's calves to elevate her heels off the bed.

Observation, on 03/26/24 at 10:30 AM, revealed the pillow remained under the resident's calves, but her heels laid directly on the bed. Licensed Nurse (LN) G removed the resident's socks and

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revealed her right heal with blue black eschar. The left heel skin was pink and intact. Interview, at that time with LN G, revealed staff applied specialized foam boots to R20's bilateral heels and the left pressure ulcer heeled, but she developed a pressure ulcer on her right heel despite the boots. LN G stated the resident could move her foot in the boot causing a shift in the off-loading ability of the boots, so staff used pillows to off load her heels. LN G confirmed the pillow ineffective in keeping the resident's heels offloaded and obtained a blanket for additional off-loading. LN G stated R20 received hospice services, and she would inform hospice of the need for more effective off-loading device.

Observation, on 03/26/24 at 02:05 PM, with Administrative Nurse E, revealed the readmitted to the facility with a deep tissue injury to her left heel. The resident had bilateral DVT in her lower extremities. The resident wore specialized pressure relieving boots and with treatments, the left heel injury resolved, however, the right heel injury developed inspire of the pressure relieving boots, so staff used pillows to elevate her heels off the bed. Administrative Nurse E confirmed the pillows may not maintain their buoyancy over time to keep the heels off the bed. Administrative Nurse E measured the right heel blue/black eschar as 4.5 cm by 6.3 centimeters and then applied skin prep to both heels. Administrative Nurse E confirmed the care plan lacked updated interventions for the right heel pressure ulcer and need for alternative means to float the resident's heels.

Observation, on 03/27/24 at 09:20 AM, revealed the resident sitting up in her bed, eating breakfast. A pillow and blanket positioned under

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F 657	Continued From page 34 the resident's calves, but her right and left heel lay directly on the surface of the mattress. Interview, at that time with CMA P, revealed the resident did move her feet when in bed. Observation on 03/27/24 at 09:59 AM, revealed Consulting Therapy Staff GG, applied a foam shelf-like positioning device with elevated lateral (outer edges) sides. Consulting Therapy Staff GG stated she was consulted for R20's heel positioning needs due to the development of the DTI to her right heel. Consulting Therapy Staff GG stated she felt this device was a more appropriate device for floating R20's heels. Interview, on 03/28/24 at 10:00 AM, with Administrative Nurse D, stated she would expect licensed nursing staff to revise the care plan to include the development of the right heel pressure ulcer and assess effectiveness of heel floating interventions and initiate alternatives. The facility policy "Standards of Care and Care Planning Practice" dated 04/01/23, instructed staff instructed staff to ensure that all services are provided to the resident to ensure the care plan is resident centered and specific to the unique needs of each resident. The facility failed to review and revise R20's care plan to include the development of the right heel deep tissue injury and assess the effectiveness of off-loading interventions for the prevention/healing of her deep tissue injury.	F 657		
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	F 677		

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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 reported a census of 92 residents with 22 residents sampled, including five residents reviewed for Activity of Daily Living (ADL). Based on observation, interview and record review, the facility failed to provide appropriate care to one dependent Resident (R)241, regarding facial shaving.

Findings included:

- The "Physician's Order Sheet" (POS), dated 03/21/24, documented Resident (R)242 had a diagnosis of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

The "Annual Minimum Data Set" (MDS), dated 01/15/24, documented the staff assessment for cognition revealed severe impairment. The resident was dependent on staff for all activities of daily living (ADL).

The "Functional Abilities Care Area Assessment" (CAA), dated 01/15/24, did not trigger.

The "Medicare 5-day MDS," dated 03/16/24, documented the staff assessment for cognition revealed severe impairment. He was dependent on staff for all ADLs.

The care plan for ADLs, revised 01/30/24, instructed staff the resident was dependent on

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staff for all ADLs.

Review of the resident's electronic medical record (EMR), from 02/27/24 through 03/26/24, revealed the resident was dependent on staff for personal hygiene, including shaving.

On 03/25/24 at 01:50 PM, the resident sat in his room in his wheelchair. He was unshaven with scraggly overgrowth of facial hair.

On 03/26/24 at 09:55 AM, the resident sat in his wheelchair in the dining room. He remained unshaven with scraggly overgrowth of facial hair.

On 03/27/24 at 08:29 AM, the resident sat in his wheelchair in the commons area. He remained unshaven with scraggly overgrowth of facial hair.

On 03/26/24 at 01:15 PM, Certified Medication Aide (CMA) NN stated residents were to be shaved on their shower days.

On 03/27/24 at 11:13 AM, Certified Nurse Aide (CNA) RR stated residents were to be shaved on their shower days.

On 03/26/24 at 12:26 PM, Licensed Nurse (LN) H stated the staff were to shave the residents on their shower days and whenever they wanted to be shaven.

On 03/27/24 at 01:38 PM, Administrative Nurse D stated staff were expected to shave residents on their shower days and as needed.

The facility policy for "Activities of Daily Living (ADL)", revised 01/2024, included: A resident who is unable to carry out activities of daily living

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F 677	Continued From page 37 will receive the necessary services to maintain good nutrition. The facility failed to provide appropriate care to this dependent resident regarding facial shaving.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: The facility reported a census of 92 residents with 22 residents selected for review which included six residents reviewed for activities. Based on observation, interview, and record review, the facility failed to ensure appropriate activities for five Residents (R)7, R20, R33, R37, and R78, of the six residents reviewed for activities. Findings included: - Review of Resident (R) 7's medical record, revealed diagnoses that included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), anxiety (mental or	F 679		

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emotional reaction characterized by apprehension, uncertainty, and irrational fear) and major depressive disorder (major mood disorder).

The "Admission Minimum Data Set" (MDS), dated 10/23/23, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The resident rated books, music, animals, and group activities as very important.

The "Activities Care Area Assessment" (CAA), dated 10/23/23, did not trigger.

The "Care Plan" reviewed 01/26/24, instructed staff to provide an activity program that was meaningful and of interest and provide opportunities for exercise and physical activity. Staff to plan activities during optimal times when pain and stiffness are abated.

Review of the task "Activities" for the past 30 days revealed only two entries for active participation on 03/04/24 for social, and 03/22/24 for musical.

Review of the "March Activity Calendar" indicated the following activities available:

On 03/25/24 at 09:30 AM, chair exercises, 03:00 PM, UNO a card game, and 04:30 PM Bingo.

On 03/26/24 at 09:30 AM, Noodle ball, at 03:00 PM- cards, and 06:00 PM -Table Talk.

On 03/27/24 at 09:30 AM, Chair Yoga, at 03:00 PM- Bible study, and 06:00 PM- World Travel.

On 03/28/24 at 10:00 AM- Bingo, and at 10:30

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AM - group exercises.

On 03/29/24 at 09:30 AM - Coffee Social, and at 03:00 PM --Kings in Corner, and at 06:00 PM- Residents Choice.

On 03/30/24, Saturday at 09:00 AM -bingo, at 03:00 PM -manicures, and at 06:00 PM- Movie of Choice.

On 03/31/24 Sunday at 09:00 Mass TV, 11:00 AM- First United Methodist church , and at 06:00 PM - Name Five.

Observation on 03/25/24 at 03:00 PM, revealed lack of the activity UNO.

Observation, on 03/26/24 at 09:30 AM, revealed lack of Noodle Ball and at 03:00 PM lack of cards being offered.

Observation on 03/27/24 at 10:00 AM revealed lack of Chair Yoga and at lack of Bible Study and 03:00 PM being offered.

