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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 10/30/24.	F 000		
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 by:	F 657		

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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The facility had a census of 23 residents. The sample included 12 residents, with one reviewed for post-traumatic stress disorder (PTSD-psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress, such as natural disaster, military combat, serious automobile accident, airplane crash, or physical torture). Based on observation, record review, and interview the facility failed to revise the care plan for Resident (R) 21, to provide direction to staff to ensure R21 received care to eliminate or mitigate triggers that may cause re-traumatization of the resident. This placed the resident at risk for impaired care due to uncommunicated care needs.

Findings included:

- R21's Electronic Medical Record (EMR) documented diagnoses of PTSD, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a progressive mental disorder characterized by failing memory and confusion), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type 2.

The "Quarterly Minimum Data Set" (MDS), dated 08/08/24, documented R21 had moderately impaired cognition, felt down and depressed for two to six days, exhibited hallucination (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent

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belief or perception held by a person although evidence shows it was untrue), and had other behaviors for four to six days. R21 was independent with eating, mobility, transfers, and ambulation. R21 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and antidepressant (a class of medications used to treat mood disorders) medications on a routine basis.

R21's "Care Plan." dated 08/14/24, directed staff to monitor for behavior or changes in depression or thoughts of suicide using the behavior flow sheet. The care plan documented R21's mood and behaviors, which were monitored on the quarterly and comprehensive MDS and by staff. R21's "Care Plan" directed staff to monitor for reminders of past trauma events that resulted in the resident re-experiencing the initial trauma and reporting to the charge nurse though the care plan lacked documentation of R21's actual triggers and nonpharmocological strategies to manage related behavior.

The "Veteran's Administration Progress Notes," dated 04/25/23, before admission to the facility, documented R21 had flashbacks when he was in the Air Force with triggers of loud noises, crowds, and delusions of jealousy with his wife.

The "PTSD-Trauma Assessment," undated, documented R21 experienced trauma from a car accident, and when he was flying in the Air Force, he fired a gun, and it was a traumatic experience. The assessment noted that R21 stated he had flashbacks of the car wreck.

The "Physician's Order," dated 06/13/24, directed

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staff to administer sertraline (an antidepressant), 100 milligrams (mg), by mouth, daily for depression.

The "Physician's Order," dated 06/13/24, directed staff to administer aripiprazole (an antipsychotic medication), 7.5 mg, by mouth, at bedtime for PTSD.

The "Nurse's Note," dated 06/15/24 at 09:58 PM, documented R21 attempted to call his wife and became upset when he was unable to reach her and made repetitive statements about the "situation tonight." R21 talked about having a ball of anger and becoming enraged.

The "Nurse's Note," doted 06/27/24, at 01:00 PM, documented R21 was upset off and on throughout the day with paranoia (a thought process believed to be heavily influenced by anxiety or fear to the point of irrational thinking). R21 had delusional thoughts and was not easily redirectable.

The "Nurse's Note," dated 07/15/24, at 01:49 PM, documented R21 was exiting various times that day, changing clothes multiple times, putting on his housecoat, and wanting to leave.

The "Nurse's Note," dated 09/27/24 at 03:27 PM, documented R21 had increased wandering and pacing, looked for his wife often, was exit seeking, and set off the door alarms. R21 was redirected with conversation, food, and staff one-to-one.

On 10/23/24 at 02:54 PM, observation revealed R21 ambulated down the hall and into the dining room.

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On 10/24/24 at 07:47 AM, Licensed Nurse (LN) G stated she thought R21 had PTSD but was unsure and did not know what his triggers might be. LN G said she thought maybe things on the television would be his triggers. LN G stated R21 did not receive mental health services as he was hard of hearing and had dementia. LN G stated R21 came from the Veteran's Administration and provided R21's preadmission paperwork to review for documentation of any triggers R21 might have.

On 10/24/24 at 09:30 AM, Certified Nurse Aide (CNA) M stated R21 had behaviors and often looked for his wife. CNA M did not know if R21 had PTSD but stated the staff recently had training regarding PTSD.

On 10/23/24 at 10:13 AM, Social Service X stated she spent a lot of time with R21 as she took him to a weekly appointment in town. Social Service X stated she knew R21 had PTSD but did not know what his triggers were and had talked with the family to try to find out what they were.

On 10/23/24 at 11:15 AM, Administrative Nurse D stated R21 had PTSD and verified there were no triggers on the care plan.

Upon request, a policy for care plan revision was not provided by the facility.

