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	175387	A. BUILDING _____ B. WING _____	10/09/2024

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and complaint investigation # K00190072. This 2567 was electronically sent on 10/16/24.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565		

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

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

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§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 74. The sample included 18 residents. Based on observations, record reviews, and interviews, the facility failed to address and resolve recurring issues reported by the Resident Council. This deficient practice placed the residents at risk for decreased psychosocial well-being.

Findings Included-

- A review of the facility's "Resident Council Minutes" from 09/2023 through 09/2024 indicated the council had recurring concerns with the food temperatures.

The 10/19/23 "Resident Council Minutes" documented concerns that corn dogs were being served cooked on the outside but remained "icy" in the inside.

The 10/18/24 "Resident Council Minutes" documented concerns that foods that were shelf-stable at room temperature were being served cold.

The 02/15/24 "Resident Council Minutes" documented concerns that foods that were shelf-stable at room temperature were being served cold. The minutes lacked actions taken or outcomes for the repeat concerns.

The 08/15/24 "Resident Council Minutes"

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documented concerns that hamburgers and tater tots were being served cold. The minutes lacked actions taken or outcomes for the repeat concerns.

The 09/19/24 "Resident Council Minutes" noted continued concerns that hamburgers and tater tots were being served cold. The minutes lacked actions taken or outcomes for the repeat concerns.

On 10/09/24 at 02:07 PM, Social Services Designee (SSD) E stated residents expressed their grievances during the resident council meetings and SSD E was unable to produce a grievance log that reflected the multiple concerns from residents with regards to food temperatures. SSD E stated kitchen staff had access to a plate wormer that was intermittently operational, and she was unsure if it was currently operational.

The facility's "Right to Voice Grievances" policy, dated 01/01/24 documented residents and/or their representatives had the right to express a grievance, concern, or complaint without fear of retribution and that the resident/representative had the right to expect prompt efforts by the facility staff to resolve the grievance(s). The policy further documented if the facility did not resolve a grievance the facility would refer the resident/representative to the State Ombudsman (an official appointed to investigate individual's complaints against maladministration), legal services, or State Adult Protective Service programs.

The facility failed to address and resolve recurring issues reported by the Resident Council. This deficient practice placed the residents at risk for

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F 565	Continued From page 3 decreased psychosocial well-being and impaired quality of life.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.	F 578		

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(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 34 residents, with 12 residents sampled, including review for advanced directives (a written document, which indicates the medical decisions for health care professionals when the person could not make their own decisions). Based on interview and record review, the facility failed to ensure one resident's advanced directives were thoroughly completed. Resident (R)16 had a Do Not Resuscitate (DNR- or no code, a legal document or order that means the person does not desire cardiopulmonary resuscitation [CPR is an emergency lifesaving procedure performed when the heart stops beating] in the event of cardiac arrest), which was only signed by a physician.

Findings included:

- Resident (R)16 's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and depression.

The 06/27/24 "Annual Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) score, which could not be determined as the assessor was unable to interview resident. The staff interview for mental status indicated severely impaired cognition. The resident had a total mood severity score of seven, indicating mild depression and behaviors noted one to three

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days. R16 required total assistance with activities of daily living (ADLs), which included bed mobility, toileting, dressing, eating, transferring, and bathing.

The 07/08/24 "Cognitive Loss/Dementia Care Area Assessment" (CAA) Cognitive Loss CAA triggered secondary to orientation, memory, and recall deficits noted during BIMS interview. Contributing factors included dementia, delusions, and altered mental status. Risk factors included self-care deficits, falls, and injuries, incontinence, decreased socialization. The resident's care plan would be reviewed to maintain current cognitive status.

The 09/12/24 "Quarterly MDS" documented a staff interview for mental status indicating severely impaired cognition. R16 required total assistance with ADLs.

The 10/07/24 "Care Plan" R16 had a DNR date initiated 09/25/24.

The "Physician Orders" dated 12/30/22 revealed a DNR order.

Review of the DNR form signed 12/21/22 revealed it was only signed by a physician.

On 10/08/24 at 01:00 PM, R16 laid in bed, with no concerns noted. On R16's nametag outside of her room on the wall a red colored circle sticker the size of a dime was noted.

On 10/08/24 at 01:34 PM, Certified Medication Aide (CMA) H reported if a red dot was on the resident's name tag outside of their room it meant the resident had a DNR code status. Additionally,

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F 578	Continued From page 6 if the resident had a green dot that meant they required CPR. On 10/09/24 at 10:40 AM, Social Service Designee (SSD) E confirmed that R16's DNR that was uploaded in the EHR was incorrect with having only the physician signature. The facility's "Advanced Directives" policy dated 01/01/24 documented to ensure compliance with Federal and State requirements regarding advance directive and to comply with the resident's wishes. Social Services will review the document for validity and certify that the document has been duly executed and is in compliance with State law. The document will be placed in the resident's clinical record. The facility failed to ensure R16 had a fully completed advanced directive. This deficient practice had the potential to lead to uncommunicated needs specifically to end-of-life care.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		

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clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 34 residents with 12 residents sampled, including one resident

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reviewed for notification of change. Based on observation, interview, and record review, the facility failed to ensure the resident/resident's representative for Resident (R) 35, the right to be informed when the resident had a new order for an anti-psychotic (class of medications used to treat major mental conditions which cause a break from reality) medication dosage change.

Findings included:

- Resident (R)35 's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and encephalopathy (broad term for any brain disease that alters brain function or structure).

The 07/08/24 "Admission Minimum Data Set (MDS)" documented a "Brief Interview for Mental Status" (BIMS) score of four, indicating severely impaired cognition. The MDS documented a total mood severity score of 00, indicating no depression and noted R35 had behaviors of yelling, cursing and making noises for 1 to 3 days of the look back period. R35 required total assistance with activities of daily living (ADLs), including toileting hygiene, transfer, personal hygiene and wheelchair mobility. R35 received antipsychotic medication in lookback period.

The 07/16/24 "Psychotropic Drug Use Care Area Assessment" (CAA) documented R35 was administered Seroquel (antipsychotic medication that treats several kinds of mental health conditions including schizophrenia and bipolar disorder) for delusional behaviors. R35 was at risk for side effects of the medication and would be monitored for therapeutic effect.

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The 08/30/24 "Quarterly MDS" documented a BIMS score of four, indicating severely impaired cognition. R35 required total assistance with wheelchair mobility, toileting. and footwear. R35 required maximal assistance with transfers and had one non-injury fall. R35 received antipsychotic medication in the lookback period.

The 10/07/24 "Care Plan" documented the following interventions:
07/23/24 - Discuss with family regarding ongoing dosage reduction when clinically appropriate.
10/02/24 - The resident would be administered medication as ordered by doctor.
Monitor/document for side effects and effectiveness every shift. Staff were instructed to monitor behaviors and document observed behavior and attempted interventions. Staff were instructed to guide R35 away from source of distress if R35 became agitated. Engage R35 in conversation, if response is aggression, staff were instructed to calmly walk away and reapproach later.

The "Physician Orders" included a 09/06/24 order for staff to administer Seroquel, 25 milligram (mg) tablet, one tablet by mouth, at bedtime for delusions for R35.

The 09/06/24 at 01:57 PM "Progress Note" included a verbal order received from the physician to decrease the Seroquel dose to once daily at bedtime, for a gradual dose reduction.

The "Progress Notes" lacked evidence the staff notified R35's responsible party was notified of medication change.

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F 580	Continued From page 10 During an interview on 10/07/24 at 11:32 AM, R35's family member revealed the staff did not provide notification of medication change that occurred on 09/06/24. The family member reported the last facility notification received was when R35 fell in August 2024. During an interview on 10/09/24 at 09:30 AM, Licensed Nurse (LN) K reported a progress would be documented in EHR when staff notified the resident or responsible party in a change of orders or conditions. During an interview on 10/09/24 at 09:42 AM, Social Service Designee (SSD) E reported the charge nurse was responsible to notify responsible party on any medication change or change in condition and would document that in a progress note in EHR. During an interview on 10/09/24 at 02:09 PM, Administrative Nurse C confirmed when a change in condition or a change in medication orders occurred, the nurse would notify the resident or responsible party and document it in the resident's chart. The facility lacked a policy regarding notification of change. The facility failed to ensure the resident/resident's representative for R35, the right to be informed when the resident had a new order for an antipsychotic medication dosage change.	F 580		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		

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§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 34 residents which included 12 residents sampled, with three residents reviewed for hospitalization. Based on observation, interview, and record review, the facility failed to provide three residents, Resident (R) 2, R10 and R31 and/or their representative with a written notice of the bed hold policy, at the time of the resident's' transfers to the hospital. This deficient practice placed these residents at risk to not be allowed to return to their former

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rooms at the facility.

Findings include:

- Review of the Electronic Health Record (EHR) for R2 included the pertinent diagnoses of cellulitis (a skin infection caused by bacteria characterized by heat, redness and swelling), pseudomonas (a bacteria that's commonly found in the environment, for example in soil and water and is spread through contaminated surfaces) as the cause of diseases classified elsewhere, urinary tract infection (UTI-an infection in any part of the urinary system) and dementia (a progressive mental disorder characterized by failing memory, confusion).

The "Significant Change Minimum Data Set (MDS)" dated 09/02/24 documented a Brief Interview of Mental Status (BIMS) of 15, which indicated intact cognition. The assessment documented that R2 utilized a motorized wheelchair and mechanical lift and was dependent on staff for all cares except oral care which required partial/moderate assistance and eating, which required supervision and setup.

The 09/12/24 "Care Plan" lacked documentation related to hospitalizations.

The "Progress Notes" documented on 08/25/24 at 10:25 AM, R2 transferred to a hospital via ambulance and returned to the facility on 08/30/24 at approximately 10:50 AM.

The "Progress Notes" documented on 10/06/24 at 06:10 PM, R2 transferred to a hospital via ambulance and remained at the hospital.

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The "Progress Notes" lacked documentation related to resident or resident representative being notified in writing related to the facility's bed hold policy.

On 10/09/24 at 09:30 AM, Licensed Nurse (LN) K stated that when a resident is transferred that the nurses do not complete any bed hold documentation.

On 10/09/24 at 10:11 AM, Administrative Nurse C stated that when a resident is transferred to the hospital, the LN on duty would complete the bed hold documentation and notify the resident's representative which included information related to the bed hold policy. Additionally confirmed the EHR lacked bed hold documentation and stated that Social Services Designee (SSD) E may have the documentation in the SSD office.

On 10/09/24 at 09:42 AM, SSD E stated that the facility would call the resident or resident's representative to confirm whether or not they wanted to hold the resident's bed. Further stated that the LN sent a copy of the bed hold policy at the time of discharge to a hospital. SSD E was unable to produce proof of requested written bed hold communication with resident or resident's representative.

On 10/09/24 at 10:28 AM, SSD E produced requested bed hold documentation and lacked resident or resident representative signature or witness signature of telephone communication or consent. SSD E stated that the bed hold notification was provided to family via telephone

On 10/09/24 at 03:30 PM, Administrative Staff A and SSD E confirmed that the bed hold forms

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were not provided in writing to the resident or resident's representative as required. Administrative Staff A further stated that residents and their representatives are provided with a blank bed hold policy when they are admitted to the facility and not every time when a resident is discharged from the facility to the hospital.

The facility's "Bed Hold Policy" policy, dated 01/01/24 documented that a notice of bed hold policy must be provided to the resident and resident's representative at the time of transfer or therapeutic leave and arrangements must occur within 24 hours of admission to the hospital.

The facility failed to provide a written bed-hold notice to R2 for a hospitalization on 10/06/24. This deficient practice placed R2 at risk to not be allowed to return to their former room at the facility.
- The Electronic Health Records (EHR) documented R31 had the following diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), abnormalities of gait and mobility and muscle weakness.

The 01/21/24 "Annual Minimum Data Set (MDS)" documented a "Brief Interview for Mental Status" (BIMS) score of four, indicating severely impaired cognition, the depression score was two, indicating minimal depression and she had no behaviors. R31 required maximal assistance with activities of daily living (ADLs), with toileting hygiene, transfer, showering, personal hygiene, and upper body dressing.

The 01/29/24 "Functional Abilities Care Area Assessment" (CAA) documented R31 required

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substantial assistance with ADL's related to healing fractures of a shoulder and pelvis and was at risk for decline in ADLs, contractures (abnormal permanent fixation of a joint or muscle) and skin integrity.

The 09/19/24 "Quarterly MDS" documented a BIMS score of four, indicating severely impaired cognition. R31 required maximal assistance with bathing, bed mobility and transfers. She required moderate assistance with toileting, dressing, personal hygiene, and ambulation.

The 01/24/24 "Care Plan" lacked documentation related to hospitalizations.

The "Progress Note" on 01/12/24 at 04:45 PM, documented R31 transferred to hospital.

The "Progress Note" on 01/14/24 at 09:53 AM, documented R31 admitted to hospital for a urinary tract infection.

The "Progress Note" on 01/16/24 at 06:39 PM, documented 31 re-admitted to facility.

The "Progress Notes" lacked documentation related to resident or resident representative being notified in writing related to the facility's bed hold policy.

On 10/09/24 at 09:30 AM, Licensed Nurse (LN) K stated that when a resident was transferred the nurses did not complete any bed hold documentation.

On 10/09/24 at 10:11 AM, Administrative Nurse C stated that when a resident was transferred to the hospital, the LN on duty would complete the bed

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hold documentation and notify the resident's representative, which included information related to the bed hold policy. Additionally confirmed the EHR lacked bed hold documentation and stated that Social Services Designee (SSD) E may have the documentation in the SSD office.

On 10/09/24 at 09:42 AM, SSD E stated that the facility would call the resident or resident's representative to confirm whether or not they wanted to hold the resident's bed. SSD E further stated that the LN sent a copy of the bed hold policy at the time of discharge to a hospital. SSD E was unable to produce proof of requested written bed hold communication with resident or resident's representative.

On 10/09/24 at 10:28 AM, SSD E produced requested bed hold documentation and lacked resident or resident representative signature or witness signature of telephone communication or consent. SSD E stated the facility provided a bed hold to family via telephone.

On 10/09/24 at 03:30 PM, Administrative Staff A and SSD E confirmed that the bed hold forms were not provided in writing to the resident or resident's representative as required. Administrative Staff A further stated that residents and their representatives are provided with a blank bed hold policy when they are admitted to the facility and not every time when a resident is discharged from the facility to the hospital.

The facility's policy "Bed Hold" dated 01/01/24, documented that a notice of bed hold policy must be provided to the resident and resident's representative at the time of transfer or therapeutic leave and arrangements must occur

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within 24 hours of admission to the hospital.

The facility failed to provide a written bed-hold notice to R31 for a hospitalization on 01/12/24. This deficient practice placed R31 at risk to not be allowed to return to their former room at the facility.

- Review of the Electronic Health Record (EHR) revealed R10 had the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), west Nile virus (WNV - a virus that is spread by mosquitos that can cause critical illness that can include encephalitis [inflammatory condition of the brain]), cataract (clouding of the lens of the eye), contracture (abnormal permanent fixation of a joint or muscle) and motor neuron disease (a condition that causes weakness in the muscles, leading eventually to paralysis).
Review of the 6/20/24,"Admission Minimum Data Set (MDS)" revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of 10, which indicated moderately impaired cognition. The resident required maximum assistance with toileting, personal hygiene, rolling side to side, changing positions, transferring, propelling in wheelchair for mobility along with upper body dressing.

A "Progress Note" dated 07/20/23 at 11:08 AM revealed R10 transferred to a hospital via ambulance. The note lacked documentation that the resident/resident representative were given the bed hold notice.

A "Progress Note" dated 07/24/23 at 04:19 PM revealed R10 returned to the facility.

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On 10/09/24 at 09:30 AM, Licensed Nurse (LN) K stated when a resident was transferred the nurses do not complete bed hold documentation.

