DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165426	A. BUILDING _____ B. WING _____	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF PERRY	2625 IOWA STREET PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

✓ ok/CP Correction date: January 16, 2025

The following deficiencies resulted from the facility's Annual Recertification Survey and investigation of Facility Reported Incidents #125275-I and 125290-I, conducted December 9, 2024 to December 17, 2024.

Facility reported incident #125275-I and 125290-I were substantiated.

See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.

F 567 SS=E — Protection/Management of Personal Funds — F 567
CFR(s): 483.10(f)(10(i)(ii)

§483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.
(i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.
(ii) Deposit of Funds.
(A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating

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

Administrator Amanda Crew 1/16/25

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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accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.
(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interviews and policy review the facility failed to ensure 29 of 29 residents who use the facility to manage their personal finances had access to their funds as desired including evening and weekends. The facility reported a census of 33 residents.

Findings include:

1. The Minimum Data Set (MDS) Assessment for Resident #24 dated 7/27/24 documented a Brief Interview for Mental Status (BIMS) of 15 indicated no cognitive impairment.

During an interview on 12/09/24 at 10:59 AM with Resident #24 revealed he did not have access to his personal fund on the weekend.

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2. The MDS assessment for Resident #12 dated 7/20/24 documented a BIMS of 15 indicated no cognitive impairment.

During an interview on 12/10/24 at 11:51 AM with Resident #12 revealed he did not have access to his personal funds when he needs money, and informed it can take several days.

3. The MDS assessment for Resident #4 dated 8/1/24 documented a BIMS of 15 indicated no cognitive impairment.

During an interview on 12/10/24 at 11:35 AM with Resident #4 revealed she requested on 12/4/24 a gift card for $50 and has not received it yet. She then informed the lady in charge of Social Services ran out of cash and could not get it for her yesterday, and ever since she took over they have had problems with getting money and has been going on since June 2024.

During a follow up interview on 12/12/24 at 10:42 AM with Resident #4 revealed she requested on 12/4/24 a gift card for $50 and still has not received it.

During an interview on 12/12/24 at 11:12 AM with the facilities Social Services revealed she spoke with Resident #4 this morning and discussed the $50 gift card.

During an interview on 12/12/24 at 10:30 AM with the facilities Senior Revenue Cycle Manager, revealed the facility had a $300 petty cash supply on hand and when it gets to $150 the facilities Social Services employee is to contact her and ask for more petty cash to keep the balance around $300. She revealed if multiple residents

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F 567	Continued From page 3 requested cash from their accounts on the same day or over the weekend the facility would have to divide the $300 out evenly and residents may not get the amount of money they request, even if it is in their account. She then informed if a resident requests cash over $99 they will give them a check and that takes around 48 hours to process. She then revealed if all 29 residents that had their personal funds managed by the facility requested $50 dollars on the same day equaling $1,450 the facility would not be able to give the residents their money as they only had $300 in the building at most at a time. Record review of the facilities job description for Social Services Director, last revised 6/2021 lacked information this position would manage resident personal funds.	F 567		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		

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§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on interview, record and policy review the facility failed to provide residents and family with adequate notification of financial responsibility when Medicare Part A services were scheduled to

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be discontinued for 2 of 3 residents reviewed (Resident #6 and #34.) The facility reported a census of 33 residents.

Findings include:

1) According to the Significant Change Minimum Data Set (MDS) dated 10/10/24, Resident #6 had a Brief Interview for Mental Status score of 15 (intact cognitive ability.) The resident was totally dependent on staff for toileting hygiene and dressing, and required substantial assistance with sit to stand transfers.

The Care Plan for Resident #6 showed that she was at risk for injury from falls related to impaired mobility. She required assistance of 2 staff with walking.

According to the Beneficiary Protection Notification Review (ABN), Resident #6 started Medicare Part A services on 4/16/24 and coverage terminated on 5/15/24. Question #1 on the form stated: "Was an SNF (Skilled Nursing Facility) ABN Form CMS-10055 provided to the resident?" the response was "yes." The chart for Resident #6 lacked a signed 10055 form.

2) According to the MDS dated 9/22/24, Resident #34 had a BIMS score of 15 (intact cognitive ability.) The resident was independent with toileting, dressing, transfers and eating. She qualified for Part A Therapies, which included physical therapy.
The Care Plan updated on 10/3/24, showed that Resident #34 had recent radiation/chemotherapy treatments related to breast cancer.
According to the census tab in the electronic chart, Resident #34 was admitted to the facility on

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8/6/24 with Medicare Part A services.

The ABN form for Resident #34, showed she had Medicare Part A Skilled Services beginning, 8/6/24 and scheduled for termination on 8/20/24. A note written on the form indicated that the Power of Attorney (POA) for the resident had been emailed and agreed to the Resident going off skilled services therapy on 8/20/24. The CMS-10055 form was incomplete with none of the options chosen, and the form lacked a signature.

On 12/12/24 at 2:30 PM, the Social Worker (SW) said that she notified the POA that Part A services were ending and she received an email with the response "okay." She said that she understood that response to mean that the POA didn't want to continue or pay for services. When asked if she had presented the information on the 10055 form with the daily rate, and appeal options, the SW acknowledged that she should have gotten a signature and verification that the options were presented. The SW said that she couldn't answer for the missing form for Resident #6 because that was before she started working at the facility.

According to the facility policy titled: Beneficiary Notices, revised on 8/2024, the facility would prepare the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN), CMS 10055, and issue to the resident if the resident intended to continue services and the Interdisciplinary Team (IDT) had determined that serviced may not be covered under Medicare. The facility would inform the resident of potential non-coverage and document in the record that the resident understood they were accepting

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F 582	Continued From page 7 financial liability. Forms should be maintained in the binder in the Social Services.	F 582		
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 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	F 584		

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levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview the facility failed to keep the walls and floors in good repair in hallways and shower room. The facility also failed to keep the facility free of unpleasant ammonia odors (urine). The facility reported a census of 33 residents.

Findings include:

During an observation of the facility on 12/09/24 at 12:45 PM a strong unpleasant ammonia (urine) odor was present on the facilities west hallway.

During an observation of the facility on 12/10/24 at 11:51 AM a a strong unpleasant ammonia (urine) odor was present on the facilities south hallway.

During an interview on 12/12/24 at 12:44 PM with the facilities Director of Nursing (DON) revealed the facility should not have a smell of urine.

During onsite observations of the facility on 12/9/24, 12/10/24, 12/11/24, 12/10/24 and 12/16/24 the facilities East hallway had a broken recliner with brown substance in the hallway. Chipped paint on doors, walls, and floor boards as well as broken tile on the flooring were observed.

An observation of the facilities East hallway

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F 584	Continued From page 9 shower room on 12/16/24 at 2:42 PM revealed the shower room was missing tiles, 8 plus floor tiles stained with a brown substance, gaps in the shower wall that would allow water in, and lacked floor boards.	F 584		
F 606 SS=E	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure that background checks were cleared before staff worked in the resident population. An agency staff worked 3 shifts as a Certified Nurse Aide (CNA) with a suspended certification due to abuse. The	F 606		

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same staff worked 1 shift passing medications as a Certified Medication Aide (CMA) without verification of education or certification as a CMA. The Director of Nursing (DON) started working for the facility before a background check had been completed. The facility reported a census of 33 residents.

Findings include:

1) In an observation on 12/9/24 at 3:31 PM, Staff B, CMA was at the medication cart and fumbled through the med cards to find medications. She went from the second drawer to the third drawer several times, then went to Staff A, CMA for assistance. He looked in the cart and pulled out a bubble pack of pills and handed it to her.

On 12/9/24 at 4:00, Staff B and Staff A were at the medication cart counting the narcotics at shift change. Staff A expressed frustration as he instructed Staff B to document on the narcotic sheet at the time of administration because the count for several narcotics had been off. Staff B said she was taught to document at the end of the shift.

On 12/10/24 at 8:57 AM Staff B said that she had just started at the facility and she did not get any orientation on the medication cart. She said that she was just given the keys and left to figure it out on her own. When asked where she received her medication aide certificate she said "I didn't get it around here."

On 12/11/24 at 2:51 PM Staff A said he had trouble with Staff B the previous day on the medication cart because she didn't seem to understand. Staff H, Scheduler, said others had

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noticed that she was struggling, and many times, she had to ask someone to help her find the medications.

On 12/11/24 at 10:55 AM, Staff H, scheduler, said she did not have a file for Staff B or an orientation checklist. On 12/12/24 at 8:30 AM, Staff H said that some of the staffing agencies that the facility contracted with would provide access to their portal so she could see the staff information, but the Staffing Agency (SA) that hired Staff B had not provided copies of background checks or certification verification. Staff H said that she had reached out to them to get a copy of her file.

A Single Contact License and Background Check (SING) dated 12/11/24 at 12:07 PM, showed that Staff B was ineligible to work in Iowa and further research was required.

A report from the Direct Care Worker website on 12/11/24 at 2:28 PM, revealed that the status of Staff B, Certified Nurse Aide was listed as "abuser."

On 12/12/24 at 9:14 AM, a representative from the SA said that she was in charge of the contracts and scheduling for the facilities, and not responsible for taking applications or doing the background checks. She said they had a Human Resources Department and did not understand how Staff B had been sent out to work in a facility when she was ineligible. The SA representative said that she talked to Staff B and asked her about her CMA certification. Staff B just responded that she would get a copy to her, but she would not tell her where she had gotten her education.

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As of 12/17/24 at 12:45 PM, the SA had not returned requests to call on 12/12/24 at 11:25, and 12/16/24 at 1:28 PM.

