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	165324	A. BUILDING _____ B. WING _____	03/30/2023

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ACCURA HEALTHCARE OF PLEASANTVILLE, LLC	909 NORTH STATE STREET PLEASANTVILLE, IA 50225

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F 000	INITIAL COMMENTS Correction Date_____. An Annual Recertification survey and investigation of Complaints # 110108-C, # 110338-C and Facility Reported Incident # 110814-I were conducted on March 20, 2023 to March 30, 2023. Complaint #110338-C was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	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	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/19/2023

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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 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:
Based on observation, record review, and staff interview, the facility failed to treat a resident in a dignified manner for 1 of 4 residents reviewed for dignity(Resident #6). The facility reported a census of 46 residents.

Findings Include:

1. The Minimum Data Set(MDS) assessment tool, dated 1/31/23, listed diagnoses for Resident #6 which included heart failure, diabetes, and non-Alzheimer's dementia. The MDS stated the
resident required extensive assistance of 2 staff for toileting and listed the resident's Brief Interview for Mental Status(BIMS) score as 6 out of 15, which indicated severely impaired cognition.

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During an observation on 3/23/23 at 12:09 p.m., Resident #6 was in the dining room and stated to Staff C Licensed Practical Nurse(LPN) that she had to go to the bathroom. Staff C stated to her "no, you were just there, you need to eat". At this time, the dining room was full of residents and Staff C could be heard from across the room. The resident started to roll away from the table and Staff L Dietary Aide asked the resident if she wanted to eat and the resident stated to Staff L that she had to go to the bathroom and continued to roll away from the table. Staff C was present and was within earshot of the resident stating this to Staff L. Staff C then told the resident to "come and eat". The resident returned to the table at 12:13 p.m. and started to eat but stated again to Staff C that she had to urinate. Staff C then whispered to her that she had a catheter and stated this in a loud enough voice that she could be heard across the dining room.

During an interview on 3/29/23 at 9:50 a.m., the Director of Nursing(DON) stated if Resident #6 stated she had to urinate, staff should take her and should "absolutely" not say anything about it out loud. She stated what Staff C stated to the resident in the dining room should not have happened and it was a dignity issue.

During an interview on 3/29/23 at 3:03 p.m., the Administrator stated what Staff C said to Resident #6 was disappointing and staff should treat residents with respect and talk to them quietly without trying to embarrass them.

An email sent by the Administrator on 3/30/23 at 8:56 a.m. stated the facility did not have a policy related to dignity but the facility followed the

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F 550	Continued From page 3 standards of care and/or the regulations.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or 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	F 580		

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update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review, family interview and staff interview, the facility failed to document family had been notified with significant changes in the resident's condition for one of six residents reviewed. (Resident #36). The facility reported a census of 46 residents.

Findings included:

The Minimum Data Set (MDS) dated 2/23/23 identified Resident #36 as severely cognitively impaired with a BIMS score of 0 and identified the resident with the following diagnoses: Diabetes Mellitus, Osteoperosis (a condition where the bones become brittle and fragile) and Cerebrovascular Accident (stroke). The MDS also identified the resident as totally dependent on staff for transfers, locomotion on and off the unit, eating and bathing. The MDS documented that the resident required extensive staff assistance with bed mobility, dressing, toileting and personal hygiene.

A review of the Care Plan with the last revision

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date of 2/27/23 identified the resident with the problem of at risk for alteration in blood glucose levels related to routine use of insulin and diagnosis of diabetes on 7/22/20 and did not direct staff to notify family of any changes in condition.

During an interview on 3/21/23, the resident's family member reported the facility did not notify her after the resident had a very high blood sugar and if they were able to lower the sugar with insulin afterward and did not notify her when the resident had to be admitted to the hospital on 2/1/23.

A review of the nurse's notes revealed the following:

11/14/22 at 3:18 PM Late entry for 11/7/22 this nurse forgot to hook up the feeding tube. The doctor and Power of Attorney (POA) had been notified.
2/1/23 at 2:58 AM Resident's blood sugar monitor read High, called on call, wanted her sent to ER (emergency room). called EMS (emergency medical services) and they will send someone this way.
2/1/23 at 3:05 AM resident's daughter notified of elevated BS (blood sugar)
2/1/23 at 3:35 Resident transported by ambulance to the hospital.
2/1/23 at 1:28 PM Spoke with hospital regarding resident condition and transferred to another hospital for further testing to be completed. Admitted with aspiration pneumonia. Evaluating cause of hyperglycemia.
2/17/23 at 9:21 PM Blood sugar 67 and resident laid in bed lethargic. Writer unable to obtain pulse ox (oxygen reading) on the resident due to

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the oximeter not reading. Writer started resident's tube feeding at 80 ml/hr (milliliters per hour) per order and called 911 to transfer resident to ED (emergency department) due to the resident's condition, no PRN (administer as needed) Glucagon order, and writer being unable to access E-Kit (emergency kit)
The notes did not include documentation to show the POA (power of attorney) had been notified of the changes in a timely manner.

A review of the physician history and physical report dated 2/1/23 had documentation of the following:
Records show tonight at 7:30 PM, blood glucose had been 538 and 5 units of Novolog had been given. At 2:30 AM, blood glucose read "high" no further orders had been given. EMS (emergency medical services) started an IV (intravenous fluids) of normal saline. In the ED, she received 6 units of regular insulin IV. The initial physician did not document a blood glucose level.
An addendum documented as added at 6:00 by a second physician identified a concern for renal insufficiency (kidney failure) and sepsis (a body's response to an extreme infection) and given two different IV antibiotics. A blood sugar of 454 required 10 units of Regular Insulin IV.
An addendum added by above physician on 2/1/23 at 10:12 AM revealed another physician recommended an insulin drip. However, given the decrease in glucose from 802 to 494 with 10 units of Regular Insulin IV, felt the insulin drip was not warranted. Later transported to another hospital with the following diagnoses: hyperglycemia, lactic acidosis and acute renal insufficiency.

In an interview on 3/23/23 at 10:14 AM, Staff C,

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F 580	Continued From page 7 LPN reported nurses should notify the resident's family of any changes such as falls, any incidents, hospitalizations and this should be documented in the progress notes. In an interview on 3/23/23 at 11:22 AM, the ADON (assistant director of nursing) reported nurses should notify the resident's family of any changes . In an interview on 3/23/23 at 12:51 PM, the vice president of operations of the facility reported the facility did not have a policy on family notification.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not	F 582		

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covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review, and staff interview, the facility failed to provide advance notice to a resident regarding the charges for services not covered by Medicare. The facility failed to obtain accurate documentation of the options a resident or resident representative chose upon discharge from skilled services for 1 of 2 residents reviewed for discharge from skilled services (Resident

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F 582	Continued From page 9 #44). The facility reported a census of 46 residents. Findings Include: A Therapy Discharge Notification, dated 8/30/22, stated Resident#44 would discharge from therapy. The resident's clinical file lacked an Advance Beneficiary Notice of Non-Coverage form to indicate if the resident wished to continue the services and the estimated charges of those services. The clinical file lacked documentation to indicate whether or not the resident wished to appeal the discharge. The "Medicare Beneficiary Notice Requirements for Skilled Nursing Facilities", dated April 2018, and utilized as the facility's policy, stated the facility would provide the proper notices when a resident discharged from skilled services. On 3/23/23 at 10:00 AM,, the Administrator shared that the facility did not have their own policy but utilized the Medicare Beneficiary Notice form. The business office manager has been trained on the procedure for Medicare Beneficiary Notices.	F 582		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures	F 607		

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F 607	Continued From page 10 to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on personnel file review, policy review, and staff interview, the facility failed to ensure 2 of 8 staff members (Staff E and F) completed dependent adult abuse (DAA) training within 5 years of the previous training. The facility reported a census of 46 residents. Findings Include: Staff E's, Certified Medication Aide (CMA) file contained a dependent adult abuse training certificate dated 3/14/17. Staff F's, Certified Nurses Aide (CNA) file contained a dependent adult abuse training certificate dated 2/19/18.	F 607		

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F 607	Continued From page 11 The facility "Nursing Facility Abuse Prevention, Identification ,Investigation and Reporting Policy" dated 10/19/22, indicated within 6 months every employee was required to take a 2 hour training on recognizing and reporting dependent adult abuse would complete training every 3 years thereafter. On 3/22/23 at 4:00 PM, the Administrator shared that Staff E and Staff F were informed of the need to complete the renewal of dependent adult buse training. The Administrator acknowledged that Employee E and Employee F completed training over 5 years ago.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		

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§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review, and staff interview, the facility failed to immediately report an allegation of abuse to the State Agency for 1 of 1 residents reviewed for an allegation of abuse (Resident #1). The facility reported a census of 46 residents.

