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	165436	A. BUILDING _____ B. WING _____	06/05/2023

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IVY AT DAVENPORT	800 EAST RUSHOLME STREET DAVENPORT, IA 52803

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F 000	INITIAL COMMENTS AMENDED 6/14/23 VW Correction Date: July 5, 2023 The following deficiencies resulted from the facility's Annual Recertification Survey and investigation of Complaints #105496-C, #106699-C, #108013-C, #108419-C, #109473-C, #109874-C, #109904-C, #109976-C, #110224-C, #111180-C, #111407-C, #111582-C, #111698-C, #111842-C, #111903-C, #111906-C, #111920 -C and Facility Self-Reported Incidents #107494-I, #107932-I, #109124-I and #110320-I conducted April 11, 2023 to June 5, 2023. Complaints #105496-C, #106699-C, #109473-C, #109874-C, #109904-C, #110224-C, #111582-C, #111698-C, #111842-C, #111903-C, #111906-C, and #111920-C were substantiated. Facility Self-Reported Incidents #107494-I, #107932-I, #109124-I and #110320-I were substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
OK/TAG ✓				
F 550 SS=E	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	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Administrator | TITLE | (X6) DATE: ~~05/17/2023~~ 6/23/23

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

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with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the 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 observations, clinical record review and staff interviews, the facility staff failed to ensure residents' dignity upheld for 4 of 14 residents reviewed (Residents #11, #33, #49, and #70). The facility reported a census of 69 residents.

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Findings Include:

1. The Minimum Data Set (MDS) dated 3/14/23 identified Resident #11 as cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15, and had the following diagnoses: Atrial Fibrillation, UTI and Diabetes Mellitus. The MDS also identified the resident required extensive staff assistance with all activities off daily living (ADL's)) except for eating and that he had an indwelling catheter.

Observations of the resident revealed the a Foley catheter bag hanging off the bed frame without a dignity bag and visible to anyone walking into the room at the following times:
a. On 4/11/23 at 11:25 AM, while the resident lying in bed
b. On 4/11/23 at 1:10 PM, assessment unchanged.
c. On 4/11/23 at 2:23 PM, assessment unchanged.
d. On 4/12/23 at 10:30 AM, asleep in bed.
e. On 4/12/23 at 11:15 AM, assessment unchanged.
f. On 4/12/23 at 12:20 PM, assessment unchanged, door to room open.

A review of the Care Plan identified the resident with the problem of having an indwelling Catheter on 4/5/23 (resident admitted to facility on 3/8/23) and directed staff to position catheter bag and tubing below the level of the bladder and away from entrance room door.

2. The MDS dated 4/10/23 identified Resident #49 as cognitively intact with a BIMS score of 15

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out of 15 and had the following diagnoses: Multiple Sclerosis, neurogenic bladder and paraplegia. It identified the resident required extensive staff assistance with repositioning in bed, and totally dependent on staff for bathing. The MDS also identified the resident with an indwelling urinary catheter.

Observations of the resident revealed a Foley catheter bag not placed in a dignity bag at the following times:
a. On 4/11/23 at 12:09 PM, sitting up in a power chair.
b. On 4/11/23 at 1:16 PM, sitting up in power chair, assessment unchanged.
c. On 4/11/23 2:11 PM, sitting up in power chair in the main dining room, underneath his seat.
d. On 4/12/23 at 3:36 PM, during an observation of wound care, also found the catheter bag and tubing lying on the floor.
e. On 4/13/23 7:21 AM, asleep in bed, door to room wide open, the Foley catheter bag hung on the bed frame in full view of anyone walking past the room.
f. On 4/13/23 8:36 AM, assessment unchanged.
g. On 4/13/23 9:15 AM, resident in bed with Foley catheter bag in full view of anyone walking by his room as door left wide open.
h. On 4/17/23 8:10 AM, sitting up in bed, holding the wound vac and Foley bag (without being placed in a dignity bag) over his groin area.

On 2/20/23, the Care Plan identified the resident with the problem of having an indwelling catheter and directed staff to position the catheter bag and tubing below the level of the bladder and away from entrance room door.

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3. The MDS for Resident #33 dated 1/25/23, included diagnoses of diabetes mellitus (DM), rheumatoid arthritis. The MDS listed Resident # 33's BIMS as 11 out of 15 (moderately impairment cognition).

The Care Plan for Resident #33 dated 12/23/22, reflected Resident # 33's indwelling catheter placed related to fluid retention at recent hospitalization. The Care Plan directed position catheter bag and tubing below the level of the bladder and away from entrance room door.

On 04/12/23 at 1:03 PM, Resident #33 sat in her wheel chair (w/c), staff failed to place a dignity bag over her catheter bag under the w/c.

On 4/13/23 at 8:37 AM, Resident #33 propelled herself in the wheelchair in A Hallway all the way to dining room and the facility failed to place a dignity bag over Resident # 33's catheter bag.

On 4/13/23 at 9:40 AM, Resident #33 walked her self up the hall as she sat in the w/c. The urinary catheter bag under her w/c lacked a dignity cover as she walked herself in the w/c in the hall to the Front DR area.

On 4/13/23 at 11:35 AM, Resident #33 wheeled herself from the nurses station by A hall into her room as her catheter bag lacked a dignity cover.

Observations of Resident #33 on 4/17/23 revealed the following:
a. On at 8:29 AM, able to self propel from dining room back to her room with Foley bag without a dignity bag under the wheelchair seat and tubing dragging across the floor.

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b. On at 8:33 AM, able to self propel from her room to the activity room with Foley bag without a dignity bag and tubing dragging across the floor.
c. On at 8:46 AM, able to self propel from activity room back to her room with Foley bag still without a dignity bag and tubing dragging across the floor.

On 4/17/23 at 1:00 PM, Resident # 33 sat at the table in the dining room, the facility failed to utilize a dignity cover over Resident # 33 catheter bag under her w/c.

On 4/18/23 at 12:42 PM, Staff DD, Certified Medication Aide (CMA), placed Resident # 33 catheter bag in a dignity bag.

On 4/18/23 at 12:42 PM, Staff DD reported, she finished fixing her dignity bag cover for Resident # 33's privacy. Staff DD stated, catheter bags needed a dignity cover place all the times.

On 04/18/23 at 2:15 PM, the Director of Nursing (DON) stated, her expectation is all catheter bags covered with a dignity bag.

The facility policy titled Catheter Care dated 3/2023, revealed the following:
It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.
Policy Explanation:
1. Catheter care will be performed every shift and as needed by nursing personnel.
2. Privacy bags will be available and catheter drainage bags will be covered at all times while in use.

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3. Privacy bags will be changed out when soiled, with a catheter change or as needed.
Leg bags may be used for ambulatory residents or per resident request.

The facility Admission Agreement included Exhibit B Residents Rights undated, directed each resident shall have the right:
a. To privacy in treatment and personal care.

4. The MDS Assessment Tool, dated 1/3/23, listed diagnoses for Resident #70 which included heart failure, paraplegia, and anxiety disorder. The MDS documented the resident required supervision assistance of 2 staff for personal hygiene, limited assistance of 2 staff for transfers, extensive assistance of 1 staff for dressing, extensive assistance of 2 staff for toilet use, and depended completely on 2 staff for bathing. The MDS listed the resident's BIMS score of 14 out of 15, indicating intact cognition.

Care Plan entries, dated 4/20/22, stated the resident had a self-care performance deficit related to paraplegia and stated the resident required staff assistance for bathing, bed mobility, dressing, toilet use, and transfers.

During an interview on 4/12/23 at 10:11 a.m. , Resident #70 stated a nurse told her that she needed to "pick up the slack" when it came to helping with cares. Resident stated that she was at the facility to have help and could not move.

The facility policy "Promoting/Maintaining Resident Dignity During Mealtimes" reviewed

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F 550	Continued From page 7 March 2023, stated it was the practice of the facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintained or enhanced his or her quality of life.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and policy review, the facility failed to provide items in residents' rooms to meet resident needs for 2 of 26 residents reviewed (Residents #52 and #63). The facility reported a census of 69 residents. Findings Included: 1. The Minimum Data Set (MDS) dated 2/6/23 identified Resident #52 as cognitively intact with a Brief Interview for Mental Status score of 12 out of 15 and had the following diagnoses: end stage renal disease (required Dialysis), heart failure and coronary artery disease. The MDS also identified the resident extensive staff assistance with bathing and required limited staff assistance with transfers, walking in and out of his room, toileting and personal hygiene. Observations of the resident's room revealed the	F 558		

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following:
a. On 4/11/23 at 11:09 AM, the resident lying in bed with several plastic zippered bags on the floor next to his bed which contained food. The room did not have a nightstand and he reported he had not had a nightstand since he moved in (1/31/23).
b. On 4/11/23 at 2:23 PM, assessment unchanged, currently in the therapy room. Remains without nightstand in his room and Ziploc bags containing food on the floor beside his bed.
c. On 4/12/23 at 9:40 AM, room remains without a nightstand and plastic zippered bags on the floor beside his bed
d. On 4/12/23 at 12:18 PM, assessment unchanged.
e. On 4/13/23 at 7:18 AM, asleep in bed and room remains without a nightstand.
f. On 4/17/23 at 8:06 AM, currently not in his room, out at Dialysis. Room remains without nightstand and bags of potato chips on the floor next to his bed.

The Care Plan with the last revision date of 2/8/23 identified the resident with the problem of an activities of daily living (ADL) performance deficit and did not identify the need to ensure his room had been equipped to meet his needs.

Interviews with staff revealed the following:
a. In an interview on 4/24/23 at 1:46 PM, the Social Worker reported every resident should have a nightstand and that the facility just received a lot of new nightstands.
b. In an interview on 4/25/23 at 9:06 AM to 9:23 AM, Staff OO, Certified Nursing Assistant/Certified Medication Aide (CNA/CMA) reported Housekeeping is supposed to make

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sure the room is all set up before the resident moves in, then the Nurse and CNA need to follow up if anything is missing. She did not know why Resident #52's room did not have a nightstand.
c. In an interview on 4/25/23 at 10:24 AM, Staff PP, CNA reported all staff, including Housekeeping had the responsibility to ensure the resident's room had the items needed, such as a nightstand. She had not been aware that Resident #52 did not have a nightstand in his room.
d. In an interview on 4/25/23 at 3:04 PM , the Director of Nursing (DON) reported she would expect the following items to be placed in all resident rooms: basic hygiene needs, night stand and trash can. Both housekeeping and nursing staff had the responsibility to ensure all items had been placed in the residents' rooms.

The facility policy titled: Resident Rooms Furniture dated as last revised March 2023 had documentation of the following:
1. Each resident will have:
a. Functional furniture appropriate to the resident's needs.
2. The facility shall request and/or maintain variances from the survey agency if the room variances:
a. Are in accordance with the special needs of the resident;
b. Will not adversely affect the residents' health and safety.
3. Resident rooms will be furnished with functional furniture and arranged according to resident needs and preferences.

2. The 3/9/23 MDS Assessment Tool listed diagnoses for Resident #63 which included

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F 558	Continued From page 10 diabetes, burns, and unspecified fall and listed the resident's BIMS score as 15 out of 15, indicating intact cognition. The MDS identified the resident admitted to the facility on 3/3/23. During an observation on 4/12/23 at 7:41 a.m., Resident #63 had a garbage receptacle in her room near her bed which overflowed with refuse. The bathroom contained no garbage can and the resident stated she did not have one for the bathroom and had not had one since she admitted on 3/3/23. She stated she was incontinent and when she had to change her brief, she had to carry the soiled brief out of the bathroom into her room and stated this was not sanitary. Care Plan entries, stated 3/13/23, stated the resident had occasional bladder incontinence and stated she utilized incontinence briefs. The facility policy "Resident Rooms Furniture" reviewed March 2023, documented the facility would furnish rooms with functional furniture arranged according to resident needs and preferences. The policy did not include information regarding garbage cans in bathrooms.	F 558		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.	F 565		

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(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.
(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.
(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.
(A) The facility must be able to demonstrate their response and rationale for such response.
(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

§483.10(f)(6) The resident has a right to participate in family groups.

§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, policy review, and staff interview, the facility failed to act promptly to Resident Council concerns with regard to call light response times. 5 of 5 residents who attended the April 2023 Resident Council interviewed reported call light wait time of more than 15 minutes. The facility knew about the call light concern since January 2023. The facility reported a census of 69 residents.

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Findings Include:

Review of the Resident Council Minutes revealed the following concerns:
a. The January 2023 Resident Council Meeting Minutes revealed call lights were not answered timely. It took more than 30 minutes to get a response. Certified Nursing Assistant's (CNA) were on cell phones and used ear buds. The Director of Nursing (DON) was at the meeting and was made aware of the concern.
b. The February 2023 Resident Council Meeting Minutes revealed call lights were not being answered. CNA wore ear buds and was on the phone during care. The DON was at the meeting and agreed to address the concern.
c. The March 2023 Resident Council Meeting Minutes revealed call lights were not being answered and staff wore earbuds and used phones. A Grievance Paper was filled out and was given to the DON.

Review of policy titled "Resident Council Meetings" revised March 2023 stated the facility shall act upon concerns and recommendations of the Council, make attempts to accommodate recommendations to the extent practicable, and communicate its decisions to the Council.

The facility failed to provide any written information during the survey regarding the call light Grievance Form submitted by Resident Council in March 2023.

On 4/11/23 at 1:00 PM, call lights were identified as a concern for 5 of 5 residents who attended the April Resident Council Group interview. Call light concerns were reported to facility staff and the group was told that the facility was trying to

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F 565	Continued From page 13 get the call light wait time down to a half hour. The group provided examples of residents waiting 2 hours in soiled pants and linens. Residents tracked time by watches and clocks. The Resident Council reported that staff shut call lights off and did not provide the requested care. Group members agreed that the average wait time for a response was more than 30 minutes. No one answered call lights at shift change according to one member. On 4/19/23 10:55 AM, the DON was asked about the facility response to the Resident Council's Call Light Grievance. The Assistant Director of Nursing (ADON) began inservice training with staff on call light response times. The ADON completed training with 5 staff. The DON was asked about plans to reduce call light times and reported she and the Social Worker developed a training on call lights on 4/18/23. The training began on 4/19/23 to inform staff they must answer all call lights. A no tolerance policy was implemented for use of cell phone and ear buds on the job. Those expectations were included in the new training. The DON stated that one problem was that staff were not answering call lights for residents that they were not assigned to assist during their shift.	F 565		
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	F 580		

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physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to

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room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff and resident representative interviews and facility policy review, the facility staff failed to document the residents' Power of Attorney (POA)) had been notified of room changes, physician appointments and transfers to the hospital for two of two residents reviewed (Residents #9 and #121). The facility reported a census of 69 residents.

Findings Include:

1. The Minimum Data Set (MDS) dated 4/5/23 identified Resident #9 as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) of 2 out of 15 and had the following diagnoses: Renal Insufficiency, Non-Alzheimer's Dementia and Bipolar Disorder. The MDS also identified the resident required extensive staff assistance with bed mobility, transfers, dressing, toileting and hygiene.

In an interview on 4/13/23 at 3:49 PM, the resident's POA reported the resident had been moved to different rooms four different times and the facility did not notify her of the room changes and of a doctor's appointment they made for her to be seen by a doctor in Iowa City for a spot on her nose that she constantly picks at daily. The POA also reported there has been a total lack of communication from the facility to inform her of different issues.

On 1/31/22 the Care Plan identified the resident with the problem of being at risk for COVID, however did not address the need to notify the

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POA/family of room changes.

A review of the Social Worker and Nurse's Progress Notes in the past year revealed no documentation that the POA notified of the room changes or of the doctor's appointment.

A review of the electronic medical record revealed resident lived in the following rooms:
a. On 3/23/22 room A 15-2.
b. On 5/6/22 room B 8-1.
c. On 7/5/22 room 4-1.
d. On 1/6/23 room 1-1.
e. On 1/6/23 room A 11-2.
f. On 1/18/23 room 3-1.

In an interview on 4/25/23 at 9:43 AM, Staff D, Licensed Practical Nurse (LPN) reported the resident's POA should be notified with any changes in the resident's condition, orders or behaviors. The nurses are responsible for contacting the POA and this should be documented in the progress notes.

In an interview on 4/25/23 at 9:53 AM, Staff K, Registered Nurse (RN) reported the resident's POA should be notified with any changes in the resident's condition, injuries or if the resident is sent to the hospital. The nurse working the floor is responsible for notification and should document in the progress notes.

In an interview on 4/25/23 at 3:05 PM, the Director of Nursing (DON) reported she would expect nurses to notify family with any change of condition, if there is a reportable incident or a room change and document it in the progress notes.

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2. The MDS Assessment Tool, dated 5/16/22, listed diagnoses for Resident #121 which included heart failure, high blood pressure, diabetes, and cerebral vascular accident (which is an interruption in the flow of blood to cells in the brain), and aphasia resulted (when a person has difficulty with their language or speech), and listed the BIMS score as 7 out of 15, indicating severely impaired cognition.

The Care Plan dated 4/13/22 showed the resident had communication problems related to Expressive Aphasia (a condition where a person may understand speech, but they have difficulty speaking fluently themselves). On 5/9/22 the Care Plan was updated to include behaviors of confabulation in regard to not getting medications, food, and believing things that are not true.

During an interview on 4/17/23 at 8:20 AM, the resident's POA stated not being notified when the resident had been transferred to an Emergency Room (ER) for evaluation on 5/16/22.

Review of the Iowa Physician for Scope of Treatment (IPOST) dated 4/14/22 showed the interviewee had been the POA since the date signed.

Review of Resident #121 electronic health record lacked documentation of the POA notification when the resident transferred on 5/16/22 for an ER evaluation.

A review of the facility policy titled: Notification of Changes dated as last reviewed March 2023 documented the following:

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F 580	Continued From page 18 The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: 1. Accidents a. Resulting in injury. b. Potential to require physician intervention. 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include life-threatening conditions, or clinical complications, circumstances that require a need to alter treatment. This may include: new treatment. discontinuation of current treatment due to: adverse consequences, acute condition or exacerbation of a chronic condition. 3. A transfer or discharge of the resident from the facility. 4. A change of room or roommate assignment. 5. A change in resident rights.	F 580		
F 584 SS=E	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	F 584		

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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 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 observations, resident and staff interviews and facility policy review the facility failed to maintain clean floors, empty trash, clean resident equipment, prevent urine odors in resident rooms and the hallways, noted cigarette butts are littered on the ground in the smoking area and failed to provide linens for 7 out of 26 residents reviewed (Residents # 3, #15, #9, # 24, #41, #46, and# 56). The facility reported a census of 69 residents.

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Findings Include:

1. On 4/11/23 at 10:58 AM, Resident # 15 reported housekeeping cleans daily. Resident # 15 stated, she's failed to know if housekeeping cleaned the bathroom.

On 4/11/23 at 10:58 AM, the bathroom floor in Resident # 15's room held a dried 4 by 4 inch brown substance and smears of brown on the toilet riser. The resident's son stated the bathroom floor appeared disgusting.

2. On 4/12/23 at 10:50 AM, a night gown, incontinent pad and wash cloth sat on the floor in Resident # 56's room.

3. On 4/12/23 at 12:23 PM, the smoking area out the door on the North side of the building revealed cigarette butts in the grass and a large number sat on the sidewalk.

4. On 4/13/23 at 11:25 AM, Staff L, Housekeeping, used her foot and cloth towel to dry up the ice spilt and melted on the floor. The white cloth appears black/gray in color as she picked it up off the floor and carried down the hall to the dirty linen cart room.

On 4/20/23 at 10:50 AM, Staff M, Housekeeping, reported she started here 7 months ago. She stated the facility provided training on the use of chemicals for the cleaning.

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The facility provided a policy titled Preventative Maintenance Program dated 3/2022, reflected a Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.

The facility provided an undated policy titled Routine Cleaning and Disinfection, the policy revealed the facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.

The policy directed: Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms, and at the time of discharge.

The policy included direction for:
Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to:
a. Toilet flush handles;
b. Bed rails;
c. Tray tables;
d. Call buttons;
e. TV remote;
f. Telephones;
g. Toilet seats;
h. Monitor control panels, touch screens and cables;
i. Resident chairs;
j. IV poles;
k. Blood pressure cuffs;
l. Sinks and faucets;

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m. Light switches;
n. Door knobs and levers.

The policy listed, horizontal surfaces with infrequent hand contact (window sills and hard surface flooring) in routine resident-care areas should be cleaned:
a. On a regular basis.
b. When soiling and spills occur.
c. When a resident is discharged from the facility.

5. During an observation on 4/11/23 at 11:07 AM, revealed white powder on the floor in Resident #24 room.

During observation on 4/11/23 at 4:11 PM, the floor under the dining room table in the dining area had a dried spilled area. The table had an empty cup, milk carton, an empty plastic cup on it. No residents occupied the table. Multiple tables observed dirty and not wiped down.

During an observation on 4/18/23 at 12:59 PM, a sticky floor in Resident #24 room. Shoes stuck to the floor when ambulating throughout room.

During an interview on 4/24/23 at 1:17 PM, Staff GG, Housekeeping queried how often the resident's rooms cleaned and she stated everyday. Staff GG asked how often the floors in the hallways and resident's rooms are mopped and she stated everyday.

During an interview on 4/25/23 at 1:03 PM, the Administrator queried on how often they clean the resident's room and mopped the floors and she stated they cleaned, mopped, and took out the trash in the resident's room daily and mopped the

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floors in the hallways at least daily and they also did spot cleaning.

6. During an observation on 04/18/23 at 10:21 AM, Resident #41 laid on his bed with no linens on it.

During an observation on 4/18/23 at 10:22 AM, no linens present on Resident #3 bed.

During an observation on 4/18/23 at 11:33 AM, Resident #41 laid on his bed without a pillow case or linens covering the mattress.

During an observation on 4/18/23 at 12:47 PM, no linens on Resident #3 and Resident #41 beds.

During an observation on 4/18/23 at 2:58 PM, no linens on the Resident #3 and Resident #41 beds. Both residents laid on their beds.

During an interview on 4/18/23 at 2:59 PM, Resident #3 queried why he didn't have linens on his bed and he stated because no sheets were available. He stated they threw them away when they got soiled. He stated the facility ordered new ones, but they hadn't come in yet. Resident #3 asked when they removed the linens from his bed and he stated yesterday afternoon.

During an observation on 4/18/23 at 4:16 PM, no noted linens on Resident #3 and Resident #41 beds.

During an interview on 4/19/23 at 10:30 AM, Staff A, Housekeeping Supervisor queried on the process of linen changes and she stated the Certified Nurse Aide (CNA) took them off and

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changed them. She stated Housekeeping wiped down the mattress and let it dry or sometimes the CNA came and got the spray and did it. The CNA or Housekeeping made them when the linens available. She stated no supplies available to hurry up and get beds made and they waited for Laundry to wash them. Staff A asked if linens not on residents beds happened frequently and she stated no, the CNAs stripped the beds, Laundry washed the linens and put them in a closet, and Laundry informed the CNAs the linens available to make beds. Staff A stated it could take 2 to 3 hours for beds to be made.

During an interview on 4/20/23 at 9:27 AM, Staff HH, CNA queried if she ever saw beds without linens on them and she stated sometimes when she came on shift. Staff HH queried if the facility short on linens and she stated yes, she found out last night because no sheets were found in the closet in the back hallway.

During an interview on 4/20/23 at 9:52 AM, Staff II, CNA queried if the facility short on linens and she stated yes, they are really short on linens. Staff II asked how long it took between removing linens on the bed and replacing them and she stated it depended on availability of sheets and at times it took a couple of hours. Staff II, queried if enough sheets were available with routine laundering/incontinent issues and she stated no, not all the time.

During an interview on 4/24/23 at 1:21 PM, Staff B, Laundry Aide queried how often they changed the linens and she stated they were supposed to be changed daily but if they were not dirty they didn't get changed. . She stated they had no linens and didn't have a lot of fitted sheets. She

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stated a lot of beds in the halls didn't have linens on them.

During an interview on 4/25/23 at 1:03 PM, the Administrator queried on the expectations of linens being changed on the resident's beds after the removal of soiled linens and she stated she didn't have a time frame but they should definitely know the resident's routine and it should be done quickly.

7. During random observations of the facility, noted areas with strong odors smelling of urine, body odor and garbage:
a. On 4/11/23 at 11:03 AM revealed Resident #24 room smelled of urine and body odor.
b. On 4/12/23 at 12:31 PM, Hall B smelled of urine near Resident #24 room.
c. On 4/13/23 at 12:53 PM, Hall B smelled of urine near Resident #24 room.
d. On 4/17/23 at 1:21 PM, smelled urine when entering Resident #24 room.
e. On 4/18/23 at 12:59 PM, walked by Resident #24 room and smelled a strong odor of urine.

During an interview on 4/20/23 at 9:12 AM, Staff CC, Licensed Practical Nurse (LPN) queried if she noticed odors when she started her shift and she stated yes, at the front of the building from garbage bags lined up to be taken out. Staff CC asked if she noticed odors in B Hall and she stated she didn't know, she usually wore a face mask.

During an interview on 4/20/23 at 9:52 AM, Staff II, Certified Nursing Assistant (CNA) queried if she noticed odors when she started her shift and she stated yeah, typically it stunk of urine

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especially in the back. Staff II asked if she noticed an odor in B Hall and she stated the back usually smelled of urine especially when one CNA worked because of the trash and incontinent briefs. Staff II queried if she ever smelled an odor in Resident #24's room and she stated urine, definitely. Staff II asked what she thought caused it and she stated his roommate took himself to the bathroom and didn't have good aim and the urinals in the room didn't get dumped very often or might get spilled.

During an interview on 4/24/23 at 1:17 PM, Staff GG, Housekeeping queried if she noticed an odor in the facility and she stated an urine smell, just in B Hall. Staff GG asked when she smelled urine and she stated she guessed in the mornings. Staff queried if she noticed it more in any of the resident's rooms and she stated they were all about the same to her.

During an interview on 4/25/23 at 1:03 PM, the Administrator queried if she noticed odors in the resident's rooms or hallways and she stated not specifically but if she did she got hold of housekeeping and got it cleaned up. She stated she noticed B hallway that had an urine odor and looked into ways to eliminate the problem.

The undated Facility Policy titled Routine Cleaning and Disinfection revealed the policy ensured the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and preventing the development and transmission of infections to the extent possible. The facility indicated routine cleaning and disinfection of frequently touched or visibly soiled surfaces would be performed in common areas, resident rooms, and at the time of discharge.

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8. On 4/12/23 at 10:08 AM, Staff A, Housekeeping Supervisor, stated supplies of linens decreased recently. Soiled linens were not brought into the laundry room. Due to the delay before washing, the linens stained and were thrown away and not replaced. The supply shelf in the laundry room held 4 fitted sheets and 9 flat sheets. There were 0 linen incontinence pads and 0 bedspreads. The supply closet on Unit B had 0 linen incontinence pads. Staff A stated the facility lacked linens, especially linen incontinence pads. Staff A stated there was not enough linens for the facility and CNA's were waiting on linens that were in the laundry.

9. The Minimum Data Set (MDS) dated 4/5/23 identified Resident #9 as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 2 out of 15 and had the following diagnoses: Renal Insufficiency, Non-Alzheimer's Dementia and Bipolar Disorder. It also identified the resident required extensive staff assistance with bed mobility, transfers, dressing, toileting and hygiene.

Observations of the resident revealed the following:
a. On 4/13/23 at 8:43 AM the resident ambulated independently in the hall wearing only pajamas and no footwear. The Assistant Director of Nursing (ADON) redirected her away from the exit door at end of hall. Multiple areas of brown residue noted on the carpeting. The resident began to walk the other way. Neither the ADON

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nor Staff F, Certified Medication Aide (CMA) in hallway placed any gripper socks or shoes on the resident's feet
b. On 4/13/23 at 8:48 AM the resident remained ambulating independently in hall without any socks or shoes on her feet, had pushed the bar on the exit door at end of hall, but did not attempt to go outside. Staff F stood in the hallway and did not encourage her or assist her with putting socks or shoes on her feet.
c. On /13/23 at 9:06 AM female therapy staff member assisted the resident to change into clean clothing and gripper socks and walked her down to therapy room.

A review of the Care Plan identified the resident on 8/27/21 with the problem with being at risk for falls and directed staff to ensure the resident wore appropriate footwear when ambulating. It also identified her on the same date with the problem of an activities of daily living (ADL) self-care performance deficit and directed staff to assist of 1 to move between surfaces and as necessary. make sure she has shoes on will often refuse/take off.

In an interview on 4/24/23 at 1:46 PM, the Social Worker reported the resident did have a history of wandering the halls independently and the staff should make sure she has her feet covered with gripper socks or shoes when walking in the hallways as the carpeting is not the cleanest.

In an interview on 5/1/23 at 10:07, Staff QQ, CNA, reported Resident #9 had a history of walking in the halls
independently and did so frequently. She also reported if staff saw her walking around in her bare feet, they should take her back to her room

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and put socks and shoes on her. When asked what she thought the brown spots were on the carpeting, she reported it could be feces as she had actually witnessed Resident #9 removing a bowel movement (BM) from her pants and throw it on the carpeting.

In an interview on 5/1/23 at 10:19 AM, Staff E, Licensed Practical Nurse (LPN) reported Resident #9 had a history of walking in the halls independently and did so frequently. She also reported if staff saw her walking around in her bare feet, they should take her back to her room as she is easily re-directed and put socks and shoes on her.

In an interview on 5/1/23 at 11:03 AM, the Director of Nursing (DON) reported Resident #9 did have a history of walking in the halls independently several times a day. If staff saw her walking around in her bare feet, she would expect the staff to take her to her room and put on socks, shoes or slippers on her feet. When asked what she thought the brown spots may be on the carpeting, she thought it might be food that the resident spit out and not BM.

10. A review of the MDS dated 3/15/23 identified Resident #46 as cognitively intact with a BIMS score of 13 out of 15 and with the following diagnoses: Multiple Sclerosis, Coronary Artery Disease and Respiratory Failure. It also identified the resident required extensive staff assistance with all ADLs (activities of daily living) except for eating and totally dependent on staff for showers/baths.

Observations of the resident's room revealed the

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following:
a. On 4/11/23 at 1:12 PM, asleep in bed, no side rails up. Floor mat beside bed covered with liquid residue.
b. On 4/11/23 at 2:21 PM, assessment unchanged.
c. On 4/13/23 at 7:13 AM, asleep in bed with door to room open and the floor mat beside the bed had a sticky residue, debris of tissues and food particles on floor beside bed.
d. On 4/13/23 at 7:40 AM, The floor to the resident's room remains with food particles and tissues beside bed.
e. On 4/13/23 at 9:32 AM, Staff C, CNA walked into the resident's room, provided cares and left the room without picking up food particles and tissues by the bed.
f. On 4/17/23 at 8:20 AM, resident now in room in the A hall. The resident's floor appeared very sticky and the floormat next to bed covered with food particles. Clothing and blankets were also observed lying on the floor at the foot of the bed.

The Care Plan identified the resident with the problem on 1/25/23 of being at risk for falls due to decreased mobility and directed staff to ensure her room was free of clutter.

11. During an observation on 4/11/23 at 9:44 a.m., Resident #56's room had a crumpled bed pad and hospital gown in the middle of the floor. There were pieces of paper and refuse on the floor near the resident's bed.

During an observation on 4/13/23 at 8:13 a.m., the Central Hall near the Activity Room door had 2 pieces of crumpled up white paper. Near the

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F 584	Continued From page 31 door to the north dining room, there was a blue piece of paper on the floor and smashed raisins. 12. In an interview on 4/11/23 at 10:10 a.m., the Administrator stated odors were better in the facility and stated when she first started at the facility she thought the odors were stronger. She stated she would like to redo some flooring and that the removal of garbage was not just a housekeeping responsibility. An observation on 4/11/23 at 11:40 a.m. revealed a strong odor of urine in the center hall.	F 584		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, resident interviews, staff interviews, and facility policy review, the facility neglected residents when they failed to provide required nursing	F 600		

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services to residents who needed assistance wtih grooming, bathing, incontinence care and failed to provide housekeeping and laundry services for 16 out of 26 residents reviewed for activities of daily living assistance and homelike environment (Resident #35, #2, #10, #4, #46, #56, #61, #63, #70, #15, #9, #24, #41, #3). The facility reported a census of 69 residents.

Findings Include:

1. The Minimum Data Set (MDS) Assessment for Resident #35 dated 1/18/23, listed diagnoses of dementia and cancer. The MDS identified the Brief Interview of Mental Status (BIMS) score of of 00 (indicating severe cognitive impairments), and showed Resident #35 required extensive assist of 1 staff for personal hygiene and bathing.

The Care Plan dated 10/28/19, identified Resident #35's activities of daily living (ADL) self-care performance deficit related to Dementia. The Care Plan intervention included to keep fingernails short and keep skin clean and dry.

The Bath Record dated 4/18/23, showed Resident #35 received 3 baths in 30 days. The record reflected baths given to Resident #35 on 3/21/23, 3/28/23 and 4/11/23.

The Hospice Communication log at the Nurses Station included notes from the nurses and lacked documentation of bathing.

The Hospice Care Plan dated 3/16/23, failed to reflect bathing provided for Resident #35.

During the following observations of Resident #35, noted dirty fingernails on both hands:

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a. On 4/11/23 at 12:50 PM, the resident's right and left hands under her fingernails noted a dark substance.
b. On 4/12/23 at 12:26 PM, Resident #35 finger nails on her left hand continued with a dark colored substance under the nails.
c. On 4/12/23 at 12:15 PM, under all five finger nails on Resident #35's right hand contained dark substance.
d. On 4/13/23 at 8:42 AM, Resident #35's fingernails to her right hand remained with dark colored substance under the nail.
e. On 4/17/23 12:54 PM, Resident #35's right hand under her finger nails held dark black colored substance as she sat at the dining room table.
f. On 4/18/23 at 12:34 PM, Resident #35's sat at the dining room table and her right hand under her fingernails held a dark colored substance.

The facility provided a policy titled Nail Care dated 3/2023, identified The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health.
The policy directed at point # 3: routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis.
The policy included at point #4: Routine nail care, to include trimming and filing, will be provided on a regular basis. Nail care will be provided between scheduled occasions as the need arises.

2. The MDS Assessment dated 2/22/23, revealed Resident #2 scored 14 out of 15 on a BIMS exam, which indicated cognition intact. The MDS indicated the resident independent and bathed with no set up or physical help from staff.

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During an interview on 4/11/23 at 12:07 PM, Resident #2 stated they only showered him once and they were supposed to give him bed baths because of his pressure ulcers but they never asked if he wanted one. He stated his last bath happened 2 or 3 months ago. Resident #2 stated he waited for the staff to ask him to shower and didn't. Resident sat in his wheelchair and the resident disheveled wearing camo pants and a shirt.

During an interview on 4/12/23 at 3:44 PM, Resident #2 stated he received one bed bath while he resided in the front hall and when they moved him to the back hall he stated didn't receive a bath.

The Care Plan dated 3/1/23 revealed a focus problem of an Activities of Daily Living (ADL) performance deficit related to impaired mobility, paraplegia. The interventions dated 9/22/23 indicated Resident #2 required extensive assistance by (1) staff with bathing/showering.

The Documentation Survey Report for March 2023 and April 2023 revealed the resident scheduled showers/baths on Tuesdays and Fridays between 6:00 AM and 2:00 PM and contained no documentation indicating the resident received a shower/bath.

Task Sheet for Bathing/Shower for the last 30 days documented 1 shower on 4/18/23.

During an interview on 4/20/23 at 9:27 AM, Staff HH, Certified Nurse Aide (CNA) queried how often Resident #2 showered and she stated she never provided his shower before and no one told her he took showers in rounds.

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During an interview on 4/20/23 at 09:52 AM, Staff II, CNA queried if refusals of showers are documented and she states yes and the resident signed the refusal on a Shower Sheet if able. Staff II asked how often Resident #2 showered and she stated she didn't work with him and personally not sure.

During an interview on 4/24/23 at 4:31 PM, Staff L, CNA queried how often Resident #2 received a shower and she stated she didn't know, she didn't usually work B Hall, she usually worked A Hall.

3. The MDS Assessment dated 2/22/23 revealed Resident #10 scored 9 out of 15 on a BIMS exam, which indicated moderate cognitive impairment. The MDS revealed the resident needed physical help in part of the bathing activity with a one person assist. The MDS revealed the needed extensive assistance with one person physical assist with personal hygiene.

