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	175298	A. BUILDING _____ B. WING _____	01/23/2025

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F 000	INITIAL COMMENTS The following citations represent the findings of a health resurvey and complaint investigation KS00192950, KS00191743, and KS00191800. The 2567 was sent electronically 02/04/2025.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

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

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

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resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 112 residents. The sample included 23 residents with three residents reviewed for dignity. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 32's right to be treated with respect, and dignity when her privacy curtain or door was closed when she was uncovered and exposed from the waist down. This deficient practice placed R32 at risk for negative psychosocial outcomes and decreased dignity.

Findings included:

- R32's Electronic Medical Record (EMR) documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), type 2 diabetes mellitus (a chronic disease that occurs when the body is unable to use insulin properly, resulting in high blood sugar levels), and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid).

R32's "Admission Minimum Data Set (MDS)" dated 02/27/24 documented she had a Brief Interview for Mental Status (BIMS) score of 14

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which indicated an intact cognition. R32 required substantial assistance from staff to roll from left to right. R32 was dependent on staff for toileting hygiene and transfers. R32 had an indwelling catheter and was incontinent of bowel.

R32's "Quarterly MDS" dated 1/13/24 documented she had a BIMS score of nine which indicated moderately impaired cognition. R32 required substantial assistance from staff for bathing, lower body dressing, and rolling from side to side. R32 was dependent on staff for toileting, personal hygiene, putting on footwear, and transfers. R32 had an indwelling catheter and was incontinent of bowel.

R32's "Functional Abilities Care Area Assessment (CAA)" dated 03/05/24 documented she was at risk for alteration in self-care related to an indwelling catheter (a tube placed in the bladder to drain urine into a collection bag), bowel incontinence, and required assistance with activities of daily living (ADL) and was at risk for complications.

R32's "Care Plan" dated 01/20/25 documented staff would anticipate and meet her needs.

On 01/21/25 at 08:06 AM R32 laid on her back on the bed uncovered from the waist down. R32's incontinence brief was pulled to the right side; her groin area was visible from the open doorway. R32's privacy curtain was not pulled to provide privacy.

On 01/23/25 at 10:22 AM, Licensed Nurse (LN) I stated R32 would get hot and liked to only have a sheet on the bed. LN I stated the privacy curtain should be pulled to provide privacy if the door

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F 550	Continued From page 3 was open to the hallway. On 01/23/25 at 11:15 AM, Administrative Nurse D stated she expected staff to provide R32 with privacy to maintain her dignity if she was uncovered from the waist down. The "Resident Rights - Dignity and Respect" policy that was last revised October 2023 documented that residents would be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtains shields the resident from passers-by. The privacy of a resident's body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff assistance was needed for the resident's safety. The facility failed to ensure R32's right to be treated with respect, and dignity when her door was left open to the hallway when she was uncovered and exposed. This deficient practice placed R32 at risk for negative psychosocial outcomes and decreased dignity.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility had a census of 112 residents. The sample included 23 residents with five reviewed for accommodation of needs related assistive	F 558		

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devices. Based on observation, record review, and interview the facility failed to utilize wheelchair foot pedals for Resident (R) 14, R47, and R82. This placed the resident at risk for preventable accidents and injuries.

Findings Included:

- On 01/21/25 at 07:45 AM, R14 (a severely cognitively impaired resident) was wheeled to the small dining room for breakfast. Her wheelchair had no foot pedals and her feet slid on the ground as she was pushed.

On 01/21/25 at 09:20 AM, R14 was pushed by staff from the second-floor small dining room to her room. R14's wheelchair lacked foot pedals as her feet slid on the ground multiple times while being pushed to her room.

On 01/22/25 at 08:09 AM, R82 (a severely cognitively impaired resident) was pushed by staff out of his room and to the main second-floor dining room for breakfast. R82's feet touched the ground multiple times while being pushed while being pushed. Staff verbally reminded him to raise his feet.

On 01/23/25 at 08:10 AM R47 (a severely cognitively impaired resident) was pushed to the small second-floor dining room by staff by Certified Nurses Aide (CNA) N. R47's wheelchair lacked foot pedals and her feet slid on the ground while being pushed.
On 01/23/25 at 08:21 AM R14 was pushed to the dining room by CNA N. R14 feet slid on the floor as she was pushed.

