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F 000	INITIAL COMMENTS The following citations represent the findings of a health resurvey and complaint investigation KS00192252, KS00191907, KS00191785, KS00191452, and KS00191021. The 2567 was sent electronically on 02/11/25.	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.	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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§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 72 residents. The sample included 19 residents, with Resident (R)28 reviewed for dignity. Based on observation, record review, and interview, the facility failed to ensure staff respected R28's privacy and dignity while in bed. This deficient practice placed R28 at risk of decreased self-esteem and decreased self-worth.

Findings included:

- R28's Electronic Medical Record (EMR) documented diagnoses of chronic respiratory failure (a condition where your blood does not have enough oxygen), dementia (a progressive mental disorder characterized by failing memory and confusion), and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid).

R28's "Admission Minimum Data Set (MDS)" dated 07/21/24 documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. R28 had an impairment of his lower extremity on one side. R28 used a wheelchair to assist with mobility.

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R28 required substantial assistance to total dependence on staff for his functional abilities and activities of daily living (ADL). R28 was frequently incontinent of bowel and bladder. R28 required supplemental oxygen. R28 required using a Bilevel positive airway pressure (BiPAP - ventilation device that helps people with breathing difficulties by providing pressurized air through a mask worn over the nose or mouth) machine.

R28's "Quarterly MDS," dated 10/21/24, documented a BIMS score of 13, which indicated intact cognition. R28 had an impairment of his lower extremity on one side. R28 used a wheelchair to assist with mobility. R28 was dependent on staff for all functional abilities and ADLs. R28 was occasionally incontinent of bowel and bladder. R28 required supplemental oxygen. R28 required using a BiPAP at night.

R28's "Functional Abilities Care Area Assessment (CAA)" dated 07/24/24 documented he was admitted after a fall and then had a hospitalization due to a change in cognition and continued functional decline. R28 continued supplemental oxygen and BiPAP. R28 was dependent on staff for self-care and mobility tasks. R28 was able to make needs known. R28 used a wheelchair for primary locomotion.

R28's Care Plan, last revised on 11/14/24, directed staff he was substantial to max assist with bed mobility and dependent on staff for transfers. Staff was directed to set supplemental oxygen at two liters continuously via nasal cannula (a clear hollow tube used to deliver supplemental oxygen). Staff was directed that R28 required BiPAP at night per setting as ordered.

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F 550	Continued From page 3 On 01/28/25 at 10:39 AM, R28 lay on his bed. R28's room door was open. R28's right leg and brief were visible from the doorway. The curtain in the room was not drawn to protect his privacy. On 01/30/25 at 12:29 PM, Certified Nurse Aide (CNA) M stated a resident should not be exposed from their room. CNA M stated a resident should be covered with their sheet or their curtain drawn to protect their privacy. On 01/30/25 at 12:47 PM, Licensed Nurse (LN) H stated some residents did prefer to be uncovered at times. LN H stated their door should be shut or the privacy curtain drawn to protect their privacy. On 12/30/25 at 01:05 PM, Administrative Nurse D stated a resident had a right to be uncovered. Administrative Nurse D stated a resident's door should be closed or the privacy curtain should be drawn to avoid exposure from outside the room. The facility failed to provide a policy regarding dignity as requested. The facility failed to ensure staff respected R28's privacy and dignity while in bed. This deficient practice placed R28 at risk of decreased self-esteem and decreased self-worth.	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	F 558		

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other residents.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 72 residents. The sample included 19 residents, with five reviewed for accommodation of needs related to assistive devices. Based on observation, record review, and interview, the facility failed to utilize and ensure the appropriate use of foot pedals during wheelchair transports for Resident (R) 65 and R51. The facility additionally failed to ensure that R43, R24, and R8 call lights remained within their reach. This deficient practice placed the resident at risk for preventable accidents and injuries.

Findings Included:

- A review of R65's (severely cognitively impaired resident) EMR under "Progress Notes" revealed a "Fall Committee Note" completed on 07/22/24. The note indicated R65 had a minor injury fall on 07/19/24. The note revealed that R65 fell out of his wheelchair while being pushed in the hallway without foot pedals. The note revealed that R95 became fatigued while he attempted to hold his legs up. The note revealed he suffered a skin tear on his left elbow, left wrist, left hand, and below his left eye. The note revealed all staff were educated to utilize foot pedals for the wheelchairs.

On 01/28/25 at 09:40 AM, R51 (severely cognitively impaired resident) was pushed down the hallway and his room. R51's wheelchair lacked foot pedals, and staff had to remind him several times to pick up his feet.

On 01/29/25 at 08:40 AM, R43 (cognitively impaired resident) sat in her wheelchair to the left

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of her nightstand. She stated she was cold but could not get to her call light. R43's call light was on her bed across the room.

On 01/29/25 at 10:02 AM, R24 (severely cognitively impaired resident) lay on her bed asleep. R24's call light was pinned to the cord on the wall at the foot of her bed. R24's pancake call light was pinned to her recliner, which also was at the foot of her bed, out of reach.

On 01/29/25 at 03:35 PM, R8 (cognitively impaired resident) laid in bed. R8's call light was stuck between his mattress and the bed cane out of reach.

On 01/30/25 at 12:04 PM, Certified Nurse's Aide (CNA) M stated all wheelchairs should have foot pedals for when the residents were being pushed. She stated staff should ensure each resident's call light was either clipped onto their clothing or within reach.

On 01/30/25 at 12:04 PM, Licensed Nurse (LN) H stated staff should always ensure foot pedals were in place before pushing the residents and the call lights were left within reach.

On 01/30/25 at 01:07 PM, Administrative Nurse D stated staff were expected to place the call lights within reach or clipped to the resident's clothing. She stated staff was expected to use foot pedals when they pushed the residents in their wheelchairs to prevent falls or injuries.

The facility's "Accommodation of Needs" revised 01/2023 indicated the facility was to ensure the availability of and the appropriate use of assistive devices and call lights. The policy indicated the

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F 558	Continued From page 6 facility will evaluate each resident's individual level of functioning and care needs. The facility failed to utilize and ensure the appropriate use of foot pedals during wheelchair transports for R65 and R51. The facility additionally failed to ensure that R43, R24, and R8 call lights remained within their reach. This deficient practice placed the resident at risk for preventable accidents and injuries.	F 558		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		

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(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part

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C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 72 residents. The sample included 19 residents, with four residents reviewed for hospitalization. Based on observation, record review, and interview, the facility failed to provide written notification of transfer to Resident (R) 28 and his representative for his facility-initiated transfers. This deficient practice placed R28 at risk for uninformed care choices.

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Findings included:

- R28's Electronic Medical Record (EMR) documented diagnoses of chronic respiratory failure (a condition where your blood does not have enough oxygen), dementia (a progressive mental disorder characterized by failing memory and confusion), and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid).

R28's "Discharge Minimum Data Set (MDS)" dated 03/15/24 documented an admission to the facility on 03/06/24. The MDS documented an unplanned discharge to an acute hospital with a return anticipated.