On 10/09/24 at 10:11 AM, Administrative Nurse C stated that when a resident transferred to the hospital, the LN on duty would complete the bed hold documentation and notify the resident's representative which included information related to the bed hold policy. Additionally, she confirmed the EHR lacked bed hold documentation and stated that Social Services Designee (SSD) E may have the documentation in the SSD office.

On 10/09/24 at 09:42 AM, SSD E stated that the facility would call the resident or resident's representative to confirm whether they wanted to hold the resident's bed. She further stated that the LN sent a copy of the bed hold policy at the time of discharge to a hospital. SSD E was unable to produce proof of requested written bed hold communication with the resident or resident's representative.

On 10/09/24 at 10:28 AM, SSD E produced requested bed hold documentation that lacked resident or resident representative signature or witness signature of telephone communication or consent. SSD E stated that the bed hold notification were provided to family via telephone.

On 10/09/24 at 03:30 PM, Administrative Staff A and SSD E confirmed that the bed hold forms were not provided in writing to the resident or resident's representative as required. Administrative Staff A further stated that residents and their representatives are provided with a blank bed hold policy when they are admitted to

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F 625	Continued From page 19 the facility and not every time when a resident is discharged from the facility to the hospital. The facility's "Bed Hold Policy" policy, dated 01/01/24 documented that a notice of bed hold policy must be provided to the resident and resident's representative at the time of transfer or therapeutic leave and arrangements must occur within 24 hours of admission to the hospital. The facility failed to provide a written bed-hold notice to R10 for a hospitalization on 10/06/24. This deficient practice placed R10 at risk to not be allowed to return to their former room at the facility.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents with 12 residents selected for review. Based on observation, interview, and record review, The facility failed to accurately complete the Minimum Data Set for three residents, Resident (R) 35 related to falls and injections, R31 related to the use of a Foley catheter (tube inserted into the bladder to drain urine into a collection bag) and oxygen, and R 24 related to falls. This placed the residents at risk for uncommunicated care needs. Findings included: - Resident (R)35 's Electronic Health Record (EHR) revealed diagnoses of repeated falls,	F 641		

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dementia (progressive mental disorder characterized by failing memory, confusion), muscle weakness and closed fracture (broken bone without a break in the skin) with routine healing of right femur (thigh bone) and diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The 07/08/24 "Admission Minimum Data Set (MDS)" documented a "Brief Interview for Mental Status" (BIMS) score of four, indicating severely impaired cognition, the depression score was 00, indicating no depression and he had behaviors 1-3 days yelling, cursing and making noises. Impairment of upper extremity. R35 required total assistance with activities of daily living (ADLs), with toileting hygiene, transfer, personal hygiene and wheelchair mobility. Falls with fracture in the past months.

The 07/16/24 "Falls Care Area Assessment" (CAA) documented R35 had a significant history of falls with major injury. R35 is unaware of his safety and can be impulsive. A care plan for R35 will be initiated to address risk of falls and to minimize them.

The 08/30/24 "Quarterly MDS" documented a BIMS score of four, indicating severely impaired cognition. R35 required total assistance with wheelchair mobility, toileting and footwear. Maximal assistance with transfers and one non-injury fall. No skin integrity concerns. Received injections six times in lookback time lacked documentation of the insulin injections.

The 10/07/24 "Care Plan" documented the following interventions:

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07/15/24 - The resident would take diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. 08/19/24 - Staff were instructed to make sure foot pedals are in place if they are attached to wheelchair.

The 10/07/24 "Physician Orders" documented Insulin Lispro (a fast-acting, human-made insulin that helps people with diabetes control their blood sugar levels) 100 units/milliliter(ml) inject subcutaneous(beneath the skin) with meals and a bedtime inject as per sliding scale (a method of treating diabetes that involves administering insulin based on a patient's blood glucose level before meals) if blood sugar (BS)150 - 199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 - 999 = 5 units and call the doctor. Date ordered 07/04/24 for diabetes.

The "Progress Note" on 08/18/24 at 07:30 PM revealed R35 was found lying on the floor on his right side in the commons area. Skin tears were noted on R35's left forearm and left hand, additionally, a skin tear was located on right elbow. R35 had a purple-colored bruise assessed on mid back.

The "Progress Note on 08/29/24 at 12:54 PM revealed R35 skin-tear right elbow from fall R 35 stood self-up from wheelchair, walked a very short distance, lost his balance and fell.

The "Medication Administration Record" documented R35 was administered insulin six times in the lookback period.

On 08/25/24 at 10:19 AM and 06:01 PM.

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F 641	Continued From page 22 On 08/26/24 at 05:23 PM. On 08/27/24 at 11:03 AM. On 08/28/24 at 11:44 AM and 04:46 PM. On 08/29/24 at 02:11 PM. On 08/30/24 at 12:21 PM. On 10/09/24 at 02:09 PM, Administrative Nurse C reported bruises and skin-tears that occurred with a fall would be assessed as a fall with minor injury. She confirmed the MDS was inaccurately coded. Additionally, she confirmed the six days of insulin injections administered were not captured on the MDS. On 10/0924 at 03:30 PM, Administrative Nurse B reported her expectations of completing a MDS would be they are completed accurately. The facility's policy "MDS Assessment Policy" dated 01/01/24, documented all residents will have a comprehensive assessment upon admission, annually, and with significant change in status. Quarterly assessments will be performed according to schedule. Each MDS must accurately depict the resident's current status. The facility failed to accurately complete the MDS for (R)35 related to falls and insulin injections. This placed the resident at risk for uncommunicated care needs. - The Electronic Health Record (EHR) documented R31 had diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion),	F 641		

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abnormalities of gait, and mobility and muscle weakness.

The 01/21/24 "Annual Minimum Data Set (MDS)" documented a "Brief Interview for Mental Status" (BIMS) score of four, indicating severely impaired cognition and the total mood severity score was two, indicating minimal depression, and she had no behaviors. R31 required maximal assistance with activities of daily living (ADLs), with toileting hygiene, transfer, showering, personal hygiene, and upper body dressing. The resident was always incontinent of bladder and she had a Foley catheter (tube inserted into the bladder to drain urine into a collection bag). The resident had no oxygen assessed on MDS.

The 01/29/24 "Functional Abilities Care Area Assessment" (CAA) documented R31 required substantial assistance with ADL's related to healing fractures of a shoulder and pelvis and was at risk for decline in ADLs, contractures (abnormal permanent fixation of a joint or muscle), and skin integrity.

The 01/29/24 "Urinary Incontinence and Indwelling Catheter CAA" documented it triggered secondary to use of Foley catheter. Contributing factors included Vancomycin-Resistant Enterococci (a type of bacteria that is resistant to antibiotics) (VRE) in urine and immobility related to a fractured pelvis. Risk factors included recurrent urinary tract infections and injury from use of catheter.

The 09/19/24 "Quarterly MDS" documented a BIMS score of four, indicating severely impaired cognition. R31 required maximal assistance with bathing, bed mobility, and transfers. She required

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moderate assistance with toileting, dressing, personal hygiene, and ambulation. R31 was frequently incontinent of bowel and bladder.

The 10/07/24 "Care Plan" lacked any documentation related to her use of oxygen and Foley catheter.

The 10/07/24 "Physician Orders" lacked any orders for the use of oxygen and Foley catheter.

The "Progress Note" on 01/16/24 at 06:39 PM, documented the resident had oxygen via nasal cannula (a medical device that provides supplemental oxygen or increased airflow to a patient through the nose). The head of the resident's bed was elevated at 30 degrees. R31 required supplemental oxygen at night from one to two liters via nasal cannula related to R31's oxygen level dropping down to mid to upper 80's (92-100% normal range). The resident's urinary catheter was intact with clear, yellow urine.

The "Progress Note" on 01/18/24 at 01:32 PM revealed the resident had an order for oxygen at one to two liters per nasal cannula to keep oxygen levels above 90%, which was stopped at this time. Staff needed to check oxygen levels periodically but was not in the orders at this time as it came from hospital paperwork. The resident's urinary catheter was intact with clear yellow urine in place.

Review of the resident's "Vital Signs" reviewed:
On 01/18/24 at 08:59 AM the resident's oxygen level measured 98.0% with oxygen via nasal cannula.
On 01/18/24 at 10:33 AM the resident's oxygen level measured 93.0% with oxygen via nasal

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cannula.
On 01/18/24 at 10:43 AM the resident's oxygen level measured 93.0% with oxygen via nasal cannula.
On 01/30/24 at 01:30 PM the resident's oxygen level measured 97.0% with two liter/minute of oxygen via nasal cannula.

On 10/07/24 at 11:00 AM and oxygen concentrator was noted in R31's room, next to bathroom door, with no date on the tubing or humidifier bottle, which was filled halfway with a cloudy liquid. The nasal cannula was wrapped around the concentrator and hanging on the top.

On 10/09/24 at 01:35 PM, Certified Medication Aide (CMA) P reported R31 had not worn oxygen in a long time and stated R31 wore oxygen at night. CMA P confirmed there was a oxygen concentrator and tubing in R31's room.

On 10/09/24 at 02:50 PM, Administrative Nurse C confirmed that Foley catheter and oxygen were not entered correctly on the MDS.

On 10/09/24 at 03:30 PM, Administrative Nurse B reported her expectations of completing a MDS would be they are completed accurately.

The facility's policy "MDS Assessment Policy" dated 01/01/24, documented all residents will have a comprehensive assessment upon admission, annually, and with significant change in status. Quarterly assessments will be performed according to schedule. Each MDS must accurately depict the resident's current status.

The facility failed to accurately complete the MDS

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for R31 related to catheter and oxygen. This placed the resident at risk for uncommunicated care needs.

- Review of the Electronic Health Record (EHR) for Resident (R)24 revealed diagnoses that included diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and unspecified epilepsy (a brain disorder characterized by repeated seizures and glaucoma (abnormal condition of elevated pressure within an eye which can cause loss of vision).

Review of the 05/02/24 "Annual Minimum Data Set (MDS)" revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The resident required supervision/setup assistance with eating and bathing but was otherwise independent with all cares. The resident used a walker. The resident had no falls since the previous assessment.

Review of the "Falls Care Area Assessment (CAA)" dated 05/02/24 revealed R24 utilized a walker for ambulation and had a history of falls with injury prior to admission and several falls without injury since admission.

Review of the "Activities of Daily Living (ADL) Functional / Rehabilitation Potential CAA", dated 05/02/24 revealed R24 utilized a walker.

Review of the 07/18/24 "Quarterly MDS" revealed the resident had a BIMS score of 15, which indicated intact cognition. The resident required supervision/setup assistance with eating and bathing but was otherwise independent with all

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cares. The resident used a walker. The resident had no falls since the previous assessment.

Review of the "Morse Fall Scale" (an assessment tool utilized to determine an individual's risk or likelihood of falls) dated 02/16/24, 05/01/24, 05/05/24 and 07/16/24 revealed the resident had a high risk for falls.

Review of the "Care Plan" provided by the facility on 10/08/24, revealed R24 was at high risk for falls related to a recent fall at home with injury and diagnoses that included epilepsy, weakness, and impaired balance.

The care plan also included the following interventions:
On 09/21/23, staff would ensure a shower chair was on a level surface during showers.
On 09/25/23, staff would reeducate R24 to utilize his walker for ambulation (walking) and not rely on furniture. Staff would remind R24 to use the call light if something needed to be picked up from the floor. Staff would further ensure R24's call light was within reach.
On 01/17/24, R24 had an actual fall without injury and instructed staff to remind R24 to change positions more slowly for safety.

Review of the "Care Plan" provided by the facility on 10/08/24, lacked an intervention related to the resident's fall on 06/21/24.

Review of the 06/21/24 at 07:39 PM "Progress Note" documented staff found R24 on the floor in the pantry area at around 06:00 PM. R24 stated that he was trying to get a soda and fell, denied injury, and declined to allow staff to assess him for injuries. Two staff assisted R24 off of the floor.

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The documentation lacked an intervention to prevent the resident from another fall.

The facility lacked any fall investigation reports for the look-back period of 04/01/24 to 10/08/24 (which included the fall on 06/21/24) as requested on 10/08/24 while the survey team was on-site. The facility provided a fall investigation report on 10/10/24 (after surveyors exited the facility) at 11:45 AM, dated 06/21/24, and documentation determined the root cause of the fall was R24's unwillingness to ask staff for help. The fall investigation report lacked an immediate intervention to mitigate the risk for falls for the remainder of the shift. Additionally, the fall investigation report lacked a signature of the staff member or licensed nurse (LN) who completed the report.

An observation on 10/08/24 at 12:00 PM revealed R 24 ambulating with a walker positioned at an arm's length in front of him with shuffling gait (style or manner of walking), head down, back arched, and arms almost fully extended.

An observation on 10/09/24 at 09:45 AM revealed R24 ambulating with a walker positioned at an arm's length in front of him, shuffling gait, head down, back arched, and arms almost fully extended.

On 10/07/24 at 11:11 AM, R24 stated that he had falls since admission to the facility, but was unable to recall when his last fall was. R24 further stated that his walker had a therapy band tied to his walker to remind him to walk close to the walker when ambulating.

On 10/06/24 at 10:20 AM, Certified Nurse Aide

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(CNA) N stated that if a fall happened or resident was found on the floor, staff would ensure that the resident was safe and alert other staff and the nurse for assistance. Once the nurse arrived, staff would follow the instructions of the nurse.

On 10/09/24 at 10:37 AM, Certified Medication Aide (CMA) M stated that if a fall happened, or if a resident was discovered to have fallen, staff would stay with the resident and make sure they were safe and alert other staff for assistance which included the nurse on duty. The staff would then follow the instructions of the nurse once the nurse arrived.

On 10/08/24 03:25 PM, LN K stated if a resident fell, the LN would assess the resident make sure they were safe, perform an investigation to determine the root cause of the fall, develop an immediate intervention to mitigate the risk of falls for the remainder of the shift and communicate that to all staff, then submit the investigation so Administrative Nurse B or Administrative Nurse C would update the permanent care plan with an appropriate intervention.

On 10/09/24 at 09:44 AM, Administrative Nurse C stated that a fall was defined as an unplanned change in position or plane such as from standing to standing to floor, or bed/chair to floor. Administrative Nurse C confirmed the progress note dated 06/21/24 at 07:39 PM and determined that a fall had occurred. Administrative Nurse C further confirmed the lack of a fall investigation, root cause analysis, immediate intervention, permanent care plan intervention or documentation of the fall on the MDS dated 07/18/24. Administrative Nurse C stated that the LN on duty on 06/21/24 failed to investigate the

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fall to determine a root cause, therefore an immediate intervention and permanent care plan intervention were not possible. Administrative Nurse C stated in the event of a fall, the expectation was for staff to ensure the safety of the resident and alert other staff for assistance, which included the nurse on duty. The LN would then assess the resident for injuries and render aid as appropriate. The staff would then assist the resident as needed off of the floor. The LN was to perform an investigation to determine the root cause of the fall and communicate an immediate intervention to mitigate the risk for further falls to the staff on duty. The LN should submit a fall investigation report that would be reviewed during the next interdisciplinary team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.) meeting on the next business day. Administrative Nurse B or C would update the care plan to reflect an appropriate permanent care plan intervention related to that fall. Administrative Nurse C stated the LN have the ability to update the care plan with permanent interventions, but that they have declined to perform this task.

The facility policy "MDS Assessment Policy" dated 01/01/24 documented that MDS assessments would accurately depict the resident's current status.

The facility failed to accurately capture the fall on 06/21/24. This deficient practice had the potential to create inaccurate or uncommunicated care needs and placed R24 at risk for continued and on-going risk for falls which had the potential to negatively impact R24's physical and psychosocial well-being.

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

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(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 34 residents with 12 residents sampled that included one resident reviewed for baseline care plan. Based on interviews, observations, and record review, the facility failed to develop a person-centered baseline care plan for one resident, Resident (R) 238. This deficient practice had the potential to lead to uncommunicated needs and accidents.