On 01/23/25 at 09:30 AM, R47 was wheeled back

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F 558	Continued From page 5 to her room by CNA N. R47 struggled to keep her feet raised and slid on the floor several times en route to her room. On 01/23/25 at 10:03 AM, CNA N stated most of the residents wheel themselves around the unit and don't have foot pedals installed on the chairs. She stated the resident's feet should not slide or touch the ground while being pushed. On 01/23/24 at 11:10 AM, Administrative Nurse D stated staff should always use foot pedals for physically and cognitively impaired residents to prevent falls. She stated the resident's feet should never slide or touch the ground while being pushed. The facility's "Accommodation of Needs Policy" revised 08/2024 indicated the facility would assure each resident's assistive devices were implemented and used safely to prevent accident or injury. The policy indicated the facility will provide reasonable accommodations based on each resident's individualized needs and preferences. The facility failed to utilize wheelchair foot pedals for R14, R47, and R82. This placed the resident at risk for preventable accidents and injuries.	F 558		
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	F 580		

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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 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

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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 identified a census of 112 residents. The sample included 23 residents with one reviewed for notification of changes. Based on observation, record review, and interviews, the facility failed to notify Resident (R) 13's physician with refused daily weights. This deficient practice placed R13 at risk for unmet needs.

Findings included:

- R13's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hypertension (high blood pressure), rheumatoid arthritis (chronic inflammatory disease that affects joints and other organ systems), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), obesity (excessive body fat), absence of right leg below the knee, wheelchair weakness, sleep apnea (a disorder of sleep characterized by periods without respirations), congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), need for assistance with personal care, and contracture (abnormal permanent fixation of a joint or muscle) of right hand.

The "Quarterly Minimum Data Set (MDS)" dated 11/02/24, documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R13 had an impairment on one side of his body. The MDS documented R13 needed partial to moderate

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assistance with toileting and substantial to moderate assistance with bathing and was independent with eating and oral hygiene.

R13's " Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA)" dated 01/31/24 documented R13 had alteration in self-care related to bowel and bladder incontinence and required assistance with activities of daily living (ADLs) and was at risk for complications due to decreased functional mobility, COPD, CHF, DM, obesity, and lower leg amputation.

R13's "Care Plan" dated 01/25/23 was at potential nutrition and hydration risk related to diagnosis of obesity, on diuretic (a pill to increase urine) therapy, R14 was overweight, and on a therapeutic diet about diabetes mellitus. Staff were to assist with developing a support system to aid in weight loss efforts, and staff were to follow diet as ordered by the physician.

R13's EMR under "Orders" documented the following physician's order:
Daily weight every day shift dated 08/01/24.
Torsemide (medication to remove fluid) oral tablet 20 milligrams (mg) give three tablets by mouth two times a day for edema dated 08/01/24.

R13's EMR under "Nursing Progress Notes" documented R13 refuses weights.

R13's medical record lacked documentation the physician was informed of the refused weights.

On 01/21/24 at 08:32 AM, R13 sat in the dining area in his wheelchair, awaiting his breakfast.

On 01/23/24 at 09:33 AM, Licensed Nurse (LN) G

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F 580	Continued From page 9 stated she left at two PM; she stated it would be the evening nurse's responsibility to call the physician if the weight was not received by the nurse prior to six PM. LN G stated the facility did not call the physician on a regular basis for missed weights. On 01/23/24 at 11:23 AM, Administrative Nurse D stated any resident that had refused services, would be discussed in the nurse's morning meeting. Administrative Nurse D stated the facility would not call the doctor if the resident habitually refused weights. The facility did not provide a policy for notification to the physician. Based on observation, record review, and interviews, the facility failed to notify R13's physician with refused daily weights. This deficient practice placed R13 at risk for unmet needs.	F 580		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		

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new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 112 residents. The sample included 23 residents with four residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure pressure reducing heel supportive device was in place for Resident (R) 51 who had a pressure-related injury on his right buttocks. This deficient practice placed R51 at risk for complications related to further skin breakdown.

Findings included:

- R51's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of foot drop in right foot (inability or difficulty in moving the ankle and toes upward), pressure ulcer of right buttocks, need for assistance with personal care, muscle weakness, weakness, reduced mobility, contractures (abnormal permanent fixation of a joint or muscle) of the right shoulder, left shoulder, right knee, left knee, right ankle, and left ankle.