Interview, on 03/25/24 at 12:17 PM, with R7 revealed she usually just watched TV in her room. She stated she usually just sat around, and the only activity was bingo once a week.

Interview, on 03/26/24 at 07:35 AM, with Certified Medication Aide(CMA/CNA) M revealed staff did not have time to do any activities.

Interview, on 03/26/24 at 07:54 AM, with Activity Staff Z, revealed the evening staff should do activities.

Interview, on 03/27/24 at 03:10 PM, with CMA

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F 679	Continued From page 40 /CNA N, revealed evening staff did not provide activities and lacked tools/supplies to provide residents with activities.. Interview, on 03/27/24 at 03:30 PM, with CMA Q, revealed on nice days staff should encourage residents to go outside on the patio and often have cook outs. CMA Q revealed few structured activities provided. Interview, on 03/28/24 at 10:20 AM, with Administrative Staff A, confirmed activities in the Greenhouses have been an issue. The facility policy for "Resident Rights", dated 10/2022, included: The resident has the right to choose which activities they wish to participate in, including social, religious and community activities. The facility failed to provide activities to the residents of this facility to increase their sense of well-being. - Review of Resident (R)20's medical record revealed diagnoses that included deep vein thrombosis (DVT- blood clots) in the right and left leg, heart disease, diabetes (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion) and unstageable pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction and the wound is covered by a layer of dead tissue).	F 679		

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	175385	A. BUILDING _____ B. WING _____	03/28/2024

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F 679	Continued From page 41	F 679		

The "Significant Change Minimum Data Set" (MDS), dated 02/05/24, assessed the resident with a BIMS score of nine, which indicated moderate cognitive impairment. The resident had no impairment in her upper or lower extremities, dependent on staff for Activities of Daily Living (ADL). R20 rated having books, newspaper, and magazines to read, listening to music, having animals around, keep up with the news, and do favorite activities as very important.

The "Activities Care Area Assessment" (CAA), dated 02/05/24, did not trigger.

The "Care Plan" reviewed 02/21/24, instructed staff the resident had little, or no activity involvement related to disinterest and resident wishes. The resident's preferred activities include bingo, crocheting, and adult coloring books. The resident preferred TV channels include news, Hallmark, Discovery, Bravo, and home decorating channels.

Observation, on 03/26/24 at 09:45 AM, revealed the resident seated in her wheelchair in her room. Certified Medication Aide (CMA) XXX and CMA Y assisted R20 to pivot transfer into her bed. The TV was on a shopping channel and CMA XXX or CMA Y did not ask the resident regarding her preference for the channel. The resident's embroidery supplies were out of her reach.

Observation, on 03/27/24 at 09:20 AM, revealed the resident's television was on the shopping channel.

Interview, on 03/26/24 at 10:09 AM, with R20, revealed she likes to read and embroider. R20 stated she would enjoy a book club. R20 stated

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F 679	Continued From page 42 she enjoyed watching old movies on TV. Interview, on 03/26/24 at 07:54 AM, with Activity Staff Z, revealed the evening staff should do activities. Interview, on 03/27/24 at 02:55 PM, with Certified Nurse Aide QQ, revealed the residents usually do not want to attend activities, but thought someone does bingo for the residents. Interview, on 03/27/24 at 02:56 PM with CNA YYY, revealed she provided one on one visits with the residents and the residents liked getting their nails done, but there were no structured activities as she did not think the residents would participate. Interview, on 03/28/24 at 10:20 AM, with Administrative Staff A, confirmed activities in the Greenhouses have been an issue. The facility policy for "Resident Rights", 10/2022, included: The resident has the right to choose which activities they wish to participate in, including social, religious and community activities. The facility failed to provide activities to the residents of this facility to increase their sense of well-being. - Review of Resident (R)33's medical record revealed diagnoses that included heart failure, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), and major depressive disorder (major mood	F 679		

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disorder).

The "Annual Minimum Data Set" (MDS), dated 05/06/23, assessed the resident with a Brief interview for Mental Status (BIMS) score of 15, which indicated normal cognitive function. The resident rated doing favorite activities and go outside when the weather was good as very important.

The "Activities Care Area Assessment" (CAA) dated 05/06/23 did not trigger.

The "Care Plan" reviewed 02/16/24, instructed staff to encourage the resident to participate in activities of her choice and provide opportunities for social interaction.

Review of the "March Activity Calendar" indicated the following activities available:

On 03/25/24 at 09:30 AM -chair exercises, at 03:00 PM- UNO a card game, and 04:30 PM- Bingo.

On 03/26/24 at 09:30 AM- Noodle ball, at 03:00 PM- cards, and 06:00 PM -Table Talk.

On 03/27/24 at 09:30 AM - Chair Yoga, at 03:00 PM- Bible study, and 06:00 PM- World Travel.

On 03/28/24 at 10:00 AM- Bingo and at 10:30 AM - group exercises.

On 03/29/24 at 09:30 AM - Coffee Social, at 03:00 PM- Kings in Corner, and at 06:00 PM- Residents Choice.

On 03/30/24 - Saturday at 09:00 AM -bingo, at

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03:00 PM- manicures, and at 06:00 PM- Movie of Choice.

On 03/31/24- Sunday at 09:00- Mass TV, at 11:00 AM -First United Methodist church , and at 06:00 PM - Name Five.

Interview on 03/25/24 at 12:50 PM with R33, revealed the facility provided bingo once a week and would like to participate in more frequent bingo games. R33 stated she would also like to play cards.

Observation on 03/25/24 at 03:00 PM, revealed lack of the activity UNO provided to the residents.

Observation, on 03/26/24 at 09:30 PM revealed lack of Noodle Ball and at 03:00 PM lack of cards offered to the residents.

Observation on 03/27/24 at 10:00 AM, revealed lack of Chair Yoga, and at 03:00 PM, Bible Study was not offered to the residents.

Interview on 03/25/24 at 12:50 PM with R33, revealed the facility provided bingo once a week and would like to participate in more frequent bingo games. R33 stated she would also like to play cards.

Interview, on 03/26/24 at 07:35 AM, with Certified Medication Aide(CMA) M revealed staff did not have time to do activities.

Interview, on 03/26/24 at 07:54 AM, with Activity Staff Z, revealed the evening staff should do activities. Activity Staff Z stated the facility provided one bingo game per week.

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Interview, on 03/26/24 at 02:20 PM, with Licensed Nurse G, revealed the resident only came out of her room for bingo.

Interview, on 03/28/24 at 10:20 AM, with Administrative Staff A, confirmed activities in the Greenhouses have been an issue.

The facility policy for "Resident Rights", 10/2022, included: The resident has the right to choose which activities they wish to participate in, including social, religious and community activities.

The facility failed to provide activities to the residents of this facility to increase their sense of well-being.

- Review of Resident (R) 37's medical record revealed diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).

The "Admission Minimum Data Set" (MDS), dated 07/25/23, assessed the resident with a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. R37 rated music, animals and doing favorite activities as very important. The resident required moderate/partial assistance for mobility.

The "Activities Care Area Assessment" (CAA), dated 07/25/23, did not trigger.

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The "Cognitive Loss/Dementia CAA" dated 07/25/23, assessed the resident with risk factors that included decreased socialization and need to encourage active participation in facility functions.

The "Care Plan", reviewed 03/20/24, instructed staff to provide the resident with materials for individual activities as desired. The resident likes knitting/crocheting, puzzles, some reading material and simple coloring. The resident preferred educational programs and game shows. The resident enjoys arts/crafts, bingo card games, baking, group discussions and was independent on staff with activity participation.