During an observation on 4/12/23 at 10:20 AM, Resident #10 wore a white shirt with a stain on it and his hair not combed. Resident grabbed a comb out of his drawer and started to comb his hair.

The Care Plan 2/16/23 revealed a focus problem of ADL self performance deficit related to impaired balance, limited Range of Motion (ROM), stroke with right-sided deficits. The interventions dated 6/11/19 revealed to check the nail length and trim and clean on bath day and as necessary; provide sponge bath when a full bath or shower cannot be tolerated and resident will often refuse shower; resident required extensive

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assistance by staff with bathing/showering and as necessary; resident required extensive to limited assistance by staff with personal hygiene and he preferred facial hair and will often refuse grooming; and preferred long nails and would at times allow cleaning but would refuse trim.

The Documentation Survey Report for March 2023 and April 2023 revealed Resident #10 scheduled for showers on Monday and Thursday on the PM shift. The report lacked documentation to indicate any showers received during the 2 months.

The Task Record Report for ADL-Bathing/Shower for April 2023 lacked documentation after the date of 4/6/23 for Resident #10's shower completion.

During an observation on 4/17/23 at 12:15 AM, Resident #10 sat in his wheelchair with a blanket over him in the common area. Hair not combed.

During an interview on 4/18/23 11:20 AM, Resident #10 queried how often he preferred to shower and he stated once a week. Resident #10 asked if he ever refused to shower and he stated no, well yeah sometimes.

During an observation on 4/18/23 at 4:17 PM, Resident #10 sat in the common area in his wheelchair. Fingernails were long. The resident asked how often they clipped his nails and he made a sound and stated he didn't know.

During an interview on 4/20/23 at 9:52 AM, Staff II, CNA queried how often resident's showered and she stated they are short staffed and she got them done as soon as she could. She stated she

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came in on her days off and provided showers and bed baths to the residents. She stated the showers are not being completed regularly and the residents received a shower maybe once a week. Staff II queried how often Resident #10 offered a shower and she stated she believed his shower scheduled on the PM and he took his shower for her but refused with certain aides.

During an interview on 4/24/23 at 4:01 PM, the Director of Nursing (DON) queried how often residents are showered and she stated they have a shower schedule and the residents should be showered on the scheduled days. The DON queried what it meant if the shower date was left blank on the task sheet in the computer and she responded like it not charted, either they forgot to do their charting or the shower not given.

During an interview on 4/24/23 at 4:31 PM, Staff L, CNA queried how often residents are showered and she stated daily on their scheduled shower days at least a majority of the time they received their showers on their scheduled shower days. She stated except for days they are short staffed like that day. Staff L queried if the residents received showers that day and she stated no.

4. The MDS dated 1/31/23 for Resident #4 identified a BIMS score of 12 which indicated moderate cognitive impairment. The MDS revealed the resident dependent on staff for toileting and the resident needed substantial assistance rolling side to side while lying in bed. The MDS listed diagnosis of congestive heart failure (CHF), type two diabetes, chronic obstructive pulmonary disease (COPD), sleep apnea and morbid obesity.

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On 4/11/23 at 10:00 AM, the resident observed sitting in bed, with greasy hair, incontinence brief showing at the waist, and overall disheveled look. Resident #4's speech difficult to understand however able to answer yes and no questions by shaking head. When asked if a shower had been taken recently the resident shook her head no.

A 10/31/22 Care Plan entry directed only female staff to provide personal care and stated the resident required extensive assistance in the shower and to provide a sponge bath when a shower could not be tolerated.

Review of the Electronic Health Care Record showed the resident last received a shower on 3/22/23 and documented the activity did not occur on 3/29/23. Dates of 4/1/23 and 4/12/23 documented the activity was not applicable.

The electronic reports lacked documentation of further showers/bath assistance given during the time period.

5. The MDS dated 3/15/23 identified Resident #46 as cognitively intact with a BIMS score of 13 out of 15 and with the following diagnoses: Multiple Sclerosis, Coronary Artery Disease and Respiratory Failure. It also identified the resident required extensive staff assistance with all ADL's except for eating and totally dependent on staff for showers/baths.

In an interview on 4/12/23 at 10:50 AM, the resident's family member reported she would visit the resident once or twice a week. The family member reported they were supposed to

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reposition the resident every 2 hours. She reported she would be at the facility for 5 hours and not see anyone come in to reposition her.

Observations of the resident's room on 4/11/23 at 1:12 PM revealed the floor mat beside bed covered with liquid residue and remained on the floor mat at 2:21 PM.

Observations of the resident revealed the following on 4/12/23:
a. At 1:30 PM remained lying on her back in bed, both resident and her mother verified it had been 2.5 hours and no one had been in to reposition the resident.
b. At 2:45 PM remained lying on her back in bed, she and her mother both reported no staff member had been in to reposition the resident for the past 3.75 hours.

Continuous observations of the resident on 4/13/23 from 7:13 AM to 9:32 AM revealed the following:
a. At 7:13 AM asleep in bed with door to room open and the floor mat beside the bed had a sticky residue, debris of tissues and food particles on floor beside bed. .
b. At 7:20 AM no staff in hall
c. At 7:40 AM remained asleep in bed lying on back, bells used to call staff on tray table out of the resident's reach. The floor remained with food particles and tissues beside bed.
d. At 8:09 AM Staff C entered resident's room, and placed her breakfast tray on the tray table.
e. At 8:12 AM resident asleep again, tray remained on tray table, untouched.
f. At 8:29 AM, the ADON entered room and assisted the resident with breakfast.
g. At 8:45 AM, the ADON left the resident's room.

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The resident reported the ADON did not provide cares, that it had been several hours since anyone had washed her private parts.
h. At 8:49 AM, Staff F, entered room to administer medications. No cares provided
i. At 8:56 AM, Staff C walked by the resident's room and removed linens from linen closet and walked down the other way; no cares provided
j. At 9:13 AM, housekeeping staff entered the room to move belongings to another room.
k. At 9:25 AM, Staff C walked into the resident's room and refilled resident's water pitcher with ice water but provided no cares. At 9:29 AM, Staff C walked by the resident's room but provided no cares.
l. At 9:31 AM resident ringing her bells to call staff, no staff in the hallway. "North Dining Room Alarm" sounding overhead and bells could not be heard above alarm sounding. The resident did not have peri cares for 2 hours and 18 minutes.
m. At 9:32 AM Staff C entered room to provide peri cares. Staff C left the room without picking up food particles and tissues by the bed.

Observations of the resident on 4/17/23 revealed the following:
a. The resident now resided in room on A hall. At 8:20 AM, the resident's floor appeared very sticky and the floormat next to bed covered with food particles. Clothing and blankets observed lying on the floor at the foot of the bed. The resident laid in bed with the call light wrapped around frame of her bed behind her head, and the resident stated "I've been calling out for over an hour now, I can't find my call light, I need my brief changed". Surveyor turned on the call light for the resident. Staff BB, Registered Nurse (RN) stood out in the hallway by a medication cart, did not check on resident.

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b. At 8:25 AM the call light remained on, audible, Staff BB in the hall and walked into another resident's room. Staff L, CNA walked into another resident's room at the end of the hall.
c. At 8:27 AM, Staff BB walked by this resident's room as her call light remained lit and did not check on her.
d. At 8:28 AM, Staff L walked into the resident's room and turned off the call light and left the room and brought two bags of linens down the hall.
e. At 8:30 AM, the surveyor asked the resident if Staff L addressed her needs, she reported "I asked her to change my brief and she left my room without doing it".
f. At 8:37 AM, the resident's cell phone rang, resident called out "can someone help me get my phone" No staff provided assistance.
g. At 8:54 AM, Staff BB entered the room to check on resident, did not provide peri cares. The resident had been waiting 24 minutes to have someone provide peri care.
h. At 10:00 AM, the resident's call light remained on. She reported no one ever came to change her incontinent brief. Then Staff BB entered the room to ask what she needed, she said "I need my brief changed". Staff BB responded "let me get someone to help you" and left the room. The resident reported the day before she turned on her call light from 8:30 AM to get her brief changed and no one changed her brief until 2:30 AM that night. "I'll turn on my call light, they keep coming in to turn it off and don't help me and I have to keep turning my call light on again"
i. At 10:08 AM Staff L entered the room to provide cares as requested 1 hour and 48 minutes later.

On 10/29/22, the Care Plan identified the resident with the problem of bowel and bladder

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incontinence and directed staff to clean peri-area with each incontinence episode.

The facility policy titled: Incontinence dated as last reviewed March 2023 had documentation of the following:
1. The facility must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, services, and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

6. The MDS, dated 1/14/23, listed diagnoses for Resident #56 which included heart failure, diabetes, and morbid obesity. The MDS documented the resident did not receive a bath during the review period and listed the resident's BIMS score as 14 out of 15, indicating intact cognition.

During an interview on 4/12/23 at 9:44 a.m., the Resident #56 stated she missed baths but that was because she took them independently and forgot to go in and complete them. The resident's hair appeared greasy and unkempt.

A 7/2/22 Care Plan entry directed staff to provide a sponge bath when a full bath or shower could not be tolerated.

Care Plan entries, dated 11/3/22, stated the resident required assistance with ADL's due to impaired mobility and right hemiplegia (one-sided weakness).

The March 2023 Documentation Survey Report documented the resident received a shower on

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3/2/23 and 3/30/23 and documented the resident refused on 3/13/23 and the activity did not occur on 4/23/23.

The April 2023 Documentation Survey Report documented the resident received a shower on 4/6/23 and 4/13/23. The 4/10/23 entry stated the resident was not available.

The reports lacked documentation of further showers/bath assistance given during the time prior of 3/1/23-4/17/23.

During an observation on 4/11/23 at 9:44 a.m., Resident #56's room had a crumpled bed pad and hospital gown in the middle of the floor. There were pieces of paper and refuse on the floor near the resident's bed.

On 4/12/23 at 10:50 AM, a night gown, incontinent pad and wash cloth sat on the floor in Resident # 56's room.

7. The MDS, dated 3/15/23, listed diagnoses for Resident #61 which included malnutrition, morbid obesity, and weakness. The MDS documented the resident required extensive assistance of 2 staff for personal hygiene and bathing and listed the resident's cognition as moderately impaired.

During an observation on 4/13/23 at 8:07 a.m., Resident #61 laid in bed. All of his nails were very long, extending past the fingers approximately 3 millimeters(mm). The resident was unshaven, had a long beard and his hair was unkempt.

Observations on 4/17/23 at 12:29 p.m. and

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4/18/23 at 7:38 a.m. revealed the resident's nails were the same length, he was unshaven, and his hair was unkempt.

Care Plan entries, dated 4/6/23, stated the resident had a self-care performance deficit related to impaired mobility and stated the resident required extensive assistance of 1 staff for personal hygiene.

8. The 3/9/23 MDS listed diagnoses for Resident #63 which included diabetes, burns, and unspecified fall. The MDS identified the resident required extensive assistance of 1 staff for personal hygiene and completely depended on 1 staff for bathing. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition. The MDS documented the resident admitted to the facility on 3/3/23.

In an interview on 4/17/23 at 1:15 p.m., Resident #63 stated she only received 2 showers since admission to the facility.

The March 2023 Documentation Survey Report stated the resident had partial baths on 3/4, 3/6, 3/8, 3/11/23, and 3/14, and had a shower on 3/21/23.

The April 2023 Documentation Survey Report for stated the resident had a partial bath on 4/1/23 and 4/11/23.

The record lacked documentation of further showers during the period of 3/3/23-4/17/23.

A Care Plan entry, dated 3/13/23, stated the resident had a self-care performance deficit

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related to impaired mobility and stated the resident required total assistance of 1 staff for bathing and showering.

9. The MDS assessment tool, dated 1/3/23, listed diagnoses for Resident #70 which included heart failure, paraplegia, and anxiety disorder. The MDS stated the resident required supervision assistance of 2 staff for personal hygiene, limited assistance of 2 staff for transfers, extensive assistance of 1 staff for dressing, extensive assistance of 2 staff for toilet use, and depended completely on 2 staff for bathing. The MDS listed the resident's BIMS score as 14 out of 15, indicating intact cognition.

The 4/7/23 entry MDS stated the resident admitted from an acute hospital on 4/7/23.

In an interview on 4/12/23 at 10:11 a.m., Resident #70 stated she returned from the hospital "Friday night"(4/7/23) and stated she had not received a shower since. She stated she felt like she "stinks".

The April 2023 Documentation Survey Report lacked documentation the resident received a shower or bath from 4/7/23-4/12/23.

A Care Plan entry, dated 4/20/22, stated the resident required extensive assistance of 1 staff for bathing/showering.

10. On 4/11/23 at 10:58 AM, Resident #15 reported housekeeping cleaned daily but did not know if housekeeping cleaned the bathroom.

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On 4/11/23 at 10:58 AM, the bathroom floor in Resident #15's room held a dried 4 by 4 inch brown substance and smears of brown on the toilet riser. The resident's son stated the bathroom floor appeared disgusting.

11. The MDS dated 4/5/23 identified Resident #9 as severely cognitively impaired with a BIMS score of 2 out of 15 and had the following diagnoses: Renal Insufficiency, Non-Alzheimer's Dementia and Bipolar Disorder. It also identified the resident required extensive staff assistance with bed mobility, transfers, dressing, toileting and hygiene.

Observations of the resident revealed the following:
a. On 4/13/23 at 8:43 AM the resident ambulated independently in the hall wearing only pajamas and no footwear. The Assistant Director of Nursing (ADON) redirected her away from the exit door at end of hall. Multiple areas of brown residue noted on the carpeting. The resident began to walk the other way. Neither the ADON nor Staff F, Certified Medication Aide (CMA) in hallway placed any gripper socks or shoes on the resident's feet
b. On 4/13/23 at 8:48 AM the resident remained ambulating independently in hall without any socks or shoes on her feet. Staff F stood in the hallway and did not encourage her or assist her with putting socks or shoes on her feet.
c. On /13/23 at 9:06 AM female therapy staff member assisted the resident to change into clean clothing and gripper socks and walked her down to therapy room.

In an interview on 4/24/23 at 1:46 PM, the Social

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Worker reported the resident did have a history of wandering the halls independently and the staff should make sure she has her feet covered with gripper socks or shoes when walking in the hallways as the carpeting is not the cleanest.

In an interview on 5/1/23 at 10:07, Staff QQ, CNA, reported Resident #9 had a history of walking in the halls
independently and did so frequently. She also reported if staff saw her walking around in her bare feet, they should take her back to her room and put socks and shoes on her. When asked what she thought the brown spots were on the carpeting, she reported it could be feces as she had actually witnessed Resident #9 removing a bowel movement (BM) from her pants and throw it on the carpeting.

In an interview on 5/1/23 at 10:19 AM, Staff E, Licensed Practical Nurse (LPN) reported Resident #9 had a history of walking in the halls independently and did so frequently. She also reported if staff saw her walking around in her bare feet, they should take her back to her room as she is easily re-directed and put socks and shoes on her.

In an interview on 5/1/23 at 11:03 AM, the DON reported Resident #9 did have a history of walking in the halls independently several times a day. If staff saw her walking around in her bare feet, she would expect the staff to take her to her room and put on socks, shoes or slippers on her feet. When asked what she thought the brown spots may be on the carpeting, she thought it might be food that the resident spit out and not BM.

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12. Observation on 4/11/23 at 11:07 AM revealed white powder on the floor in Resident #24 room.

During random observations of the facility, noted areas with strong odors smelling of urine, body odor and garbage:
a. On 4/11/23 at 11:03 AM revealed Resident #24's room smelled of urine and body odor.
b. On 4/12/23 at 12:31 PM, Hall B smelled of urine near Resident #24's room.
c. On 4/13/23 at 12:53 PM, Hall B smelled of urine near Resident #24's room.
d. On 4/17/23 at 1:21 PM, smelled urine when entering Resident #24's room.
e. On 4/18/23 at 12:59 PM, walked by Resident #24's room and smelled a strong odor of urine. Observation further revealed a sticky floor in Resident #24's room and shoes stuck to the floor when ambulating throughout the room.

During an interview on 4/20/23 at 9:12 AM, Staff CC, Licensed Practical Nurse (LPN) queried if she noticed odors when she started her shift and she stated yes, at the front of the building from garbage bags lined up to be taken out. Staff CC asked if she noticed odors in B Hall and she stated she didn't know, she usually wore a face mask.

During an interview on 4/20/23 at 9:52 AM, Staff II, Certified Nursing Assistant (CNA) queried if she noticed odors when she started her shift and she stated yeah, typically it stunk of urine especially in the back. Staff II asked if she noticed an odor in B Hall and she stated the back usually smelled of urine especially when one CNA worked because of the trash and incontinent briefs. Staff II queried if she ever smelled an odor

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in Resident #24's room and she stated urine, definitely. Staff II asked what she thought caused it and she stated his roommate took himself to the bathroom and didn't have good aim and the urinals in the room didn't get dumped very often or might get spilled.

During an interview on 4/24/23 at 1:17 PM, Staff GG, Housekeeping queried if she noticed an odor in the facility and she stated an urine smell, just in B Hall.

During an interview on 4/25/23 at 1:03 PM, the Administrator queried if she noticed odors in the resident's rooms or hallways and she stated she noticed B hallway that had an urine odor and looked into ways to eliminate the problem.

13. On 4/12/23 at 10:08 AM, Staff A, Housekeeping Supervisor, stated supplies of linens decreased recently. Soiled linens were not brought into the laundry room. Due to the delay before washing, the linens stained and were thrown away and not replaced. The supply shelf in the laundry room held 4 fitted sheets and 9 flat sheets. There were 0 linen incontinence pads and 0 bedspreads. The supply closet on Unit B had 0 linen incontinence pads. Staff A stated the facility lacked linens, especially linen incontinence pads. Staff A stated there was not enough linens for the facility and CNA's were waiting on linens that were in the laundry.

During an observation on 4/18/23 at 10:21 AM, Resident #41 laid on his bed with no linens on it. During an observation on 4/18/23 at 10:22 AM, no linens present on Resident #3's bed.
During an observation on 4/18/23 at 11:33 AM,

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Resident #41 laid on his bed without a pillow case or linens covering the mattress.
During an observation on 4/18/23 at 12:47 PM, no linens on Resident #3's and Resident #41's beds.
During an observation on 4/18/23 at 2:58 PM, no linens on the Resident #3's and Resident #41's beds. Both residents laid on their beds.

During an interview on 4/18/23 at 2:59 PM, Resident #3 queried why he didn't have linens on his bed and he stated because no sheets were available. He stated they threw them away when they got soiled. He stated the facility ordered new ones, but they hadn't come in yet. Resident #3 asked when they removed the linens from his bed and he stated yesterday afternoon.

During an observation on 4/18/23 at 4:16 PM, no noted linens on Resident #3's and Resident #41 s beds.

During an interview on 4/19/23 at 10:30 AM, Staff A, Housekeeping Supervisor queried on the process of linen changes and she stated the Certified Nurse Aide (CNA) took them off and changed them. She stated Housekeeping wiped down the mattress and let it dry or sometimes the CNA came and got the spray and did it. The CNA or Housekeeping made them when the linens available. She stated no supplies available to hurry up and get beds made and they waited for Laundry to wash them. Staff A asked if linens not on residents beds happened frequently and she stated no, the CNAs stripped the beds, Laundry washed the linens and put them in a closet, and Laundry informed the CNAs the linens available to make beds. Staff A stated it could take 2 to 3 hours for beds to be made.

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F 600	Continued From page 51 During an interview on 4/20/23 at 9:27 AM, Staff HH, CNA queried if she ever saw beds without linens on them and she stated sometimes when she came on shift. Staff HH queried if the facility short on linens and she stated yes, she found out last night because no sheets were found in the closet in the back hallway. During an interview on 4/20/23 at 9:52 AM, Staff II, CNA queried if the facility short on linens and she stated yes, they are really short on linens. Staff II asked how long it took between removing linens on the bed and replacing them and she stated it depended on availability of sheets and at times it took a couple of hours. Staff II, queried if enough sheets were available with routine laundering/incontinent issues and she stated no, not all the time. During an interview on 4/24/23 at 1:21 PM, Staff B, Laundry Aide queried how often they changed the linens and she stated they were supposed to be changed daily but if they were not dirty they didn't get changed. . She stated they had no linens and didn't have a lot of fitted sheets. She stated a lot of beds in the halls didn't have linens on them. During an interview on 4/25/23 at 1:03 PM, the Administrator queried on the expectations of linens being changed on the resident's beds after the removal of soiled linens and she stated she didn't have a time frame but they should definitely know the resident's routine and it should be done quickly.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		

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§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.

§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 record review, staff interviews and policy review, the facility failed to report an allegation of abuse for 3 of 10 residents reviewed for abuse (Residents #12, #21,and # 70). The facility reported a census of 69 residents.

Findings Include:

1. The Minimum Data Set(MDS) Assessment

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Tool, dated 1/3/23, listed diagnoses for Resident #70 which included heart failure, paraplegia (paralysis from the waist down), and anxiety disorder. The MDS documented the resident required supervision assistance of 2 staff for personal hygiene, limited assistance of 2 staff for transfers, extensive assistance of 1 staff for dressing, extensive assistance of 2 staff for toilet use, and depended completely on 2 staff for bathing. The MDS listed the resident's Brief Interview for Mental Status Score (BIMS) of 14 out of 15, indicating intact cognition.

A 5/30/22 Behavior Note for Resident #70 stated Resident #70 rammed her wheelchair into Resident #21 and then Resident #21 stood up to hit Resident #70.

A 5/31/22 Physician Note for Resident #70 documented the resident admitted to punching a 92 year old (Resident #21) resident and no injuries were sustained.

A 6/2/22 Physician Note for Resident #21 stated the resident denied being punched.

A 8/27/22 General Note documented Resident #70 and her roommate (Resident #12) threw water at each other and the resident changed rooms.

A 7/19/22 Care Plan entry stated the resident could be verbally aggressive related to ineffective coping skills and poor impulse control. An 11/25/22 revision of the entry stated on 11/10 the resident was physically aggressive and required 1:1 monitoring.

The Care Plan lacked documentation of alleged

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physical altercations prior to 11/25/22.

In an interview on 4/25/23 at 8:35 a.m., Staff JJ, Licensed Practical Nurse (LPN) stated Resident #70 had physical altercations with other residents. She stated once Resident #70 smoked outside and she threw a lit cigarette on another resident. She stated she did not see this but heard about it.

In an interview on 4/25/23 at 1:00 p.m., the Director of Nursing (DON) stated she heard about the allegation that the resident threw a lit cigarette. She stated staff should report physical altercations between residents and the facility would separate the residents and interview residents and staff. She stated the Care Plan should address the resident's behaviors.

In an interview on 4/27/23 at 10:50 a.m., the Administrator stated staff should report allegations of abuse within 2 hours. She stated the facility would investigate the allegation and would separate the residents.

The facility lacked documentation of an investigation related to the above altercations and lacked documentation they reported the allegations to the State Agency or separated the resident from other residents.

The facility policy "Abuse, Neglect, and Exploitation", dated March 2023, stated the facility would provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibited and prevented abuse, neglect, exploitation, and misappropriation of resident property. The policy stated the facility would complete an immediate investigation and ensure

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F 609	Continued From page 55 all residents were protected upon a suspicion of abuse.	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 staff interviews and facility policy review, the facility failed to document a complete investigation of allegations of abuse for 3 of 10 residents reviewed (Residents #12, #21 and #70). The facility reported a census of 69 residents. Findings Include: 1. The Minimum Data Set (MDS) Assessment Tool, dated 1/3/23, listed diagnoses for Resident	F 610		

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F 610	Continued From page 56	F 610		

#70 which included heart failure, paraplegia (paralysis from the waist down), and anxiety disorder. The MDS documented the resident required supervision assistance of 2 staff for personal hygiene, limited assistance of 2 staff for transfers, extensive assistance of 1 staff for dressing, extensive assistance of 2 staff for toilet use, and depended completely on 2 staff for bathing. The MDS listed the resident's Brief Interview for Mental Status Score (BIMS) of 14 out of 15, indicating intact cognition.

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A 8/27/22 General Note documented Resident #70 and her roommate (Resident #12) threw water at each other and the resident changed rooms.

A 7/19/22 Care Plan entry stated the resident could be verbally aggressive related to ineffective coping skills and poor impulse control. An 11/25/22 revision of the entry stated on 11/10 the resident was physically aggressive and required 1:1 monitoring.

The Care Plan lacked documentation of alleged physical altercations prior to 11/25/22.

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F 610	Continued From page 57	F 610		

In an interview on 4/25/23 at 8:35 a.m., Staff JJ Licensed Practical Nurse (LPN) stated Resident #70 had physical altercations with other residents. She stated once Resident #70 smoked outside and she threw a lit cigarette on another resident. She stated she did not see this but heard about it.

In an interview on 4/25/23 at 1:00 p.m., the Director of Nursing (DON) stated she heard about the allegation that the resident threw a lit cigarette. She stated staff should report physical altercations between residents and the facility would separate the residents and interview residents and staff. She stated the Care Plan should address the resident's behaviors.

In an interview on 4/27/23 at 10:50 a.m., the Administrator stated staff should report allegations of abuse within 2 hours. She stated the facility would investigate the allegation and would separate the residents.

The facility lacked documentation of an investigation related to the above altercations and lacked documentation they reported the allegations to the State Agency or separated the resident from other residents.

The facility policy "Abuse, Neglect, and Exploitation", dated March 2023, stated the facility would provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibited and prevented abuse, neglect, exploitation, and misappropriation of resident property. The policy stated the facility would complete an immediate investigation and ensure

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F 610	Continued From page 58 all residents were protected upon a suspicion of abuse. A review of the facility policy titled: Abuse, Neglect and Exploitation dated as last reviewed March 2023, had documentation of the following: Investigation of Alleged Abuse, Neglect and Exploitation: a. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. b. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to:	F 610		

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a. Responding immediately to protect the alleged victim and integrity of the investigation;
b. Removal of the alleged perpetrator until the conclusion of the investigation;
c. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed;
d. Increased supervision of the alleged victim and residents;
e. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator;
f. Protection from retaliation;
g. Providing emotional support and counseling to the resident during and after the investigation, as needed;

Reporting/Response
a. The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:
b. 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
c. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.
d. Assuring that reporters are free from retaliation or reprisal;
e. Reporting to the state nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service;
f. Taking all necessary actions as a result if the investigation, which may include, but are not

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F 610	Continued From page 60 limited to, the following: aa. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; bb. Defining how care provision will be changed and/or improved to protect residents receiving services; cc. Training of staff on changes made and demonstration of staff competency after training is implemented; dd. Identification of staff responsible for implementation of corrective actions; ee. The expected date for implementation; and ff. Identification of staff responsible for monitoring the implementation of the plan. g. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.	F 610		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interview and facility policy review, the facility failed to provide accurate documentation on the Minimum Data Set (MDS) for 1 of 3 residents for falls (Resident #22); for 2 of 2 residents reviewed for Preadmission Screening and Resident Review (PASARR) Level II (Residents #16 and #41); and	F 641		

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for 1 of 8 for functional abilities for accuracy of the MDS (Resident #2). The facility reported a census of 69.

Findings Include:

1. The Minimum Data Set (MDS) assessment dated 2/22/23 revealed Resident #2 scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS indicated the following documentation for Functional Abilities:
a. Walked in room- how resident walked between locations in room- activity occurred only once or twice
b. Walked in corridor- how resident walked in corridor on unit- activity occurred only once or twice
c. Bathing- self performance- resident independent and no set up or physical help from staff
d. Balance during transitions and walking- moving from seated to standing position- resident steady at all times.
e. Balance during transitions and walking- walking (with assuasive device if used)- resident steady at all times
f. Balance during transitions and walking- turning around and facing the opposite direction while walking- steady at all times.
e. Mobility- walked 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space- resident independent
f. Mobility- walked 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns- resident independent
g. Mobility- walked 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space- resident independent

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h. Mobility- walked 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel- resident independent

The Care Plan dated 3/1/23 revealed a focus problem of an Activities of Daily Living (ADL's) performance deficit related to impaired mobility, paraplegia. The interventions dated 9/22/23 indicated Resident #2 required extensive assistance by (1) staff with bathing/showering.

The Electronic Medical Record revealed the following Medical Diagnosis of paraplegia.

During an observation on 4/11/23 at 12:07 PM, Resident #2 sat with his legs crossed in his wheelchair playing a video game. The resident disheveled wearing camo pants and a shirt.

During an interview on 4/20/23 at 10:29 AM, Staff MM, MDS Coordinator queried if she trained on how to do the MDS and she stated she yes, she completed MDS for many, many years and trained at different times. Staff MM asked how she obtained the information for the MDS and she stated information pulled over from the electronic medical record and what the staff charts. Informed Staff MM of discrepancies found for Resident #2, #22, and #41 and she stated remote staff helped with the MDS. She reviewed the MDS for the three residents and stated Resident #22 she completed and made the error.

During an interview on 4/24/23 at 4:01 PM, the Director of Nursing (DON) queried on the expectations of the MDS accuracy and she responded it should be updated as changes happen.

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2. The MDS Assessment dated 2/15/23 revealed Resident #22 scored 5 out of 15 on a BIMS exam, which indicated severe cognitive impairment. The MDS revealed medical diagnosis of chronic obstructive pulmonary disorder (COPD) and heart failure. The MDS revealed the resident took antianxiety, antidepressant, opioid medications 7 out of 7 days. The MDS documented no falls since admission/entry or reentry or prior admission and failed to address the number of falls since admission/entry or reentry or prior admission.

The Care Plan dated 2/20/23 revealed a focus problem of risk of falls related to decreased mobility for Resident #22. The interventions dated 12/15/21 included the call light within reach and encouraged the resident to use for assistance as needed and resident needed activities that minimized the potential for falls while providing diversion.

During observation on 4/11/23 at 10:46 AM, Resident #22 laid in bed with no shirt on, wearing an arm sling on his left arm. Fall mat next to the bed, with the bed in the lowest position and bed rail up on the right side of the bed.

During an interview on 4/24/23 at 4:01 PM, the DON queried on the expectations of the MDS accuracy and she responded it should be updated as changes happen.

The Care Plan dated 4/25/23 revealed a focus problem of an actual fall with no injury related to unsteady gait on the following dates 6/10/22; 6/14/22; 7/7/22; 10/4/22; 2/26/23; 2/28/23; 3/9/23;

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3/15/23; 4/10/23; and 4/21/23.

3. The MDS Assessment dated 3/1/23 revealed Resident #41 scored 10 out of 15 on a BIMS exam, which indicated moderate impairment cognition. The MDS revealed the medical diagnosis of schizophrenia and anxiety. The MDS indicated the resident received antipsychotic medications 7 out of 7 days and antipsychotic medications received on routine basis.

The PASARR Level II completed on 9/2/20 and revealed the resident had a diagnosis of Schizophrenia. The PASARR Level II identified the following:
a. Specialized Services: Ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders and evaluate ongoing need for additional behavioral health services.
b. Rehabilitative Services: Obtain archived psychiatric records to clarify history and to provide to treating physicians
c. Rehabilitative Services: A guardian/conservator or POA (Power of Attorney) for healthcare to assist with decision-making, health and safety

The Care Plan dated 3/3/23 revealed a focus problem of a PASARR Level II for person with a Mental Health Disorder or Intellectual Disability. The Care Plan dated 3/3/23 failed to document the PASARR Level II Specialized and Rehabilitative Services.

During an observation on 4/11/23 at 10:36 AM, Resident #41 sat on his bed wore a flannel shirt, cap, and pajamas bottoms with a walker by the

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bed.

During an interview on 4/20/23 at 10:46 AM, Staff Y, Social Services queried on the expectations of PASARR level II being addressed on the MDS and she responded she don't think she did that part of the MDS. She stated she addressed Section C, D, E, and part of Section Q. She stated she didn't do Section A.

During an interview on 4/24/23 at 4:01 PM, the DON queried on the expectations of a a PASARR Level II being addressed on the MDS and she responded she honestly didn't know and would find out.

During an interview on 4/26/23 at 2:34 PM, Staff MM, MDS Coordinator verified Social Services completed the PASARR on the MDS and she stated she also completed it when needed.

4. The MDS Assessment Tool, dated 10/26/22, documented Resident #16 did not require a Level II PASARR.

The Notice of PASARR Level II Outcome, dated 10/8/22, documented the resident required a Level II assessment and included the following specialized services:
a. ongoing psychiatric medication management by a psychiatrist or psychiatric Advanced Registered Nurse Practitioner (ARNP).
b. individual therapy by a licensed behavioral health professional.
c. a designated Power of Attorney (POA) for healthcare and financial matters

The Care Plan lacked documentation of the

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F 641	Continued From page 66 implementation of the above interventions. The facility policy "MDS 3.0 Completion" reviewed March of 2023, stated the facility conducted accurate and standardized assessments.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility policy review, the facility failed to address the Preadmission Screening and Resident Review (PASARR)) Level II on the Care Plan for 2 of 2 residents reviewed for PASARR Level II (Resident #16, Resident #41). The facility reported a of 69. Findings Include:	F 644		

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1. The Annual Minimum Data Set (MDS) Assessment Tool, dated 7/20/22 documented Resident #41 did not require a Level II PASARR.

The MDS Assessment dated 3/1/23 revealed Resident #41 scored 10 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated moderate impairment cognition. The MDS revealed the medical diagnosis of schizophrenia and anxiety. The MDS indicated the resident received antipsychotic medications 7 out of 7 days and antipsychotic medications received on routine basis.

The PASARR Level II completed on 9/2/20 and revealed the resident had a diagnosis of schizophrenia. The PASARR Level II identified the following:
a. Specialized Services: Ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders and evaluate ongoing need for additional behavioral health services.
b. Rehabilitative Services: Obtain archived psychiatric records to clarify history and to provide to treating physicians
c. Rehabilitative Services: A guardian/conservator or POA for healthcare to assist with decision-making, health and safety

The Physician Medication Orders are the following:
a. Benztropine mesylate tablet- ordered 9/17/20- Give 1 tablet by mouth two times a day
b. Olanzapine 20 mg tablet- ordered 5/28/22- Give 1 tablet at bedtime with 10 mg tablet to equal 30 mg

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The Electronic Medical Record revealed the following Medical Diagnosis:
a. Schizophrenia, unspecified
b. Anxiety disorder, unspecified

The Care Plan dated 3/3/23 revealed a focus problem of a PASARR Level II for person with a Mental Health Disorder or Intellectual Disability. The interventions dated 1/7/21 included resident used psychotropic medications related to schizophrenia and anxiety. The Care Plan dated 3/3/23 failed to document the PASARR Level II Specialized and Rehabilitative Services.

During an interview on 4/20/23 at 10:46 AM, Staff Y, Social Services queried on the expectations of PASARR level II being addressed on the care plan and she responded they needed to be care planned with their medical diagnosis. Staff Y asked if the resident's specialized services should be addressed and she responded they should be on the care plan. Staff Y informed Resident #41 PASARR Level II specified resident needed a guardian and he didn't have one documented and she responded the State was really behind on finding them and it needed to be done. She stated he had a payee through the corporation. She reviewed Resident #41 chart and stated she didn't see anything for his PASARR and needed corrected.

During an interview on 4/24/23 at 4:01 PM, the Director of Nursing (DON) queried on the expectations of a a PASARR Level II being addressed on the Care Plan and she responded the MDS Coordinator entered the initial Care Plan.

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F 644	Continued From page 69 The Facility Policy titled Resident Assessment - Coordination with PASARR Program dated March 2023 revealed the following: a. Recommendations, such as any specialized services, from a PASARR level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care. 2. The Minimum Data Set(MDS) assessment tool, dated 10/26/22, documented Resident #16 did not require a Level II PASARR. The Notice of PASARR Level II Outcome, dated 10/8/22, documented the resident required a Level 2 assessment and included the following specialized services: a. Ongoing psychiatric medication management by a psychiatrist or psychiatric Advanced Registered Nurse Practitioner (ARNP). b. Individual therapy by a licensed behavioral health professional. c. A designated Power of Attorney (POA) for healthcare and financial matters. The Care Plan lacked documentation of the implementation of the above interventions.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		

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objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.