Findings included:

- Review of the Electronic Health Record (EHR) revealed Resident (R)238 had the following diagnoses: extradural and subdural abscess (cavity containing pus and surrounded by inflamed tissue that is inside your skull or near your spine), Methicillin susceptible staphylococcus aureus infection (MRSA - a type of bacteria resistant to many antibiotics), sepsis (a systemic reaction that develops when the chemicals in the immune system release into the blood stream to fight an infections which cause inflammation throughout the entire body instead. Severe cases of sepsis can lead to the medical emergency, septic shock), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), severe protein-calorie malnutrition, acute kidney failure, and management of a vascular device.

Review of the 09/25/24 "Admission Minimum Data Set" revealed the resident had a Brief

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Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident had a total mood score of 7, which indicated mild depression. He had a functional limited range of motion impairment to bilateral (both) upper and lower extremities. R238 utilized a wheelchair for mobility. He was dependent with toileting, personal hygiene, and wheelchair mobility. He required substantial to maximal assistance with lower body dressing, applying footwear and going form laying to sitting position. He required partial to moderate assistance with upper body dressing, rolling from one side to the other in bed and going from a sitting to laying position, moving from a sitting to a standing position and transferring from a chair to a bed. R238 was totally incontinent of bowel and had a catheter. He had a fall within the last month prior to admission, also had a fall in the last two to six months prior to admission and a fall with a fracture in the 6 months prior to admission. The resident received antibiotics during the look back period. Has a surgical wound with dressing changes.

Review of the "Falls Care Area Assessment" dated 10/01/24, revealed R238 had falls prior to admission that resulted in fractures. He was impulsive and had a mild cognitive deficit. He was resistive to care at times.

Review of the 09/21/24 "Baseline Care Plan" revealed R238 had a history of falling. The base line care plan lacked interventions to prevent falls. The "Baseline Care Plan" revealed he was on an intravenous antibiotic, had an indwelling catheter, and had a surgical wound with no enhanced barrier precautions.

Review of the resident's "Care Plan" revealed a

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new focus added on 09/27/24 to address the fall on 09/26/24. R235 had an actual fall with serious injury, poor balance, and unsteady gait. Prior to admission R238 had several falls at home. Staff were to assist the resident in a recliner or a bed when taking him into his room.

Review of the assessments revealed a "Morse Fall Scale" assessment (a fall risk assessment that predicts the likely hood of falls) completed on 09/20/24 and on 10/8/24, and both assessments documented a score of 95, indicating R238 was a high risk for falls.

Review of the assessments tab revealed two "Skin assessments" completed on 09/27/24 indicating a laceration with no location that was 5.8 centimeters (cm) by 1.2 cm that required stitches on 09/26/24 and a 3.9 cm by 3.1 cm abrasion to the left shoulder.

Review of the 09/26/24 at 04:04 PM "Incident Note" revealed R238 fell and was on his right side in front of his wheelchair with Administrative Nurse B applying pressure to the left side of his head. There was blood on the floor, his shirt, and his face. He was alert and talking but did not make sense. The resident reported pain to his head, legs, shoulders, and back. There were three lacerations (wound to the skin) to his left side of his head, above the eyebrow, next to the left eye, and under the left eye. Staff later noticed that his eyeglasses had fallen off him and had a piece of skin attached to them. R238 was not sure how he fell or what caused him to fall. The brakes were locked on the wheelchair and the catheter bag was attached to the wheelchair. Staff had R238 transferred to the Emergency Department at a hospital.

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Review of the 09/26/2024 at 08:01 PM "Health Status Note" revealed R238 received stitches.

Review of the 09/26/2024 at 08:01 PM "Health Status Note" revealed new orders to apply ice as needed and provide wound treatment.

Review of the hospital's "Discharge Instructions" revealed R238 had multiple deep lacerations to the forehead and left cheek area which required glue and stitches. The instructions included warnings for Head Injury Precautions: An observer must check on the patient frequently for 24 hrs. Also watch for signs and symptoms of infection.

Review of physicians orders from 09/20/24 through 10/07/24 revealed, a peripherally inserted central catheter (PICC- is a thin, flexible tube that's inserted into a vein in the upper arm and threaded into a large vein near the heart), PICC line dressing change, intravenous (IV-administered directly into the bloodstream via a vein) access for saline flushes and antibiotics, catheter, and a dressing change of an infected surgical sight that required enhance barrier precautions.

On 10/08/24 at 09:02 AM, R238 stood in front of his reclining chair in his room and attempted to push himself up. PICC line dressing observed. Edges of dressing were peeling up.

On 10/08/24 at 12:52 PM, Certified Nurse Aide (CNA) J reported she was to review the care plan in EHR for all the residents' care needs. She also reported that the nurses were to write on the communication board in the EHR to notify staff of

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change of care for residents.

Interview on 10/09/24 at 10:48 AM, with Certified Medication Aide (CMA) H revealed that if a person was on precautions it was listed in the care plan, there is an IPC symbol in the EMR, personal protective equipment (PPE) is located outside the room, and there is a sign in the bathroom with IPC on it. These precautions are for anyone with wounds, catheter, or any diseases that can be transferred to another person.

Interview on 10/09/24 at 12:45 PM with Administrative Nurse C revealed when a resident entered the facility a base line care plan was completed by the nurse. It was printed and gone over with the family and/or the resident and signed and uploaded to the EHR.

The facility policy "Fall Follow-Up Protocol" dated 01/01/24 documented each resident will be provided services to ensure that the resident's environment remains as free from accident hazards as possible, and each resident receives adequate supervision and assistive devices to prevent accidents. Every resident will be assessed for casual risk factors for falling at the time of admission, and after every fall and develop interventions to prevent further falls. Fall interventions are documented on the care plan.

The facility policy "Care Planning Policy" last reviewed on 01/01/24 documented the Baseline Care Plan will be developed within 48 hours of admission and will include Falls and Safety concerns. A written summary of the Baseline Care Plan will be presented to the resident and/or their representative if desired. Documentation

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F 655	Continued From page 37 that the summary was offered must be made in the chart. The Baseline Care Plan will be started at admission and contains information that staff will utilize to care for the resident. The facility failed to provide an environment that remained free from accident hazards for R238 when the facility failed to complete care plan interventions for history of falls.	F 655		
F 656 SS=D	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 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.	F 656		

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(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 had a census of 34 residents, the sample included 12 residents. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan with interventions to address the enhanced barrier precautions for Resident (R)12's wounds, to ensure infection control precautions, which placed other residents at risk.

Findings included:

- Review of the Electronic Medical Record (EMR) included diagnoses of hypertension (HTN-elevated blood pressure), chronic kidney disease (CKD- a long term condition where the kidneys are damaged and cannot filter the blood properly), restless leg, history of venous thrombosis (clot that developed within a blood vessel) and embolism (an obstruction in a blood

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vessel due to a blood clot or other foreign matter that gets stuck while traveling through the blood stream), and presence of vascular implants.

The 07/23/24 "Admission Minimum Data Set" (MDS), documented a "Brief Interview for Mental Status" (BIMS) score of 14, which indicated intact cognition. R12 used a walker and wheelchair and required supervision or touching assistance with oral hygiene, toileting hygiene, rolling in bed, siting to standing, chair to bed transfers, toilet transfers, tub/shower transfers, and walking. She required partial assistance with showers. R12 was independent with dressing, putting on shoes, personal hygiene, laying down and sitting up and wheelchair mobility. No skin issues were identified on the assessment and the resident required a nonsurgical dressing.

The 08/01/24 "Pressure Ulcer/Injury Care area assessment " (CAA) stated R12 had a potential for skin impairment. She had venous status ulcers to her bilateral (both) lower legs. A care plan would be initiated to address skin impairment of R12's lower legs.

Review of the resident's comprehensive care plan, as provided by the facility on 10/08/24, lacked interventions related to the resident's skin or wounds regarding enhanced barrier precautions (infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact cares). The care plan did not include interventions related to R12's refusal to wear coverings for wounds.

Review of the resident's "Physician Orders" dated 07/18/24 through 10/08/24 revealed R12 had an

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order for Tubigrip (elasticated tubular bandage designed to provide tissue support in treating strains, sprains, soft tissue injuries, general edema and tissue protection). R12 had an order for an additional border gauze to the lower extremities from 07/22/24 through 07/29/24.

Review of the "Medication Administration Record" (MAR) revealed R12 had an order for Tubigrip from 07/18/24 to 09/10/24. Review of the MAR revealed R12 refused the Tubigrip as follows:

Five times in July (07/23/24, 07/24/24, 07/26/24, 07/30/24, 07/31/24).

Nine times in August (08/03/24, 08/07/24, 08/08/24, 08/10/24, 08/24/24, 08/26/24, 08/28/24, 08/29/24, 08/31/24).

Six times in September (09/01/24, 09/03/24, 09/06/24, 09/07/24, 09/09/24 and 09/10/24).

Review of the "MAR" revealed on 07/29/24 the border gauze to both of the resident's legs was discontinued, but a duplicate order for Tubigrip continued until 08/10/24.

Review of the "MAR" revealed the resident refused the duplicate orders for Tubigrip as on 07/29/24, 07/30/24, 08/03/24, 08/07/24, 08/08/24 and 08/10/24.

Review of the "MAR" dated 09/10/24 revealed a revised order for Tubigrip, to include staff would notify the nurse if the resident's condition worsened, which the resident refused as follows:

10 days in September (09/16/24, 09/22/24, 09/23/24, 09/24/24, 09/25/24, 09/26/24, 09/27/24,

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09/28/24, 09/29/24, 09/30/24).

Nine days in October (10/01/24, 10/02/24, 10/03/24, 10/04/24, 10/05/24, 10/06/24, 10/07/24, 10/08/24 and 10/09/24).

Review of the resident's "Skin and Wound Evaluation" on 10/08/24 revealed two venous wounds. The wound on her left lower leg measured 13.2 centimeters (cm) by 7.9 cm and had slough. It had increased drainage, pain, redness, and inflammation. It had moderate, sanguineous/bloody drainage with no odor. The wound to her right lower leg measured 13.5 cm by 6.4 cm. It had increased drainage, redness, and inflammation, with moderate, sanguineous/bloody drainage and no odor.

Review of the "Bath Sheets" from 07/22/24 through 10/06/24 revealed on 08/12/24 a CNA documented open areas to the resident's legs. On 08/19/24, 08/23/24 and 08/26/24 the CNA documented on the bath sheets that R12 had redness to her calves. Bath sheet on 09/12/24 revealed R12 had sores on her calves.

A "Communication with Physician Note" dated 09/10/24 revealed the nurse sent a fax to R12's provider stating the resident's legs were red, hot, swollen, and weeping.

A "Health Status Note" dated 10/09/24 revealed the nurse sent a fax to provider that both lower extremities had open areas with moderate yellow tinged drainage. The area to the right lower leg measured 13.2 cm by 7.9 cm and the area to the left lower leg measures 13.5 cm by 6.4 cm. The resident's right lower leg was dressed with a gauze pad and wrapped in Kerlix. The left lower

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leg had Telfa in place and was wrapped with Kerlix. The nurse documented the resident declined to wear the Tubigrips off and on, per usual, due to pain. The resident agreed to wear the Tubigrip today and she was slightly elevating her legs while she was in her recliner. As needed Tylenol (pain medication) and Tramadol (narcotic pain medication) were administered for pain control. The writer inquired with the provider over which treatment she wanted.

Observation on 10/07/24 at 11:10 AM revealed R12 sat in her recliner with her legs down and she stated she had cellulitis to her legs. Both of her lower legs were swollen with redness noted, had small open areas present, and no dressing or coverings on her legs or feet.

Observation on 10/08/24 at 09:06 AM revealed R12 was assisted to the dining area in her wheelchair by an unidentified staff member. She did not have any footwear on and there were no foot pedals in place on the wheelchair to rest her feet. R12's right leg had dried, bloody drainage noted, which left a streak from the lower leg to the bottom of the foot.

Observation on 10/08/24 at 12:49 PM revealed the resident in her recliner with her legs down and no dressing or coverings in place.

Observation on 10/09/24 at 07:58 AM revealed R12 in the dining room with no socks or feet coverings in place. She had a Kerlix dressing (stretchy gauze bandage) on her right lower leg, covering the open areas.

During an observation on 10/09/24 at 09:00 AM, revealed Licensed Nurse (LN) H performed a

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dressing change to the resident's legs while not wearing a gown. The nurse wore gloves as she removed the soiled dressing. Performed proper hand washing, applied clean gloves and applied a gauze pad (large pad to absorb drainage) and Kerlix to both of her lower legs. The resident's bed was unmade and blood from her legs was present on her sheets.

During an interview on 10/08/24 at 12:25 PM, Certified Nurse Aide (CNA) J reported the only way to understand which residents is on Enhanced Barrier Precautions (EBP), is if there is a bag on the outside of their door that has gowns placed in them. CNA J reported is a resident had a wound, Foley catheter or an infection they will have EBP. CNA J reported she had never observed signage on any resident's door for any type of precautions.

During an interview on 10/09/24 at 08:47 AM, Certified Medication Aide (CMA) H revealed R12 had an order for Tubigrip on her legs, but she refused them until her legs healed.

During an interview on 10/09/24 at 09:30 AM, LN K reported EBP baskets are hung outside the resident's door to let the staff know. She reported that if a resident was on a true precaution, a personal protective equipment (PPE, a term used to describe the clothing, gear, and equipment that protects people from hazards that can cause injury or illness in the workplace or medical setting) bag would be hung on the resident's door and a set up for laundry and trash would be placed in the resident's room. LN K reported she had forgot to place R12's EBP bag outside her room a couple of days ago as the ulcers on her right leg had weeping drainage.

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During an interview on 10/09/24 at 02:09 PM, Administrative Nurse C reported that the EBP basket was hung outside of the resident's door and that is how staff knew if a resident was on EBP. She reported there was no sign placed as that would be a dignity concerns. Administrative Nurse C revealed she was unsure if R12 required EBP as the wounds were chronic and did confirm the wounds did have drainage the past two days. Administrative Nurse C confirmed that R12 having drainage from wounds from legs and being mobile in the hallway and dining room, and not wearing socks, shoes, or dressings was a concern.

During an interview on 10/09/24 at 03:30 PM, Administrative Nurse B reported that R12 may not need EBP as she had chronic wounds which may not require EBP. Administrative Nurse B confirmed R12's wounds on both legs had drainage secreting from the open areas the past two days. Administrative Nurse B said hygiene practices and techniques are critical to prevent the spread of infections.

The facility's policy "Enhanced Barrier Precautions" dated 04/01/24, documented EBP are implemented as one intervention to reduce transmission of resistant organisms that employs targeted PPE use during high contact residents care activities. Chronic wounds may include venous stasis ulcers (open sores can occur when the veins in your legs do not push blood back up to your heart as well as they should). If a wound could serve as a reservoir for multiple drug resistant organism (MDRO-common bacteria that have developed resistance to multiple types of antibiotics) colonization or a portal for infection,

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) 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	F 657		

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by:
The facility reported a census of 34 residents with 12 residents selected for review. Based on observation, interview and record review, the facility failed to review and revise the comprehensive care plan for two residents, Residents (R) 24 and R31 related to falls and accident hazards. These deficient practices had the potential to lead to uncommunicated needs that would negatively affect the physical and psychosocial well-being of the residents.

Findings included:

- Review of the Electronic Health Record (EHR) for Resident (R) 24 revealed diagnoses that included diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and unspecified epilepsy (a brain disorder characterized by repeated seizures and glaucoma (abnormal condition of elevated pressure within an eye which can cause loss of vision).

Review of the 05/02/24 "Annual Minimum Data Set (MDS)" revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The resident required supervision/setup assistance with eating and bathing but was otherwise independent with all cares. The resident used a walker. The resident had no falls since the previous assessment.

Review of the "Falls Care Area Assessment (CAA)" dated 05/02/24 revealed R24 utilized a walker for ambulation and had a history of falls with injury prior to admission and several falls without injury since admission.

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Review of the "Activities of Daily Living (ADL) Functional / Rehabilitation Potential CAA", dated 05/02/24 revealed R24 utilized a walker.