Review of the "Task" tab "Activities" in the electronic medical record for the last 30 days, revealed an entry on 03/04/24 for social and on 03/22/24 for music. No other activity participation provided.

Observation, on 03/25/25 at 02:20 PM, revealed the resident sleeping in her recliner in her room.

Review of the "March Activity Calendar" indicated the following activities available:

On 03/25/24 at 09:30 AM -chair exercises, at 03:00 PM- UNO a card game, and 04:30 PM -Bingo.

On 03/26/24 at 09:30 AM -Noodle ball, at 03:00 PM- cards, and 06:00 PM- Table Talk.

On 03/27/24 at 09:30 AM -Chair Yoga, at 03:00 PM- Bible study, and 06:00 PM- World Travel.

On 03/28/24 at 10:00 AM Bingo, and at 10:30

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AM group exercises.

On 03/29/24 at 09:30 AM Coffee Social, and at 03:00 PM Kings in Corner, and at 06:00 PM Residents Choice.

On 03/30/24 Saturday at 09:00 AM bingo, at 03:00 PM manicures, and at 06:00 PM Movie of Choice.

On 03/31/24 Sunday at 09:00 Mass TV, 11:00 AM First United Methodist church , and at 06:00 PM Name Five.

Observation on 03/25/24 at 03:00 PM, revealed lack of the activity UNO.

Observation, on 03/26/24 at 09:30 revealed lack of Noodle Ball and at 03:00 PM lack of cards.

Observation on 03/27/24 at 10:00 AM revealed lack of Chair Yoga and at lack of Bible Study and 03:00 PM.

Interview, on 03/25/24 at 02:10 PM, with a family member revealed the facility did not provide many activities.

Interview, on 03/26/24 at 07:35 AM, with Certified Medication Aide (CMA) M revealed staff did not have time to do activities.

Interview, on 03/26/24 at 07:54 AM, with Activity Staff Z, revealed the evening staff should do activities.

Interview, on 03/27/24 at 03:10 PM, with CMA N, revealed evening staff did not provide activities and lacked tools for providing them.

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Interview, on 03/27/24 at 03:30 PM, with CMA Q, revealed on nice days staff should encourage residents to go outside on the patio and would have cook outs. CMA Q revealed few structured activities as residents do not want to attend. CMA Q stated R37 did attend bingo games.

Interview, on 03/28/24 at 10:20 AM, with Administrative Staff A, confirmed activities in the Greenhouses have been an issue.

The facility policy for "Resident Rights", 10/2022, included: The resident has the right to choose which activities they wish to participate in, including social, religious and community activities.

The facility failed to provide activities to the residents of this facility to increase their sense of well-being.

- Review of Resident (R)78's electronic medical record (EMR) included a diagnosis of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord).

The "Modification of the Admission Minimum Data Set" (MDS), dated 08/06/23, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. It was very important for her to listen to music she liked, participate in religious services and do her favorite activities. She required total staff assistance with transfers, locomotion on and off the unit, and she had impaired range of motion (ROM) on bilateral (both) upper and lower extremities.

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The "Activities Care Area Assessment" (CAA), dated 08/06/23, documented the resident was at risk for decreased socialization and worsening depression. The facility would encourage active participation in facility functions to engage in sensory stimulation.

The "Quarterly MDS," dated 01/23/24, documented the staff assessment for cognition revealed the resident was independent with daily decision making. She was dependent on staff for all activities of daily living (ADL).

The care plan for activities, revised 08/01/23, instructed staff the resident was dependent on staff for participation in activities. Her favorite activities included visiting, watching group activities, watching TV and listening to music.

Review of the resident's "Activities Admission Data Collection", dated 08/01/23, documented it was very important for her to listen to the music she liked, participate in religious services and to do her favorite activities. The primary respondent for the assessment was the resident.

Review of the resident's "Activities Readmission Data Collection", 02/21/24, lacked activity preferences.

Review of the facility's activity calendar revealed an activity of morning music would occur every morning at 09:30 AM and religious services would occur each Sunday morning at 09:30 AM and 11:00 AM.

Review of the resident's EMR, from 03/01/24 through 03/27/24, revealed she participated in a

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social on three occasions and had visitors on two occasions. No other activities documented.

On 03/26/24 at 08:14 AM, Certified Nurse Aide (CNA) T and Certified Medication Aide (CMA) MM entered the resident's room to prepare the resident for the day. The resident's room lacked a device to listen to music and her TV was not turned to a music station.

On 03/27/24 at 09:48 AM, the resident sat in her wheelchair in the commons area facing the TV. The TV, which was tuned to a soap opera, had no volume.

On 03/28/24 at 09:01 AM, the resident sat in her wheelchair in her room with CNA X. The TV was turned off and no music played in the resident's room.

On 03/28/24 at 09:01 AM, the resident stated she prefers to listen to rap music. She stated she was a Baptist but had not been able to participate in a Baptist service for a long time.

On 03/26/24 at 03:09 AM, CNA PP stated she was unsure of what the resident liked to watch on TV but staff would put her in the commons area in front of the TV so she was able to watch whatever was on at that time.

On 03/27/24 at 08:14 AM, CNA T stated the resident's family would turn the TV on to a music station when they visited, but CNA T was unsure of what music the resident preferred.

On 03/28/24 at 07:38 AM, Activity Staff Z stated the staff were responsible for activities in the green houses.

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F 679	Continued From page 51 On 03/28/24 at 09:01 AM, CNA X stated she was unsure of what music the resident preferred. On 03/28/24 at 09:51 AM, Administrative Nurse D stated the staff were to do the activities in the green houses. Administrative Nurse D was unsure of how church services were set up for the green houses. The facility policy for "Resident Rights", dated 10/2022, included: The resident has the right to choose which activities they wish to participate in, including social, religious and community activities. The facility failed to implement an ongoing resident centered activity program for this dependent resident.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		

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The facility reported a census of 92 residents with 22 residents selected for review and included three residents reviewed for pressure ulcers. Based on observation, interview, and record review, the facility failed to ensure alternative methods of pressure relief provided for one Resident (R)20, of the three residents reviewed for pressure ulcers.

Findings included:

- Review of Resident (R)20's medical record revealed diagnoses that included deep vein thrombosis (DVT blood clots) in the right and left leg, heart disease, diabetes (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), and unstageable pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction and the wound is covered by a layer of dead tissue).

The "Quarterly Minimum Data Set" (MDS), dated 11/24/23, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The resident had an unstageable pressure ulcer present upon admission/reentry. The resident had no impairment in function range of motion in her upper or lower extremities and was dependent on staff for Activities of Daily Living (ADL).

The "Significant Change Minimum Data Set" (MDS), dated 02/05/24, assessed the resident with a BIMS score of nine, which indicated

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moderate cognitive impairment. The resident had no impairment in her upper or lower extremities, was dependent on staff for ADL, and at risk for pressure ulcers with no current pressure ulcer injury.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 02/05/24, assessed the resident due to impairment with functional mobility, recent acute illness, and incontinence. Licensed staff were to assess R20's skin each week and initiate proper interventions to prevent skin breakdown, and caregivers assist with repositioning as needed.

The "Care Plan" reviewed 02/21/23, instructed staff the resident admitted to hospice. The resident had a potential for impairment of skin integrity related to fragile skin. An intervention added 11/21/23, instructed staff to avoid positioning the resident on her heals and use foam off-loading boots when in bed at all times due to a deep tissue injury (DTI) to the left heel following hospitalization (11/13-11/20/23). Staff instructed to apply skin prep (a solution when applied that forms a protective waterproof barrier on the skin) to bilateral (both) heels daily.