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This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, staff interviews and policy review, the facility failed to address continuous oxygen for one resident (Residents #48) and identify a resident as at risk for elopement (Resident #71) for a total of 2 of 26 residents reviewed for Comprehensive Care Plans. The facility reported a census of 69 residents.

Findings Include:

1. The MDS dated 3/13/23 identified Resident #48 as cognitively intact with a BIMS score of 15 out of 15 and with the following diagnoses: Cancer, Atrial Fibrillation (an abnormal heart rhythm) and chronic obstructive pulmonary disease (COPD). The MDS also identified the resident required extensive staff assistance with all activities of daily living except with eating (she had been independent) and with walking where she had been totally dependent on staff for assistance. The MDS failed to identify the resident required continuous oxygen.

Observations of the resident revealed the following:
a. On 4/11/23 at 11:02 AM asleep in bed with continuous oxygen maintained at 2.5 liters per nasal cannula per concentrator. Respirations even and unlabored.
b. On 4/12/23 at 9:36 AM sitting up in bed with continuous maintained at oxygen maintained at 2.5 liters per nasal cannula per concentrator. Respirations even and unlabored.
c. On 4/13/23 at 7:18 AM asleep in bed with oxygen maintained at 2.5 liters per nasal cannula per concentrator. Respirations even and

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unlabored.

A review of the Care Plan identified the resident with the problem of Emphysema/COPD on 3/14/23, however the interventions did not address the use of continuous oxygen.

A review of the undated policy titled: Comprehensive Care Plans revealed the following documentation:
a. The Care Planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the Comprehensive Care Plan, shall be culturally-competent and trauma-informed.
b. The Comprehensive Care Plan will be developed within 7 days after the completion of the comprehensive MDS
assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record.
c. The comprehensive care plan will describe, at a minimum, the following:
The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and
psychosocial well-being.
d. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her

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right to refuse treatment.

2. The MDS Assessment Tool, dated 8/29/22, listed diagnoses for Resident #71 which included non-Alzheimer's dementia, unspecified dementia with behavioral disturbance, and anxiety disorder. The MDS documented the resident was independent with transfers, and required supervision for walking and eating, extensive assistance of 1 staff for dressing, extensive assistance of 2 staff for toilet use and personal hygiene, and depended completely on 2 staff for bathing. The MDS listed the resident's BIMS score as 1 out of 15, indicating severely impaired cognition and stated he had wandering behaviors 4-6 days out of the 7 day review period and stated his behaviors placed the resident at significant risk of getting to a potentially dangerous place.

An 8/23/22 Elopement Risk Evaluation stated the resident displayed exit seeking behaviors and was a high risk to elope.

A 9/6/22 Social Service Note stated facility staff called the resident's sister to discuss possibly having to find a different placement for the resident due to exit seeking behaviors.

A 9/12/22 Physician Note stated the nursing staff reported on 8/23/22 that the resident stated he wanted to leave and be with his brother and that the resident tried to go out the doors twice "last night". The note stated staff discussed the possible risk for elopement and they would keep an eye on him.

A 9/19/22 1:45 p.m., General Note stated the

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resident sat quietly eating lunch and denied pain or the need for analgesia (pain medication) at this time.

A 9/19/22 4:44 p.m., General Note stated the resident got out of the facility and the police were contacted. The note stated the resident was found shortly after by a Certified Nursing Assistant (CNA) outside of the facility.

A 9/21/22 Physician Note stated the resident had an elopement on 9/19/22 and was found a few blocks away from the facility.

Care Plan entries, dated 9/19/22, stated the resident was an elopement risk and wanderer related to disorientation to place. The resident had a history of attempts to leave the facility unattended and had impaired safety awareness and wandered aimlessly. Further 9/19/22 entries stated the resident's safety would be maintained through the review date and directed staff to:
a. Distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books.
b. Monitor for fatigue and weight loss.
c. Provide structured activities such as toileting, walking inside and outside, and reorientation strategies including signs, pictures and memory boxes.
d. Identify a pattern of wandering.

The Care Plan lacked documentation of the resident's risk/history of eloping or interventions directed at the prevention of elopement prior to the 9/19/22 incident.

The National Weather Service Climatological Data retrieved from

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https://www.weather.gov/wrh/Climate?wfo=dvn on 4/19/23 listed the high and low temperatures on 9/19/22 as 83 degrees Fahrenheit and 63 degrees Fahrenheit.

During a phone interview on 4/18/23 at 4:11 p.m., Staff I, CNA stated she remembered the resident leaving the facility. She stated while staff were in a meeting, the resident got out and they looked for him. She stated she found him on Garfield and Davenport streets. She stated the resident was walking on the sidewalk and it was about an hour from the time they realized he was missing to the time they located him. She stated they found him about a 5 minute walk away.

During a phone interview on 4/18/23 at 4:33 p.m., Staff J, former Director of Nursing (DON) stated when the resident eloped the door alarm was not engaged. She stated staff observed the door opened and immediately did a count and noticed the resident was not there. She stated the B Hall door was broken and had been intermittently problematic when she worked there. She stated because of Resident #71's past history, when the door was open, they immediately thought of him. She stated the resident had exit seeking behaviors and was constantly walking. She stated he eloped from the Group Home he was at previously. Staff J stated it was 30 minutes by the time they found him. She stated some interventions they utilized to address his wandering were redirection and maintaining a visual on the resident. She stated the resident was in the "Elopement Book" which had his picture and basic information. She stated the Elopement Book was a tool used if someone eloped but would not prevent an elopement. Staff J explained the doors were supposed to be

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locked and stated they requested a wanderguard (a device which alerted when residents were near exits)for Resident #71 multiple times because the resident should "absolutely" have one.

During an observation on 4/19/23 at 9:49 a.m., the Administrator demonstrated the door alarm mechanisms on the left hall door, right hall door, front dining room door, back dining room door, B Hall door, and A Hall door. The Administrator pushed on the door for 15 seconds and the door alarmed and the light turned red. In order to rearm the doors, the Administrator utilized a key. A Receptionist sat next to the front door so the door was unarmed. She stated the door was armed when the receptionist was not present and required a code to be silenced.

During an interview on 4/19/23 at 7:45 a.m., Staff F, Certified Medication Aide (CMA) stated prior to the resident's elopement he kept getting out and they brought him back in. She reported on the day of the elopement, she did not hear the alarm.

During an interview on 4/19/23 at 8:22 a.m., the Assistant Director of Nursing (ADON) stated if one pushed on the B Hall door, the light would turn red and the alarm would be disabled. She stated staff did not rearm the door after the resident touched the door. She stated prior to the elopement, the resident touched the door and they removed him and disabled the door but did not re-arm the door. She reported if the door was green, that indicated the door alarm was armed. The ADON reported it was her practice to look at the doors and after the elopement, the facility completed education related to the door locks.

During an interview 4/19/23 at 10:05 a.m., the

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Administrator stated prior to the elopement, the resident was agitated and staff had disarmed the door but not rearmed it. She stated it was staff error.

During an observation on 4/20/23 at 7:20 a.m., when the facility front door was pushed, it was locked and would not open.

During an interview on 4/20/23 at 9:13 a.m., Staff N, CNA stated she did not know how the resident got out of the facility but she heard a Code Silver. She stated staff were trying to figure out who eloped but she knew it was him because of his history of wandering.

During a phone interview on 4/20/23 at 9:44 a.m., Staff O, former Administrator stated the biggest concern he had with the resident was that he would pace. He stated the day before the elopement, the facility shut off the door annunciator due to complaints but stated the doors also had local alarms staff could still hear. He stated the resident left the facility and they completed a search and found the resident within the hour near a park sitting on some bleachers. He reported if the door opened, the light at the top would turn red to indicate the door was not engaged. He stated a key was needed in order to re-arm the door and stated more than likely, the door opened prior to the elopement and staff failed to re-arm the door After the elopement, he stated the facility turned the annunciators back on and completed staff education regarding elopement and door locks.

The undated facility document "Cognitively Impaired and Independently Mobile", provided on 4/25/23 listed 26 cognitively impaired and

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F 656	Continued From page 78 independently mobile residents. During an interview on 4/26/23 at 2:04 p.m., the DON stated a resident's history of elopement and related interventions should be included on the Care Plan. The facility policy "Elopements and Wandering Residents" reviewed 1/2023, stated the facility ensured that residents who exhibited wandering behavior and were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		

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resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews and policy review, the facility failed to address oxygen use for 1 of 5 residents reviewed for oxygen (Resident #46), failed to create fall prevention interventions for 1 of 2 residents reviewed for falls (Resident #46), failed to create interventions to treat a pressure ulcer for 1 of 5 residents reviewed for pressure ulcers (Resident #4), failed to address drug use for 2 of 2 residents reviewed for alleged illicit drug use in the facility (Residents #46 and #70), and failed to address a history of physical altercations for 1 of 1 residents reviewed for a history of physical altercations with other residents(Resident #70). The facility reported a census of 69 residents.

Findings Include:

1. The Minimum Data Set(MDS) Assessment Tool, dated 1/3/23, listed diagnoses for Resident #70 which included heart failure, paraplegia, and anxiety disorder and listed the resident's Brief Interview for Mental Status Score (BIMS) of 14 out of 15, indicating intact cognition.

A 5/27/22 Physician Note stated the resident snorted Xanax (a medication for anxiety) and used a THC(tetrahydrocannabinol-a psychoactive component of cannabis) pen in the building and

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her urine tested positive for THC and opiates (narcotic pain medications).

Care Plan entries, dated 4/20/23, documented the resident required a substance abuse evaluation with a treatment plan. The Care Plan did not address the resident's history of alleged illicit drug use in the facility.

In an interview on 4/25/23 at 1:00 p.m., the Director of Nursing (DON) stated the Care Plan should include the resident's history of illicit drug use in the facility.

2. The MDS, dated 1/3/23, listed diagnoses for Resident #70 which included heart failure, paraplegia, and anxiety disorder. The MDS identified the resident required supervision assistance of 2 staff for personal hygiene, limited assistance of 2 staff for transfers, extensive assistance of 1 staff for dressing, extensive assistance of 2 staff for toilet use, and depended completely on 2 staff for bathing. The MDS listed the resident's BIMS of 14 out of 15, indicating intact cognition.

A 5/30/22 Behavior Note for Resident #70 stated Resident #70 rammed her wheelchair into Resident #21 and then Resident #21 stood up to hit Resident #70.

A 5/31/22 Physician Note for Resident #70 documented the resident admitted to punching a 92 year old (Resident #21) resident and no injuries were sustained.

A 6/2/22 Physician Note for Resident #21 stated the resident denied being punched.

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A 8/27/22 General Note documented Resident #70 and her roommate (Resident #12) threw water at each other and the resident changed rooms.

A 7/19/22 Care Plan entry stated the resident could be verbally aggressive related to ineffective coping skills and poor impulse control. An 11/25/22 revision of the entry stated on 11/10 the resident was physically aggressive and required 1:1 monitoring.

The Care Plan lacked documentation of alleged physical altercations prior to 11/25/22.

In an interview on 4/25/23 at 8:35 a.m., Staff JJ, Licensed Practical Nurse(LPN) stated Resident #70 had physical altercations with other residents. Staff JJ stated once Resident #70 smoked outside and threw a cigarette on another resident. She stated she did not see this but heard about it.

In an interview on 4/25/23 at 1:00 p.m., the Director of Nursing (DON) stated she heard about the allegation that the resident threw a lit cigarette. She explained staff should report physical altercations between residents and the facility would separate the residents and interview residents and staff. She stated the Care Plan should address the resident's behaviors.

In an interview on 4/27/23 at 10:50 a.m., the Administrator stated staff should report allegations of abuse within 2 hours. She stated the facility would investigate the allegation and would separate the residents.

The facility lacked documentation of an

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investigation related to the above altercations and lacked documentation they reported the allegations to the State Agency or separated the resident from other residents.

The facility policy "Abuse, Neglect, and Exploitation", dated March 2023, stated the facility would provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibited and prevented abuse, neglect, exploitation, and misappropriation of resident property. The policy stated the facility would complete an immediate investigation and ensure all residents were protected upon a suspicion of abuse.

3. Review of Resident #4 Minimum Data Set (MDS) dated 1/31/23 listed a BIMS score of 12 out of 15, indicating the resident with moderate impairment of cognition. The MDS identified Resident #4 used a manual wheelchair and with partial assistance could wheel approximately 50 feet and make two turns and dependent on staff for toileting, picking up drooped objects from the floor, and Resident #4 needed substantial assistance rolling side to side while lying in bed, and dependent on staff for taking off and putting on footwear. Resident #4 documented with active medical diagnosis of sleep apnea, chronic obstructive pulmonary disease (COPD), Congestive Heart Failure (CHF) and Type Two Diabetes.

Review of the Wound Notes on 1/16/23, shown the wound provider documented Resident #4 acquired a Stage III left heel in house pressure ulcer. The wound provider had ordered for

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Resident #4 to float heels in bed; off-load wound; reposition per facility protocol; turn side to side and front to back in bed every 1-2 hours if able; and apply a sponge Pressure Relief Ankle Foot Orthosis (PRAFO) boot. The facility ordered PRAFO boot which is used for residents who spend a significant amount of time in bed and helps prevent pressure ulcers from developing on the back of the heel.

Review of the Care Plan initiated on 10/31/22, shown the Care Plan updated on 1/30/23 to include a focus area for left heel pressure wound, however failed to include interventions to off-load pressure to the left heel when resident up in wheelchair (WC).

Observations of Resident #4 while up in the WC had taken place on the following dates and times. The resident had been observed using the left foot heel with PRAFO boot on to propel the WC. The WC left leg rest had been in the down position:
a. On 4/11/23 at 11:30 AM, the resident observed using left heel to propel WC in Hallway B.
b. On 4/12/23 at 1:00 PM, the resident observed using left heel to propel WC in the North Dining Room.
c. On 04/13/23 at 2:00 PM, the resident observed using left foot to propel WC in the South entry of the facility.
d. On 04/17/23 at 9:00 AM, the resident observed using left foot to propel WC in the South hallway outside of conference room area.

In an interview on 4/19/23 at 8:04 AM, Staff LL, Licensed Practical Nurse (LPN), stated the resident did not have the PRAFO boot on all night (4/18/23). Staff LL further stated the PRAFO boot

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had been on the floor when she entered the resident room and the residents left heel had not been positioned to float on a pillow either.

During an interview on 4/19/23 at 10:02 AM, the Advanced Registered Nurse Practitioner (ARNP) for Resident #4 stated the expectations of use of the PRAFO boot while the resident was up in the wheelchair had been discussed. The ARNP stated the resident needed to wear the PRAFO boot and have the left leg rest elevated at all times when up in the wheelchair. ARNP was made aware the resident had been observed on more than one occasion using the left heel with PRAFO boot on to propel the wheelchair.

4. The MDS dated 3/15/23 identified Resident #46 as cognitively intact with a BIMS score of 13 out of 15 and with the following diagnoses: Multiple Sclerosis, Coronary Artery Disease and Respiratory Failure. It also identified the resident required extensive staff assistance with all activities of daily living (ADL'S)) except for eating and totally dependent on staff for showers/baths. It did not identify the resident had continuous oxygen.

Observations of the resident revealed the following:
a. On 4/11/23 10:59 AM resident lying in bed without continuous oxygen on.
b. On 4/12/23 9:34 AM lying in bed with continuous oxygen maintained at 3.5 liter per minute per nasal cannula per concentrator.
c. On 4/13/23 7:13 AM asleep in bed with door to room open. Continuous oxygen maintained at 3.5 liters per nasal cannula per concentrator.
d. On 4/17/23 8:20 AM lying in bed without

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continuous oxygen on.

A review of the Physician Orders for March and April did not show orders for continuous oxygen.

The Care Plan identified the resident with the problem of shortness of breath on 10/29/22, however, interventions did not include continuous oxygen.

A review of the Incident Reports revealed the resident had falls on the following dates/times:
a. On 8/25/22 at 00:03 AM - Resident is alert and oriented. Resident found lying on her back beside her bed. Resident stated that she did not hit her head. Resident stated that she was trying to turn over in bed and rolled onto the floor. No injuries noted at this time. Resident placed back into bed by 2 staff members and a gait belt.
b. On 11/8/22 at 5:07 PM - The staff observed the resident laying on the floor of her room next to bed. The resident stated she was "getting candy" off bedside table.
c. On 11/19/22 at 7:33 AM - Certified medication Aide (CMA), called nurse to room, resident was laying on floor next to bed
d. On 1/12/23 at 8:00 AM - The resident had been observed sitting on her buttocks on floor next to her bed, stated she "slipped out" of bed. No new skin alterations or injuries noted at this time.
e. On 2/6/23 at 6:28 PM - Resident found on the ground at 2:00 PM. She attempted to exit the bed. increased confusion to place.
f. On 3/10/23 at 4:19 PM - Resident was found laying on floor on side of bed on floor mat.

The Care Plan did not include any new interventions after the falls occurred starting August 2022. The record failed to have

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F 657	Continued From page 86 documentation of a Root-Cause Analysis of the falls. In an interview on 4/25/23 at 9:00 AM, the facility Chief Clinical Officer reported the staff had been discussing falls after they occurred, however, they did not document the completion of the Root Cause Analysis.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff and resident interviews and policy review, the facility failed to complete dressing changes as ordered for 2 of 5 residents reviewed for dressing changes (Residents #61 and #2) and failed to obtain weights as ordered for 2 of 5 residents reviewed for weights (Residents #4 and #12). The facility reported a census of 69 residents. Findings: 1. The MDS Assessment Tool, dated 3/15/23, listed diagnoses for Resident #61 which included malnutrition, morbid obesity, and weakness. The MDS documented the resident had a feeding tube and listed his cognition as moderately impaired. On 4/18/23 at 10:36 a.m., the resident laid in bed with a gauze dressing applied to his feeding tube site dated 4/11/23. Staff BB, Registered Nurse	F 658		

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(RN) was present and confirmed the date of the dressing was 4/11/23.

The facility policy "Physician Orders" reviewed March 2023, directed staff to enter orders into the Medical Record.

A 4/6/23 Care Plan entry directed staff to provide local care to the gastrostomy tube (G-tube-a type of feeding tube) site as ordered.

The April 2023 Treatment Administration Record (TAR) listed a 4/19/23 order for split gauze to G-tube, change daily. The TAR lacked documentation of a completed dressing change from 4/1/23-4/18/23.

On 4/25/23 at 1:00 p.m., the DON stated staff should complete dressing changes as ordered and the nurse caring for Resident #61 should have obtained an order prior to putting the dressing on.

2. The MDS Assessment dated 2/22/23, revealed Resident #2 scored 14 out of 15 on a BIMS exam, which indicated cognition intact. The MDS revealed three Stage 4 pressure ulcers. The MDS identified medical diagnosis of paraplegia.

During an interview on 4/11/23 at 11:50 AM, Resident #2 stated pressure ulcers on each side of the buttock and
on the lower back and the rods popped through the skin. He stated his pressure ulcers present on admission to the facility and stated the staff skipped dressing changes and he reminded them on Saturdays and Sundays the dressing changes needed completed.

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The Care Plan dated 3/1/23 revealed a focus problem of potential for and actual impairment to the skin integrity related to Stage 4 pressure sores on the sacrum, Stage 4 to the right ischium. The interventions dated 4/26/22 indicated to monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration, etc. to Medical Doctor (MD).

The Physician Orders dated 3/3/23 revealed the following:
a. Wound order for stage 4 pressure wound of the right and left ischium (present on admission: apply Dakins soaked gauze and cover with ABD pad and secure with tape twice daily. two times a day for wound orders
b. Wound orders for stage 4 wound of the sacrum (present on admission : apply Dakins 0.125% soaked gauze and cover with ABD pad 2 x daily two times a day for wound orders

The Electronic Medical Record identified the following Medical Diagnoses:
a. Pressure ulcer of unspecified site, unspecified stage.
b. Osteomyelitis of vertebra, sacral, and sacrococcygeal region.
c. Paraplegia, unspecified.
d. Pressure ulcer of sacral region, unstageable.

The review of the Treatment Administration Record TAR) for April 2023 for wound dressing completion revealed the following documentation:
a. April 1st- 7:00 PM, dressing change - "7" (sleeping)
b. April 3rd- 12:00 PM, dressing change left blank
c. April 3rd- 7:00 PM, dressing change- "7"

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(sleeping)
d. April 5th- 7:00 PM, dressing change- "7" (sleeping)
e. April 9th- 7:00 PM, dressing change- "2" (drug refused)
f. April 10th- 7:00 PM, dressing change- "2" (drug refused)
g. April 14th- 7:00 PM, dressing change- "9" (other/see progress notes)
h. April 16th- 7:00 PM, dressing change- "2: (drug refused)
i. April 17th- 7:00 PM, dressing change- "2: (drug refused)

During an interview on 4/19/23 at 11:39 AM, Resident #2 stated he doesn't refuse the wound dressing changes, but it is too late at times and he is already in bed so he didn't want them at that time. He stated he didn't want them after 8:00-8:30 PM. He stated he didn't feel like its his choice when they completed the wound dressing changes.

During the interview on 4/20/23 at 9:21 AM, Staff CC, Licensed Practical Nurse (LPN) queried if Resident #2 refused his wound dressings and she stated he doesn't refuse for me.

During an interview on 4/24/23 at 4:01 PM, the Director of Nursing (DON) queried on the expectations nurse's performing dressing changes and she stated they should follow the TAR and if the resident refused, document the refusal and then notify the Physician. The DON asked if sleeping an acceptable reason for not performing dressing changes and she stated no, if the resident said no they needed to document appropriately. She queried if the resident continued to refuse or their wound dressing what

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interventions would be expected and she responded the Wound Doctor met with the resident and reinforced the importance of the dressing change. She stated they asked the resident if they wanted a specific time. She stated for continued refusal, it needed to be Care Planned.

During an interview on 4/25/23 at 8:53 PM, Staff JJ, LPN queried if she ever completed dressing changes on Resident #2 and she stated no, she watched it once. She stated she asked him last night around 7:30 PM and he refused because his afternoon dressing change completed late in the afternoon. She stated he preferred to have it done at certain times and if it too late, he refused because he wanted to go to bed.

3. Review of the MDS for Resident #4 dated 1/31/23 listed a BIMS score of 12 out of 15, indicating the resident with moderate impairment of cognition. The MDS identified Resident #4 used a manual wheelchair and with partial assistance could wheel approximately 50 feet and make two turns, dependent on staffs for toileting, picking up dropped objects from the floor, and needed substantial assistance rolling side to side while lying in bed. Resident #4 identified with active medical diagnosis of sleep apnea, chronic obstructive pulmonary disease (COPD), and Congestive Heart Failure (CHF).

Review of the Care Plan initiated on 10/31/22 showed the facility failed to document a focus Care Plan area for CHF. The Care Plan failed to include an intervention or update for daily weights.

Review of provider orders showed on 1/24/23, the

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Advanced Registered Nurse Practitioner (ARNP) ordered Resident #4 to be weighed every day for CHF and for the provider to be notified if weight is +3 lb/1 day or 5 lb/1 week.

Review of the Electronic Health Record (EHR) under the task category shown the facility failed to complete daily weights as ordered for Resident #4. Review of February 2023 weights had shown 14 days completed out of 28 days. March 2023 weights had shown 8 days completed out of 31 days. Review of the April 2023 record on April 17, 2023 shown only 3 days completed for the month.

On 4/16/23 at 1:00 PM an interview with the facility Registered Dietician (RD), stated this was the third week of the month and 19 residents were missing a monthly weight. The RD stated she discussed monthly weights not being completed several times with the current Administrator. The RD further stated she emailed the providers to make weight changes known.

On 4/17/23 at 4:05 PM, during an interview with the facility Director of Nursing (DON) and Assistant Director of Nursing (ADON) a discussion of weighing residents had taken place. The DON asked who was responsible to complete weights as ordered by providers and stated the process had been changed and the ADON further stated the Restorative Staff had been weighing the residents however due to tasks added to the Restorative Aides' duties, the Nursing Staff expected to make sure the resident weights are completed. When asked who would audit and review the resident charts to make sure the weights are completed, the DON and ADON stated who ever has time.

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Both the DON and ADON made aware of two residents that are to have daily weights #4 and #12 for CHF and daily weights had not been completed. The DON reviewed the computer task list for each resident and acknowledged the failure of provider orders not being followed.

4. Review of Resident #12's MDS) dated 1/20/23, a BIMS score of 14 out of 15, indicating the resident with intact cognition, used a manual wheelchair and had been dependent on staffs for toileting, picking up dropped objects from the floor, and Resident #12 had needed substantial assistance rolling side to side while lying in bed. The MDS identified Resident #12 with active medical diagnosis of sleep apnea, chronic obstructive pulmonary disease (COPD), Congestive Heart Failure (CHF), and dependent on oxygen.

Review of the Care Plan initiated on 2/17/22, shown Resident #12 with a Focus Care Plan area for CHF which included an intervention that had been initiated 11/7/22 to weigh the resident daily and to report a +3 lb/1 day or 5 lb/1 week to the provider.

Review of provider orders shown the Advanced Registered Nurse Practitioner (ARNP) reordered daily weights on 1/13/23 with direction to call a provider for +3 lb/1 day or 5 lb/1 week to the provider.

Review of the Electronic Health Record (EHR) under the task category shown the facility failed to complete daily weights as ordered for Resident #12. Review of February 2023 weights shown 8 days completed out of 28 days. March 2023

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F 658	Continued From page 93 weights shown 10 days completed out of 31 days. Review of April 2023 weights on April 17, 2023 shown only 4 days completed for the month. so far. On 4/16/23 at 1:00 PM, during an interview with the facility Registered Dietician (RD), the RD stated this was the third week of the month and 19 residents were missing a monthly weight. The RD stated she discussed monthly weights not being completed several times with the current Administrator. The RD further stated she emailed the providers to make weight changes known. On 4/17/23 at 4:05 PM, during an interview with the facility Director of Nursing (DON) and Assistant Director of Nursing (ADON), the discussion of weighing residents took place. The DON asked who had been responsible to complete weights as ordered by providers. The DON stated the process had been changed and the ADON had further stated the Restorative Staff had been weighing the residents however due to tasks added to the Restorative Aides' duties that now the Nursing Staff is expected to make sure the resident weights are completed. When asked who would audit and review the resident charts to make sure the weights are completed, the DON and ADON stated who ever has time. Both the DON and ADON made aware of two residents that are to have daily weights #4 and #12 for CHF and daily weights not completed. The DON reviewed the computer task list for each resident and acknowledged the failure of provider orders not being followed.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		

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§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 personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, staff and resident interviews and facility policy review the facility failed to keep 1 out of 1 residents hands clean for 5 out of 5 days observed (Resident #35), failed to trim the finger nails of 1 out of 2 residents reviewed (Resident # 61), failed to provide bathing 9 out of 9 out of residents reviewed (Resident #2, #4, #10, #35, #56, #61, #63, and #70), and failed to provide incontinence cares for 1 out of 7 residents reviewed (Resident # 46). The facility reported a census of 69.

Findings Include:

1. The Minimum Data Set (MDS) Assessment for Resident #35 dated 1/18/23, listed diagnoses of dementia and cancer. The MDS identified the Brief Interview of Mental Status (BIMS) score of of 00 (indicating sever cognitive impairments), and showed Resident #35 required extensive assist of 1 staff for personal hygiene and bathing.

The Care Plan dated 10/28/19, identified Resident #35's activities of daily living (ADL) self-care performance deficit related to Dementia. The Care Plan reflected Resident #35 able to assist with showers. The Care Plan intervention included, avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short and keep skin clean and dry.

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Use lotion on dry skin.

The Task List Report dated 2/20/23, directed ADL - Bathing/Shower
Task Scheduled as needed (PRN): 6 AM-2 PM, 2 PM-10 PM, 10 PM-6 AM. Tuesday/Friday Shift: 6-2 shift.

The Bath Record dated 4/18/23, showed Resident #35 received 3 baths in 30 days. The record reflected baths given to Resident #35 on 3/21/23, 3/28/23 and 4/11/23.

The Hospice Communication log at the Nurses Station included notes from the nurses and lacked documentation of bathing.

The Hospice Care Plan dated 3/16/23, failed to reflect bathing provided for Resident #35.

On 4/18/23 at 2:17 PM, the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) reported they expected staff wash residents faces and hands after meals and when they go bed. The DON continued to state baths are completed two times a week.

On 4/18/23 at 2:23 PM, the DON stated Resident #35 is on Hospice care. The DON reported Hospice completed the bath 2 times a week. The DON stated Hospice staff took her into the shower if she could tolerate it.

During the following observations of Resident #35, noted dirty fingernails on both hands:
a. On 4/11/23 at 12:50 PM, Resident #35 sat in her wheel chair (w/c) at the dining room. The resident's right and left hands under her fingernails noted a dark substance.

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b. On 4/12/23 at 12:26 PM, Resident #35 finger nails on her left hand continued with a dark colored substance under the nails.
c. On 4/12/23 at 12:15 PM, under all five finger nails on Resident #35's right hand contained dark substance.
d. On 4/13/23 at 8:42 AM, Resident #35's fingernails to her right hand remained with dark colored substance under the nail.
e. On 4/17/23 12:54 PM, Resident #35's right hand under her finger nails held dark black colored substance as she sat at the dining room table.
f. On 4/18/23 at 12:34 PM, Resident #35's sat at the dining room table and her right hand under her fingernails held a dark colored substance.

On 4/17/23 at 1:17 PM Staff L, Certified Nurse Aid (CNA) removed Resident #35 from the dining room and took her to her room. Staff L transferred Resident #35 to her bed, positioned her and left the room. Staff L failed to wash Resident #35's hands.

The facility provided a policy titled Resident Showers dated 3/2022, identified it is the facility practice to assist resident with bathing to maintain hygiene, stimulate circulation and help prevent skin issues as per current standard of practice.

The facility provided a policy titled Incontinence dated 3/2022, directed at point #4, Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.

The facility provided a policy titled Nail Care dated 3/2023, identified The purpose of this procedure is to provide guidelines for the provision of care to

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a resident's nails for good grooming and health. The policy directed at point # 3: routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis.
The policy included at point #4: Routine nail care, to include trimming and filing, will be provided on a regular basis. Nail care will be provided between scheduled occasions as the need arises.

The facility failed to provide a policy directing staff when and how to provide Incontinence Care.

2. The MDS Assessment dated 2/22/23, revealed Resident #2 scored 14 out of 15 on a BIMS exam, which indicated cognition intact. The MDS indicated the resident independent and bathed with no set up or physical help from staff.

During an interview on 4/11/23 at 12:07 PM, Resident #2 stated they only showered me once and they are supposed to give me bed baths because of his pressure ulcers but they never asked if he wanted one. He stated his last bath happened 2 or 3 months ago. Resident #2 stated he waited for the staff to ask him to shower and didn't. Resident sat in his wheelchair and the resident disheveled wearing camo pants and a shirt.

During an interview on 4/12/23 at 3:44 PM, Resident #2 stated he received one bed bath while he resided in the front hall and when they moved him to the back hall he stated didn't receive a bath.

The Care Plan dated 3/1/23 revealed a focus problem of an Activities of Daily Living (ADL) performance deficit related to impaired mobility,

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paraplegia. The interventions dated 9/22/23 indicated Resident #2 required extensive assistance by (1) staff with bathing/showering.

The Documentation Survey Report for March 2023 and April 2023 revealed the resident scheduled showers/baths on Tuesdays and Fridays between 6:00 AM and 2:00 PM and documented the following information:
a. 3/3/23- left blank
b. 3/7/23- resident not available
c. 3/10/23- not applicable
d. 3/17/23- not applicable
e. 3/21/23- left blank
f. 3/24/23- left blank
g. 3/28/23- Activity did not occur
h. 3/31/23- left blank
i. 4/4/23- left blank
j. 4/7/23- left blank
k. 4/11/23- left blank
l. 4/14/23- left blank
m. 4/21/23- left blank
n. 4/25/23- left blank

Task Sheet for Bathing/Shower for the last 30 days revealed the following information:
a. 3/28/23- activity did not occur
b. 4/18/23- documented resident showered

During an interview on 4/20/23 at 9:27 AM, Staff HH, Certified Nurse Aide (CNA) queried how often Resident #2 showered and she stated she never provided his shower before and no one told her he took showers in rounds.

During an interview on 4/20/23 at 09:52 AM, Staff II, CNA queried if refusals of showers are documented and she states yes and the resident signed the refusal on a Shower Sheet if able.

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Staff II asked how often Resident #2 showered and she stated she didn't work with him and personally not sure.

During an interview on 4/24/23 at 4:31 PM, Staff L, CNA queried how often Resident #2 received a shower and she stated she didn't know, she didn't usually work B Hall, she usually worked A Hall.

3. The MDS Assessment dated 2/22/23 revealed Resident #10 scored 9 out of 15 on a BIMS exam, which indicated moderate cognitive impairment. The MDS revealed the resident needed physical help in part of the bathing activity with a one person assist. The MDS revealed the needed extensive assistance with one person physical assist with personal hygiene.

During an observation on 4/12/23 at 10:20 AM, Resident #10 wore a white shirt with a stain on it and his hair not combed. Resident grabbed a comb out of his drawer and started to comb his hair.

The Care Plan 2/16/23 revealed a focus problem of ADL self performance deficit related to impaired balance, limited Range of Motion (ROM), stroke with right-sided deficits. The interventions dated 6/11/19 revealed to check the nail length and trim and clean on bath day and as necessary; provide sponge bath when a full bath or shower cannot be tolerated and resident will often refuse shower; resident required extensive assistance by staff with bathing/showering and as necessary; resident required extensive to limited assistance by staff with personal hygiene and he preferred facial hair and will often refuse grooming; and preferred long nails and would at

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times allow cleaning but would refuse trim.

The Documentation Survey Report for March 2023 and April 2023 revealed Resident #10 scheduled for showers on Monday and Thursday on the PM shift. The report revealed the following information:
a. 3/2/23- left blank
b. 3/23/23- left blank
c. 3/30/23- not applicable
d. 4/6/23- left blank.

The Task Record Report for ADL-Bathing/Shower for April 2023 did not provide documentation after the date of 4/6/23 for Resident #10's shower completion.

During an observation on 4/17/23 at 12:15 AM, Resident #10 sat in his wheelchair with a blanket over him in the common area. Hair not combed.

During an interview on 4/18/23 11:20 AM, Resident #10 queried how often he preferred to shower and he stated once a week. Resident #10 asked if he ever refused to shower and he stated no, well yeah sometimes.

During an observation on 4/18/23 at 4:17 PM, Resident #10 sat in the common area in his wheelchair. Fingernails are long. The resident asked how often they clip his nails and he made a sound and stated he didn't know.

During an interview on 4/20/23 at 9:52 AM, Staff II, CNA queried how often resident's showered and she stated they are short staffed and she got them done as soon as she could. She stated she came in on her days off and provided showers and bed baths to the residents. She stated the

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showers are not being completed regularly and the residents received a shower maybe once a week. Staff II queried how often Resident #10 offered a shower and she stated she believed his shower scheduled on the PM and he took his shower for her but refused with certain aides.

During an interview on 4/24/23 at 4:01 PM, the Director of Nursing (DON) queried how often residents are showered and she stated they have a shower schedule and the residents should be showered on the scheduled days. She stated the shower schedule recently redone to fit acuity. She stated if the resident refused, CNA notified the nurse and the resident signed a paper. The DON asked if the facility had any issues with showers not being completed and she stated not to her knowledge. The DON queried what it meant if the shower date was left blank on the task sheet in the computer and she responded like it not charted, either they forgot to do their charting or the shower not given.

During an interview on 4/24/23 at 4:31 PM, Staff L, CNA queried how often residents are showered and she stated daily on their scheduled shower days at least a majority of the time they received their showers on their scheduled shower days. She stated except for days they are short staffed like today. Staff L queried if the residents received showers today and she stated no.

4. The MDS dated 1/31/23, listed diagnosis for Resident #4 of congestive heart failure (CHF), type two diabetes, chronic obstructive pulmonary disease (COPD), sleep apnea and morbid obesity. The MDS listed the resident dependent on staff for toileting, and picking up dropped

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objects from the floor, and the resident needed substantial assistance rolling side to side while lying in bed, and listed the resident's BIMS score as 12 out of 15, indicating moderate impairment of cognition.