Findings Include:

1. The Minimum Data Set(MDS) assessment tool, dated 1/12/23, listed diagnoses for Resident #1 which included Alzheimer's disease, anxiety disorder, and depression. The MDS documented the resident completely depended on 1 staff for toilet use, personal hygiene, and bathing, and completely depended on 2 staff for bed mobility and transfers. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 0 out of 15, which indicated severely impaired cognition.

A Care Plan entry, initiated 5/18/22, revealed the resident had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's and directed staff to reduce any distractions and utilize simple, directive sentences.

An undated facility "Self Report" stated on

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1/12/23, Staff K Certified Nursing Assistant (CNA) reported that on 1/11/23 at approximately 3:30 p.m., Staff J CNA took out her vape pen and blew vapor into Resident #1's face during a Hoyer transfer. The report stated the facility notified the State Agency at approximately 5:00 p.m. on 1/12/23.

An untitled employee time clock report stated Staff J worked from 5:51 a.m. until 6:39 p.m. on 1/11/23.

The facility "Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy", updated 10/19/22, stated all allegations of abuse should be reported to the charge nursed and would be reported to the State Agency not later than 2 hours after the allegation was made.

During a phone interview on 3/29/23 at 1:18 p.m., Staff K stated on 1/11/23, she and Staff J transferred Resident #1 from the bed using a Hoyer lift. She stated she(Staff K) was stood by the lift's control panel and Staff K was on the other side of the resident. She stated as the resident was lifted into the air, Staff J pulled out a blue Alto vape pen and blew vapor directly into the resident's face. Staff J stated she felt like it was intentional. Staff K stated she asked Staff J what if the resident was allergic and Staff K stated Staff J stated it was not her problem. Staff K stated this occurred around 4:00 p.m.-4:30 p.m. and stated Staff J worked the rest of her shift until 6:00 p.m. Staff K stated she did not report this that day because the facility had agency management and she felt like they did not really care.

During an interview on 3/29/23 at 3:03 p.m., the

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F 609	Continued From page 14 Administrator stated Staff K was new (at the time of the alleged vape incident) and was concerned with retaliation. She stated Staff K reported it the day after it allegedly occurred. The Administrator stated she would have wanted it reported right away and they would have separated Staff J from residents right away.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, and staff interview, the facility failed to immediately report an allegation of abuse to the State Agency, and failed to separate the staff member from the residents after the incident had been observed for 1 of 1 residents reviewed for an allegation of abuse(Resident #1). The facility reported a census of 46 residents.	F 610		

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Findings Include:

1. The Minimum Data Set(MDS) assessment tool, dated 1/12/23, listed diagnoses for Resident #1 which included Alzheimer's disease, anxiety disorder, and depression. The MDS documented the resident completely depended on 1 staff for toilet use, personal hygiene, and bathing, and completely depended on 2 staff for bed mobility and transfers. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 0 out of 15, which indicated severely impaired cognition.

A Care Plan entry, initiated 5/18/22, stated the resident had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's and directed staff to reduce any distractions and utilize simple, directive sentences.

An undated facility "Self Report" stated on 1/12/23, Staff K Certified Nursing Assistant(CNA) reported that on 1/11/23 at approximately 3:30 p.m., Staff J CNA took out her vape pen and blew vapor into Resident #1's face during a hoyer transfer. The report stated the facility notified the State Agency at approximately 5:00 p.m. on 1/12/23.

An untitled employee time clock report stated Staff J worked from 5:51 a.m. until 6:39 p.m. on 1/11/23.

The facility "Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy", updated 10/19/22, stated upon receiving a report of an allegation of abuse, the facility

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F 610	Continued From page 16 would immediately implement measures to prevent further potential abuse and stated if the allegation involved an employee, the employee would be separated from all residents. During a phone interview on 3/29/23 at 1:18 p.m., Staff K stated on 1/11/23, she and Staff J transferred Resident #1 from the bed using a hoyer lift. She stated she (Staff K) stood by the lift's control panel and Staff K was on the other side of the resident. She stated as the resident was lifted into the air, Staff J pulled out a blue Alto vape pen and blew vapor directly into the resident's face. Staff J stated she felt like it was intentional. Staff K stated she asked Staff J what if the resident was allergic and Staff K stated Staff J stated it was not her problem. Staff K stated this occurred around 4:00 p.m.-4:30 p.m. and stated Staff J worked the rest of her shift until 6:00 p.m. Staff K stated she did not report this that day because the facility had agency management and she felt like they did not really care. During an interview on 3/29/23 at 3:03 p.m., the Administrator stated Staff K was new (at the time of the alleged vape incident) and was concerned with retaliation. She stated Staff K reported it the day after it allegedly occurred. The Administrator stated she would have wanted it reported right away and they would have separated Staff J from residents right away.	F 610		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		

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personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, policy review, and staff interview, the faciltiy failed to assist resident's with incontinence cares and positioning for 3 of 5 residents(Residents #1, #36, and #37) reviewed for activities of daily living(activities of daily living). The facility reported a census of 46 residents.

Findings Include:

1. The Quarterly Minimum Data Set(MDS) assessment tool, dated 1/26/23, listed diagnoses for Resident #37 which included coronary artery disease, diabetes, and Alzheimer's disease. The MDS documented that the resident was always incontinent of urine and frequently incontinent of bowel and listed the resident's Brief Interview for Mental Status(BIMS) score as 0 out of 15, which indicated severely impaired cognition.

Continuous observation on 3/22/23 revealed the following:
At 9:15 a.m., the resident sat at the dining room table eating breakfast. The resident remained at the table. At 10:27 p.m., Staff B Certified Medication Aide(CMA) asked the resident if she wanted to play bingo but did not offer to take her to the bathroom. The resident remained at the table for bingo which lasted until 11:33 p.m. At 11:50 a.m. the Director of Nursing(DON) administered medication to the resident but did not offer to take her to the bathroom. At 12:05 p.m., the resident received her lunch. At 12:42 the DON placed a gait belt on the resident and walked her to the bathroom. The DON pulled

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down the resident's pants and her incontinent brief was saturated with feces and urine. The resident's buttocks were red with indentations present. After the resident sat on the toilet, the DON left the room. The ADON and Staff B returned and assisted the resident with incontinence care. The observation revealed staff did not offer to take the resident to the bathroom or change her incontinent brief during the period from 9:15 a.m.-12:42 p.m.

Care Plan entries, dated 4/20/21 stated the resident had bladder incontinence and would have decreased episodes of incontinence through participation in a bowel/gladder program over the next review period.

A Care Plan entry, dated 6/9/21, directed staff to assist the resident to the toilet before and after meals, at bedtime and as needed.

Per an email from the Adminstrator dated 3/30/23 at 8:56 a.m. the email documented that the facility did not have a specific policy related to toileting and incontinence care. The email further indicated that the faiclity would follow standards of care and or regulations related to toileting and incontinence care.

2. The Minimum Data Set dated 1/12/23 identified Resident #1 as severely cognitively impaired with a BIMS (brief interview for mental status) of 0 and with the following diagnoses: It also identified the resident to be totally dependent on staff for moving in and out of bed, moving in and out of her room, toileting, personal hygiene and bathing and required extensive staff

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assistance with dressing. It also identified her to be incontinent (no control of) bladder and bowel.