On 02/29/24, the physician instructed staff to apply skin prep to bilateral heels daily.

A "Skin/Wound New Observation" note dated 02/09/24, indicated the resident developed a 1.5 by 1 centimeter (cm) deep tissue injury to her right heel. This note indicated staff to continue to utilize the off-loading boots.

A "Skin/Wound Weekly Observation" note, dated 02/13/24, indicated the DTI measured 3.3 cm by

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4.5 cm and staff instructed to continue the use of off-loading boots.

A "Skin/Wound Weekly Observation" note, dated 02/20/24, indicated the DTI measured 4 cm by 6 cm, with a mushy feeling.

A "Skin/Wound Weekly Observation" note, dated 03/07/24, indicated the DTI measured 6 cm by 3.5 cm with a depth of 1 cm, with wound edges intact. The note indicated a treatment of skin prep to both heels and float the heel off the bed with pillows.

A "Skin/Wound Weekly Observation" note, dated 03/12/24, indicated the DTI measured 7 cm by 4 cm with no depth. This note indicated the area improved with softness decreased.
A "Skin/Wound Weekly Observation" note, dated 03/19/24, indicated the DTI measured 5.2 cm by 7.4 cm with a dark colored eschar (dead tissue) and no changes in treatment.

A "Skin/Wound Weekly Observation" note, dated 03/26/23, indicated the DTI measured 4.5 cm by 6.3 with 100% eschar with no changes in treatment.

An Interdepartmental Team (IDT) Comprehensive Care Review dated 02/15/24, indicated the resident had a new DTI to her right heel with a wound treatment of offloading the heels by floating the heels.

An Interdepartmental Team (IDT) note, dated 02/22/24, indicated the right heel decreased in size.

An Interdepartmental Team (IDT) note, dated

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03/01/24, indicated the right heel as mushy with the appearance of a blood blister.

An Interdepartmental Team (IDT) note, dated 03/14/24, indicated the resident had a DTI to the right heel with stable wound margins.

The resident had DVT's to both lower legs and was on hospice for end-of-life cares. The resident had a pressure redistributing mattress on her bed and used a pillow to float her heels off the surface.

Observation, on 03/26/24 at 09:45 AM, revealed the resident seated in her wheelchair in her room. Certified Medication Aide (CMA) XXX and CMA Y assisted R20 to pivot transfer into her bed. CMA Y placed a pillow under the resident's calves to elevate her heels off the bed.

Observation, on 03/26/24 at 10:30 AM, revealed the pillow remained under the resident's calves, but her heels laid directly on the bed. Licensed Nurse (LN) G removed the resident's socks and revealed her right heal with blue black eschar. The left heel skin was pink and intact. Interview, at that time with LN G, revealed staff applied specialized foam boots to R20's bilateral heels and the left pressure ulcer heeled, but she developed a pressure ulcer on her right heel despite the boots. LN G stated the resident could move her foot in the boot causing a shift in the off-loading ability of the boots, so staff used pillows to off load her heels. LN G confirmed the pillow ineffective in keeping the resident's heels offloaded and obtained a blanket for additional off-loading. LN G stated R20 received hospice services, and she would inform hospice of the need for more effective off-loading device.

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F 686	Continued From page 56 Observation, on 03/26/24 at 02:05 PM, with Administrative Nurse E, revealed the readmitted to the facility with a deep tissue injury to her left heel. The resident had bilateral DVT in her lower extremities. The resident wore specialized pressure relieving boots and with treatments, the left heel injury resolved, however, the right heel injury developed inspire of the pressure relieving boots, so staff used pillows to elevate her heels off the bed. Administrative Nurse E confirmed the pillows may not maintain their buoyancy over time to keep the heels off the bed. Administrative Nurse E measured the right heel blue/black eschar as 4.5 cm by 6.3 centimeters and then applied skin prep to both heels. Administrative Nurse E confirmed the care plan lacked updated interventions for the right heel pressure ulcer and need for alternative means to float the resident's heels. Observation, on 03/27/24 at 09:20 AM, revealed the resident sitting up in her bed, eating breakfast. A pillow and blanket positioned under the resident's calves, but her right and left heel lay directly on the surface of the mattress. Interview, at that time with CMA P, revealed the resident did move her feet when in bed. Observation on 03/27/24 at 09:59 AM, revealed Consulting Therapy Staff GG, applied a foam shelf-like positioning device with elevated lateral (outer edges) sides. Consulting Therapy Staff GG stated she was consulted for R20's heel positioning needs due to the development of the DTI to her right heel. Consulting Therapy Staff GG stated she felt this device was a more appropriate device for floating R20's heels.	F 686		

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F 686	Continued From page 57 Interview, on 03/28/24 at 10:00 AM, with Administrative Nurse D, stated she would expect staff to assess effectiveness of heel floating interventions and initiate alternatives. The facility lacked a policy specific for pressure ulcers. The facility policy "Standards of Care and Care Planning Practice" dated 04/01/23, instructed staff instructed staff to ensure that all services are provided to the resident to ensure the care plan is resident centered and specific to the unique needs of each resident. The facility failed to provide effective heel off-loading interventions in a timely manner for the prevention/healing of R20's deep tissue injury.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		

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reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:

The facility reported a census of 92 residents with 22 selected for review, which included three residents reviewed for restorative services. Based on observation, interview and record review, the facility failed to ensure staff provided range of motion (ROM) services for one Resident (R)78, of the three residents reviewed for restorative.

Findings included:

- Review of Resident (R)78's electronic medical record (EMR) revealed diagnoses which included multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord) and quadriplegia (inability to move the arms, legs and trunk of the body below the level of an associated injury to the spinal cord).

The "Modification of Admission Minimum Data Set (MDS)", dated 08/06/23, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She required extensive assistance of staff with all activities of daily living (ADL) and had impairment on both sides of her upper and lower extremities. She received restorative cares for two days of the assessment period.

The "Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 08/06/23, did not trigger.

The "Quarterly MDS," dated 01/23/24, documented the staff assessment for cognition

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revealed the resident was independent with daily decision making. She was dependent on staff for all ADLs and had impairment on both sides of her upper and lower extremities. She received active range of motion (AROM) four days of the assessment period.

The care plan for restorative cares, revised 11/13/23, instructed staff the resident was to receive passive range of motion (PROM) to the upper and lower extremities and neck.

Review of the "Nursing Restorative Program" instructions, provided by the facility, documented staff were to provide PROM and AROM with prolonged stretch at the end range or within pain tolerance for shoulder flexion (bending of a limb or joint), abduction (moving away from the body). Staff were to provide elbow flexion, extension (moving towards the body), pronation (turn so that the palm was facing downward or inward) and supination (turn so the palm is facing outward). Staff were also to perform wrist and finger flexion and extension. Perform gentle neck stretches turning the resident's head side to side, up and down and ear to shoulder. PROM and AROM of the bilateral (both) lower extremities in supine (lying on the back) hip flexion, extension, abduction and adduction (movement of a limb toward the middle of the body). Restorative programs are to be completed for 15 minutes three to six times per week.

Review of the resident's EMR from 02/28/24 through 03/27/24, revealed the staff failed to complete restorative cares for eight of the day's restorative was to be performed.

On 03/25/24 at 10:35 AM, Consultant staff HH

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stated the resident's fingernails were beginning to dig into her other fingers due to her hands being clenched so tightly. He was unsure if the resident received the ROM services she was supposed to be receiving.