On 4/11/23 at 10:00 AM, the resident observed sitting in bed, with greasy hair and Depend brief on showing at waist. Overall disheveled look. Resident speech difficult to understand however able to answer yes and no questions by shaking head. When asked if a shower had been taken recently the resident shook her head no.

A 10/31/22 Care Plan entry directed only female staff to provide personal care and stated the resident required extensive assistance in the shower and to provide a sponge bath when a shower could not be tolerated.

Review of the Electronic Health Care Record showed the resident last received a shower on 3/22/23 and documented the activity did not occur on 3/29/23. Dates of 4/1/23 and 4/12/23 documented the activity was not applicable.

The electronic reports lacked documentation of further showers/bath assistance given during the time period.

5. The MDS dated 3/15/23 identified Resident #46 as cognitively intact with a BIMS score of 13 out of 15 and with the following diagnoses: Multiple Sclerosis, Coronary Artery Disease and Respiratory Failure. It also identified the resident required extensive staff assistance with all ADL's except for eating and totally dependent on staff for showers/baths.

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In an interview on 4/12/23 at 10:50 AM, the resident's family member reported she would visit the resident once or twice a week. They are supposed to reposition her every 2 hours. She reported she would be at the facility for 5 hours and not see anyone come in to reposition her.

Observations of the resident revealed the following on 4/12/23:
a. At 1:30 PM remains lying on her back in bed, both resident and her mother verified it had been 2.5 hours and no one had been in to reposition the resident.
b. At 2:45 PM remains lying on her back in bed, she and her mother both reported no staff member has been in to reposition the resident for the past 3.75 hours.

Observations of the resident revealed the following on 4/13/23:
a. At 7:13 AM asleep in bed with door to room open. Continuous oxygen maintained at 3.5 liters per minute per nasal cannula per concentrator.
b. At 7:20 AM assessment unchanged. No staff in hall
c. At 7:40 AM remains asleep in bed lying on back, bells used to call staff on tray table out of the resident's reach. Remainder of assessment unchanged.
d. At 7:43 AM, Staff F, CMA outside resident's room with a medication cart.
e. At 7:46 AM Staff F entered the resident's room and administered medications to the resident and left the room. No other cares provided.
f. At 7:57 AM assessment unchanged.
g. At 8:03 AM assessment unchanged.
h. At 8:09 AM Staff C entered resident's room, and placed her breakfast tray on the tray table.
i. At 8:12 AM resident asleep again, tray remains

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on tray table, untouched. Remainder of assessment unchanged.
j. At 8:22 AM Staff C passing breakfast trays in this hall
k. At 8:23 AM the Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Social Worker in room across the hall, no staff provided cares or repositioned resident for 43 minutes now. Resident remains asleep, remainder of assessment unchanged.
l. At 8:29 AM, the ADON entered room and assisted the resident with breakfast.
m. At 8:45 AM, the ADON left the resident's room. The resident reported the ADON did not provide cares, that it had been several hours since anyone had washed her private parts.
n. At 8:49 AM, Staff F, entered room to administer medications. No cares provided
o. At 8:56 AM, Staff C walked by the resident's room and removed linens from linen closet and walked down the other way. No peri cares provided for 1 hr and 16 minutes.
p. At 9:07 AM assessment unchanged, no staff in hallway
q. At 9:13 AM, housekeeping staff entered the room to move belongings to another room.
r. At 9:25 AM, Staff C walked into the resident's room and refilled resident's water pitcher with ice water. She did not provide peri cares before leaving the room.
s. At 9:29 AM, Staff C walked by the resident's room with a cart of water pitchers and cooler with ice. No peri cares provided to this resident.
t. At 9:31 AM resident ringing her bells to call staff, currently no staff in the hallway. "North Dining Room Alarm" sounding overhead and bells could not be heard above alarm sounding. The resident did not have peri cares for 2 hours and 18 minutes.

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u. At 9:32 AM Staff C entered room to provide peri cares.

Observations of the resident on 4/17/23 revealed the following:
a. At 8:20 AM resident lying in bed with the call light wrapped around frame of her bed behind her head, stated "I've been calling out for over an hour now, I can't find my call light, I need my brief changed" Surveyor turned on the call light for the resident. Staff BB, RN stood out in the hallway by a medication cart, did not check on resident.
b. At 8:25 AM the call light remains on, audible, Staff BB moved the medication cart down the hall and walked into another resident's room. Staff L, CNA walked into another resident's room at the end of the hall. Call light on for 5 minutes.
c. At 8:27 AM, Staff BB walked by this resident's room as her call light remained lit and did not check on her.
d. At 8:28 AM, Staff L walked into the resident's room and turned off the call light and left the room and brought two bags of linens down the hall.
e. At 8:30 AM, the surveyor asked the resident if the Staff L addressed her needs, she reported "I asked her to change my brief and she left my room without doing it"
f. At 8:37 AM, the resident's cell phone rang, resident called out "can someone help me get my phone" No staff provided assistance
g. At 8:54 AM, Staff BB entered the room to check on resident, did not provide peri cares. The resident has been waiting 24 minutes to have someone provide peri care.
h. At 10:00 AM, the resident's call light remained on. She reported no one ever came to change her incontinent brief. Then Staff BB the entered room to ask what she needed, she said "I need

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my brief changed" Then he said "let me get someone to help you" and left room. The resident reported yesterday she turned on her call light from 8:30 AM to get her brief changed and no one changed her brief until 2:30 AM that night. "I'll turn on my call light, they keep coming in to turn it off and don't help me and I have to keep turning my call light on again"
i. At 10:08 AM Staff L entered the room to provide cares as requested 1 hour and 48 minutes later.

On 10/29/22, the Care Plan identified the resident with the problem of bowel and bladder incontinence and directed staff to clean peri-area with each incontinence episode.

The facility policy titled: Incontinence dated as last reviewed March 2023 had documentation of the following:
1. The facility must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, services, and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.
2. For residents with urinary incontinence, the facility will ensure that residents are not catheterized unless the
resident's clinical condition demonstrates that catheterization was necessary.
3. Residents that enter the facility with an indwelling catheter, or receives one while in the facility, will be assessed for
removal of the catheter as soon as possible, unless the resident's clinical condition demonstrates that catheterization was necessary.
4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to

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F 677	Continued From page 107 restore continence to the extent possible. 6. The MDS, dated 1/14/23, listed diagnoses for Resident #56 which included heart failure, diabetes, and morbid obesity. The MDS documented the resident did not receive a bath during the review period and listed the resident's BIMS score as 14 out of 15, indicating intact cognition. During an interview on 4/12/23 at 9:44 a.m., the Resident #56 stated she missed baths but that was because she took them independently and forgot to go in and complete them. The resident's hair appeared greasy and unkempt. A 7/2/22 Care Plan entry directed staff to provide a sponge bath when a full bath or shower could not be tolerated. Care Plan entries, dated 11/3/22, stated the resident required assistance with ADL's due to impaired mobility and right hemiplegia(one-sided weakness). The March 2023 Documentation Survey Report documented the resident received a shower on 3/2/23 and 3/30/23 and documented the resident refused on 3/13/23 and the activity did not occur on 4/23/23. The April 2023 Documentation Survey Report documented the resident received a shower on 4/6/23 and 4/13/23. The 4/10/23 entry stated the resident was not available. The reports lacked documentation of further	F 677		

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showers/bath assistance given during the time prior of 3/1/23-4/17/23.

7. The MDS, dated 3/15/23, listed diagnoses for Resident #61 which included malnutrition, morbid obesity, and weakness. The MDS documented the resident required extensive assistance of 2 staff for personal hygiene and bathing and listed the resident's cognition as moderately impaired.

During an observation on 4/13/23 at 8:07 a.m., Resident #61 laid in bed. All of his nails were very long, extending past the fingers approximately 3 millimeters(mm). The resident was unshaven, had a long beard and his hair was unkempt.

Observations on 4/17/23 at 12:29 p.m. and 4/18/23 at 7:38 a.m. revealed the resident's nails were the same length, he was unshaven, and his hair was unkempt.

Care Plan entries, dated 4/6/23, stated the resident had a self-care performance deficit related to impaired mobility and stated the resident required extensive assistance of 1 staff for personal hygiene.

8. The 3/9/23 MDS listed diagnoses for Resident #63 which included diabetes, burns, and unspecified fall. The MDS identified the resident required extensive assistance of 1 staff for personal hygiene and completely depended on 1 staff for bathing. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition. The MDS documented the resident admitted to the facility on 3/3/23.

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In an interview on 4/17/23 at 1:15 p.m., Resident #63 stated she only received 2 showers since admission to the facility.

The March 2023 Documentation Survey Report stated the resident had partial baths on 3/4, 3/6, 3/8, 3/11/23, and 3/14, and had a shower on 3/21/23.

The April 2023 Documentation Survey Report for stated the resident had a partial bath on 4/1/23 and 4/11/23.

The record lacked documentation of further showers during the period of 3/3/23-4/17/23.

A Care Plan entry, dated 3/13/23, stated the resident had a self-care performance deficit related to impaired mobility and stated the resident required total assistance of 1 staff for bathing and showering.

9. The MDS assessment tool, dated 1/3/23, listed diagnoses for Resident #70 which included heart failure, paraplegia, and anxiety disorder. The MDS stated the resident required supervision assistance of 2 staff for personal hygiene, limited assistance of 2 staff for transfers, extensive assistance of 1 staff for dressing, extensive assistance of 2 staff for toilet use, and depended completely on 2 staff for bathing. The MDS listed the resident's BIMS score as 14 out of 15, indicating intact cognition.

The 4/7/23 entry MDS stated the resident admitted from an acute hospital on 4/7/23.

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F 677	Continued From page 110 In an interview on 4/12/23 at 10:11 a.m., Resident #70 stated she returned from the hospital "Friday night"(4/7/23) and stated she had not received a shower since. She stated she felt like she "stinks". The April 2023 Documentation Survey Report lacked documentation the resident received a shower or bath from 4/7/23-4/12/23. A Care Plan entry, dated 4/20/22, stated the resident required extensive assistance of 1 staff for bathing/showering.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review, the facility failed to provide wound care in a manner to reduce the risk of wound infections and failed to implement offloading devices to decrease pressure for 2 of 4 residents observed with pressure ulcers	F 686		

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(Residents #4, #49). This failure led to harm when Resident #4 developed a facility acquired Stage 3 pressure ulcer. The facility reported a census of 69 residents.

Findings include:

Minimum Data Set (MDS) Definitions of Pressure Ulcers

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat)

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is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

1. The MDS assessment dated 11/4/22 for Resident #4 identified an original admission date of 10/28/22. The MDS documented no pressure ulcers present upon assessment.

The wound physician Initial Wound Evaluation &

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Management Summary notes dated 1/16/23 documented under History of Present Illness that the resident had a Stage 3 pressure wound of the left, posterior heel for at least 2 days duration. The summary included the following:
a. Focused Wound Exam (Site 1) - Stage 3 pressure wound of the left, posterior heel full thickness
Wound Size: 6.0 cm (centimeters) by 4.0 cm by 0.2 cm with surface area 24.00 cm 2 (square centimeters)
Duration: greater than 2 days
Recommendations: float heels in bed, offload wound, reposition per facility protocol, turn side to side and front to
back in bed every 1 to 2 hours if able, sponge boot.
Coordination of Care: offloading is the resident's main issue and her compliance would be difficult due to her
behavioral issues, severe schizophrenia/bipolar issues, and having her comply had been difficult. they would get
her a sponge boot but unsure if she would be able to keep it on but discussed with RN (Registered Nurse) staff
and resident and they would try.

The MDS assessment dated 1/17/23 documented the resident discharged to the hospital with return not anticipated.
The MDS assessment dated 1/23/23 documented an entry tracking when the resident returned from the hospital.

The MDS assessment dated 1/31/23 identified a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. The MDS revealed the resident

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used a manual wheelchair and with partial assistance could wheel approximately 50 feet and make two turns. The MDS recorded the resident dependent on staff for toileting, picking up dropped objects from the floor, needed substantial assistance rolling side to side while lying in bed, and dependent on staff for taking off and putting on footwear. The MDS documented diagnoses that included sleep apnea, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and type two diabetes. The MDS recorded the presence of an unstageable pressure ulcer upon admit to the facility.

The Care Plan focus area initiated 1/30/23 identified on 1/16/23 the resident had an in-house (facility) acquired Stage 3 pressure ulcer develop on her left heel. The care plan interventions directed staff to avoid positioning the resident with heels touching bed or chair. The care plan lacked documentation regarding a sponge boot or directions to raise wheelchair legs to offload pressure to the heel.

The Progress Notes dated 3/21/23 at 12:20 PM documented a late entry physician progress note. The entry recorded on 3/8/23 the wound MD (doctor) continued to follow the resident and the resident to continue to try to offload the heel with the help of NS (nursing staff). The entry documented the wound continued to improve and the resident did have the PRAFO boots as well.

The wound physician Wound Evaluation & Management Summary notes dated 4/3/23 documented the following:
a. Focused Wound Exam (Site 1) - Stage 3 pressure wound of the left, posterior heel full

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thickness
Wound Size: 1.5 cm by 3.0 cm by 0.1 cm with surface area 4.50 cm 2 (square centimeters)
Duration: greater than 75 days
Wound Progress: improved
Recommendations: offload wound, turn side to side and front to back in bed every 1 to 2 hours if able, float heels
in bed, sponge boot, reposition per facility protocol, antibiotic choice Bactrim DS 1 tab orally twice a day for 14
days.

Observation on 4/11/23 at 11:30 AM revealed the resident used her left heel to propel her wheelchair in Hallway B.
Observation on 4/12/23 at 1:00 PM revealed the resident used her left heel to propel her wheelchair in the North Dining Room.
Observation on 4/13/23 at 2:00 PM revealed the resident used her left foot to propel her wheelchair in the South entry of the facility.

The wound physician Wound Evaluation & Management Summary notes dated 4/14/23 documented the following:
a. Focused Wound Exam (Site 1) - Stage 3 pressure wound of the left, posterior heel full thickness
Wound Size: 1.7 cm by 3.0 cm by 0.1 cm with surface area 5.10 cm 2 (square centimeters)
Duration: greater than 86 days
Wound Progress: no change
Recommendations: offload wound, turn side to side and front to back in bed every 1 to 2 hours if able, float heels
in bed, sponge boot, reposition per facility protocol, antibiotic choice Bactrim DS 1 tab orally twice a day for 14

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days.

Observation on 4/17/23 at 9:00 AM revealed the resident used her left foot to propel her wheelchair in the South hallway outside of conference room area.

In an interview on 4/19/23 at 7:55 AM, Staff LL, LPN, stated the resident had a PRAFO (sponge) boot however the resident used her left foot to propel her wheelchair throughout the day. At 8:04 AM, Staff LL commented the resident's sponge boot had not been on all night due to the boot being on the floor.

Observation on 4/19/23 at 8:04 AM revealed Staff LL, LPN, completed the daily wound care as provider ordered for the left heel Stage 3 pressure ulcer. Staff LL elevated the lower left leg and left foot on a pillow. Staff LL washed hands, donned gloves, removed the old dressing. Staff LL proceeded to cleanse wounds and apply the ordered treatment. Staff LL used scissors to cut a new medicated dressing then applied another dressing as ordered. Staff LL never washed hands or changed gloves during the wound care when removing dirty dressings, cleaning the wound, and then applying new dressings.

In an interview on 4/19/23 at 8:40 AM, Staff LL responded she should have changed her gloves when going from a dirty field to a clean field.

In an interview on 4/19/23 at 10:02 AM, the Advanced Registered Nurse Practitioner (ARNP) responded when asked about the resident's wounds and expectations that the resident was to have a PRAFO boot on her left foot for offloading.

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The ARNP stated the resident had a blister that opened and the resident to offload when sitting in the wheelchair with leg rest in the up position. After being informed that observations from 4/11/23 through 4/19/23 revealed the resident's wheelchair not observed in the up position, the ARNP responded the leg rest was to be in the up position whenever the resident was up.

In an interview on 4/19/23 at 4:05 P.M. the Director of Nursing (DON) and Assistant Director of Nursing (ADON) stated they expected nursing staff to follow the policy to wash hands and change gloves when going from a dirty to a clean wound field.

The facility policy revised March 2023 titled Clean Dressing Change included the following documentation:
7. Wash hands and put on clean gloves.
9. Loosen the tape and remove the existing dressing (old dressing).
10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle.
11. Wash hands and put on clean gloves.
12. Cleanse wound.
13. Remove gloves.
14. Wash hands and put on clean gloves
17. Discard disposable items and gloves into appropriate trash receptacle and wash hands.

2. The MDS assessment dated 2/23/23 for Resident #49 identified the resident admitted from the hospital originally on 2/16/23. The MDS recorded a BIMS score of 14 which indicated intact cognition. The MDS documented diagnoses included Multiple Sclerosis (MS), paraplegia (paralysis of the legs and lower body), osteomyelitis (inflammation of the bone) of sacral

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region, bacterial infection unspecified, neurogenic bladder, pressure ulcer of sacral region Stage 4, and pressure ulcer of right buttock Stage 4. The MDS coded the presence of an indwelling catheter as well as 1 Stage 3 pressure ulcer and 2 Stage 4 pressure ulcers present upon admit to the facility. The MDS revealed the resident required extensive physical assistance of 1 person for bed mobility, extensive physical assistance of 2 persons for transfers, and totally dependent upon staff for bathing.

The hospital discharge summary dated 2/16/23 documented discharge diagnoses that included osteomyelitis, Stage 4 decubitus ulcer, wound infection, chronic kidney disease stage 2, multiple sclerosis, paraplegia, and neurogenic bladder. The summary recorded the resident wheelchair-bound with chronic sacral decubitus ulcers with ulcer present on the coccyx, right ischial buttock, and left lateral ankle.

The Care Plan focus area initiated 2/17/23 identified the resident had infection of the wounds of the coccyx and directed staff to administer antibiotics as per doctor orders and to maintain universal precautions when providing resident care.

The Care Plan focus area initiated 2/20/23 identified the presence of a Stage 3 pressure ulcer on the left ankle and Stage 4 on the sacrum and right ischium related to a history of ulcers and immobility. The Care Plan interventions included notification to staff the resident needed to turn/reposition at least every 2 hours, more often as needed or requested.

The Progress Notes dated 2/20/23 at 1:39 PM

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recorded a nutrition/dietary note which documented the resident seen by the wound MD (doctor) that day. The skin measurements recorded as:
a. Stage 3 to left lateral ankle 7.0 cm (centimeters) by 3.0 cm by 0.2 cm surface area 21.00 cm 2 (square centimeters)
b. Stage 4 to right ischium 8.0 cm by 5.0 cm by 2.5 cm surface area 40.00 cm 2
c. Stage 4 to sacrum 8.0 cm by 8.0 cm by 20 cm surface area 64.00 cm 2.

The Progress Notes dated 2/22/23 at 2:44 PM recorded a Physician Note. The assessment portion documented the resident had a Stage 4 decubitus ulcer complicated with osteomyelitis and treated with IV (intravenous) antibiotics for 2 weeks after wound debridement performed 1/31/23 prior to admission to the facility.

The Progress Notes dated 3/27/23 at 1:19 PM documented a change in condition summary that recorded the resident seen by the wound care provider due to increased drainage and foul odor and exposed necrotic bone exposed. The resident sent to the ER (Emergency Department) for evaluation.

The Progress Notes dated 4/4/23 at 3:00 PM recorded the resident readmitted to the facility.

The wound physician Wound Evaluation & Management Summary notes dated 3/6/23 documented the following:
a. Focused Wound Exam (Site 1) - Stage 3 pressure wound of the left, lateral ankle full thickness
Wound Size: 5.0 cm (centimeters) by 3.0 cm by 0.2 cm with surface area 15.00 cm 2 (square

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F 686	Continued From page 120 centimeters) Duration: greater than 44 days Wound Progress: Improved Recommendations: offload wound, reposition per facility protocol, turn side to side in bed every 1 to 2 hours if able b. Focused Wound Exam (Site 2) - Stage 4 pressure wound of the right ischium full thickness Wound Size - 8.0 cm by 5.0 cm by 2.5 cm, surface area 40.00 cm 2 Duration: greater than 164 days Wound Progress: no change Recommendations: Limit sitting to 60 minutes, offload wound, reposition per facility protocol, turn side to side in bed every 1 to 2 hours if able, upgrade offloading chair cushion, low air loss mattress c. Focused Wound Exam (Site 3) - Stage 4 pressure wound sacrum full thickness Wound Size - 8.0 cm by 8.0 cm by 20 cm, surface area 64.00 cm 2 Duration: greater than 164 days Wound Progress: no change Recommendations: Limit sitting to 60 minutes, offload wound, reposition per facility protocol, turn side to side in bed every 1 to 2 hours if able, Group 2 mattress, upgrade offloading chair cushion The Care Plan focus area lacked documentation to reflect the recommendations made by the wound physician to offload the wound, limit sitting to 60 minutes, upgrade the offloading chair cushion, low air loss mattress, and Group 2 mattress. The wound physician Wound Evaluation & Management Summary notes dated 4/3/23	F 686		

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documented the resident was not seen due to a wound-related hospitalization since the previous visit.

The wound physician Wound Evaluation & Management Summary notes dated 4/14/23 documented the following:
a. Focused Wound Exam (Site 2) - Stage 4 pressure wound of the right ischium full thickness
Wound Size - 3.1 cm by 4.4 cm by 0.3 cm, surface area 13.64 cm 2
Duration: greater than 202 days
Wound Progress: improved
Primary Dressing: negative pressure wound therapy (wound vac) apply three times per week for 30 days
Recommendations: upgrade offloading chair cushion, offload wound, limit sitting to 60 minutes, low air loss
mattress, reposition per facility protocol, turn side to side in bed every 1 to 2 hours if able, low air loss mattress
b. Focused Wound Exam (Site 3) - Stage 4 pressure wound sacrum full thickness
Wound Size - 3.0 cm by 2.2 cm by 1.0 cm, surface area 6.60 cm 2
Duration: greater than 202 days
Wound Progress: improved
Primary Dressing: negative pressure wound therapy (wound vac) apply three times per week for 30 days
Recommendations: Group 2 mattress, upgrade offloading chair cushion, reposition per facility protocol, turn side
to side in bed every 1 to 2 hours if able, limit sitting to 60 minutes, offload wound, low air loss mattress

Observations of wound care on 4/12/23 revealed

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the following:
a. At 3:33 PM, Staff D, Licensed Practical Nurse (LPN), and Staff E, LPN, both entered room, washed their hands and donned gloves.
b. At 3:53 PM, after Staff D had placed new foam into the wounds for the wound vac, she picked up the Foley (indwelling catheter) bag, handed it to Staff HH, LPN, and proceeded to finish the dressing change to the pressure ulcers without changing her gloves after she handled the Foley bag.

In an interview on 4/25/23 at 9:43 AM, Staff D, LPN, reported during wound care nurses should change gloves after picking up dirty dressings and before putting on new dressings. She also admitted she should have changed her gloves after picking up the resident's Foley bag during wound care.

In an interview on 4/25/23 at 9:53 AM, Staff K, Registered Nurse (RN), reported during wound care nurses should change gloves after touching anything soiled, wash hands, and put on new gloves.

In an interview on 4/25/23 3:12 PM, the Director of Nursing (DON) reported during wound care she would expect nurses to change gloves before and after removing soiled dressings or if the gloves become visibly soiled. She would also expect nurses to change gloves after picking up a Foley bag before resuming the wound care.

A review of the facility policy titled: Clean Dressing Change dated as last reviewed March 2023 had documentation of the following:
1. When multiple wounds are being dressed, the dressings will be changed in order of least

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contaminated to most
contaminated (i.e. change extremity wounds before wounds contaminated with stool). Dressings of infected wounds should be changed last.
2. Set up clean field on the overbed table with needed supplies for wound cleansing and dressing application:
a. If the table is soiled, wipe clean.
b. Place a disposable cloth or linen saver on the overbed table.
c. Place only the supplies to be used per wound on the clean field at one time (include wound cleanser, gauze for
cleansing, disposable measuring guide and pen/pencil, skin protectant products as indicated, dressings, tape).
d. If performing photo documentation, label measuring guide with patient identifier and date.
e. Use no-touch techniques to remove ointments and creams from their containers (i.e. use tongue blade or
applicator). Liquid solutions should be poured directly onto gauze sponges.
3. Establish area for soiled products to be placed (Chux or plastic bag).
4. Wash hands and put on clean gloves.
5. Place a barrier cloth or pad next to the resident, under the wound to protect the bed linen and other body sites.
6. Loosen the tape and remove the existing dressing. If needed to minimize skin stripping or pain, moisten with
prescribed cleansing solution or use adhesive remover to remove tape.
7. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle.
8. Wash hands and put on clean gloves.
9. Cleanse the wound as ordered, taking care to

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F 686	Continued From page 124 not contaminate other skin surfaces or other surfaces of the wound (i.e. clean outward from the center of the wound). Pat dry with gauze. 10. Measure wound using disposable measuring guide. (Note: If performing photo documentation, remove gloves and wash hands. Photograph wound being careful to avoid any contamination of the camera equipment). 11. Wash hands and put on clean gloves. 12. Apply topical ointments or creams and dress the wound as ordered. Protect surrounding skin as indicated with skin protectant. 13. Secure dressing. Mark with initials and date. (Add time if dressing is more than once daily.) 14. Discard disposable items and gloves into appropriate trash receptacle and wash hands.	F 686		
F 689 SS=K	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 observation, clinical record review, resident interviews, staff interviews, and facility policy review, the facility failed to ensure the functioning of a door alarm in order to prevent an elopement for 1 of 1 cognitively impaired residents reviewed for an elopement (Resident #71), failed to ensure residents could safely store and administer medications for 2 of 2 residents	F 689		

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reviewed for self-administration of medications (Resident #36, #24), failed to ensure 2 of 2 treatment carts and 1 of 2 medication carts locked or secured when staff not present, and failed to secure the kitchen steam table in a manner to prevent unsafe access by cognitively impaired residents with 5 residents nearby during 1 of 1 observations. The facility identified 26 residents as cognitively impaired and self-mobile. These failures resulted in possible endangerment for the residents, therefore causing an Immediate Jeopardy (IJ) to the health, safety, and security of the residents. The facility reported a census of 69 residents.

On April 19, 2023 at 12:45 p.m., the State Survey Agency informed the facility of the staff's failure to ensure a cognitively impaired resident would not elope from the facility creating an Immediate Jeopardy situation, which began on September 19, 2022.

The SA informed the facility they removed the immediacy on September 19, 2022, when the facility staff implemented the following Corrective Actions:
a. Turned the door annunciators back on.
b. Supervised the egress doors until the Maintenance Director assessed the 15 second delayed egress annunciators for functionality.
c. Initiated an immediate investigation, including staff and resident interviews.
d. Completed a visual head count of every resident to ensure all were present and safe.
e. Evaluated Resident #71 by a nurse, with no signs of trauma, harm or injuries, or further psychological impairment.
f. Re-evaluated all facility residents for elopement risk and updated care plans and elopement

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books.
g. Conducted staff education on elopement risk and procedures; elopement triggers; elopement response plans; monitoring of doors and ensured no one worked without education prior to the start of shift.
h. Conducted simulated elopement drills.
i. Completed a root cause analysis of the event.
j. Placed the resident on 1:1 supervision until door mechanics could be assessed.

After CMS review, the State Agency informed the facility on 5/28/23 at 11:00 a.m. that based on the identification of additional failures to provide adequate supervision, a current IJ situation existed related to the unsecured medications and access to the steam table. Therefore, another IJ template presented to the facility on 5/28/23.

The facility removed the IJ on 5/31/23 after taking the following actions:
a. lock/latch on the door to the kitchenette changed to ensure the door locked when it closed
b. locks on all medication and treatment carts changed on 5/31/23
c. no observations of the hazards or unsecured medications in rooms on 5/31/23.

The facility staff's actions lowered the scope and severity from a "K" to an "E" at the time of the survey, after the State Survey Agency verified the facility staff had implemented the education and additional corrective actions.

Findings Include:

1. The Minimum Data Set (MDS) Assessment Tool, dated 8/29/22, listed diagnoses for Resident

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#71 which included non-Alzheimer's dementia, unspecified dementia with behavioral disturbance, and anxiety disorder. The MDS documented the resident independent with transfers, and required supervision for walking and eating, extensive assistance of 1 staff for dressing, extensive assistance of 2 staff for toilet use and personal hygiene, and depended completely on 2 staff for bathing. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 1 out of 15, indicating severely impaired cognition and identified he had wandering behaviors 4-6 days out of the 7-day review period and stated his behaviors placed the resident at significant risk of getting to a potentially dangerous place.

An 8/23/22 Elopement Risk Evaluation stated the resident was currently actively exit seeking and was a high risk to elope.

A 9/6/22 Social Service Note documented facility staff called the resident's sister to discuss possibly having to find a different placement for the resident due to exit seeking behaviors.

A 9/12/22 Physician Note established the Nursing Staff reported on 8/23/22 that the resident stated he wanted to leave and be with his brother and that the resident tried to go out the doors twice "last night". The note stated staff discussed the possible risk for elopement and they would keep an eye on him.

A 9/19/22 1:45 p.m., a General Note indicated the resident sat quietly eating lunch and denied pain or the need for analgesia (pain medication) at this time.

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A 9/19/22 4:44 p.m., a General Note reported the resident got out of the facility and the Police were contacted. The note revealed the resident was found shortly after by a Certified Nursing Assistant (CNA) outside of the facility.

A 9/21/22 Physician Note documented the resident had an elopement on 9/19/22 and was found a few blocks away from the facility.

Care Plan entries, dated 9/19/22, stated the resident was an elopement risk and wanderer related to disorientation to place. The resident had a history of attempts to leave the facility unattended and had impaired safety awareness and wandered aimlessly. Further 9/19/22 entries stated the resident's safety would be maintained through the review date and directed staff to:
a. Distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books.
b. Monitor for fatigue and weight loss.
c. Provide structured activities such as toileting, walking inside and outside, and reorientation strategies including signs, pictures and memory boxes.
d. Identify a pattern of wandering.

The Care Plan lacked documentation of the resident's risk/history of eloping or interventions directed at the prevention of elopement prior to the 9/19/22 incident.

The National Weather Service Climatological Data retrieved from https://www.weather.gov/wrh/Climate?wfo=dvn on 4/19/23 listed the high and low temperatures on 9/19/22 as 83 degrees Fahrenheit and 63 degrees Fahrenheit.

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During a phone interview on 4/18/23 at 4:11 p.m., Staff I, CNA stated she remembered the resident leaving the facility. She stated while staff were in a meeting, the resident got out and they looked for him. Staff I stated she found him on Garfield and Davenport streets near the facility. She stated the resident was walking on the sidewalk and it was about an hour from the time they realized he was missing to the time they located him. Staff I stated they found him about a 5-minute walk away.

During a phone interview on 4/18/23 at 4:33 p.m., Staff J, former Director of Nursing (DON) stated when the resident eloped the door alarm was not engaged. She stated staff observed the door opened and immediately did a head count and noticed the resident was not there. She stated the B Hall door alarm was broken and had been intermittently problematic when she worked there. She stated because of Resident #71's past history, when the door was open, they immediately thought of him. The former DON stated the resident had exit seeking behaviors was constantly walking and he eloped from the Group Home he was at previously. She stated it was 30 minutes by the time they found him. She explained some interventions they utilized to address his wandering were redirection and maintaining a visual on the resident. The former DON reported the resident was in the "Elopement Book" which had his picture and basic information. She stated the Elopement Book was a tool used if someone eloped but would not prevent an elopement. She stated the doors were supposed to be locked and reported the facility staff requested a Wanderguard (a device which alerted when residents were near exits)

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multiple times because the resident should "absolutely" have one.

During an observation on 4/19/23 at 9:49 a.m., the Administrator demonstrated the door alarm mechanisms on the left hall door, right hall door, front dining room door, back dining room door, B Hall door, and A Hall door. The Administrator pushed on the door for 15 seconds and the door alarmed and the light turned red. In order to rearm the doors, the Administrator utilized a key. A receptionist sat next to the front door so the door was unarmed. She stated the door was armed when the receptionist was not present and required a code to be silenced.

During an interview on 4/19/23 at 7:45 a.m., Staff F Certified Medication Aide (CMA) stated prior to the resident's elopement he kept getting out and they brought him back in. She stated on the day of the elopement, she did not hear the alarm.

During an interview on 4/19/23 at 8:22 a.m., the Assistant Director of Nursing (ADON) stated if one pushed on the B hall door, the light would turn red and the alarm would be disabled. She stated staff did not rearm the door after the resident touched the door. The ADON reported prior to the elopement, the resident touched the door and they removed him and disabled the door but did not re-arm the door. She stated if the door was green, that indicated the door alarm was armed. She stated it was her practice to look at the doors and after the elopement, the facility completed education related to the door locks.

During an interview 4/19/23 at 10:05 a.m., the Administrator stated prior to the elopement, the resident was agitated and staff had disarmed the

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door but not rearmed it. She remarked it was staff error.

During an observation on 4/20/23 at 7:20 a.m., when the facility front door was pushed, it was locked and would not open.

During an interview on 4/20/23 at 9:13 a.m., Staff N, CNA stated she did not know how the resident got out of the facility but she heard a Code Silver. She stated staff were trying to figure out who eloped but she knew it was him because of his history of wandering.

During a phone interview on 4/20/23 at 9:44 a.m., Staff O, former Administrator stated the biggest concern he had with the resident was that he would pace. He explained the day before the elopement, the facility shut off the door annunciator due to complaints but stated the doors also had local alarms staff could still hear. He stated the resident left the facility and they completed a search and found the resident within the hour near a park sitting on some bleachers. The former Administrator stated if the door opened, the light at the top would turn red to indicate the door was not engaged. He stated a key was needed in order to re-arm the door and stated more than likely, the door opened prior to the elopement and staff failed to re-arm the door. After the elopement, he stated the facility turned the annunciators back on and completed staff education regarding elopement and door locks.

The undated facility document "Cognitively Impaired and Independently Mobile", provided on 4/25/23 listed 26 cognitively impaired and independently mobile residents.

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During an interview on 4/26/23 at 2:04 p.m., the Director of Nursing (DON) stated a resident's history of elopement and related interventions should be included on the Care Plan.

The facility policy "Elopements and Wandering Residents" reviewed 1/2023, stated the facility ensured that residents who exhibited wandering behavior and were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.

2. The MDS assessment dated 2/22/23 listed diagnoses for Resident #36 which included psychotic disorder, schizophrenia, and paranoid schizophrenia. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, indicating intact cognition.

A 10/6/21 Care Plan entry stated the resident had delusions and hallucinations.

During an observation on 4/13/23 at 10:39 a.m., Resident #36 sat in her wheelchair next to a small dresser. In the top dresser drawer, the resident had 2 medication cups containing approximately 5 pills each. The resident reached into one of the cups and consumed a blue pill. The resident stated that pill was for blood pressure and stated the other pills were mostly vitamins but pointed to other pills in the cups and stated one was for gout (a type of arthritis) and the others included metformin (used to treat diabetes), magnesium, and potassium. She stated one of the cups was from yesterday.

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On 4/13/23 at 10:50 a.m., the Administrator was aware that the resident had 2 pill cups in her drawer.

A 4/13/23 3:48 p.m., a General Note stated the resident requested for her vitamins to be left at bedside and stated the resident was alert and oriented and able to make her own decisions.

A 4/13/23 Medication Self-Administration Evaluation stated the resident was deemed able to safely self-administer medications. The resident's clinical record lacked an evaluation completed prior to 4/13/23.

A Care Plan entry, dated 4/14/23, directed staff to complete a self-administration of medication assessment. The Care Plan lacked prior documentation regarding the self-administration of medications.

The facility policy "Resident Self-Administration of Medication", reviewed January 2023, stated the facility would evaluate residents to determine if they could self-administer safety.

During an interview on 4/25/23 at 1:00 p.m., the Director of Nursing (DON) stated the resident could only have her vitamins at bedside and stated she observed the resident's 2 cups containing other medications.

3. The MDS Assessment dated 2/5/23 revealed Resident #24 scored 15 out of 15 on a BIMS exam, which indicated cognitively intact.