A review of the care plan revealed on 2/4/22 identified the resident with being at risk for skin breakdown related to incontinence and immobility and directed staff to reposition her frequently. On 3/7/22 it identified her with being completely incontinent of bowel and bladder due to Alzheimer's and directed staff to provide peri cares twice daily and as needed.

Observations of the resident revealed the resident had not been repositioned or check and changed as follows:
3/22/23 at 10:55 AM remains sitting up in Broda chair, but now in her room watching TV, properly positioned and appears comfortable.
3/22/23 at 11:07 AM assessment unchanged
3/22/23 at 11:09 AM, Staff D, CNA entered res room and dropped a snack for her on her counter by the sink. No cares provided
3/22/23 at 11:27 AM assessment unchanged.
3/22/23 at 11:30 AM Staff B, CNA and Staff D, CNA entered resident's room. Did not check and change resident. Staff B pushed the resident in Broda chair out to the main dining room for lunch. Properly positioned and appears comfortable.
3/22/23 at 12:11 PM resident remains sitting up in Broda chair, able to feed herself in main dining room, properly positioned and appears comfortable
3/22/23 at 12:19 AM assessment unchanged
3/22/23 at 12:26 PM assessment unchanged
3/22/23 at 12:32 PM resident's daughter sat down beside her in main dining room. Assessment unchanged.
3/22/23 at 12:44 PM assessment unchanged
3/22/23 at 12:55 PM Has not been repositioned

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or had cares for 2 hours
3/22/23 at 1:10 PM has not been repositioned for 2 hours and 15 minutes

3. The Minimum Data Set dated 2/23/23 identified Resident #36 as severely cognitively impaired with a BIMS score of 0. It also identified the resident with the following diagnoses: Diabetes Mellitus, Osteoperosis (a condition where the bones become brittle and fragile) and Cerebrovascular Accident (stroke) It also identified the resident as totally dependent on staff for transfers, locomotion on and off the unit, eating and bathing. It identified her as requiring extensive staff assistance with bed mobility, dressing, toileting and personal hygiene.

A review of the care plan revealed the resident had been identified with the following problems:
On 8/30/22 identified with being at risk for skin breakdown due to limited mobility related to stroke and right sided hemiplegia (paralysis on one side) and moisture and directed staff to frequent the resident frequently.
On 7/22/20 identified with being incontinent of urine due to CVA (stroke) history and directed Interventions: Check and change upon awakening, after breakfast in AM, PM, HS (hour of sleep) and PRN (as needed)

Observations of the resident revealed the resident had not been repositioned or check and changed as follows:
3/22/23 at 10:36 AM lying in bed asleep with head of the bed elevated with mattress on the floor beside her bed. Properly positioned and appears comfortable.
3/22/23 at 10:48 AM assessment unchanged
3/22/23 at 11:34 AM assessment unchanged

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F 677	Continued From page 21 3/22/23 at 11:57 AM assessment unchanged 3/22/23 at 12:15 PM assessment unchanged 3/22/23 at 12:38 assessment unchanged. Has not been repositioned or check and changed for 2 hours and 2 minutes 3/22/23 at 12:53 PM assessment unchanged, has not been repositioned or check and changed for 2 hours and 17 minutes. In an interview on 3/23/23 10:46 AM, Staff G, CNA reported residents should be repositioned and check and changed every 2 hours and this should be documented in POC (electronic record) under the tab labeled "tasks". She felt there had not been enough staff to provide residents with the care they need. She is responsible for caring for 16 residents. In an interview on 3/23/23 at 10:59 AM, Staff D, CNA reported residents should be be repositioned and check and changed every 2 hours and this should be documented in POC (electronic record) under the tab labeled "tasks". She felt there had not been enough staff to provide residents with the care they need as there are at least 80% of the residents that require the assist of two to transfer or reposition. She is responsible for 15 or 16 residents. In an interview on 3/23/23 at 12:51 PM, the vice president of operations of the facility reported the facility did not have a policy on repositioning residents.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

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applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to carry out assessments and interventions for for 1 of 3 residents reviewed for hospitalizations (Resident #24), for 2 of 2 residents reviewed for bowel protocols (Residents #15 and #40), for 1 of 1 residents reviewed for an allegation of abuse (Resident #1), and for 1 of 1 residents reviewed for insulin (Resident #36). The facility reported a census of 46 residents.

Findings Include:

1. The Minimum Data Set (MDS) assessment tool, dated 12/15/22, listed diagnoses for Resident #24 which included heart failure, Alzheimer's disease, and non-Alzheimer's dementia. The MDS stated the resident required extensive assistance of 1 staff for dressing, personal hygiene, and bathing, and extensive assistance of 2 staff for bed mobility, transfers, and toilet use. The MDS stated the resident's cognition was severely impaired.

A Care Plan entry, initiated 4/7/22, stated the resident utilized a Hoyer lift for transfers.

A 1/23/23 7:29 a.m. Nursing Note, written as a late entry by Staff A Licensed Practical Nurse(LPN) on 1/26/23 at 5:56 p.m. stated a

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Certified Nursing Assistant(CNA) told the writer that the resident's left knee was swollen. The writer assessed the knee and it was swollen and painful when moved with no bruising and the writer instructed staff members to utilize the Hoyer lift due to pain.

A 1/23/23 1:32 p.m. Nursing Note, written as a late entry by the Assistant Director of Nursing(ADON) on 1/31/23 at 3:44 p.m. stated a CNA asked the writer to look at the resident's knee. The writer assessed and the left knee was not swollen. The writer asked the CNA to report this to the nurse on duty.

A 1/24/23 7:00 a.m. Nursing Note, written as a late entry by Staff C LPN on 1/25/23 at 10:40 p.m. stated the resident's left knee had "some swelling" but was not much bigger than the right.

A 1/24/23 4:07 Progress Note stated the facility obtained an order for an x-ray to the left knee and stated the left knee had a little more swelling and the resident "moaned a little" when the knee and the resident moved.

A 1/24/23 4:22 p.m. Nursing Note stated the facility obtained an order for an x-ray for increased swelling and pain to the left knee.

A 1/24/23 5:09 p.m. HAWK-Change in Condition V2 report stated the resident had increased swelling noted to the left knee.

A 1/24/23 5:38 p.m. Nursing Note stated the x-ray provider could not complete an x-ray until Wednesday(1/25/23).

A 1/25/23 10:00 a.m. Nursing Note stated the

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x-ray provider was onsite to complete an x-ray.

A 1/25/23 2:10 p.m. Nursing Note stated the facility obtained an order to send the resident to the ER for evaluation and treatment for a fracture.

A 1/26/23 4:17 p.m. Nursing Note stated the family decided not to pursue surgery for the fracture and the resident would return to the facility.

A 1/26/23 9:14 p.m. Nursing Note stated the resident returned from the hospital.

The Documentation Survey Report v2 for January 2023 revealed the following:
On 1/21/23 the report lacked documentation the resident ate.
1/22/23 the report stated the resident at 26-50% of her breakfast, 0% of her lunch, and lacked documentation the resident ate dinner.
On 1/23/23 the report stated the resident ate 26-50% of her breakfast, 0 % of her lunch and refused dinner.
On 1/24/23, the resident at 26-50% of her breakfast and 0 % of her lunch and dinner.
On 1/25/23, the report lacked documentation the resident ate breakfast or lunch.

The resident's Pain Level Summary lacked documentation of a pain assessment completed on 1/23/23 or 1/24/23 and lacked a pain assessment completed on 1/25/23 until 11:09 a.m.

The January 2023 Medication Administration Record listed an order for Furosemide (a medication used to treat fluid retention such as swelling) solution 10 milligrams(mg)/milliliter(ml),

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2 ml by mouth two times per day for heart failure. The MAR entries for the period of 1/1/23 until the breakfast entry on 1/25/23 revealed staff administered all scheduled doses of the medication. The MAR lacked documentation the resident refused her furosemide during this time period.