R28's "Discharge MDS" dated 03/22/24 documented an unplanned discharge to an acute hospital with a return anticipated.

R28's "Admission Minimum Data Set (MDS)" dated 03/29/24 documented he entered from a short-term hospital. R28 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R28 had an impairment of his lower extremity on one side. R28 used a wheelchair to assist with mobility. R28 required partial assistance with upper body dressing and toilet transfers. R28 was substantial assistance for lower body dressing. R28 was frequently incontinent of bowel and bladder. R28 required supplemental oxygen.

R28's "Discharge MDS" dated 05/30/24 documented an admission to the facility on 03/06/24. The MDS documented an unplanned discharge to an acute hospital with a return

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anticipated.

R28's "Discharge MDS" dated 07/15/24 documented an admission to the facility on 03/06/24. The MDS documented an unplanned discharge to an acute hospital with a return anticipated.

R28's "Admission MDS," dated 07/21/24, documented a score of 10, which indicated moderately impaired cognition. R28 had an impairment of his lower extremity on one side. R28 used a wheelchair to assist with mobility. R28 required substantial assistance to total dependence on staff for his functional abilities and activities of daily living (ADL). R28 was frequently incontinent of bowel and bladder. R28 required supplemental oxygen. R28 required using a Bilevel positive airway pressure (BiPAP - ventilation device that helps people with breathing difficulties by providing pressurized air through a mask worn over the nose or mouth) machine.

R28's "Discharge MDS" dated 08/30/24 documented an unplanned discharge to an acute hospital with a return anticipated.

R28's "Entry MDS" dated 09/01/24 documented a re-entry to the facility from an acute hospital.

R28's "Quarterly MDS," dated 10/21/24, documented a BIMS score of 13, which indicated intact cognition. R28 had an impairment of his lower extremity on one side. R28 used a wheelchair to assist with mobility. R28 was dependent on staff for all functional abilities and ADLs. R28 was occasionally incontinent of bowel and bladder. R28 required supplemental oxygen. R28 required using a BiPAP at night.

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R28's "Discharge MDS" dated 12/06/24 documented an unplanned discharge to an acute hospital with a return anticipated.

R28's "Entry MDS" dated 12/08/24 documented a re-entry to the facility from an acute hospital.

R28's "Functional Abilities Care Area Assessment (CAA)" dated 07/24/24 documented he was admitted after a fall and then had a hospitalization due to a change in cognition and continued functional decline. R28 continued supplemental oxygen and BiPAP. R28 was dependent on staff for self-care and mobility tasks. R28 was able to make needs known. R28 used a wheelchair for primary locomotion.

R28's Care Plan, last revised on 11/02/24, had canceled staff direction he wanted to return to assisted living upon discharge. A canceled intervention directed staff to make arrangements with the required community resources to support his independence post-discharge.

The facility provided the appropriate bed holds for R28's discharges on 03/15/24, 03/22/24, 05/30/24, 07/15/24, 08/30/24, and 12/06/24.

The facility failed to provide the required written notification of transfer to R28 and his representative for his discharges on 03/15/24, 03/22/24, 05/30/24, 07/15/24, 08/30/24, and 12/06/24 that included the reason for the transfer; the effective date of transfer; the specific location of the transfer; an explanation of the right to appeal the transfer to the state; the name, address, and telephone number of the state entity which receives appeal requests; the name,

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address, and phone number of the representative of the office of the stated long-term care ombudsman; and the notice must be provided to the resident and resident's representative as soon as practicable.

On 01/28/25 at 10:39 AM, R28 lay on his bed. R28's supplemental oxygen was not on.

On 01/30/25 at 12:38 PM, Social Services X stated she completed the bed hold form when a resident was sent out to the hospital but was not aware of a form that was provided to the resident or their representative about the discharge. Social Services X stated the facility would call the representative when a resident was sent out.

On 01/30/25 at 12:47 PM, Licensed Nurse (LN) H stated the nursing staff would call the family representative to notify them when a resident was sent out to the hospital. LN H stated she did not know of any written notification of transfer that was given to the resident or mailed to the resident's representative.

On 01/30/25 at 01:05 PM, Administrative Nurse D stated that a bed hold was completed by social services upon each discharge. Administrative Nurse D stated she did not know of a written notification form that was required. Administrative Nurse D stated the facility had always only done the bed hold and would call the family to notify them when a resident was discharged or sent out to the hospital.

The "Discharge or Transfer" policy, last revised in January 2023, lacked any direction regarding the Centers for Medicaid and Medicare (CMS) state operations manual (SOM) federal guideline

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F 623	Continued From page 13 483.15(c)(3): Notice before transfer. The facility failed to provide written notification of transfer to R28 and his representative for his facility-initiated transfers. This deficient practice placed R28 at risk for uninformed care choices.	F 623		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 72 residents. The sample included 19 residents, with four 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 interviews, observations, and record reviews, the facility failed to ensure Resident (R) 19's low air-loss mattress was set to the appropriate weight settings per her current weight. The facility additionally failed to ensure R34's Wheelchair had a pressure-reducing cushion in place per her care-planned	F 686		

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interventions. This deficient practice placed both residents at risk for complications related to skin breakdown and pressure ulcers.

Findings included:

- The "Medical Diagnosis" section within R19's Electronic Medical Records (EMR) noted diagnoses of muscle weakness, cognitive-communication disorder, and deep surgical incision with wound-vac (a vacuum-assisted wound treatment that applies gentle suction to a wound to help it heal).

R19's "Admission Minimum Data Set (MDS)" completed on 01/13/25 noted a Brief Interview for Mental Status (BIMS) score of seven, indicating severe cognitive impairment. The MDS indicated she required substantial to maximal assistance from staff to complete transfers, toileting, bathing, dressing, bed mobility, and personal hygiene. The MDS indicated she was admitted with two stage-two (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters) pressure injuries upon admission and was at risk for further pressure injury development. The MDS noted she weighed 144 pounds (lbs.)

R19's "Functional Abilities Care Area Assessment (CAA)" was completed on 10/28/24 noted she had a recent hip replacement related to a fall before her admission. The CAA noted she required substantial assistance with her activities of daily living (ADL). The CAA noted care plan interventions were implemented to address her care risks.

R19's "Pressure Ulcer CAA" completed 10/28/24

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noted she was admitted to the facility with two pressure ulcers to her lower left extremity. The CAA noted she had a surgical incision on her left hip surgery. The CAA noted she had a pressure-reducing mat for her bed and wheelchair.

R19's "Care Plan," initiated on 11/08/24, indicated she had potential for further pressure ulcer development related to her immobility, incontinence, and medical diagnoses. The plan instructed staff to encourage fluid hydration and follow her diet as ordered. The plan noted she should have heel protectors on her heels while in bed. The plan noted she had a low air-loss mattress for her bed and a pressure-reducing mattress for her wheelchair.