During an observation on 4/18/23 at 1:01 PM, medications found in a pill cup on Resident #24's

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bedside table. The medication cup had 1 brown capsule, 1 oval tablet and 3 small round tablets in it. Resident #24 stated he was getting ready to take them. Resident #24 queried if staff left medications on his table often and he stated 99% of the time they brought them and left them on the table. Resident #24 asked if he knew what the medications in the cup were and he stated he knew one pill was gabapentin (nerve pain med) and wasn't sure about the other pills. Resident #24 stated he waited for his milk to take the pills. Resident #24 proceeded to open his milk carton and took the pills in the medication cup.

Resident #24 had a Self-Administration of Medications Assessment completed on 9/16/21 and 2/4/22 and both assessments indicated Resident #24 not capable of storing medications in a secured area and not capable of opening or closing medication containers.

The Care Plan dated 3/24/23 failed to reveal any documentation on Self-Administration of medications.

The April MAR (Medication Administration Record) included the following medications:
a. Acetaminophen (Tylenol) 325 mg tablet
b. Buspirone (antianxiety med) 7.5 mg tablet
c. Furosemide (diuretic med) 20 mg tablet
d. Gabapentin 400 mg tablet
e. Magnesium oxide tablet 400 mg tablet
f. Spironolactone (diuretic med) 25 mg tablet
g. Tamsulosin (treats urinary symptoms) 0.4 mg capsule

During an interview on 4/18/23 at 1:26 PM, Staff AA, Certified Medication Aide (CMA) queried if the facility had any residents who

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Self-Administered their medications and she stated no, that is why the facility had Medication Aides and Nurses. Staff AA asked if she watched the residents take their medications and she stated yes, we watch them. Informed Staff AA medications were found on Resident #24 bedside table and Staff AA stated he supposed to take them with milk and she put them on the table to get him milk and planned on coming back and forgot because she doing something for another resident. Staff AA informed Resident #24 had milk and she queried if she watched Resident #24 take his pills and Staff AA stated no, she didn't watch him, she forgot to and she knew they were supposed to watch the residents take their medications.

During an interview on 4/24/23 at 4:01 PM, the DON queried if anyone in the facility Self-Administered medications and she stated Resident #15 could Self-Administer her lactase and Resident #36 issued a locked box for her vitamins and self administered her vitamins. The DON asked what the expectations of medication administration for the nurses and CMA's and she stated don't pre-pop the medications, watch the residents take their medications, take vitals when indicated, and medications not be left at the bedside.

The Facility Policy titled Medication Administration dated 3/2023 indicated the following:
a. Observe resident consumption of medication.

4. During an observation on 4/12/23 at 2:48 PM, a Medication Cart left unlocked in the dining hall when staff delivered medication to resident in the dining hall. Observed a resident pass in a

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wheelchair by the unlocked cart.

During an observation on 4/13/23 at 7:51 AM, Staff BB, Registered Nurse (RN) walked down Hall B with the Treatment Cart unlocked and stated he needed to get a computer and walked away from the Treatment Cart and left it unlocked.

During an observation on 4/13/23 at 7:53 AM, Staff BB returned to the cart and looked for blood glucose paperwork and stated he grabbed the wrong paper and walked away from the unlocked cart and walked into the dining room and retrieved the papers and returned to the cart. Staff BB prepared the insulin for the resident and went into the resident's room and left the insulin vial and insulin pen on top of the treatment cart and left the cart unlocked in the hallway. Staff CC, Licensed Practical Nurse (LPN) observed in the hallway with her back turned to the Treatment Cart and residents in the hallway in their wheelchairs.

During an observation on 4/13/23 at 8:09 AM, Staff BB prepped insulin for another resident and left the insulin vial and insulin pen on top of the Treatment Cart and left the cart unlocked when he went into the resident's room to ask the resident if he wanted his fast-acting insulin. The cart observed sitting in the hallway 2 doors down from the resident's room.

During an interview on 4/13/23 at 8:13 AM, Staff BB queried if the Treatment Carts expected to be locked and he stated yes, the carts are supposed to be locked. Staff BB stated he guessed he had left it unlocked. He stated they had a lack of keys. Staff BB asked if medications were supposed to

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be secured in the carts and he stated yes, and he walked back to the cart to check. Staff BB informed he had left the insulin vials and pens on top of the cart when he administered the medications and Staff BB did not respond.

During an observation on 4/13/23 at 8:16 AM in Hall B, Staff BB drew up insulin and went into a resident's room and left the insulin vial on top of the cart and left the cart unlocked.

During an interview on 4/13/23 at 8:25 AM, Staff CC, LPN queried if medication carts are supposed to be locked and she stated yes, unless you are pulling or popping pills. Staff CC asked if the facility was short on keys and she stated she didn't know, she just started, maybe so.

During an observation on 4/13/23 at 9:52 AM in Hall A, Treatment Cart #1 left unlocked between rooms A 5 and A 7. Observed Staff DD, Certified Medication Aide (CMA), down the hall two doors looking at the computer on her Medication Cart. The following observations made with the unlocked Treatment Cart:
a. At 9:55 AM, staff walked by the cart and didn't lock the cart. A resident in an electric wheelchair circled around the cart.
b. At 10:04 AM, staff walked by the cart and asked Staff DD where to locate Staff BB and looked at the treatment cart and walked away.
c. At 10:16 AM, resident wheeled by the unlocked treatment cart.
d. At 10:17 AM, Staff DD wheeled her Medication Cart past the treatment cart and didn't lock it.
e. At 10:21 AM, resident wheeled by the treatment cart in their wheelchair.
f. At 10:22 AM, surveyor opened the cart and

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observed insulin and syringes found in the drawers.
g. At 10:46 AM, Staff BB, approached the Treatment Cart and moved it next to the Medication Cart by room A 3 and opened the drawers and pulled up medication into a syringe.
h. At 10:48 AM, Staff BB went into a resident's room with syringe and left the cart unlocked and the 3rd drawer slightly opened on the cart.

During an observation on 4/13/23 10:50 AM, found a set of keys left on the Treatment Cart in B Hall. At 10:51 AM. Staff DD, CMA picked up the keys off the cart.

During an interview on 4/13/23 at 10:52 AM, Staff DD queried who the keys belonged to that she picked up and she stated she believed the keys belonged to one of the nurses and not supposed to be left on the cart so she snatched them up. Staff DD asked what the keys unlocked and she stated she didn't know, but thought the Treatment Carts and something else.

During an interview on 4/13/23 at 2:11 PM, Staff BB queried if he had keys in his pocket and he stated yeah. Staff BB informed a pair of keys found on the Treatment Cart and he pulled out the keys from his pocket and stated his keys went to the utility room. Staff BB asked if the keys unlocked the Medication or Treatment Carts and he stated no, he didn't even know what most of the keys on the chain went to. He stated he was the A and B Hall Nurse and when he needed to do treatments he went to someone else to get the keys for the carts because they were short on keys. Staff BB queried why they were short on keys and he stated the Medication and Treatment keys are on the same key chain and if he needed

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something he would need to go to the Nurse or the Medication Aide for their keys.

During an observation on 4/18/23 at 2:51 PM, the Medication Cart left unlocked in the dining hall. Staff EE, Activity Director with her back to the cart sat at a table with 9 residents and another staff member. Three other residents observed at tables in the dining area.

During an observation on 4/18/23 at 2:53 PM, Resident #70 wheeled by the Medication Cart and spoke to a staff member right next to the cart.

During an observation on 4/18/23 at 2:55 PM, Staff EE walked out of the dining area, another staff member walked into the dining area and sat behind the Nurse's Station with a computer monitor and counter between the staff member and unlocked Medication Cart.

During an observation on 4/18/23 at 2:56 PM, the DON walked by the cart and then turned around and stood in front of the cart and locked the Medication Cart.

During an interview on 4/24/23 at 4:01 PM, the DON queried about the expectations of medication and treatment carts being locked and she stated they should be locked at all times. The DON asked about the expectations of key control and she stated the Medication Aides had their own set of keys and the nurses had their own keys. The DON queried if the facility was short on keys and she stated she knew that one set of keys for A Hall had the Medication Cart and Treatment Cart keys and at one time the Assistant Director of Nursing (ADON) requested more keys for the carts. The DON stated she had

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F 689	Continued From page 140 the master keys for the carts. The undated document named "Cognitively impaired and independently mobile" provided by the Administrator revealed 26 residents cognitively impaired and independently mobile. The Facility Policy titled Medication Storage dated March 2022 revealed the following: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel accessed to the keys to locked compartments. c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. 5. Observation on 4/12/23 at 11:50 AM, revealed the North kitchenette keypad door had been open. The door was noted to be left open 4-6 inches and the commercial steam table was left on. No facility Dietary or Nursing Staff observed in the North Dining room area. Noted approximately five residents, both ambulatory and able to propel a wheelchair within five to ten feet of the open door.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is	F 690		

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F 690	Continued From page 141 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review and facility policy review the facility failed to have Physician's Orders for the placement of indwelling catheters 2 out of 3 resident reviewed (Resident # 11 and # 49). The facility failed to have 1 out of 3 resident's catheter tubing secured off the floor (Resident #33). The facility reported a census of 69 residents.	F 690		

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Findings Include:

1. The Minimum Data Set Assessment (MDS) for Resident #33 dated 1/25/23, included diagnosis of diabetes mellitus(DM), and rheumatoid arthritis. The MDS listed Resident # 33's Brief Interview for Mental Status score as 11 out of 15, indicating moderately impaired cognition. The MDS indicated Resident #33 required extensive assist of 1 staff for toileting and personal hygiene. The MDS identified a catheter placed for Resident # 33.

The Care Plan for Resident #33 dated 12/23/22, reflected Resident #33's indwelling catheter placed related to fluid retention at recent hospitalization. The Care Plan directed position catheter bag and tubing below the level of the bladder and away from entrance room door. Monitor, record, report to Physician signs or symptoms of urinary tract Infection (UTI): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse,increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.

Updated Care Plan dated 12/30/22, Resident #33 will show no signs or symptom of Urinary infection through review date.

Resident #33's Care Plan dated 7/19/21, reflected a history of dehydration/fluid deficit related to a history of UTI and poor oral intake.

Staff G, Advanced Registered Nurse Practitioner (ARNP), Physician Note dated 4/13/23, reflected UTI. Hospital course - Urine culture grew Aerococcus urinae (a rare organism isolated from

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urine cultures). On 2/13/23 saw by Urology, who stated they could not proceed with her cystoscopy (a procedure that allows your doctor to examine the lining of your bladder and the tube that carries urine out of your body) due to having high suspicion for active UTI. Recent urine culture positive for 2 bacteria that were both susceptible to Macrobid. The note continued on 2/17/23 the Urology office faxed over recent urine culture results showed Klebsiella pneumoniae (bacteria), e.coli (bacteria) and actinotignum schaalii (bacteria), ESBL (enzymes produced by some bacteria that may make them resistant to some antibiotics) positive. Susceptible to Gentamycin. The Urologist ordered Gentamycin 80 milligrams (mg) intramuscular (IM) everyday for 5 days.

The facility Matrix provided on 4/11/23, reflected Resident #33 with an active UTI.

The Medication Administration Record (MAR) dated 4/23, directed Cephalexin Oral Tablet 250 milligrams (mg), give 1 tablet by mouth at bedtime for UTI.

On the following days noted the catheter tubing for the resident dragging on the floor:
a. On 04/11/23 at 1:05 PM, Resident #33 sat in her wheel chair (w/c) with 10 inches of her catheter tubing sitting on the floor under her.
b. On 4/11/23 at 2:51 PM, Resident #33 sat in her w/c in the lunch room next to a table with 4-6 inches of her catheter tubing drug on the floor under her w/c as she took herself back down to her room (approximately 100 feet).
c. On 4/12/23 at 1:03 PM, Resident #33 wheeled herself into the dining room and up to the table by the restroom door as 8 inches of her catheter tubing drug on the floor under her w/c. Resident

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#33 lacked a dignity bag over her catheter bag under the w/c. The catheter bag held amber urine.
d. On 4/13/23 at 7:45 AM, Resident #33 sat in her w/c in the dining room while 4 inches of her catheter drug on the floor under her w/c and she moved he feet.
e. On 4/13/23 at 8:37 AM, Resident #33 propelled herself in the wheelchair in A hallway to dining room as her catheter tubing drug on the floor. As Resident #33 moved herself back and forth at the table in her w/c her catheter tubing drug back and for on the floor.
f. On 4/13/23 at 9:04 AM, Resident #33 walked herself in the w/c from the edge of the A hall to the kitchen doorway asked staff for coffee as 5 inches of the catheter tubing drug on the floor under her w/c. Resident # 33 moved herself back to her seating spot in the dining room.
g. On 4/13/23 at 11:35 AM, Resident #33 wheeled herself from the nurses station by A hall, into her room as her catheter tubing drug on the floor under her w/c.
h. On 04/13/23 at 1:09 PM, Resident #33's catheter bag hung on the grab bar on the right side of her bed above the height of her shoulder as she laid in the bed.
i. On 04/17/23 at 11:52 AM, Resident #3 sat at an activity while 8 inches of her catheter tubing sat on the floor under her.
j. On 04/17/23 at 1:00 PM, Resident #33 sat at the dining room table as 8 inches of her catheter tubing sat on the floor under her. The facility failed to utilize a dignity cover over Resident #33's catheter bag under her w/c in the dining room.
k. On 4/18/23 at 12:37 PM, Resident #33 sat in her w/c in her room as the room door sat open, her catheter bag laid flat out on the floor.

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Resident #33 wheeled herself over the catheter bag that laid on the floor.

On 4/18/23 at 12:42 PM, Staff DD, Certified Medication Aid (CMA), placed Resident #33's catheter bag in a dignity bag.

On 4/18/23 at 12:42 PM, Staff DD stated she just emptied the catheter bag. Staff DD, reported staff are expected to keep catheter tubing off the floor.

On 04/18/23 at 2:15 PM, the Director of Nursing (DON) stated her expectation is catheter tubing is up off the floor and not drug all over the building. She stated she expected all catheter bags covered with a dignity bag.

The facility provided titled Catheter Care dated 3/2023, documented the following directive:
It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.
Policy Explanation:
a. Catheter care will be performed every shift and as needed by nursing personnel.
b. Privacy bags will be available and catheter drainage bags will be covered at all times while in use.
c. Privacy bags will be changed out when soiled, with a catheter change or as needed.
d. Leg bags may be used for ambulatory residents or per resident request.
e. Legs bags may be worn during the day, but need to be removed and a bedside drainage bag replaced on the catheter at night.
f. Legs bags will be attached to the resident ' s thigh or calf making sure to have slack on the

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tubing to minimize pressure and tension. Ensure straps are snug but not tight.
g. Leg bags may be stored in a clean, plastic bag when not in use or as per facility policy.
h. Empty drainage bags when bag is half-full or every 3 to 6 hours.
i. Ensure drainage bag is located below the level of the bladder to discourage backflow of urine.

The facility policy failed to address the storage of the catheter tubing.

2. The MDS dated 3/14/23 identified Resident #11 as cognitively intact with a BIMS score of 15 out of 15, and identified with the following diagnoses: Atrial Fibrillation, UTI and Diabetes Mellitus. The MDS identified the resident required extensive staff assistance with all activities off daily living (ADL's)) except for eating and that he had an indwelling catheter.

Observations of the resident revealed the following:
a. On 4/11/23 at 11:25 AM lying in his bed with a Foley (indwelling catheter) bag below bladder which had not been placed in a dignity bag.
b. On 4/11/23 at 1:10 PM asleep in bed with the Foley bag that remained without a dignity bag.
c. On 4/11/23 at 2:23 PM assessment unchanged
d. On 4/12/23 at 10:30 AM asleep in bed with Foley bag which remained without a dignity bag and visible to anyone walking into his room.
e. On 4/12/23 at 11:15 AM assessment unchanged.
f. On 4/12/23 at 12:20 PM sitting up in bed eating lunch, Foley bag remains without dignity bag visible to anyone walking into his room, door to room cracked open

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The hospital discharge summary dated 3/8/23 revealed documentation that the resident had a chronic indwelling Foley.

A review of the current Physician Orders did not have orders for indwelling catheter.

On 4/5/23, the Care Plan identified the resident with the problem of an indwelling catheter (the resident had been admitted to the facility on 3/8/23)
Interventions had been documented as follows:
a. Catheter: last changed: (Specify Date). Change catheter (frequency). (Specify Size) (Specify Type) Date Initiated: 04/05/2023
b. Catheter: The resident has (Specify Size) (Specify Type of Catheter).
c. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Date Initiated: 04/05/2023.
The Care Plan did not address the size and type of catheter and how often to change the catheter.

3. The MDS dated 4/10/23 identified Resident #49 as cognitively intact with a BIMS score of 15 out of 15 and had the following diagnoses: Multiple Sclerosis, neurogenic bladder and paraplegia. It also identified the resident required extensive staff assistance with repositioning in bed, and totally dependent on staff for bathing.

Observations of the resident revealed the following:
a. On 4/11/23 at 12:09 PM sitting up in power chair with the Foley which had not been placed in a dignity bag.
b. On 4/11/23 at 1:16 PM sitting up in power

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chair, assessment unchanged.
c. On 4/11/23 2:11 PM sitting up in power chair with Foley bag which remained without a dignity bag.
d. On 4/12/23 at 3:36 PM, during an observation of wound care, the Foley bag had not been placed in a dignity bag and found lying on the floor along with the Foley tubing also on the floor.
e. On 4/13/23 7:21 AM asleep in bed, door to room wide open. Foley bag below bladder in full view of anyone walking past the room and not in dignity bag. No tubing noted on the floor.
f. On 4/13/23 8:36 AM assessment unchanged
g. On 4/13/23 9:15 AM Foley bag remains in full view of anyone walking by his room as door wide open, not in dignity bag, no tubing on the floor.
h. On 4/17/23 8:10 AM sitting up in bed, holding wound vac and Foley bag (not in dignity bag) over his groin area. Properly positioned and appears comfortable.

On 2/20/23 the Care Plan identified the resident with the problem of having an Indwelling Foley Catheter: size - 14FR (French)/10 cubic centimeters (cc) with interventions to position catheter bag and tubing below the level of the bladder and away from entrance room door.

The Hospital Discharge Summary dated 4/3/23 revealed documentation that the resident had a neurogenic bladder with chronic indwelling urinary catheter

A review of the current Physician Orders revealed no orders for the indwelling catheter.

In an interview on 4/19/23 at 10:02 AM, Staff H, Nurse Practitioner reported the following:
1. Residents with indwelling catheters should

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F 690	Continued From page 149 have physician orders to include: monitor I&O, empty the catheter, size of the catheter and type and peri care 2. When asked why Resident #11 and #49 did not have orders for their Foley catheters, she reported the facility had an admissions nurse here in charge of double checking all admission orders and she was terminated 4 to 6 weeks ago. She also reported none of the floor nurses knew how to put in admission orders in, they only put in orders for medications in the computer. A review of the facility policy titled: Catheter Care and dated as last revised January 2023 did not have documentation to address the need to obtain a physician order for an indwelling catheter.	F 690		
F 692 SS=J	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 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;	F 692		

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§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 observations, staff interviews, clinical record review, and policy review, the facility failed to address a resident's significant weight loss of 41 pounds or a 13.59% weight loss in 35 days (Resident #61). Resident #61 received 51% or more of his calories and 501 cc (cubic centimeters) per day or more of fluid intake via tube feeding. The facility also failed to notify the physician of residents' significant weight loss, seek orders to address the weight loss, and follow physician ordered interventions that addressed the loss for 2 residents (Resident #25, #45). The failure resulted for 3 of 7 residents reviewed for significant weight change and this situation resulted in an immediate jeopardy to health and safety of the residents. The facility reported a census of 69 residents.

The State Agency notified the facility of the IJ on 5/28/23 at 11:00 a.m. The IJ began on 3/3/23 with the first failure to notify the physician of Resident #45's significant weight loss.

The facility abated the IJ on 6/5/23 by assessing all resident ' s current weights, reviewing weight histories and identifying residents with significant weight loss or at risk for significant weight loss, reviewing and revising physician orders related to diet and interventions specific to residents at risk for weight loss, and education to dietary staff to follow orders as directed and specified on each resident ' s meal ticket at every meal.

The facility staff's actions lowered the scope and

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severity from a "J" to a "D" at the time of the survey, after the State Survey Agency verified the facility staff had implemented the education and additional corrective actions.

Findings Include:

1. The Minimum Data Set (MDS) Assessment Tool, dated 3/15/23, listed diagnoses for Resident #61 which included malnutrition, morbid obesity, and weakness. The MDS documented the resident required supervision assistance with eating and listed the resident's cognition as moderately impaired. The MDS listed the resident's weigh as 312 pounds (lbs).

A 3/2/23 Hospital History and Physical listed the resident's weight as 142 kilograms (kg) or 313 lbs.

A 3/28/23 Hospital Discharge Summary listed the resident's weight as 156.2 kg or 344 lbs.

The resident's Weights Summary listed the following weights:
a. On 3/1/23: 303.2 lbs.
b. On 3/10/23: 312.4 lbs.
c. On 4/5/23: 262.0 lbs (crossed out on 4/19/23 and reweighed).
d. On 4/19/23: 287.2 lbs.

The resident's weight loss during the period of 3/1/23-4/5/23 calculated as a 13.59% loss.

The facility lacked documentation of Physician Notification or additional interventions related to the resident's significant weight loss from the resident's weight on 4/5/23 and 4/19/23.

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Care Plan entries, dated 3/30/23, documented the resident was at risk for malnutrition related to recent critical illness and stated the resident would maintain adequate nutritional status as evidenced by maintaining weight within 5% current body weight. The entries documented the resident received nothing by mouth (NPO) and directed staff to provide the ordered enteral (referring to via the stomach/intestinal tract) feeding of Jevity 1.5 cal (a nutritional feeding) 360 milliliters (ml) with 50 ml water before and after three times daily.

A 3/30/23 Nutrition Evaluation listed the most recent weight as 312.4 lbs on 3/10/23 and stated the resident was at risk for malnutrition with the goal to maintain current body weight. The Evaluation recommended increasing the tube feeding order to better meet estimated needs: Jevity 1.5 cal, 360 ml 5 times per day.

A 4/3/23 order directed staff to weigh the resident weekly every Thursday. The facility lacked documentation of a weight obtained between 4/5/23-4/19/23.

During an observation on 4/18/23 at 10:36 a.m., Staff BB Registered Nurse (RN) administered a bolus (single dose) of Jevity 1.5 360 ml per the resident's G-tube (gastrostomy tube-a type of feeding tube).

During an interview on 4/18/23 at 10:01 a.m., Staff G, Nurse Practitioner (NP) stated she was not aware of the resident's weight loss. She stated he needed a re-weight and would like to know about such losses. She stated in the past, the facility did not complete weights in a timely

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manner.

During an interview on 4/25/23 at 1:00 p.m., the Director of Nursing (DON) stated from now on staff should provide her the list of weights for review. She stated if someone had a weight loss, the facility would speak to the Registered Dietician and possibly talk to psychiatric services. She stated they would reweigh the resident. She stated she would review Resident #61's weight and look at adjusting his caloric intake.

In an interview on 4/26/23 at 2:04 p.m. the DON stated she thought the resident's weight was an error so they completed a reweigh.

The facility policy "Weight Monitoring" revised March 2023, documented the facility would ensure all residents maintained acceptable parameters of nutritional status such as usual body weight. The policy defined a significant change in weight as 5% in 30 days, 7.5 % in 90 days, or 10% in 180 days.

2. The 5/24/23 Minimum Data Set (MDS) Assessment revealed Resident #25 had diagnoses that included congestive heart failure, hypertension (high blood pressure), cerebrovascular accident (a stroke) with hemiplegia (paralysis on 1 side of the body) and malnutrition, required extensive assistance from at least 1 staff for transfers to and from bed or chair, dressing and toileting, non-ambulatory and set-up assistance required for eating. The assessment reported the weight 181 pounds and not identified as a significant change in the last month, described as a change of 5 percent body weight, or a 10 percent change of body weight in

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the last 6 months.

The resident's weights, recorded in pounds, revealed:
9/3/22 193.7
10/1/22 194.9
11/4/22 192.6
12/2/22 198.8
1/2/23 199.5
2/14/23 197.2
3/7/23 193.1
4/3/23 187.5
5/4/23 180.5
6/1/23 175.9
The 6/1/23 weight indicated a 11.52 percent weight loss for 6 months and a significant weight loss.
,
Physician orders directed staff:
2/21/23 Provide Ensure Plus twice daily for risk of malnutrition.
3/9/23 Provide a regular diet, soft and bite sized texture, add gravy/sauce on meats. Needs assist with all meals.

A Swallowing Deficit related to Dysphagia (difficulty or inability to swallow) problem initiated 10/29/22 on the nursing care plan directed staff:
Follow prescribed diet, initiated 10/29/22.
Monitor for shortness of breath choking, labored respirations or lung congestion, initiated 10/29/22.
Monitor/document/report any signs or symptoms of dysphagia that included pocketing food, choking, coughing, drooling, several attempts at swallowing, refusing to eat or appears concerned during meals, initiated 10/29/22.

A Progress Note transcribed by the facility's Registered and Licensed Dietician (RDLD) on

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4/13/12 at 2:35 p.m. stated significant weight change note, Albumin 2.7, a low value, on 2/23/23 (a measurement of serum protein level), resident received regular diet, soft and bite sized texture (consistent with mechanical soft texture), Ensure Plus (liquid supplement) provided twice daily, extra nourishments provided through snacks and activity attendance. Meal intake variable from 25 to 100 percent, feeding ability ranged from independent to limited assistance. Significant weight loss for 30 days, unplanned/undesired with etiology likely related to possible need for feeding assistance at meals. Observed at lunch and half of meal was eaten with food found on his shirt. When asked if he needed help with eating he said "yes". Spoke with nursing about administration of supplement. Education provided to offer and encourage this drink twice daily and not to be given at meals. It is my belief that either this has not been given as ordered or was refused by the resident. Will trial this and see if albumin improves.
The RDLD's recommendations described in the Progress Note included continue the current diet order, please elaborate to have gravy/sauce on meats and starch, request order for assistance at meals, request order for protein snacks, request Speech Therapy (ST) to evaluate and treat, request vitamin D, folate and vitamin B12 lab levels, request multiple vitamin with mineral supplement administered oral daily.
The RDLD summarized the information transcribed in the Progress Note in an email transcribed at 7:24 p.m. on 4/13/23 and send to the Administrator, Director of Nursing (DON) and Certified Dietary Manager (CDM).
Progress Notes transcribed by the Advanced Practice Registered Nurse Practitioner (ARNP) on 4/14/23, 4/19/23, 4/21/23, all that describe a

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physical assessment of the resident, made no mention of the resident's significant weight loss or notification of such.

The planned Soft & Bite Sized menu for the 5/31/23 evening meal included:
6 ounces Vegetable Soup
3 ounces Barbequed Chicken
4 ounces Baked Beans
4 ounces Mashed Potatoes

Observations on 5/31/23 between 6:18 p.m. and 6:37 p.m. revealed Staff R, Cook, plated the evening meal from the steam table in the North Kitchenette, and did not utilize resident tray tickets or resident information diet cards for reference to plate the meals
Observations 5/31/23 at 6:29 p.m. revealed the resident received 4 breaded Chicken Nuggets (not Barbequed), French Fries, Baked Beans, ketchup used for the French Fries, no other gravy or sauces observed and feeding assistance not provided.
During an interview 6/1/23 at 12:42 p.m., the facility's RDLD stated she observed the resident during a meal without feeding assistance, the resident had spilled food on his chest area, she asked him if he needed assistance with eating and he stated that he did. The RDLD stated she communicated her findings and recommendations to key facility staff via email for documentation purposes, and dietary staff should follow physician orders and directives for resident diet and nutrition orders.

On 6/5/23 at 9:09 a.m., the facility was asked to provide documentation that the physician was notified of the identified weight loss and the RDLD's recommendations, and could not provide

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the documentation as of the survey exit on 6/5/23.

Other staff interviews related to weight loss:
On 6/2/23, administrative staff at the Iowa Department of Inspections & Appeals notified the facility Administrator that she had to provide an updated list of resident weights, completed between 6/1/23 and 6/4/23, to the Nurse Surveyor assigned on the morning of 6/5/23.
During an interview 6/5/23 at 9:58 a.m., the facility RDLD provided a list of June, 2023 weights for 49 residents, and stated she thought there were 15 residents without an updated weight at that time.
During an interview 6/5/23 at 2:53 p.m., the facility Administrator and interim Director of Nursing provided an updated June, 2023 weight list for 63 residents and stated they had just obtained the last resident weight.

3. The 3/15/23 MDS Assessment revealed Resident #45 had diagnoses that included hypertension (high blood pressure), a cerebrovascular accident (a stroke), Parkinson ' s disease, diabetes and dysphagia (difficulty or inability to swallow), required extensive assistance of at least 1 staff for transfers to and from bed and chair, dressing and toileting, non-ambulatory, and supervision with 1 staff assist required for eating. The MDS Assessment revealed the resident ' s weight 178 pounds and a significant weight loss of 10 percent or more in 6 months.

The resident's weights, recorded in pounds, revealed:
9/3/22 209.8

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10/1/22 181.8
11/4/22 186.4
12/6/22 184.4
1/9/23 181.9
2/14/23 179.4
3/3/23 177.7
4/13/23 178.4
5/3/23 179.4
6/5/23 179.8
The 3/3/23 weight represented a 15.3 percent loss in 6 months and a significant weight loss.

Physician orders directed staff:
3/9/23 Serve a Controlled Carbohydrate Diet (CCD), No Added Salt (NAS), regular texture, large portion diet.
11/15/22 Serve 4 ounces of House Supplement (Mighty Shakes) 3 times daily with meals.

Resident #45's record revealed the last assessment and note transcribed by the facility's RDLD was on 1/19/23, the former RDLD prior to 4/1/23. Resident #45's record lacked documentation the physician was notified of the significant weight loss in March, 2023, or any additional interventions implemented as a result of the documented weight loss.

A Nutritional Problem related to Diabetes, Parkinson's disease and need for therapeutic diet and supplementation problem initiated 8/18/21 on the Nursing Care Plan directed staff:
Weigh per physician orders, initiated 3/20/23.
Monitor/document/report any signs or symptoms of dysphagia that included pocketing food, choking, coughing, drooling, several attempts at swallowing, refusing to eat or appears concerned during meals initiated, initiated 8/18/21.
Provide and serve diet as ordered, initiated

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F 692	Continued From page 159 8/18/21. Provide and serve supplements as ordered: Sugar Free Might Shakes times a day, initiated 11/14/22. RDLD to evaluate and make diet change recommendations as needed, initiated 11/14/22. Report to physician signs or symptoms of malnutrition that include muscle wasting, significant weight loss of 5 percent or more in 1 month, or 10 percent or more in 6 months, initiated 8/18/21. The facility's planned CCD menu for the 5/31/23 evening meal included: 6 ounces Vegetable Soup 3 ounces Barbequed Chicken 4 ounces Baked Beans 4 ounces French Fries Observation on 5/31/23 at 6:10 p.m. revealed Resident #45 seated in the Dining Room, received 4 ounces of Baked Beans, plate approximately ½ covered with French Fries and 3 pieced of Barbequed Chicken, each approximately 3 inches in length, 1 inch in width, with heavy breading/coating and bone inside each piece. Observation in the kitchen on 5/31/23 at 6:50 p.m. with the facility's Chief Clinical Officer revealed 2 pieces of Barbequed Chicken, that included the breading and bone, weighed 2.5 ounces. During an interview 5/31/23 at 6:31 p.m., Staff R, Cook, stated 4 pieces was the regular serving size of Barbequed Chicken.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		

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F 695	Continued From page 160 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff and resident interviews, the facility failed to provide administered oxygen and other respiratory treatments in accordance with Provider Orders and each resident's individual Care Plan for 3 of 6 residents reviewed (Residents #12, #46 and #48) . The facility had reported a census of 69. Findings include: 1. Review of Resident #12 Minimum Data Set (MDS) dated 1/20/23, listed the resident with a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating the resident with intact cognition. Resident #12 used a manual wheelchair and had been dependent on staffs for toileting, picking up dropped objects from the floor, and needed substantial assistance rolling side to side while lying in bed. The MDS listed Resident #12 with active medical diagnosis of sleep apnea, chronic obstructive pulmonary disease (COPD), and oxygen dependent. Resident #12's Care Plan dated 2/12/23 included	F 695		

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COPD interventions, but failed to include oxygen as ordered by the residents' provider. The Care Plan listed Resident #12 with Advance Directives in place that included if respiratory breathing stopped, then staff needed to proceed with full respiratory resuscitation. The Care Plan further identified the resident with a focus area of sleeplessness and insomnia which had included interventions, however failed to identify oxygen needs. The Care Plan identified a focus area that stated the resident had oxygen therapy related to congestive heart failure. The intervention listed had been to apply 3 liters humidified oxygen by nasal prongs/nasal cannula. The Care Plan failed to identify any respiratory diagnosis for oxygen.

Review of the Electronic Health Record (EHR) on 4/11/23, shown the Advanced Registered Nurse Practitioner (ARNP) ordered on 2/9/23 for Resident #12 to have nightly BIPAP (Non-Invasive Mechanical Respiratory Ventilator); therapy with IPAP of 25, EPAP 13 using full face mask and heated humidifier (reference to machine settings), bleed daytime oxygen into machine, use at bedtime and during naps.

An observation on 4/12/23 at 2:00 PM, shown Resident #12 lying in bed without the head of bed elevated and no BIPAP machine observed at the bedside. The resident had an oxygen concentrator at the bedside with oxygen tubing connected to the oxygen concentrator, however Resident #12 observed not wearing the oxygen.

Again, on 4/13/23 at approximately 9:30 AM, Resident #12 observed lying in bed without the head of bed elevated and no BIPAP machine observed at the bedside, with an oxygen concentrator at the bedside with oxygen tubing

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connected to the oxygen concentrator at the bedside however Resident #12 observed not wearing the oxygen. The oxygen concentrator observed to not be on.

Further observation on 4/13/23 at 10:41 AM, shown Resident #12 sitting in a wheelchair in the North Dining Room. Staff BB, Registered Nurse (RN) observed removing an oxygen tank from the back of Resident #12's wheelchair and placing a new oxygen tank into the wheelchair. Staff BB then observed turning the oxygen tank on and assisting Resident #12 to place the oxygen nasal cannula in her nares.

An observation of Resident #12 on 4/17/23 at 7:24 AM, shown the resident lying on her left side in bed, dressed in a hospital gown, and oxygen on at 2 liters per nasal cannula per the oxygen concentrator and no BIPAP machine observed at the bedside.

During an interview on 4/17/23 with Staff E, Licensed Practical Nurse (LPN) at 7:30 AM, the residents respiratory orders reviewed. Staff E stated being unaware of Resident #12's BIPAP orders when asked why the machine had not been in the residents' room. Staff E also reviewed the EHR and the Electronic Medication Administration Record (EMAR)and shown facility staff repeated daily documentation of the number 9 at 8:00 P.M. on the EMAR. The directions on the form instructed staff when the number 9 charted there should have been a note in the EHR progress note why, but no explanations were found.

During an interview with the Resident #12 on 4/17/23 at 8:50 AM, the resident had

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acknowledged completing testing for sleep apnea however when asked about a BIPAP machine the resident stated there had not been a machine for her to try. The resident further stated utilizing oxygen when needed however not using oxygen at all times.

During an interview on 4/17/23 at 4:05 PM, the facility Director of Nursing (DON) and Assistant Director of Nursing (ADON) discussed Resident #12's BIPAP. The DON and ADON had both verbalized the resident had not wanted to use the BIPAP. When asked if the BIPAP machine had been obtained then the ADON had stated, yes. The ADON had further stated the BIPAP machine had been rented and had been removed from the resident room and moved to an office within the facility for security reasons. When asked further questions about the order being current then the ADON had stated no knowledge of the order being current. When asked if the provider made aware of the resident refusal to use the BIPAP, the DON and ADON stated the Nursing Staff would have to let the provider know. The DON and ADON asked where the Provider Communication would be located, then both stated in the EHR Progress Note Section. The DON and ADON made aware there no Provider Communication found and there had been no communication by Nursing Staff when a daily 8:00 PM documentation of number 9 made.

2. The MDS dated 3/15/23 identified Resident #46 as cognitively intact with a BIMS score of 13 out of 15 and with the following diagnoses: Multiple Sclerosis, Coronary Artery Disease and Respiratory Failure. The MDS also identified the resident required extensive staff assistance with all activities of daily living (ADL's) except for

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eating and totally dependent on staff for showers/baths. The MDS failed identify the resident had continuous oxygen.