The resident's nursing notes and clinical record lacked any further assessments of the resident's knee or level of pain from the morning of 1/23/23 until discharge to the hospital. The facility lacked documentation of physician notification that the resident did not eat well or refused meals.

A hospital history and physical, dated 1/25/23, documented that the resident had a left distal femur fracture and stated there was an "obvious deformity of left inferior femur, tenderness to palpation, crepitus (cracking sounds) with palpation".

During a phone interview on 3/28/23 at 12:33 p.m., Staff D, Certified Nurses Aide (CNA) stated she noticed the resident's knee was swollen in the morning when she first got her up. She stated the resident was in pain and she reported this to Staff A around 6:30 a.m.-7:00 a.m. and stated Staff A told her they had trouble getting the resident to take her medications to help with the swelling. Staff G stated prior to this day, the resident utilized a stand lift but because of her knee Staff D utilized a Hoyer lift the whole day. She stated when she and Staff G CNA assisted the resident after lunch, her leg was bent and "not the right angle". She stated she informed the ADON and she looked at it.

During an interview on 3/28/23 at 12:56 p.m.,

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Staff G CNA stated she worked with Resident #24 on the first day they noticed something was wrong with her knee. She stated it was swollen in the morning and later in the day when she took her pants off and her leg moved, her leg was not in the right position, it was "sideways". She stated the ADON was in the next room and she came over and stated it was the resident's edema(swelling). Staff A LPN then looked at it and stated it was "just edema". She Staff C also stated it was the resident's edema. Staff G stated it did not look like just edema to her and stated the resident was moaning and groaning and it was "bad and sad". She stated this happened when the nurses did not listen to the CNAs and now they had a system where the CNAs documented information they relate to the nurses.

During an interview on 3/29/23 at 9:40 a.m., Staff A she arrived at work one day and a CNA reported to her that Resident #24's leg was swollen. She stated she looked at it around 8:30-9:00 a.m. and it was swollen but not discolored and she though maybe it was a strain from the stand lift. She stated she instructed the staff members to utilize the Hoyer lift and looked at it again later in the day and it was still swollen. She stated she reported it to the next shift but did not remember if she reported this to the physician.

During an interview on 3/29/23 at 10:16 a.m., the ADON stated staff thought Resident #24's knee looked funny but it was not swollen and had no bruising. She saw Staff A in the hall and asked her to complete an assessment and obtain and x-ray. The ADON stated she did not think that Staff A followed up but stated the next day they obtained an x-ray and it showed a fracture.

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During an interview on 3/29/23 at 3:03 p.m., the Administrator stated she was in Resident #24's hall when Staff D and G asked her if she had heard about the resident's knee. She stated the ADON completed a quick assessment and notified Staff A. She stated the next day they obtained a portable x-ray and found a fracture. She stated they had several aides saying something about the resident and stated she would have wanted an x-ray sooner and documentation was key.

2. The MDS assessment tool, dated 2/2/23, listed diagnoses for Resident #15 which included non-Alzheimer's dementia, coronary artery disease, and hemiplegia(one-sided paralysis). The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 4 out of 15, which indicated severely impaired cognition.

The resident's document "Bowel Movement" documented the resident had a BM (bowel movement) on 3/8/23 and did not have a bowel movement again until 3/20/23.

A review of the resident's Progress Notes revealed a lack of documentation regarding the resident's lack of bowel movement for the period between 3/8/23 and 3/20/23.

The March 2023 Medication Administration Record(MAR) displayed orders for Milk of Magnesia(a laxative) 30 ml twice daily as needed and Biscaodyl(a laxative) 10 mg(milligrams) suppository every 24 hours as needed for bowel management The MAR lacked documentation of the administration of either medication during the

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period of 3/8/23-3/20/23.

A Care Plan entry, revised 5/29/22, stated the resident would have no psychotropic drug related complications such as constipation or impaction.

3. The MDS assessment tool, dated 1/19/23, listed diagnoses for Resident #40 which included non-Alzheimer's dementia, muscle weakness, and morbid obesity. The MDS identified the resident's cognition as severely impaired.

The facility record "Bowel Movement" stated the resident had a bowel movement on 3/15/23 and on 3/21/23. The record lacked documentation the resident had a bowel movement from 3/15/23-3/20/23.

Resident Progress Notes for the period of 3/15/23-3/20/23 did not address the resident's lack of bowel movements.

The March 2023 Medication Administration Record(MAR) displayed orders for Milk of Magnesia(a laxative) 30 ml as needed and Biscaodyl(a laxative) 10 mg(milligrams) suppository every 24 hours as needed for bowel management The MAR lacked documentation of the administration of either medication during the period of 3/15/23-3/20/23.

A 10/21/23 Care Plan entry directed staff to monitor for adverse reactions to antidepressant therapy including fecal impaction and constipation.

During an interview on 3/28/23 at 1:41 p.m., Staff C stated with regard to tracking BMs, the night shift was supposed to check this. She stated the

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problem was that the CNAs did not chart and stated they sometimes did not receive a list from the night shift. Staff C stated with regard to resident #24, she arrived on a Tuesday and a CNA asked her to look at the resident because her knee hurt. Staff C stated she had more edema than normal and was refusing her medications. She stated the DON decided to obtain an x-ray but they could not come out that night. She stated the x-ray revealed a fracture. She stated on the Sunday prior, staff utilized a stand lift with her but Monday they had to use a Hoyer lift.

During an interview on 3/29/23 at 9:50 a.m., the Director of Nursing (DON) stated night shift pulled a report which indicated if a resident went three days without a BM. She stated they give resident's Milk of Magnesia(MOM) on Day 3 and then a suppository. She stated they recently implemented a new checklist for the night shift and stated monitoring of the BMs had been missed. She stated with regard to Resident #24, she worked as a CNA on Sunday 1/22/23 and got her up with a stand lift. She stated after this, something must have happened and thought maybe the EZ Stand put too much pressure on her leg. She stated the next day(Monday) the CNAs stated they needed to look at her. She stated Tuesday came and nothing had been done. She stated they informed Staff C about it and on Wednesday they came to get the x-ray. She stated this was a learning experience and they needed to notify the physician. She stated there should have been more follow-up to make sure they were assessing the resident and putting them on the "hot rack". She stated nurses should assess and keep documenting and stated since then they implemented a new system where

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CNAs documented information they provided to the nurses.

An email sent by the Administrator on 3/30/23 at 8:56 a.m. stated the facility did not have a policy related to assessment and intervention or change of condition but stated they followed the standards of care and/or the regulations.

During an email sent on 3/30/23 at 1:02 p.m., the Administrator stated the facility did not have a specific policy on bowel protocols and followed the standards of care and/or regulations.

4. The Minimum Data Set dated 1/12/23 identified Resident #1 as severely cognitively impaired with BIMS (brief interview for mental status) of 0 and with the following diagnoses: Alzheimer's Disease, anxiety, and depression. The MDS also documented the resident to be totally dependent on staff for moving in and out of bed, moving in and out of her room, toileting, personal hygiene and bathing and required extensive staff assistance with dressing. The MDS identified her to be incontinent (no control of) bladder and bowel.

A review of the care plan revealed the resident had been identified with the following problems on:
1/11/23 History of trauma/life event with potential for PTSD (post traumatic stress disorder) and directed staff to attempt non-pharmacological interventions such as one on ones, spontaneous activities, quiet room and observe effectiveness.
On 5/18/22 the problem of impaired cognitive function/dementia or impaired thought processes related to Alzheimer's and directed staff to:
a. Administer medications as ordered.

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Monitor/document for side effects and effectiveness
b. Use the resident preferred name. Identify yourself at each interaction.
c. Face the resident when speaking and make eye contact.
d. Reduce any distractions- turn off TV, radio, close door etc.
e. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated.