A review of the manual of low air-loss mattress manufacturers' operation (Drive Model #14029) indicated that the mattress system was intended to reduce the incidence of pressure ulcers while optimizing comfort. The manual indicated the mattress pump's pressure levels and firmness were preset based on the weight range and comfort settings. The manual indicated an optimal bed system assessment should be conducted on each patient by a qualified clinician or medical provider to ensure maximum safety.

R19's EMR under "Weights" noted her current weight was 135.4 lbs. on 01/15/25.

On 01/28/25 at 07:10 AM, R19 rested in her bed and waited for her breakfast to arrive. R19 had bilateral heel protectors on both her legs. R19's Wheelchair had a pressure-reducing mat in place. R19's bed had a Drive Model #14029 low air-loss mattress. The mattress pump had fixed

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weight settings of 50lbs, 100lbs, 150lbs, 200lbs, 250lbs, 300lbs, 350lbs. and 450lbs. R19's mattress control panel was locked at 200lbs.

On 01/30/25 at 08:11 AM, R19's low air-loss mattress remained locked on 200lbs.

On 01/30/25 at 08:15 AM Licensed Nurse (LN) G stated maintenance would set the beds up and program the weights settings, but nursing was responsible for ensuring the beds were functioning. She stated the beds were set by the resident's current weight but was not sure how they would reset it with the weight changes. She stated that R19 was at risk for pressure ulcers, and her mattress was set per her current weight.

On 01/30/25 at 01:07 PM, Administrative Nurse D stated the low air-loss mattress was to be set per the resident's current weight. She stated nursing staff were able to change the weight settings if needed.

The facility's provided "Skin Management System" policy revised 12/2024 indicated the facility was to implement preventative interventions to minimize the risk associated with skin breakdown and pressure injuries. The policy noted the facility will utilize pressure redistribution surfaces deemed appropriate based on the resident's risk factors and care needs.

The facility failed to ensure R19's low air-loss mattress was set to the appropriate weight settings per her current weight. This deficient practice placed R19 at risk for complications related to skin breakdown and pressure ulcers.
- R19's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of

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muscle weakness, lack of coordination, dementia (a progressive mental disorder characterized by failing memory and confusion), repeated falls, history of falls, and cognitive communication deficit.

The "Admission Minimum Data Set" (MDS) dated 01/29/24 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R19 was at risk of developing of pressure ulcers. The MDS documented R19 had no unhealed pressure ulcers at the time of admission. The MDS documented R19 was to have pressure-reducing devices on her bed and in her chair to prevent the development of pressure ulcers.

The "Quarterly MDS" dated 10/31/24 documented a BIMS score of 12, which indicated moderately impaired cognition. The MDS documented that R19 was at risk of development of pressure ulcers. The MDS documented R19 had no unhealed pressure ulcers during the observation period. The MDS documented R19 was to have pressure-reducing devices on her bed and in her chair to prevent the development of pressure ulcers.

R19's "Pressure Ulcer Care Area Assessment" (CAA) dated 02/05/24 documented she was at risk of skin breakdown related to decreased mobility and bladder incontinence. Nursing staff would provide R19 with assistance with mobility and activities of daily living to help reduce her risk for development of pressure ulcers. A pressure-reducing mattress would be placed on her bed and a pressure-reducing cushion would be placed in her wheelchair.

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R19's "Care Plan," dated 02/19/24, documented a pressure-reducing mattress was placed on her bed, and a pressure-reducing cushion was placed in her wheelchair.

R19's EMR under the "Orders" tab revealed the following physician orders:
Enhanced Barrier Precautions related to pressure ulcer every shift dated 12/03/24.

Review of R19's EMR revealed a "Skin Pressure Ulcer Weekly" dated 01/15/25 documented a pressure ulcer with the onset date of 11/26/24 on the left buttocks.

On 01/28/25 at 11:18 AM, R19 lay on her bed; her wheelchair was locked next to the bed without a pressure-reducing cushion in the wheelchair.

On 01/29/25 at 10:17 AM, R19 sat in her recliner with her lower extremities elevated. R19's wheelchair was the foot of her recliner. The wheelchair lacked Dycem (non-slip mat used for stabilization and gripping to prevent slipping) or pressure-reducing cushion.

On 01/30/25 at 10:51 AM, R19 sat in her recliner and watched TV. R19's wheelchair sat next to her bed with a folded white bath towel in the seat of the wheelchair. The wheelchair lacked a pressure-reducing cushion and a Dycem.

On 01/30/25 at 10:53 AM, Certified Nurse Aide (CNA) N stated that R19 was at risk for skin breakdown and that R19 should have a pressure-reducing cushion in her wheelchair. CNA N stated that R19 had a pressure ulcer on her buttocks but had just recently healed. CNA N

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F 686	Continued From page 19 stated everyone ensured the cushion was in place in R19's wheelchair. On 01/30/25 at 10:58 AM, Licensed Nurse (LN) H stated that R19 had a recent pressure ulcer on her left buttocks. LN H stated that R19 should have a cushion in her wheelchair. LN H stated it was everyone's responsibility to ensure pressure-reducing devices were in place. On 01/30/25 at 01:10 PM, Administrative Nurse D stated R19 should have a pressure-reducing device in her wheelchair. Administrative Nurse D stated that R19 was at risk for skin breakdown. Administrative Nurse D stated she expected all staff would ensure pressure-reducing interventions were in place. The facility's "Skin Management System" policy, last revised 12/22/24, documented it was the policy of the facility that any resident who entered the facility without pressure ulcers would have appropriate preventive measures taken to ensure that the resident did not develop pressure ulcers, or that residents admitted with wounds would not develop signs and symptoms of infection unless the resident's clinical condition makes the development unavoidable. The facility failed to ensure a pressure-reducing heel cushion was in place for R19, who had a history of a pressure injury on her left buttocks. This deficient practice placed R19 at risk for complications related to skin breakdown and the development of further pressure ulcers.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		

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§483.25(c) Mobility.
§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 72 residents. The sample included 19 residents, with two residents reviewed for positioning and mobility. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 24 was provided services and treatment to prevent worsening of contractures (abnormal permanent fixation of a joint or muscle) in his left hand. This deficient practice placed R24 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:

- R24's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of contracture of left hand, hemiparesis (muscular weakness of one half of the body), hemiplegia

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(paralysis of one side of the body), and cerebral infarction (stroke - 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).

The "Significant Change Minimum Data Set" (MDS) dated 08/26/24 documented a Brief Interview of Mental Status (BIMS) score of four which indicated severely impaired cognition. The MDS documented R24 had limited ROM in the upper and lower extremities on one side. The MDS documented R24 was dependent on staff assistance for activities of daily living (ADLs) during the observation period.

The "Quarterly MDS" dated 11/19/24 documented a BIMS score of four, which indicated severely impaired cognition. The MDS documented that R24 had limited ROM in the upper and lower extremities on one side. The MDS documented R24 was dependent on staff assistance for her ADLs during the observation period.

R24's "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 09/11/24 documented she was alert and able to make her needs known. R24 was cooperative with her care and periods of confusion.