The facility failed to revise R21's care plan with individualized person-centered interventions to provide direction to staff to ensure R21 received care to eliminate or mitigate triggers that may cause re-traumatization of the resident. This placed the resident at risk for impaired care due

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F 657	Continued From page 5 to uncommunicated care needs.	F 657		
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 identified a census of 23 residents. The sample included 12 residents with seven residents reviewed for falls. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 4 remained free from a preventable accident during a sit-to-stand mechanical lift transfer. This deficient practice resulted in a fractured finger and placed R4 at risk for further complications. Findings included: - R4's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of muscle weakness, low back pain, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest),dementia (a progressive mental disorder characterized by failing memory and confusion), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle	F 689	Past noncompliance: no plan of correction required.	

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rigidity, and weakness).

The "Annual Minimum Data Set" (MDS) dated 08/15/24 documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R4 had limited function in bilateral extremities. The MDS documented R4 was dependent on staff assistance for toileting, bathing, lower extremity dressing and transfers. The MDS documented R4 had no falls since the MDS dated 05/22/24.

R4's "Falls Care Area Assessment" (CAA) dated 08/15/24 documented he had a fall that resulted in a fractured finger. R4's fractured finger was noted two days after his fall.

R4's "Care Plan" dated 07/24/22 documented staff would rearrange his current room to be exactly like his previous room to avoid falls and confusion. The plan of care dated 05/22/23 documented staff were educated on bed positioning. R4's plan of care dated 07/24/24 documented staff were educated on sling and lift placement with the sling.

R4's EMR under the "Clinical Documentation" tab recorded a "Note" dated 07/24/24 at 06:30 AM that documented R4 had to be assisted to the floor during a transfer with a sit-to-stand mechanical lift. The sling had become unhooked from the sit-to-stand lift on the right side during the transfer. R4 complained of pain to his ring finger on his right hand. R4 was able to complete active range of motion to the finger on his right hand without difficulty.

A "Note" dated 07/24/24 at 09:30 AM documented

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R4's ring finger on his right hand started to swell and bruise.

A "Note" dated 07/24/24 at 05:49 PM documented R4 continued to complain of pain in his fourth digit on his right hand. That finger had been caught in the sling during the fall from the sit-to stand lift that morning. R4's finger was red and swollen. R4's finger was bruised on the inner part and was bruised and swollen greater than the other finger on his right hand. The licensed nurse decided R4 would need an X-ray to rule out a possible fracture of his finger on the right hand.

A "Note" dated 7/24/24 at 11:44 PM documented R4 continued to complain of pain in his fourth digit on right hand. R4's finger remained bruised.

A "Note" dated 07/25/24 at 10:13 AM documented R4's ring finger on his right hand remained swollen, bruised, and he continued to complain of pain.

A "Note" dated 07/25/24 at 03:50 PM documented R4 returned from an appointment with the physician and was waiting for the results of an X-ray of R4's right hand.

A "Note" dated 07/25/24 at 06:06 PM documented the physician recommended to tape R4's ring finger on his right hand to the next finger to prevent bending his finger till the x-ray results came back. R4 continued to complain of pain in his finger on his right hand.

A "Note" dated 07/26/24 at 10:59 AM documented the physician's office called with x-ray results that revealed a fracture to the fourth digit of his right hand. The physician wanted R4 to return to the

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clinic and be fitted for the correct splint.

An undated and untitled form provided by the facility documented the sling had come loose during a transfer with the sit-to-stand lift for R4 and that resulted in a fall. The form documented the root cause was one of the hooks of the sling gave way and that caused R4 to slide out of sling. The analysis noted that it was apparent that staff did not fully loop the hooks on the sling to the right-side causing the resident to fall.

On 10/24/24 at 08:44 AM R4 sat in his wheelchair on the back patio smoking.

On 10/24/24 at 09:13 AM, Certified Nurse Aide (CNA) M stated she had been trained on how to safely use the mechanical lifts by another CNA. CNA M stated a resident's weight determined the size of sling and placements of the sling loops on the mechanical lifts was determined by the comfort of the resident. CNA M stated the only way she could think the sling would come loose from the lift was if it was not placed on the lift correctly.

On 10/24/24 at 09:35 AM, Licensed Nurse (LN) G stated all mechanical lift transfers are always completed with two staff members. LN G stated the facility provided in-services on lifts. LN G stated the staff train each other on the transfers for each resident. LN G stated the therapy department would determine the placement of sling loops on the mechanical lift.

On 10/24/24 at 10:00 AM, Consultant Staff GG stated she would train the staff on safe transfers when a resident started to use a mechanical lift. Consultant Staff GG stated she believed the sling

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loop had not been placed on the sit-to-stand lift correctly and that is why it had slipped loose during R4's transfer on 07/24/24.

On 10/24/24 at 10:44 AM, Administrative Nurse D stated the nursing staff had received yearly skills fair to go over the mechanical lift transfers. Administrative Nurse D stated the current nursing staff did train the new nursing staff members on the resident's transfers during their training. Administrative Nurse D stated the therapy department did provide education and training on safe transfers with the mechanical lifts.