A review of the facility's investigation revealed the following dated
On 1/11/23 at 3:30 PM, Staff J, CNA took out her vape pen and blew vapor into Resident #1's face which had been witnessed by Staff K, CNA.
1/12/23 Staff K did not report this to administration until the following day after it occurred.
1/16/23 at 1:00 PM, the ADON completed a physical assessment on the resident and noted to have no injuries.
A review of the nurse's notes revealed no documentation of the description of the above incident, only the following:
1/11/23 at 10:20 AM a quarterly assessment had been documented
1/11/23 at 10:20 Assessment completed with, refer to assessment for details.
1/11/23 at 11:08 Resident calmer, quieter, and not yelling a lot
1/11/23 at 1:51 PM Labs drawn from left hand. Resident tolerated without difficulty. Specimens labeled and prepared for lab.

A review of the Trauma Informed Care Assessment Form dated 1/11/23 revealed the resident had been interviewed, however, no

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narrative documentation noted. No cultural preferences identified. No trauma identified. Triggered for care plan on trauma life events

5. The Minimum Data Set dated 2/23/23 identified Resident #36 as severely cognitively impaired with a BIMS score of 0. It also identified the resident with the following diagnoses: Diabetes Mellitus, Osteoporosis (a condition where the bones become brittle and fragile) and Cerebrovascular Accident (stroke) It also identified the resident as totally dependent on staff for transfers, locomotion on and off the unit, eating and bathing. It identified her as requiring extensive staff assistance with bed mobility, dressing, toileting and personal hygiene.

A review of the care plan with the last revision date of 2/27/23 identified the resident with the problem of at risk for alteration in blood glucose levels related to routine use of insulin and diagnosis of diabetes on 7/22/20 and did not direct staff to notify family of any changes in condition.

During an interview on 3/21/23, the resident's family member reported the facility did not notify her after the resident had a very high blood sugar and if they were able to lower the sugar with insulin afterward and did not notify her when the resident had to be admitted to the hospital on 2/1/23.

A review of the Nurse's Notes revealed the following:
11/14/22 at 3:18 PM Late entry for 11/7/22 this nurse forgot to hook up feeding tube. The doctor and Power of Attorney (POA) have been notified 2/1/23 at 2:58 AM Resident's blood sugar

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monitor read High, called on call provider, wanted her sent to ER. called EMS and they will send someone this way.
2/1/23 at 3:05 AM residents daughter notified of elevated BS (blood sugar)
2/1/23 at 3:35 Resident transported by ambulance to the hospital.
2/1/23 at 1:28 PM Spoke with hospital regarding resident condition and transferred to another hospital for further testing to be completed. Admitted with aspiration pneumonia. Evaluating cause of hyperglycemia.
2/17/23 at 9:21 PM Blood sugar 67 and resident laid in bed lethargic. Writer unable to obtain pulse ox (oxygen reading) on the resident due to the oximeter not reading. Writer started resident's tube feeding at 80 ml/hr (milliliters per hour) per order and called 911 to transfer resident to ED (emergency department) due to the resident's condition, no PRN (administer as needed) Glucagon order, and writer being unable to access E-Kit (emergency kit)
The notes did not include documentation of complete assessments of the resident prior to being sent to the hospital.

A review of the February 2023 Medication Administration Record revealed an order to check blood sugar. If over 300 give 4 units of Novolog every 24 hours for check at 2:00 AM if above 300 give 4 units Novolog - on 2/1/23 no blood sugar was documented on the MAR timed at 2:47 AM and coded as results had been outside parameters for treatment.

A review of the physician history and physical report dated 2/1/23 had documentation of the following:
Records show tonight at 7:30 PM, blood glucose

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had been 538 and 5 units of Novolog had been given. At 2:30 AM, blood glucose read "high" no further orders had been given. EMS (emergency medical services) started an IV (intravenous fluids) of normal saline. In the ED, she received 6 units of regular insulin IV. The initial physician did not document a blood glucose level.
An addendum documented as added at 6:00 by a second physician identified a concern for renal insufficiency (kidney failure) and sepsis (a body's response to an extreme infection) and given two different IV antibiotics. A blood sugar of 454 required 10 units of Regular Insulin IV.
An addendum added by above physician on 2/1/23 at 10:12 AM revealed another physician recommended an insulin drip. However, given the decrease in glucose from 802 to 494 with 10 units of Regular Insulin IV, felt the insulin drip was not warranted. Later transported to another hospital with the following diagnoses: hyperglycemia, lactic acidosis and acute renal insufficiency.

In an interview on 3/23/23 at 10:14 AM, Staff C, Licensed Practical Nurse (LPN) reported the following:
a. When a resident has a blood sugar above 400, the protocol the nurse should follow is to call the doctor, some we have to give 5 units and recheck in 30 minutes to an hour - this should get charted on the MARs and progress notes.
b. On 2/1/23 when the resident had been sent to the hospital, she did not work that night and could not explain why she went to the hospital.
c. When sending a resident to the hospital, the nurse should chart what is going on, who we called, the doctor, the family, get the orders to send out, set of vitals, if it's an injury, what type of injury, size, dimensions of injury, a full

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F 684	Continued From page 35 assessment. In an interview on 3/23/23 at 11:22 AM, the ADON reported the following: a. When a resident has a blood sugar above 400, the protocol she would expect the staff to follow would be to call the doctor, I don't think there is a protocol that tells the nurses when they should recheck it. I would expect them to recheck within 30 minutes b. She could not explain what happened when the resident had been sent to the hospital on 2/1/23. When sending a resident to the hospital, she would expect that the nurse called the doctor, received the order, notify the family and managers. She would expect the nurse to do a complete assessment of the resident, so she would be able to understand from a clear picture that they paint from one minute to the next minute. In an interview on 3/23/23 at 12:51 PM, the vice president of operations of the facility reported the facility did not have a policy on assessments of the residents.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		

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desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to prevent a significant weight loss on one of one residents reviewed with a tube feeding. (Resident #36) The facility reported a census of 46 residents.

Findings included:

The Annual Minimum Data Set (MDS) dated 2/23/23 identified Resident #36 as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 0. The MDS also identified the resident with the following diagnoses: Diabetes Mellitus, Osteoporosis (a condition where the bones become brittle and fragile) and Cerebrovascular Accident (stroke) The MDS documented that the resident required total dependence on staff for transfers, locomotion on and off the unit, eating and bathing, and identified the resident as requiring extensive staff assistance with bed mobility, dressing, toileting and personal hygiene.

A review of the care plan revealed the following: On 10/28/21 identified with the problem of having an an alteration in my nutrition due to HTN

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(hypertension - high blood pressure), T2DM (type 2 Diabetes Mellitus) and pro-cal malnutrition diagnosis & NPO (nothing by mouth) status. It directed the staff to:
a. Check residual before administration. If greater than 100 ml (milliliters) hold feeding and contact the doctor.
b. Diet as ordered: 960 ml Glucerna 1.2 at 80 ml for 12 hours via kangaroo pump with water flushes per orders.
c. I need to be weighed as ordered or PRN (as needed)
d. Keep HOB (head of bed) elevated at 35 degrees during feeding and 2 hours after feeding.
e. Monitor for signs/symptoms of intolerance-N/V/D (nausea/vomiting/diarrhea), GI (gastrointestinal) pain etc.
f. Notify my doctor if I have a significant weight change
g. Please bring me to dining room area at meals for increased socialization
h. Registered Dietician to follow up as needed

A review of the nurse's notes revealed the following:
10/9/22 at 2:44 AM Notification from dietitian noted by ARNP (advanced registered nurse practitioner), resident is showing significant weight loss of 14% in 90 days. No problems with TF (tube feeding). TF provides greater than 100% of EEN (exclusive enteral nutrition - tube feeding). Hospice being discussed any new orders.

On 01/01/2023, the resident weighed 75.6 lbs. On 01/29/2023, the resident weighed 67.4 pounds which is a -10.85 % Loss.