Review of the 07/18/24 "Quarterly MDS" revealed the resident had a BIMS score of 15, which indicated intact cognition. The resident required supervision/setup assistance with eating and bathing but was otherwise independent with all cares. The resident used a walker. The resident had no falls since the previous assessment.

Review of the "Morse Fall Scale" (an assessment tool utilized to determine an individual's risk or likelihood of falls) dated 02/16/24, 05/01/24, 05/05/24 and 07/16/24 revealed the resident had a high risk for falls.

Review of the "Care Plan", provided by the facility on 10/08/24 revealed R24 was at high risk for falls related to a recent fall at home with injury and diagnoses that included epilepsy, weakness and impaired balance.

The care plan also included the following interventions:

On 09/21/23, staff would ensure a shower chair was on a level surface during showers.

On 09/25/23, staff would reeducate R24 to utilize his walker for ambulation (walking) and not rely on furniture. Staff would remind R24 to use the call light if something needed to be picked up from the floor. Staff would further ensure R24's call light was within reach.

On 01/17/24, R24 had an actual fall without injury

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and instructed staff to remind R24 to change positions more slowly for safety.

Review of the 10/08/24 "Care Plan" lacked an intervention related to the resident's fall on 06/21/24.

Review of the 06/21/24 at 07:39 PM "Progress Note" documented staff found R24 on the floor in the pantry area at around 06:00 PM. R24 stated that he was trying to get a soda and fell, denied injury, and declined to allow staff to assess him for injuries. Two staff assisted R24 off of the floor. The documentation lacked an intervention to prevent the resident from another fall.

The facility lacked any fall investigation reports for the look-back period of 04/01/24 to 10/08/24 (which included the fall on 06/21/24) as requested on 10/08/24 while the survey team was on-site. The facility provided a fall investigation report on 10/10/24 (after surveyors exited the facility) at 11:45 AM, dated 06/21/24, and documentation determined the root cause of the fall was R24's unwillingness to ask staff for help. The fall investigation report lacked an immediate intervention to mitigate the risk for falls for the remainder of the shift. Additionally, the fall investigation report lacked a signature of the staff member or licensed nurse (LN) who completed the report.

An observation on 10/08/24 at 12:00 PM revealed R24 ambulating with a walker positioned at an arm's length in front of him with shuffling gait (style or manner of walking), head down, back arched, and arms almost fully extended.

An observation on 10/09/24 at 09:45 AM revealed

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R24 ambulating with a walker positioned at an arm's length in front of him, shuffling gait, head down, back arched, and arms almost fully extended.

On 10/07/24 at 11:11 AM, R24 stated that he had falls since admission to the facility but was unable to recall when his last fall was. R24 further stated that his walker had a therapy band tied to his walker to remind him to walk close to the walker when ambulating.

On 10/06/24 at 10:20 AM, Certified Nurse Aide (CNA) N stated that if a fall happened or resident was found on the floor, staff would ensure that the resident was safe and alert other staff and the nurse for assistance. Once the nurse arrived, staff would follow the instructions of the nurse.

On 10/09/24 at 10:37 AM, Certified Medication Aide (CMA) M stated that if a fall happened, or if a resident was discovered to have fallen, staff would stay with the resident and make sure they were safe and alert other staff for assistance which included the nurse on duty. The staff would then follow the instructions of the nurse once the nurse arrived.

On 10/08/24 03:25 PM, LN K stated if a resident fell, the LN would assess the resident make sure they were safe, perform an investigation to determine the root cause of the fall, develop an immediate intervention to mitigate the risk of falls for the remainder of the shift and communicate that to all staff, then submit the investigation so Administrative Nurse B or Administrative Nurse C would update the permanent care plan with an appropriate intervention.

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On 10/09/24 at 09:44 AM, Administrative Nurse C stated that a fall was defined as an unplanned change in position or plane such as from standing to standing to floor, or bed/chair to floor. Administrative Nurse C confirmed the progress note dated 06/21/24 at 07:39 PM and determined that a fall had occurred. Administrative Nurse C further confirmed the lack of a fall investigation, root cause analysis, immediate intervention, permanent care plan intervention or documentation of the fall on the MDS dated 07/18/24. Administrative Nurse C stated that the LN on duty on 06/21/24 failed to investigate the fall to determine a root cause, therefore an immediate intervention and permanent care plan intervention were not possible. Administrative Nurse C stated in the event of a fall, the expectation was for staff to ensure the safety of the resident and alert other staff for assistance, which included the nurse on duty. The LN would then assess the resident for injuries and render aid as appropriate. The staff would then assist the resident as needed off of the floor. The LN was to perform an investigation to determine the root cause of the fall and communicate an immediate intervention to mitigate the risk for further falls to the staff on duty. The LN should submit a fall investigation report that would be reviewed during the next interdisciplinary team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.) meeting on the next business day. Administrative Nurse B or C would update the care plan to reflect an appropriate permanent care plan intervention related to that fall. Administrative Nurse C stated the LN have the ability to update the care plan with permanent interventions, but that they have declined to perform this task.

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The facility policy "Care Planning Policy" dated 01/01/24 documented that care plans would be updated as needed with interventions that contained changes such as falls.

The facility failed to review and revise the permanent care plan to include any interventions to mitigate the risk for additional falls after the fall on 06/21/24. This deficient practice placed R24 at risk for uncommunicated needs as well as continued and on-going risk for falls which had the potential to negatively impact R24's physical and psychosocial well-being.
- The Electronic Health Records (EHR) documented R31 had the following diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), abnormalities of gait and mobility, and muscle weakness.

The 01/21/24 "Annual Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) score of four, indicating severely impaired cognition. The depression score was two, indicating minimal depression, and she had no behaviors. R31 required maximal assistance with activities of daily living (ADLs), with toileting hygiene, transfer, showering, personal hygiene, and upper body dressing . Falls with fractures.

The 01/29/24 "ADL [Activities of Daily Living] Functional / Rehabilitation Potential Care Area Assessment" (CAA) documented R31 required substantial assistance with ADLs related to healing fractures of a shoulder and pelvis and was at risk for decline in ADLs, contractures (abnormal permanent fixation of a joint or muscle), and skin integrity.

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The 01/29/24 "Falls" CAA triggered secondary to impaired gait and mobility and R31 required assistance for transfers. The contributing factors included history of falls prior to admission, weakness, and physical performance limitations. The risk factors included falls and other major/minor injuries related to falls.

The 09/19/24 "Quarterly" MDS documented a BIMS score of four, indicating severely impaired cognition. R31 required maximal assistance with bathing, bed mobility, and transfers. She required moderate assistance with toileting, dressing, personal hygiene, and ambulation.

The 10/07/24 "Care Plan" lacked any safety interventions to prevent falls until R31 had a fall on 02/17/24. The plan included the following interventions:
02/27/24 (10 days after the fall) Staff instructed to assist applying socks footwear in the morning.
04/10/24, Staff were instructed to monitor and document for risk of falls and educate the resident, family, and caregivers on safety measures that need to be taken to reduce risk for falls. R31 was at high risk for falls and staff instructed to provide call light and encourage the resident to use a call bell. R31 required prompt response to all requests for assistance. Staff instructed to apply appropriate footwear when ambulating or mobilized in wheelchair.

The "Progress Note" on 02/17/24 at 08:20 AM included staff found R31 on the floor, seated upright at the foot of the bed attempting to put on her socks. The staff noted no injuries and two staff assisted R31 off the floor and transferred the resident to a wheelchair.

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On 01/08/24, 01/17/24, 04/09/24, 07/09/24 and 09/16/24, the Morse Fall Scale (assessment of a residents fall risk) all assessments were scored at 55, indicating a high risk for falling.

The facility failed to provide a fall investigation upon inquiry of the fall experienced by R31 On 02/17/24.

On 10/07/24 at 11:00 AM, R31 was in her room watching television her call pendant was on a table behind the resident, out of resident reach and sight. R31 reported she was not sure if she required staff to assist her with ambulation.

On 10/08/24 at 11:55 AM, R31 sat in the dining room with a call pendant (a wearable call light system) around her neck.

On 10/09/24 at 01:33 PM, R31 sat outside in front of a facility building and had her call pendant around her neck. R 31 reported, she loved to sit outside to get fresh air.

On 10/08/24 at 01:10 PM, Certified Nurse Aide (CNA) J reported she reviews the care plan in EHR for all the residents' care needs. She reported that the nurses should write on the communication board in EHR to notify staff of any change of care for residents.

On 10/08/24 at 03:25 PM, License Nurse (LN) K reported if a resident had a fall, the nurse would assess the resident, make sure they were safe, determine a root cause and complete a neurological assessment (is a series of tests and questions that evaluate a person's nervous system) for 72 hours. LN K said if the resident

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had a high enough BIMS and could tell the staff they did not hit their head, then no neurological assessment would be required. LN K said staff should update the family or responsible party, physician, Administrative Nurse B, and Administrative Staff A of a resident fall.

On 10/09/24 at 09:30 AM, LN K reported nurses do not update care plans in the EHR, she reported that an intervention should be immediately completed after an incident and communicated on the communication board in EHR. LN K reported that Administrative Nurse B or Administrative Nurse C should add the intervention to the care plan in the EHR. If neither of them was in the facility, they were to update the care plan the next day. The staff are responsible to read and review the care plan.

On 10/09/24 at 09:44 AM, Administrative Nurse C reported she expected staff to stay with the resident to ensure safety, alert the nurse who would assess and render aid as needed, investigate the root cause, develop an immediate intervention to mitigate risks for the remainder of the shift, then the interdisciplinary team would meet on the next morning or business day to develop a permanent care plan entry.

On 10/09/24 at 01:35 PM, Certified Medication Aide (CMA) P reported R31 liked to sit outside, and staff were responsible to apply her call pendant when R31 was not in her room. CMA P reported that R31 sometimes not call staff and she required staff assistance with transfers and ambulation.

The facility's policy "Care Planning" dated 01/01/24, documented to gather definitive

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F 657	Continued From page 55 information on a resident's strengths and needs, to formulate an individualized care plan. To provide interdisciplinary observation and assessment, ensuring the most accurate assessment and care plan for each resident's functional capacity. Care plans will be updated as needed with interventions pertaining to changes such as falls. The facility failed to revise R31's care plan after a fall in a timely manner, when staff did not add a fall intervention to the care plan until ten days after R31's fall. This placed the resident at risk for uncommunicated care needs and at risk for further falls.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents with 12 residents selected for review. Based on observation, interview, and record review, the facility failed to assess and address skin issues including open areas to her bilateral legs and edema (swelling resulting from an excessive accumulation of fluid in the body tissues) for Resident (R) 12. This deficient practice had the potential to place R12 at an increased risk for	F 684		

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development of additional medical problems.

Findings included:

- Review of the "Electronic Medical Record" (EMR) included diagnoses of hypertension (HTN-elevated blood pressure), chronic kidney disease (CKD- a long term condition where the kidneys are damaged and cannot filter the blood properly, restless leg, history of venous thrombosis (clot that developed within a blood vessel) and embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the blood stream), and presence of vascular implants.

The 07/23/24 "Admission Minimum Data Set" (MDS), documented a "Brief Interview for Mental Status" (BIMS) score of 14, which indicated intact cognition. The resident had a total mood severity score of 0, which indicated no depression. No behaviors were documented. R12 used a walker and wheelchair and required supervision or touching assistance with oral hygiene, toileting hygiene, rolling in bed, siting to standing, chair to bed transfers, toilet transfers, tub/shower transfers, and walking. She required partial assistance with showers. R12 was independent with dressing, putting on shoes, personal hygiene, laying down and sitting up and wheelchair mobility. She was occasionally incontinent of urine. No skin issues were identified on the assessment, the resident required a nonsurgical dressing.

The 08/01/24 "Pressure Ulcer/Injury Care area assessment " (CAA) stated R12 had a potential for skin impairment. She has venous status ulcers to her bilateral lower legs. A care plan

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would be initiated to address skin impairment of lower legs.

Review of the "Baseline Care Plan" dated 07/18/24 revealed R12 had a venous ulcer to her lower extremities, with no interventions noted.

Review of the resident's comprehensive care plan on 10/08/24 lacked any interventions related to the resident's skin or wounds.

Review of the resident's "Physician Orders" dated 07/18/24 through 10/08/24 revealed R12 had an order for Tubigrip (elasticated tubular bandage designed to provide tissue support in treating strains, sprains, soft tissue injuries, general edema and tissue protection). R12 had an order for an additional border gauze to the lower extremities from 07/22/24 through 07/29/24.

Review of the "Medication Administration Record" (MAR) revealed R12 had an order for Tubigrip from 07/18/24 to 09/10/24. Review of the MAR revealed R12 refused the Tubigrip as follows:
Five times in July (07/23/24, 07/24/24, 07/26/24, 07/30/24, 07/31/24).
Nine times in August (08/03/24, 08/07/24, 08/08/24, 08/10/24, 08/24/24, 08/26/24, 08/28/24, 08/29/24, 08/31/24).
Six times in September (09/01/24, 09/03/24, 09/06/24, 09/07/24, 09/09/24 and 09/10/24).

Review of the "MAR" revealed on 07/29/24 the border gauze to both of the resident's legs was discontinued, but a duplicate order for Tubigrip continued until 08/10/24.

Review of the "MAR" revealed the resident refused the duplicate orders for Tubigrip as on

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07/29/24, 07/30/24, 08/03/24, 08/07/24, 08/08/24 and 08/10/24.

Review of the "MAR" dated 09/10/24 revealed a revised order for Tubigrip, to include staff would notify the nurse if the resident's condition worsened, which the resident refused as follows:
10 days in September (09/16/24, 09/22/24, 09/23/24, 09/24/24, 09/25/24, 09/26/24, 09/27/24, 09/28/24, 09/29/24, 09/30/24).
Nine days in October (10/01/24, 10/02/24, 10/03/24, 10/04/24, 10/05/24, 10/06/24, 10/07/24, 10/08/24 and 10/09/24).

Review of the resident's "Skin and Wound Evaluation" on 10/08/24 revealed two venous wounds. The wound on her left lower leg measured 13.2 cm x 7.9 cm and had slough. It had increased drainage, pain, redness, and inflammation. It had moderate, sanguineous/bloody drainage with no odor. The wound to her right lower leg measured 13.5 cm x 6.4 cm. It had increased drainage, redness and inflammation. It had moderate, sanguineous/bloody drainage with no odor.

Review of the "Skin Only Evaluation" dated 08/05/24 revealed the resident's skin was warm and dry, skin color within normal limits and turgor was normal. No new skin concerns were noted. This was the first skin assessment documented in the EHR since readmission on 07/18/24, and lacked additional assessments performed by a licensed nurse.

Review of the "Bath Sheets" from 07/22/24 through 10/06/24 revealed on 08/12/24 a CNA documented open areas to the resident's legs. On 08/19/24, 08/23/24 and 08/26/24 the CNA

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documented on the bath sheets that R12 had redness to her calves. The bath sheets lacked any skin documentation from 08/26/24 through 09/08/24. On 09/08/24, the bath sheet documented the nurse noted skin on lower part of legs. Bath sheet on 09/12/24 revealed R12 had redness under folds of stomach and sores on her calves. No skin documentation was noted on bath sheets from 09/12/24 through 10/06/24. The bath sheet on 10/06/24 revealed a drawing of the legs circled, and the peri area circled with "redness under folds" written and a line drawn to the peri area.

Review of "Nurses Notes" from 08/12/24 through 10/07/24, revealed the facility failed to document or assess the resident's skin concerns identified on the bath sheets.

A "Health Status Note" dated 09/09/24 at 03:14 PM revealed R12 requested treatment for a rash under her abdominal folds. The resident's record lacked follow up notes and/or any orders for treatments provided.

A "Communication with Physician Note" dated 09/10/24 revealed the nurse sent a fax to R12's provider stating the resident's legs were red, hot, swollen, and weeping.