The "Annual Minimum Data Set" (MDS) dated 04/28/24 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R51 was at risk of development of pressure ulcers and had one unhealed pressure ulcer during the observation period. The MDS documented R51 had no limitation in range of motion (ROM - the full movement potential of a joint, usually its range of

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flexion and extension).

The "Quarterly MDS" dated 10/29/24 documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R51 was at risk of development of pressure ulcers and had one unhealed pressure ulcer during the observation period. The MDS documented R51 had limited ROM on both sides of his upper and lower extremities.

R51's "Pressure Ulcer Care Area Assessment" (CAA) dated 05/10/24 documented he was at risk for skin breakdown or pressure ulcer related to incontinence, decreased functional mobility, and he required assistance with activities of daily living (ADLs).

R51's "Care Plan" dated 09/01/21 documented staff would elevate his heels on a supportive device when in bed.

On 01/22/25 at 01:33 PM, R51 laid on the bed with his bilateral heel resting directly on the bed. R51 upper body was leaned toward his left side next to the left upper side rail. R51's head of the bed was slightly elevated with the side rails pulled up on both sides of the bed.

On 01/23/25 at 08:20 AM, R51 laid on his bed with his bilateral heel rested directly on the mattress.

On 01/23/25 at 10:22 AM, Licensed Nurse (LN) I stated R51's heels should be floated when in bed. LN I stated everyone was responsible to ensure the residents at risk for skin breakdown had their pressure-relieving devices were in place.

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F 686	Continued From page 12 On 01/23/25 at 11:15 AM, Administrative Nurse D stated she would expect the charge nurse to ensure any pressure relieving measures were in place for the residents who were at risk for the development of skin breakdown. The facility's "Pressure Ulcer Skin Monitoring and Management" policy dated 10/2023 documented It was the policy of this facility that when a resident entered the facility without pressure ulcers, they do not develop a pressure ulcer unless the individual's clinical condition or other factors demonstrate that a developed pressure ulcer was unavoidable. A resident having a pressure ulcer received the necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable sores from developing. The facility failed to ensure pressure reducing heel supportive device was in place for R51 who had a pressure injury on his right buttocks. This deficient practice placed R51 at risk for complications related to skin breakdown and the development of pressure ulcers.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688		

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services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:
The facility identified a census of 112 residents. The sample included 23 residents with five residents reviewed for positioning and mobility. Based on observation, record review, and interviews, the facility failed to ensure Resident (R)26's orthotic (support or brace for limbs) was in place. This deficient practice placed the resident at risk for discomfort and decreased range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension).

Findings Included:

- R26's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), hypertension (high blood pressure), colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body), hyperlipidemia (condition of elevated blood lipid levels), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), intellectual disabilities, muscle weakness, need for assistance with personal care, mood disorder (category of mental health problems, feelings of

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sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time), communication deficit, contracture (abnormal permanent fixation of a joint or muscle) of left hand, right ankle, and left ankle.

The "Quarterly Minimum Data Set" (MDS) dated 01/08/24 documented a Brief Interview of Mental Status (BIMS) score of two which indicated severely impaired cognition. The MDS documented R26 a mental status should be conducted. The MDS documented R26 had an impairment on both sides of his body. The MDS documented R26 was dependent on staff for oral hygiene, toileting, dressing, and showers. The MDS documented R26 did not receive occupational, restorative, or physical therapies during the observation period.

R26's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 10/08/24 documented R26 had an alteration in cognition and was at risk for complications as evidenced by cognitive communication deficit, intellectual disability, and cerebral palsy.

R26's "Communication" CAA dated 10/08/24 documented R26 was at risk for alteration in communication related to impaired ability to make self-understood, impaired ability to understand others, and was at risk for complications as evidenced by intellectual disability, cerebral palsy, and cognitive communication deficit.

R26's "Care Plan" dated 10/17/22 documented R26 had an alteration in musculoskeletal (having to do with muscles, bones, and tendons) status related to contractures of the left elbow and left

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wrist and was at risk for complications. Staff was to encourage the use of his supportive devices, and R26 was to wear a left elbow extension splint and left hand medical device that immobilizes R26's hand, worn as tolerated.

On 01/21/24 at 09:22 AM, R26 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in the dining room, eating his breakfast. R26's left hand was curled at the wrist, upwards toward his chest.

On 01/22/24 at 8:22 AM, R26 sat in the dining room waiting for his breakfast, R26's left wrist was curled upwards toward his chest.