The facility's "Safe lift, Transfer, and Repositioning Policy" last revised 07/01/24 documented it was the policy of this facility to provide safe, appropriate and timely care to each elder in accordance with the eider's comprehensive care plan. All elders would be assessed by the Interdisciplinary Team (IDT) with regard to the need for assistance with transfer activities, mobility, or repositioning in accordance with the Resident Assessment Instrument (RAI) procedures and requirements. Subject to IDT determinations regarding rehabilitation, restoration, or maintenance of functional abilities, or medical contraindications or emergencies or other exceptional circumstances. Elders identified as totally dependent or extensive assistance would be transferred by means of mechanical lift equipment and/or other assistive devices rather than by manual lift. All mechanical lifting devices always required two-person assistance without exception. The nursing supervisors would ensure that mechanical lifting devices and other equipment/aids are accessible to staff. Nursing and environmental services supervisors would ensure that mechanical lifting devices and other

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F 689	Continued From page 10 equipment/aids are maintained regularly and kept in proper working order. All mechanical lifting devices would be checked on a weekly basis with findings documented on the maintenance log. Nursing supervisors and staff would ensure that mechanical lifting devices and other equipment/aids are stored conveniently and safely. The facility failed to ensure R4 remained free from a preventable accident during a sit-to-stand mechanical lift transfer. This deficient practice resulted in a fractured finger and placed R4 at risk for further complications. The facility completed the following corrections by 07/24/24: The facility updated R4's "Care Plan" on 07/24/24. Physical Therapy (PT) provided staff education for "Safety Steps when using Patient lifts" to CNA staff on 07/24/24. Because the facility implemented and completed the corrections prior to the onsite survey, this deficient practice was cited as past noncompliance at a "G" scope and severity.	F 689		
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;	F 883		

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F 883	Continued From page 11 (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 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	F 883		

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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 identified a census of 23 residents. The sample included 12 residents with five reviewed for immunization status. Based on record reviews, and interviews, the facility failed to offer or obtain informed declinations or a physician-documented contraindication for the Pneumococcal Conjugate Vaccine (PCV20-vaccination for bacterial infections) pneumococcal (type of bacterial infection) vaccination for Resident (R) 6, R8, and R21. This placed the residents at increased risk for complications related to pneumonia.

Findings included:

- Review of R6's clinical record revealed the PCV13 was administered on 01/29/18 and the Pneumococcal Polysaccharide Vaccine (PPSV23) was administered on 02/19/19. R6's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or physician-documented contraindication.

A review of R8's clinical record revealed that the PCV13 was administered on 08/28/15 and the PPSV23 was administered on 08/29/16. R8's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or physician-documented contraindication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 13	F 883		

A review of R21's clinical record revealed the PCV13 was administered on 02/29/15 and the PPSV23 was administered on 01/19/17. R37's clinical record lacked documentation the PCV20 was offered or declined and lacked documentation of a historical administration or physician-documented contraindication.

Upon request for R6, R8, and R21's records of declination or administration of the PCV20 vaccine, the facility was unable to provide consent or declination for these residents. The facility was unable to provide a physician-documented contraindication for all three residents.

On 10/23/24 at 01:20 PM, Administrative Nurse D stated her understanding was the PCV20 was not required if the resident had been administered PCV13 and PPSV23. Administrative Nurse D stated the local physician had not ordered or recommended the PCV20 in the past.

The facility's undated "Influenza, COVID, and Pneumonia Immunization Policy" documented that the Advisory Committee on Immunization Practices recommends vaccinating persons who are at high risk for serious complications from influenza, COVID-19, and/or pneumonia, including those 5O years of age and older, who are residents of nursing homes. Recognizing the major impact and mortality of influenza, COVID-19, and/or pneumonia disease on residents of nursing homes; and the effectiveness of vaccines in reducing healthcare costs and preventing illness, hospitalization, and death, this facility had adopted the following policy statements. The Centers for Disease Control and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175426	A. BUILDING _____ B. WING _____	10/24/2024

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F 883	Continued From page 14 Prevention (CDC) recommended two pneumococcal vaccines for all adults 65 years or older. The facility would administer a dose of PCV13 first, followed by a dose of PPSV23 at least one year later. If any doses of PPSV23 have been administered, a dose of PCV13 would be administered at least one year after the most recent PPSV23 dose. The facility failed to offer and administer PCV20 or obtain informed declinations for R6, R8, and R21 who were eligible to receive the vaccination. This placed R6, R8, and R21 at increased risk for acquiring, transmitting, or experiencing complications from the pneumococcal disease.	F 883		