On 12/12/24 at 11:52 AM, the Director of Nursing (DON) said that the day that Staff B was working on the medication cart was "horrible." She said that the staff member was confused, and looked like she hadn't ever administered medications before. The DON said that the Agency was responsible for doing the background checks and the facility must be able to trust that they are doing their job to verify licensure and certification. She said that the facility did not have the time to be looking up the background of all agency staff.

An investigation of all the agency staff that were scheduled to work at the facility in the previous 3 months, revealed that Staff K, CNA did not have a valid certification as a nurse aid.

On 12/16/24 at 4:30 PM, the Administrator said that she was in touch with the agency and they did not have verification that Staff K, CNA had a certification. She said that Staff K hadn't actually worked at the facility because she called in sick the one day that she was scheduled.

According to the facility policy titled: Abuse Prevention Program, Prevention of Abuse, review date of 4/2025, the community would establish policies and procedures encompassing all facets of the Abuse Program, including screening. The abuse prevention/intervention program included conduction of background investigations per state regulations.

2. Record review of the Director of Nursing (DON) Single Contact License & Background

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F 606	Continued From page 13 Check was ran on 11/22/24 and due to further research required not completed until 11/26/24. Record review of the DON's time sheet revealed she was employed by the facility on 11/22/24 and worked the following hours: 11/22/24 - 8.75 hours 11/23/24 - 9 hours 11/24/24 - 7.5 hours 11/25/24 - 11.5 hours 11/26/24 - 11.5 hours During an interview on 12/11/24 at 11:42 AM, Staff H, Certified Nurse Aide (CNA), Scheduler, revealed the Administrator instructed the DON she was allowed to start working at the facility but to stay away from residents. During an interview on 12/12/24 at 12:44 PM, the DON revealed she started at the facility on 11/12/24 and was supposed to meet with Staff N, Human Resources Manager but she was not in the building to do her paperwork. She then informed she is aware a background check needs to be completed but didn't have it done.	F 606		
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.	F 610		

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§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, staff and resident interviews and facility policy review, the facility failed to implement interventions to safeguard the dignity and wishes of Resident #34 after a Resident to Resident incident between Resident #34 and Resident #18. The facility reported a census of 33.

Findings include:

The Minimum Data Set (MDS) Assessment of Resident #34, dated 8/12/24, identified a Brief Interview of Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS documented the resident experienced delusions during the 7 day look back period. The MDS documented diagnoses that included depression, bipolar disorder, psychotic disorder and schizophrenia.

The MDS Assessment of Resident #18, dated 10/6/24 identified a BIMS score of 15 which indicated cognition intact. The MDS documented the resident exhibited behavioral symptoms not directed toward others such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, daily during the 7-day look back

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period. The MDS documented diagnoses that included anxiety and depression.

On 12/9/24 at 3:06 pm, Resident #34 reported she had recently been standing near the nurses desk, conversing with an employee. She stated Resident #18 was self propelling his wheelchair past her, and his arm went up her leg and then to her right buttocks. She said that he made a statement of not trying to do anything to her. She stated he touched her with his hand, and it was not a "brush up with his arm". She said it made her wonder, as nobody expects anything like that to happen."

On 12/9/24 at 2:56 pm, Resident #18 stated he had bumped into Resident #34. He stated it was accidental and he apologized.

The Contact Form for Facility Reported Incidents revealed the date of the incident to be 12/5/24.

The Social Services Progress Note in the Electronic Health Record (EHR) of Resident #34, dated 12/5/24, authored by the Director of Nursing (DON), documented Resident #34 reported Resident #18 touched her bottom and it made her feel uncomfortable. The DON documented she made all necessary notifications. The note failed to document any interventions put in place to keep Resident #34 and Resident #18 separated.

The Social Services Progress Note in the EHR of Resident #18, effective date 12/6/24, created date 12/10/24 (late entry), authored by the Director of Nursing, documented Resident #18 thought he had bumped the foot of Resident #34 with his wheelchair as he was passing by. The

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note documented Resident #18 reported he patted her bottom to apologize and denied the touch as being sexual. The note failed to documented any interventions put in place to keep the two residents separated.

The Witness Statements by three facility staff members on duty on 12/5/24 revealed statements were gathered five days later, on 12/10/24. None of the statements documented any interventions put in place to keep the two residents separated.

On 12/10/24 10:54 AM, The Care Plan of Resident #18 was reviewed. The Care Plan revealed a focus area dated 10/5/24 noted alleged inappropriate behavior towards a female. It failed to reveal any documentation of interventions to keep Resident #18 and #34 separated.

On 12/10/24 at 10:56 am, the Care Plan of Resident #34 was reviewed. It failed to reveal any documentation of interventions to keep Resident #34 separated from Resident #18.

On 12/10/24 at 11:43 am, the DON stated no staff had directly witnessed the incident between the two residents. She stated Resident #34 had felt Resident #18 touch her bottom and it made her feel uncomfortable. The DON stated Resident #34 had initially reported this to Staff I, Certified Nurse Aide (CNA) and Staff I then brought Resident #34 to the DON office. The DON further stated Resident #18 had admitted to patting the buttocks of Resident #34 as an apology for bumping into her. She stated she believed Resident #18's intentions were not sexual. She stated Resident #34 is not always "the most reliable".

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The DON further stated the two residents live on separate hallways. She stated the incident happened on a Thursday and she followed up with Resident #34 the next Monday. She said Resident #34 reported no further concerns. She added the two residents do not eat at the same table or attend the same activities. She stated the care plans had not been updated for either resident as the facility was still in the window for submitting a five day follow up on the incident. She stated she would update the care plans of both residents for staff to monitor the two residents to make sure they are kept apart. She said staff that were on duty on 12/5/24 did receive education but no further staff received any education at that time.

On 12/10/24 at 11:52 am, the State Surveyor was standing at the nursing desk waiting for Staff G, Licensed Practical Nurse (LPN) to complete a phone call. The State Surveyor observed the DON and Staff I, CNA speaking privately in the dining room.

On 12/10/24 at 11:55 am, Staff G, LPN stated when Resident #34 told her concerns to Staff I, CNA, Resident #34 was then taken to the DON office to notify her. She stated the facility has an abuse hotline flyer at the nursing station. She stated no direction was given to her to keep the residents separated but she stated she would consider that a given to do in this situation and kept an eye on the residents.

On 12/10/24 at 12:01 pm, Staff I, CNA stated she was sitting at the nurses station charting on 12/5/24 when Resident #34 came to her and told her Resident #18 had went past her in his

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wheelchair and had "groped her behind". She stated she told Resident #34 she needed to report this to the DON and she took Resident #34 to the DON office. She stated the DON told her to keep the residents separated and to check on the residents every 15 minutes. She stated the 15 minute checks were to be completed every 15 minutes.

On 12/10/24 at 12:08 pm, Staff J, CNA stated she did know have any information on the interaction between Resident #18 and Resident #34. She stated she did not witness anything. She further stated she received no education regarding the two residents and nobody asked her to watch the two of them.

On 12/10/24 at 12:09 pm, Staff A, Certified Medication Aide (CMA) stated he came on duty at 2:00 pm on 12/5/24. He stated he had no knowledge of any incident between the two residents and nobody at the facility had said anything to him about it. He was unaware of any incident prior to the State Surveyor asking him.

On 12/10/24 at 12:49 pm, Resident #34 was observed sitting at the far end of the dining room, near the exit to the patio. Staff J, CNA, stated that was not the resident's normal place to sit in the dining room.

On 12/10/24 at 12:55 pm, Resident #34 stated she was sitting in at a different table because a different resident was sitting in her normal spot when she arrived to the dining room. When asked about how she was feeling regarding Resident #18, Resident #34 replied she felt scared because she felt it could happen again because Resident #18 knew what he was doing.

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In a follow up interview on 12/10/24 at 1:00 pm, Resident #18 stated the facility staff asked him what had happened during the incident and he told them. He stated he said he was sorry and the facility staff said ok. He denied receiving any direction or requests to keep distance from Resident #34.

The Care Plan of Resident #18 was updated on 12/10/24 by the DON to keep Resident #18 and Resident #34 separated as much as possible. It directed staff to not sit the two residents together in the dining room or at activities. It additionally directed staff to attempt to keep Resident #18 from going down Resident #34's hallway as much as possible.

The Care Plan of Resident #34 was updated on 12/10/24 by the DON. A revision was made to the Focus Area of risk for behavior problems indicating an incident of reporting to staff a male resident touching her on her bottom. It directed staff to keep Resident #34 and Resident #18 away from each other as much as possible, to not have them next to each other in dining room or activities. It additionally directed staff to discourage Resident #34 from being near Resident #18.

The Facility Policy Resident-to-Resident Altercations F600, revision date 10/2022 documented the following:

Point 2:
a. Separate the residents, and institute measures to calm the situation;
b. Identify what happened, including what might have led to aggressive conduct on the part of one

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F 610	Continued From page 20 or more of the individuals involved in the altercation; c. Provide and document re-direction and provide protection as required by the situation d. Notify each resident's representative and Attending Physician of the incident; e. Review the events with the Nursing Supervisor and Director of Nursing, including interventions to try to prevent additional incidents; f. Consult with the Attending Physician to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem; g. Make any necessary changes in the care plan approaches to any or all of the involved individuals h. document in the resident's clinical record all interventions and their effectiveness;	F 610		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication.	F 636		

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F 636	Continued From page 21 (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)	F 636		

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(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to complete and transmit Comprehensive Minimum Data Set (MDS) Assessments within federal guidelines for 3 of 14 residents (#24, #31, #34) reviewed for MDS Assessments. The facility reported a census of 33 residents.