Observations of the resident revealed the following:
a. On 4/11/23 10:59 AM resident lying in bed without continuous oxygen on.
b. On 4/12/23 9:34 AM lying in bed with continuous oxygen maintained at 3.5 liter per minute per nasal cannula per concentrator.
c. On 4/13/23 7:13 AM asleep in bed with door to room open. Continuous oxygen maintained at 3.5 liters per nasal cannula per concentrator.
d. On 4/17/23 8:20 AM lying in bed without continuous oxygen on.
A review of the physician orders for March and April did not show orders for continuous oxygen.

The Care Plan identified the resident with the problem of shortness of breath on 10/29/22, however, interventions did not include continuous oxygen.

3. The MDS dated 3/13/23 identified Resident #48 as cognitively intact with a BIMS score of 15 out of 15 and with the following diagnoses: Cancer, Atrial Fibrillation (an abnormal heart rhythm) and Chronic Obstructive Pulmonary Disease (COPD). It also identified the resident required extensive staff assistance with all activities of daily living except with eating (she had been independent) and with walking where she had been totally dependent on staff for assistance. The MDS failed to identify the resident required continuous oxygen.

Observations of the resident revealed the

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following:
a. On 4/11/23 at 11:02 AM asleep in bed with continuous oxygen maintained at 2.5 liters per nasal cannula per concentrator. Respirations even and unlabored.
b. On 4/12/23 at 9:36 AM sitting up in bed with continuous maintained at oxygen maintained at 2.5 liters per nasal cannula per concentrator. Respirations even and unlabored.
c. On 4/13/23 at 7:18 AM asleep in bed with oxygen maintained at 2.5 liters per nasal cannula per concentrator. Respirations even and unlabored.

A review of the Care Plan identified the resident with the problem of Emphysema/COPD on 3/14/23, however the interventions did not address the use of continuous oxygen.

In an interview on 4/25/23 at 9:43 AM, Staff D, Licensed Practical Nurse (LPN) reported residents with continuous oxygen should have a Doctor's Order for it. If a resident admitted with continuous oxygen and did not have an order, the nurse who admitted the resident should have clarified and obtain an order from the doctor. When asked why there were no orders for Resident #46, Staff D explained the resident did not have oxygen unless Hospice placed it on her and did not tell us. Currently Resident #46 does not have oxygen. Staff D could not recall why Resident #48 did not have orders.

In an interview on 4/25/23 at 9:53 AM, Staff K, Registered Nurse (RN) reported residents with continuous oxygen should have a Doctor's Order for it. The nurse is responsible for ensuring orders are received. She also reported the facility used to have a Corporate Person (who is not a

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F 695	Continued From page 166 nurse) to ensure Admission Physician Orders had been verified. The nurse who admitted the resident had the responsibility to verify if any orders needed to be obtained from the provider. In an interview on 4/25/23 at 3:16 PM, the Director of Nursing (DON) reported she would expect the nurse to obtain a Doctor's Order for a resident with continuous oxygen.	F 695		
F 725 SS=E	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	F 725		

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nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observations, staff and resident interviews, and facility policy review the facility failed to answer call lights in a timely manner for 8 of 26 residents reviewed (Residents #10, #18, #24, #46, #48 and #122) and for 5 of 5 residents who participated in the Group Interview (Residents #13, #17, #24, #26, and #55). The facility reported a census of 69 residents.

Findings Include:

1. The Minimum Data Set (MDS) dated 1/13/23 identified Resident #18 as cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 11 out of 15 and with the following diagnoses: Deep Vein Thrombosis, Diabetes Mellitus, and a wound infection. The MDS identified the resident required extensive staff assistance with repositioning in bed, locomotion on and off the unit, dressing, toileting and personally hygiene and it also identified her to be totally dependent on staff for transfers out of bed.

Observations on 4/17/23 revealed the following:
a. At 8:30 AM, the resident's call light turned on.
b. At 8:38 AM, Staff BB, RN showed a visitor in to the resident's room, but did not ask if either resident needed help and walked out of the room.
c. At 8:42 AM, the call light has been on 12 minutes now. Staff DD, Certified Medication Aide (CMA) stood at the end of the hall with a medication cart and did not check on resident.
d. At 8:49 AM, the call light was still on, Staff BB, Registered Nurse (RN) walked past the room with the medication cart without stopping to check on

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the resident, while the call light is audible. Staff DD remained at the end of hall and failed to checked on the resident.
e. At 8:50 AM, the Housekeeping Supervisor walked by the resident's room and said "I'll tell the girls" and did not check to see what the resident needed. The call light has been on x 20 minutes now.
f. At 8:53 AM, Staff BB walked by the room without checking on resident, the call light remained on.
g. At 8:54 AM, Staff L, CNA entered the room and turned off the call light which had been on for 25 minutes

On 12/22/20, the Care Plan identified the resident with the problem of being dependent on staff for meeting physical and social needs, however, no interventions addressed the need to answer call lights in a timely manner.

2. The MDS dated 3/15/23 identified Resident #46 as cognitively intact with a BIMS score of 13 out of 15 and with the following diagnoses: Multiple Sclerosis, Coronary Artery Disease and Respiratory Failure. The MDS also identified the resident required extensive staff assistance with all activities of daily living (ADL's) except for eating and totally dependent on staff for showers/baths. It did not identify the resident had continuous oxygen.

In an interview on 4/12/23 at 10:50 AM, the resident's family member reported she would come to the facility once or twice a week. When the resident did have a call light she would turn it on and the longest they had to wait was 30 minutes for someone to come in and help. This

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happened every time she would turn the call light on for her.

Observations of the resident on 4/17/23 revealed the following:
a. At 8:20 AM resident lying in bed with the call light wrapped around frame of her bed behind her head, stated "I've been calling out for over an hour now, I can't find my call light." Surveyor turned on the call light for the resident. Staff BB, RN stood out in the hallway by a medication cart, did not check on resident.
b. At 8:25 AM the call light remains on, audible, Staff BB moved the medication cart down the hall and walked into another resident's room. Staff L, Certified Nursing Assistant (CNA) walked into another resident's room at the end of the hall. Call light on for 5 minutes.
c. At 8:27 AM, Staff BB walked by this resident's room as her call light remained lit and did not check on her.
d. At 8:28 AM, Staff L walked into the resident's room and turned off the call light and left the room and brought two bags of linens down the hall.
d. At 8:30 AM, the surveyor asked the resident if the Staff L addressed her needs, she reported "I asked her to change my brief and she left my room without doing it"
e. At 8:37 AM, the resident's cell phone rang, resident called out "can someone help me get my phone" No staff provided assistance
f. At 8:54 AM, Staff BB entered the room to check on resident, did not provide peri cares. The resident has been waiting 24 minutes to have someone provide peri care.
g. At 10:00 AM, the resident's call light remained on. She reported no one ever came to change her incontinent brief. Then Staff BB the entered

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room to ask what she needed, she said "I need my brief changed" Then he said "let me get someone to help you" and left room. The resident reported yesterday she turned on her call light from 8:30 AM to get her brief changed and no one changed her brief until 2:30 AM that night. "I'll turn on my call light, they keep coming in to turn it off and don't help me and I have to keep turning my call light on again"
g. At 10:08 AM Staff L entered the room to provide cares as requested 1 hour and 48 minutes later.

On 8/12/22, the Care Plan identified the resident with the problem of being at risk for falls and directed staff to place the call light within reach and encourage her to use it

3. The Minimum Data Set dated 3/13/23 identified Resident #48 as cognitively intact with a BIMS score of 15 out of 15 and with the following diagnoses: Cancer, Atrial Fibrillation (an abnormal heart rhythm) and chronic obstructive pulmonary disease (COPD). The MDS also identified the resident required extensive staff assistance with all ADL's except with eating (she had been independent) and with walking where she had been totally dependent on staff for assistance.

Interviews with the resident revealed the following:
a. On 4/11/23 at 11:02 AM, the resident reported she had to wait as long as an hour to get call light, has been incontinent waiting for help as she is unable to stand on her own. This happens 3 times a week on 2nd shift. The resident had a clock on wall easily visible from her bed and a cell

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phone.
b. On 4/12/23 at 9:36 AM, the resident reported last night on evenings, the staff would answer the call light timely, but turn off the light and never come back, then she had to turn her call light on again. Twice she lost control of her bladder because she had to wait so long for them to come back, especially after she takes her medication for diuresis.

On 3/14/23 the Care Plan identified the resident with the problem of bowel incontinence and directed staff to check on the resident every 2 hours and assist with toileting as needed.
On 3/14/23, the Care Plan identified the resident with the problem of being at risk for falls and directed staff to place the call light in reach and encourage the resident to use it.

4. The MDS dated 1/9/23 identified Resident #122 as moderately cognitively impaired with a BIMS score of 10 out of 15 and with the following diagnoses: necrotizing fasciitis, heart failure and renal insufficiency (kidney failure). The MDS identified he required extensive staff assistance with repositioning, moving between surface, walking, dressing, toileting and totally dependent on staff for showers/baths. The MDS documented the resident as frequently incontinent of bowel and identified the resident with an indwelling urinary catheter. It also identified the resident admitted with a Stage IV pressure ulcer.

In an interview on 4/13/23 at 11:16 AM, the resident's family member reported the resident would have to wait to get his call light answered for one to two hours on a daily basis and the longest he waited to get a soiled incontinent brief

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changed was 5 hours.

On 12/28/22 the Care Plan identified the resident required assistance to be repositioned at least every 2 hours, more often as needed or requested. It had documentation of the following intervention:
Toilet Use: The resident requires (Specify assistance) by (X) staff for toileting. Date Initiated: 01/25/2023
The Care Plan failed to specify the type of assistance the resident required for toileting.

In an interview on 4/25/23 at 9:06 AM, Staff OO, CNA/CMA reported that staff should answer call lights right away and within 13 minutes. She also reported Residents #18 and #46 had complained to her about their call lights not being answered in a timely manner.

In an interview on 4/25/23 at 10:24 AM, Staff PP, CNA reported staff are expected to answer call lights within 15 minutes and that Resident #46 had complained to her about her call lights not being answered in a timely manner. She also reported Resident #122 had been incontinent of stool and he complained to her that his call light not being answered timely on 3rd shift.

In an interview on 4/25/23 at 9:43 AM, Staff D, Licensed Practical Nurse (LPN) reported staff are expected to answer call lights within 12 to 13 minutes. She also reported Residents #24, #46 and #70 complained to her about their call lights not being answered in a timely manner.

In an interview on 4/25/23 at 9:53 AM, Staff K, RN reported staff are expected to answer call lights within 12 to 15 minutes. She also reported

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residents who complained to her about their call lights not getting answered in a timely manner were Residents #7, #24, #70 and #48 who also reported when certain staff are not there, their call light does not get answered. They all complained about their call lights on a weekly basis.

In an interview on 4/25/23 at 3:17 PM, the Director of Nursing (DON) reported she expected staff to answer call lights within 15 minutes, that no residents have complained to her about their call lights. She also reported she was not sure if this had been an issue reviewed by the Quality Assurance Committee, but felt it should have been. She also reported staff have been educated on answering call lights.

A review of the facility policy titled: Call Lights: Accessibility and Timely Response with the last review date of March 2023 had documentation of the following:
1. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. (Examples include: replace "call light", provide a bell or whistle, increase frequency of rounding, etc.)
2. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified.
3. Process for responding to call lights:
a. Turn off the signal light in the resident's room.
b. Identify yourself and call the resident by name.
c. Listen to the resident's request and respond accordingly. Inform the resident if you cannot meet the need and

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assure him/her that you will notify the appropriate personnel.
d. Inform the appropriate personnel of the resident's need.
e. Do not promise something you cannot deliver.
f. If assistance is needed with a procedure, summon help by using the call light. Stay with the resident until help
arrives.

5. The 3/9/23 MDS listed diagnoses for Resident #63 which included diabetes, burns, and unspecified fall. The MDS documented the resident required extensive assistance of 1 staff for personal hygiene and completely depended on 1 staff for bathing. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition.

During an interview on 4/12/23 at 7:41 a.m., Resident #63 stated sometimes it took staff more than an hour to respond to call lights and she stated this occurred last weekend.

6. The MDS dated 1/3/23, listed diagnoses for Resident #70 which included heart failure, paraplegia, and anxiety disorder. The MDS documented the resident required supervision assistance of 2 staff for personal hygiene, limited assistance of 2 staff for transfers, extensive assistance of 1 staff for dressing, extensive assistance of 2 staff for toilet use, and depended completely on 2 staff for bathing. The MDS listed the resident's BIMS score as 14 out of 15, indicating intact cognition.

During an interview on 4/12/23 at 10:11 a.m.,

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Resident #70 stated staff were supposed to turn her at night every 2 hours but they did not. She stated "last night" Staff JJ, Licensed Practical Nurse (LPN) came in and told her they did not have time to turn her. She stated Staff JJ was the only nurse with 1 aide for Halls A and B.

During a phone interview on 4/25/23 at 8:29 a.m., Staff JJ stated staffing was absolutely horrible and she could not express how bad it was. She stated she sometimes worked the back hall with only 1 Certified Nursing Assistant(CNA) when there was supposed to be 2. She stated they did not have time to turn residents every 2 hours.

During a phone interview on 4/25/23 at 9:10 a.m., Staff KK, CNA stated they did not have enough staff to take care of everyone and it affected the residents a lot. She stated they did not have time to turn people or answer call lights in a timely manner.

7. The MDS dated 2/22/23 revealed Resident #10 scored 10 out of 15 on the BIMS, which indicated moderate cognitive impairment.

During an interview on 4/12/23 at 10:15 AM, the Resident #10 stated it took from 30 minutes to an hour to answer call lights and he used the clock on his TV to determine the time. He stated no certain time of the day worse than other times.

8. The MDS dated 2/5/23 revealed Resident #24 scored 15 out of 15 on the BIMS exam, which indicated cognitively intact.

During an interview on 4/11/23 at 11:09 AM,

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Resident #24 stated the Nurse Aides used their cell phones when they performed cares.

During an interview on 4/11/23 at 11:21 AM, Resident #24 stated it took up to 2 hours to answer call lights and he used his clock and watch to gauge the time. He stated it occurred mostly on 3rd shift.

During an interview on 4/24/23 at 4:31 PM, Staff L, CNA queried how often residents are showered and she stated daily on their scheduled shower days at least a majority of the time they received their showers on their scheduled shower days. She stated except for days they are short staffed like today. Staff L queried if the residents received showers today and she stated no.

9. Reviewed the Resident Council Meeting Minutes documented the following concerns:
a. The January Resident Council Meeting Minutes revealed call lights were not answered timely. Residents present reported it took more than 30 minutes for a response. CNA's were on cell phones and used ear buds. The DON was at the meeting and made aware of the concern. .
b. The February Resident Council Meeting Minutes revealed call lights were not being answered. CNA's continued to wear ear buds and on cell phones during care. The DON present at the meeting and agreed to address the concern.
c. The March Resident Council Meeting Minutes revealed call lights still not being answered and staff wore earbuds and used phones. A Grievance Paper was filled out and was given to the DON.

The facility failed to provide any written

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information during the survey regarding the Call Light Grievance Form submitted by Resident Council in March 2023.

Resident Council Members met on 4/11/23 at 1:00 PM to discuss concerns within the facility. Residents #13, #17, #24, #26 and #55 were present. Call lights continued as a concern of the Council Members and the group agreed that call light wait times were at least a half hour on average. The group reported that the worst time was between shifts when no one answered lights. The group reported that residents waited in soiled pants or linens for two hours because the call light was not answered. The group was concerned that staff shut off call lights and did not provide care.

During an interview on 4/19/23 at 10:55 AM, the Director of Nursing (DON) was asked what response was implemented based on the Resident Council's Grievance about call lights. The Assistant Director of Nursing (ADON) educated 5 staff members on call lights through a in service training. The DON stated it depended on the day how long it took to get lights answered. One problem identified was that not everyone was answering the call lights. Staff indicated it was not their patient and would not answer the light. The DON stated she would provide training on that to correct it. There was a new no tolerance for cell phone and ear bud use implemented by the facility.

Review of policy titled "Resident Council Meetings" revised March 2023 stated the facility shall act upon concerns and recommendations of the Council, make attempts to accommodate recommendations to the extent practicable, and

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F 725	Continued From page 178 communicate its decisions to the Council.	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on personnel file review, policy review, and staff interview, the facility failed to ensure 1 of	F 726		

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5 staff members (Staff K, Registered Nurse/RN) possessed the proper licensing to ensure residents safety. There was no documentation in staff K's file that she was a licensed nurse in the state of Iowa. The facility reported a census of 69 residents.

Findings Include:

On 4/17/23 at 2:27 PM, Record review of Staff K, RN employee file completed and the file failed to contain proof of RN licensure in the state of Iowa.

On 4/19/23 at 2:30 PM, record review of additional employee file information shown the facility provided written proof of RN licensure in the state of Iowa for staff K. The print date on the Verification Form was 4/18/23. The license approval date for RN licensure in Iowa was 8/25/22. Staff K's hire date was 5/20/22

On 4/20/23 at 8:07 AM, review of facility policy titled Abuse, Neglect and Exploitation stated:
a. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property.
b. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants.
c. Screenings may be conducted by the facility itself, third-party agency or academic institution.
d. The facility will maintain documentation of proof that the screening occurred.

On 4/19/23 at 2:35 PM, an interview with Assistant Director of Nursing (ADON) and the Administrator of the facility revealed the following:

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F 726	Continued From page 180 The Administrator was not employed at the facility in 2022 and deferred to the ADON for questions on staff K. The ADON reported Staff K hired in May of 2022, but Staff K did not work at the facility until they received verbal confirmation she had an Iowa License in August of 2022. The Administrator verified no written proof of licensure was contained in Staff K's file prior to 4/18/23.	F 726		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and family member interviews, the facility failed to address a resident's history of drug abuse for one of one residents reviewed. (Resident #46). The facility reported a census of 69 residents. Findings Include: 1. The Minimum Data Set (MDS) dated 3/15/23 identified Resident #46 as cognitively intact with a Brief Interview for Mental Status (BIMS) of 13 out of 15 and with the following diagnoses: Multiple Sclerosis, Coronary Artery Disease and Respiratory Failure. The MDS also identified the	F 740		

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resident required extensive staff assistance with all activities of daily living (ADL's) except for eating and totally dependent on staff for showers/baths. The MDS failed to identify the resident had continuous oxygen.

A review of the Hospital History and Physical Report dated 12/11/22 documented the following: Chief complaint: Unresponsive and cardiac arrest.
It seems there is a history of a family member or ex-husband bringing drugs in the past. Currently resident is intubated, most of history from record review and nurse interviews. Resident received 3 rounds of Cardiopulmonary Resuscitation (CPR). When she came to the Emergency Room (ER), 2 doses of Narcan (a medicine that rapidly reverses an opiod overdose) were given. The resident hypotensive and pressors were started. Urine drug screen came back positive for THC (tetrahydrocannabinonol- primary psychoactive cannabinoid extracted from the cannabis (marijuana) and opiates (chemicals extracted from natural plant matter, ie: opium, morphine, codeine and heroin) Critically ill and in ICU.

The Care Plan with the last revision date of 4/6/23 failed to identify the resident with the problem of history of drug abuse and failed to implement interventions to address it. The diagnoses listed on the Care Plan included cannabis use.

In an interview on 4/11/23 at 2:57 PM, the resident's family member reported the resident was able to purchase drugs at the Nursing Home. That was the 2nd time within 2 weeks that she got drugs somewhere. The 2nd time, Resident #46 got a hold of a Fentanyl patch, chewed it and

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then became unresponsive. Then that's when they sent her to the ER. She has a drug history of taking pretty much anything she can get her hands on, meth, cocaine. The resident claimed she can buy drugs at the home. Her husband was bringing in illegal drugs and giving it to her. One time she was sent to the ER and tested positive for marijuana. He was bringing her CBD gummies and another family member was bringing vape pens with marijuana.

In an interview on 4/18/23 at 9:53 AM, Staff G, Nurse Practitioner (NP), reported people came in from outside and brought her drugs. Resident #46 does have a history of drug abuse - methamphetamines and marijuana, and has had substance abuse overdose in the past.

In an interview on 4/19/23 at 10:02 AM, Staff H, NP reported the following:
a. The staff notified me in December that they found the resident unresponsive and sent to the hospital. Before she
went, she was on a low dose Fentanyl patch that Staff H had ordered. The day Resident #46 went to the ER, she had a visit from her husband who told her she could tear her Fentanyl patch in pieces and chew it up. Resident #46's Power Of Attorney (POA) voiced concerns that family members were bringing in drugs in to the resident, however, did not say what kind of drugs.
b. When the resident was admitted to the hospital, they had to give her two or three doses of Narcan and the resident was in the hospital for a week.
c. Resident #46 had history of using meth, cocaine and marijuana before she came to this facility. She would have
family members, sister, husband and Mom would

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F 740	Continued From page 183 want to bring in CBD oil in for her, we told her we could not allow that here. The staff told me they found a bag of white powder in her room, don't know if anyone tested it. She was told numerous times that she could not use them. d. The staff would catch Resident #46 vaping with marijuana at least once a day. Before her family member became the official POA, the staff could not restrict family members from bringing in marijuana vape pens to her. In an interview on 4/25/23 at 9:43 AM, Staff D, Licensed Practical Nurse (LPN) reported the resident had a history of drug use before admission to the facility and her spouse would bring in illicit drugs. She had an addiction to crack cocaine. This should be addressed on her Care Plan. In an interview on 4/25/23 at 9:53 AM, Staff K, Registered Nurse (RN) reported not sure if the resident had a history of drug use prior to admission and not sure it should be addressed on the Care Plan. In an interview on 4/25/23 at 3:19 PM, the Director of Nursing (DON) reported if a resident had a history of drug abuse, she would expect that to be addressed on the resident's Care Plan. If any of the staff suspected any of the residents had illicit drugs in the room, she would expect them to report it to her, the Administrator, then the police, Nurse Practitioner and the Physician. The family is blaming the husband for bringing in illicit drugs in and is no longer allowed to visit unless it's a supervised visit.	F 740		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		

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F 756	Continued From page 184 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		

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F 756	Continued From page 185	F 756		

This REQUIREMENT is not met as evidenced by:
Based on record review and facility policy review, the facility failed to document Pharmacy Consultant Visits monthly for two of two residents reviewed (Residents #9 and #46). The facility reported a census of 69 residents.

Findings included:

1. The Minimum Data Set (MDS) dated 4/5/23 identified Resident #9 as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) of 2 out of 15 and had the following diagnoses: Renal Insufficiency, Non-Alzheimer's Dementia and Bipolar Disorder. The MDS also identified the resident required extensive staff assistance with bed mobility, transfers, dressing, toileting and hygiene.

A review of the Physician Orders revealed the following:
a. On 7/5/22, Risperidone tablet 0.5 mg (milligrams) Give 1 tablet by mouth two times a day for bipolar.
b. On 9/22/22, Eliquis Tablet 2.5 mg (Apixaban) Give 2.5 mg by mouth two times a day for pulmonary embolism (PE).
c. On 1/30/23, Sertraline Tablet 50 mg Give 1 tablet by mouth in the morning for anxiety, irritability.
d. On 3/22/23, Lorazepam Tablet 1 mg Give 1 tablet by mouth every 24 hours as needed for anxiety for 60 Days.

A review of the Pharmacy Medication Regimen Reviews revealed the last entry dated 2/28/23.

On 10/27/22, the Care Plan identified the resident

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with the problem of using psychotropic medications antidepressant, anti anxiety, and anti psychotic medication and directed staff to discuss with the doctor and family regarding the ongoing need for use of medication.

2. The MDS dated 3/15/23 identified Resident #46 as cognitively intact with a BIMS score of 13 out of 15 and with the following diagnoses: Multiple Sclerosis, Coronary Artery Disease and Respiratory Failure. It also identified the resident required extensive staff assistance with all activities of daily living (ADL's)) except for eating and totally dependent on staff for showers/baths. It did not identify the resident had continuous oxygen.

A review of the physician orders revealed the following:
a. On 2/3/23 Lorazepam Concentrate 2 MG/ML *Controlled Drug* Give 0.25 ml by mouth every 4 hours for anxiety.
b. On 2/20/23 Morphine Sulfate (Concentrate) Solution 20 MG/ML *Controlled Drug* Give 0.25 ml by mouth every 2 hours as needed for Pain.
c. On 3/7/23 Hydrocodone-Acetaminophen Tablet 7.5-325 MG *Controlled Drug* Give 1 tablet by mouth three times a day for Pain.
d. On 3/21/23 Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) *Controlled Drug* Give 0.25 ml by mouth every 2 hours as needed for Anxiety/restlessness.

A review of the Pharmacy Medication Regimen Reviews revealed the last entry dated 2/28/23.

On 10/29/22, the Care Plan identified the resident with the problem of using psychotropic

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F 756	Continued From page 187 medications anti anxiety anti depressant and anti psychotic and directed staff to discuss with the doctor and family regarding the ongoing need for use of medication. A review of the facility policy titled: Medication Regimen Review and dated as last reviewed March 2023 documented the following: a. Timelines and responsibilities for Medication Regimen Review: The Consultant Pharmacist shall schedule at least one monthly visit to the facility, and shall allow for sufficient time to complete all required activities.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		

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behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

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

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

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews and facility policy review, the facility failed to re-evaluate and re-order for as needed (PRN) antianxiety medications for two of two residents reviewed (Residents #9, and #46). The facility reported a census of 69 residents.

Findings include:

1. The Minimum Data Set (MDS) dated 4/5/23 identified Resident #9 as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) of 2 out of 15 and had the following

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diagnoses: Renal Insufficiency, Non-Alzheimer's Dementia and Bipolar Disorder. The MDS also identified the resident required extensive staff assistance with bed mobility, transfers, dressing, toileting and hygiene.

A review of the physician orders revealed the following:
a. On 1/30/23 Sertraline Tablet 50 milligrams (mg), give 1 tablet by mouth in the morning for anxiety, irritability.
b. On 3/22/23 Lorazepam Tablet 1 mg, give 1 tablet by mouth every 24 hours as needed for anxiety for 60 Days.

A review of attempted Gradual Dose Reductions (GDR)) from the Pharmacy Consultant to the Physician revealed the following:
a. On 10/31/22 3:43 PM, Medication regimen review for October completed. No response yet regarding possible GDR on sertraline 50 mg from September 2022 Medication Regimen Review (MMR).
b. On 11/30/22 2:21 PM, Medication regimen review for November completed. No new medication irregularities but no response yet from September MRR letter to prescriber regarding sertraline GDR. Will send note to DON (director of nursing).
c. On 12/29/22 5:18 PM, Medication Regimen Review for December completed. GDR request from September pending.
d. On 2/28/2023 21:31, February Medication Regimen Review completed. Lorazepam 1 mg daily as needed for anxiety/agitation is on the regimen with no length of therapy specified. A recommendation letter to prescriber will be created.

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2. The MDS dated 3/15/23, identified Resident #46 as cognitively intact with a BIMS of 13 out of 15 and with the following diagnoses: Multiple Sclerosis, Coronary Artery Disease and Respiratory Failure. It also identified the resident required extensive staff assistance with all activities of daily living (ADL's) except for eating and totally dependent on staff for showers/baths. The MDS failed to identify the resident had continuous oxygen.

A review of the Physician Orders revealed the following:
a. On 2/3/23 Lorazepam Concentrate 2 MG/ML *Controlled Drug* Give 0.25 ml by mouth every 4 hours for anxiety
b. On 2/20/23 Morphine Sulfate (Concentrate) Solution 20 MG/ML *Controlled Drug* Give 0.25 ml by mouth every 2 hours as needed for Pain
c. On 3/7/23 Hydrocodone-Acetaminophen Tablet 7.5-325 MG *Controlled Drug* Give 1 tablet by mouth three times a day for Pain
d. On 3/21/23 Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) *Controlled Drug* Give 0.25 ml by mouth every 2 hours as needed for Anxiety/restlessness

The order for the give as needed (PRN) order for Lorazepam did not have a re-evaluation or re-order by the physician after 14 days.

On 4/26/23 at 2:00 PM, when asked for a policy on antipsychotic medications ordered to be given as needed, the Administrator reported their policy titled: Medication Regimen Review policy had information requested. A review of the policy dated as last revised March 2023 failed to have documentation on the process to re-evaluate and

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F 758	Continued From page 191 re-assess the resident's need to have the order after fourteen days.	F 758		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident and staff interviews, and facility policy review, the facility failed to provide medications as ordered to 1 out of 15 resident reviewed by giving the wrong medications to a resident causing the resident to be transported to the Emergency Room for medication overdose (Resident #19). The facility reported a census of 69 residents. Findings Include: The Minimum Data Set Assessment (MDS) for Resident #19 dated 5/18/22, revealed the diagnosis of Coronary artery disease (CAD), and hypertension (HTN). Resident #19's Brief Interview for Mental Status (BIMS) score reflected 14 out of 15 indicating intact cognition. The medications utilized in the past 7 days reflect antidepressant daily. The MDS medication utilized over the 7 day lookback failed to include antipsychotic medication, and opioids. The Care Plan for Resident # 19 dated 1/13/2022, directed Nursing Staff to administer medications as ordered and monitor/document for side effects and effectiveness. The Situation, Background, Assessment and	F 760		

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Recommendation (SBAR) on 7/10/22 reflected Resident #19 lethargic, decreased consciousness, slurred speech. Transferred to the hospital.

The General Note 7/10/2022 at 7:15 PM, included Resident #19 sat at table in Min Dining Room asleep. Resident easily aroused but returned to sleep quickly. Staff FF, Certified Medication Aide (CMA) reported she made a medication error. Staff FF stated she gave Resident #19 another resident's medications. The note continued Resident #19 sat at the Main Dining Room table unresponsive. Vitals assessed. B/P. 69/52. Respirations 12 and shallow. Multiple attempts to arouse Resident #19 ineffective. Call placed on call provider and order received to send to Emergency Room (ER).

The facility provided a document titled #931 Medication dated 7/10/22, the report revealed the CMA reported to the Nurse she gave another residents medication to Resident #19. Resident #19 unresponsive at the time. Vital signs included blood pressure 69/52, respiration 12 and shallow. Staff attempted multiple times to arouse resident unsuccessfully. Called Staff H, Nurse Practitioner and ordered to send Resident #19 to the ER for evaluation and treatment. The report reflected potential medication side effect.

The Physician Progress Note dated 7/11/2022 at 4:01 PM, reflected the chief complaint medication overdose. The note identified a medication overdose on 7/10/22 per Nursing Service, when an accident on medication administration occurred. Resident # 19 sent to ER and received intravenous (IV) fluids. Resident #19 evaluated at the bedside. Nursing Services reported

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yesterday Resident #19 received the wrong resident's medications. Resident #19 took 2 milligrams (mg) Risperidone (anti-psychotic), 300 mg trazodone (antidepressant), 0,4 mg tamsulosin (alpha blockers), Docusate Senna (stimulant laxatives), 10 mg buspirone (anxiolytics), 500 mg Keppra and 300 mg gabapentin (anticonvulsants).

On 4/11/23 at 1:28 PM, Resident #19 denied concerns or problems with the facility administering his medications.

On 4/17/23 at 1:40 PM, Staff DD, CMA, stated the facility does monthly mandatory education. Staff DD reported if medication errors happened in the facility she would expect some education.

On 4/18/23 at 5:22 PM, Staff FF, CMA confirmed she administered the wrong medication to Resident # 19 on 7/10/22. She stated the nurse sent him to the hospital because he seemed very sleepy. Staff FF said she just started at the facility the two residents looked alike.
Staff FF stated the facility provided her educated to pay attention, if unsure who the residents are, ask another staff.

On 4/18/23 at 2:04 PM, the Assist Director of Nursing (ADON), reported the Medication Aide administered Resident #19 the wrong medication on 7/10/22. She reported the nurse called her and reported the medication error. The ADON stated the Medication Aide completed a return demonstration on medication administrations. The ADON reported she failed to document the education provided to the CMA.

On 4/18/23 at 2:15 PM, the Director of Nursing

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F 760	Continued From page 194 DON stated she expected medications administered per the Physician's Order. On 4/19/23 at 10:21 AM, Staff H, Advanced Registered Nurse Practitioner (ARNP) stated she knew staff administered Resident #19 medications that belonged to another resident. Staff H stated the nurses sent Resident # 19 to the ER related a lethargic condition. Staff H stated the Hospital administered intravenous (IV) fluids and sent the resident back to the facility for staff to monitor. The facility policy titled Medication Administration dated 3/23, directed medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: point #3 directed; Identify resident by photo in the Medication Administration R (MAR) Record.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		

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biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews, and facility policy review, the facility failed to ensure 2 out of 2 Treatment Carts and 1 out of 2 Medication Carts were locked and secured when staff not present. The facility reported a census of 69.

Findings Include:

During an observation on 4/12/23 at 2:48 PM, a Medication Cart left unlocked in the dining hall when staff delivered medication to resident in the dining hall. Observed a resident pass in a wheelchair by the unlocked cart.

During an observation on 4/13/23 at 7:51 AM, Staff BB, Registered Nurse (RN) walked down Hall B with the Treatment Cart unlocked and stated he needed to get a computer and walked away from the Treatment Cart and left it unlocked.

During an observation on 4/13/23 at 7:53 AM, Staff BB returned to the cart and looked for blood

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glucose paperwork and stated he grabbed the wrong paper and walked away from the unlocked cart and walked into the dining room and retrieved the papers and returned to the cart. Staff BB prepared the insulin for the resident and went into the resident's room and left the insulin vial and insulin pen on top of the treatment cart and left the cart unlocked in the hallway. Staff CC, Licensed Practical Nurse (LPN) observed in the hallway with her back turned to the Treatment Cart and residents in the hallway in their wheelchairs.

During an observation on 4/13/23 at 8:09 AM, Staff BB prepped insulin for another resident and left the insulin vial and insulin pen on top of the Treatment Cart and left the cart unlocked when he went into the resident's room to ask the resident if he wanted his fast acting insulin. The cart observed sitting in the hallway 2 doors down from the resident's room.

During an interview on 4/13/23 at 8:13 AM, Staff BB queried if the Treatment Carts expected to be locked and he stated yes, the carts are supposed to be locked. Staff BB stated he guessed he had left it unlocked. He stated they had a lack of keys. Staff BB asked if medications were supposed to be secured in the carts and he stated yes, and he walked back to the cart to check. Staff BB informed he had left the insulin vials and pens on top of the cart when he administered the medications and Staff BB did not respond.

During an observation on 4/13/23 at 8:16 AM in Hall B, Staff BB drew up insulin and went into a resident's room and left the insulin vial on top of the cart and left the cart unlocked.

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During an interview on 4/13/23 at 8:25 AM, Staff CC, LPN queried if medication carts are supposed to be locked and she stated yes, unless you are pulling or popping pills. Staff CC asked if the facility was short on keys and she stated she didn't know, she just started, maybe so.

During an observation on 4/13/23 at 9:52 AM in Hall A, Treatment Cart #1 left unlocked between rooms A5 and A7. Observed Staff DD, Certified Medication Aide (CMA), down the hall two doors looking at the computer on her Medication Cart. The following observations made with the unlocked Treatment Cart:
a. At 9:55 AM, staff walked by the cart and didn't lock the cart. A resident in an electric wheelchair circled around the cart.
b. At 10:04 AM, staff walked by the cart and asked Staff DD where to locate Staff BB and looked at the treatment cart and walked away.
c. At 10:16 AM, resident wheeled by the unlocked treatment cart.
d. At 10:17 AM, Staff DD wheeled her Medication Cart past the treatment cart and didn't lock it.
e. At 10:21 AM, resident wheeled by the treatment cart in their wheelchair.
f. At 10:22 AM, surveyor opened the cart and observed insulin and syringes found in the drawers.
g. At 10:46 AM, Staff BB, approached the Treatment Cart and moved it next to the Medication Cart by room A 3 and opened the drawers and pulled up medication into a syringe.
h. At 10:48 AM, Staff BB went into a resident's room with syringe and left the cart unlocked and the 3rd drawer slightly opened on the cart.

During an observation on 4/13/23 10:50 AM,

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found a set of keys left on the Treatment Cart in B Hall.