A "Health Status Note" dated 10/09/24 revealed the nurse sent a fax to provider that both lower extremities had open areas with moderate yellow tinged drainage. The area to the right lower leg measured 13.2 cm x 7.9 cm and the area to the left lower leg measures 13.5 cm x 6.4 cm. The resident's right lower leg was dressed with a gauze pad and wrapped in Kerlix. The left lower leg had Telfa in place and was wrapped with

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Kerlix. The nurse documented the resident declined to wear the tubigrips off and on per usual due to pain. The resident agreed to wear the tubigrips today and she has been slightly elevating her legs while she was in her recliner. As needed Tylenol (pain medication) and Tramadol (pain medication) were administered for pain control. The writer inquired with the provider over which treatment she wanted.

Observation on 10/07/24 at 11:10 AM revealed R12 seated in her recliner with her legs down and she stated she had cellulitis to her legs. Both of her lower legs were swollen with redness noted, had small open areas present, and no dressing or coverings on her legs or feet.

Observation on 10/08/24 at 09:06 AM revealed R12 was being assisted to the dining area in her wheelchair by an unidentified staff member. She did not have any footwear on and there were no foot pedals in place on the wheelchair to rest her feet. R12's right leg had dried, bloody drainage noted, which left a streak from the lower leg to the bottom of the foot.

Observation on 10/08/24 at 12:49 PM revealed the resident in her recliner with her legs down and no dressing or coverings in place.

Observation on 10/09/24 at 07:58 AM revealed R12 in the dining room with no socks or feet coverings in place. She had a Kerlix dressing (stretchy gauze bandage) on her right lower leg, covering the open areas.

Observation on 10/09/24 at 09:00 AM, revealed Licensed Nurse (LN) H performed a dressing change to the resident's legs and applied a gauze

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pad (large pad to absorb drainage) and Kerlix to both of her lower legs. The resident's bed was unmade and blood from her legs was present on her sheets.

Interview on 10/09/24 at 08:47 AM, with Certified Medication Aide (CMA) H revealed R12 had an order for tubigrips on her legs, but she refused them until her legs healed.

Interview on 10/09/24 at 08:58 AM, with Licensed Nurse (LN) H revealed that on 10/08/24 she put Telfa (nonstick gauze) on the resident's wounds and wrapped her leg with Kerlix. Today she applied an ABD pad (large pad to absorb drainage) pad and Kerlix until the wound care provider could come in to see her. LN H reported R12 refused her tubigrips. The resident agreed to wear them, but they were not in her room.

Interview on 10/09/24 at 10:46 AM with Certified Nurse Aide (CNA) J revealed if she saw a skin issue or a wound that was draining, she would tell the nurse. The nurse would assess it and dress it.

Interview on 10/09/24 at 12:45 PM with Administrative Nurse C revealed when a skin issue was reported to a nurse it was expected that the nurse completed a root cause analysis and documented it in the progress notes. CNA's could alert the nurse if there was a new skin issue or fill it out on the skin assessment sheet.

Interview with LN H on 10/09/24 at 03:33 PM revealed when a CNA notified a nurse of a skin issue it was the expectation that the nurse took a picture of the issue and documents it in the EHR.

Interview on 10/09/24 at 06:05 PM with

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F 684	Continued From page 62 Administrative Nurse B revealed that it was her expectation that a skin assessment would be completed and documented weekly. The facility policy "Skin Integrity" last reviewed on 01/01/24 documented the charge nurse will complete the skin deviation form. It will then be reviewed by a licensed professional with appropriate documentation, nurse progress note, follow up notification to primary care physician (PCP) and durable power of attorniey (DPOA). Staff would continue observations and treatments as prescribed. When an area is resolved, a nurse progress note will be completed stating the specific area is resolved and the treatment has been discontinued. The facility failed to assess and address skin issues for R12. This deficient practice had the potential to place R12 at an increased risk for development of additional medical problems.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 resident, with 12 sampled, including seven residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to provide an	F 689		

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environment free from accident hazards for five residents. The facility failed to include fall prevention interventions on the care plan for Resident (R)238, who fell and sustained deep lacerations to his face, which required transfer to the ER and sutures/stitches and glue as treatment. The facility further failed to implement new care plan interventions to prevent further falls for R31 and failed to investigate the fall experienced by R24. The facility also failed to ensure staff did not leave R10 unattended in his bathroom, attached to the sit to stand mechanical lift (helps transfer patients from one seated surface to another) and staff also did not provide adequate supervision to R18 when staff left R18 unattended in his room and R18 attempted to self-transfer from his wheelchair. These deficient practices could potentially result in an injury.

Findings included:

- Review of the Electronic Health Record (EHR) revealed Resident (R)238 had the following diagnoses: extradural and subdural abscess (cavity containing pus and surrounded by inflamed tissue that is inside your skull or near your spine), Methicillin susceptible staphylococcus aureus infection (MRSA - a type of bacteria resistant to many antibiotics), sepsis (a systemic reaction that develops when the chemicals in the immune system release into the blood stream to fight an infections which cause inflammation throughout the entire body instead. Severe cases of sepsis can lead to the medical emergency, septic shock), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), severe protein-calorie malnutrition, acute kidney failure, and management of a vascular device.

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Review of the 09/25/24 "Admission Minimum Data Set" revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The resident had a total mood severity score of seven, which indicated mild depression. The MDS documented R238 had functional limited range of motion impairment to bilateral (both) upper and lower extremities. R238 utilized a wheelchair for mobility. He was dependent with toileting, personal hygiene, and wheelchair mobility. He required substantial to maximal assistance with lower body dressing, applying footwear and going form laying to sitting position. He required partial to moderate assistance with upper body dressing, rolling from one side to the other in bed and going from a sitting to laying position, moving from a sitting to a standing position and transferring from a chair to a bed. R238 was totally incontinent of bowel and had a urinary catheter. He had a fall within the last month prior to admission, also had a fall in the last two to six months prior to admission, and a fall with a fracture in the 6 months prior to admission.

Review of the "Falls Care Area Assessment" (CAA) dated 10/01/24, revealed R238 had falls prior to admission that resulted in fractures. He was impulsive and had a mild cognitive deficit and resistive to care at times.

Review of the 09/21/24 "Baseline Care Plan" revealed R238 had a history of falling. The baseline care plan lacked interventions to prevent falls.

Review of the 09/26/24 "Neurological Check List" revealed the facility completed one neuro check.

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Review of the resident's "Care Plan" revealed a new focus added on 09/27/24 to address the fall on 09/26/24. R238 had an actual fall with serious injury, poor balance, and unsteady gait. Prior to admission R238 had several falls at home. Staff were to assist the resident in a recliner or a bed when taking him into his room.

Review of the assessments revealed a "Morse Fall Scale" assessment (a fall risk assessment that predicts the likelihood of falls) completed on 09/20/24 and on 10/08/24, and both assessments documented a score of 95, indicating R238 was a high risk for falls.

Review of the assessments tab revealed two "Skin Assessments" completed on 09/27/24 indicating a laceration with no location documented, that measured 5.8 centimeters (cm) by 1.2 cm and required stitches on 09/26/24, and a 3.9 cm by 3.1 cm abrasion to the left shoulder.

Review of the 09/26/24 at 04:04 PM "Incident Note" revealed R238 fell at 01:50 PM and was on his right side in front of his wheelchair with Administrative Nurse B applying pressure to the left side of his head. There was blood on the floor, his shirt, and his face. He was alert and talking but did not make sense. The resident reported pain to his head, legs, shoulders, and back. There were three lacerations (wound to the skin) to his left side of his head, above the eyebrow, next to the left eye, and under the left eye. Staff later noticed that his eyeglasses had fallen off him and had a piece of skin attached to them. R238 was not sure how he fell or what caused him to fall. The brakes were locked on the wheelchair and the catheter bag was attached to

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the wheelchair. The facility transferred R238 to the Emergency Department at a hospital.

Review of the 09/26/24 at 08:01 PM "Health Status Note" revealed R238 received stitches.

Review of the 09/26/204 at 08:01 PM "Health Status Note" revealed new orders to apply ice as needed and provide wound treatment.

Review of the "Health Status Note" on 09/26/24 at 11:31 AM, revealed that staff checked on R238 every two hours He responded when questioned, refused vital signs and assessment. No further documentation found on checks or assessments.

Review of the "Health Status Note" on 09/27/24 at 6:23 PM, revealed that the nurse spoke to the hospital and they stated R238 had a computed tomography scan (CT scan- test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue and blood vessels) that was "clear". EHR lacked documentation from the hospital that a CT scan was completed or results.

Review of the hospital's "Discharge Instructions" revealed R238 had multiple deep lacerations to the forehead and left cheek area which required glue and stitches. The instructions included warnings for Head Injury Precautions: An observer must check on the patient frequently for 24 hrs. Also watch for signs and symptoms of infection.

On 10/08/24 at 09:02 AM, R238 stood in front of his reclining chair in his room and attempted to push himself up to a standing position.

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During an interview on 10/08/24 at 12:52 PM, Certified Nurse Aide (CNA) J reported she was to review the care plan in EHR for all the residents' care needs. She also reported that the nurses were to write on the communication board in the EHR to notify staff of a change of care for residents.

During an interview on 10/08/24 at 03:25 PM, License Nurse (LN) K reported if a resident had a fall the nurse would assess the resident make sure they are safe, determine a root cause a neurological assessment (is a series of tests and questions that evaluate a person's nervous system) would be completed for 72 hours. If the resident had a high enough BIMS and could tell the staff, they did not hit their head, no neurological assessment was required. LN K reported they would update the family or responsible party, physician, Administrative Nurse B and Administrative Staff A if a resident fell.

During an interview on 10/09/24 at 12:45 PM, Administrative Nurse C revealed when a resident entered the facility the nurse completed a baseline care plan. Administrative Nurse C revealed it was printed and reviewed with the family and/or the resident, signed, and uploaded to the EHR.

The facility policy "Fall Follow-Up Protocol" dated 01/01/24 documented each resident will be provided services to ensure that the resident's environment remains as free from accident hazards as possible, and each resident receives adequate supervision and assistive devices to prevent accidents. Every resident will be assessed for casual risk factors for falling at the time of admission, and after every fall and

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develop interventions to prevent further falls. Fall interventions are documented on the care plan.

The facility policy "Care Planning Policy" last reviewed on 01/01/24 documented the Baseline Care Plan will be developed within 48 hours of admission and will include Falls and Safety concerns. A written summary of the Baseline Care Plan will be presented to the resident and/or their representative if desired. Documentation that the summary was offered must be made in the chart. The Baseline Care Plan will be started at admission and contains information that staff will utilize to care for the resident.

The facility failed to provide an environment that remained free from accident hazards for R238, who had a history of falls, when the facility failed to include fall prevention interventions on the care plan. R238 fell and sustained deep lacerations to his face, which required transfer to the ER and sutures/stitches and glue as treatment.

- The Electronic Health Records (EHR) documented R31 had the following diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), abnormalities of gait and mobility and muscle weakness.

The 01/21/24 "Annual Minimum Data Set (MDS)" documented a "Brief Interview for Mental Status" (BIMS) score of four, indicating severely impaired cognition, the depression score was two, indicating minimal depression and she had no behaviors. R31 required maximal assistance with activities of daily living (ADLs), with toileting hygiene, transfer, showering, personal hygiene

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and upper body dressing.

The 01/29/24 "Functional Abilities Care Area Assessment" (CAA) documented R31 required substantial assistance with ADL's related to healing fractures of a shoulder and pelvis and was at risk for decline in ADLs, contractures (abnormal permanent fixation of a joint or muscle) and skin integrity.
The "Falls" CAA triggered secondary to impaired gait and mobility and R31 required assistance for transfers. Contributing factors included history of falls prior to admission, weakness, and physical performance limitations. Risk factors included falls and other major/minor injuries related to falls.

The 09/19/24 "Quarterly MDS" documented a BIMS score of four, indicating severely impaired cognition. R31 required maximal assistance with bathing, bed mobility and transfers. She required moderate assistance with toileting, dressing, personal hygiene, and ambulation. No falls documented.

The 10/07/24 "Care Plan" Lacked any safety interventions to prevent falls until R31 had a fall on 02/17/24.
Staff instructed to assist applying socks footwear in the morning, date completed 02/27/24, which was ten days after the fall.
Staff were instructed to monitor and document for risk of falls and educate the resident, family, and caregivers on safety measures that need to be taken to reduce risk for falls. R31 was at high risk for falls and staff instructed to provide call light and encourage the resident to use a call bell. R31 required prompt response to all requests for assistance. Staff instructed to apply appropriate

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footwear when ambulating or mobilized in wheelchair, all initiated on 04/10/24.

The Progress note on 02/17/24 at 08:20 AM, staff found R31 on the floor, seated upright at the foot of the bed attempting to put on her socks. No injuries noted, two staff assisted R31 off the floor and transferred the resident to a wheelchair.

On 01/08/24, 01/17/24, 04/09/24, 07/09/24 and 09/16/24, a Morse fall scale (is a rapid and simple method of assessing a patient's likelihood of falling) completed all assessments were scored at 55, indicating a high risk for falling.

The facility failed to provide a fall investigation upon inquiry.

On 10/07/24 at 11:00 AM, R31 was in her room watching television her call pendant was placed on a table that was behind the resident out of reach and sight. Her call bell was located on the other side of her bed not in reach. R31 reported she was not sure if she required staff to assist her with ambulation.

On 10/08/24 at 11:55 AM, R31 seated in dining room with a call pendant (a wearable call light system) around her neck.

On 10/09/24 at 01:33 PM, R31 seated outside in front of a facility building and had her call pendant around her neck. R 31 reported, she loved to sit outside to get fresh air.

On 10/08/24 at 01:10 PM, Certified Nurse Aide (CNA) J reported that she reviews the care plan in EHR for all the residents' care needs. She reported that the nurses should write on the

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communication board in EHR to notify staff of any change of care for residents.

On 10/08/24 at 03:25 PM, License Nurse (LN) K reported if a resident had a fall, the nurse would assess the resident, make sure they were safe, determine a root cause and a neurological assessment (is a series of tests and questions that evaluate a person's nervous system) would be completed for 72 hours. If the resident had a high enough BIMS and could tell the staff they did not hit their head, then no neurological assessment would be required. Staff should update the family or responsible party, physician, Administrative Nurse B and Administrative Staff A.

On 10/09/24 at 09:30 AM, LN K reported nurses do not update care plans in the EHR, she reported that an intervention should be immediately completed after an incident and communicated on the communication board in EHR. LN K reported that Administrative Nurse B or Administrative Nurse C should add the intervention to the care plan in the EHR. If neither of them was in the facility, they were to update the care plan the next day. The staff are responsible to read and review the care plan.

On 10/09/24 at 09:44 AM, Administrative Nurse C reported her expectation for staff was to stay with the resident to ensure safety, alert the nurse who would assess and render aid as needed, investigate the root cause, develop an immediate intervention to mitigate risks for the remainder of the shift, then the interdisciplinary team would meet on the next morning or business day to develop a permanent care plan entry.

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On 10/09/24 at 01:35 PM, Certified Medication Aide (CMA) P reported R31 liked to sit outside, and staff were responsible to apply her call pendant when R31 was not in her room. She reported R31 will sometimes not call staff and she required staff assistance with transfers and ambulation.

The facility policy "Fall Follow-Up Protocol" dated 01/01/24, documented each resident will be provided services to ensure that the resident's environment remains as free from accident hazards as possible, and each resident receives adequate supervision and assistive devices to prevent accidents. Every resident will be assessed for casual risk factors for falling at the time of admission, and after every fall and develop interventions to prevent further falls. Fall interventions are documented on the care plan.

The facility failed to provide an environment that remained free from accident hazards for R31 when the facility failed to place effective interventions in place for this resident with a history of falls.

- Review of the Electronic Health Record (EHR) for Resident (R)24 revealed diagnoses that included diabetes mellitus type 2 (DM2 - when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and unspecified epilepsy (a brain disorder characterized by repeated seizures and glaucoma (abnormal condition of elevated pressure within an eye which can cause loss of vision).