Findings include:

1. The Annual (Comprehensive) MDS of Resident #24 documented an Assessment Reference Date (ARD) of 10/30/24. On 12/16/24 the MDS was still displayed as "In Progress". Twelve of the eighteen sections of the MDS were not completed. The MDS tab of the resident's Electronic Health Record (EHR) showed his last annual MDS was dated 10/30/23.

2. The Annual (Comprehensive) MDS of Resident #31 documented an ARD of 10/27/24. On 12/16/24, the MDS was still showing as "In Progress". Twelve of the eighteen sections of the MDS were not completed. The MDS tab of the EHR showed the last comprehensive MDS, the resident's Admission MDS, was dated 10/27/23.

3. The Admission (Comprehensive) MDS of Resident #34 documented an ARD of 8/12/24. The MDS recorded the resident had an admission date to the facility of 8/6/24. Page 58 of the MDS recorded a completion date of 8/29/24, the 24th day of the resident's stay.

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F 636	Continued From page 23 According to the 2024 Resident Assessment Instrument (RAI) Manual, for an annual (comprehensive) assessment, the Assessment Reference Date (ARD) must be within 366 days of the prior comprehensive assessment. The Assessment must be completed within 14 days of the ARD. According to the 2024 RAI, for an Admission (comprehensive) assessment, the ARD must be no later than the 14th calendar day of the resident's admission date and must be completed by the 14th calendar day of the resident's admission. On 12/12/24 at 4:30 pm, the Director of Nursing stated she is trying to take over the MDS duties as the facility does not have an MDS Coordinator. She stated she is currently locked out of the system but she will get the assessments caught up. The Facility Policy MDS Assessment Coordinator F642, review date 11/2017 documented "A Registered Nurse (RN) shall be designated the responsibility of conducting and coordinating each resident's assessment (RN).	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by	F 637		

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implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to complete and transmit Comprehensive Minimum Data Set (MDS) Assessments following a significant change within federal guidelines for 3 of 14 residents (#6, #7 and #32) reviewed for MDS Assessments. The facility reported a census of 33 residents.

Findings include:

1. The Census Line portion of the Electronic Health Record (EHR) of Resident #6 documented the resident enrolled in hospice care on 10/3/24. The Significant Change MDS of Resident #6 documented an Assessment Reference Date (ARD) of 10/10/24. Page 58 of the MDS documented the MDS was signed as Assessment Completion on 10/28/24, three and half weeks following hospice admission.

2. The Progress Notes of Resident #7 documented hospice admission on 11/30/24. On 12/12/24 at 1:14 pm a staff member of the hospice company verified the admission date for hospice care to be 11/30/24.

The Significant Change MDS for Resident #7 documented an ARD of 12/10/24. On 12/16/24 the MDS was still displayed as "In Progress". Thirteen of the eighteen sections of the MDS

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F 637	Continued From page 25 were not documented as complete. 3. The Census Line portion of the EHR of Resident #32 documented the resident enrolled in hospice care on 11/22/24. The Significant Change MDS of Resident #32 documented as ARD of 12/4/24. On 12/16/24, the MDS was still displayed as "In Progress". Twelve of the eighteen sections of the MDS were not documented as complete. According to the 2024 RAI, a Significant Change (comprehensive) assessment, the ARD must be no later than the 14th calendar day after determination that a significant change in the resident's status occurred. The RAI stated a Significant Change MDS is required to be performed when a terminally ill resident enrolls in a hospice program. On 12/12/24 at 4:30 pm, the Director of Nursing stated she is trying to take over the MDS duties as the facility does not have an MDS Coordinator. She stated she is currently locked out of the system but she will get the assessments caught up. The Facility Policy MDS Assessment Coordinator F642, review date 11/2017, documented "A Registered Nurse (RN) shall be designated the responsibility of conducting and coordinating each resident's assessment (RN).	F 637		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State	F 638		

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and approved by CMS not less frequently than once every 3 months.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to complete and transmit Quarterly Minimum Data Set (MDS) Assessments within federal guidelines for 9 of 14 residents (#4, #5, #7, #8, #9, #12, #19, #23, #34) reviewed for MDS Assessments. The facility reported a census of 33 residents.

Findings include:

1. The Quarterly MDS for Resident #4 documented an ARD of 11/1/24. On 12/16/24 the MDS was still displayed as "In Progress". Nine of sixteen sections of the MDS were not documented as complete. The MDS section of the Electronic Health Record (EHR) of Resident #4 documented the prior quarterly MDS had an ARD date of 8/1/24.

2. The Quarterly MDS for Resident #5 documented an ARD of 11/10/24. On 12/16/24 the MDS was still displayed as "In Progress". Nine of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #5 documented the prior quarterly MDS had an ARD date of 8/10/24.

3. The Quarterly MDS for Resident #7 documented an ARD of 10/25/24. On 12/16/24 the MDS was still displayed as "In Progress". Ten of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #7 documented the prior

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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MDS, Admission MDS, had an ARD date of 7/25/24.

4. The Quarterly MDS for Resident #8 documented an ARD of 11/23/24. On 12/16/24 the MDS was still displayed as "In Progress". Ten of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #8 documented the prior quarterly MDS had an ARD date of 8/23/24.

5. The Quarterly MDS for Resident #9 documented an ARD of 11/17/24. On 12/16/24 the MDS was still displayed as "In Progress". Nine of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #9 documented the prior quarterly MDS had an ARD date of 8/17/24.

6. The Quarterly MDS for Resident #12 documented an ARD of 10/20/24. On 12/16/24 the MDS was still displayed as "In Progress". Nine of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #12 documented the prior quarterly MDS had an ARD date of 7/20/24.

7. The Quarterly MDS for Resident #19 documented an ARD of 10/20/24. On 12/16/24 the MDS was still displayed as "In Progress". Nine of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #19 documented the prior quarterly MDS had an ARD date of 7/20/24.

8. The Quarterly MDS for Resident #23 documented an ARD of 11/7/24. On 12/16/24 the MDS was still displayed as "In Progress". Nine of sixteen sections of the MDS were not

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F 638	Continued From page 28 documented as complete. The MDS section of the EHR of Resident #23 documented the prior MDS, Annual MDS, had an ARD date of 8/7/24. 9. The Quarterly MDS for Resident #34 documented an ARD of 11/12/24. On 12/16/24 the MDS was still displayed as "In Progress". Eleven of sixteen sections of the MDS were not documented as complete. The MDS section of the EHR of Resident #34 documented the prior MDS, Admission MDS, had an ARD date of 8/12/24. According to the 2024 RAI, a Quarterly assessment must be completed no later than the 14th calendar day after the ARD date, and the ARD date must be no longer than 92 days following the prior assessment. On 12/12/24 at 4:30 pm, the Director of Nursing stated she is trying to take over the MDS duties as the facility does not have an MDS Coordinator. She stated she is currently locked out of the system but she will get the assessments caught up. The Facility Policy MDS Assessment Coordinator F642, review date 11/2017 documented "A Registered Nurse (RN) shall be designated the responsibility of conducting and coordinating each resident's assessment (RN).	F 638		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a	F 640		

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facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

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§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to complete and transmit Minimum Data Set (MDS) Assessments within federal guidelines for 2 of 14 residents (#26, #32) reviewed for MDS Assessments. The facility reported a census of 33 residents.

Findings include:

1. The Census Line portion of the Electronic Health Record (EHR) of Resident #26 documented the resident discharged from the facility on 10/22/24. The Discharge MDS of Resident #26 documented an Assessment Reference Date (ARD) of 10/22/24. On 12/16/24 the MDS was still displayed as "In Progress". Nine of fifteen sections of the MDS were not documented as complete.

2. The MDS section of the EHR of Resident #32 documented a quarterly MDS with an ARD date of 10/20/24. On 12/16/24 the MDS was showing as "export ready". The MDS revealed a completion date of 11/22/24. The facility had not yet transmitted the completed MDS to CMS (Centers for Medicare & Medicaid Services) per federal guidelines.

According to the 2024 RAI, a Quarterly assessment must be transmitted no later than 14

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F 640	Continued From page 31 days after the completion date. The RAI also documents a discharge assessment must be dated for the date of the resident's discharge from the facility and must be completed no later than 14 days following the discharge date. On 12/12/24 at 4:30 pm, the Director of Nursing stated she is trying to take over the MDS duties as the facility does not have an MDS Coordinator. She stated she is currently locked out of the system but she will get the assessments caught up. The Facility Policy MDS Assessment Coordinator F642, review date 11/2017 documented "A Registered Nurse (RN) shall be designated the responsibility of conducting and coordinating each resident's assessment (RN).	F 640		
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 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	F 656		

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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.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual and facility policy review, the facility failed to fully develop and implement a Comprehensive Care Plan for 1 of 5 residents reviewed for Unnecessary Medications (Resident #6). The facility reported a census of 33.

Findings include:

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The Minimum Data Set (MDS) Assessment of Resident #6 dated 10/10/24 documented diagnoses that included diabetes and heart failure. The MDS documented the resident received insulin injections on 7 out of 7 days of the assessment reference period.

The Active Diagnoses of Resident #6 listed Diabetes Mellitus due to Underlying condition dated 4/15/2023.

The Active Orders of Resident #6 revealed an order for Insulin Glargine, dated 6/8/24, to be administered every night, and an order for Humalog Insulin, dated 6/13/24, to be administered three times a day based on the resident's blood glucose level.

