STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. BUILDING _____ B. WING _____	C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB	4911 SW 19TH STREET DES MOINES, IA 50315

(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 000	INITIAL COMMENTS Correction date: _____ The following deficiencies resulted from the investigation of Complaints #111311-C, #111623-C, #111994-C, #112082-C, and Facility Reported Incident #112399-I conducted on April 24, 2023 to May 1, 2023. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, family interview and policy review the facility failed to ensure resident call lights within in reach for 3 of 3 residents reviewed (Resident #1, # 6 and #9). The facility reported a census of 73. Findings include: 1. The Quarterly Minimum Data Set (MDS) dated 3/15/23 documented that Resident#9 scored 2 out 15 on a Brief Interview of Mental Status (BIMS) which indicated severe cognitive impairment. The MDS revealed the resident required one-person assistance with transfers, extensive assistance of one-person physical	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. BUILDING _____ B. WING _____	C 05/01/2023

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F 558	Continued From page 1	F 558		

assistance with dressing, personal use and hygiene. The MDS documented the resident had diagnoses which included cerebral palsy, bi-polar and schizoaffective disorder.

The Care Plan updated 3/14/23 for Resident #9 included resident's gait/balance problems, communication deficits, alteration in musculoskeletal status, self-care deficits and intellectual deficit. The Care Plan directed Staff to allow adequate time to respond, eye contact, ask yes /no questions, simple and brief, documented resident needs for a safe environment with intervention to educate and give reminders, anticipate to meet needs, call light within reach and respond promptly to all requests for assistance.

On 4/26/23 at 9:45 am Resident #9 in bed, awake, waved approval to enter. His call light was on the floor near head of bed, under top of the bed. Resident #9 nodded indicating he could not reach the call light and then attempted to reach leaning over, unsteadily, demonstrated understanding and was not able to reach.

On 4/26/23 at 9:53 am, Staff A, Certified Nurse Aide (CNA) stated Resident #9 will put his call light on when needing assistance. Staff A acknowledged the call light was not within the resident's reach, and relayed he could get to it if needed.

2. The Quarterly MDS dated 3/1/23 documented that Resident #1, had short and long term memory impairment. The MDS revealed the resident required extensive physical assistance of 1 staff member for bed mobility and required totally assist of 2 staff for transfers.

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F 558	Continued From page 2	F 558		

The Care Plan with revised date 4/24/23 identified a focus area for Activities of Daily Living(ADL) self care performance deficit. The Care Plan directed staff to provide assistance of 2 staff with a mechanical Hoyer lift for transfers.

On 4/25/23 at 1:00 pm, Resident #1 laid in bed wearing a C-Collar. Her call light sat in a flower basket next to her bed out of reach.

3. The MDS of Resident #6, dated 3/9/23 identified a BIMS score of 15 which indicated cognition intact. The MDS revealed the resident required extensive physical assistance of 1 staff member for bed mobility and revealed the resident totally dependent upon 2 person physical assistance for transfers.

The Care Plan of Resident #3 revised 1/16/21 identified a focus area for Activities of Daily Living(ADL) self care performance deficit. The Care Plan directed staff the resident required assistance of 2 staff members with a mechanical Hoyer lift for transfers.

During an observation of on 4/26/23 at 11:12 am Resident #6 laid in bed watching television. Her bedside table was approximately a foot and a half away from her bed out of her reach. Her call light was on the bedside table. When asked if she was able to reach her call light, Resident #6 replied yes but when she tried to reach it she was unable to. Resident #6 stated she requires assistance to turn over in bed and uses the Hoyer lift for transfers.

On 4/26/23 at 09:56 am the Director of Nursing (DON) stated her expectation is for the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. BUILDING _____ B. WING _____	C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB	4911 SW 19TH STREET DES MOINES, IA 50315

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F 558	Continued From page 3 call light to be within residents reach. Facility policy titled Call Light, Use of, noted be sure call lights are placed within resident reach at all times, never on the floor or bedside stand.	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. BUILDING _____ B. WING _____	C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 4	F 584		

levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview with staff and residents the facility failed to provide a clean, comfortable homelike environment for 2 of 3 resident reviewed Resident #9 and Resident #15. The facility reported the census is 73.