Review of the 05/02/24 "Annual Minimum Data

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Set (MDS)" revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The resident required supervision/setup assistance with eating and bathing but was otherwise independent with all cares. The resident used a walker. The resident had no falls since the previous assessment.

Review of the "Falls Care Area Assessment (CAA)" dated 05/02/24 revealed R24 utilized a walker for ambulation and had a history of falls with injury prior to admission and several falls without injury since admission.

Review of the "Activities of Daily Living (ADL) Functional / Rehabilitation Potential CAA", dated 05/02/24 revealed R24 utilized a walker.

Review of the 07/18/24 "Quarterly MDS" revealed the resident had a BIMS score of 15, which indicated intact cognition. The resident required supervision/setup assistance with eating and bathing but was otherwise independent with all cares. The resident used a walker. The resident had no falls since the previous assessment.

Review of the "Assessments" Morse Fall Scale (an assessment tool utilized to determine an individual's risk or likelihood of falls) dated 02/16/24, 05/01/24, 05/05/24 and 07/16/24 revealed the resident had a high risk for falls.

Review of the 10/08/24 "Care Plan", revealed R24 was at high risk for falls related to a recent fall at home with injury and diagnoses that included epilepsy, weakness and impaired balance. The care plan included the following interventions:

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On 09/21/23, staff would ensure a shower chair was on a level surface during showers.
On 09/25/23, staff would reeducate R24 to utilize his walker for ambulation (walking) and not rely on furniture and remind R24 to use the call light if something needed to be picked up from the floor. Staff would further ensure that R24's call light was within reach.
On 01/17/24, R24 had an actual fall without injury and instructed staff to remind R24 to change positions more slowly for safety.
Review of the 10/08/24 "Care Plan" lacked an intervention related to the fall on 06/21/24.

Review of the 06/21/24 at 07:39 PM "Progress Note" documented staff found R24 on the floor in the pantry area at around 06:00 PM. R24 stated that he was trying to get a soda and fell, denied injury, and declined to allow staff to assess him for injuries. Two staff assisted R24 off the floor. The documentation lacked an intervention to possibly prevent the resident from another fall.

The facility was unable to provide any fall investigation reports for the look-back period of 04/01/24 to 10/08/24 (which included the fall on 06/21/24) as requested on 10/08/24 while the survey team was on-site. However, when surveyors were off-site, the facility provided a fall investigation report on 10/10/24 at 11:45 AM, dated 06/21/24, and documentation determined the root cause of the fall was R24's unwillingness to ask staff for help. The fall investigation report lacked an immediate intervention to mitigate the risk for falls for the remainder of the shift. Additionally, the fall investigation report lacked a signature of the staff member or licensed nurse (LN) who completed the report.

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On 10/08/24 at 12:00 PM, R24 observed ambulating with a walker positioned at an arm's length in front of him with shuffling gait (style or manner of walking), R24's head was down, back was arched with arms almost fully extended.

On 10/09/24 at 09:45 AM, R24 observed ambulating with a walker positioned at an arm's length in front of him and he had a shuffling gait, R24's head was down, back was arched with arms almost fully extended.

On 10/07/24 at 11:11 AM, R24 stated that he had fallen since admission to the facility but was unable to recall when his last fall was. R24 further stated that his walker had a therapy band tied to his walker to remind him to walk close to the walker when ambulating.

On 10/06/24 at 10:20 AM, Certified Nurse Aide (CNA) N stated that if a fall happened or resident was found on the floor, staff would ensure that the resident was safe and alert other staff and the nurse for assistance. Once the nurse arrived, staff would follow the instructions of the nurse.

On 10/09/24 at 10:37 AM, Certified Medication Aide (CMA) M stated that if a fall happened, or if a resident was discovered to have fallen, staff would stay with the resident and make sure they were safe and alert other staff for assistance which included the nurse on duty. The staff would then follow the instructions of the nurse once the nurse arrived.

On 10/08/24 03:25 PM, LN K stated if a resident fell, the LN would assess the resident make sure they are safe, perform an investigation to determine the root cause of the fall, develop an

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immediate intervention to mitigate the risk of falls for the remainder of the shift and communicate that to all staff, then submit the investigation so Administrative Nurse B or Administrative Nurse C would update the permanent care plan with an appropriate intervention.

On 10/09/24 at 09:44 AM, Administrative Nurse C stated that a fall was defined as an unplanned change in position or plane such as from standing to standing to floor, or bed/chair to floor. Administrative Nurse C confirmed the progress note dated 06/21/24 at 07:39 PM and determined that a fall had occurred. Administrative Nurse C further confirmed the lack of a fall investigation, root cause analysis, immediate intervention, permanent care plan intervention or documentation of the fall on the MDS dated 07/18/24. Administrative Nurse C stated that the LN on duty on 06/21/24 failed to investigate the fall to determine a root cause, therefore an immediate intervention and permanent care plan intervention were not possible. Administrative Nurse stated in the event of a fall, the expectation was for staff to ensure the safety of the resident and alert other staff for assistance which included the nurse on duty. The LN would then assess the resident for injuries and render aid as appropriate. The staff would then assist the resident as needed off the floor. The LN was to perform an investigation to determine the root cause of the fall and immediately communicate an immediate intervention to mitigate the risk for further falls to the staff on duty. The LN should submit a fall investigation report that would be reviewed during the next interdisciplinary team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance,

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therapy, etc.) meeting on the next business day. Administrative Nurse B or C would update the care plan to reflect an appropriate permanent care plan intervention related to that fall. Administrative Nurse C stated the LN have the ability to update the care plan with permanent interventions, but that they have declined to perform this task.

The facility policy "Fall Follow-Up Protocol" dated 01/01/24 documented each resident will be provided services to ensure that the resident's environment remains as free from accident hazards as possible, and each resident would receive adequate supervision and assistive devices to prevent accidents. Every resident would be assessed for causal risk factors for falls at admission, and after every fall and develop interventions to prevent further falls. Fall interventions are documented on the care plan.

The facility failed to complete the fall investigation and develop immediate and permanent care plan interventions to mitigate the risk for additional falls after the fall on 06/21/24. This deficient practice placed R24 at continued and on-going risk for falls which had the potential to negatively impact R24's physical and psychosocial well-being.

- Review of The Electronic Medical Records (EMR) for Resident (R)18 included the diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), abnormal posture, cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), cerebrovascular accident (CVA-stroke-

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sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), dysphagia (swallowing difficulty), hemiplegia (paralysis of one side of the body), repeated falls, non-suicidal self-harm (intentional self-inflicted bodily harm without intent to kill themselves), and disorders of bone density and structure (disorders involve a loss of bone mass and changes in the bone's internal structure).

A review of R18's "Annual Minimum Data Set" (MDS) dated 6/20/24, revealed a Brief Interview for Mental Status (BIMS) score of five, indicating severe impairment of cognition. The resident had a total mood severity score of one, indicating minimal depression. The MDS indicated he required total dependence on staff for toileting, dressing, and transfers. The MDS noted he required staff supervision for locomotion and eating his meals. The resident had hallucinations and delusions present, with no other behaviors noted. The resident required antipsychotic, antidepressant, anticoagulant, diuretic, opioid, and antiplatelet medications. The resident was frequently incontinent of bowel/bladder, no falls in since the last assessment documented.

Review of the "Falls Care Area Assessment" dated 06/20/24 revealed R18 had a high risk for falls related to having a history of falls, medications he received, and a history of CVA. R18 needed assistance with transfers due to a history of falls, weakness, and physical performance limitations affecting his balance, gait, strength, and muscle endurance. Risk factors included falls and other major/minor injuries related to falls.

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Review of the 04/05/24, "Quarterly MDS" revealed the resident had a BIMS score of 4, which indicated moderately impaired cognition. The resident had episodes of behaviors that included delusions and hallucinations. The MDS indicated he required maximum assistance for most cares. R18 used a wheelchair and walker for mobility. The resident had a fall in the last 2 to 6 months prior to admission/entry to the facility or reentry or most recent assessment. The resident had one fall identified since the prior assessment without injury.

Review of the "Morse Fall Scale" (an assessment tool utilized to determine an individual's risk or likelihood of falls) dated 01/10/24, 04/09/24, 06/17/24, 08/04/24 and 09/18/24 revealed the resident had a high risk for falls.

Review of the 09/20/24 at 10:30 AM "Nurse Note" revealed the Certified Medication Aide (CMA) arrived at the resident's room at approximately 10:30 AM. Upon entering R18's room the resident was found on the floor in front of the bathroom. The staff charted that R18 was toiled last at 09:30 AM and there was an abrasion noted on the left side of the resident's temple. His doctor was notified and aware that R18 was on prescribed blood thinners.

The resident's record revealed only one fall follow up documented on 09/21/20 at 02:24 directly after his fall.

Review of the 09/19/24, completed "Care Plan" revealed an intervention initiated dated 09/20/24, which stated for staff to please encourage the resident to be in the commons area when in wheelchair. If in his room the resident must be

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transferred to the bed or recliner. Intervention initiated dated 04/28/23, revised dated 10/13/23 stated, when the resident fell asleep in his wheelchair, staff were directed to assist him to the bed or recliner to sleep.

During an interview on 10/09/24 at 10:13 AM, R18 stated he would rather sleep in his recliner than his wheelchair but, would prefer his bed over anything. R18 stated if he really wanted to move to the recliner, he could do it himself.

During an observation on 10/09/24 11:43 AM, R18 uncovered his bed, which was left in a high position. R18 reached for his 3/4 side rail and attempted to transfer himself into his bed.

On 10/09/24 at 10:25 AM, Certified Nurse Aide (CNA) N stated R18 required checks every two hours, and staff toileted him at that time. When R18 fell asleep in his wheelchair he only slept for short periods of time and in small intervals. He did not like to be confined or not able to get up and move when he felt that he wanted to. When he woke up, he was startled and delusional.

On 10/09/24 at 03:30 PM, Licensed Nurse (LN) K stated R18 would be checked every two hours. LN K stated he used to have the tendency to go back to his room to attempt to go to bed, now R18 was not to stay in his room anymore. This change was to allow for staff to have eyes on him continuously. The expectation was that if R18 was sleeping in his wheelchair staff would offer to assist him into a recliner to sleep in the living area where everyone could visually keep an eye on him. Staff could offer to assist him into bed and place his bed in lowest position with his fall mat down so he could rest. Being left to sleep in his

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room while in his wheelchair was not an approved options for the resident.

On 10/09/24 at 01:11 PM, Administrative Nurse C stated R18 was expected to have eyes placed on him every 30 minutes. If R18 was sleeping in his wheelchair, in his room, then the staff were to put him in the recliner in his room and if that was not available the other option was to offer the resident the recliner that was in the day room.

The facility's "Behavior Management for Dementia Care" policy dated 01/01/24 documented the facility would promote person-centered care and consider all the resident's needs, not just medical or physical. The policy further documented the resident had the right to live in a safe, structured, and predictable environment.

The facility failed to provide an environment free of accident hazards when staff left R18 unattended in his wheelchair, in his room after multiple assessments that documented him as a high risk for falls. This deficient practice placed R18 at continued and on-going risk for accident hazards which had the potential to negatively impact R18's physical and psychosocial well-being.

- Review of the Electronic Health Record (EHR) revealed R10 had the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), west Nile virus (WNV - a virus that is spread by mosquitos that can cause critical illness that can include encephalitis [inflammatory condition of the brain]), cataract (clouding of the lens of the eye),

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contracture (abnormal permanent fixation of a joint or muscle), and motor neuron disease (a condition that causes weakness in the muscles, leading eventually to paralysis).

Review of the 06/20/24,"Admission Minimum Data Set (MDS)" revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of 10, which indicated moderately impaired cognition. The resident required maximum assistance with toileting, personal hygiene, rolling side to side, changing positions, transferring, propelling in wheelchair for mobility, and upper body dressing. The assessment documented no falls in the last month prior to admission/entry.

Review of the 03/29/24, "Quarterly MDS" revealed the resident had a BIMS score of 10, which indicated moderately impaired cognition. The resident had episodes of behaviors that included delusions. The resident required maximum assistance for all cares and used a wheelchair for mobility. The assessment documented that R10 had impairment with both the upper and lower extremities. The resident had one fall identified since the prior assessment without injury.

Review of the "Morse Fall Scale" (an assessment tool utilized to determine an individual's risk or likelihood of falls) dated 02/07/23, 05/02/23, 08/02/23, 10/15/23, 01/03/24, 04/05/24, 06/17/24 and 09/18/24 revealed the resident had a high risk for falls.

Review of the "Assessments" lacked a safety assessment for R10 to be safely left unattended while attached to a mechanical lift.

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Review of the 08/31/24, "Care Plan" revealed an intervention dated 01/31/22 and revised 01/17/24, which stated the resident required extensive to total assistance of two staff to move between surfaces. He used the sit-to-stand lift (a mechanical lift that assists persons who are unable to bear weight to maintain a standing position) for all transfers. This intervention documented the resident as being a fall risk related to deconditioning, hearing problems, decreased mobility, and left sided weakness.

On 08/15/23 at 07:24 PM, "Therapy Notes" revealed the resident faced multiple barriers to their treatment including severe skilled caregiver shortage, local deficiency of needed health care workers, and cognitive communication deficit precautions. The goal for the resident was stated as being able to reduce dependency on care staff by knowing foot and hand placement on the mechanical lift by following verbal cues. Caregivers and the resident received training on how to operate equipment safely and appropriately.

During an observation on 10/07/24 at 10:43 AM, Certified Medication Aide (CMA) M and Certified Nurse Aide (CNA) N transferred R10 to the toilet with the use of a sit-to-stand lift. Staff left R10 in the lift sling and attached to the lift. They locked the lift before leaving the resident to check on other residents in the house. At 11:01 AM both staff came back to R10's room and assisted him from the bathroom.

On 10/07/24 at 11:34 AM, R10 stated that he can wait up 30 minutes for staff to be available to transfer him from the toilet due to them getting busy helping others.

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F 689	Continued From page 84 On 10/09/24 at 10:20 AM, Certified Nurse Aide (CNA) N stated when they took R10 to the bathroom, sometimes they left R10 hooked up to the sit-to-stand lift while R10 was on the toilet. (CNA) N stated that was to allow R10 watch TV and allowed CNA N to check on other residents. CNA N stated it was R10's preference and R10 enjoyed watching TV while in the bathroom when having a bowel movement. On 10/09/24 at 03:08 PM Certified Medication Aide (CMA) Q stated residents were never to be left alone in the bathroom while still attached to the sit-to-stand lift, if staff were not within the line-of-sight. If staff needed to leave to answer another call light, staff should remove the sling from the resident and remove the lift unless the resident was care planned that the lift could be locked for them to hold on to for stability. On 10/09/24 at 03:24 PM, Licensed Nurse (LN) K stated residents would be within line-of-sight of a staff member when attached to the sit-to-stand lift and in the bathroom. LN K further stated residents should not be left alone while attached to a mechanical lift. On 10/09/24 at 01:20 PM, Administrative Nurse C stated if a resident was in the bathroom, on the toilet, and attached to the sit-to-stand lift she expected staff locked the lift before leaving the resident alone. Staff were to give the resident their call light if the resident was working with therapy. Staff should know which residents could be left alone due it being documented in the care plan. The facility assumed that everyone could be safely left alone unless it was documented that they should not. Therefore, if a resident was not	F 689		

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safe to be left in the bathroom alone, while attached to the sit-to-stand lift, the facility would have that specifically put on their care plan to let staff know if they could not be safely left alone. The facility's position would be to error on the side that they could safely be left attached to the lift unsupervised rather than the resident was unsafe to be unattended while attached to the lift.

On 10/09/24 at 06:28 PM, Administrative Staff A stated a resident being left attached to a sit-stand lift alone in the bathroom, unsupervised was a safety concern and that was not an acceptable expectation for staff performance. Additionally, Administrative Staff A stated that there was a high potential for danger in this practice, staff were educated multiple times regarding this topic, and all staff should be aware that this was not what was unacceptable practice.