A review of the dietitian progress notes revealed the following:

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1/19/23 at 10:54 AM Tube Feeding Assessment: 78 year old female with the previous medical history of aspiration pneumonia, T2DM (type 2 Diabetes Mellitus) Current body weight is 75.8 pounds. Ht: 56 inches, BMI: 17. Weight stable. Receives Glucerna 1.2, 80ml per hours for 12 hours overnight. Current tube feeding order provides ~1140kcal, 56g protein, 1428ml fluids. Noted to have a missed tube feeding overnight 11/7, no adverse side effects. RD (registered dietitian) does not recommend increased tube feeding due aspiration pneumonia risk and current toleration. RD will monitor and follow up as needed.

In an interview on 3/23/23 at 10:14 AM, Staff C, LPN reported the resident's weight loss could be caused by the resident pulling her tube out, which she has never wanted. She had pulled it out continuously, however, she does not do it as often anymore.

In an interview on 3/23/23 at 11:22 AM, the Assistant Director of Nursing (ADON) reported the resident was in the hospital when the weight loss occurred. There was a time she would disconnect her feeding tube. She does not want the feeding tube, she wants to die, but the family does not want to make her a Do Not Resusitate (DNR).

A review of the census tab in the electronic record revealed the resident had not been hospitalized until February, the weight loss occurred in January 2023.

In an interview on 3/23/23 at 12:51 PM, the vice president of operations of the facility reported the facility did not have a policy on preventing weight

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F 692	Continued From page 39 loss.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interview, the facility failed to administer the resident's tube feeding as ordered for one of one residents reviewed (Resident #36) The facility reported a census of 46 residents. Findings included: The Minimum Data Set dated 2/23/23 identified Resident #36 as severely cognitively impaired with a BIMS score of 0. It also identified the	F 693		

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resident with the following diagnoses: Diabetes Mellitus, Osteoporosis (a condition where the bones become brittle and fragile) and Cerebrovascular Accident (stroke) It also identified the resident as totally dependent on staff for transfers, locomotion on and off the unit, eating and bathing. It identified her as requiring extensive staff assistance with bed mobility, dressing, toileting and personal hygiene.

A review of the care plan revealed the following: On 10/28/21 identified with the problem of having an an alteration in my nutrition due to HTN (hypertension - high blood pressure), T2DM (type 2 Diabetes Mellitus) and pro-cal malnutrition diagnosis & NPO (nothing by mouth) status. It directed the staff to:
a. Check residual before administration. If greater than 100 ml (milliliters), hold feeding and contact MD.
b. Diet as ordered: 960 ml Glucerna 1.2 at 80 ml for 12 hours via kangaroo pump with water flushes per orders.
c. I need to be weighed as ordered or PRN (as needed)
d. Keep HOB (head of bed) elevated at 35 degrees during feeding and 2 hours after feeding.
e. Monitor for signs/symptoms of intolerance-N/V/D (nausea/vomiting/diarrhea), GI (gastrointestinal) pain etc.
f. Notify my doctor if I have a significant weight change
g. Please bring me to dining room area at meals for increased socialization

A review of the physician orders revealed an order dated 8/30/22 Enteral Feed order every night shift (6Pto 6A) Glucerna 1.2 at 80/ml/hr (milliliters per hour) for 12 hours continuous.

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A review of the Physcian Orders reveled an order dated 12/02/22 Glucerna 1.2 Cal Liquid (Nutritional Supplements) Give 80/ml/hr (milliliters per hour).

A review of the nurse's notes revealed the following entry: 11/14/2022 3:18 PM Late entry for 11/7 this nurse forgot to hook up feeding tube. Doctor and POA (power of attorney) have been notified.

Observations of the resident revealed the following:
On 3/21/23 at 6:24 AM lying in low bed with the head of the bed elevated 30 degrees. Resident slouching halfway down the bed, with the continuous tube infusing at 60 mls/hr (milliliters per hour) per Kangaroo pump with a bag of water flush. The tube feeding bag had a label which only showed the date as hung on 3/20 at 8:35 PM. No documentation of contents of bag or the rate the feeding should have been running at.
3/21/23 7:16 AM assessment unchanged
3/21/23 7:30 AM assessment unchanged.
3/21/23 8:25 AM Staff A, LPN and Staff B, CNA/CMA entered room, closed door to room, donned gloves. Staff A turned off kangaroo pump which was alarming and rate set at 60 ml/hr.

In an interview on 3/23/23 at 10:14 AM, Staff C, LPN reported the following:
a. When hanging a bag of tube feeding, the steps she would take would be to fill one bag with water, fill the other bag with the tube feeding, will need to label it with the date, time, my initials. It will automatically run for 8 hours.
b. Her tube feeding should be running at 80 cc/hr
c. She should check the tube feeding after it's hung at least every hour to every 2 hours. To

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ensure it is running properly.

In an interview on 3/23/23 at 11:22 AM, the ADON reported the following:
a. When hanging a bag of tube feeding, the steps you would take would be to pour tube feeding in one bag, water into the other bag. They should be labeled with the date, tube feeding itself, rate and initials
b. Her tube feeding should be running at 80 cc/hr
c. She should check the tube feeding after it is hung every couple of hours to ensure it is running properly.
d. When asked to explain the entry on the nurse's notes on 11/14/22 regarding her tube feeding not hooked up, she reported the nurse should have checked on it the next day and informed the POA

In an interview on 3/23/23 at 12:51 PM, the vice president of operations of the facility reported the facility did not have a policy on tube feeding, however, provided a facility competency titled: Competency for Enteral Feeding: Gastrostomy Feeding/Jejunostomy Feeding dated as last updated 5/11/21. It had documentation of the following:
a. Flush tube with 30 to 60 cc (cubic centimeters) warm water as ordered, rinse syringe afterward
b. Attach feeding set adapter to the G/J tubing.
c. Mark feeding bag: resident name, start date and time/flow rate
d. Set up Enteral Feeding formula bag/pump per manufacturer's guidelines
e. Begin feeding as ordered for the prescribed rate - water flush as ordered.
f. Monitor infusion rate periodically throughout feeding

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F 725	Continued From page 43	F 725		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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 §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to answer the call light for two of four residents reviewed. (Resident #16 and #19) The facility reported a census of 46 residents. Findings included:	F 725		

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1. The Admission Minimum Data Set (MDS) dated 1/12/23 identified Resident #16 as cognitively intact with a BIMS (brief interview for mental status) of 15 and with the following diagnoses: Arthritis, Spinal Stenosis(where the space in the backbone is too small and can put pressure on the spinal cord) and Lupus Erythematosus (an autoimmune disease in which the immune system attacks its own tissues) It also identified the resident required extensive staff assistance with moving in and out of bed, dressing, toileting and personal hygiene and totally dependent on staff for bathing.

On 1/6/23 the care plan identified the resident with the problem of having and ADL (activities of daily living) deficit due to generalized weakness. Interventions did not include timely response to answering her call lights, however, it did identify multiple interventions that required the assistance of two staff members such as transfers, bed mobility and dressing.

Observations of the resident's call light revealed the following:
3/22/23 at 7:53AM resident sitting up in recliner, call light to room on, white, audible, not flashing, the DON and Staff C, LPN stood in the hallway with med cart. Staff D, CNA walked by the room and did not check on resident.
3/22/23 7:58 AM assessment unchanged, light on. No staff entered room.
3/22/23 8:03 AM call light remains on, DON, Staff C, LPN in hallway with med cart. No other staff in hallway no one answered call light
3/22/23 8:15 AM Staff D, CNA walked into the resident's room and turned off the call light which had been on for 22 minutes.

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In an interview on 3/21/23 9:20 AM, Resident #8 (with a BIMS of 15) reported the longest she had to wait to get her call light answered had been 30 minutes. She fell asleep while waiting. She had a clock beside her bed and wore a wrist watch. She also reported it happened at least once a month.