R24's "Care Plan" dated 06/20/24 documented staff would encourage her to use the supportive devices as tolerated. The plan of care dated 11/14/24 documented staff may use a washcloth in her hand as tolerated to prevent further contracture formation. Staff may also use a weighted puppy stuffed animal on the forearm of her upper left extremity for comfort. The plan of care also documented that R24 could wear a

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hand splint for up to one hour at a time, up to three times a day as tolerated, to prevent further contracture formation. The plan of care dated 12/23/24 documented that therapy would screen R24 as needed for further contracture prevention and management.

Review of R24's EMR from 12/01/24 to 01/29/25 lacked documentation of R24's supportive devices being applied or refused.

On 01/29/25 at 10:02 AM, R24 lay asleep on her bed; her bed was in the lowest position. R24's hand rested on her chest area. R24's hands lacked any time of contracture prevention device in the palms of her hands. R24's one call light was pinned to the cord on the wall at the foot of her bed. R24's pancake call light was pinned to her recliner, which also was at the foot of her bed, out of reach.

On 01/29/25 at 04:05 PM, R24 lay asleep on her bed; her bed was in the lowest position. R24's hand rested on her chest area. R24's hands lacked any time of contracture prevention device in the palms of her hands.

On 01/30/25 at 11:03 AM, R24 lay asleep on her bed; her bed was in the lowest position. R24's hand rested on her chest area. R24's hands lacked any time of contracture prevention device in the palms of her hands.

On 01/30/25 at 11:02 AM, Certified Medication Aide (CMA) R stated she did not believe there was anywhere to document the application of any contracture prevention supportive devices for R24.

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F 688	Continued From page 23 On 01/30/25 at 11:15 AM, Licensed Nurse (LN) I stated the therapy department determined what supportive devices would be utilized for contracture care. LN I stated she thought R24 had difficulty with the palm supportive device in November 2024 and was referred to therapy. On 01/30/25 at 01:10 PM, Administrative Nurse D stated the therapy department maintained contracture care. Administrative Nurse D stated she expected the care plan to be followed. The facility's "Range of Motion" policy, last revised 01/2023, documented it was the policy of the facility to prevent a resident's loss of range of motion (ROM). Appropriate treatment and services would be administered to increase the range of motion and/or prevent further decrease in the range of motion. Residents would be assessed to determine the level of range of motion. Preventive care would be provided so that the resident would not experience a reduction in range of motion unless clinical condition demonstrates a decline was unavoidable. The facility failed to ensure R24 received services and treatment for his contractures to prevent an avoidable reduction of ROM. This deficient practice left R24 at risk for further decline and discomfort.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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§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 72 residents. The sample included 19 residents, with two residents reviewed for accidents and/or hazards. Based on observation, record review, and interview, the facility failed to secure an electrical furnace closet out of reach of 30 cognitively impaired/independently mobile residents. The facility additionally failed to ensure Resident (R)19's care-planned fall interventions were in place. This deficient practice placed the identified residents at risk for preventable injuries and accidents.

Findings Included:

- On 01/28/25 at 07:05 AM, an initial walkthrough of the facility was completed. Upon inspection of the West Hall, it revealed a furnace closet next to the resident rooms. The closet double doors were locked but easily pulled open due to damage to the door's frame. The closet contained numerous electrical boxes that contained the warning, "high voltage - danger of electric shock."

On 01/28/25 at 07:06 AM, Administrative Staff B verified the door would not secure and stated the room should be lockable. She stated maintenance was on the way to the facility.

On 01/28/25 at 07:35 AM, The door was fixed by maintenance.

On 01/30/25 at 11:07 PM, Administrative Staff A

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identified 30 cognitively impaired / independently mobile residents within the facility.

ON 01/30/25 at 01:07 PM, Administrative Nurse D stated all hazardous materials and electrical closets should remain locked and inaccessible for the residents.

The facility's "Accident" policy revised 01/2023 indicated the facility was expected to ensure an environment that was free from hazards and potential injuries. The policy indicated staff were expected to assess the care environment and report all potential areas of concern to prevent avoidable accidents.

The facility failed to secure an electrical furnace closet out of reach of 30 cognitively impaired / independently mobile residents. This deficient practice placed the identified residents at risk for preventable injuries and accidents.
- R19's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of muscle weakness, lack of coordination, dementia (a progressive mental disorder characterized by failing memory and confusion), repeated falls, history of falls, and cognitive communication deficit.

The "Admission Minimum Data Set" (MDS) dated 01/29/24 documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R19 had a history of falls prior to her admission. The MDS documented R19 had a non-injury fall during the observation period.

The "Quarterly MDS" dated 10/31/24 documented a BIMS score of 12, which indicated moderately

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impaired cognition. The MDS documented that R19 was at risk of development of pressure ulcers. The MDS documented that R19 had one non-injury fall and two injury falls during the observation period.

R19's "Falls Care Area Assessment" (CAA) dated 02/05/24 documented she had a history of falls related to a functional decline. R19 required supervision and assistance. R19 had one non-injury fall since her admission.

R19's "Care Plan" dated 12/02/24 documented Dycem (non-slip mat used for stabilization and gripping to prevent slipping) was placed in R19's wheelchair to reduce her risk of sliding out of the wheelchair.

R19's EMR under the "Assessment" tab revealed a "Fall Risk Evaluation" dated 12/27/24, which documented R19 was a high fall risk.

On 01/29/25 at 10:17 AM, R19 sat in her recliner with her lower extremities elevated. R19's wheelchair was the foot of her recliner. The wheelchair lacked Dycem or pressure-reducing cushion.

On 01/30/25 at 10:51 AM, R19 sat in her recliner and watched TV. R19's wheelchair sat next to her bed with a folded white bath towel in the seat of the wheelchair. The wheelchair lacked a pressure-reducing cushion and a Dycem.

On 01/30/25 at 10:53 AM, Certified Nurse Aide (CNA) N stated R19 was at risk for falls. CNA N stated she was not sure if R19 should have a Dycem in her wheelchair.

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F 689	Continued From page 27 On 01/30/25 at 10:58 AM, Licensed Nurse (LN) H stated that R19 should have Dycem in her wheelchair to prevent her from sliding out of her chair. LN H stated it was everyone's responsibility to ensure all fall interventions are in place. On 01/30/25 at 01:10 PM, Administrative Nurse D stated she expected everyone to ensure fall interventions were in place for each resident. The facility's "Fall Prevention" policy, last revised 01/20/23, documented it was the policy of the facility to investigate the circumstances surrounding each resident fall and implement actions to reduce the incidence of additional falls and minimize the potential for injury. The facility failed to ensure that Dycem was in the wheelchair or recliner as care planned for R19, who had multiple falls. This deficient practice placed R19 at further risk for injuries related to falls.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		

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indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 72 residents. The sample included 19 residents, with two residents reviewed for bowel/bladder incontinence, a catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid), and urinary tract infection (UTI - an infection in any part of the urinary system). Based on observation, record review, and interviews, the facility failed to provide appropriate treatment for Resident (R) 67 with an indwelling catheter (a tube inserted into the bladder to drain urine into a collection bag) when the facility failed to prevent his catheter drainage bag from resting on the floor. This deficient practice placed R67 at risk for catheter-related complications.