On 03/26/24 at 08:14 AM, Certified Nurse Aide (CNA) T stated the staff do not do ROM exercises with the resident. They had a restorative aide who would do ROM, but she quit a few weeks ago.

On 03/26/24 at 08:19 AM, Certified Medication Aide (CMA) MM stated the staff will put on the resident's braces and splints but do not do ROM exercises with the resident.

On 03/26/24 at 12:57 PM, CNA ZZZ stated there had not been a restorative aide for the green houses for about six weeks. The CNAs in the green houses do not do the ROM because they do not know how.

On 03/27/24 at 10:37 AM, CNA QQ stated they do not do ROM exercises with the resident.

On 03/26/24 at 10:37 AM, Licensed Nurse (LN) G stated the CNAs and CMAs on the green houses do not do ROM with the residents. They have not had a restorative aide in the green houses for a little over a month.

On 03/28/24 at 09:51 AM, Administrative Nurse D stated the restorative aide for the green houses left about a month or two ago and were aware the restorative program was an issue at this time.

The facility policy for "Restorative Nursing Care", undated, included: Restorative nursing care shall

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F 688	Continued From page 61 be performed daily for residents who require such services. These programs include maintaining good body alignment and proper positioning and assisting residents with their routine ROM exercises. The facility failed to provide appropriate treatment and services to prevent further decrease in ROM for this dependent resident with hand contractures.	F 688		
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	F 690		

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continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 92 residents with 22 residents included in the sample, including four residents reviewed for indwelling urinary catheters (insertion of a catheter into the bladder to drain the urine into a collection bag). Based on observation, interview, and record review, the facility failed to utilize an anchoring device for one Resident (R)78 and failed to ensure catheter tubing was kept up off the floor for R 242.

Findings included:

- Review of Resident (R)78's electronic medical record (EMR) revealed a diagnosis of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying).

The "Modification of Admission Minimum Data Set (MDS), dated 08/06/23, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She required extensive assistance of two staff for toileting and had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

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The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 08/06/23, documented the resident had an indwelling urinary catheter.

The "Quarterly MDS," dated 01/23/24, documented the staff assessment for cognition revealed the resident was independent with daily decision making. She was dependent on staff for all activities of daily living (ADLs) and had a urinary catheter.

The care plan for the urinary catheter, dated 08/01/23, instructed staff to keep the catheter bag and tubing below the level of the bladder.

On 03/26/24 at 08:14 AM, Certified Nurse Aide (CNA) T and Certified Medication Aide (CMA) MM were performing catheter care on the resident as she rested in her bed. When staff removed the resident's pants, the catheter tubing was not anchored to the resident's thigh. The anchoring device was folded onto itself, causing it to be ineffective in preventing tugging of the catheter tubing.

On 03/26/24 at 08:14 AM, CNA T stated the catheter tubing should be anchored to the resident's leg to prevent the tubing from tugging and possibly causing pain or injury to the resident.

On 03/26/24 at 08:19 AM, CMA MM stated the resident's catheter tubing anchor kept coming off, so the staff do not always put the anchor back on her.

On 03/26/24 at 09:01 AM, Licensed Nurse (LN) G

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stated residents with a urinary catheter should have an anchor for the tubing to prevent injury to the resident. She was unaware the anchor kept coming off the resident.

On 03/27/24 at 01:38 PM, Administrative Nurse D stated it was the expectation for all residents with an indwelling urinary catheter to have an anchoring device to prevent the tubing from being pulled.

The facility policy for "Urinary Catheter Care", dated 02/2017, included: Staff shall ensure the catheter tubing remains secure by using a catheter securing device to reduce friction and movement at the insertion site.

The facility failed to utilize an anchoring device for this dependent resident with a urinary catheter in order to prevent injury to the resident.

- Review of Resident (R)242's electronic medical record (EMR) revealed a diagnosis of neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system).

The "Annual Minimum Data Set" (MDS), dated 01/15/24, documented the staff assessment for cognition revealed severe impairment. The resident was dependent on staff for all activities of daily living (ADL's) and was always incontinent of bowel and bladder.

The "Urinary Incontinence/Indwelling Catheter Care Area Assessment" (CAA), dated 01/15/24, documented the resident was dependent on staff for toileting hygiene.

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The "Medicare 5-Day MDS," dated 03/16/24, documented the staff assessment for cognition revealed severe impairment. The resident was dependent on staff for all ADLs and was always incontinent of bowel and bladder.

The indwelling catheter care plan, revised 03/25/24, instructed staff to position the catheter bag and tubing below the level of the bladder.

Review of the resident's EMR revealed the following physician's order:

Indwelling urinary catheter for acute urinary retention (inability to urinate), ordered 03/20/24.

On 03/26/24 at 09:55 AM, the resident sat in his wheelchair in the dining room. The catheter bag hung underneath the resident's wheelchair seat with the catheter tubing resting directly on the floor.

On 03/26/24 at 12:26 PM, the resident sat in his wheelchair in his room. The catheter bag hung underneath the resident's wheelchair seat with the catheter tubing resting directly on the floor.

On 03/27/24 at 01:15 PM, the resident sat in his wheelchair in the commons area. The catheter bag hung underneath the resident's wheelchair seat with the catheter tubing resting directly on the floor.

On 03/26/24 at 01:15 PM, Certified Medication Aide (CMA) NN stated the catheter tubing should be kept off the floor.

On 03/27/24 at 11:13 AM, Certified Nurse Aide (CNA) RR stated the catheter tubing should be

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F 690	Continued From page 66 kept in the dignity bag and not come into contact with the floor. On 03/27/24 at 01:38 PM, Administrative Nurse D stated the catheter tubing should never be on the floor. It was the expectation for staff to coil the tubing and place it in the dignity bag with the catheter bag. The facility policy for "Urinary Catheter Care", dated 02/2017, included: Staff shall ensure catheter tubing and drainage bag are kept off the floor. The facility failed to prevent this dependent resident's catheter tubing from coming into contact with the floor.	F 690		
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;	F 692		

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F 692	Continued From page 67 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility census totaled 92 residents with 22 residents included in the sample. Based on observation, interview, and record review, the facility failed to monitor one Resident (R)35, for a physician ordered fluid restriction. Findings included: - R35's physician orders revealed the following diagnoses included orthostatic hypotension (blood pressure dropping with change of position), essential (primary) hypertension (elevated blood pressure), viral hepatitis C (inflammatory condition of the liver), chronic obstructive pulmonary disease (COPD, a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), chronic kidney disease, and fluid overload (increase in the volume of extracellular and/or intravascular fluids). The "Annual Minimum Data Set" (MDS) dated 10/12/23, revealed a "Brief Interview for Mental Status" (BIMS) score of 09, indicating moderate cognitive impairment. The resident used a wheelchair or walker for mobility. The quarterly MDS dated 01/10/24, revealed no significant changes in status. The "Dehydration/ Fluid Maintenance Care Area Assessment" (CAA), dated 10/12/23, revealed R35 was on a fluid restriction, and nursing staff	F 692		

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were to monitor the resident's fluid intake.

Review of the care plan dated 01/23/24, lacked guidance related to the resident's fluid restriction.

The physician's order dated 04/23/23 revealed the following:

The resident has a daily 2000 milliliter (ml) fluid restriction. Fluids include anything that is liquid at room temperature.

During the day shift, the resident may have 480 ml at breakfast and 360 ml at lunch from dietary. The resident may have 360 ml during the shift from Nursing. A total for dayshift would be 1200 ml.