On 01/23/24 at 08:09 AM Certified Nursing Aide (CNA) M stated CNAs do not apply splints, she stated therapy applies splints and then nursing takes the splint off. CNA M stated she had not seen a splint for R26 for a few months.

On 01/23/24 at 09:33 AM Licensed Nurse (LN)G stated therapy would put on splints and ask nursing to take the splint off. LN G stated she was aware R26's care plan stated he should wear a splint as tolerated. She stated therapy had not been putting the splint on at this time, she was unsure why the splint was not being applied.

01/23/24 at 09:40 AM Consult Therapist GG stated if a splint was to be worn the splint would be monitored by occupational therapy. She stated at this time the splint was not being applied.

On 01/23/24 at AM, Administrative Nurse D stated the facility had a restorative aide, who applied splints, and did ROM. She stated the restorative aide was on maternity leave at this

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F 688	Continued From page 16 time, and the facility had not replaced her. Administrative Nurse D stated the facility was working on a plan to put the restorative program back in place. She stated nursing and therapy would be working together to ensure all therapies were initiated. The facility did not provide a policy for positioning or ROM. The facility failed to ensure R26's orthotic was in place. This deficient practice placed the resident at risk for discomfort and decreased range of motion.	F 688		
F 689 SS=E	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 had a census of 112 residents. The sample included 23 residents with five residents reviewed for accidents and/or hazards. Based on observation, record review, and interview the facility failed to secure areas containing hazardous materials out of reach of seven cognitively impaired /independently mobile residents in the secured unit. This deficient practice placed the affected residents at risk for preventable injuries and accidents.	F 689		

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Findings Included:

- The facility identified Residents (R) 14, R45, R47, R63, R103, R105, and R110 were cognitively impaired residents within the secured 2nd-floor.

On 01/21/25 at 07:30 AM, an inspection of the 2nd-floor nursing station revealed an alcohol-based disinfectant container of alcohol-based disinfectant wipes on the outside counter of the nurse's station. A shelf next to the sensory room, behind the nurse's station revealed two more disinfectant containers on the top shelf. The wipe's containers contained the warning, "Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed.

On 01/21/25 at 07:35 AM, R105 (severely cognitively impaired resident) wandered around the 2nd-floor nurse's station while the chemical wipes were accessible.

On 01/21/25 at 12:30 PM, the identified cleaning products were no longer accessible on the unit.

On 01/23/25 at 10:03 AM, CNA N stated cleaning products should be secured in locked closets or rooms. She stated that cognitively impaired residents should not have access to these products due to the risks of accidental poisoning.

On 01/23/24 at 11:10 AM, Administrative Nurse D stated staff were expected to lock up cleaning products and areas with potential hazards to prevent accidents.

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F 689	Continued From page 18 The facility failed to provide a policy related to accidents or safe chemical storage as requested on 01/23/25. The facility failed to secure areas containing hazardous materials out of reach of seven cognitively impaired /independently mobile residents in the secured unit. This deficient practice placed the affected residents at risk for preventable injuries and accidents.	F 689		
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 identified a census of 112 residents. The sample included 23 residents with two residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 27's continuous positive airway pressure (CPAP - ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask was stored in a sanitary manner. This deficient practice placed R27 at an increased risk for respiratory infection and complications. Findings included:	F 695		

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- R27's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hypertension (high blood pressure), dependence on dialysis (a procedure where impurities or wastes are removed from the blood), hyperlipidemia (condition of elevated blood lipid levels), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), unsteadiness of feet, cognitive communication deficit, need for assistance with personal care, and hemiparesis/hemiplegia (weakness and paralysis on one side of the body) affecting left non-dominant side.

The "Quarterly Minimum Data Set" (MDS) dated 11/02/24 documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented R27 was impaired on one side of his body. The MDS documented R27 needed partial to moderate assistance from staff for personal hygiene, bathing, and oral hygiene. The MDS lacked documentation for the required CPAP during the observation period.

R27's "Functional Abilities (Self-Care Mobility) Care Area Assessment" (CAA) dated 08/02/24 documented R27 had an alteration in self-care related to bowel and bladder incontinence. The CAA documented R27 required assistance with activities of daily living (ADL) and is at risk for complications due to dialysis and pain.