During an observation on 4/13/23 10:51 AM. Staff DD, CMA picked up the keys off the cart.

During an interview on 4/13/23 at 10:52 AM, Staff DD queried who the keys belonged to that she picked up and she stated she believed the keys belonged to one of the nurses and not supposed to be left on the cart so she snatched them up. Staff DD asked what the keys unlocked and she stated she didn't know, but thought the Treatment Carts and something else.

During an interview on 4/13/23 at 2:11 PM, Staff BB queried if he had keys in his pocket and he stated yeah. Staff BB informed a pair of keys found on the Treatment Cart and he pulled out the keys from his pocket and stated his keys went to the utility room. Staff BB asked if the keys unlocked the Medication or Treatment Carts and he stated no, he didn't even know what most of the keys on the chain went to. He stated he was the A and B Hall Nurse and when he needed to do treatments he went to someone else to get the keys for the carts because they were short on keys. Staff BB queried why they were short on keys and he stated the Medication and Treatment keys are on the same key chain and if he needed something he would need to go to the Nurse or the Medication Aide for their keys.

During an observation on 4/18/23 at 2:51 PM, the Medication Cart left unlocked in the dining hall. Staff EE, Activity Director with her back to the cart sat at a table with 9 residents and another staff member. Three other residents observed at tables in the dining area.

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During an observation on 4/18/23 at 2:53 PM, Resident #70 wheeled by the Medication Cart and spoke to a staff member right next to the cart.

During an observation on 4/18/23 at 2:55 PM, Staff EE walked out of the dining area, another staff member walked into the dining area and sat behind the Nurse's Station with a computer monitor and counter between the staff member and unlocked Medication Cart.

During an observation on 4/18/23 at 2:56 PM, the Director of Nursing (DON) walked by the cart and then turned around and stood in front of the cart and locked the Medication Cart.

During an interview on 4/24/23 at 4:01 PM, the DON queried about the expectations of medication and treatment carts being locked and she stated they should be locked at all times. The DON asked about the expectations of key control and she stated the Medication Aides had their own set of keys and the nurses had their own keys. The DON queried if the facility was short on keys and she stated she knew that one set of keys for A Hall had the Medication Cart and Treatment Cart keys and at one time the Assistant Director of Nursing (ADON) requested more keys for the carts. The DON stated she had the master keys for the carts.

The undated document named "Cognitively impaired and independently mobile" provided by the Administrator revealed 26 residents cognitively impaired and independently mobile.

The Facility Policy titled Medication Storage dated March 2022 revealed the following:

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F 761	Continued From page 200 a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel accessed to the keys to locked compartments. c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, food temperature checks, staff and resident interviews, the facility failed to provide food at a safe and appetizing temperature from the steamtable located within the North Dining Room kitchenette and failed to ensure food items held at a safe temperature after plated for serving on Hallway R. The facility had reported a census of 69. Findings Include: On 4/12/23 at 11:35 AM, the Noon meal food items temperatures checked by Staff S, Dietary Cook for the steam table in the South Main	F 804		

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kitchen.

The Hallway R and Hallway L Noon meals were individually plated for each resident and then each individual tray placed on an open transport wheeled cart rack. Dietary Staff responsible for transporting the plated tray rack to each hallway and labeled as Hallway R and Hallway L.

After all resident Hallway R and Hallway L (South) individual trays plated, Dietary Staff individually plate Hallway A and Hallway B trays (North).

On 4/12/23 at 12:06 PM, Staff X, Dietary Manager completed a temperature check, utilizing a digital ThermoWorks brand thermometer to check an individual plated tray located in the Hallway R with the following results:
a. At 11:35 AM, Regular squash had temperature checked at 188 degrees and then at 12:06 P.M. had cooled to 131 degrees.
b. At 11:35 AM, Regular peas and carrots had temperature checked at 168 degrees and then at 12:06 P.M. had cooled to 129 degrees.
c. At 11:35 AM, roast beef had temperature checked at 197 degrees and then at 12:06 P.M. had cooled to 152 degrees.
d. At 12:06 PM, the Fruit Cocktail had been temperature checked and had been warm at 58 degrees.

On 4/12/23 at 12:06 PM, during an interview with Staff X the discussion of warm fruit cocktail had led to Staff X stating the fruit had never been refrigerated and a new can had been opened and dispersed into individual containers for serving.

On 4/12/23 after all Hallway individual trays plated in the Main kitchen, the Dietary Staff observed to

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place stainless-steel containers of prepared meal items from the Main kitchen steam table onto a plastic 3-tier cart and then transported the cart to the North Dining Hall kitchenette. The stainless-steel containers then placed within the North Dining Hall kitchenette steam table.

On 4/12/23 at 12:31 PM, Staff S completed a temperature check of all food items prior to serving North Dining Hall residents individual plated Noon meals. Staff S utilized a digital ThermoWorks brand thermometer to check all food items located in the North Dining Hall kitchenette steamtable prior to serving. the temperature registered below safe parameters and had cooled as follows:
a. At 11:35 AM, the pureed butternut squash temperature checked at 160 degrees and then at 12:31 PM, the temperature had cooled to 131 degrees.

2. The Minimum Data Set (MDS) Assessment dated 3/09/23 for Resident #63 shown the Brief Interview for Mental Status (BIMS) score was 15 out of 15 indicating intact cognition.

During an interview on 4/12/23 at 7:41 a.m., Resident #63 stated the food was always cold.

3. The MDS Assessment dated 3/13/23 for Resident #48 shown the BIMS score was 15 out of 15 indicating intact cognition.

Interviews with Resident #48 in regards to food temperatures revealed the following:
a. On 4/11/23 at 11:02 AM, the resident reported the food is not always warm
b. On 4/12/23 at 9:36 AM, the resident reported

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F 804	Continued From page 203 the food in the meals she received yesterday were not warm.	F 804		
F 812 SS=L	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 record review, the facility failed to store, prepare and serve residents ' food under sanitary conditions that met professional standards of food service, for 5 of 5 observed resident meals. The failures led to an immediate jeopardy situation for the health and safety of residents. The facility reported a census of 69 residents. The State Agency notified the facility of the IJ on 5/28/23 at 11:00 a.m. The IJ began on 4/11/23 upon the first initial kitchen tour.	F 812		

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The facility abated the IJ on 6/5/23 by adding cleaning of the ceiling air return vents to the maintenance staff's routine schedule, cleaning the AC vents added to the routine cleaning dietary duties, and all dietary employees completed components of "Safe Serve" food safety education, and following the planned menu education through Relias, a computer based education program utilized by the facility. The facility did not have documentation of the dietary staffs completion of the required education prior to 6/1/23, all training completed by 6/5/23.

The facility staff's actions lowered the scope and severity from a "L" to a "F" at the time of the survey, after the State Survey Agency verified the facility staff had implemented the education and additional corrective actions.

Findings include:

The initial kitchen observations for the Main Kitchen on 4/11/23 with the Dietary Manager (DM) at 9:00 AM, revealed the following:
a. Plate warmer located inside the door did not work according to the DM.
b. Plate warmer contained visible dry food debris of chips and cereal on the bottom shelf; the middle shelf contained a dried-on, pink colored substance on the surface and outside edge; and the top shelf contained a dried pink substance sporadically across the surface.
c. The middle shelf was noted to have a tray of clean drinking glasses and a banana lying on them.
d . Inside the main kitchen South entry door was a fire extinguisher. Beside the extinguisher was

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noted brown buildup substance on the wall.
e. All walls inside of the microwave contained a dried brown substance.
f. The bottom of the toaster had approximately a quarter inch thick buildup of brown substance.
g. A visible brown substance present on the bottom of the Glove brand mixer and the clear plastic attachment sticky to touch.
h. A white wheeled container approximately 3 feet by 3 feet by 2 feet in size contained a dried light brown substance and a couple of buildup nickel size darker brown spots of a sticky consistency.
i. Above the food prep stainless steel table a cluttered shelf observed with stickers hanging down at various lengths, a personal cell phone, an opened partially drank plastic water bottle with no date or name, and a a slightly wet linen cloth approximately 6 inches by 6 inches in size.
j. The milk cooler contained a visible dried yellow substance across the front, lower half of the cooler.
k. The six gas burners of the gas range with a build-up of black substance with an adjacent griddle that contained a dried black substance on the griddle and across the back.
l. To the left of the Southbend range, the ceiling contained a circular heating, ventilation, air conditioner (HVAC) vent that had been approximately two feet in diameter. Adjacent to the vent the ceiling white paint had been visible for approximately two inches and then noted a dark ring approximately 19-24 inches in diameter where air blows out of the vent.
m. A Motak freezer located against the left wall of the kitchen contained a dried dark substance across the bottom of the horizontal vents and the wheeled casters; the inside contained a sticky pink substance across the bottom shelf and dried

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food contents.
n. The refrigerator labeled number 1 contained a dried dark gray and black substance on the horizontal vents at the bottom.
o. Freezer #1 contained dried contents around the handles and the wheeled casters had a gray substance. The top left outside of the freezer had a gray visible substance that included a one-inch length piece dangling vertically.
p. Freezer #2; and noted across the bottom horizontal vent and the bottom of the right shelf had been pieces to include freezer burnt french fry and cardboard box pieces.
q. Adjacent to the second Freezer #2 was a small porcelain white handwashing sink that had a buildup of brown substance around both water faucets, and noted beside the sink was a plastic trash can with visible soiling on the top of lid and several items stuck to the outside of lid.
r. On the wall above the clean dishes' storage, a Garrisons brand portable air conditioner had visible gray substance built up on all horizontal vents. The top of the Garrison brand air condition had a buildup of gray substance.
s. Below the air conditioner, on the same wall, an Ecolab dishwasher machine noted on the floor area with discarded disposable plastic cups, pieces of paper, visible debris, and polyvinyl chloride (pvc) pipe had a buildup of a gray substance.
t. Clean dishes rack with clear acrylic drinking glasses with white residue on the inside of several glasses.
u. The separate dry goods storage room noted with dry uncooked noodles on the floor, storage wood shelves with peeling white paint and a gritty substance to touch. A large can storage rack noted to have a visible brown dust substance on the unused shelves.

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F 812	Continued From page 207 On 4/11/23 at 11:25 AM, an initial observation took place of the North Dining Room Kitchenette with the following noted: a. On the left wall, brown stains dried vertically beside on the wall. b. A Haier brand refrigerator with a sign, for residents and staff, full of to-go containers, drinks, and sacks with few names or dates. Outside surface of the refrigerator door had a dried brown substance splattered across the front. c. On top was a gray color silverware container and the front of the container noted to have dried brown substance in streaks. d. A small Hiscense brand refrigerator with a buildup of a gray substance. e. Inside of the microwave, dried bright yellow substance on the clear rotating tray and all walls inside the microwave, observed a brown color substance buildup f. The steamer noted to have a brown dried substance on the outside right and noted on the lower shelf was dried material and food content. The wall surface between the steam table and serving window was noted to have a brown dried substance. g. On the kitchenette back wall noted a stainless-steel sink with a buildup of brown substance around the water faucets and the sink itself had dried brown stains. The cold-water faucet was not working, as no water flowed when the faucet was turned on. Noted below the sink was a cabinet floor with visible brown and loose gray substance, and noted storage of Behr brand paint cans, Ecolab brand lime-a-way, and Ecolab cleaning gel. Paint cans had apparent rust on lids. When opening the left side door, a few small winged insects had flown out.	F 812		

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h. A large area of liquid brown color substance drying and dry coffee grounds across the counter by the Keurig small coffee pot.
i. A commercial Warine brand coffee pot was noted to be on as a green light was noted. The outside of the coffee pot contained brown streaks down the left side.

Observations on 4/11/23 at 9:00 AM and on 4/12/23 at 7:44 AM revealed Staff P, Dietary, wore a hair net that did not cover all scalp hair while in the main kitchen. On the right and left side of Staff P's face there was approximately one to two inches of thick hair hanging past facial chin.

Observation on 4/12/23 at 11:00 A.M. revealed two plastic oscillating fans approximately two feet in height present on the prep counter in the main kitchen. Observation revealed both fans contained a visible gray substance on the fan blades and the blade cover; both fans positioned to produce air flow over the prep table and gas range area.

Observation on 4/12/23 at 11:20 AM, revealed Staff P, Cook did not wash her hands nor don gloves prior to preparing resident lunch food. Staff P touched her face cheek area, then facial chin and then touched silverware to assemble for residents' lunch. Staff P continued in this manner touching her bare skin on arms, clothing and then took plated food from the cook and put a plastic lid over the plate.

On 4/12/23 at 12:06 PM, observed a male Dietary Staff enter the kitchen and not wash his hands. The male staff touched his facial skin and arms and then pulled aluminum foil sheets with bare

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hands and Staff P picked up the foil to cover a resident's plated food. The male staff transferred cooked steam table container pans of resident food items to a plastic cart for transport to the North Dining room kitchenette.

On 4/12/23 at 12:30 PM, the Dietary Manager (DM) observed in the North Dining Room kitchenette did not wash her hands, touching resident coffee cups to fill and putting vegetables in the microwave that had not temped on the steam table.

On 4/12/23 at 4:03 PM, in an interview with the DM, she showed a Daily Cleaning Checklist instituted in the last month. When asked who would be responsible to follow-up on the check sheets and verify the cleaning completed, the DM stated that was her responsibility. During the interview an opened 5-pound bag of shredded cheddar cheese was noted left out on the stainless-steel counter, with the bottom contents noted to be melting. No Dietary Staff present. The floor dirty with a discarded disposable glove and a piece of bread. Staff T, Cook entered the kitchen and the DM asked Staff T about the cheese and then requested the oscillating fans be put away. Staff T responded using profanity. The DM observed shaking her head.

On 4/13/23 at 7:55 AM, observation of the North Dining Room kitchenette showed Staff P enter the kitchen and noted there was no handwashing, Staff P touched her skin and then was observed making coffee in the Warine coffee pot.

An observation on 4/13/23 at 8:16 AM, showed Staff U transport breakfast food to the North Dining Room kitchenette. Staff U touched her

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bare skin arms, face and then put gloves on without washing hands. Staff U observed using a personal cell phone, placed the phone in a pocket and then continued to plate resident food.
At 8:18 AM, Staff U asked if the kitchenette sink had working water faucets and Staff U stated unaware if the water worked. Noted no paper towels on the kitchenette counter.

On 4/18/23 at 12:15 PM, an observation of the main kitchen had shown Staff V, Dietary Aide was working at the food prep table area with no hairnet worn. Staff V wore white framed plastic sunglasses on top of her head. When Staff V asked about wearing a hairnet, she stated that her mind had just been going while taking items out of a refrigerator.

On 4/20/23 at 11:00 A.M. an observation of the North Dining room kitchenette had taken place and the following noted:
a. The black plastic trash can lid was off with trash overflowing to the floor.
b. A black dried and partially wet circle of liquid noted on the trash can and on the linoleum floor around the garbage can.
c. Winged insects noted flying around the garbage can.
e. The floor noted with empty cardboard boxes, silver aluminum piece, food, and white condiment packets.
f. The toaster on the counter observed with winged insects on the tray and the tray stained with a dark brown substance.

2. Observation in the facility kitchen on 5/31/23 at 11:03 a.m. revealed:
a. Water temperature at the handwashing sink

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was cool, and did not warm when the faucet was left on for over a minute.
b. The low-temp dishwasher in operation, the exit surface/counter from the dishwasher approximately 7 feet long, clean dishes in dishwasher racks were on the exit counter and a window type of Air Conditioning (AC) unit positioned on the wall, at the end and approximately 24 inches above the counter surface, and blew down over the dishes on the counter. The grates on the lower ½ of the AC unit, through which the cold air blew, were covered with a gray dusty substance approximately 2 to 3 millimeters (mm) thick, that looked similar to lint from a clothes dryer.
c. An opened box with 24 Chocolate Mighty Shakes (a dairy-based 4 ounce nutritional supplement shipped and stored in a frozen state, served after thawed) and an unopened box of 50 Mighty Shakes that were not dated when the containers were removed from frozen storage. The product expires 3 days after removed from frozen storage.
d. A scoop positioned in a bin container of dry oats used for oatmeal.
e. Broken thermometers located in a 3 door refrigerator located next to the 3 compartment sink, and in the milk cooler where various 8 ounce cartons of milk were stored, at least 200 cartons in milk crates inside the cooler.

Observation in the facility kitchen on 5/31/23 at 12:50 p.m. revealed:
a. Water temperature at the handwashing sink remained cool, did not warm when faucet was left on for over 3 minutes.
b. The wall AC unit continued to have dust that covered the grate on the lower half of the unit and blew down on cleaned dishes in dishwasher

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racks positioned on the dishwasher exit counter.
c. Two air return vent grates located in the ceiling above food preparation counters, approximately 24 inches square, that were covered with gray colored dusty substance approximately 2 to 3 mm thick.
d. The daily cleaning assignments and schedule did not list the ceiling vents or wall AC unit.

During an interview 5/31/23 at 12:56 p.m., Staff RR, the interim Dietary Manager was informed that the window AC and ceiling air return grates were covered with what appeared to be dust, the scoop in the oats bin and broken thermometers found in the refrigerators. Staff RR stated she cleaned the wall AC grate and ceiling air return grates on 5/28/23, a contracted company came on 5/19/23 and cleaned the Kitchen floor, she cleaned the other Kitchen issues on that date and after that were identified as concerns on the initial annual survey exit on 5/1/23.

During an interview 5/31/23 at 1:03 p.m., the facility Administrator was informed there was no hot water at the handwashing sink in the Kitchen.

During an interview 5/31/23 at 2:55 p.m., the facility Administrator stated the handwashing sink water temperature was fixed, it was a mixing valve issue that Staff TT, the Maintenance Director had taken care of, and had not been reported as a problem by any of the dietary staff.

Observation on 5/31/23 at 4:10 p.m. in the North Kitchenette revealed:
a. A strong odor of coffee that came from an approximate 20 inch by 5 to 6 inch puddle of coffee that dripped on the counter from the Coffee dispenser that was turned on and in use

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above the area.
b. A microwave unit with 6 to 7 dried brown spots that varied in size from 2 - 3 mm to 6 - 10 mm located inside on the bottom of the unit, located between the door and the edge of the glass turntable plate. There were no staff in the area and the microwave was not in use.
c. Four chocolate Mighty Shake containers in the refrigerator, fully thawed, undated when pulled from frozen storage.

Observation on 5/31/23 at 4:20 p.m. in the facility Kitchen revealed:
a. Hot water from the handwashing sink faucet.
b. The wall AC unit grate and ceiling air return grates unchanged in appearance, remained covered in dust-like substance.
c. Staff RR, interim Dietary Manager, observed the open box with undated and thawed Mighty Shakes, and the unopened box of 50 Mighty Shakes in the refrigerator. Staff RR stated she did not know when the opened box was pulled from the freezer, would throw the cartons away, the unopened box was pulled from the freezer that day and she wrote 5/31/23 with a marker on the outside of the unopened box of Might Shakes.

On 5/31/23 at 4:33 p.m., the Surveyor requested to speak to Staff TT, maintenance Director, in reference to the ceiling air return vents in the Kitchen, and informed Staff TT had left for the day but could return.

On 5/31/23 at 5:14 p.m., the facility Administrator stated staff TT returned, the window AC grate and ceiling air return grates had a greasy-residue substance under the dust, they ran them through the dishwasher, they were cleaned and the ceiling air return vents were added to Staff TT's duties to

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clean/inspect.

Observations on 5/31/23 between 6:18 p.m. and 6:37 p.m. revealed Staff R, Cook, plated the evening meal from the steam table in the North Kitchenette and wore the same gloves throughout the process. At 6:29 p.m., Staff R grabbed 4 chicken nugget pieces with the same gloves worn throughout the plating process and did not use serving utensils, or remove his gloves and apply new gloves.

On 6/1/23 at 9:50 a.m., the Surveyor requested a report from the facility's computer based staff education program that listed the dietary staff's completion of food sanitation and safety education, and education on following the planned menu, both mandated upon initial employment for dietary duties.

On 6/1/23 at 2:18 p.m., the facility's Chief Clinical Officer stated the facility could not provide documentation the dietary employees had received the required education upon hire, he ensured all the dietary staff on duty would receive the education that afternoon, and if a dietary employee wasn't on duty, they would receive the education prior to work on their next day assigned in the Kitchen.

On 6/1/23 at 3:44 p.m., the facility's Chief Clinical Officer stated they had provided education to the dietary staff and wanted the Immediate Jeopardy status to be abated as of that time because they provided the required education. As of that time, there were 9 employees listed on the dietary employee roster, their position and hire date listed below:

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Staff Q, Cook, hired 1/2/23
Staff R, Cook, hired 12/15/22
Staff S, Cook, hired 10/19/21
Staff T, Cook, hired 12/27/21
Staff V, Dietary Aide, hired 8/6/21
Staff W, Dietary Aide, hired 6/8/22
Staff RR, interim Dietary Manager, hired 11/26/21
Staff UU, Cook, hired 1/17/22

During an interview 6/5/23 at 7:19 a.m., Staff Q, Cook, in the facility Kitchen and in process of breakfast meal preparation, stated she had not received education related to food safety or following the planned menu on 6/1/23, she didn't work that day, she had received education on the cleaning schedule at a staff meeting that she thought occurred on 5/30/23. Staff S, Cook, also present in the Kitchen at the time, stated Staff Q didn't work on 6/1/23 and wasn't there when they went over that education. Staff Q was unaware that she required the training before she worked again.

Observation on 6/5/23 at 11:25 a.m. revealed Staff Q in the administrator's office with education in process.

Observation on 6/5/23 at 12:23 p.m. revealed 19 residents seated in the Dining Room for the noon meal, resident room trays for the North A and B Halls and food for the steamtable in the Kitchenette had not been distributed by the dietary department. During an interview on 5/31/23 at 9:39 a.m., a dietary employee stated room trays for the noon meal went out to the North A and B Halls at approximately 12:00 noon, with meal service to the Dining Room immediately after that.

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Observation on 6/5/23 at 12:25 p.m., through the glass window of the Kitchen door, revealed Staff RR, interim Dietary Manager and 2 dietary employees, 1 that appeared texting on a cell phone, all positioned by the prep counter. Staff RR responded to the knock at the door, emerged from the Kitchen with the cart used for the A Hall room trays, said they would be going out now and transported the cart to the A Hall.

Observation on 6/5/23 at 12:34 p.m. revealed the B hall room trays and food for the Kitchenette not dispensed from the dietary department, 21 residents were seated in the Dining Room.

On 6/5/23 at 12:34 p.m., the facility RDLD was informed of the meal status for B Hall room trays and Dining Room residents, and concern for the number of insulin dependent diabetic residents who had not received their noon meal as of that time. The RDLD went into the Kitchen immediately, returned from the Kitchen at 12:40 p.m. and stated dietary staff were finishing up on some things for the front/skilled hall, would take the food to the North Kitchenette after that for the meal service, and they were running behind due to the required education for Staff Q.

Observation on 6/5/23 at 12:50 p.m. revealed the dietary department had not delivered food for the North Kitchenette/Dining Room residents, 22 residents seated there, 1 of the residents asked when they could have their food, stated they were hungry and had waited for a long time for their lunch, then stated don ' t you work for the State, can ' t you make them serve our food?

Observation on 6/5/23 at 12:57 p.m. revealed dietary staff delivered food for the North

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F 812	Continued From page 217 Kitchenette steamtable and meal service commenced. Observation on 6/5/23 at 1:08 p.m. through the service window at the North Kitchenette revealed Staff S, Cook, wore gloves throughout meal plating, grabbed a handful of French Fries and served to a resident without changing gloves, and did not have a utensil present to serve with. The RDLD was informed of that at that time, went to the Kitchenette, observed Staff S did not have a utensil for the French Fries and addressed the matter with the employee. During an interview 6/5/23 at 1:11 p.m., the RDLD stated staff should always use serving utensils, should not touch or handle food, and if unavoidable, staff should apply clean, single use gloves if they had to handle resident food.	F 812		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility policy review, the facility failed to maintain an effective pest control program to assure the environment remained free of pests and rodents. The facility reported a census of 69. Findings Include: 1. On 4/11/23 at 11:25 AM, observation of the North Dining Hall kitchenette shown small winged insects flown out from beneath the stainless-steel	F 925		

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sink.

2. On 4/13/23 at 8:18 AM, a green fly swatter had been observed lying on the Nurse's Station counter that had brown spots on it.

3. On 4/20/23 at 11:00 AM, an observation of the North Dining Hall kitchenette shown a black plastic garbage can lid on the floor and the trash can observed overflowing with garbage and small winged insects flying around the garbage can. A toaster placed on a tray sitting on the counter with small winged insects flying around the toaster.

During an interview on 4/12/23 at 3:30 PM, Staff R stated on 4/11/23 at 8:10 PM, observed a mouse run in front of his foot in the main kitchen.

During an interview the facility Registered Dietician (RD) on 4/16/23 at 1:00 P.M., she reported facility staff reported within the last month that rodents were in the building.

During an interview on 4/26/23 at 12:25 PM, Staff NN, Licensed Practical Nurse (LPN) stated staff spoke of the facility had mice. When asked if mice seen in the last month, Staff NN stated yes. When asked if mice seen in a particular area of the facility, Staff NN stated no, but during the nightshift mice seen throughout the hallways and in resident rooms in the last month.

The facility provided an Extermination Invoice dated 4/21/23 at 9:58 AM, for services provided on that date. Documented evidence of small flies/gnats found in the kitchenette and treated. Also Interior rodent service performed by checking and reset all traps, and checked and reset temporary snap traps in patient and office

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F 925	Continued From page 219 areas. The facility policy titled Pest Control had been reviewed by the facility March 2023. The Policy documented the facility responsible to maintain a written agreement with a qualified outside pest service to provide comprehensive pest control services on a regular and scheduled basis, and also issues that may arise in between scheduled visits with the outside pest service were to be treat as indicated. The facility failed to provide an Extermination Company agreement when asked. 4. The Minimum Data Set (MDS) Assessment dated 1/03/23 for Resident #70 shown the Brief Interview for Mental Status (BIMS) score was 14 out of 15 indicating intact cognition. During an interview on 4/11/23 at 2:05 p.m., Resident #70 stated she observed mouse feces in rooms.	F 925		

F550 Resident Rights/Exercise of Rights

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (11) was provided an indwelling catheter dignity cover. Social Service Director provided information related to rights as a resident of the facility. The resident was discharged from the facility on 06-01-2023

Resident (33) was provided an indwelling catheter dignity cover. Social Service Director provided information related to rights as a resident of the facility.

Resident (49) was provided an indwelling catheter dignity cover. Social Service Director provided information related to rights as a resident of the facility.

Resident (70) was provided personal care services. Social Service Director provided information related to rights as a resident of the facility.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) will be conducted for residents with an indwelling urinary catheter to ensure a dignity cover is present.

Quality Care Review (QCR) will be conducted to ensure personal care services have been provided in a dignified manner.

Facility Residents/Representatives will be provided information related to rights as a resident of the facility.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Added a new urology product to facility that includes a built-in dignity cover.

Director of Nursing/designee will obtain information utilizing administrative and clinical meeting, and 24-hour report to identify residents who have concerns related to personal care services.

Staff will be educated by the Director of Nursing/designee on the components of the regulation with an emphasis on,

- Rights as a resident of the facility.
- Providing care and services that promote a dignified experience such as;
    - response to call lights
    - response to resident needs
    - providing dignity covers for residents with an indwelling catheter.

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Director of Nursing/designee will conduct a QCR of 5 residents to include those residents with indwelling catheters weekly x 4 weeks, and then every 2 weeks x 2 months to ensure the presence of a dignity cover.

The Director of Nursing/designee will conduct a QCR of 5 residents to include those residents who require assistance with personal care weekly x 4 weeks, and then every 2 weeks x 2 months to ensure services are provided.

The Social Service Director/designee will conduct a QCR of 5 residents x 4 weeks, and then every 2 weeks x 2 months to ensure they are aware of their rights as a resident of the facility, they know who the Grievance Officer is and how to file a grievance.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date of Alleged Compliance 7/5/2023

F558 Reasonable Accommodation of Needs/Preferences

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (52) items were removed from the floor, trash receptacle was emptied, and the resident was provided with a nightstand.

Resident (63) trash receptacle was emptied, and the resident was provided with a bathroom trash receptacle. The resident was discharged from the facility on 06-08-2023.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Environment Review (QER) will be conducted of resident rooms to ensure a nightstand is present.

Quality Environment Review (QER) will be conducted in resident rooms to ensure a trash receptacle is present.

Quality Environment Review (QER) will be conducted in resident bathrooms to ensure a trash receptacle is present.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Facility policy will be updated to include trash receptacles for use in resident bathrooms.

Nursing Home Administrator/designee will obtain information utilizing administrative meeting, 24-hour report and TELS platform to identify resident room needs.

Staff will be educated by the Director of Nursing/designee on the components of the regulation with an emphasis on,

- Communicating resident room needs utilizing
    - 24-hour report
    - building management platform: TELS
    - department to department communication form

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Nursing Home Administrator/designee will conduct a QER of 5 resident rooms weekly x 4 weeks, and then every 2 weeks x 2 months to ensure resident room/bathroom furniture equipment and trash receptacle needs are met.

The Social Service Director/designee will conduct a QER of 5 residents x 4 weeks, and then every 2 weeks x 2 months to ensure they know who the Grievance Officer is and how to file a grievance related to resident room needs.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date of Alleged Compliance 7/5/2023

F565 Resident/Family Group and Response

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Staff (DON) is no longer employed effective 03-17-2023

Resident Council meeting was conducted on 05-01-2023 to review/resolve outstanding resident grievances.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) will be conducted of resident council meeting minutes for last 3 months to ensure concerns/ grievances have resolution.

Alert and oriented residents, or the resident representative will be interviewed by the Social Service Director/designee to inquire if resident personal care needs are being met.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Staff will be educated by the Director of Nursing/designee on the components of the regulation with an emphasis on,

- Prompt action to grievances/ concerns
- Timely response to call lights and ensuring resident personal care needs are met
- Delivering resident care/communication in a dignified manner
- Refraining from use of personal cell phones and ear buds in resident care areas
- Processing a resident grievance form

Activity Director will be educated on prompt action to grievances/concerns and processing a resident grievance form.

Social Service Director will be educated on prompt action to grievances/concerns and processing a resident grievance form.

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Social Service Director/designee will conduct a QCR observation/interview of 5 residents on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure if a concern / grievance has been communicated, that prompt action and timely resolution occurred.

The Nursing Home Administrator/designee will conduct a QCR of 5 grievances weekly x 4 weeks, and then every 2 weeks x 2 months to ensure if a concern / grievance has

been communicated, that prompt action and timely resolution occurred.

The Nursing Home Administrator/designee will review resident council meeting minutes monthly to ensure if a concern / grievance has been communicated that prompt action and timely resolution occurred.

The Director of Nursing /designee will conduct a QCR call light observations on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure timely response and care needs of the resident are being met.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Date of Alleged Compliance 7/5/2023

F580 Notify of Change

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (9) was evaluated by a Licensed Nurse. The results of the assessment were communicated to the resident/representative. The resident has remained in the same room since 01-18-2023.

Resident (121) was discharged from the facility on 05-18-2023.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Resident evaluations will be completed by a Licensed Nurse and the resident / resident representative will be notified of active or a new change in health status or under the following circumstances:

- Transfer to a Higher-Level of Care
- Room/Roommate Change
- Appointment/s

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee will educate Licensed Nurses on the components of the regulation with emphasis on:

- Resident / Resident Representative Notification related to:
    - resident change in health status
    - transfer to a higher-level of care
    - room/roommate change
    - appointment/s

Director of Nursing/designee will educate Certified Nursing Assistants regarding licensed nurse notification of a residents change in condition utilizing the following alert tool, in addition/substitution to verbal communication:

- EInteract – Stop and Watch

Nursing Home Administrator/designee will educate Social Service Director on documenting resident room changes utilizing "Room Change Notification" in EHR.

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Director of Nursing/designee will conduct a QCR of 5 residents records on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure a new change in health status, room or roommate change, appointment/s or transfer to a higher-level of care there was applicable notification.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance

has been maintained and recommends moving to quarterly monitoring.

Date of Allegation of Compliance 7/5/2023

F584 Safe/Clean/Comfortable/Homelike Environment

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (3) had linens placed on the bed

Resident (9) had socks placed on her feet and encouraged to keep them on.

Resident (15) bathroom floor and toilet was cleaned

Resident (24) white powder on floor was picked up and discarded. Floor was mopped, and general cleaning was completed to include mattress and bathroom. Resident received ADL assistance for bathing. Urinal was replaced, and roommate's urinal was replaced.

Resident (41) had linens placed on the bed

Resident (46) trash was discarded. Clothing and blankets were placed in soiled linen bin. New linens placed on bed after cleaning. The room was cleaned to include the floors, mat by bed and the electric bed.

Resident (56) incontinent pad disposed of, and wash cloth was placed in soiled linen bin.

North side smoking area had cigarette butts discarded into appropriate container.

Cloth towel was laundered

Floors were mopped/cleaned to remove debris to include the dining room and hallways.

Carpet was cleaned by an outside vendor.

Dining areas were cleared of trash, and cleaned

Hallways cleared of trash, and cleaned

Additional linen was purchased for the facility

Linen carts were ordered.

Trash receptacles were ordered.

Mobile carts were ordered for soiled linen/garbage.

Carpet cleaning placed on routine schedule.

Resident rooms placed on routine cleaning schedule

Common areas placed on routine cleaning schedule

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; .

Quality Observation Review (QOR) will be completed to identify rooms in need of bed linen and general cleaning.

Issues or concerns were addressed as they were identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee will educate nursing, kitchen, and housekeeping staff on the components of the regulation with emphasis on,

- Routine cleaning schedules, for resident rooms and common areas
- General cleanliness of resident rooms and common areas, and need for episodic cleaning
- Cleaning the dining areas after each meal
- Emptying and replacing urinals routinely
- Appropriate cigarette disposal

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Nursing Home Administrator/designee will conduct a QCR of 5 resident rooms weekly x 4 weeks, and then every 2 weeks x 2 months to ensure urinals are empty and clean (when applicable), bed linens are in place, trash and dirty linen is in the appropriate receptacle, area is free of clutter, and is generally clean.

The Nursing Home Administrator/designee will conduct a QCR of 5 common areas weekly x 4 weeks, and then every 2 weeks x 2 months to ensure trash and dirty linen is in the appropriate receptacle, the area is free of clutter, and is generally clean.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date of Alleged Compliance 7/5/2023

F600 Freedom from Abuse and Neglect

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (2) was provided assistance with bathing.

Resident (3) had linens placed on the bed

Resident (4) was provided assistance with bathing. Cell phone and call light was placed within reach.

Resident (9) had socks placed on her feet and encouraged to keep them on.

Resident (10) was provided assistance with nail trim, facial trim, hair care and bathing.

Resident (15) bathroom floor and toilet was cleaned

Resident (24) white powder on floor was picked up and discarded. Floor was mopped, and general cleaning was completed to include mattress and bathroom. Resident received ADL assistance for bathing. Urinal was replaced, and roommate's urinal was replaced.

Resident (35) was provided assistance with hand hygiene, and bathing

Resident (41) had linens placed on the bed

Resident (46) trash was discarded. Clothing and blankets were placed in soiled linen bin. New linens placed on bed after cleaning. The room was cleaned to include the floors, mat by bed and the electric bed.

Resident (56) was provided assistance with bathing. Incontinent pad disposed of, and wash cloth was placed in soiled linen bin.

Resident (61) was provided assistance with a nail trim and bathing.

Resident (63) was provided assistance with bathing. The resident was discharged on 06-08-2023.

Resident (70) was provided assistance with bathing.

North side smoking area had cigarette butts discarded into appropriate container.

Cloth towel was laundered

Floors were mopped/cleaned to remove debris to include the dining room and hallways.

Carpet was cleaned by an outside vendor.

Dining areas were cleared of trash, and cleaned

Hallways cleared of trash, and cleaned

Additional linen was purchased for the facility

Linen carts were ordered.

Trash receptacles were ordered.

Mobile carts were ordered for soiled linen/garbage.

Carpet cleaning placed on routine schedule.