The Comprehensive Care Plan of Resident #6, last reviewed 12/3/24, failed to reveal any documentation of the resident having the diagnosis of diabetes or orders for insulin.

The 2024 RAI, Page N-6, Planning for Care, High-Risk Drug Classes, documented the following:

High-Risk Drug Classes: Use and Indication (includes hypoglycemic drugs and insulin) Target Symptoms and goals for use of these medications should be established for each resident. Progress towards meeting the goals should be evaluated routinely.

On 12/17/24 at 11:27 am, the Vice President of Operations stated her expectation is any active diagnosis which have specific medications and/or treatments for the resident should be included on

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F 656	Continued From page 34 the Care Plan. The Facility Policy Comprehensive Care Plans, revision date 8/2022 documented the following: Policy Statement: An individualized comprehensive person centered care plan that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, cultural and psychological needs is developed for each resident. Guidelines, Point 2: The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS and physicians orders. Assessments of residents are ongoing and Care Plans are revised as information about the resident and the resident's condition change.	F 656		
F 657 SS=D	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	F 657		

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medical record if the participation of the resident and their resident representative is determined not practicable for the development of the 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 record review, staff interview, and policy review the facility failed to review and revise 1 of 1 Care Plans for a resident who vapes (a device used for inhaling vapor containing nicotine and flavoring) at the facility (Resident #21). The facility reported a census of 33 residents.

Findings include:

During an interview on 12/09/24 at 9:29 AM with the Administrator revealed Resident #21 will occasionally vape.

Record review of Resident #21 Care Plan on 12/11/24 lacked instruction and direction regarding her vaping.

During an interview on 12/12/24 at 12:44 PM with the Director of Nursing (DON) revealed she would expect Resident #21 Care Plan inform she vapes with appropriate safety interventions.

Review of the facilities policy, Accident Prevention - Smoking Policy, effective 8/2024 instructed staff for residents whom wish to smoke

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F 657	Continued From page 36 will be evaluated for "safe smoking" per community protocol. The policy lacked instruction to implement into the residents Care Plan. Review of the facilites policy, Comprehensive Care Plans, effective 8/2024 instructed the following: Each resident's comprehensive Care Plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; d. Reflect the resident's expressed wishes regarding care and treatment goals if applicable; e. Reflect treatment goals, timetables and objectives in measurable outcomes; f. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; g. Enhance the optimal functioning of the resident	F 657		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		

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receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and facility policy, the facility failed to implement and maintain a Restorative Program for 6 of 6 residents reviewed who require assistance to complete their Activities of Daily Living (Resident #1, #8, #9, #19, #30, #32)

Findings Include:

1. The Minimum Data Set (MDS) of Resident #1 dated 8/9/24 revealed the resident required supervision for sitting to standing, chair/bed-to-chair transfers and toilet transfers. The MDS revealed the resident required partial/moderate assistance for tub/shower transfer, total staff assistance for toileting hygiene and substantial assistance for bathing. The MDS revealed the resident received no Restorative Therapy services.

The Care Plan of Resident #1 failed to document any restorative nursing programs.

2. The MDS of Resident #8 dated 8/23/24 revealed the resident to be dependent upon staff for bathing. The MDS revealed the resident received no Restorative Therapy services.

The Care Plan of Resident #8 documented the resident to be incontinent of bowel and bladder. The Care Plan documented the resident required assistance with bathing, dressing, toileting, and transferring. The Care Plan failed to document

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any restorative nursing programs.

3. The MDS of Resident #9 dated 8/17/24 revealed the resident to require substantial assistance for eating and bathing. The MDS coded the resident to be dependent upon staff for oral hygiene, toileting hygiene, and dressing. The MDS coded the resident to require substantial assistance for sit to stand and toilet transfers The MDS revealed the resident received no Restorative Therapy services.

The Care Plan of Resident #9 failed to document any restorative nursing programs.

4. The MDS of Resident #19 dated 7/20/24 revealed the resident to be dependent upon staff assistance for oral hygiene, toileting hygiene, dressing and bathing. The MDS coded the resident to be dependent upon staff for transfers and required substantial staff assistance for bed mobility. The MDS revealed the resident received no Restorative Therapy services.

The Care Plan of Resident #19 failed to document any restorative nursing programs. A Care Plan goal for the resident listed as follows; I will maintain current level of function through the review date. (Target date 2/20/25).

5. The MDS of Resident #30 dated 9/19/24 revealed the resident to be dependent upon staff for bathing, hygiene, dressing, transferring and bed mobility. The MDS revealed the resident received no Restorative Therapy services.

The Care Plan of Resident #30 failed to document any restorative nursing programs. The Residents Care Plan identified contractures to the

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right upper and lower extremities.

6. The MDS of Resident #32 dated 10/20/24 revealed the resident to require substantial staff assistance for dressing, toileting hygiene, and tub/shower transfers. The MDS revealed the resident received no Restorative Therapy services.

The Care Plan of Resident #30 failed to document any restorative nursing programs.

On 12/11/24 at 9:56 am, the Director of Nursing (DON) stated the facility does not have a Restorative Aide on staff. She additionally stated none of the nurses or Certified Nurse Aides performed any Restorative programs and none of the facility's residents currently had any Restorative program. She said the facility is short staff and she is working on hiring and hopes to include a Restorative Aide.

The Facility Policy Goals and Objectives, Restorative Services, Revision date 10/2024 documented a Policy Statement of "Specialized rehabilitative service goals and objectives shall be developed for problems identified through resident assessments."

Point 1 - Rehabilitative goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services.

Point 2 - Goals may include, but are not limited to:
a. Assisting the resident in adjusting to his/her abilities
b. Assisting the resident in developing and strengthening his/her physiological and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 40 psychological resources; c. Encouraging the resident to maintain his/her independence and self-esteem; d. Encouraging the resident to participate in the development and implementation of his/her plan of care; and e. Other information as may become necessary or appropriate.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §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 record review, staff interview, and policy review the facility failed to implement safety interventions for vaping (a mechanical device used for inhaling vapor containing nicotine and flavoring) for 1 of 1 residents who vapes at the facility (Residents #21). The facility also failed to ensure 1 of 1 residents who leaves for appointments had appropriate caregivers with her (Resident #8). The facility reported a census of 33 residents. Findings include: 1. During an interview on 12/09/24 at 9:29 AM with the Administrator revealed Resident #21 will occasionally vape.	F 689		

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F 689	Continued From page 41 Record review of Resident #21 Assessments in her Electronic Health Record (EHR) on 12/11/24 lacked nursing assessment of her vaping. During an interview on 12/12/24 at 12:44 PM with the Director of Nursing (DON) revealed she would expect Resident #21 to have a smoking assessment completed and implement appropriate safety interventions as needed. Review of the facilities policy, Accident Prevention - Smoking Policy, effective 8/2024 instructed staff of the following: Residents whom wish to smoke will be evaluated for "safe smoking" per community protocol. 2. During an interview on 12/09/24 at 1:42 PM with Resident #8 Power of Attorney (POA) revealed on 12/3/24 resident #8 left the facility for a Cardiologist appointment on a bus unaccompanied by facility staff. She revealed she arrived to Resident #8 appointment shortly after she was dropped off by the bus and found her needing assistance to get checked in, as she is unable to do by herself. During an interview on 12/12/24 at 12:44 PM with the DON revealed she would expect incompetent residents be assisted to appointments.	F 689		
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:	F 758		

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F 758	Continued From page 42 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §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	F 758		

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prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, and policy review the facility failed to ensure a Gradual Dose Reduction (GDR) was attempted yearly for 1 of 3 residents reviewed on an antipsychotic medication (Resident #15). The facility reported a census of 33 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment for Resident #15 dated 9/5/24 documented Brief Interview for Mental Status (BIMS) of 13 indicated severe cognitive impairment. The MDS documented he was admitted to the facility on 11/13/2017 and received antipsychotic medications on a daily basis and a GDR has not been attempted. The MDS documented diagnoses of Non-Alzheimer dementia, depression, and bipolar disorder.

Record review of Resident #15 Orders in his Electronic Health Record (EHR) documented on 12/16/24 he had an active order of Seroquel (oral antipsychotic medication) 25 milligrams daily that started on 6/10/2023.

Record review of Resident #15 Care Plan on 12/12/24 documented an intervention to monitor for any psychotropic drug related problems such as dizziness, confusion and consult with pharmacy and his Doctor for dosage reductions when appropriate.

Record review of resident #15 Progress Notes documented on 2/29/24 a Telemed Psych Note

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F 758	Continued From page 44 Encounter and instructed a gradual dose reduction is not recommended for Resident #15 as this time to prevent decompensation (the failure to generate effective psychological coping mechanisms in response to stress, resulting in personality disturbance or disintegration). During an interview on 12/10/24 at 11:42 AM with the Director of Nursing (DON) revealed she would expect all psychotropic medications used by residents be routinely monitored. The facilities policy Tapering Medications and Gradual Drug Dose Reduction, last revised 9/2022 instructed the following: For any individual who is receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia, bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated, if: a. The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; or b. The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time could be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews and record review the facility failed to accurately document narcotic mediation use and failed to destroy narcotic medication after discontinuation for 2 of 3 residents reviewed (Resident #20, & #6.) The facility reported a census of 33 residents.

Findings include:

On 12/09/24 at 4:09 PM, Staff B, Certified Medication Aide (CMA) and Staff A, CMA were at

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the medication cart counting the narcotics and comparing the number of pills to the documentation on The Controlled Medication Utilization Record (CMUR.) They were frustrated, and Staff A told Staff B that she needed to document right away after giving narcotics and not wait until the end of the shift.