R27's "Care Plan" dated 08/09/24 documented R27 had COPD and was using a CPAP. Staff were to change the CPAP water humidifier

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chamber nightly with distilled water. Staff were to empty the water chamber prior to refilling. R27 was to wear CPAP nightly, R27 exhibits shortness of breath when lying flat, he was dependent on CPAP and prefered the head of his bed elevated and may need extra pillows.

R37's EMR under the "Orders" tab revealed the following physician orders:

CPAP at night and as needed (PRN) settings 19 centimeters of water pressure (cm) humidifier four, air fit 20 dated 01/09/25.

Clean CPAP mask. Wash with soap and water and let air dry every shift dated 01/09/25.

Change the CPAP water humidifier chamber nightly with distilled water only. Empty and rinse the chamber prior to refilling every night shift on Wednesday dated 01/15/25.

On 01/21/24 at 08:33 AM, R27 laid in his bed. R27's CPAP mask was laid directly on the bedside table.

On 01/22/24 at 09:50 AM, R27 sat in his room in his wheelchair. R27's CPAP mask laid directly on the outside of his CPAP bag.

On 01/23/24 at 09:22 AM, Certified Nurse's Aide (CNA) M stated all respiratory equipment should be stored in a plastic bag if the equipment was not in use.

On 01/23/24 at 09:33 AM PM, Licensed Nurse (LN) G stated all trach tubing and nasal cannulas should be placed in a plastic bag if not in use. She stated that CPAP masks should be washed

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F 695	Continued From page 21 and air-dried in a sanitary manner. On 01/23/24 at 11:23 AM, Administrative Nurse D stated all respiratory equipment including tubing for humidified air for the trachea (a surgical opening through the windpipe to help a person breathe), CPAP mask, and oxygen tubing should be stored in plastic bags, always in a sanitary manner. The facility's policy "Non-Invasive Ventilation" documented the facility to provide noninvasive ventilation as per physician's orders and current standards of practice. The facility would follow the manufactures recommendation for equipment. The facility failed to ensure R27's CPAP mask was stored in a sanitary manner. This placed R27 at an increased risk for respiratory infection and complications.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700		

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F 700	Continued From page 22 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: The facility identified a census of 112 residents. The sample included 23 residents with five residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to ensure that Resident (R) 51 had a documented risk assessment for the use of side rails, consent for the use of the side rails, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed the R51 at risk for uninformed decision and impaired safety related to the risks associated with the use of side rails. Findings included: - R51's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of foot drop in right foot (inability or difficulty in moving the ankle and toes upward), pressure ulcer of right buttocks, need for assistance with personal care, muscle weakness, weakness, reduced mobility, contractures (abnormal permanent fixation of a joint or muscle) of the right shoulder, left shoulder, right knee, left knee, right ankle, and left ankle. The "Annual Minimum Data Set" (MDS) dated 04/28/24 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact	F 700		

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cognition. The MDS documented R51 was at risk of development of pressure ulcers and had one unhealed pressure ulcer during the observation period. The MDS documented R51 had no limitation in range of motion (ROM - the full movement potential of a joint, usually its range of flexion and extension). The MDS documented no side rails had been utilized during the observation period. The MDS documented R51 was dependent on staff assistance for transfers.

The "Quarterly MDS" dated 10/29/24 documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R51 was at risk of development of pressure ulcers and had one unhealed pressure ulcer during the observation period. The MDS documented R51 had limited ROM on both sides of his upper and lower extremities. The MDS documented no side rails had been utilized during the observation period. The MDS documented R51 was dependent on staff assistance for transfers.

R51's "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) dated 05/10/24 documented he had an alteration in self-care related to incontinence and he required assistance with his activities of daily living (ADLs).

R51's "Care Plan" dated 07/08/24 documented he required substantial to maximal assistance with bed mobility. The plan of care documented R51 preferred to have his bed up against the wall on the right side. The plan of care documented the staff would remind R51 to utilized the trapeze bar and the bilateral side rails to assist him with positioning.

R51's EMR under the "Orders" tab revealed the

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following physician orders:
May utilize bed mobility or transfer assist bars dated 08/01/24.

R51's EMR revealed a "Restraint/Enabling Device/Safety Device Evaluation" dated 07/08/24 was completed for side rails. The assessment documented he had weakness. The assessment indicated side rails were utilized for bed mobility and repositioning. The evaluation did not acknowledge the use of R51's low air-loss mattress. The facility was unable to provide the documentation of a safety assessment upon request.