During the evening shift, the resident may have 360 ml at supper from dietary. The resident may have 240 ml during the shift from nursing. A total for evening shift would be 600 ml.

During the night shift, the resident may have 180 ml from nursing. A total for night shift would be 180 ml.

Observation on 03/25/24 at 01:40 PM revealed the resident sat in his chair in his room with feet elevated.

On 03/25/24 at 01:40 PM, the resident reported he was on an 1800 ml fluid restriction, but the staff did not bother him a whole lot because he has been on it a long time and just knows what he can drink and if he wants extra, he will just get it.

On 03/26/24 at 11:55 AM, Certified Nursing

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F 692	Continued From page 69 Assistant (CNA) SS reported she did not know how staff monitored the resident's fluid restriction. She thought it was probably up to dietary to restrict his fluids and thought he usually had a coffee cup and a glass of fluid at each meal. She was unable to determine the amount of fluid would total for a cup of coffee and a glass of fluid. She reported there was no intake sheet to chart his fluids, but as long as he had no fluid in his room, nursing did not need to monitor his fluid intake. On 03/26/24 at 12:10 PM, Licensed nurse (LN) I reported she was not sure what the fluid restriction was. She knew they have a chart in the kitchen to tell how much each size glass held. There was no intake sheet that she was aware of and thought dietary measured the fluids. She reported staff did not monitor the resident's fluid intake. On 03/27/24 at 10:30 AM, Administrative Nurse F reported she would expect the resident's fluid restriction to be included on the care plan. All staff caring for the resident should be aware of his fluid restriction and how to monitor it. The facility lacked a policy related to fluid restrictions. The facility failed to monitor the physician prescribed fluid intake for this resident that required a fluid restriction.	F 692		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 757		

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unnecessary drugs. An unnecessary drug is any drug when used-

§483.45(d)(1) In excessive dose (including duplicate drug therapy); or

§483.45(d)(2) For excessive duration; or

§483.45(d)(3) Without adequate monitoring; or

§483.45(d)(4) Without adequate indications for its use; or

§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 92 residents with 22 residents selected for review, which included five residents reviewed for unnecessary medication use. Based on observation, interview, and record review, the facility failed to monitor one of the five Residents (R)7 for hypotension and bowel movements and one resident, R 41, regarding a failure to follow physician ordered blood pressure parameters. (instructions to hold medication for blood pressures below a threshold).

Findings included:

- Review of Resident (R) 7's medical record, revealed diagnoses that included Parkinson's disease (slowly progressive neurologic disorder

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characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder), and hypertension (elevated blood pressure).

The "Admission Minimum Data Set" (MDS), dated 10/23/23, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The resident received antianxiety (medication to decrease anxiety), antidepressant (medications used to treat feelings of sadness), anticoagulant (medications used to prevent blood clots), and opioid (narcotic pain-relieving medications).

The "Psychoactive Drug Use Care Area Assessment" (CAA) dated 10/23/23, was not developed.

The "Care Plan" reviewed 01/26/24, instructed staff to consult with the provider regarding ongoing need for use of medications, which included antianxiety, antidepressant, antihypertensives, and pain medications.

The physician instructed staff to administer the following medications:

On 10/18/23, Levothyroxine, 75 micrograms (mcg) daily (QD), for hypothyroidism (low thyroid hormone).

On 10/18/23, Lexapro, 20 milligrams (mg), QD, for major depressive disorder (MDD).

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On 03/18/20, Miralax, 17 grams (gm), at hour of sleep (HS), for constipation.

On 03/02/24, Movantik, 12.5 mg, QD, for constipation.

On 01/19/24, Naldemedine Tosylate, 0.2 mg, QD on Monday, Wednesday, and Friday, for opioid constipation, and discontinued on 03/02/24.

On 01/17/23, Remeron, 15 mg, at HS for MDD.

On 10/17/23, Baclofen, 5 mg, twice a day (BID), for muscle spasm.

On 10/17/23, Buspirone HCL (hydrochloride), 10 mg, BID, for anxiety.

On 10/17/23, MS Contin (morphine sulfate continuous release) ER (extended release), 30 mg, every12 hours, for pain.

On 12/19/23, Senna, 8.6 mg, BID, for constipation.

On 03/20/24, Topiramate, 50 mg, BID, for mood stabilization.

On 10/17/23, Gabapentin, 300 mg, three times a day (TID), for pain.

On 10/17/23, Sinemet, 25-100 mg, every six hours, for Parkinson.

On 03/18/24, Milk of Magnesia, 30 milliliters, TID, for constipation as needed (prn).

On 02/29/24, Norco 10-325 mg, every four hours, as needed for pain.

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On 10/17/23, Tylenol, 650 mg, every six hours, as needed for pain, not to exceed 3000 mg in 24 hours.

On 01/28/24, the physician instructed staff to monitor vital signs weekly. Staff recorded vital signs in the electronic medical record on the treatment administration record, with the last recorded blood pressure on 03/03/24, with a blood pressure reading of 90/48.

Review of the resident's blood pressures from 11/01/23 through 03/03/24 revealed a range of 80/49- 132/64 with most current blood pressure on 03/03/24 of 90/48.

Interview, with Administrative Nurse E, confirmed the lack of vital signs/blood pressure monitoring since 03/03/24 due to "computer issues". Administrative Nurse E stated it is the facility standard of care to monitor vital signs weekly.

The facility policy "Standards of Care and Care Planning Practice, dated 04/01/23 instructed staff that routine practices are services that are expected to be provided to all residents based on accepted clinical guidelines and resident status.

The facility failed to monitor R7's vital signs which included blood pressure, at least weekly to determine presence of and adverse effects of hypotension.

Furthermore, review of the "Task B&B Bowel Elimination" tab, for March 2024, revealed the resident lacked a bowel movement from 03/09/24 through 03/19/24 for a total of 10 days at which time the resident had two medium bowel

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movements.

A "Nurses' Note" dated 03/14/24, indicated lack of bowel movement documented for six days, and interview with the resident confirmed the lack of bowel movement. This note indicated staff administered Miralax and lacked further documentation of bowel status.

Interview, on 03/27/24 at 03:10 PM, with Certified Medication Staff (CMA) N, revealed the charge nurse notified her of the need for as needed laxative measure when a resident has not had a bowel movement in three days.

Interview, on 03/28/24 at 10:14 AM, with Administrative Nurse E, revealed the electronic record had built in alerts for the charge nurse to access the bowel movement reports for residents who have not had a bowel movement in three days, however the alerts do not always show up on the dashboard. Administrative Nurse E stated she would expect Licensed staff to follow up the resident's bowel status.

The facility policy "Standard of Care and Care Planning Practice" dated 04/01/23, instructed staff to implement bowel protocol on day three if not bowel movement.

The facility policy "Standing Orders" dated 11/28/23 instructed staff to administer the following for constipation:
Milk of Magnesia, 30 ml, every 12 hours, as needed for two doses in 24 hours.
Senna, 1 tablet, twice a day, as needed.
Bisacodyl suppository, one suppository per rectum, if no stools in three days.
Fleets enema, rectally, as needed if Milk of

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Magnesia or suppository was not effective.

The facility failed to monitor R7's bowel status as at risk for constipation due to opioid use, which resulted in lack of bowel movement for 10 days.

- Review of Resident (R)41's electronic medical record (EMR), dated 03/21/24, included a diagnosis of hypertension (HTN-elevated blood pressure).

The "Annual Minimum Data Set (MDS)", dated 11/16/23, documented the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition and had a diagnosis of HTN.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 11/16/23, documented the resident had impaired cognition.