1) According to the Minimum Data Set (MDS) dated 10/10/24, Resident #6 had a Brief Interview for Mental Status score of 15 (intact cognitive ability.) The resident was totally dependent on staff for toileting hygiene and dressing and she required substantial assistance with sit to stand transfers.

The Care Plan for Resident #6 showed that she was at risk for injury from falls related to impaired mobility. She required assistance of 2 with walking and had chronic pain. Staff were directed to use medication as ordered and document side effects.

An order audit report, from the electronic chart, showed that Resident #6 had an order dated 10/3/24 at 5:11 AM, for Tramadol tablet 50 milligrams (mg) give 1 tablet every 8 hours as needed (PRN) for pain. The order was discontinued on 11/22/24 at 10:24 AM, and changed to Tramadol 50 mg Three Times a Day (TID) scheduled.

A review of the narcotics storage drawer on 12/9/24 revealed that the discontinued PRN package of Tramadol had not been destroyed and was still in the drawer.

The CMUR showed that on 12/3/24, one tab had been taken from the PRN order and on 12/5/24, 3

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tabs had been used from the PRN order.

The CMUR for the Tramadol 50 mg TID order showed no tabs had been dispensed from this bubble package on 12/5/24, and just one was dispensed on 12/9/24. The Medication Administration Record (MAR) for December was inconsistent with the CMUR and indicated that the resident received 3 doses of Tramadol 50 mg on 12/9/24.

2) The MDS dated 10/6/24, showed that Resident #20 did not have a BIMS assessment because she was rarely understood. She required substantial assistance with eating, sit to stand, toilet transfers and was totally dependent for hygiene and dressing.

The Care Plan for Resident #20, updated on 10/13/24, showed that she was at risk for injury due to impaired safety awareness. The resident had chronic pain related to osteo arthritis and used antianxiety medication related to dementia. She was at risk for alterations in nutritional status and had diagnoses that included chronic kidney disease and heart failure.

A review of the narcotic drawer on 12/9/24 at 4:10 PM, reveled that Resident #20 had 5 bubble pack cards of Ativan tablets with expired orders.

1. 60 tabs of 1 mg Ativan delivered on 12/4/24 for the order; ½ tab in the morning and 1 mg in the afternoon, 1 mg at bedtime.
2. 30, ½ tabs of Ativan 1 mg. delivered on 12/4/24 for the order: ½ tab in the morning 1 mg in the afternoon and 1 mg at bedtime. A sticker in the upper left corner read: "morning"
3. 8, 0.5 mg Ativan tabs delivered on 11/25/24 for

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order: 1 tab at 2 PM, 2 tabs at night. A sticker on left corner read: "bedtime"
4. 8, 0.5 mg tabs Ativan delivered on 11/25/24 for order: 1 tab at 2 PM, 2 tabs at night. Sticker on left corner read: "afternoon"
5. 10, 1 mg tabs Ativan delivered on 11/25/24 for order: 1 tab three times daily and 1 every 4 hours as needed.

The following medication audits were found in the electronic chart orders tab:

1. Order dated 11/21/24 at 10:10 PM, Ativan 1 mg every 4 hours as needed for agitation/restlessness. Discontinued on 12/6/24 at 10:18 AM.
2. Order dated 11/21/24 at 10:07 PM, Ativan 1 mg three times a day for agitation and restlessness. Discontinued on 12/5/24 at 4:26 PM.
3. Order dated 11/15/24 at 2:00 PM, Ativan 1 mg one tab in the afternoon. Discontinued on 11/21/24 at 10:09 PM.
4. Order dated 11/8/24 at 1:50 AM, Ativan 1 mg in the evening. Discontinued on 11/15/24 at 1:50 PM.
5. Order dated 12/5/24 at 4:33 AM, Ativan 0.5 mg. in the morning for anxiety. Discontinued on 12/6/24 at 10:16 AM.
6. Order dated 12/5/24 at 4:29 AM, Ativan 1 mg two times a day for anxiety. Discontinued on 12/6/24 at 10:17 AM.

The CMUR for Ativan 1 mg. three times daily and 1 ever 4 hours as needed, showed that Staff B signed the CMUR on 12/9/24 and indicated that one tab had been given that day.

On 12/11/24 at 5:57 AM, Staff E, Registered Nurse (RN) said that when a narcotic medication

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F 761	Continued From page 49 was discontinued, they destroy the tabs with two nurses and have a new card with the new orders. She looked at the bubble packages in the drawer for Resident #20 and acknowledged that those should not have been in the drawer anymore because the resident was on Hospice and no long swallowing pills, they were using the liquids. On 12/12/24 at 2:30 PM, The Director of Nursing (DON) said that she would expect the nurses to destroy any narcotics that had been discontinued and to make sure that this was completed with a second nurse, and signed. According to a facility policy titled: Medication Storage, last revised on 8/1/21, Schedule II drugs would be counted at the beginning and end of every shift, with count compared to Scheduled II medications ordered.	F 761		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide the therapeutic meals as ordered for 3 of 7 residents with altered diets (Resident #30, #22 and #3.) Resident #30 had orders for a pureed diet and was served	F 808		

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breakfast with visible chunks, Resident's #22 and #3 had orders for a mechanical soft diet and were served crunchy garlic toast. The facility reported a census of 33 residents.

Findings include:

1) According to the Minimum Data Set (MDS) dated 9/19/24, Resident #30 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficits.) The resident was totally dependent on staff assistance for toileting hygiene, dressing, personal hygiene, chair to bed transfers. The resident was on a mechanically altered diet and a feeding tube for nutrition.

The Care Plan last updated on 9/23/24, showed that Resident #30 had impaired communication and said very few words. He required assistance with Activities of Daily Living (ADLs) related to an amputation above the left knee and he was bedfast most of the time. He required assistance with eating with pureed foods, as well as tube feedings during the day.

The orders tab in the electronic chart showed an order dated 10/11/23 at 12:04 PM, for a regular diet, pureed texture.
In an observation on 12/10/24 at 8:20 AM, Resident #30 was in a wheel chair at the dining room table. An unidentified staff person assisted him with eating the pureed eggs and toast with green peppers. The eggs contained visible chunks of green peppers that were not creamed as per a pureed textured diet.

2) The MDS dated 9/21/24, showed that Resident #22 had a BIMS score of 3 (severe cognitive deficit.) The resident required substantial

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assistance with hygiene, dressing, sit to stand and toilet transfers. She was on a mechanically altered diet and required set up assist with eating.

The Care Plan updated on 9/26/24, showed that Resident #22 had impaired cognitive function/dementia related to metabolic encephalopathy. The resident had oral/dental health problems, edentulous poor oral hygiene. Staff were to serve the diet as ordered, consult with dietitian if changes in chewing or swallowing problems were noted. Resident #22 had nutritional problems related to dysphagia and speech therapy recommended a mechanical soft diet with thin liquids.

3) The MDS dated 9/14/24, showed that Resident #3 had a BIMS score of 9 (moderate cognitive deficits.) He required substantial assistance with oral hygiene, toileting hygiene, and dressing, and set up assistance only with eating a mechanically altered diet.

The Care Plan updated on 10/3/24, showed that Resident #3 had alterations in cognition related to dementia, staff were to monitor intake to assure an adequate fluid intake to prevent dehydration and to provide and serve diet as ordered.

An order dated 4/8/24 at 10:05 AM, Showed that Resident #3 had a regular diet order with mechanical soft texture, thin consistency, cut up food into smaller pieces.

In a review of the altered diet menu on 12/11/24 at 12:00 PM, Staff C, Cook, and Staff D, Cook, acknowledged that they did not understand the acronyms listed in the different columns of diet texture used by the International Dysphagia Diet

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Standardization Initiative (IDDSI.) They did not know what SBMM (Small Bite Minced & Moist) meant on the altered menu. They were not sure which column on the menu was related to what they knew as mechanical soft. The Small Bite (SB) column and the Minced and Moist (MM) column required a pureed dinner roll for the bread option on 12/11/24. The SB and MM columns both indicated the lasagna (SBMM) would be small bites, minced and moist.

On 12/11/24 at 12:15 PM, Staff C served Resident #22 and Resident #3 crispy garlic toast.

On 12/11/24 at 4:30 PM, the Dietician said that she had talked to the staff about the different IDDSI codes and what those diets looked like, but she also acknowledged that it was often complicated for the staff to know the differences. She said that serving garlic toast to resident on mechanical soft was concerning and they should have known not to serve crisp bread. The Dietician also said that the chunks of green pepper in the pureed eggs was concerning, they should have pureed the eggs until it was smooth, or just not add the green pepper.

On 12/12/24 at 9:39 AM, The Dietary Manager (DM) said that she was very frustrated with the IDDSI menus and trying to teach staff what foods they could serve on a mechanical soft diet. She said she would reach out to the Dietician and work on finding a solution.

A facility policy titled: Therapeutic Diets, effective on 10/2024, indicated that the mechanically altered diets, as well as diets modified for medical or nutritional needs would be considered therapeutic diets. The regular menu would be

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F 808	Continued From page 53 modified by the Registered Dietitian for therapeutic diets with the input from the Dietary Manager.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a clean, well maintained kitchen area for food preparation, failed to maintain adequate water temperature on the dishwasher, and failed to use proper sanitation and glove use during lunch service. The facility reported a census of 33 residents. Findings include: In an observation of the kitchen on 12/11 at 11:30	F 812		

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AM, it was discovered that just inside the kitchen, there was a wood counter top with a surface that was peeling off. The kitchen staff said that someone had used a counter top paint, not realizing that the chemical cleaners would cause it to peel. Several of the doors and door frames had chipped and stained paint. The corners of the floors and along the floor base was dirty and stained. The garbage disposal water lines had built up rust and dirt collected around and underneath.