R51's EMR lacked a safety assessment for the use of his side rails which addressed the risk of entrapment between the device and the mattress, a consent for the use, and lacked evidence the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails.

On 01/22/25 at 01:33 PM R51 laid on the bed with his bilateral heel resting directly on the bed. R51 upper body was leaned toward his left side next to the left upper side rail. R51's head of the bed was slightly elevated with the side rails pulled up on both sides of the bed.

On 01/23/25 at 11:15 AM, Administrative Nurse D stated the therapy department helped complete the assessment for the use of side rails for the risk of entrapment. Administrative Nurse D stated she would find that assessment.

The facility's "Siderails" policy dated last revised 03/2019 documented it was the policy of the facility to limit the use of siderails as there was

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F 700	Continued From page 25 debate of the safety and efficacy of their use. This policy would outline protocols for use of side rails in the facility. All residents with side rails would be assessed on admission, quarterly, and with each significant change in condition for the necessity of the use of side rails. For residents deemed a fall risk, other alternatives would be utilized. A trapeze device or turn rails, which have been found to be safer, would be used for those residents needing assistive devices for turning and positioning in bed. A resident or family insists on using side rails, the treatment team must explain the risks of their use, document the education, and have the resident or responsible patty sign a consent that they understand the risks associated with the use of side rails. The facility failed to ensure that R51 had a documented risk assessment, a consent for the use of the side rails and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the side rails. This placed the resident at risk for uninformed decision and impaired safety related to the risks associated with the use of side rails.	F 700		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 712		

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§483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.

§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 112 residents. The sample included 23 residents with four residents reviewed for frequency of physician visits. Based on observation, record review, and interviews, the facility failed to ensure the attending physician conducted the required visits for Resident (R) 51. This deficient practice placed R51 at risk of unrealized changes in condition leading to unnecessary complications in his wellbeing.

Findings included:

- R51's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of foot drop in right foot (inability or difficulty in moving the ankle and toes upward), pressure ulcer of right buttocks (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), need for assistance with personal care, muscle weakness, weakness, reduced mobility, and contractures (abnormal permanent fixation of a joint or muscle) of the right shoulder, left shoulder, right knee, left knee, right ankle, and left ankle.

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The "Annual Minimum Data Set" (MDS) dated 04/28/24 documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R51 was at risk of development of pressure ulcers and had one unhealed pressure ulcer during the observation period. The MDS documented R51 had no limitation in range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension).

The "Quarterly MDS" dated 10/29/24 documented a BIMS score of 15 which indicated intact cognition. The MDS documented that R51 was at risk of development of pressure ulcers and had one unhealed pressure ulcer during the observation period. The MDS documented R51 had limited ROM on both sides of his upper and lower extremities.

R51's "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) dated 05/10/24 documented he had an alteration in self-care related to incontinence and he required assistance with his activities of daily living (ADL).

R51's "Care Plan" dated 05/01/22 documented he had a behavior problem related to his refusal of medications, wound care, and bathing regardless of the education provided from the physician and staff.

Review of R51's clinical record revealed no "Physician Progress Notes" for the past six months. The facility was unable to provide any documentation of the attending physician visits.

On 01/22/25 at 01:33 PM, R51 laid on the bed

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with his bilateral heel resting directly on the bed. R51 upper body was leaned toward his left side next to the left upper side rail. R51's head of the bed was slightly elevated with the side rails pulled up on both sides of the bed.

On 01/23/25 at 08:35 AM, Administrative Staff A stated she was unable to locate any attending physician documentation for R5's care in the past six months.

On 01/23/25 at 10:22 AM, Licensed Nurse (LN) I stated the nurse practitioner was at the facility Monday through Friday weekly. LN I stated she was not sure when the physician made rounds.

On 01/23/25 at 11:15 AM, Administrative Nurse D stated she expected the attending physician to come to the facility every three months. Administrative Nurse D stated the medical records staff tracked the physician visits and have realized some of the residents had not been seen for several months.

The facility's "Physician Services Physician Visits" policy dated 08/2024 documented it was the policy of this facility that residents must be seen by their attending physician in accordance with current State and Federal regulations. The resident must be seen by his/her attending physician at least once every quarter following the resident's admission. A physician assistant or nurse practitioner may alternate visits with a physician after the initial visit unless restricted by law or regulation.