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Findings included:

- R67's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of benign prostatic hyperplasia (BPH - non-cancerous enlargement of the prostate, which can lead to interference with urine flow, urinary frequency, and urinary tract infections), cognitive-communication deficit, and hypertension (HTN - elevated blood pressure).

The "Admission Minimum Data Set" (MDS) dated 07/03/24 documented a Brief Interview of Mental Status (BIMS) score of one, which indicated severely impaired cognition. The MDS documented R67 had an indwelling catheter during the observation period. The MDS documented R67 was dependent upon staff assistance for toileting hygiene.

The "Quarterly MDS" dated 12/27/24 documented a BIMS score of seven, which indicated severely impaired cognition. The MDS documented that R67 had an indwelling catheter during the observation period. The MDS documented R67 was dependent on staff assistance for toileting.

R67's "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA) dated 07/17/24 documented he was admitted with the indwelling catheter.

R67's "Care Plan" dated 01/13/25 documented nursing staff would position his catheter bag and tubing below the level of his bladder. The plan of care also documented the staff position R67's catheter bag away from the entrance of the room door.

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R67's EMR under the "Orders" tab revealed the following physician orders:
Catheter care every shift related to BPH dated 01/23/25.

Leave catheter in place until urology appointment dated 01/23/25.

On 01/29/25 at 03:36 PM, R67 sat reclined in his recliner. R67's catheter bag and tubing, which contained amber-colored urine, rested directly on the floor under his recliner.

On 01/30/25 at 10:53 AM, Certified Nurse Aide (CNA) N stated that R67's catheter bag and tubing should never be on the floor.

On 01/30/25 at 10:58 AM, Licensed Nurse (LN) H stated that R67's catheter bag should never be placed on the floor.

On 01/30/25 at 01:10 PM, Administrative Nurse D stated R67's catheter bag or tubing should never be on the floor. Administrative Nurse D stated sometimes it was hard to find a good place to attach the catheter bag on the recliners.

The facility's "Indwelling Urinary Catheter Care" policy, last revised 01/2023, documented it was the policy of the facility that each resident with an indwelling catheter would receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection.

The facility failed to ensure the standard of care was provided for R67's catheter bag, which rested directly on the floor. This. This deficient practice placed R67 at risk of catheter-related

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F 690	Continued From page 31 complications.	F 690		
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 72 residents. The sample included 19 residents, with two residents reviewed for respiratory care. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 28 had his physician-ordered supplemental oxygen on as ordered. The facility failed to ensure R28's nasal cannula (NC - a thin hollow tube that assists in providing supplemental oxygen) was appropriately stored when not used. This deficient practice placed R28 at risk of respiratory complications and possible infection. Findings included: - R28's Electronic Medical Record (EMR) documented diagnoses of chronic respiratory failure (a condition where your blood does not have enough oxygen), dementia (a progressive mental disorder characterized by failing memory and confusion), and congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid).	F 695		

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R28's "Admission Minimum Data Set (MDS)" dated 07/21/24 documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. R28 had an impairment of his lower extremity on one side. R28 used a wheelchair to assist with mobility. R28 required substantial assistance to total dependence on staff for his functional abilities and activities of daily living (ADL). R28 was frequently incontinent of bowel and bladder. R28 required supplemental oxygen. R28 required using a Bilevel positive airway pressure (BiPAP - ventilation device that helps people with breathing difficulties by providing pressurized air through a mask worn over the nose or mouth) machine.

R28's "Quarterly MDS," dated 10/21/24, documented a BIMS score of 13, which indicated intact cognition. R28 had an impairment of his lower extremity on one side. R28 used a wheelchair to assist with mobility. R28 was dependent on staff for all functional abilities and ADLs. R28 was occasionally incontinent of bowel and bladder. R28 required supplemental oxygen. R28 required using a BiPAP at night.

R28's "Functional Abilities Care Area Assessment (CAA)" dated 07/24/24 documented he was admitted after a fall and then had a hospitalization due to a change in cognition and continued functional decline. R28 continued supplemental oxygen and BiPAP. R28 was dependent on staff for self-care and mobility tasks. R28 was able to make needs known. R28 used a wheelchair for primary locomotion.

R28's Care Plan, last revised on 11/14/24, directed staff to set supplemental oxygen at two

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liters continuously via nasal cannula. Staff was directed that R28 required BiPAP at night per setting as ordered.

R28's "Order Summary" documented a physician's order dated 12/08/24 for continuous oxygen via NC at two liters.

On 01/28/25 at 10:39 AM, R28 lay on his bed. R28's room door was open. R28's NC was attached to the oxygen concentrator (a machine that provides supplemental oxygen). The NC was not on R28 and was noted not to be in the provided storage bag. The oxygen concentrator was not turned on.

On 01/30/25 at 12:29 PM, Certified Nurse Aide (CNA) M stated if a resident was supposed to be on continuous oxygen, that should be in the care plan. CNA M stated R28 was on oxygen and a BiPAP at night. CNA M stated the NC should be stored in a plastic bag when not in use and should be replaced if it was found on the floor.

On 01/30/25 at 12:47 PM, Licensed Nurse (LN) H stated R28 should have his supplement oxygen on all the time due to his respiratory issues. LN H stated it was the responsibility of all nursing staff to ensure a resident has their oxygen on to avoid further breathing issues.

On 12/30/25 at 01:05 PM, Administrative Nurse D stated all staff should be checking residents to ensure they have their oxygen on and the tubing was properly stored when not in use. R28 was supposed to be on continuous oxygen.

The "Oxygen Administration (Mask, Cannula)" policy revised in January 2023 documented that

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F 695	Continued From page 34 oxygen therapy was administered as ordered by the physician or as an emergency measure until the order could be obtained. The facility failed to ensure R28 had his physician-ordered supplemental oxygen was on as ordered. The facility failed to ensure R28's NC was properly stored when not in use. This deficient practice placed R28 at risk of respiratory complications and possible infection.	F 695		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides.	F 726		

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The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:

The facility identified a census of 72 residents. The sample included 19, with one reviewed for competent staffing. Based on interviews and record reviews, the facility failed to ensure staff possessed the appropriate skills and knowledge to order Resident (R) 33's physician-ordered eyedrops. This deficient practice placed R33 at risk for impaired quality of care.

Findings included:

- The "Medical Diagnosis" section within R33's Electronic Medical Records (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, cognitive-communication deficit, and cerebral infarction (stroke - 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).

R33's "Admission Minimum Data Set (MDS)" completed 10/18/24 noted a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. The MDS indicated she required partial to moderate assistance from staff to complete transfers, toileting, bathing, dressing, bed mobility, and personal hygiene. The MDS noted she had adequate vision and did not have corrected lenses.

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R33's "Dementia Care Area Assessment (CAA)" completed 01/24/25 noted she required supervision and moderate assistance for her activities of daily living (ADLs) related to her severe cognitive impairment. The CAA noted she was at risk for a functional decline, incontinence, skin breakdown, and nutritional impairment. The CAA noted she was able to converse with staff and make her needs known.