The "Quarterly MDS," dated 02/09/24, documented the resident had a BIMS score of 10, indicating moderately impaired cognition and had a diagnosis of HTN.

The care plan for cardiovascular, revised 02/18/24, instructed staff the resident had a diagnosis of HTN and to encourage low salt intake.

Review of the resident's EMR revealed the following physician's order:

Norvasc (a hypertensive medication used to lower blood pressure-BP), five milligrams (mg), by mouth (po), every day (QD) for HTN. Hold if

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the systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 120, ordered 12/22/23.

Review of the resident's Medication Administration Record (MAR) for February 2024, revealed the following dates the SBP was outside of the ordered parameters and staff administered the medication:

On 02/29/24, the resident's BP was 104/58.

On 02/22/24, the resident's BP was 113/67.

On 02/20/24, the resident's BP was 112/66.

On 02/19/24, the resident's BP was 102/56.

On 02/15/24, the resident's BP was 112/64.

On 02/12/24, the resident's BP was 114/67.

On 02/04/24, the resident's BP was 112/59.

On 02/01/24, the resident's BP was 105/64.

Review of the resident's MAR for March 2024, revealed the following dates the SBP was outside of the ordered parameters and staff administered the medication:

On 03/16/24, the resident's BP was 117/60.

On 03/21/24, the resident's BP was 113/80.

On 03/26/24, the resident's BP was 114/74.

On 03/27/24 at 08:22 AM, Certified Medication

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F 757	Continued From page 77 Aide (CMA) S stated the resident did have a BP parameter for her HTN medication. CMA confirmed she administered the medication to the resident with the BPs outside of parameters. On 03/27/24 at 08:25 AM, Licensed Nurse (LN) H stated the staff were to notify her if a resident's BPs were outside of the parameters ordered by the physician. She would expect the staff to follow physician's ordered parameters when administering medications. On 03/27/24 at 01:38 PM, Administrative Nurse D stated it was the expectation for staff to follow the physician's orders while administering medications, including holding a medication if the resident's BP was outside of the ordered parameters. The facility policy for "Administering Medications", revised 02/2022, included: Medications must be administered in accordance with the physician's orders. Vital signs must be verified for the resident prior to administering medications. The facility failed to hold this dependent residents HTN medications when her BPs were outside of the physician's ordered parameters on multiple days.	F 757		
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.	F 812		

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(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 reported a census of 92 residents. Based on observation, record review, and interview, the facility failed to prepare and serve food under sanitary conditions, to the residents of the facility appropriately to prevent the potential for food borne bacteria.

Findings included:

- During an initial tour of the resident kitchenette, on 03/25/24 at 11:07 AM, the following areas of concern were noted in the kitchen of greenhouse 1202:

1. The inside of the toaster had a heavy build-up of crumbs.

2. The top of the stove had dried-on food debris.

3. A large plastic container of corn chips lacked a lid and there were corn chips on the floor.

4. The deep freeze had food debris on the bottom.

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5. The silverware drawer contained wet silverware and food debris.

6. There were multiple greasy fingerprints on the hood of the range.

During a tour of the kitchenette of the first floor, on 03/25/24 at 01:00 PM, the following areas of concern were noted:

1. The resident refrigerator contained a can of an opened energy drink which was unlabeled and undated.

2. The sink had a brownish substance on the back rim up against the wall.

3. The trash can had dried-on food debris and lacked a lid.

During an initial tour of the kitchen, on 03/26/24 at 07:49 AM, the following areas of concern were noted:

1. The reach-in refrigerator racks had an extremely heavy build-up of a black substance in between the front lip of six white, plastic-covered racks.

2. The top of the ice machine and the oven contained a layer of dust.

3. A white, four-tiered cart, used to dry clean dishes, had ground in dirt and debris into the four plastic tiers and the handles of the cart, causing them to be discolored.

4. Ten knives plastic handles were deeply

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grooved and had ground in dirt and debris causing the handles to be discolored. The plastic container holding the knives contained food debris.

5. Three plastic containers holding spatulas, tongs and divider bars contained food debris in the bottom of the closed containers.

6. The inside of the microwave had dried-on food debris.

7. Two shelves over the cold cart had a layer of dust.

8. The shelf on the steam table, used to cut food for resident's consumption, had deep cuts causing the surface to be discolored and uncleanable.

9. Three doors of the cold cart had a large amount of ground-in food debris in the rubber seal of the doors.

During a tour of the kitchen in green house 1212, on 03/25/24 at 10:55 AM, the following areas of concern were noted:

1. Two open cans of 2-cal (a nutritionally complete, high-calorie formula designed to meet the needs of people with increased protein and calorie requirements) were partially used and undated.

2. There was a mug of a milky substance was undated.

3. There was a plastic bag of cucumbers, undated. The cucumbers had a slimy

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F 812	Continued From page 81 appearance. 4. There were two pitchers of juice, undated. 5. Two cartons of juice concentrate to be used within 48 hours of thawing, lacked date. On 03/25/24 at 10:50 AM, Dietary staff DD stated the staff should date foods when opened. On 03/28/24 at 10:07 AM, Dietary staff DD stated the staff were responsible for keeping the kitchens and kitchenettes clean and sanitary. The facility policy for "Food Safety Requirements", reviewed 01/2024, included: It is the policy of the facility to provide safe and sanitary storage, handling and consumption of all foods. The food service workers are responsible to adhere to the food safety requirements. The facility failed to prepare and serve food under sanitary conditions for the residents of the facility appropriately to prevent the potential for food borne bacteria.	F 812		
F 880 SS=F	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.	F 880		

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

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

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

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F 880	Continued From page 83 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility reported a census of 92 residents with 22 included in the sample. Based on observation, interview, and record review, the facility failed to ensure infection control techniques for Resident (R)9, regarding oxygen (O2) tubing/cannula storage, for R60, related to urinary catheters and perineal care, R242, related to storage of soiled catheter collection device stored next to personal care items of toothbrush and toothpaste, and R78, related to incontinence cares, to prevent the spread of infections in the facility. Findings included: - R9's physician orders revealed the following diagnoses that included chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).	F 880		

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The "Annual Minimum Data Set" (MDS) dated 01/04/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 indicating intact cognition.

Review of the Quarterly MDS dated 03/01/24, revealed a BIMS score of 15. R9 received oxygen (O2).

The care plan dated 03/17/2023 revealed the resident had COPD and staff were to give oxygen therapy as ordered by the physician.

Observation on 03/25/24 at 11:45 AM, revealed Certified Nursing Assistant (CNA) UU entered the resident's room to assist the resident to lunch. CNA UU removed R9's O2 cannula and placed the tubing and nasal cannula directly on the bed. The room lacked a storage container for the O2 cannula. CNA UU removed a trash filled bag out of the trash can, reached into the trash can and obtained a new trash bag out and placed R9's cannula into the trash bag, and laid the cannula back onto the bed. No hand hygiene completed between removing the trash and handling R9's cannula. Observation revealed a second nasal cannula stored directly on R9's walker and was not stored in a container. CNA UU applied the opened, unbagged nasal cannula to R9 and assisted R9 to the dining room.

Observation on 03/26/24 at 12:10 PM, CNA SS entered the resident's room to assist the resident to the dining room. She removed R9's O2 cannula and placed the cannula/tubing directly on the bed and placed a magazine on top of the cannula.
CNA SS removed O2 tubing/cannula from the walker and placed it on the resident. That

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cannula was not in a storage bag and was wrapped around the back of the walker with the cannula having contact with the top of the O2 tank.