In an interview on 3/27/23 at 6:00 AM, the ADON reported she expected staff to answer call lights within 15 minutes. Residents that have complained about not getting their call lights answered in a timely manner have been Resident #16 as her room is across from the ADON's office. She is a two person transfer and sometimes will have to wait until the second person gets there.

2. During an interview on 3/21/23 at 8:50 a.m., Resident #19 stated the facility did not have enough staff. She stated she sometimes had to wait 45 minutes-1 hour for staff to respond to her call light. She stated she timed it with a clock on the wall.

3. During an interview on 3/29/23 at 10:56 a.m., Resident #16 stated she often had to wait for staff to answer her call light and sometimes had to wait up to 30 minutes. She stated she utilized the clock on her wall to determine the call light response time.

An email sent by the Administrator on 3/30/23 at 8:56 a.m. stated the facility did not have a policy related to call lights but stated they followed the standard of care and/or the regulations.

During an interview on 3/29/23 at 3:03 p.m., the Administrator stated staff should answer call

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F 725	Continued From page 46 lights within 10 minutes and stated residents could have a situation such as choking.	F 725		
F 812 SS=E	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: Based on observations, staff interviews, and facility policy reviews the facility failed to ensure food was stored and prepared under sanitary conditions. The facility identified a census of 46 residents. Findings include: An initial kitchen tour conducted on 03/20/23 at 10:34 AM revealed the following observations: 1. The following items were found in the kitchen	F 812		

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area:
Ham, half submerged, in cold standing water
White crusty build up around the dishwasher
Black build up of a dust like substance under the dishwasher counter area and under the toaster area and around the doorway going into the dining room. A white doorstop to prop the dining door open was covered with a black substance in the ridged areas. The baseboards had black debris on them.
White debris on the metal stove hood.
2. The following items stored in the kitchen refrigerator:
An open bag of sausage lacked a label or open date
An open bag of lettuce lacked a label or open date
An open bag of shredded cheese was unsealed.
An open bottle of sweet and sour sauce lacked an open date.
An open chocolate milk container lacked an open date.
An open white milk container lacked an open date.
An open orange juice container lacked an open date.
Walls, signs and outlets had dark smudges and splatter marks.
3. The following items were stored in freezers:
An open bag of spaetzle in freezer #2 not labeled or dated or secured shut.
A spot of pink frozen liquid and black marks in the #office freezer and a brown drip spot on the top of the #office refrigerator door seal .
brown crumb debris on top of freezer #3
Frozen droplets and crumb debris on the bottom, inside of freezer #1.
4. There was missing documentation on the March 2023 kitchen cleaning schedule.

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The following items were noted during observation of the meal service on 3/20/23 at 12:09 PM.

1. The Dietary Manager (DM) cook failed to use hand hygiene prior to serving meals to the residents. The DM washed her hands in the kitchen sink. The DM then unplugged the steam cart from the kitchen outlet and pushed the steam table down the hall to the lodge. The DM opened the door and pressed the code buttons to stop the Lodge alarm from sounding. The DM plugged the steam cart into the Lodge wall outlet. The DM did not wash or sanitize hands before serving fruit, wrapped silverware, and drinks. The DM handled menus for multiple residents and then served meals to the residents without hand hygiene. After the meal service, the DM put the tongs, including the handle she had touched with her bare hands, inside the steam container that held chickenstrips. The DM unplugged the steam cart from the outlet, opened the door to the lodge, touched the alarm keypad to stop the alarm and moved the steam cart back to the kitchen. The DM opened the kitchen door and plugged the steam cart into the kitchen outlet. The tongs transported in the chicken strip container in the steam table were used to serve chicken strips in the main dining room. The DM did not complete hand hygiene prior to serving residents in the main dining room.

The facility policy and procedure for "General Sanitation of Kitchen", updated 2021, indicated that food and nutrition services staff would maintain the sanitation of the kitchen through compliance with a written comprehensive cleaning schedule.

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The facility policy "Accura Hand Hygiene" updated 10/19/22 indicated that staff should always complete hand hygiene before eating, drinking or handling food.

On 3/21/23 at 7:10 AM the Dietary Manager (DM) stated the normal process for thawing was to pull the meat out the previous day and put it on a tray in the bottom of the refrigerator. The DM was gone on 3/20/23 and the meat was not taken out of the freezer to thaw. The DM took the ham out of the freezer and put it in the sink with cold water to thaw. The DM agreed that it was her expectation open food would be labeled and dated in the refrigerator. There was a cleaning checklist in the kitchen that staff were to complete. The DM reported the checklist was not always completed. The DM said the floor was cleaned with floor cleaner and a scrub brush for dark areas. The DM reported a new garbage disposal was installed last week and the DM reported she had not yet gotten to cleaning under where it was installed. The cart that held dishwashing racks had dark build up and splatter marks on it. The DM stated that she power washed the cart outside one time per month. The DM agreed that the white substance on the stove hood appeared to be paint chips. The DM reported that the ceiling above the stove hood was painted last week. The DM was able to move the white material with her finger. The white substance was not adhered to the hood of the stove. The DM described the expected hand hygiene for meal service. She reported the cook should wash hands before going to the Lodge for meal service and should use sanitizer at the Lodge before service. The DM said that when the cook returned to the front dining room

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F 812	Continued From page 50 for meal service the cook should wash hands again. The DM was asked if she followed that practice on 3/20/23 and she was not able to recall. On 3/21/23 at 3:40 PM, the Infection Preventionist (IP) shared that her expectation is that staff wash their hands and or use sanitizer for infection prevention. The IP ' s rule for staff was to use sanitizer 3 times and then staff should wash their hands the next time. With regard to kitchen staff, the IP relayed that hand sanitizer is fine for those passing trays because there is no sink nearby. The IP shared that a person serving food should wash hands prior to serving food. The person serving food should also wash hands again after touching a door or other surface.	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 51 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review and staff interview, the facility failed to document Pneumococcal vaccination consents/declinations	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165324	A. BUILDING _____ B. WING _____	03/30/2023

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F 883	Continued From page 52	F 883		

for 4 of 5 residents reviewed for immunizations. (Residents #17, #26, #25, and #40) The facility reported a census of 46 residents.

Findings include:
Resident #17's clinical immunizations report stated she had the Prevnar 13 vaccine 8/30/17. The facility lacked documentation of further pneumococcal vaccination or declination.
Resident #26's clinical immunization report stated she had the Prevnar 13 vaccine on 8/11/17. The facility lacked documentation of further pneumococcal vaccination or declination.
Resident #35's clinical immunizations report stated he had the PNEUMOVAX on 5/11/20. The facility lacked documentation of further pneumococcal vaccination or declination.
Resident #40's clinical immunizations report stated she had the Prevnar 13 vaccine on 8/27/19. The facility lacked documentation of further pneumococcal vaccination or declination.

The facility "Pneumococcal Vaccination" policy updated on 10/19/22 indicated all residents be provided opportunity and encouragement to get the Pneumococcal vaccination and referenced a consent and vaccination information statement.

On 3/23/23 at 2:10 PM, the facility Administrator stated documentation was present in resident charts with regard to received and declined vaccinations but staff were unable to locate the documents at this time. The pharmacy was contacted for copies.