R33's EMR under "Physician Orders" revealed an order (started 01/15/25) for staff to administer Refresh Plus Ophthalmic Solution (artificial tear eye drops used to treat dry eyes), one drop in her right eye four times daily for dry eyes.

R33's EMR under "Progress Notes" revealed a "Nursing" note completed 01/14/25. The note revealed nursing staff received R33's prescribed eyedrop medication on 01/07/25 and instructions from her representative to contact her outside medical provider. The note indicated that R33's eyedrops were never added to her orders or administered. The note indicated staff called R33's outside medical provider on 01/07/25 but were not able to reach him. The note indicated the information was passed on to the next shift. The note revealed the facility never followed up with the provider until 01/14/25. The note indicated that R33's eyedrops had to be reordered from the pharmacy on 01/14/25 and were delivered on 01/15/25.

On 01/28/25 at 09:01 AM, R33's resident representative stated the facility failed to administer prescribed R33's eyedrops ordered on 01/07/24 by her eye doctor. He stated he complained to the facility that she had not given her eye drops for over a week since they had

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F 726	Continued From page 37 been ordered. He stated he dropped off R33's eyedrops to the nurse on duty and explained that R33 was to receive the drops four times a day. On 01/30/25 at 08:15 AM, Licensed Nurse (LN) G stated when the resident came back to the facility with outside orders, the nurse on duty was responsible for verifying the orders and placing them in the EMR system. She stated the facility was responsible for following through with all medication orders and not delaying the resident's medication routine. On 01/30/25 at 01:07 PM, Administrative Nurse D stated nursing staff were responsible for ensuring all medication orders were received, verified, and entered accurately to ensure the continuity of care. The facility's provided "Nursing Staff Competency" policy revised 12/2023 indicated the facility was to ensure staff had the sufficient competencies and skill sets to provide nursing services to ensure resident safety. The facility failed to ensure staff possessed the appropriate skills and knowledge to ensure Resident (R)33's physician-ordered eyedrops were ordered and administered. This deficient practice placed R33 at risk for impaired quality of care.	F 726		
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,	F 744		

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mental, and psychosocial well-being.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 72 residents. The sample included 19 residents, with one 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) 65 to promote his highest practicable level of well-being, resulting in numerous non-injury falls. This deficient practice placed R65 at risk for decreased quality of life, isolation, and impaired dignity.

Findings Included:

- The "Medical Diagnosis" section within R65's Electronic Medical Records (EMR) included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dysphagia (difficulty swallowing), muscle weakness, cognitive-communication disorder, and a history of falls.

R65's "Quarterly Minimum Data Set (MDS)" completed 10/18/24 revealed a Brief Interview for Mental Status (BIMS) score of six that indicated severe cognitive impairment. The MDS revealed no wandering, rejection of care, or aggressive behaviors since his admission. The MDS noted he had lower extremity impairments. The MDS noted he used a wheelchair for mobility. The MDS noted he required substantial to maximal assistance with transfers, bed mobility, dressing, bathing, personal hygiene, and mobility in his wheelchair. The MDS revealed he had multiple

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non-injury falls since his admission.

R65's "Dementia Care Area Assessment (CAA)" completed 04/20/24 indicated he was at risk for falls, nutritional impairment, incontinence, and skin breakdown related to his severe cognitive impairments and medical diagnoses.

R65's "Care Plan" initiated 04/17/24 noted he had a functional deficit related to his dementia and limited mobility. The plan noted he required substantial assistance from staff for transfers, bathing, dressing, oral hygiene, toileting, and bed mobility. The plan noted he had numerous non-injury-related falls and was at risk. The plan instructed remind him to use his soft-touch call light and ensure it was within his reach (05/28/24). The plan noted R95's foot pedals were to be on his wheelchair while being pushed by staff (07/19/24). The plan noted occupational therapy was to evaluate him for the use of some fidget devices to use at the nurse's station to prevent falls (10/11/24).

R65's EMR revealed no documentation related to the attempted use of the fidget devices or R65's refusal to use the devices.

R65's EMR under "Progress Notes" revealed a "Fall Committee Note" completed on 07/22/24. The note indicated R65 had a minor injury fall on 07/19/24. The note revealed R65 fell out of his wheelchair while being pushed in the hallway without foot pedals. The note revealed R95 became fatigued while he attempted to hold his legs up. The note revealed he suffered a skin tear on his left elbow, left wrist, left hand, and below his left eye. The note revealed all staff were educated to utilize foot pedals for the

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wheelchairs.

R65's EMR under "Progress Notes" revealed a "Fall Committee Note" completed on 09/30/24. The note revealed he had a non-injury on 09/29/24. The note revealed staff found him lying on the floor in his room. The note revealed R65 was confused and reported to staff he was working on his tractor at the time of his fall. The note revealed R65 had continued impulsiveness and lacked safety awareness. The note indicated occupational therapy was to evaluate and determine a plan to utilize some fidget devices to use at the nurse's stations to engage his interest in tractors.

R65's EMR under "Progress Notes" revealed a "Fall Committee Note" completed on 10/11/24. The note revealed he had a non-injury fall on 10/10/24. The note revealed R65 fell out of his bed while he attempted to transfer himself out of bed. The note revealed R65's care-planned fall mat was not in place at the time of his fall, and he suffered a right arm skin tear. The note revealed he was assessed with no major injuries.

R65's EMR under "Progress Notes" revealed a "Fall Committee Note" completed on 11/01/24. The note revealed R65 had a non-injury fall in his room when he attempted to transfer himself from his wheelchair to his bed. The note indicated he was impulsive and had poor safety awareness.

R65's EMR under "Progress Notes" revealed a "Fall Committee Note" completed on 12/28/24. The note revealed R65 reported he attempted to self-transfer to his bed and slid out of his wheelchair. The note revealed staff assessed him and moved him to the nurse's station to sit.

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On 01/27/25 at 08:30 AM, R95 sat at the East Hall nurse's station. R65 had no activities or entertainment. R65 remained at the nurse's station until lunchtime at 11:05 AM. At 12:34 AM, R65 returned to the East Hall nursing station. R65 sat at the nurse's station desk until 02:15 PM without any activity or staff engagement.

On 01/30/25 at 12:30 PM, Certified Nurse Aide (CNA) M stated R65 was impulsive and would often attempt to move himself or transfer without assistance. She stated he liked tractors and talking about farming. She stated staff would often talk to him about farming. She stated the faculty attempted using fidget devices to engage, but he would refuse. She was not sure where the refusals were documented. She stated staff were expected to ensure his fall mat and foot pedals were in place to prevent falls or injuries.

On 01/30/25 at 01:07 PM, Administrative Nurse D stated sensory devices were used on him, but he would refuse to use them. She stated he would talk about farming and tractors with staff for entertainment. She stated staff were also expected to ensure his current fall interventions were in place.