The facility failed to ensure R51 was seen by his attending physician as required in the past six months. This deficient practice placed R51 at risk

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F 712	Continued From page 29 of the potential for unrealized changes in his condition leading to unnecessary complications in his well-being.	F 712		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility identified a census of 112 residents. The sample included 23 residents with four reviewed for dementia (a progressive mental disorder characterized by failing memory, and confusion) care. Based on interviews, record review, and observations, the facility failed to provide dementia-related behavioral services for Resident (R) 14 to promote her highest practicable level of well-being. This deficient practice placed R14 at risk for decreased quality of life, isolation, and impaired dignity. Findings Included: - The "Medical Diagnosis" section within R14's Electronic Medical Records (EMR) included diagnoses of dementia, cognitive-communication disorder, repeated falls, muscle weakness, need for assistance with personal care, and scoliosis (curvature of the spine). R14's "Admission Minimum Data Set (MDS)" completed 11/27/24 documented a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. The MDS noted a	F 744		

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history of hallucinations (sensing things while awake that appear to be real, but the mind created). The MDS indicated she required partial to moderate assistance with bed mobility, transfers, toileting, bathing, personal hygiene, and dressing. The MDS indicated she used a manual wheelchair for mobility. The MDS indicated she was frequently incontinent of the bladder and occasionally incontinent of bowel. The MDS indicated she had no toileting program in place. The MDS indicated she was at risk for falls with a major injury prior to her admission.

R14's "Dementia Care Area Assessment (CAA)" completed 12/01/24 documented she indicated she was at risk for alterations related to her severe cognitive impairment. The CAA documented a care plan was implemented to address her risks.

R14's "Urinary Incontinence CAA" completed 12/01/24 documented she required assistance with her activities of daily living (ADL) and had occasional bladder incontinence. The CAA documented her incontinence put her at risk for falls, skin breakdown, and an ADL decline. The CAA documented a care plan was implemented to address her risks.

R14's EMR under "Progress Notes" revealed R14 had a non-injury on 11/27/24 at 05:10 AM. The note documented R14 was found on the floor in her restroom's doorway. The note indicated staff were to provide toileting every two hours as an intervention.

R14's "Care Plan" initiated 11/21/24 documented she had an alteration in self-care related to her medical diagnoses. The plan noted she required

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assistance for her ADLs. The plan noted she had occasional bladder incontinence. The plan instructed staff to check her for incontinence, provide peri-care, and change her clothing as needed (12/03/24). The plan documented she was at risk for wandering (12/03/24). The plan instructed staff to provide pleasant diversions and document wandering behaviors (12/03/24). The plan instructed staff to provide toileting, walks, reorientation, and memory boxes to assist with her wandering (12/03/24). The plan indicated she was to eat in the Serenity dining room (01/09/25).

R14's EMR under "Progress Notes" revealed R14 had a non-injury on 12/16/24 at 12:00 AM. The note documented R14 was found on her fall mat in between her bed and bathroom entryway. The note indicated she had no clothes on and covered herself with a clothe bed-pad. The note indicated she had no injuries.

R14's EMR under "Progress Notes" revealed a note dated 12/23/24. The note documented that R14 was found on the fall mat between her bed and the bathroom entryway. The note indicated she wore only a t-shirt, underpants, and socks when she was found. The note indicated she had no injury and was provided toileting.

R14's EMR under "Progress Notes" revealed R14 had a non-injury on 12/30/24 at 07:10 PM. The note documented R14 was confused and wandered into the unit's sensory room. The note documented R14 thought the room was her bathroom and the recliner was her toilet. The note indicated R14 fell while attempting to toilet herself. The note documented mealtime toileting was implemented as an intervention.

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R14's EMR under "Progress Notes" revealed a note dated 01/06/25. The note documented staff observed R14 as she stood in at the doorway of her bedroom and urinated on the floor. The note documented staff educated R14 to call for help and to use the restroom instead of going on the floor. The note indicated R14 was confused and stated "Well I had to go".

R14's EMR under "Progress Notes" revealed a note dated 01/19/25 at 12:15 AM. The note documented staff found R14 in her room. The note indicated she sat on the floor in urine with her back to the entry door. The note documented she was not wearing socks or shoes.

R14's EMR under "Progress Notes" revealed a note dated 01/20/25. The note documented R14 was found at the nurse's station going through folders. The note documented staff asked R114 to give the folders back and R14 became verbally and physically aggressive towards staff. The note indicated the physician was notified.