A thermometer below the dishwasher read 110 degrees Fahrenheit (F). Staff D, Dietary Aide acknowledged that the target temperature was 120 but it wasn't getting any higher than 118 F. She said that they had a new water heater in the basement but the maintenance man failed to get it hooked up and he had been terminated. A review of the temperature log posted on the refrigerator showed that the temperatures for the month of December, logged three times a day, on just one occasion had gotten up to 120 degrees F.

On 12/11/24 at 11:30 AM, kitchen staff prepared the lunch and a pan of garlic toast was on a cookie sheet, on the top of the stove. Staff C prepared the pureed meals, beginning with the broccoli. As he scooped the vegetable out of the pan and into the blender, he laid the utensil on the counter without a barrier, where there were visible crumbs.

On 12/11/24 at 12:15 PM, Staff C donned disposable gloves, touched several surfaces, utensils and bread bag, then with the same gloved hands retrieved a piece of bread from the bag. As he prepared a peanut butter sandwich,

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F 812	Continued From page 55 he set the bread on the counter without a barrier. On 12/12/24 at 9:39 AM, the Dietary Manager (DM) said that she was aware of the temperatures on the dishwasher not getting above 118 degrees F most of the time. The maintenance man left abruptly and didn't get the new water heater hooked up. She acknowledged the need for paint on the doors and walls, and the need to deep clean stained corners on the floors. The DM said that she hadn't noticed paint chipping off of the wood counter and said that they have stainless steel tables that could be installed. The DM said that the glove use and putting the bread on the counter without barrier are concerns with infection control and she would reeducate staff. According to the facility policy titled: Handwashing/Hand Hygiene, last revised 10/2022, Staff would follow the Handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. The use of gloves did not replace Handwashing/hand hygiene.	F 812		
F 838 SS=C	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update	F 838		

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this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.

§483.71(a) The facility assessment must address or include the following:
§483.71(a)(1) The facility's resident population, including, but not limited to:
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20;
(iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population;
(iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.71(a)(2) The facility's resources, including but not limited to the following:
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific

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rehabilitation therapies;
(iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).

§ 483.71(b) In conducting the facility assessment, the facility must ensure:
§ 483.71(b)(1) Active involvement of the following participants in the process:
(i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and
(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.
(iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.

§483.71(c) The facility must use this facility assessment to:

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§483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).

§483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population.

§483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population.

§483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.

§483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to create and implement a facility assessment timely once identified it did not have one in place to ensure residents needs are met. The facility reported a census of 33 residents.

Findings include:

Record review of a document titled

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F 838	Continued From page 59 Self-Identification Form and Correction Form dated 12/10/24 but the Director of Nursing (DON) revealed on 11/22/24 she identified the facility does not have a facility assessment. She documented it would be completed by 12/31/24. During an interview on 12/12/24 at 12:44 PM with the DON revealed the facility did not have a facility assessment completed but hopes to by the end of the month.	F 838		
F 865 SS=C	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State	F 865		

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Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for

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F 865	Continued From page 61 ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and	F 865		

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F 865	Continued From page 62 policy review the facility failed to develop, implement, and maintain an effective, comprehensive, data-driven Quality assurance and performance improvement (QAPI) program that focused on indicators of the outcomes of care and quality of life timely. The facility reported a census of 33 residents. Findings include: Record review of a document titled Self-Identification Form and Correction Form dated 12/10/24 by the Director of Nursing (DON) revealed on 11/22/24 she identified the facility does not have a QAPI program in place and on 1/7/24 the facility will begin to meet monthly. During an interview on 12/12/24 at 12:32 PM with the Director of Nursing (DON) revealed she started her position in November 2024 and had a large binder with a QAPI plan but no one is completing it at this time.	F 865		
F 867 SS=C	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such	F 867		

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information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems

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impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this

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section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, and policy review the facility Quality Assurance and Performance Improvement (QAPI) program failed to be implemented resulting in no monitoring of: facility adverse events, program systematic analysis and systemic actions, program activities, and quality assessment and assurance. The facility reported a census of 33 residents.

Findings include:

Record review of a document titled Self-Identification Form and Correction Form dated 12/10/24 by the Director of Nursing (DON) revealed on 11/22/24 she identified the facility does not have a QAPI program in place and on 1/7/24 the facility will begin to meet monthly.

During an interview on 12/12/24 at 12:32 PM with

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F 867	Continued From page 66 the Director of Nursing (DON) revealed she started her position in November 2024 and had a large binder with a QAPI plan but no one is completing it at this time.	F 867		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least	F 868		

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one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:

Based on facility record review, staff interview and facility policy review, the facility failed to hold quarterly Quality Assurance Process Improvement (QAPI) meetings for 2024. The facility additionally failed to employ a required Quality Assessment & Assurance (QAA) committee member, a qualified Infection Preventionist, to perform infection control surveillance and report to the governing body. The facility reported a census of 33 residents.

Findings include:

On 12/9/24 at 9:29 am, the Interim Director of Nursing (DON) stated the facility did not have an infection preventionist. She stated she is currently enrolled in the course and will be overseeing the role for the facility.

On 12/10/24, the DON provided a Self-Identification & Correction Form. The form identified the facility had no active QAPI program for Monitoring, Performance Improvement Project (PIP) identification of collaboration between departments to ensure that audits/issues are being taken care of. The form identified this was noted on 11/22/24. It identified monthly meetings would begin in January.

On 12/11/24 at 8:56 am, the DON stated the facility's administrator had started at the facility in September of 2024 and there has been no formal QAPI program in the facility under his leadership.

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A QAPI binder provided during the survey documented monthly signature sheets for employees in attendance at monthly meetings.

No signature sheets were provided for January through April. Signature sheets for May, June and July were dated 2023 rather than 2024.

The first signature sheet provided for 2024 was dated 8/30/24. No designated Infection Preventionist was listed on the signature sheet.

The second signature sheet provided for 2024 was dated 9/27/24. Neither the Director of Nursing or any nurse was present for this meeting. The Medical Director was noted to have been called an hour after the meeting began.

The facility policy titled Quality Assessment and Performance Improvement Plan and Program F865, revision date 10/2022 identified the following:

Point 5:
a. Develop, implement and maintain an effective, comprehensive, data driven QAPI Program that focuses on indicators of the outcomes of care and quality of life.
b. Maintain evidence of ongoing QAPI Program which include:
i. Reports demonstrating identification ,reporting, investigation, analysis and prevention of adverse events;
ii. Data collection and analysis at regular intervals; and
iii. Documentation demonstrating development, implementation and evaluation of corrective actions or performance improvement activities.

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, staff interviews, guidance from the Centers for Disease Control (CDC) and facility policy review the facility failed to follow infection control standards during personal care of a resident (Resident #30) and during medication administration. The facility also failed to properly sanitize the ice machine, develop a water management plan and conduct infection control audits. The facility reported a census of 33 residents.

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Findings include:

1. The Minimum Data Set (MDS) of Resident #30, dated 9/19/24 identified a Brief Interview of Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. The MDS documented the resident to be dependent upon staff to perform toileting hygiene. The MDS recorded the resident to always be incontinent of bowel and bladder. The MDS documented the presence of a feeding tube.

The Care Plan of Resident #30 documented a Focus Area of Enhanced Barrier Precautions in place to decrease transmission of CDC-targeted MDRO's (multi drug resistant organisms), dated 9/23/24. The Care Plan stated this was related to Gastronomy (feeding tube). The Care Plan directed staff to use Personal Protective Equipment (PPE) when providing high-contact resident care activities including changing briefs or assisting with toileting. The Care Plan documented an additional Focus Area requiring assistance with Activities of Daily Living (ADLs) due to amputation of left leg above the knee, revision date 7/2/24. The Care Plan directed staff the resident to be totally dependent for toilet use. The Care Plan documented the resident to be incontinent at all times due to his inability to safely sit on a toilet.

Observation on 12/9/24 at 10:53 am, Resident #30 was lying in bed. A strong odor of urine was noted in the room. His brief was visibly soaked with urine. At the entrance to his room, an Enhanced Barrier Precautions (EBP) sign was on the wall and a fully stocked isolation cart was at the doorway to the room.

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An article from the CDC dated 6/28/24 titled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes documented the following:

Point 1. Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of Multidrug-Resistant Organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).

Point 3. Enhanced Barrier Precautions require the use of gown and gloves only for high-contact resident care activities (unless otherwise indicated as part of Standard Precautions). Residents are not restricted to their rooms and do not require placement in a private room. Enhanced Barrier Precautions also allow residents to participate in group activities. Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.

On 12/11/24 at 9:25 am, Staff L, Certified Nurse Aide (CNA) was observed wheeling Resident #30 back to his room following breakfast. At 9:28 am, Staff I, CNA joined Staff L to transfer Resident #30 back to his bed.

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On 12/11/24 at 9:30 am, the State Surveyor knocked and asked permission to enter the room to observe the staff providing care. Resident #30 was in his specialty wheelchair with a full body mechanical lift sling in place under his body. Staff I and Staff L, CNAs, were both wearing gloves and were in the process of attaching the sling loops to the full body lift. No additional PPE was observed.