Findings include:

1. The Quarterly (MDS) dated 3/15/2023 documented a Brief Interview of Mental Status (BIMS) for Resident#9 as 02 which indicated severe cognitive impairment. The MDS documented the need for supervision of one-person assistance with transfer, extensive assistance of one-person physical assistance with dressing, personal use and hygiene. The MDS documented Resident #9 had diagnoses including cerebral palsy, bi-polar and schizoaffective disorder.

Care plan updated 3/14/2023 for Resident #9 documented resident's communication deficits, intellectual deficit, gait/balance problems, alteration in musculoskeletal status and self-care deficits. The Care Plan directed staff to allow adequate time to respond, ensure understanding, with eye contact, ask yes /no questions, be simple and brief. Care plan noted the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. BUILDING _____ B. WING _____	C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 5	F 584		

needed a safe environment with intervention to educate, give reminders and anticipate to meet needs of the resident.

2. The Quarterly MDS dated 3/16/2023 for Resident #15 documented a Brief Interview of Mental Status (BIMS) as 15 which indicated intact cognition The MDS documented Resident #15 had diagnoses which included stroke, diabetes with chronic kidney disease and weakness.

Residents bill of Rights provided by the facility revealed rights of residents for respect and dignity, in a manner and environment that promotes quality of life.

Observation on 04/26/23 at 12:21 PM residents room had the following items on the floor; clothing a disposable brief, a cup, clothing bag under the bed and paper items on the floor. Closet door partially open with bags and clothes piled up several feet, items directly on the floor. Bed side tables cluttered with clothes and other items. During the observation a mouse scurried across the room.

On 4/26/23 at 12:30 PM Staff E Business Office Manager in the room of Resident #9. Staff E, mentioned seeing a mouse, Resident #9 pointed to the floor, appeared as if he said mouse. Staff E asked Resident #9 if had seen a mouse. The Resident acknowledged nodding his head yes when asked if he had seen a mouse. Staff E acknowledged the room could be tidier to deter mice.

On 4/26/23 at 12:35 PM Staff A, Certified Medication Aide (CMA) acknowledged the Resident#9's room is untidy, and reported that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. BUILDING _____ B. WING _____	C 05/01/2023

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FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB	4911 SW 19TH STREET DES MOINES, IA 50315

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F 584	Continued From page 6	F 584		

resident is not always agreeable to housekeeping.

On 4/26/23 at 04:45 p.m. the Administrator reported she was not aware of a pest issue. The Administrator reported if mice are reported, the pest control company would be informed and expected to take care of it.

Interview with Resident # 15 on 4/27/23 at 3:04 PM resident #15 reported mice come out in the day time even with the loud television. Relayed a mouse was at her feet while another one poked his head from out from under the bedside table. Resident #15 relayed staff are aware, included maintenance staff and front office staff. Resident #15 relayed family brought her traps and she caught four in one week. Relayed she left with her blanket down to the floor and came back to the room seeing a mouse scurry across the bed. Resident relayed thought it was improving and no longer has the traps since she wasn't supposed to have them. Resident #15 pointed to her window that she taped up along the side, relayed was done to stop them from coming in and pointed to her bedside table that she taped to keep mice from hiding underneath.

Interview on 4/27/23 at 04:30 PM front office Staff D relayed is only aware of one incident, states a mouse was in the front office several months ago, was caught and has been no others.

On 5/1/23 at 10:31 a.m. Staff C, Maintenance Manager reported he saw a mouse in the three hundred hall, and have heard they are more in the four hundred hall.

On 5/1/23 at 2:45 p.m. Staff B, Maintenance

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	165273	A. BUILDING _____ B. WING _____	C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 7 Assistant he had caught mice in the traps, and thought the mice problem had improved. Staff B, reported that the pest control company had traps in the building Administrator relayed on 5/1/23 at 2:45 PM in response to follow up on facility policies requested that housekeeping is per standard of care set forth by State and Federal Guidelines. The facility did not have a specific housekeeping policy. Administrator relayed facility contracts with pest control company that is scheduled monthly and can be contacted to come for additional visits.	F 584		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, hospital record review, staff interview, policy review and observations, the facility failed to ensure the safety of residents during a mechanical lift transfer (Hoyer lift) for 1 of 3 residents reviewed for safe transfers (Resident #1). On April 26, 2023 at 2:00 p.m., the State Survey Agency informed the facility the staff's failure to ensure the proper sling was used for a Hoyer transfer of a resident created an Immediate	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 8	F 689		

Jeopardy situation, which began on April 18, 2023. The facility staff removed the immedicacy on April 18, 2023, when the facility staff implemented the following Corrective Actions:
a. Hoyer transfer education provided immediately to the staff involved in the transfer which resulted in a fall.
b. Review of sling size signage and placement at the nurse's station and clean utility closet
c. Hoyer and Easy Stand transfer education provided to nursing staff on 4/18/23 and ongoing.
d. TELS education provided to all staff on 4/18/23 and ongoing
e. Added hands on training for Hoyer and Easy Stand to orientation.