On 01/21/25 at 07:23 AM, R14 sat in her wheelchair next to the second-floor nurse's station. An inspection of the nurse's station revealed an alcohol-based disinfectant container of alcohol-based disinfectant wipes on the outside counter of the nurse's station. A shelf next to the sensory room behind the nurse's station revealed two more disinfectant containers on the top shelf.

At 01/21/25 at 07:45 AM, R14 was wheeled to the small dining room for breakfast. Her wheelchair had no foot pedals and her feet slid on the ground as she was pushed.

On 01/23/25 at 10:05 AM, Certified Nurse's Aide

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(CNA) N stated she had to monitor R14 closely due to her wandering. She stated that R14 could be aggressive towards staff when confused. She stated staff would attempt to provide incontinence checks every two hours for R14. She stated that R14 was impulsive and would not always remember to call for help and staff should anticipate her needs. She stated the sensory room was used for dementia residents, but staff were expected to monitor them while the room was in use.

On 01/23/25 at 11:10 AM, Administrative Nurse D stated R14 should be monitored closely due to her confusion and wandering. She stated staff were expected to provide two-hour incontinence checks and toileting after each meal. She stated R14 should not be in the sensory room unsupervised, and all residents were to have foot pedals on their wheelchairs while being pushed. She stated potentially hazardous chemicals should be stored out of reach of the resident's.

A review of the facility's "Dementia Care "policy reviewed 03/2024 indicated the facility provided dementia treatment and services to ensure adequate medical care, person-centered care, safety, and dignity. The policy indicated the facility will provide care to ensure the resident received the highest practicable mental, physical, and psychosocial well-being.

The facility failed to provide dementia-related behavioral services for R14 to promote her highest practicable level of well-being. This deficient practice placed R14 at risk for decreased quality of life, isolation, and impaired dignity.

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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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(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 identified a census of 112 residents. The sample included 23 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 27's continuous positive airway pressure (CPAP - a machine that uses mild air pressure to keep breathing airways open while you sleep) mask was stored appropriately when not in use. The facility failed to ensure R315's tracheal (a surgical

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procedure that creates an open in the neck and windpipe to help a person breathe) tubing was stored appropriately when not in use. The facility failed to ensure R48's nasal cannula (a hollow tube device used to provide supplemental oxygen) was appropriately stored when not in use. These deficient practices placed R27, R315, and R48 at risk of infection development and possible respiratory complications.

Findings included:

- On 01/21/25 at 08:33 AM, R27 laid in his bed. R27's CPAP mask laid directly on the bedside table.

On 01/22/25 at 08:22 AM, R315 laid in her bed on her back, R315's tracheal tubing was disconnected from her trachea, and placed in a drawer in the bedside dresser, the tracheal tubing was not placed in a sanitary manner.

On 01/22/25 at 09:17 AM, R48's nasal cannula laid on the floor in his room.

On 01/22/25 at 09:50 AM, R27 sat in his room in his wheelchair. R27's CPAP mask laid directly on the outside of his CPAP bag.

On 01/23/25 at 08:45 AM, Licensed Nurse (LN) H stated that any respiratory tubing or masks should be stored in the provided plastic bag when not in use. LN H stated some resident would take off their nasal cannulas, but the tubing should never be on the floor.

On 01/23/25 at 11:12 AM, Administrative Nurse D stated that CPAP mask, nasal cannulas, and tracheal tubing should all be stored in the

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provided plastic bag when not in use. Administrative Nurse D stated she would expect staff to change out nasal cannula tubing if it had been found on the floor.

The "Infection Prevention and Control Program" policy last revised in October 2022, documented that the infection prevention and control program was comprehensive in that it addressed the detection, prevention, and control of infections among residents and personnel. The facility would follow the regulatory guidelines provided by the Centers for Medicare and Medicaid Services (CMS) state operations manual appendix PP-Guidance to surveyors for long-term care facilities (LTC).

The undated "Noninvasive Ventilation" policy documented the facility would follow the manufacturer's instructions for use of the machine. Follow the manufacturer's instructions for the frequency of cleaning/replacing filters and servicing the machine.

The facility failed to ensure that 27's CPAP mask was stored appropriately when not in use. The facility failed to ensure that R315's tracheal tubing was stored appropriately when not in use. The facility failed to ensure that R48's nasal cannula was stored appropriately when not in use. These deficient practices placed R27, R315, and R48 at risk of infection development and possible respiratory complications.