On 03/25/24 at 11:50 AM, CNA UU reported the resident's O2 cannula and tubing should be in a box but did not see one in her room. The resident's walker should have a bag to contain the O2 when not in use.

On 03/26/24 at 12:10 PM, CNA SS reported she was not sure what to do with the O2, so she just put it on the bed and laid something on top of it so it would not slide off on the floor. She was unaware anything had to be on the walker for the O2 tubing to be stored in.

On 03/26/24 at 12:20 PM, Licensed Nurse (LN) I reported everyone on O2 should have a three-compartment cart in their room for the O2. She also reported all walkers or wheelchairs that use O2 should have bags with the resident's name and date on it and changed weekly. Observation revealed LN I went into R9's room and found the O2 cart, in a closet behind a wheelchair, with piled clothing and blankets that covered the O2 cart. LNI removed the cart from the closet and placed it into R9's room to be utilized.

The facility's policy for oxygen, lacked care of the tubing and cannulas.

The facility failed to ensure good infection control techniques by the failure to store oxygen (O2) tubing and nasal cannula in a sanitary manner when not in use.

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- Resident (R) 60's signed physician orders dated 11/03/23 revealed the following diagnoses included neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), and a history of urinary tract infection (infection of any part of the urinary system).

The "Admission Minimum Data Set" (MDS) dated 11/03/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 8, indicating moderate cognitive impairment. The resident was dependent on staff for all daily cares and used a wheelchair for mobility. The resident had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) and was incontinent of bowel.

The " Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 11/03/23 revealed staff were to provide assistance to clean and dry the resident for bowel needs and the resident had an indwelling urinary catheter.

Observation on 03/25/24 at 12:10 PM, revealed Certified Nursing Assistant (CNA) V emptied the resident's catheter. CNA V donned gloves and retrieved a graduated pitcher from the bathroom and removed the tubing from the catheter bag spigot. She drained the catheter bag and placed the tubing into the spigot of the drainage bag without cleansing the spigot. CNA V failed to remove her soiled gloves and CNA V and CNA UU transferred the resident from a full body mechanical lift to the bed. The resident had a bowel movement and required incontinence cares. CNA UU provided perineal cares and grabbed disposable wipes from the container with

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the soiled gloves. CNA V and CNA UU failed to remove their soiled gloves and placed a clean brief under the resident. CNA UU then went into the bathroom with the soiled gloves on, retrieved moisture barrier, and applied moisture barrier to the resident. With soiled gloves on, the brief was placed and fastened, and staff positioned the resident onto his side with positioning devices and placed positioning devices under his legs. CNA V then removed her gloves. CNA UU emptied the trash and then removed her gloves. Both CNA's left the resident's room without washing their hands.

On 03/25/24 at 12:30 AM, CNA V reported she would usually use alcohol when emptying a catheter but thought there was no available alcohol in the resident's bathroom, so "just did not use it".

On 03/25/24 at 12:32 PM, CNA UU reported she should have changed her gloves during the incontinent care.

On 03/28/24 at 08:00 AM, Administrative Nurse D reported she expected her staff to maintain good hand hygiene with personal care. Staff should change their gloves between dirty and clean. Staff with the clean gloves should handle the wipes and hand to the aide doing the perineal care. When emptying the catheter, gloves are required along with alcohol to the tubing to clean the tubing, to prevent urinary tract infections (UTI's). Hand washing and proper usage of gloves and disinfecting the tubing is a must.

The facility's policy for "Urinary Catheter Care", dated 02/2017, included: Staff shall use standard precautions while performing urinary catheter

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cares with residents.

Review of the facility's policy for "Standards of Care" dated 04/01/23, revealed all staff are to maintain standard precautions when providing care to a resident.

The facility failed to ensure good infection control techniques by the failure to change gloves between dirty and clean while performing peri-care for R60 and the failure to properly clean the catheter spigot when emptying R 60's indwelling urinary catheter.

- Review of Resident (R)78's electronic medical record (EMR) revealed a diagnosis of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord).

The "Modification of Admission Minimum Data Set (MDS)", dated 08/06/23, documented the resident had a Brief Interview for Mental Status (BIMS) score of thee, indicating severe cognitive impairment. She required extensive assistance of two staff for toileting and was incontinent of bowel.

The "Activity of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 08/06/23, did not trigger.

The "Quarterly MDS," dated 01/23/24, documented the staff assessment for cognition revealed the resident was independent with daily

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decision making. She was dependent on staff for all ADLs and was always incontinent of bowel.

The care plan for ADLs, dated 08/01/23, instructed staff the resident required assistance with all ADLs.

Review of the resident's EMR, from 03/01/24 through 03/27/24, revealed the resident was dependent on staff for bowel incontinence and dressing.

On 03/26/24 at 08:14 AM, Certified Nurse Aide (CNA) T and Certified Medication Aide (CMA) MM entered the resident's room to get her ready for the day. The staff completed peri-care due to the resident being incontinent of bowel. The staff then applied a clean brief without changing gloves. CNA T then began to dress the resident, putting her hand through the sleeve of the resident's clean shirt, without changing her gloves.

On 03/26/24 at 08:14 AM, CNA T confirmed she had not changed her gloves after performing peri-care following the incontinent BM before she placed a new brief on the resident and began to dress her. CNA T stated she should have changed her gloves but had forgotten.

On 03/26/24 at 08:19 AM, CMA MM stated she should have changed her dirty gloves before helping to put a clean brief on the resident.

On 03/28/24 at 09:51 AM, Administrative Nurse D stated it was the expectation for staff to change their gloves after providing peri-care and before putting on a clean brief or assisting a resident to dress.

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The facility lacked a policy regarding changing gloves following peri-care.

The facility failed to use appropriate hand hygiene after performing peri-care for this dependent resident.

- Review of Resident (R)242's electronic medical record (EMR) included a diagnosis of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

The "Annual Minimum Data Set (MDS)", dated 01/15/24, documented the staff assessment for cognition revealed severe impairment. He was dependent on staff for all ADLs.

The "Urinary Incontinence/Indwelling Catheter Care Area Assessment" (CAA), dated 01/15/24, documented the resident was dependent on staff for toileting.

The "Medicare 5-Day MDS," dated 03/16/24, documented the staff assessment for cognition revealed severe impairment. He was dependent on staff for all ADLs.

The indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) care plan, revised 03/25/24, instructed staff to position the catheter bag and tubing below the level of the bladder.

Review of the resident's EMR revealed the following physician's order:

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F 880	Continued From page 91 Indwelling urinary catheter for neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), 03/20/24. On 03/26/24 at 01:15 PM, Certified Medication Aide (CMA) NN entered the room to empty the resident urinary catheter. CMA NN drained the urine into a graduate (a vessel used to measure liquids). CMA NN then emptied the urine into the toilet, filled the graduate half-way with water from the resident's bathroom faucet to rinse, poured the rinse water into the toilet then placed the graduate upside down on the back of the toilet on top of paper towels up against the resident's tooth brush, tooth paste and shaving cream. On 03/26/24 at 01:15 PM, CMA NN stated the staff kept the graduate on the back of the toilet with the rest of the resident's things all the time. On 03/27/24 at 01:38 PM, Administrative Nurse D stated the staff should not place the graduate up against the resident's toothbrush and toothpaste. The facility policy for "Urinary Catheter Care", dated 02/2017, included: Staff shall use standard precautions while performing urinary catheter cares with residents. The facility failed to use appropriate standard precautions while performing catheter care for this dependent resident with a urinary catheter.	F 880		