The facility's "Mechanical Lift Transfer" policy dated 01/2024, documented that after positioning resident, staff would lower the lift enough to allow unhooking and removal of sling straps. Staff would then remove the sling straps and back the lift away from resident. The staff would remove sling from resident by reversing installation procedure.

The facility failed to provide an environment free of accident hazards when staff left R10, with multiple assessments that documented a high risk for falls, unattended in the bathroom while attached to a mechanical lift. This deficient practice placed R10 at continued and on-going risk for accident hazards which had the potential to negatively impact R10's physical and psychosocial well-being.

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents with 12 residents selected for review which included five residents reviewed for respiratory care. Based on observation, interview, and record review, the facility failed to properly clean and store the nebulizer (a device for administering inhaled medications) for Resident (R)13 and failed to properly store the oxygen cannula for R31 and R3. These deficient practices placed residents at risk for respiratory complications. Findings included: - The Electronic Health Records (EHR) documented R13 had the following diagnoses that included asthma (a disorder of narrowed airways that caused wheezing and shortness of breath). The 03/28/24 "Admission Minimum Data Set" (MDS)" documented a "Brief Interview for Mental Status" (BIMS) score of 15, which indicated intact cognition. The assessment documented that R13 utilized a wheelchair and was dependent on staff for all cares except eating and oral care which	F 695		

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required supervision and setup.

The 03/28/24 "Care Area Assessment" (CAA) lacked documentation related to nebulizer use.

The 09/13/24 "Quarterly MDS" documented a BIMS score of 15, which indicated intact cognition. The assessment documented that R13 utilized a wheelchair and required partial/maximum assistance with all cares except upper body dressing which required partial assistance and eating/oral hygiene which required supervision and setup.

The "Care Plan" provided by the facility on 10/08/24, documented that R13 had a diagnosis of asthma and provided the following interventions:
On 04/16/24, staff would educate resident to use pursed-lip breathing and encourage fluid intake to help liquefy secretions and avoid iced or carbonated beverages. Additionally, staff would administer medications as ordered and monitor/document side effects and effectiveness. Further, staff would teach and assist R13 with deep breathing exercises and relaxation techniques.
The "care plan" lacked documentation related to care/use of nebulizer or nebulizer equipment.

The "Physician Orders" in the EHR documented the following:

Albuterol Sulfate Inhalation Nebuilzation Solution (Albuterol Sulfate, inhale one vial orally (PO) every four hours as needed (PRN) congestion, dated 08/23/24.
Clean nebulizer pieces by soaking in vinegar/water solution then rinsing off with tap

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water on Mondays, Wednesdays and Fridays, at bedtime every Monday, Wednesday and Friday for nebulizer cleaning, dated 09/18/24.

On 10/07/24 at 01:18 PM, observation of R13's room revealed nebulizer was intact and draped over arm of recliner with nebulizer machine sitting on the arm of R13's recliner.

On 10/08/24 at 07:44 AM, R13 was seated in her wheelchair in her room. Licensed Nurse (LN) K entered the room, took the nebulizer into the bathroom, rinsed with water and administered a nebulizer treatment.

On 10/08/24 at 02:48 PM, observation of R13's room revealed nebulizer was intact and sat on the nebulizer machine that sat on R13's recliner.

On 10/09/24 at 07:18 AM, R13 was resting in bed, watching TV, nebulizer was intact and sat on the nebulizer machine that sat on R13's recliner.

On 10/09/24 at 08:18 AM, LN K identified that the nebulizer sat intact and sat on the nebulizer machine and stated that at the completion of a nebulizer treatment any of the nursing staff (LN, Certified Medication Aide [CMA] or Certified Nurse Aide [CNA]) could discontinue the treatment. Further stated that it was the expectation that the staff member that discontinued the treatment would disassemble the nebulizer and rinse it out with tap water then leave the components on a paper towel to air dry until the next treatment.

On 10/08/24 at 01:10 PM, Administrative Nurse C stated that the expectation was that at the completion of a nebulizer treatment, then LN

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would disassemble the nebulizer and rinse the components with tap water then set on a paper towel to dry until the next treatment. Additionally, stated that nebulizers should be cleaned with a vinegar/water solution every night and then stowed in a manner which prevented contamination of the equipment.

The facility's "Nebulizer Treatment Policy", dated 01/01/24 documented that after each use, staff would rinse the nebulizer cup and mouthpiece/mask with warm water and set the components on a paper towel to air dry.

The facility failed to appropriately clean and store the nebulizer and nebulizer equipment for R13. This deficient practice had the potential to result in respiratory complications.

- The Electronic Health Record (EHR) documented R31 had diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), abnormalities of gait and mobility, and muscle weakness.

The 01/21/24 "Annual Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) score of four, indicating severely impaired cognition, and she had no behaviors. R31 required maximal assistance with activities of daily living (ADL), including toileting, transfers, showering, personal hygiene, and upper body dressing. The resident had no oxygen assessed on the MDS.

The 01/29/24 "ADL [Activities of Daily Living] Functional / Rehabilitation Potential Care Area Assessment" (CAA) documented R31 required

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substantial assistance with ADLs related to healing fractures of a shoulder and pelvis and was at risk for decline in ADLs, contractures (abnormal permanent fixation of a joint or muscle), and skin integrity.

The 09/19/24 "Quarterly" MDS documented a BIMS score of four, indicating severely impaired cognition. R31 required maximal assistance with bathing, bed mobility, and transfers; and required moderate assistance with toileting, dressing, personal hygiene, and ambulation.

The 10/07/24 "Care Plan" lacked any documentation related R31's use of oxygen.

The "Admission Orders" from hospital readmission dated on 01/16/24, documented oxygen at one to two liters per nasal cannula as needed for dyspnea or oxygen sats less than 88 %. Review of the facility physician order did not include the hospital oxygen order.

The "Progress Note" on 01/16/24 at 06:39 PM, documented the resident had oxygen via nasal cannula (a medical device that provides supplemental oxygen or increased airflow to a patient through the nose). The head of the resident's bed was elevated at 30 degrees. R31 required supplemental oxygen at night from one to two liters (per minute) via nasal cannula related to R31's oxygen (saturation) level dropping down to mid to upper 80's (92-100% normal range).

The "Progress Note" on 01/18/24 at 01:32 PM revealed the resident had an order for oxygen at one to two liters per nasal cannula to keep oxygen levels above 90%, which was stopped at this time. Staff needed to check oxygen levels

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periodically but was not in the orders at this time as it came from hospital paperwork.

Review of the resident's "Vital Signs" revealed:
On 01/18/24 at 08:59 AM the resident's oxygen level measured 98.0% with oxygen via nasal cannula.
On 01/18/24 at 10:33 AM the resident's oxygen level measured 93.0% with oxygen via nasal cannula.
On 01/18/24 at 10:43 AM the resident's oxygen level measured 93.0% with oxygen via nasal cannula.
On 01/30/24 at 01:30 PM the resident's oxygen level measured 97.0% with two liters per minute of oxygen via nasal cannula.

On 10/07/24 at 11:00 AM and oxygen concentrator was noted in R31's room, next to bathroom door, with no date on the tubing or humidifier bottle, which was filled halfway with a cloudy liquid. The nasal cannula was wrapped around the concentrator and hanging on the top, exposed to the environment and not in a bag.

On 10/09/24 at 01:35 PM, Certified Medication Aide (CMA) P reported R31 had not worn oxygen in a long time and then stated R31 wore oxygen at night. CMA P confirmed there was an oxygen concentrator and tubing in R31's room.

On 10/08/24 at 01:10 PM, Administrative Nurse C reported that all oxygen tubing (and oxygen/ continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep airway open during sleep) and nebulizer should be changed on the first and 15th of every month and dated. Administrative Nurse C said the Oxygen/CPAP

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and nebulizer tubing should be stowed in a bag or in a manner in which prevents contamination of the device.

The facility's policy "Oxygen Administration" dated 01/01/24, lacked documentation on labeling equipment and proper storage.

The facility failed to ensure a physician order to reflect R31's oxygen use.
- R3's "Electronic Medical Record" (EMR) documented diagnoses of atherosclerotic heart disease (heart disease caused by narrowing of the vessels on the heart), pulmonary hypertension (high blood pressure of the great vessels in the chest), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), obstructive sleep apnea (OSA - a disorder in which the upper airways of the throat become constricted during sleep and can cause periods of apnea [absence of breathing]), and atrial fibrillation (rapid, irregular heartbeat).

The "Annual Minimum Data Set" (MDS) dated 08/15/24 documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The assessment documented that R3 utilized a wheelchair or walker and required maximum/moderate assistance for personal hygiene, toileting, and bathing and received oxygen.

R3's "Activities Care Area Assessment" (CAA) dated 08/15/24 documented R3 received oxygen.

The "Care Plan" provided by the facility on 10/08/24 documented on 10/12/23 that R3 received continuous supplemental oxygen related

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F 695	Continued From page 93	F 695		

to shortness of breath and instructed staff to maintain oxygen via nasal prongs at two liters per minute (LPM) continuously.
The "Physician's Orders" dated 09/28/23 revealed an order for oxygen at 1-2 LPM via nasal cannula (NC) continuously, three times per day for shortness of air/comfort, dated 09/28/23.

The "Physician's Orders" dated 10/30/23 revealed an order to change and date oxygen tubing every other week, in the morning on Monday.

An observation on 10/07/24 at 11:23 AM revealed, R3's oxygen tubing lacked a date and was draped over the oxygen concentrator as the nasal prongs rested on the floor.

An observation on 10/08/24 at 12:57 PM, revealed R3 in the whirlpool with Licensed Nurse (LN) K and Certified Nurse Aide (CNA) N with the resident's oxygen tubing connected to the oxygen concentrator without a date and draped over the oxygen concentrator with the nasal prongs resting on the floor.

On 10/08/24 at 01:10 PM, Administrative Nurse C stated the expectation was that all oxygen tubing should be changed and dated on the first and 15th of every month, and that the tubing should be stowed in a bag or in a manner which prevented contamination.

The facility's "Nebulizer Treatment Policy", dated 01/01/24 documented that after each use, staff would rinse the nebulizer cup and mouthpiece/mask with warm water and set the components on a paper towel to air dry.

The facility failed to appropriately store the

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F 695	Continued From page 94 oxygen tubing for R3. This deficient practice had the potential to result in respiratory complications.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents with 12 residents sampled. Based on observation, interview, and record review, the facility failed to ensure one of the four medication carts observed were locked while unattended. This deficiency had the potential to affect 14 residents located on	F 761		

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F 761	Continued From page 95 the main campus. Findings included: - Observation on 10/07/24 at 11:42 AM, revealed an unlocked medication cart observed unattended in the main common area the main campus. All the medication drawers were easily opened. No staff was seen for approximately two minutes. Certified Medication Aide (CMA) H walked out of an activity room entrance that was next to the location of the medication cart. CMA H reported she just stepped away to obtain ice for the medication cart and stated that she normally locks the medication cart. CMA H confirmed the medication cart should have been locked when unattended and not in her vision. During an interview on 10/07/24 at 11:45 AM, Administrative Staff B confirmed that an unlocked medication cart was a concern . She reported the medication cart should have been locked when unattended by staff. The facility's policy "Medication Labeling and Storage" dated 01/01/24 lacked documentation to lock or secure medication carts. The facility failed to ensure one of the four medication carts observed were locked while unattended. This deficient practice had the potential to have a negative effect on the overall physical and psychosocial well-being of the resident in the facility.	F 761		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink	F 804		

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Each resident receives and the facility provides-

§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 34 residents. Based on observation, interview, and record review, the facility failed to ensure that meals were served at safe and appetizing temperature. Residents (R) 24 and 35 complained of cold food temperatures at meals.

Findings included:

- On 10/07/24 at 11:11 AM, Resident (R) 24 reported that the food was cold at times, when it should be hot. R24 revealed he was the President of the Resident Council and the concern for cold food had been discussed in the meetings over the past several months and it had improved a little.

On 10/08/24 at 09:35 AM, R35 was assisted to the dining room for breakfast by Certified Nurse Aide (CNA) J. Dietary Staff G prepared R35's food from warmer, then covered the dish as CNA J was not ready to assist R35 with his meal. At 09:40 AM, Dietary Staff G uncovered the breakfast plate full of food, opened refrigerator door looked inside of it and closed the door, he then entered the kitchen leaving the food uncovered. At 09:46 AM, Dietary Staff G exited the kitchen with a container of applesauce, he poured some applesauce in R35's divided dish, then picked up the dish to serve to R35. Dietary

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Staff G was asked to obtain a temperature of the pureed sausage gravy and toast. The temperature was 100 degrees Fahrenheit (F). Dietary Staff G stated the pureed food on the steamtable was gone and he delivered the food to R35. Dietary Staff G reported that the food was cooked to 165 degrees F and was unsure what the temperature was to be maintained in the steamer table. He confirmed he left the food uncovered when he went to the kitchen.

On 10/08/24 at 09:48 AM, Dietary Manager D confirmed that the temperature of 100 degrees F was not acceptable, that the food should have been warmed up. She reported the temperature of the food should be maintained at 135 degrees in the steam table and will re-educate staff.

On 10/09/24 at 11:29 AM, Dietary Staff R, placed cooked food items in the food delivery carts for the 400 and 500 building. It was noted Dietary Staff R temped the chicken at 150 degrees F and the hamburger patties and baked potatoes were not temped before being placed in the cart. Both carts left the main kitchen at 11:40 AM

On 10/09/24 at 12:01 PM, the 400 building cart was temped by Dietary Staff L. The hamburger patties were 113 degrees F, and the chicken was 130 degrees F. Dietary staff stated the temperatures were fine and served the food to the residents.

On 10/09/24 at 11:45 AM, Dietary Staff F in building 500, received the food delivered in an insulated container, plates stored right side up. Several bowls of pears with food coloring and multiple plates of unknown cake sat on the counter, all uncovered. Dietary Staff F picked up

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thermometer and that was resting on the non-sanitized counter and placed the thermometer into the gravy, temperature was 142 degrees F. She then temped the potatoes, chicken strips and cauliflower without sanitizing the thermometer between foods. Dietary staff F measured the pears at 62 degrees F. She stated she measured the pears at 11:10 AM at 36 degrees and left all the food uncovered.
When asked by the surveyor at 12:00 PM. Dietary Staff F sanitized thermometer and measured gravy at 122 degrees F, chicken strips at 118 degrees F, potatoes at 160 degrees F, cauliflower at 122 degrees F and chicken was at 140 degrees F.

On 10/09/24 at 12:22 PM, Dietary Staff G delivered the test tray to survey team and temped the foods. Chicken measured at 122 degrees F, cauliflower at 110 degrees F, potatoes at 126 degrees F and pears at 40 degrees.
He reported he did not know what temp the appropriate food temps would be.

On 10/09/24 at 12:30 PM, Administrative Staff A and Dietary Manager D discussed the above information regarding multiple complaints from residents about the palatability of food as it related to temperatures. Confirmed the temperatures were a concern.

The facility's policy "Food Preparation and Handling" dated 01/01/24 documented timely food distribution is essential to ensure food and beverages are served at proper temperatures. All foods will be held at temperatures between 41 degrees F and 135 degrees F, outside the danger zone of temperatures. The temperature of foods will be periodically monitored and documented

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F 804	Continued From page 99 throughout the meal service to ensure proper hot or cold holding temperatures are maintained. The facility failed to ensure that meals were served at a safe and appetizing temperature. Residents complained of cold food temperatures at meals. This deficient practice placed the residents at risk for risks related to impaired nutrition.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to the residents of the	F 812		

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F 812	Continued From page 100	F 812		

facility.

Findings included:

- Observation of the small dining room kitchen and food storage areas on 10/07/24 at 09:10 AM, revealed the following areas of concern:

One sealed bag of French toast, approximately half used, without open date or label.

One carton of opened ice cream, without an open date.

One unsealed bag of English muffins, without an open date.

One sealed bag of bagels, raisin toast, waffles, omelets, and pancakes, without an open date.

One bottle of strawberry syrup dated 08/20/24, with no expiration date noted.

Two open bottles of electrolyte drink for residents, without an open date.