Based on the actions taken by the facility prior to the start of the survey on 4/24/23 the event is considered past non-compliance.

Findings include:

The Quarterly Minimum Data Set (MDS) of Resident #1, dated 3/1/23, identified the presence of short and long term memory impairment. The MDS revealed the resident required extensive physical assistance of 1 staff member for bed mobility and revealed the resident totally dependent upon 2 person physical assistance for transfers. The MDS documented a height of 64 inches and weight of 288 pounds (lbs).

The Care Plan revised 4/24/23 identified a focus area for Activities of Daily Living(ADL) self care performance deficit. The Care Plan directed staff the resident required assistance of 2 staff members with a mechanical Hoyer lift for transfers.

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	165273	A. BUILDING _____ B. WING _____	C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 9	F 689		

The Progress Note, dated 4/18/23 documented Staff G, Registered Nurse, was called to the room of Resident #1 and observed the resident laying on her back with a laceration to her left temple which was bleeding. The resident had a delayed response to verbal stimuli and showed signs of head and neck pain. Staff G called emergency services. Resident #1 was transferred by emergency services to an acute care hospital.

The Emergency Department notes dated 4/18/23 documented Resident #1 was seen in the emergency room due to a head laceration above the left eye brown obtained from falling out of a Hoyer lift sling at the nursing facility. The notes further documented the results from a Computerized Tomography (CT) scan that showed the Resident to have right side Cervical 6 and Cervical 7 facet fractures (a breakage of the spinal vertebrae). Additional injuries were documented as a large scalp hematoma (a pool of mostly clotted blood) measuring 6.8 x 4.4 x 2.1 centimeters (cm) extending over a larger area of the calvarium (the top part of the skull) measuring 10.3 x 10.3 x 11.2 cm.

The Physician Transfer Order Report dated 4/24/23 documented the activity orders for Resident #1 upon readmission to the facility were for bedrest, rolling 20 degrees side to side, and needing to wear a Cervical Collar (C-Collar; a neck brace used to support the spinal cord) at all times.

The Investigation Summary provided by the facility documented on 4/18/23 at approximately 7:15 am, Resident #1 fell out of the Hoyer sling that was the incorrect size. The resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. BUILDING _____ B. WING _____	C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB	4911 SW 19TH STREET DES MOINES, IA 50315

(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 689	Continued From page 10	F 689		

sustained a C6-C7 fracture as a result. The investigation found that Staff H, Certified Nursing Aide (CNA) placed the wrong size sling under Resident #1. Staff I, CNA, attached this sling to the Hoyer lift and started the transfer process. Staff D, Certified Medication Aide (CMA) was getting Resident #1's wheelchair as Staff I began the transfer. As the resident was raised above the bed and the Hoyer lift was turned to transfer her into the wheelchair, one of the straps of the sling came off of the Hoyer and the resident fell to the floor.

Observation on 4/25/23 at 1:00 pm, Resident #1 was lying in bed wearing a C-Collar. Her call light was sitting in a flower basket next to her bed out of reach. A small framed wheelchair with a purple Hoyer lift sling was parked in the room, on Resident #1 ' s side of the dividing curtain.

On 4/26/23 at 11:08 am, Resident #1 was observed lying flat in bed with a C-Collar in place.

On 4/25/23 at 10:27 am, Staff G, RN stated Resident #1 is a larger sized person. At the time she was summoned to the room for the fall, she looked up and noticed immediately the Hoyer sling hanging on the Hoyer was too small. She stated Resident #1 ' s roommate also is a Hoyer lift transfer and is a very petite person. She stated the larger Hoyer sling which should have been used for Resident #1 was noted to be in the roommate ' s wheelchair at the time of the fall.