At 9:32 am, Staff I removed the disposable bed pad from the resident bed and Staff L placed a new clean bed pad on the bed. The resident was then lowered to the bed and the sling of the full body mechanical lift was disconnected from the lift. At 9:34 am, Staff L reached for a clean incontinent brief which was on the sink vanity at the entrance to the room. Staff I assisted the resident to turn to his right side and Staff L tucked the sling underneath the resident as both staff assisted to lower the resident's pants. Staff I reached to open the tabs on the soiled incontinent brief.

Still wearing the same gloves, Staff L then opened the nightstand drawer and obtained wet wipes. She used her left hand to assist the resident to stay on his side and took wet wipes from the package with her right hand. She then moved the wipes into her left hand and cleansed the resident's buttocks of stool. She repeated this process multiple times due to the resident being incontinent of bowel. Staff I then began to obtain clean wipes from the package and hand them to Staff L. The package of wet wipes was emptied and Staff L obtained a new package from the nightstand drawer and continued cleansing Resident #30's buttocks. Staff L then tucked the soiled incontinent brief underneath the resident

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and then removed her gloves and placed them in the trash can. Staff L walked into the bathroom and obtained new gloves and placed them on her hands. Staff L failed to do any hand hygiene. Staff L then tucked the clean incontinent brief under the resident. Both staff then assisted the resident to turn to his left side. Staff I removed the heel protector from the resident's foot, removed the full body lift sling from under the resident and placed it directly on the floor next to the bed. Staff I then reached for the wet wipes from the head of the bed and began to cleanse the resident buttocks from her side. She placed the soiled wipes inside of the soiled brief which was lying on the bed with no barrier. After the resident's buttocks were cleaned, Staff L picked up the trash can off the floor. She held it over the bed and Staff I placed the soiled brief in the trash can. Both staff at this time removed their gloves. Neither staff member performed hand hygiene. Neither staff were observed performing any incontinence cares on the front of Resident #30, only on his buttocks.

Staff I then secured the clean brief to the resident. She picked up the heel protector from the bed and placed it on the vanity. She then picked up the full body lift sling off of the floor. Staff L moved the bed back into place and obtained a fall mat from across the room. Staff I continued to hold the soiled full body mechanical lift sling in her hands, and picked up the remote control for the bed to lower the bed to the lowest position and raise the head of the bed. Staff L picked up the trash bag from the trash can. Staff I then put the lift sling back onto the floor and walked to the sink and washed her hands. Staff L then pushed the resident's wheelchair to the hallway, and left the room with the trash bag with

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no hand hygiene witnessed. Staff I put the resident's call light in his reach and picked the soiled lift sling up off the floor. She carried it down the hall and placed it in the laundry barrel and walked down the hall in the opposite direction of the resident's room. Staff L returned to the room with new trash bags and placed a clean trash liner in the trash can. She then washed her hands prior to exiting the room.

On 12/11/24 at 9:47 am, Staff L was asked by the State Surveyor if she had received any education from the facility regarding Enhanced Barrier Precautions. She stated she had not. When asked if she was aware of why there was signage and a stocked isolation cart at the doorway to Resident #30's room, she stated she was not aware of the reason for that.

On 12/12/24 at 10:33 am, the Interim Director of Nursing (DON) stated she would expect staff to wash their hands or use hand sanitizer prior to beginning personal care for a resident. She stated after touching any equipment, etc, gloves should be changed and hand hygiene performed. She stated gloves are not needed to transfer a resident using a lift. Staff should prepare to perform peri cares, then wash hands and place gloves on. She also stated she gave education to the staff the prior evening regarding enhanced barrier precautions and all staff signed a document that they received education and understood. She stated additional staff were educated on the day shift that morning.

The facility policy titled Perineal Care, revision date 10/2023 documented the following:
Step 1: Place the equipment on the bedside stand, arrange the supplies so they can be easily

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reached.
Step 2: Wash and dry hands thoroughly.
Step 6: Raise the resident gown or lower the pajamas.
Step 7: Put on gloves
Step 10 b (male resident): Wash perineal area starting with urethra and working outward. Continue to wash the perineal area including the penis, scrotum and inner thighs. Do not reuse the same washcloth or disposable wipes to clean the urethra.
Step 10 f: Instruct or assist the resident to turn on his side with his upper leg slightly bent, if able.
Step 10 h: Wash the rectal area thoroughly, including the area under the scrotum, the anus and the buttocks.
Step 11: Discard disposable items into designated containers.
Step 12: Remove gloves and discard into designated containers. Wash and dry hands thoroughly.
Step 13: Reposition the bed covers. Make the resident comfortable.
Step 14: Place the call light within easy reach of the resident.
Step 15: Return supplies to designated area
Step 16: Clean the bedside stand
Step 17: Wash and dry your hand thoroughly.

2. On 12/12/24 at 1:20, it was discovered that a sign off sheet hung on the side of the ice machine. The form was titled: Ice Machine Cleaning and Sanitizing; Dietary Weekly Cleaning Log. The most recent time that all the ice was emptied and machine sanitized was 10/14/24. The bucket and scoop last sanitized on 11/8/24. Staff F from housekeeping said he wasn't sure who was responsible to complete the task.

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3. On 12/10/24 at 7:46 AM, Staff A, Certified Medication Aide (CMA) prepared oral medications for an unidentified resident in the dining room. He put the pills in a small cup and filled a glass with water. He then carried the cup of water to the table with his finger inside the cup of water.

4. On 12/12/24 at 2:20 PM, Corporate Maintenance Manager (CMM) said that he traveled to different facilities to monitor the maintenance departments, and the last time he had been at this facility was the previous week. He said that they had trouble with Maintenance Man (MM) tried on many occasions to direct and teach him, but the monthly checks and documenting just wasn't getting done so they eventually had to let him go. The previous MM told him that he was doing the check, but when the CMM visited the building he found it was not completed.

When asked about the water born pathogen program and where to find the plan and mapping, the CMM said it could be found in the Maintenance Book or Fire Marshall book. A review of both binders found that the water management forms were in the binder but had not been completed.

The facility failed to establish and review water system annually and document in the Infection Control Committee minutes. Failed to demonstrate they had taken measures to minimize risk of Legionella and other opportunistic pathogens in the building water system through a documented water management program.

A facility policy titled; Water Management,

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F 880	Continued From page 78 Legionella Testing showed that the facility would handle and maintain it's water supply in accordance with recommendations of the CDC (Center For Disease Control), Healthcare Infection Control Practices Advisory Committee and the FDA (Food and Drug Administration.) The community would demonstrate its measures to minimize their risk of Legionella and other opportunistic pathogens in the building water system through a documented water management program. They would complete the review of the water system annually and document in the Infection Control Committee minutes. 5. During an interview on 12/12/24 at 12:38 PM with the DON revealed she has completed audits for infection control, including hand washing and Personal Protective Equipment (PPE) applying and removing but is unable to find them. She also informed she would expect routine and random infection control audits be completed to ensure infection control practices are being followed by all staff.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:	F 881		

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Based on record review, staff interview and policy review the facility failed to ensure an antibiotic stewardship program was in place for 33 of 33 residents. The facility reported a census of 33 residents.

Findings include:

Record review of Resident #8 Orders on her Medication Administration Record (MAR) on 12/11/24 revealed she is currently taking an antibiotic, Nitrofurantoin 100 milligrams (mg) twice a day for UTI prophylaxis (an attempt to prevent disease) she started on 12/3/24.

Request was made on 12/12/24 at 12:29 PM to review resident antibiotic tracking logs since January 2024 to December 2024 and the facility was unable to provide the requested documentation.

During an interview on 12/12/24 at 12:32 PM with the Director of Nursing (DON) revealed she started her position in November 2024 and was unable to locate tracking of antibiotic usage for residents from January 2024 to November 2024. She then informed she had a plan in place to start tracking but it will not start until January 2025 and nothing had been tracked for December 2024 thus far. She revealed she write down a few residents that had infections in November 204 but did not verify if lab cultures were completed or McGreers criteria was met (A set of surveillance definitions for infections in long-term care facilities. The criteria are used to identify infections by considering the clinical presentation, microbiologic and radiological information, and any other relevant findings).

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F 881	Continued From page 80 Review of the facilities policy dated 12/2024, Infection Prevention and Control Program, instructed a procedure to follow for tracking infections, however the facility was unable to provide documentation it was completed.	F 881		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on staff interviews, job description, and policy review the facility failed to employee a qualified person to serve as the Infection Preventionist (IP) for the facility. The facility reported a census of 33 residents. Findings include: During and interview on 12/09/24 at 9:29 AM with the Administrator revealed the facility did not have	F 882		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165426	A. BUILDING _____ B. WING _____	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF PERRY	2625 IOWA STREET PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 882	Continued From page 81	F 882		

an IP employed at the facility but the Director of Nursing (DON) is enrolled in a course.

During an interview on 12/12/24 at 12:44 PM with the DON revealed she does not have and IP certification but is in a class.

Record review of the facilities job description, Infection Preventionist dated 12/2024 instructed the following:
The employee holding this position must be able to perform these tasks satisfactorily:
a. Develops and implements an ongoing infection prevention and control program to prevent, recognize, and control the onset and spread of infections in order to provide a safe, sanitary, and comfortable environment.
b. Establishes facility-wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases of residents, staff, and visitors.
c. Develops and implements written policies and procedures in accordance with current standards of practice and recognized guidelines for infection prevention and control.
d. Oversees the facility's antibiotic stewardship program.
e. Oversees resident care activities that increase risk of infection (i.e., use and care of urinary catheters, wound care, incontinence care, skin care, point-of-care blood testing, and medication injections).
f. Leads the facility's Infection and Prevention Control Committee. Develops action plans to address opportunities for improvement.