One twelve ounce plastic cup filled with a smoothie, unsealed and without a date or label.

One opened container of half and half cream, without open date.

Observation of facility main kitchen on 10/07/24 at 09:20 AM, revealed the following areas of concern:

One half of pie that was partially uncovered and cookies on a plate in an open storage cart, without open date or label.

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F 812	Continued From page 101 One unsealed 10 pound bag of spaghetti noodles approximately three pounds left, without open date. Two opened sealed bags of noodles, without open date. One opened sealed bag of raspberry gelatin, vanilla wafers, brown sugar, pancake mix, cake mix and dried mash potatoes, all without open date. One opened bag of almonds and raisons, without open date or label. One opened unsealed frozen beef patties, without open date. One opened unsealed bag of tater tots and egg rolls, without open date. Opened sealed chicken tenders, frozen pizzas, and waffles, without open date. One bag of cooked pasta sealed, without open date or label. Three bags of opened cheese, without open date. One bag of lunch meat, without open date. One bag of salami with dried brown, green colored edges, without open date. Two bags of shredded cheese, without open date. Several bags of sealed produce tomatoes, onions and lettuce that was opened, without open date.	F 812		

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F 812	Continued From page 102 On 10/07/24 at 09:35 AM, interview with Dietary Manager D revealed she expected staff to label and date opened food items and confirmed the above concerns identified with kitchen and freezer storage, which included undated and unsealed items and noted that was unacceptable. On 10/08/24 at 08:45 AM thru 09:05 AM, Dietary Staff G lacked proper hand hygiene in the small kitchen while he served breakfast to the residents. Dietary Staff G was observed touching his face, removed soiled breakfast dished from tables, then assisted other resident with pouring coffee, serving their breakfast meal, and taking orders without washing his hands. 09:06 AM, Dietary Staff G performed hand hygiene, then was observed to removed soiled dishes, touched his face, and rubbed his nose, then he picked up a resident's napkin and she wanted it back and he gave it to her. He then retrieved the sealed bag of dish cloths from laundry, opened them up and put them away. No hand hygiene observed. On 10/08/24 at 09:48 AM, Dietary Manager D, confirmed she expected all staff to complete proper hand hygiene and confirmed it was a concern of the lack of hand hygiene that was observed. On 10/09/24 at 11:19 AM, observed the following concerns during kitchen tour. The two ovens contained several areas of bubbled burned food debris on the bottom of the inside. Three large fry pan contained multiple scratches in the cooking surface.	F 812		

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Several cutting boards had multiple scratches and several gouges noted on both sides of the board.

On 10/09/24 at 11:19 AM, Dietary Manager D, confirmed the kitchen equipment was a concern.

The facility's policy "Hand Hygiene" dated 01/01/24, documented consistent use by staff of proper hand hygiene practices and techniques is critical to prevent the spread of infections. Alcohol based hand rubs cannot be used in place of proper hand washing techniques in food service setting.

The facility's policy "Food Preparation and Handling Policy" dated 01/01/24, documented the facility will store, prepare, distribute and serve food in accordance with professional standards for food service safety.
Any food handlers will perform hand hygiene regularly in a designated hand washing sink during shift and in particular; after handling waste food or refuse and between different tasks. A label will be affixed to container of opened food with following information: Name of the food item and date food was placed in container.

The Food-Supply Storage-Food and Nutrition Services Policy dated 07/09/20 revealed food that had been opened or prepared, were to be placed in an enclosed container, dated, labeled, and stored properly.

The facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to the residents of the facility.

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F 880	Continued From page 104	F 880		
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. 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 §483.71 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;	F 880		

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F 880	Continued From page 105 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program related to the maintaining a sterile (free from germs or microorganisms) field with a peripherally inserted central catheter (PICC-a form of access directly into the bloodstream via a vein that can be used for a	F 880		

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prolonged period of time) dressing change for Resident (R) 238 and Dietary Staff G lacked proper hand hygiene during dining room service. Additionally, staff improper hand hygiene with catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) care. The facility failed to set up enhanced barrier precautions (a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs) in nursing homes) (EBP). The facility failed to provide respiratory care consistent with professional standards of care for R13, regarding the use and cleaning of the nebulizer equipment and R3, R4, and R31's oxygen supplies were not stored in a clean manner. This deficient practice had the potential to spread possible infections to the residents in the facility.

Findings included:

- On 10/07/24 at 07:44 AM, observed R13's nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) intact on machine at 07:57 AM, Licensed Nurse (LN) K took nebulizer into the bathroom, rinsed with water, added medication, and initiated breathing treatment.

On 10/08/24 at 02:48 PM, observations of R13's nebulizer revealed an intact nebulizer sitting on the machine on the arm of the chair.

On 10/09/24 at 07:18 AM, R13's intact nebulizer sat on the machine on the arm of the chair.

On 10/09/24 at 08:18 AM, LN K identified the nebulizer sat intact on the nebulizer machine and

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stated that at the completion of a nebulizer treatment any of the nursing staff (LN, Certified Medication Aide [CMA] or Certified Nurse Aide [CNA]) could discontinue the treatment. LN K further stated it was the expectation that the staff member that discontinued the treatment would disassemble the nebulizer and rinse it out with tap water then leave the components on a paper towel to air dry until the next treatment.

On 10/07/24 at 11:00 AM an oxygen concentrator was noted in R31's room, next to bathroom door, with no date on the tubing or humidifier bottle, which was filled halfway with a cloudy liquid. The nasal cannula was wrapped around the concentrator and hanging on the top.

On 10/07/24 at 11:23 AM, R3's oxygen tubing was not labeled with a date and nasal cannula was laying on the floor in her room.

On 10/08/24 at 08:45 AM thru 09:05 AM, Dietary Staff G lacked proper hand hygiene in the small kitchen while he served breakfast to the residents. Dietary Staff G was observed touching his face, removed soiled breakfast dished from tables, then assisted other resident with pouring coffee, serving their breakfast meal, and taking orders without washing his hands. 09:06 AM, Dietary Staff G performed hand hygiene, then was observed to removed soiled dishes, touched his face, and rubbed his nose, then he picked up a resident's napkin and she wanted it back and he gave it to her. He then retrieved the sealed bag of dish cloths from laundry, opened them up and put them away. No hand hygiene observed.

On 10/08/24 at 09:06 AM R12 was assisted to dining area by staff in wheelchair. She was

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barefoot and her right leg had open wounds with drainage dripped down her leg and dried drainage noted on bottom of her right foot.

On 10/08/24 at 09:48 AM, Dietary Manager D, confirmed she expected all staff to complete proper hand hygiene and confirmed it was a concern of the lack of hand hygiene that was observed.

On 10/08/24 at 10:48 AM, Administrative Nurse C confirmed that lack of proper handwashing of the dietary staff is a concern,

On 10/08/24 at 12:25 PM, Certified Nurse Aide (CNA) J reported the only way to understand which residents is on EBP, is if there is a bag on the outside of their door that has gowns placed in them. CNA J reported is a resident had a wound, Foley catheter or an infection they will have EBP. CNA J reported she had never observed signage on any resident's door for any type of precautions.

On 10/08/24 at 01:10 PM, with Administrative Nurse C, observed R4's oxygen tubing noted coiled on top of concentrator, no bag, no date.

On 10/08/24 at 01:10 PM, Administrative Nurse C stated that the expectation was that at the completion of a nebulizer treatment, then LN would disassemble the nebulizer and rinse the components with tap water then set on a paper towel to dry until the next treatment. Additionally, stated that nebulizers should be cleaned with a vinegar/water solution every night and then stowed in a manner which prevented contamination of the equipment. Administrative Nurse C reported that all oxygen tubing (and oxygen/cpap/nebulizer) should be changed on the

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first and 15th of every month and dated. Oxygen/ continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep airway open during sleep)/nebulizer tubing should be stowed in a bag or in a manner in which prevents contamination of the device.

On 10/08/24 at 02:30 PM, Administrative Nurse B, was observed completing the sterile dressing change on
Resident (R) 238's PICC line. Administrative Nurse B placed supplies on a sanitized area, applied facemask, removed old PICC dressing, removed gloves and performed hand hygiene. She opened supplies and set area, applied sterile gloves, during the dressing change, Administrative Nurse B contaminated the sterile field when she touched the outside of the package twice when it packaged folded closed. Administrative Nurse B confirmed she should have not touched the outside of the package with her sterile glove.

On 10/09/24 at 07:30 AM, Certified Medication Aide (CMA) M completed Foley catheter care for R13 no concerns with cleaning of area, CMA M removed her gloves and did not perform hand hygiene when she re-applied gloves to apply clobetasol ointment (is an ointment you can rub on your skin to reduces swelling, redness, itching and rashes) to affected areas on skin.

On 10/09/24 at 08:10 AM, CMA M confirmed that gloves were changed, but no hand hygiene was performed.

On 10/09/24 at 09:30 AM, LN K reported EBP baskets are hung outside the resident's door to

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let the staff know. She reported that if a resident is on a true precaution a personal protective equipment (a term used to describe the clothing, gear, and equipment that protects people from hazards that can cause injury or illness in the workplace or medical setting) (PPE) bag would be hung on the resident's door and a set up for laundry and trash would be placed in the resident's room. LN K reported that she had forgot to place R12's EBP bag outside her room a couple of days ago as the ulcers on her right leg had weeping drainage.

On 10/09/24 at 12:45 PM, Administrative Nurse C revealed once gloves were contaminated and removed, hand hygiene needed to be performed.

On 10/09/24 at 02:09 PM, Administrative Nurse C reported that the EBP basket was hung outside of the resident's door and that is how staff knew if a resident was on EBP. She reported there was no sign placed as that would be a dignity concerns. Administrative Nurse C revealed she was unsure if R12 required EBP as the wounds were chronic and did confirm the wounds did have drainage the past two days. Administrative Nurse C confirmed that R12 having drainage from wounds from legs and being mobile in hallway and dining room not wearing socks, shoes, or dressings was a concern.

On 10/09/24 at 03:30 PM, Administrative Nurse B reported that R12 may not need EBP as she had chronic wounds which may not require EBP. Administrative Nurse B confirmed R12's wounds on both legs had drainage secreting from the open areas the past two days.

The facility's "Nebulizer Treatment Policy" dated

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01/01/24, documented that after each use, staff would rinse the nebulizer cup and mouthpiece/mask with warm water and set the components on a paper towel to air dry.

The facility's policy "PICC/Midline" dated 06/2024, documented dressings will be changed every seven days or when dressing seal is compromised. This is done using sterile technique by a Registered Nurse only.

The facility's policy "Oxygen Administration" dated 01/01/24, lacked documentation on labeling equipment and proper storage.

The facility's policy "Enhanced Barrier Precautions" dated 04/01/24, documented EBP are implemented as one intervention to reduce transmission of resistant organisms that employs targeted PPE use during high contact residents care activities. Chronic wounds may include venous stasis ulcers (open sores can occur when the veins in your legs do not push blood back up to your heart as well as they should). If a wound could serve as a reservoir for multiple drug resistant organism (MDRO-common bacteria that have developed resistance to multiple types of antibiotics) colonization or a portal for infection, then EBP should be followed.

The facility failed to maintain an effective infection control program related to improper cleaning and storage of respiratory equipment, lacked proper hand hygiene during dining room service and after removal of soiled gloves, improper sterile technique during PICC dressing change and lacked placing a resident on EBP with draining wounds to prevent cross contamination in the facility.

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F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: The facility reported a census of 34 residents. Based on interview and record review the facility failed to ensure staff adhered to the principles of antibiotic stewardship through monitoring for the appropriate use of antibiotics prescribed for residents to prevent antibiotic resistance and spread of multidrug resistant organisms within the facility. Findings included: - Interview, on 10/09/24 at 02:09 PM, with Administrative Nurse C, reported she is the Infection Preventionist (a trained healthcare professional who works to prevent the spread of infections in healthcare facilities) (IP) of the facility. Administrative Nurse C revealed she always tracked when an antibiotic started, she reported that the nurses on the units did not always complete an infection screening evaluation or follow McGeer's Criteria (a set of guidelines for identifying infections in long-term care facilities) and that made it difficult to receive all of the resident's information. Administrative Nurse C reported that a resident who received an order for an antibiotic would have finished the	F 881		

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medication before she had time to evaluate the antibiotic, labs, and residents' EHR. She reported there was an Antibiotic Assessment Tool in the EHR she believed she should complete while the resident was on the antibiotic and stated she has not completed that tool. Administrative Nurse C reported she felt there was un-necessary prophylactic (preventative in nature) antibiotics being administered and revealed she had not spoken to the prescribing provider or the medical director for facility.

Interview, on 10/09/24 at 03:03 PM, with Administrative Nurse B, confirmed the lack of completion of the computerized infection monitoring system and lack of antibiotic stewardship for the of the facility.
She confirmed that some residents had prophylactic antibiotics prescribed and stated she did not agree with some of those antibiotics' orders. She confirmed the prescribing provider and medical director have not been updated with concerns.

The facility policy "Infection Control Policy" which included "Antibiotic Stewardship" dated 01/01/24 instructed staff to monitor antibiotic use with support from Medical Director, Pharmacist, and Director of Nursing/designee. Staff were to monitor for infections and provide the necessary instruction to staff for management of residents with infections. All practitioners would be encouraged to follow standard of practice for ordering antibiotic treatment for symptoms including but not limited to McGeer Criteria for urinary tract infections, lower respiratory infections, and skin/wound infections.

The facility failed to provide ongoing antibiotic

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F 881	Continued From page 114 stewardship to ensure appropriate antibiotic use for the residents of the facility to prevent antibiotic resistance and the spread of multi drug resistant organisms.	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	F 883		

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immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 34 residents with 12 residents sampled. Based on interview and record review the facility failed to provide the pneumococcal vaccine (vaccine designed to prevent pneumonia [inflammation of the lungs which can be debilitating or lethal in the elderly]) declination form to four of the five residents reviewed. (Resident (R) 3,11, 17 and 238). Additionally, the facility failed to provide R3 with the influenza vaccine (a vaccine designed to prevent influenza [highly contagious viral infection]) declination form for one of the five residents reviewed.

Findings included:

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- Review of the Electronic Health Record (EHR) of 2023-2024 for R3, R11, R17 and R238 lacked documentation of the pneumococcal vaccine declination form.

Review of the EHR of 2023 - 2024 for R3 lacked documentation of the influenza vaccine declination form.

On 10/09/24 at 02:09 PM, Administrative Nurse C reported that Administrative Nurse B would keep the residents' consents and declination forms as she could not located declination forms for the residents in EHR.

On 10/09/24 at 03:03 PM, Administrative Nurse B reported that R238 requested a pneumococcal vaccine and confirmed that R238 had not had the vaccine administered as of 10/09/24. Additionally, Administrative Nurse B reported that R238 would not receive the pneumococcal vaccine until he had completed therapy due to the cost and how the vaccine can make the residents feel tired, and that would interfere with therapy. Administrative Nurse B confirmed she could not locate the signed consent or declination forms for the pneumococcal vaccine for R3, 11, 17, and 238. She also confirmed she could not locate a declined influenza vaccine form for R3 from 2023-2024 Influenza system, she reported that a verbal declination was acceptable by pharmacy.

The facility's policy "Pneumococcal Vaccine" dated 01/20/24, documented resident or legal representative receives education regarding the benefits and potential side effects of the immunization. The resident's medical record includes documentation that indicated at a minimum the resident or legal representative was

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F 883	Continued From page 117 provided the education and the resident either received or did not receive the pneumococcal vaccine due to medical contradictions or refusal. The facility's policy "Influenza Vaccine" dated 01/01/24, documented resident or legal representative receives education regarding the benefits and potential side effects of the immunization. The resident's medical record includes documentation that indicated at a minimum the resident or legal representative was provided the education and the resident either received or did not receive the influenza vaccine due to medical contradictions or refusal. The facility failed to provide proof of declination of the pneumococcal vaccine for these four residents and proof of declination of the influenza vaccine for one resident.	F 883		