Resident rooms placed on routine cleaning schedule

Common areas placed on routine cleaning schedule

(2) How will you identify other residents having a potential to be affected and what corrective action will be taken;

Quality Observation Review (QOR) will be completed to identify rooms in need of bed linen and general cleaning.

Quality Care Review (QCR) observation rounds and interviews will be conducted to ensure residents are clean, appropriately dressed, and well-groomed, and to identify any concerns related to call lights response or staff response related to personal care services.

Resident interviews will be conducted to identify bathing preferences. Schedules and POC tasks will be updated.

Issues or concerns will be addressed as they are identified

(3) What measures will be put in place or what systemic changes will you make to ensure that the practice does not recur;

Director of Nursing/designee will educate staff on the components of this regulation with an emphasis on indicators of neglect,

- Call light response times, related to needs for personal care and service delivery
- Provisions of ADL care; bathing, general grooming, shaving and nail care

Director of Nursing/designee will educate nursing, kitchen, and housekeeping staff on the components of the regulation with emphasis on,

- Routine cleaning schedules, for resident rooms and common areas
- General cleanliness of resident rooms and common areas, and need for episodic cleaning
- Cleaning the dining areas after each meal
- Emptying and replacing urinals routinely
- Appropriate cigarette disposal

Newly hired employees will receive education in orientation.

(4) How the corrective action will be monitored to ensure the practice will not recur;

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The Director of Nursing/designee will conduct a QCR of 10 resident observations weekly x 4 weeks, and then every 2 weeks x 2 months to ensure residents are clean, appropriately dressed, and well-groomed.

The Director of Nursing/designee will conduct a QCR of 10 resident observations weekly x 4 weeks, and then every 2 weeks x 2 months to ensure bathing per resident preference.

The Nursing Home Administrator/designee will conduct interviews weekly x 4 weeks and then bi-weekly interviews x2 months of 10 residents/resident representatives to identify concerns related to the provision of ADL care or call light response time.

The Nursing Home Administrator/designee will conduct a QCR of 5 resident rooms weekly x 4 weeks, and then every 2 weeks x 2 months to ensure urinals are empty and clean (when applicable), bed linens are in place, trash and dirty linen is in the appropriate receptacle, area is free of clutter, and is generally clean.

The Nursing Home Administrator/designee will conduct a QCR of 5 common areas weekly x 4 weeks, and then every 2 weeks x 2 months to ensure trash and dirty linen is in the appropriate receptacle, the area is free of clutter, and is generally clean.

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The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Date of Allegation of Compliance 7/5/2023

F609 Reporting of Alleged Violations

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (12) was evaluated by a Licensed Nurse. Federal Immediate report was submitted on 4/25/23, followed by 5-Day Final report on 4/29/2023, and Law Enforcement was notified of the resident-to-resident altercation with Resident (70)

Resident (21) was evaluated by a Licensed Nurse. Federal Immediate report was submitted on 4/25/23, followed by 5-Day Final report on 4/29/2023, and Law Enforcement was notified of the resident-to-resident altercation with Resident (70)

Resident (70) was evaluated by a Licensed Nurse. Federal Immediate report was submitted on 4/25/23, followed by 5-Day Final report on 4/29/23, and Law Enforcement was notified of the resident-to-resident altercation with Resident (21)

Resident (70) was evaluated by a Licensed Nurse. Federal Immediate report was submitted on 4/25/23, followed by 5-Day Final report on 4/29/23, and Law Enforcement was notified of the resident-to-resident altercation with Resident (12)

(2) How will you identify other residents having a potential to be affected and what corrective action will be taken;

Quality Care Review (QCR) will be conducted of resident grievance logs for last 3 months to ensure no other allegations of ANEMMI were identified, and if so, reported timely.

Quality Care Review (QCR) will be conducted of resident council minutes for last 3 months to ensure no other allegations of ANEMMI were identified, and if so, reported timely.

Alert and oriented residents, or the resident representative will be interviewed by the Social Service Director/designee to ensure their safety and care needs are being met.

Employees will be allowed an opportunity to communicate any first-hand knowledge of unaddressed ANEMMI through the education process.

Issues or concerns will be addressed as they are identified, and when applicable, reporting will occur timely.

(3) What measures will be put in place or what systemic changes will you make to ensure that the practice does not recur;

Director of Nursing/designee will educate staff on the components of this regulation with an emphasis on,

- The responsibility to report allegations of ANEMMI in accordance with all applicable laws, regulations, and organizational standards

Chief Clinical Officer/designee will educate the Nursing Home Administrator on the components of this regulation with an emphasis on,

- The responsibility to file appropriate reports in accordance with all applicable laws, regulations, and organizational standards

Chief Clinical Officer/designee will educate the Director of Nursing on the components of this regulation with an emphasis on,

- The responsibility to file appropriate reports in accordance with all applicable laws, regulations, and organizational standards.

Newly hired employees will receive education in orientation.

(4) How the corrective action will be monitored to ensure the practice will not recur;

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The Nursing Home Administrator/designee will conduct a QCR of the facility grievance log weekly x4 weeks, and then every 2 weeks x2 months to ensure no other allegations of ANEMMI were identified, and if so, reported timely.

The Nursing Home Administrator/designee will conduct a QCR of facility resident council minutes monthly x4 months, and then every 2 months x 4 months to ensure no other allegations of ANEMMI were and if so, reported timely.

Department Managers will conduct a weekly QCR on their room/resident assignments to ensure no further concerns with ANEMMI are identified, and if so, reported timely x3 months.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Date of Allegation of Compliance 6/14/2023

F610 Investigate/Prevent/Correct Alleged Violation

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (12) was evaluated by a Licensed Nurse. A comprehensive investigation was completed for 08-27-2022 resident-to resident altercation with Resident (70)

Resident (21) was evaluated by a Licensed Nurse. A comprehensive investigation was completed for 05-31-2022 resident-to resident altercation with Resident (70)

Resident (70) was evaluated by a Licensed Nurse. A comprehensive investigation was completed for 08-27-2022 resident-to resident altercation with Resident (12)

Resident (70) was evaluated by a Licensed Nurse. A comprehensive investigation was completed for 05-31-2022 resident-to resident altercation with Resident (21)

(2) How will you identify other residents having a potential to be affected and what corrective action will be taken;

Quality Care Review (QCR) will be conducted of resident grievance logs for last 3 months to ensure no other allegations of ANEMMI are identified, and if so, investigated.

Quality Care Review (QCR) will be conducted of resident council minutes for last 3 months to ensure no other allegations of ANEMMI are identified, and if so, investigated.

Issues or concerns will be addressed as they are identified, and when applicable, a comprehensive investigation will be completed.

(3) What measures will be put in place or what systemic changes will you make to ensure that the practice does not recur;

Director of Nursing/designee will educate staff on the components of this regulation with an emphasis on,

- Identifying, responding, and reporting allegations of ANEMMI.
- Participating in an investigation.

Chief Clinical Officer/designee will educate the Nursing Home Administrator on the components of this regulation with an emphasis on,

- Tracking and trending through the monthly Quality Assurance/Performance Improvement (QA/PI) Committee
- Validating the following have been completed by the Director of Nursing post ANEMMI event,
    - A comprehensive investigation that includes an Interdisciplinary Team (IDT) Root Cause Analysis (RCA), and may include the following,
        - resident statement
        - witness statements
        - medical record review
        - environment observation

        - equipment safety check
        - scene reenactment
    - Care plan is updated to reflect interventions determined through the final findings of the comprehensive investigation
    - ANEMMI event is captured, and completed using the electronic risk report
    - Documents are managed and safeguarded for future retrieval or reference in the cloud-based service currently in use. This includes the electronic event, RCA, statements, evaluation of the medical record review, environmental observation, equipment safety check, scene reenactment, the updated care plan interventions, and the final findings of the investigation

Chief Clinical Officer/designee will educate the Director of Nursing will be educated on the components of this regulation with an emphasis on,

- The responsibilities of ANEMMI event management that includes,
    - A comprehensive investigation that includes an Interdisciplinary Team (IDT) Root Cause Analysis (RCA), and may include the following,
        - resident statement
        - witness statements
        - medical record review
        - environment observation
        - equipment safety check
        - scene reenactment
    - Care plan is updated to reflect interventions determined through the final findings of the comprehensive investigation
    - ANEMMI event is captured, and completed using the electronic risk report
    - Documents are managed and safeguarded for future retrieval or reference in the cloud-based service currently in use. This includes the electronic event, RCA, statements, evaluation of the medical record review, environmental observation, equipment safety check, scene reenactment, the updated care plan interventions, and the final findings of the investigation.

Newly hired employees will receive education in orientation.

(4) How the corrective action will be monitored to ensure the practice will not recur;

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The Nursing Home Administrator/designee will conduct a QCR of grievance log weekly x 4 weeks, and then every 2 weeks x 2 months to ensure no other allegations of ANEMMI were identified, and if so, investigated.

The Nursing Home Administrator/designee will conduct a QCR of resident council minutes monthly x 4 months, and then every 2

months x 4 months to ensure no other allegations of ANEMMI were identified, and if so, investigated.

Department Managers will conduct a weekly quality care review on their room/resident assignments to ensure no further concerns with ANEMMI are identified x3 months, and if so, investigated.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Date of Allegation of Compliance 7/5/23

F641 Accuracy of Assessments

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (2) had an MDS modification completed as appropriate.

Resident (16) had an MDS modification completed as appropriate. The resident was discharged from the facility on 05-15-2023.

Resident (22) had an MDS modification completed as appropriate. The resident was discharged from the facility on 04-14-2023.

Resident (41) had an MDS modification completed as appropriate.

(2) How will you identify other residents having a potential to be affected and what corrective action will be taken;

Quality Care Review (QCR) will be conducted of the resident's last MDS assessment to identify any other that require MDS modifications, and if so, completed.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put in place or what systemic changes will you make to ensure that the practice does not recur;

RAI specialist/designee will educate staff with responsibility on completing sections of the MDS on the components of this regulation with an emphasis on,

- Accuracy of the resident MDS assessments
- Coding accuracy of the resident MDS

(4) How the corrective action will be monitored to ensure the practice will not recur;

The MDS Coordinator will conduct a QCR of 5 MDS assessments weekly x 4 weeks, and then every 2 weeks x 2 months to ensure accuracy in MDS coding.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Date of Allegation of Compliance 7/5/23

F644 Coordination of PASARR and Assessments

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (16) PASARR was reviewed, revised, and resubmitted as appropriate by the Licensed Social Worker. The resident was discharged from the facility on 05-15-2023.

Resident (41) PASARR was reviewed, revised, and resubmitted as appropriate by the Licensed Social Worker.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) will be conducted of Pre-Admission Screening and Resident Review (PASARR) forms for residents currently residing in the facility to ensure forms were accurately and completely filled out.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

RAI Specialist/designee will educate the admissions and social service department on the components of this regulation with emphasis on,

- Accuracy of the Pre-Admission Screening and Resident Review (PASARR) to ensure individuals with mental illness and intellectual disabilities receive care and services in the most appropriate setting.

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Nursing Home Administrator/designee will conduct 5 medical record reviews on newly admitted residents weekly x 4 weeks, then biweekly x 2 months to ensure the PASARR is present within the medical record and accurate.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Date of Allegation of Compliance 7/5/2023

F656 Develop/Implement Comprehensive Care Plan

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (48) the resident was discharged from the facility on 05-17-2023

Resident (71) the resident was discharged from the facility on 01-18-2023

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) will be conducted of residents with continuous oxygen and/or at risk for elopement to ensure the plan of care is accurate and being carried out.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee will educate staff who contribute to initiating and updating the resident plan of care on the components of this regulation with an emphasis on,

- Residents using oxygen
- Residents at risk for elopement

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The MDS Coordinator will conduct a QCR of 5 resident care plans weekly x 4 weeks, and then every 2 weeks x 2 months to ensure accuracy and following of the care plan.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Date of Allegation of Compliance 7/5/2023

F657 Care Plan Timing and Revision

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (4) The resident was evaluated by therapy for wheelchair positioning. The Intradisciplinary Team completed a review of the resident care plans to ensure accuracy and included actual skin impairment.

Resident (46) Physician order for oxygen was reviewed for accuracy. The Intradisciplinary Team completed a review of the resident care plans to ensure accuracy and included risk of illicit drug use, risk of falls and the use of oxygen.

Resident (70) The Intradisciplinary Team completed a review of the resident care plans to ensure accuracy and included risk of illicit drug use and history of physical altercations.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) will be conducted on residents receiving treatment for pressure injuries, oxygen therapy, at risk for falls, illicit drug use and physical altercations to ensure care plans are in place with interventions.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

RAI specialist will educate the MDS staff on the components of this regulation with an emphasis on,

- The process for completing and revising person-centered care plans with appropriate interventions with a focus on,
    - Pressure injury treatment
    - Oxygen usage
    - At risk for
        - Falls
        - Illicit drug usage
        - Physical altercations

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The MDS Coordinator will conduct a QCR of 5 resident care plans weekly x 4 weeks, and then every 2 weeks x 2 months to ensure accuracy and person-centered interventions are in place.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Date of Allegation of Compliance 7/5/2023

F658 Services Provided Meet Professional Standards

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (2) was reassessed by a licensed nurse; the resident did not sustain any adverse effects. The physician was notified. The wound area was cleaned, treated and a new dressing was applied per treatment order.

Resident (4) was reweighed and was reevaluated by a Registered Dietician. Physician notified of resident status. Additional validation to ensure physician orders are in place for routine weights.

Resident (12) was reweighed and reevaluated by a Registered Dietician. Physician notified of resident status. Additional validation to ensure physician orders are in place for routine weights.

Resident (61) was reassessed by a licensed nurse; the resident did not sustain any adverse effects. The physician was notified. The wound area was cleaned, treated and a new dressing was applied per treatment order.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Skin evaluations will be conducted on residents with wounds to evaluate their current status, and ensure suitable treatments are in place and carried out per physician order.

Quality Care Review (QCR) will be conducted of resident weights to ensure there is no unidentified or untreated weight loss, and routine weight orders are in place if appropriate.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee will educate licensed and certified nursing staff on the components of this regulation with an emphasis on,

- Height and weight are obtained on admission, and routinely
- Obtaining weights per physician order
- Documenting weight in electronic health record
- Communicating changes in weight status
- Obtaining registered dietician evaluation
- Utilizing designated scale/chair for weighing residents and the scale has been calibrated quarterly

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Director of Nursing /designee will conduct a QCR of 5 wounds on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure dressing changes are occurring per physician order.

The Director of Nursing/designee will conduct a QCR of 5 residents records on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure weights have been obtained per physician order and documented in the electronic health record. If weight loss is identified, then the physician and registered dietician have been notified

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date of Allegation of Compliance 7/5/2023

F677 – Care Provided for Dependent Residents

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (2) was provided assistance with bathing.

Resident (4) was provided assistance with bathing. Cell phone and call light was placed within reach.

Resident (10) was provided assistance with nail trim, facial trim, hair care and bathing.

Resident (35) was provided assistance with hand hygiene, and bathing

Resident (56) was provided assistance with bathing.

Resident (61) was provided assistance with a nail trim and bathing.

Resident (63) was provided assistance with bathing. The resident was discharged on 06-08-2023.

Resident (70) was provided assistance with bathing.

(2) How will you identify other residents having a potential to be affected and what corrective action will be taken;

Quality Care Review (QCR) observation rounds and interviews will be conducted to ensure residents are clean, appropriately dressed, and well-groomed, and to identify any concerns related to call lights response or staff response related to personal care services.

Resident interviews will be conducted to identify bathing preferences. Schedules and POC tasks will be updated.

Issues or concerns will be addressed as they are identified

(3) What measures will be put in place or what systemic changes will you make to ensure that the practice does not recur;

Director of Nursing/designee will educate certified nursing staff on the components of this regulation with an emphasis on,

- Notification to licensed nurse when a resident refuses bathing per schedule
- Call light response times
- Provisions of ADL care; bathing, general grooming, shaving and nail care

Newly hired employees will receive education in orientation.

(4) How the corrective action will be monitored to ensure the practice will not recur;

The Director of Nursing/designee will conduct a QCR of 10 resident observations weekly x 4 weeks, and then every 2 weeks x 2 months to ensure residents are clean, appropriately dressed, and well-groomed.

The Director of Nursing/designee will conduct a QCR of 10 resident observations weekly x 4 weeks, and then every 2 weeks x 2 months to ensure bathing per resident preference.

The Nursing Home Administrator/designee will conduct interviews weekly x 4 weeks and then bi-weekly interviews x2 months of 10 residents/resident representatives to identify concerns related to the provision of ADL care or call light response time.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Date of Allegation of Compliance 7/5/2023

F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (4) was reassessed by a licensed nurse; the resident did not sustain any adverse effects from a potential opportunity for cross-contamination to have occurred. The physician was notified. The wound area was cleaned, treated and a new dressing was applied per treatment order. The resident was evaluated by therapy for positioning.

Resident (49) was reassessed by a licensed nurse; the resident did not sustain any adverse effects from a potential opportunity for cross-contamination to have occurred. The physician was notified. The wound area was cleaned, treated and a new dressing was applied per treatment order. The resident was discharged on 05-15-2023.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) of wound evaluations were completed by a licensed nurse to determine if any adverse effects from a potential opportunity for cross-contamination that may have occurred.

Quality Care Review (QCR) of residents to ensure pressure injury preventative interventions are being carried out for residents at risk for developing pressure injuries.

Issues or concerns were addressed as they were identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Licensed staff were educated on the components of the regulation with emphasis on:

- Maintaining an environment to help prevent the development and transmission of infection
- Clean dressing change process
- Carrying out interventions to prevent the development of pressure injuries

Newly hired licensed nursing staff will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Director of Nursing /designee will conduct a QCR of 5 licensed staff weekly x 4 weeks, and then every 2 weeks x 2 months to conduct a clean dressing changes competency.

The Director of Nursing /designee will conduct a QCR of 5 wounds on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure clean dressing changes are occurring.

The Director of Nursing /designee will conduct a QCR of 5 residents at risk to develop pressure injuries on each unit

weekly x 4 weeks, and then every 2 weeks x 2 months to ensure preventative interventions are being carried out.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Allegation of Compliance (June 14, 2023)

F689 Free of Accident Hazards/Supervision/Devices

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (71) resident was discharged from the facility on 01-18-2023.

Resident (24) medications were removed from bedside. Medication self-administration evaluation was completed, care plan was updated, and a bedside security lock box was provided.

Resident (36) medications were removed from bedside. Medication self-administration evaluation was completed, care plan was updated, and a bedside security lock box was provided.

Medication and treatment carts had medications and treatments secured in locked drawers.

Medication and treatment carts had lock tumblers replaced, and new keys were provided for each cart by pharmacy. A master set of keys were provided to the Director of Nursing.

Satellite kitchen, serving area door had a keypad entry lock installed.

Egress doors have primary 15-second delay annunciators, or keypad entry locks or are connected to overhead alert system. They were tested for appropriate functioning.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) for elopement risk of residents was conducted; interventions placed as appropriate.

Quality Care Review (QCR) of elopement binders was conducted to ensure binders are placed at each nursing station & front desk and are up to date post re-evaluation

Quality Environmental Review (QER) of egress doors was conducted to ensure functionality.

Quality Care Review (QCR) of medications and treatments versus physician orders was completed.

Quality Care Review (QCR) of medications and treatments at bedside was completed, and as appropriate medication self-administration evaluations were completed.

Quality Environmental Review (QER) of the kitchen serving area was completed to ensure keypad entry locks are in place and functioning.

Issues or concerns were addressed as they were identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee educated staff on the components of this regulation with an emphasis on;

- Elopement
    - Risk assessment
    - Identification of triggers
    - Interventions including supervision
    - Response procedures
    - Routine mock drills
    - Behavior alert and communication
    - Egress functionality

Director of Nursing/designee educated licensed nursing and certified medication staff on the components of the regulation with emphasis on,

- Providing medication and treatments per physician order
- Obtaining resident self -administration evaluation
- Medications and treatments at bedside
- Resident observation through medication administration

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Director of Nursing/designee will conduct a Quality Care Review (QCR) of 5 residents records on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure elopement risk assessments are completed as appropriate.

The Director of Nursing/designee will conduct a Quality Care Review (QCR) of elopement binders on each unit and the front desk weekly x 4 weeks, and then every 2 weeks x 2 months to ensure elopement binders are up to date and accurate.

The Maintenance Director/designee will conduct a Quality Environmental Review (QER) of egress doors weekly x 4 weeks, and then every 2 weeks x 2 months to ensure functionality as indicated.

The Administrator/designee will conduct a Quality Care Review (QCR) of elopement drill documentation monthly x 3 months to ensure staff participation.

The Director of Nursing /designee will conduct a QCR of 5 rooms on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure medications are not left at bedside for residents without a self-administration evaluation that indicates approval.

The Director of Nursing /designee will conduct a QCR of medication and treatment carts on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure medications are not unattended and unsecured.

The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Allegation of Compliance (June 14, 2023)

F690: Bowel/Bladder Incontinence, Catheter, UTI

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

Resident (11) resident discharged from the facility on 06-01-2023

Resident (33) foley catheter was replaced and covered with a dignity bag. Physician indwelling catheter orders were reviewed for,

- Appropriate diagnosis
- Balloon size, shape, cc
- Catheter care
- Change catheter drainage bag (routine and prn)
- Change indwelling catheter for leakage or blockage as medical necessary
- Irrigate indwelling Foley catheter PRN for blockage, occlusion, leakage, etc

Resident (49) resident discharged from the facility on 05-10-2023

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) will be completed on residents with an indwelling catheter, for the presence of physician orders and will be provided with an indwelling catheter dignity cover.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee will educate licensed and certified nursing staff on the components of this regulation with an emphasis on,

- Providing a dignity cover
- Clean environment practice and the licensed nursing staff on,
    - Physician orders for indwelling urinary catheter

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The facility Director of Nursing /designee will conduct a QCR of 5 residents with indwelling catheters on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure the presence of a dignity bag and physician orders and observation of clean environment practice.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Date of Allegation of Compliance 7/5/2023

F692 Nutrition/Hydration Status Maintenance

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (25) was reevaluated by a Registered Dietician and Physician Extender. Physician aware of current weight status, and order for speech evaluation and treatment.

Resident (45) was reevaluated by a Registered Dietician and Physician Extender. Physician is aware of resident current stable weight status and will continue to monitor.

Resident (61) was reweighed and was reevaluated by a Registered Dietician. Physician notified of resident status, and order for swallow study to evaluate continued need for enteral nutrition. Additional validation to ensure physician enteral nutrition order is in place, and liquid formula and the administration supplies are on hand.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) was conducted of resident weights by Registered Dietician, and interventions placed as appropriate.

Quality Care Review (QCR) was conducted of residents receiving enteral nutrition to ensure physician enteral nutrition orders are in place, and liquid formula and the administration supplies are on hand.

Quality Care Review (QCR) was conducted to ensure appropriate measuring/ portion control utensils were available to dietary staff.

Issues or concerns were addressed as they were identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Dietary Manager/designee educated dietary staff on portion size and use of measuring utensils.

Director of Nursing/designee educated licensed and certified nursing staff on the components of this regulation with an emphasis on,

- Height and weight are obtained on admission
- Obtaining weights per physician order
- Documenting weight in electronic health record
- Communicating changes in weight status
- Obtaining registered dietician evaluation
- Utilizing designated scale/chair for weighing residents and the scale has been calibrated quarterly

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Director of Nursing/designee will conduct a Quality Care Review (QCR) of 5 residents records on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure weights have been obtained per physician order and documented in the electronic health record. If weight loss is identified, then the physician and registered dietician have been notified.

The Director of Nursing/designee will conduct a Quality Care Review (QCR) of 5 residents records who receive enteral nutrition on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure physician enteral nutrition orders are in place, and liquid formula and the administration supplies are on hand.

The Dietary Manager/designee will conduct a Quality Review of 5 resident trays on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure tray accuracy and portion size is appropriate.

The Maintenance Director/designee will conduct a weekly Quality Environmental Review (QER) of designated scales monthly x 3 months to ensure appropriate calibration

The Administrator/designee will conduct a Quality Care Review (QCR) of scale calibration documentation monthly x 3 months to ensure completion

The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Allegation of Compliance (June 14, 2023)

F695: Respiratory/Tracheostomy care and Suctioning

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (12) BIPAP and oxygen orders were clarified, and clean equipment was provided

Resident (46) oxygen orders were clarified, and clean equipment was provided.

Resident (48) resident was discharged from the facility on 05-17-2023

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) will be conducted of physician orders for residents receiving oxygen therapy to ensure the following is included,

- Device, with LPM to be delivered
- Parameters and indication in place for PRN orders
- Monitor SPO2
- Change masks/nasal canula/tubing and hydration weekly
- Signage on door indicating oxygen in use

Quality Care Review (QCR) will be conducted of physician orders for residents receiving cpap or bipap therapy to ensure the following is included,

- Device, with LPM to be delivered
- Parameters and indication in place for PRN orders
- Monitor SPO2
- Clean masks, tubing and hydration weekly
- Signage on door indicating oxygen in use

Quality Care Review was conducted on residents receiving oxygen therapy/cpap/ bipap treatment of respiratory equipment to ensure physician orders could be carried out.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee will educate licensed nursing staff on the components of this regulation with an emphasis on,

- Obtaining physician oxygen orders
- Providing appropriate respiratory equipment
- Next steps if equipment cannot be procured.

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Director of Nursing /designee will conduct a QCR of 5 resident records on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure respiratory orders are in place, equipment is present and upon observation, is clean.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends moving to quarterly monitoring.

Date of Alleged Compliance 7/5/2023

F725 Sufficient Nursing Staff

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (10) was provided personal care services.

Resident (13) no longer resides at the facility

Resident (17) was provided personal care services.

Resident (18) was provided personal care services.

Resident (24) was provided personal care services.

Resident (26) was provided personal care services.

Resident (46) was provided personal care services.

Resident (48) resident was discharged from the facility on 05-17-2023

Resident (55) was provided personal care services.

Resident (122) resident was discharged from the facility on 01-28-2023

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) will be conducted to ensure personal care services are provided.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee will educate staff on the components of the regulation with an emphasis on their role and responsibility in,

- Timely response to call lights
- Timely response to resident needs

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Director of Nursing/designee will conduct a QCR of 5 residents to include those residents who require assistance with personal care weekly x 4 weeks, and then every 2 weeks x 2 months to ensure services are provided.

The Social Service Director/designee will conduct a QCR observation/interview of 5 residents on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure timely call light response and if a concern / grievance has been communicated, that prompt action and timely resolution occurred.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date of Alleged Compliance 7/5/2023

F726 Competent Nursing Staff

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Staff (K) nursing license was verified as active.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) will be conducted of licensed nurses, certified medication aides and certified nursing assistants was conducted to ensure licenses and certifications are active.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Personnel Services/designee will educate Huna Resource staff the on the components of the regulation with an emphasis on,

- Initial and routine license and certification verifications.

Newly hired employees in the department will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Nursing Home Administrator/designee will conduct a QCR of 5 personnel files weekly x 4 weeks, and then every 2 weeks x 2 months to ensure active licenses and certifications.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date of Alleged Compliance 7/5/2023

F740 Behavioral Health Services

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (46) was evaluated by a Licensed Nurse and does not present with signs or symptoms of acute illicit drug use or misuse of schedule II-controlled prescription medication. Pain evaluation, and medication review was completed.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) resident evaluations by a licensed nurse will be conducted for signs or symptoms of acute illicit drug use or misuse of schedule II-controlled prescription medication.

Quality Care Review (QCR) of controlled prescription medications will be reconciled by comparing descending narcotic count sheets to controlled drugs present in locked boxes and narcotic EDK boxes.

Quality Care Review (QCR) medical record review will be completed to identify residents with history of illicit drug use to include misuse of schedule II-controlled prescription medication and if so, will have their care plan reviewed and revised to minimize risk as appropriate, and will be provided psychiatric/psychological services as indicated.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing /designee will educate staff on the components of the regulation with an emphasis on,

- Facility practice that supports residents with history of illicit drug use to include misuse of schedule II-controlled prescription medication while a resident of the nursing facility, including person-centered care plans
- Providing/facilitating Behavioral Health Services as appropriate

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Director of Nursing/designee will conduct a QCR of 5 residents to include those residents with a history of illicit drug use to include misuse of schedule II-controlled prescription medication weekly x 4 weeks, and then every 2 weeks x 2 months to ensure signs or symptoms of acute use, and the respective care plan remains appropriate.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date of Allegation of Compliance 7/5/2023

F756 Drug Regimen Review, Report Irregular, Act On

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (9) the physician responded to outstanding pharmacy recommendations.

Resident (46) the physician responded to outstanding pharmacy recommendations

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) will be conducted to ensure the physician responded to outstanding pharmacy recommendations.

Monthly review process was implemented with pharmacy, resident physicians, and facility nursing management.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee educated licensed nursing staff on the components of this regulation with emphasis on,

- Ensuring monthly drug regimen review pharmacy recommendations are provided timely to the resident physician with follow up denoted related to physician response.

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Director of Nursing/designee will conduct a QCR of 5 residents records weekly x 4 weeks, and then every 2 weeks x 2 months to ensure pharmacist drug regimen review recommendations have been provided to the physician with the physician response noted for acceptance or declination.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date of Allegation of Compliance 7/5/2023

F758 Free from Unnec Psychotropic Meds/PRN Use

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (9) routine and prn psychotropic medications were evaluated for possible gradual dose reduction with the physician and mental health provider.

Resident (46) routine and prn psychotropic medications were evaluated for possible gradual dose reductions with the physician and mental health provider.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) will be conducted of residents receiving psychotropic medications was conducted to ensure routine and prn psychotropic medications are evaluated for possible gradual dose reductions, and pharmacy recommendations have been reviewed.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee will obtain information utilizing administrative and clinical meetings and 24-hour report to identify residents who have newly prescribed psychotropic medications, or who are due for re-evaluation of prn usage.

Chief Clinical Officer/designee will educate the Director of Nursing on the components of the regulation with an emphasis on,

- Facilitating physician review of pharmacy recommendations related to psychotropic medication gradual dose reductions
- Conditions and restrictions related to psychotropic prn usage

Director of Nursing/designee will educate licensed nurses on the components of the regulation with an emphasis on,

- Facilitating physician review of pharmacy recommendations related to psychotropic medication gradual dose reductions
- Conditions and restrictions related to psychotropic prn usage

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Director of Nursing/designee will conduct a QCR of 5 residents records to include those residents receiving psychotropic medications weekly x 4 weeks, and then every 2 weeks x 2 months to ensure gradual dose reductions are occurring, and prn usage is reevaluated.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date Allegation of Compliance 7/5/2023

F760 Residents Are Free of Significant Med Errors

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (19) was treated at the hospital and returned to the facility.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) will be conducted of resident nursing evaluations by a licensed nurse to ensure no active or new change in health status that could indicate a medication administration error occurred.

Quality Care Review (QCR) will be conducted to ensure current resident pictures are present in the electronic medical record.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee will educate licensed nurses and certified medication aides on the components of this regulation with an emphasis on safe resident medication administration that includes,

- The 6 rights of medication administration
    - right patient
    - right medication
    - right dose
    - right route
    - right time & frequency
    - right documentation

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Director of Nursing/designee will conduct a QCR of 5 residents records weekly x 4 weeks, and then every 2 weeks x 2 months to ensure medications are administered as ordered by the Physician or Physician extender, and a current resident picture is present in the electronic medical record.

The Director of Nursing/designee will conduct a QCR of 5 licensed nurses and 5 certified medication aides weekly x 4 weeks, and then every 2 weeks x 2 months to medications are administered as ordered by the Physician or Physician extender.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Allegation of Compliance (June 14, 2023)

F761 Label/Store Drugs & Biologicals

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Medication Cart (Dining Hall) was locked upon notification

Treatment Cart (Hall B) was locked upon notification

Treatment Cart (Hall A #1) was locked upon notification

Medication and Treatment Carts (Facility) had drugs and biologics secured in a locked compartment while unattended.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) will be conducted on medication and treatment carts to ensure drugs and biologics remained in a locked compartment while unattended.

Medication and Treatment Carts will have locks replaced and new keys distributed.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee will educate licensed nursing staff and certified medication aides on the components of the regulation with an emphasis on,

- the importance of locking medication and treatment carts while unattended.

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Director of Nursing/designee will conduct a QCR of medication/treatment carts on each unit weekly x 4 weeks, and then every 2 weeks x 2 months to ensure drugs and biologics remain in a locked compartment while unattended and the licensed nurses and medication aides have the appropriate access key.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date of Alleged Compliance 7/5/2023

F804 Nutritive Value/Appear, Palatable/Prefer Temp

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Food temperatures were obtained at point of service at the next scheduled meal.

Resident (48) has discharge from facility on 05-17-2023

Resident (63) has discharged from facility on 06-08-2023

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;

Quality Care Review (QCR) of food temperatures will be obtained at kitchen point of service and Unit point of service to ensure foods are held at appropriate temperature.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee will educate dietary on the components of this this regulation with an emphasis on

- Preparing, holding, and serving foods that are held at the appropriate temperature
- Routine temperature checks at point of service

Newly hired dietary employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Nursing Home Administrator/designee will conduct a QCR weekly x 4 weeks, and then every 2 weeks x 2 months to ensure proper preparing, holding and serving temperatures on hot and cold foods.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date of Allegation of Compliance 7/5/2023

F812 Food Procurement, Store/Prepare/Serve-Sanitary

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Ceiling air return vents were cleaned and added to the routine cleaning schedule.

AC vents were cleaned and added to the routine cleaning schedule

Dietary staff completed food safety training

Plate warmer was assessed and is operational

Banana was discarded

White wheeled container was discarded

Cluttered shelf had items removed, and it was cleaned

Gas burners and griddle were cleaned.

HVAC to the left of the South bend range and the surrounding ceiling was cleaned

AMotak freezer was cleaned

Refrigerator #1 was cleaned

Freezer #1 was cleaned

Freezer #2 was cleaned, and debris discarded

Floor was cleaned

Plate warmer, shelving, wall area behind fire extinguisher, racks, tables, milk cooler, microwave, mixer, coffee pot, steamer, cabinets, toaster, silverware container, steam tables were cleaned of debris.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; .

In the main kitchen and kitchenette areas, the following will be reviewed for cleanliness,

- Kitchen equipment; large and small
- Floors
- Walls
- Ceiling
- Vents
- Fans
- Air conditioning unit

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee will educate dietary and maintenance staff on the components of this regulation with emphasis on,

- Routine cleaning and disinfection standards
- Safe resident environment related to securing steam table behind locked door when not being supervised
- Personal hygiene
- Hand hygiene
- Hair nets
- Pest control program
- Preventative maintenance.

Director of Nursing/designee will educate dietary staff on the components of this regulation with emphasis on,

- Food safety, including appropriate food handling and temperatures
- Routine dietary duties
- Menus
- Communication related to broken equipment

Newly hire employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Nursing Home Administrator/designee will conduct a QCR of 5 food prep and serving areas weekly x 4 weeks, and then every 2 weeks x 2 months to ensure food safety practices are demonstrated, routine dietary duties are being carried out, menus are being followed

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date of Alleged Compliance 6/14/2023

F925 Maintain Effective Pest Control

(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

Resident (70) room was deep cleaned by housekeeping.

Kitchenette area was cleaned.

Garbage was emptied and lid replaced.

Toaster was cleaned.

Flyswatter was removed from nurses' station and discarded.

(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; .

Quality Observation Review (QOR) will be conducted in resident rooms for the presence of mouse feces.

Ecolab Pest Control services were onsite to address areas of concern.

Facility will secure a pest control company for routine and episodic treatments.

Issues or concerns will be addressed as they are identified.

(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;

Director of Nursing/designee will educate staff on the components of the regulation with an emphasis on,

- The facility pest control protocol.

Newly hired employees will receive education in orientation.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;

The Nursing Home Administrator/designee will conduct a QOR of 5 resident rooms weekly x 4 weeks, and then every 2 weeks x 2 months to ensure there is no visible vermin, excrement, or winged insects, and for general cleanliness

The Nursing Home Administrator/designee will conduct a QOR of common areas weekly x 4 weeks, and then every 2 weeks x 2 months to ensure there is no visible vermin, excrement, or winged insects, and for general cleanliness.

The findings of these reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been maintained and recommends quarterly monitoring.

Date of Alleged Compliance 7/5/2023