On 4/25/22 at 10:42 am, Staff D, CMA stated on the morning of the fall, she was passing medications on the hall where Resident #1 resided. She stated Staff I had entered the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. BUILDING _____ B. WING _____	C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB	4911 SW 19TH STREET DES MOINES, IA 50315

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F 689	Continued From page 11	F 689		

resident's room and she asked Staff D to assist as a 2nd person. She added when she entered the room, Staff I already had Resident #1 hooked up in the Hoyer and had already begun the transfer. Staff D stated she grabbed Resident#1's wheelchair and was looking down to guide it between the Hoyer lift legs. She stated the Hoyer lift legs were not fully open and she was concentrating on getting the wheelchair in place. She said she heard a "pop" noise and the resident fell to the ground and landed on the floor. Resident #1 hit her head on the floor during the fall. Staff D stated the sling in the Hoyer lift was purple. She voiced Resident #1 should be transferred with a larger sling colored green, blue or black. Staff D stated the normal protocol for a Hoyer transfer is to double check all the loops before beginning the transfer to ensure safety. When she entered the room, Staff had already had the resident in the air and was completing the transfer and her concern was to get the wheelchair in place since she was already up and out of the bed. She stated when the resident fell she questioned Staff I if she had double checked the loops and staff I responded she knew how to do her job. Staff D stated at that time she left to get help for the resident.

On 4/25/23 at 3:31 pm, Staff H, CNA stated the day of the fall was his 4th day of employment at the facility. He said he began work at 6:00 am and began to get the residents ready for the day who were Hoyer lift transfers. He stated he got both Resident #1 and her roommate dressed. He said the sling he placed under Resident #1 was in the larger, taller wheelchair in the room which Resident #1 used. He stated the other larger Hoyer sling was on the roommate's side of the room. He felt because the sling was in

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	165273	A. BUILDING _____ B. WING _____	C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 12	F 689		

Resident#1's wheelchair, that must have been the sling she preferred. He stated he had only worked at the facility a few days and he did not receive any training upon starting employment. After placing the sling under Resident #1, he went to answer call lights and did not care for the Resident any further that day. He was later called into the office and was told that Resident#1 had fallen and it was due to the Hoyer sling being too small. He stated he explained to them it was in her wheelchair and he put it under her, but he did not transfer the resident.

On 4/25/23 at 4:00 pm, the Director of Nursing (DON) stated in the fall investigation, the facility had determined the way the sling popped off, the sling was not placed correctly on the Hoyer lift. The DON voiced the staff recreated the situation, having a staff member in the Hoyer lift suspended above a bed. They placed one loop only partially on the Hoyer lift instead of fully over the hoops and it popped off in the same fashion in that scenario as well. This recreation was done on 4/19/23, the day after Resident#1's fall. Additionally, the sling used for Resident #1 was too small. The DON stated as a result of this fall, Resident #1 is now on strict bed rest for likely 6-8 weeks. She stated the resident is to lie flat except for when being fed her head can be raised 20 degrees under supervision of the staff and she can be log rolled for care. Otherwise she is to be flat in bed.

An undated document titled Mechanical Lift Transfer directs staff to follow manufacturer's instructions for the transfer procedure.

The Via Health Services training packet for Staff I, dated 3/2/22 included training provided to Staff I

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	165273	A. BUILDING _____ B. WING _____	C 05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB	4911 SW 19TH STREET DES MOINES, IA 50315

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F 689	Continued From page 13 for Hoyer lift transfers. Page 8 of the Transfer Audit & Training directs to place the straps of the sling over the hooks of the swivel bar. Match the corresponding colors on each side of the sling for an even lift of the patient. The unnamed document for Hoyer lift slings directs that the slings are color coded by size. Purple slings are medium with a recommended patient weight of 100-175 pounds Green slings are large with a recommended patient weight of 150-275 pounds Blue slings are extra large with a recommended patient weight of 200-400 pounds Black slings are bariatric with a recommended patient weight of 300-600 pounds. Photographs provided by the facility of the sling on the lift which Resident #1 fell out of show a purple sling was used. The Termination Report dated 4/19/23 documented the termination of employment for Staff I documented the description of the incident as "Staff member did not place Hoyer sling onto lift correctly resulting in injury to resident". The Termination Report dated 4/19/23 documented the termination of employment for Staff H documented the description of the incident as "Staff member placed wrong size Hoyer sling under resident prior to resident transfer which led to the injury of a resident".	F 689		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,	F 921		

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F 921	Continued From page 14	F 921		

sanitary, and comfortable environment for residents, staff and the public.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and resident interview the facility failed to maintain comfortable environment and safe functional equipment in resident rooms for 4 of 7 (#9, #15, #16, #17) reviewed. The facility reported a census of 76.