The facility's "Care of Dementia" policy revised 01/2023 indicated the facility was to provide each resident with individualized care interventions and use the last restrictive approaches to care. The policy noted each resident was evaluated and provided interventions to address each resident's needs.

The facility failed to provide dementia-related behavioral services for R65 to promote his

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F 744	Continued From page 42 highest practicable level of well-being, resulting in numerous non-injury falls. This deficient practice placed R65 at risk for decreased quality of life, isolation, and impaired dignity.	F 744		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 72 residents. The sample included 19 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure physician parameters were followed for a hypertensive medication (class of medication used to treat	F 757		

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hypertension (high blood pressure) for Resident (R) 2. This deficient practice had the potential of unnecessary medication administration, thus leading to possible harmful side effects.

Findings included:

- R2's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid) and hypertension.

The "Admission Minimum Data Set" (MDS) dated 10/22/24 documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition.

The "Quarterly MDS" dated 12/16/24 documented a BIMS score of 14, which indicated intact cognition.

R2's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 10/29/24 documented she had a history of falls. R2 had periods of agitation.

R2's "Care Plan," dated 10/22/24, documented staff would administer her medication as ordered.

R2's EMR under the "Orders" tab revealed the following physician orders:
Carvedilol (antihypertensive) oral tablet 3.125 milligrams (mg) give one tablet by mouth two times a day for HTN. Hold if systolic blood pressure (SBP - relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was less than (<) 110 millimeters of mercury

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(mmHg) or diastolic blood pressure (minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) is < 60mmHg dated 01/23/25.

Review of R2's "Medication Administration Record" (MAR) from 01/01/25 to 01/27/25 (27 days) revealed 12 (BP below-set parameter) was documented (seven times) on the following dates 01/02/25, 01/03/25, 01/11/25, 01/16/25, 01/20/25, 01/21/25, and 01/25/25. The MAR and clinical record lacked documentation of R2's BP.

On 01/30/25 at 10:02 AM, R2 sat on her recliner with her feet elevated as she was using her cell phone.

On 01/30/25 at 11:02 AM, Certified Medication Aide (CMA) R stated she obtained R2's BP and held Carvedilol if the BP was outside the parameter. CMA R stated there had been a place to document the BP on the MAR.

On 01/30/25 at 11:15 AM, Licensed Nurse (LN) I stated CMA should report any BP that was outside the physician-ordered parameters prior to holding that medication. LN I stated yes, the BP should be recorded so the physician could review the BP outside the ordered parameters.

On 01/30/25 at 01:10 PM, Administrative Nurse D stated she expected the physician orders for hold parameters to be followed and the care plan to be followed.

The facility's "Physician Orders" policy, last revised 01/2023, documented it was the policy of the facility that drugs would be administered only

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F 757	Continued From page 45 upon the written order of a person duly licensed and authorized to prescribe such drugs. The facility failed to ensure staff followed the physician-ordered parameter for monitoring R2 Carvedilol. This deficient practice had the potential of unnecessary medication administration, thus leading to possible harmful side effects.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		

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§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 72 residents. The sample included 19 residents, with five sample residents reviewed for unnecessary medications. Based on observation, record review, and interview. The facility failed to ensure Resident (R) 8 had an adequate Centers for Medicare and Medicaid (CMS) approved indication for the use of an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication. This deficient practice placed the resident at risk for unnecessary medication administration and related complications.

Findings included:

- The Electronic Medical Record (EMR) for R8

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documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (a progressive mental disorder characterized by failing memory and confusion), and hypertension (elevated blood pressure).

R8's Admission Minimum Data Set (MDS)" dated 01/16/25 documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated severely impaired cognition. R8 required supervision with his self-care and mobility. R8 required moderate assistance from staff with bathing. R8 ambulated with a walker. R8 was taking an antipsychotic medication.

R8's "Psychotropic Drug Use Care Area Assessment (CAA)," dated 01/22/25, documented he was taking Seroquel (an antipsychotic medication) daily to manage moods related to Alzheimer's dementia with agitation. R8 was monitored for targeted behaviors and adverse side effects. This was not a new medication for R8.

R8's "Care Plan" directed staff to document episodes of behavior such as agitation. The care plan directed staff that R8 took Seroquel. Staff was directed to document medication side effects and non-pharmacological interventions used.

R8's "Order Summary" in the EMR documented an order dated 01/23/25 for Seroquel 50 milligram (mg) tablet to give one and a half tablets by mouth daily for Alzheimer's dementia with behavioral disturbance target behavior of agitation.

A pharmacy review had not been conducted on

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R8's medication by the consultant pharmacist yet.

On 01/29/25 at 03:35 PM, R8 lay on his bed. R8 stated he was tired after working with therapy earlier today.

On 01/30/25 at 12:47 PM, Licensed Nurse (LN) H stated she could not say for certain what an appropriate diagnosis was for the use of Seroquel. LN H stated the pharmacy did help the facility a lot with the medications and would let the facility know if a medication did not have a correct diagnosis. LN H stated that Administrative Nurse D reviewed the medications after they had been entered into the Medication Administration Record (MAR).

On 01/30/25 at 01:05 PM, Administrative Nurse D stated she reviewed each resident's medications and checked to ensure an appropriate diagnosis was used for the medication. Administrative Nurse D stated that Alzheimer's disease nor dementia were approved diagnoses for the use of an antipsychotic medication. Administrative Nurse D stated that R8 came to the facility after being on the Seroquel for some time. Administrative Nurse D stated she would ensure to get the appropriate documentation from R8's physician for the Seroquel.

The facility did not provide a policy regarding psychotropic medications or physician orders as requested.

The facility failed to ensure R8 had an adequate CMS-approved indication for the use of the antipsychotic medication Seroquel. This deficient practice placed the R8 at risk for unnecessary medication administration and related

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F 758	Continued From page 49 complications.	F 758		
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 identified a census of 72 residents. The sample included 19 residents, four medication carts, and two medication rooms. Based on observation, record review, and interviews, the facility failed to properly store medications in two of the four medication carts. The facility also failed to label medication in one	F 761		

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of the two medication carts. This placed the residents at risk for adverse outcomes or ineffective medication regimens.

Findings included:

- During the initial tour on 01/28/25 at 07:10 AM, a medication cart on the West hallway was unlocked and unattended in the hallway.

On 01/28/25 at 07:19 AM, the second medication cart on the West hallway was unlocked and unattended. The medication cart contained two opened, undated insulin (a hormone that lowers the level of glucose in the blood) pens.

On 01/28/25 at 07:12 AM, Certified Medication Aide (CMA) R stated she thought she had locked the medication cart when she had walked away from the cart. CMA R stated the medication cart should never be left unlocked when not in use.

On 01/28/25 at 07:23 AM, Licensed Nurse (LN) G stated the medication cart should never be left unlocked when out of view. LN G stated insulin pens should be labeled with the open date and the discard date.

On 01/30/25 at 01:10 PM, Administrative Nurse D stated she expected the insulin pens to be stored in the refrigerator until they were to be used. Administrative Nurse D stated once the insulin pen was removed from the refrigerator, the insulin pen should have an open date and a discard date and be stored in the locked medication cart.