The Centers for Disease Control and Prevention website under section "Vaccines and Preventable Diseases" retrieved from "https://www.cdc.gov/vaccines/vpd/pneumo/hcp/w

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F 883	Continued From page 53 ho-when-to-vaccinate.html#adults-19-64" on 3/27/23 stated: For adults 65 years or older who have only received PCV13, CDC recommends you either:Give 1 dose of PCV20 or 1 dose of PPSV23 at least 1 year after PCV13 3/27/23 9:41pm Email from Regional Vice President of Operations acknowledged the concern with the pneumonia vaccine and stated they would work to get that corrected.	F 883		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure a safe environment for two of two residents reviewed (Residents #8 and #24). The facility reported a census of 46 residents. Findings included: 1. The Minimum Data Set dated 12/23/22 identified Resident #8 as cognitively intact with a BIMS of 15 and with the following diagnoses: Heart Failure, COPD (chronic obstructive pulmonary disease) and acute and chronic respiratory failure and required minimal staff assistance only with bed mobility. Observations of the resident's door entering her room revealed the following:	F 921		

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	165324	A. BUILDING _____ B. WING _____	03/30/2023

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F 921	Continued From page 54	F 921		

3/21/23 at 12:00 PM, as the resident sat in her power chair, the hard vinyl covering to lower portion of door peeling away from the door leaving exposed sharp edges.
3/22/23 at 9:35 AM assessment unchanged to the door

2. The MDS dated 12/15/22 identified Resident #24 as severely cognitively impaired with a BIMS of 99 and with the following diagnoses: It also identified the resident required extensive staff assistance with most activities of daily living.

Observations of the resident's heat register revealed the following:
3/20/23 at 11:07 AM sitting up in rocking wheelchair with feet in foot buddy. Heat register on floor - metal housing bent with sharp edges exposed
3/20/23 at 1:39 PM asleep in bed, heat register on floor remains with metal housing bent with sharp edges exposed
3/21/23 at 6:24 AM Heat register on floor remains with metal housing bent with sharp edges exposed
3/21/23 at 1:36 PM asleep in bed. Heat register on floor remains with metal housing bent with sharp edges exposed
3/22/23 at 6:18 AM asleep in bed. Heat register on floor remains with metal housing bent with sharp edges exposed
3/22/23 at 11:35 AM Staff D, CNA pushed the resident out to the main dining room in the wheelchair. Heat register on floor remains with metal housing bent with sharp edges exposed.

In an interview on 3/23/23 at 10:59 AM, Staff D,Certified Nurses Aide (CNA) reported when staff notice environmental issues like bent metal

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F 921	Continued From page 55 on heat registers or sharp edges on the vinyl covers to the doors, the process for reporting that to maintenance is staff have to fill out a maintenance request form and place in a book outside the maintenance director's door. She did report she noticed that Resident #8's door cover had been bent, however, did not know if had been reported to maintenance. She had not been aware of Resident #24's heat register. In an interview on 3/23/23 at 12:51 PM, the vice president of operations of the facility reported the facility did not have a policy on maintenance issues. In an interview on 3/27/23 at 6:00 AM , the Assistant Director of Nursing (ADON) reported when environmental problems are identified in the residents' rooms, staff are expected to report it to the maintenance director through phone calls or text messages. There is a book at the nurse's station to put things that need to be fixed. He just started working here February of this year. Resident #8's door cover has been repaired after the surveyor reported it to us. There should be documentation of repairs that have been completed. Parts have been ordered to repair Resident #24's heat register.	F 921		
F 923 SS=E	Ventilation CFR(s): 483.90(i)(2) §483.90(i)(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to maintain	F 923		

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F 923	Continued From page 56	F 923		

adequate ventilation during the survey. The facility reported a census of 46 residents.

Findings:

1. During an observation upon entrance to the facility on 3/20/23 at 10:15 a.m., the odor of urine was present in the dining room near the nursing station and the hallway outside of the Assistant Director of Nursing's(ADON) office.

2. During an interview on 3/28/23 at 12:56 p.m., Staff G Certified Nursing Assistant(CNA) stated she noticed the odor of urine and feces in the facility and stated she did not think there was enough staff to provide changing assistance to all of the residents.

An email sent by the Administrator on 3/20/23 at 8:56 a.m. stated the facility did not have a policy related to ventilation but stated they followed the standards of care and/or the regulations.

During an interview on 3/29/23 at 3:03 p.m., the Administrator stated some rooms had more of an odor than others and she didn't feel like it was any different than any other nursing home. She stated odors were not appealing to visitors and odors in the facility had improved.

3. In an interview on 3/21/23 9:20 AM , Resident #8 (with an MDS dated 12/23/22 identified the resident as cognitively intact with a BIMS of 15) reported when agency staff are working and they have been working a lot, she notices there are odors of both urine and BM (bowel movemet). She also reported when they remove soiled linens from rooms, they will throw them on the floor before they throw it in the bins and has seen BM

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F 923	Continued From page 57 on the floor. 4. On 3/30/23 at 12:58 PM the main dining room smelled like urine during the dining observation. On 3/21/23 at approximately 2:00 PM, there was a strong smell of urine noted when the Infection Preventionist's office door was opened to the north wing hallway.	F 923		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0656	A. BUILDING: _____ B. WING _____	C 03/30/2023

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N 101	50.7(1) 481- 50.7 (10A,135C) Additional notification. 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(1) Of any accident causing major injury. a. " Major injury " shall be defined as any injury which: (1) Results in death; or (2) Requires admission to a higher level of care for treatment, other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a " major injury " based upon the circumstances of the accident, the previous functional ability of the resident, and the resident ' s prognosis. b. The following are not reportable accidents: (1) An ambulatory resident, as defined in rules 481-57.1(135C), 481-58.1(135C), and 481-63.1(135C), who falls when neither the facility nor its employees have culpability related to the fall, even if the resident sustains a major injury; or (2) Spontaneous fractures; or (3) Hairline fractures. This Statute is not met as evidenced by: Based on observation, clinical record review, and staff interview the facility failed to report a fall with a major injury for 1 of 1 residents reviewed for a	N 101		

DEPARTMENT OF INSPECTIONS AND APPEALS

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	IA0656	A. BUILDING: _____ B. WING _____	C 03/30/2023

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N 101	Continued From page 1	N 101		

major injury(Resident #33). The facility reported a census of 46 residents.

Findings Include:

The Minimum Data Set(MDS) Assessment Tool, dated 10/20/22, documented that Resident#33 required supervision assistance of 1 staff member for walking and eating, limited assistance of 1 staff for bed mobility, transfers, toilet use, personal hygiene, and bathing, and extensive assistance of 1 staff for dressing. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score of 0 out of 15, which indicated severely impaired cognition.

Untitled Fall Incident Reports revealed the following:

On 2/22/22 staff found the resident lying on the floor at the foot of the bed on his right side incontinent of bowel and bladder.

On 5/8/22 the resident yelled for staff and was on his buttocks on the floor. The resident sustained 2 skin tears to his arms.

On 5/12/22 the resident was sitting on the floor.

On 1/17/23 staff found the resident lying on the floor on his left side and he had urinated on the floor and stated he slipped. The resident transferred to the ER for evaluation.

A 1/17/23 11:08 a.m. Health Status Note stated the resident had a femur(thigh bone) fracture and admitted to the hospital.

A 1/22/23 Hospital Discharge Summary stated the resident admitted to the hospital on 1/17/23

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N 101	Continued From page 2	N 101		

and discharged on 1/22/23. The report documented the resident had a closed intertrochanteric(referring to a part of the femur) fracture of the left hip and underwent a surgical procedure in which he received a hip screw.

The Documentation Survey Report V2 for the period of 1/1/23-1/17/23 documented 16 instances where the resident required limited assistance of 1 staff defined as 1 person physical assist with staff providing guided maneuvering of limbs or other non-weight-bearing assistance.

A 5/9/22 Care Plan entry directed staff to remind the resident to wait for staff for transfers.

An email sent by the Administrator on 3/30/23 at 8:56 a.m. stated the facility did not have a policy related to reporting major injuries to the State Agency but stated they followed the standards of care and/or the regulations.

During an interview on 3/29/23 at 10:34 a.m., the Nurse Specialist stated Resident #33 was independent otherwise they would have reported it. She stated they determined who was independent based on the care plan which stated he was independent.

During a phone interview on 3/30/23 at 12:39 p.m., the Regional Reimbursement Specialist stated she did not see an end date for the resident's 5/9/22 fall intervention for the resident to wait for staff in order to transfer. She stated the care plan was not up to date and this intervention was not removed to accurately reflect staff's assistance for the resident.