Findings include:

1. The Quarterly Minimum Data Set (MDS) dated 3/15/2023 documented Resident#9 scored a Brief Interview of Mental Status (BIMS) as 02 which indicated severe cognitive impairment. The MDS documented Resident diagnoses included cerebral palsy, bi-polar and schizoaffective.

Resident#9's Care Plan updated 3/14/23 documented communication deficits, and intellectual deficit.

Observation on 5/1/23 at 3:45 pm Resident #9 bed is directly against the air conditioning unit; the unit was on.

2. The Quarterly MDS dated 3/16/2023 documented Resident#15 scored a Brief Interview of Mental Status (BIMS) as 15 which indicated intact cognition The MDS documented Resident #15 diagnoses which included stroke, diabetes with chronic kidney disease and weakness.

Observation on 4/24/23 at 10:52 AM, revealed Resident #15 had boxes, containers and bedside dresser in front of the air conditions. The top

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F 921	Continued From page 15	F 921		

exhaust vent cover was missing from the unit.

On 4/24/23 at 10:51 AM Resident #15 revealed It's either too hot or too cold, reported last summer it was so hot, no one wanted to visit me. I did run the air conditioner all the time, stated, I don't think it works very well. Relayed is not sure what happened to the top exhaust vent cover, that was missing from the unit. Reported, I have a fan my daughter brought that helps some. States in the winter if it's really cold all I can do is wrap up.

3. Resident #16 MDS dated 3/30/23 did not document a Brief Interview of Mental Status (BIMS) for cognition assessment. Diagnosis included Chronic obstructive pulmonary disease, non-Alzheimer's dementia, peripheral vascular disease.

Resident #16 Care Plan revised 04/24/22 documented Resident #16 with a communication barrier, primary language is Spanish.

Observation on 4/26/23 at 10:30 AM Resident #16 in bed with air conditioning unit on, the bed is directly against the unit that is blowing air. Resident indicated was cold with gesturing for blankets at the end of the bed. Staff B, Maintenance Assistant entered and moved the bed away slightly away from the unit, acknowledged air conditioning unit should not be directly against the bed. Staff B, closed a window and adjusted the unit per resident requested. Staff B, acknowledged resident was not able to adjust the temperature, and was not sure why the window was open.

Outside temp about sixty degrees per National

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F 921	Continued From page 16	F 921		

Weather Service website on 4/26/23 at 10:30 AM.

4. Resident #17 MDS dated 3/19/23 documented BIMS score of 10 indicating moderate cognitive impairment, diagnosis included cancer, peripheral vascular disease, diabetes and Alzheimer's disease.

Observation on 5/1/23 at 3:50 PM Resident #17 in bed with air conditioning unit on, the bed is directly against the unit that is blowing air.

Observation on 4/26/23 at 3:00 PM the hall temperature was 80 degrees indicated by a kitchen thermometer, the outside temperature was cool, reported as sixty-three 63 degrees per National Weather Service website.

On 4/26/22 at 10:40 AM Staff C, Maintenance Manager reported that the thermostat in the halls are only for the heat that comes from the base board in residents' rooms. The hall thermostats are set usually between seventy-two to seventy-five depending on conditions, wind blowing and outside temperatures. The rooms have individual air conditioning units for air conditioning. Staff C reported maintenance does not adjust room units unless there is a complaint, and there is no way to determine individual room temperatures since maintenance does not have a thermometer to check room temperatures. Staff C acknowledged the air conditioning units should not be obstructed and hall temperatures are not consistent with resident room temperatures.

On 4/27/23 at 3:09 PM Staff F relayed sometimes it is hot, some days it is cold, just varies that's all I can say, it varies greatly.

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F 921	Continued From page 17 On 5/1/23 at 10:31 am staff D relayed sometimes it's hot sometimes it's cold, we give more blankets when residents ask if it is too cold. On 05/01/23 at 2:00 PM during an Interview with the administrator, relayed if temperatures are seventy-one to eighty-one degrees it is within the regulations. Acknowledged maintenance response, does not test room temperatures. On 5/1/23 at 2:04 PM the Administrator relayed via email in response to policies requested on facility temperature, wrote "Monitoring Temperature Control, we follow standard of care set forth by State and Federal Guidelines and maintain the temperature in the building between 71-81 degrees. Cognitive Residents have the right to adjust their temperature in their own room. We attempt to pair roommates the best that we can and address issues as they arise".	F 921		