The facility's undated "Storing and Controlling Medications" policy documented the facility would

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F 761	Continued From page 51 store medications safely, securely, and properly following the manufacturer's recommendations or those of the supplier and in accordance with federal and state laws and regulations. The medication supply was accessible only to authorized personnel. The facility failed to properly label and store medications. This deficient practice could potentially cause adverse consequences or ineffective treatment to the affected residents.	F 761		
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 identified a census of 72 residents. The facility had one main kitchen and one dining room. Based on observation, record review, and	F 812		

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interview, the facility failed to ensure food was properly stored. The facility failed to ensure that the freezer was in proper working condition. The facility failed to ensure freezer temperatures remained at the required temperatures. The facility failed to ensure food temperatures were logged to ensure appropriate temperatures were reached before serving.

Findings included:

- Upon entry to the kitchen on 01/28/245 at 07:20 AM, it was observed and noted:

In the server refrigerator, a half-gallon container of cottage cheese was over half empty and lacked an open date on the outside of the container. A gallon container of milk had been opened but lacked an open date.
The bread rack had three opened loaves of bread and buns that were not in sealed, dated, or labeled bags.

The dry storage room had a bag of macaroni and a bag of pasta shells that had been opened but were not in a sealed, dated, or labeled bag.
The walk-in freezer had a package of opened potato patties that were not in a sealed, dated, and labeled bag. A bag of breaded chicken strips had been opened but was not in a sealed, dated, or labeled bag. A bag of breadsticks was open but was not in a sealed, dated, or labeled bag.

Upon request, the facility was unable to provide daily prepared food temperature logs.

A review of the November 2024 Refrigerator/Freezer Temperature Log revealed on the days of 11/24/24 to 11/28/24, it appeared

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that the walk-in freezer temperatures had been whited out and altered from the original temperature.

A review of the "Daily Food Temperatures" for 12/03/24 lacked the food listing and temperature readings for the breakfast and lunch meals.

A review of the "Daily Food Temperatures" for 12/04/24 lacked the food listing and temperature readings for the breakfast and lunch meals.
An invoice dated 12/11/24 from a heating and cooling company documented a service to clean the condensate drain and thawed out the coil. Verified unit operation, and the temperature was zero degrees upon departure.

Administrative Staff A provided a list of residents from the dates 12/03/24 to 12/06/24 that Resident (R) 3, R6, R16, R26, R27, R35, R44, R47, R56, R57, R58, R67, R116, R173, and R174 had complaints of nausea, vomiting, or diarrhea.

On 01/30/25 at 11:01 AM, Dietary BB stated he was not aware of all the events that had taken place prior to his employment that began in December. Dietary BB stated he was not able to find the food temperature logs for the month of November 2024. Dietary BB stated he was made aware that the previous dietary manager left abruptly. Dietary BB stated that daily temperature logs of food, refrigerators, and freezers needed to be logged. All foods should be in sealed, labeled, and dated bags.

On 01/30/25 at 11:22 AM, Dietary CC stated the former dietary manager was escorted out of the kitchen by Administrative Staff A. Dietary CC stated she was aware that there had been a few

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	175332	A. BUILDING _____ B. WING _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK OF OTTAWA	1100 W 15TH STREET OTTAWA, KS 66067

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F 812	Continued From page 54	F 812		

days in November where the food temperatures had not been logged. Dietary CC stated she was never aware that the walk-in freezer was down or not at the proper temperature.

On 01/39/25 at 02:25 PM, Administrative Staff A stated that the previous dietary manager was escorted out of the building at the end after it was discovered that he had not been logging food temperatures as required. Administrative Staff A stated the prior dietary manager failed to inform her that the walk-in freezer was not retaining the proper temperature until five or six days after it had not been working properly. Administrative Staff A stated she had to call a repair company to come to fix the walk-in. Administrative Staff A stated during the first few days of December 2024, there were numerous resident complaints with symptoms of nausea, vomiting, or diarrhea.

The "Food, Sanitary Conditions" policy revised on January 2023 documented: It was the policy of this facility to procure food from sources approved or considered satisfactory by federal, state, and or local authorities. The facility would store, prepare, distribute, and serve food under sanitary conditions. Hot food would leave the kitchen (or steam table) above 140 degrees Fahrenheit (F) and cold foods at or below 41 degrees F. Freezer temperatures should be at zero degrees F or below. Foods placed in the freezer were to be left in the original wrapping with an identifying label. If an item must be re-wrapped, a moisture-proof wrapping or closed container should be used to prevent freezer burn. All items must be labeled. Food will be covered, wrapped, or packaged to protect against contamination during food transport.

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F 812	Continued From page 55 The facility failed to ensure food was properly labeled and stored. The facility failed to ensure that the walk-in freezer maintained proper temperatures. The facility failed to ensure food temperature was logged to ensure the appropriate temperatures were reached before serving.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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	F 880		

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

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 72 residents. The sample included 19 residents. Based on

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F 880	Continued From page 57	F 880		

record review, observations, and interviews, the facility additionally failed to follow sanitary infection control practices related to oxygen equipment storage and Foley catheter care. These deficient practices placed the residents at risk for infectious diseases.

Findings Included:

- On 01/29/25 at 03:36 PM, Resident (R) 67 sat in his recliner in his room. R67's urinary catheter collection bag rested directly on the floor. Amber-colored urine was visible in his collection bag.

On 01/28/25 at 10:40 AM, R28's supplemental oxygen nasal cannula was found resting on top of his bed. No plastic storage bag was observed in his room.

On 01/30/25 at 12:04 PM, Certified Nurse's Aide (CNA) M stated all oxygen tubing and equipment should be stored inside clean plastic bags when not in use. She stated the tubing and cannulas should be replaced when contaminated. She stated the masks should be wiped down. She stated the urine collection bag was to be placed below the level of the bladder and never touch the floor.

On 01/30/25 at 01:07 PM, Administrative Nurse D stated staff were expected to store the oxygen tubing and equipment in bags once the residents were out of the rooms. She stated the catheter collection bag and tubing were to be maintained below the level of the resident's bladder to prevent the backflow of urine. She stated no part of the urinary catheter should touch contaminated surfaces.

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F 880	Continued From page 58 The facility's "Infection Prevention and Control Program" policy revised 10/2022 indicated all staff were expected to be trained and follow safe infection prevention practices. The policy noted the facility was to ensure medical equipment was handled and stored in a manner that reduced the risk of contamination and exposure to contaminated surfaces. The policy noted oxygen therapy equipment was to be stored in a clean bag when noted in use. The policy noted the tubing or attachments must never come in contact with potentially contaminated surfaces. The policy indicated urinary catheter equipment must be maintained in a manner to prevent potential infection risks or urinary tract infections. The facility additionally failed to follow sanitary infection control practices related to oxygen equipment storage and Foley catheter care. These deficient practices placed the residents at risk for infectious diseases.	F 880		