Record review of the facilities policy, Infection Prevention and Control Program dated 12/2024 documented:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 882	Continued From page 82 The Infection Prevention and Control Program is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 882		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 883		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 83 (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record and policy review, and interview the facility failed to provide pneumococcal vaccine as requested for 1 of 5 residents reviewed. Resident #34 consented to receive the vaccine and the facility failed to follow through and provide the immunization. The facility reported a census of 33 residents. Findings include: According to the Minimum Data Set (MDS) dated 9/22/24, Resident #34 had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability.) She was independent with toileting, dressing, transfers and eating.	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 883	Continued From page 84 The Care Plan updated on 10/3/24, showed that Resident #34 was receiving radiation/chemotherapy treatments related to breast cancer. According to the Vaccine tab in electronic chart, Resident #34 was given an influenza vaccine on 10/23/24. A Pneumococcal Vaccine Informed Consent dated 9/11/24 at 9:56 AM, signed by the Power of Attorney (POA), indicated that they received information and gave consent to receive the vaccine. On 12/12/24 at 2:30 PM, the Director of Nursing (DON) said that any vaccines received at the facility would be documented in their record. She was not at the facility in September and didn't know why the pneumococcal vaccine had not been administered to Resident #34. A facility policy titled; Pneumococcal Vaccine, last revised 10/2024 showed that residents would be offered the pneumococcal vaccine to aid in preventing pneumococcal infections. Prior to admission, resident would be assessed for eligibility to receive the pneumococcal vaccine and when indicated would be offered the vaccination unless medically contraindicated or the resident had already been vaccinated.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the	F 887		

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F 887	Continued From page 85	F 887		

facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;
(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;
(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;
(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and

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F 887	Continued From page 86	F 887		

(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:
Based on interview, record and policy review, the facility failed to provide the Covid-19 immunization booster as requested for 2 of 5 residents. Resident's #20, and #30 signed consent agreements to get the Covid-19 booster, the facility failed to follow through and provide those immunizations. The facility reported a census of 33 residents.

Findings include:

1) According to the Minimum Data Set (MDS) dated 10/6/24, Resident #20 did not have a Brief Interview for Mental Status (BIMS.) assessment because she was rarely understood. She required substantial assistance with eating, sit to stand, toilet transfers and was totally dependent for hygiene and dressing. The MDS showed that her Covid-19 vaccination was up to date.

The Immunization tab for Resident #20, showed that Resident #20 received dose 2 of the Covid-19 vaccine which was administered on 4/8/21.

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The care plan for Resident #20, updated on 10/13/24, showed that she was at risk for injury due to impaired safety awareness. She had chronic pain related to osteo arthritis and used antianxiety medication related to dementia. She was at risk for alterations in nutritional status and had diagnoses that included chronic kidney disease, heart failure, and history of Covid-19.

A Resident Consent Form for Covid-19 Vaccine (RCFCV) dated 5/13/24, showed that a resident representative gave verbal permission for the resident to get the vaccine.

2) According to the Minimum Data Set (MDS) dated 9/19/24, Resident #30 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficits.) The resident was totally dependent on staff assistance for toileting hygiene, dressing, personal hygiene and chair to bed transfers. The resident was on a mechanically altered diet and a feeding tube for nutrition.

The care plan last updated on 9/23/24, showed that Resident #30 had impaired communication and said very few words. He required assistance with Activities of Daily Living (ADLs) related to an amputation above the left knee and he was bedfast most of the time. He required assistance with eating pureed foods, as well as tube feedings during the day.

The Immunization tab in the electronic chart lacked documentation of a Covid-19 immunization.

A RCFCV form showed that on 5/13/24, the Power of Attorney (POA) gave permission via

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F 887	Continued From page 88	F 887		

telephone, to administer the Covid-19 vaccine to Resident #30.

On 12/12/24 at 2:30 PM, the interim Director of Nursing (DON) acknowledged that the facility did not have any evidence that the Covid-19 booster had been offered to residents. She thought that maybe the pharmacy would have come to the facility to provide those in the fall, but according to the resident files, that had not happened in 2023 or 2024.

According to a facility policy titled: Vaccination of Residents, Including Influenza, Pneumococcal, RSV and COVID-19, effective 10/2024, residents would be offered flu, pneumovax and COVID-19 vaccinations per CDC (Centers for Disease Control) and CMS (Center for Medicaid and Medicare Services) guidelines, based upon availability to the community. The community would offer the COVID-19 vaccination when available to the community.

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0132	A. BUILDING: _____ B. WING _____	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF PERRY	2625 IOWA STREET PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 257	58.12(1) Admission, transfer, and discharge 481-58.12(135C) Admission, transfer, and discharge. 58.12(1) General admission policies. This Statute is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to verify eligibility to receive Veteran's benefits for 3 of 4 residents reviewed (Resident #11, #32 and #33) Findings include: On 12/12/24 at 10:28 am, the Social Services Director (SSD) stated the corporate business office had always input the Veteran Status in the Electronic Health Record (EHR) of the resident prior to their admission to the facility. She stated corporate decided all referrals for the facility after reviewing the medical record. The facility was made aware of admissions once corporate made the decision to admit. She stated she had never been trained to ask about veteran status during admission and does not have user access to the Veterans Administration computer system. The facility has recently changed ownership and the SSD stated this process will be changing with the change of ownership. The Electronic Health Record (EHR) of Residents #11, 32 and 33 failed to provide any documentation of veteran status upon review on 12/16/24. The facility was unable to provide any documentation of Residents #11, 32 or 33 being asked about Veteran Benefits Eligibility within 30 days of admission to the facility.	L 257		

DEPARTMENT OF INSPECTIONS AND APPEALS

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	IA0132	A. BUILDING: _____ B. WING _____	12/17/2024

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F567

Corrective action taken for residents found to have been affected by deficient practice

Residents #24, #12, and #4 have had their individual cash needs addressed. Residents with a trust have access to cash during evening and weekend hours.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility with a trust have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Cash and a resident ledger always available to nursing staff provide to residents.
- Current licensed nurses will be re-educated by the administrator/designee regarding the process of providing cash to residents during evenings and weekends.
- Mission Health controller re-educated the administrator, activities, and human resources to the Resident Funds Management Process on 1/8/25.
- Administrator/designee will audit the Resident Funds Management Process weekly x4 for sufficient funds available on off-business hours and weekends. Administrator/designee will interview 2 residents for satisfaction of service weekly x4, then monthly for 3 months.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.

1/16/25

F582

Corrective action taken for residents found to have been affected by deficient practice.

Resident #6 is a current resident of the facility.
Resident #34 is a current resident of the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- ABN Form CMS-10055 are provided to all residents ending Medicare A services effective 1/10/2025.
- The interdisciplinary team were educated by the Administrator regarding the process of providing notification of end of Medicare/Medicaid Coverage and financial liability.

- The Administrator/designee will audit residents ending Medicare/Medicaid services weekly x4 weeks, then monthly x3 months.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
1/16/25

F584
Corrective action taken for residents found to have been affected by deficient practices.
- No urine odor noted on 1/9/25.
- Repairs made to chipped paint on walls, floorboards, and walls in east hallway.
- Broken chair disposed of 1/10/25.
- Broken Floor tiles on east hallway replaced 1/15/25.
- East hall shower room floor tiles replaced and gap were sealed in shower wall.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Maintenance and housekeeping audits completed for all community areas for odors, chipped paint and broken tiles, broken furniture 1/16/25.
- Current staff were educated by the administrator regarding the maintenance and housekeeping standards 1/16/25. This includes completing maintenance requests for broken tiles, chipped paint and broken floorboards.
- The Administrator/designee will audit the community areas for housekeeping and maintenance standards twice weekly x4 weeks then monthly x3 months.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
1/16/25

F606
Corrective action taken for residents found to have been affected by deficient practices.
Staff A and Staff B were removed from the schedule and will not be returning.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- The interdisciplinary team will be re-educated by the Administrator/designee regarding the requirements of licensure and background checks for all permanent and agency staff prior to working on-site. This education was completed on or before 1/8/25.
- The Administrator/designee will audit facility and agency employees for licensure and background checks of agency staff and new hires 3 times a week x2 weeks, 2 times a week x2 weeks, 1 times a week for 4 weeks.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
1/8/25

F610
Corrective action taken for residents found to have been affected by deficient practices.
Residents were separated.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Current staff were re-educated by the Administrator on the requirement to protect residents immediately from any resident physical and/or sexual contact observed or alleged. This education was completed on or prior to 1/8/25.
- The Administrator/designee will audit facility incidents for presence of any inappropriate physical contact for proper follow up between residents weekly x4, then monthly 2.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.

1/8/25

F636

Corrective action taken for residents found to have been affected by deficient practice

Resident #1 the annual was completed and submitted on 12/4/2024.
Resident #121 Admission assessment was completed and submitted on 12/9/2024.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility have the potential to be affected.

What changes will be implemented to ensure that the problem will be corrected and will not recur.

- Current residents will be audited to ensure all overdue MDS assessments have been completed and submitted. Current residents have been audited and are up to date with MDS assessments.
- DON/Designee will review the MDS planner for timing of assessments 3 times weekly for 4 weeks, then weekly x4.
- The interdisciplinary team will be re-educated by the administrator/designee on the requirements of timely completion of MDS.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

Identified concerns shall be reviewed by the facilities QAA Committee Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.

01/16/2025

F637

Corrective action taken for residents found to have been affected by deficient practice

Resident #6 significant change assessment has been completed and transmitted 10/30/24.
Resident #7 significant change assessment has been completed and transmitted 12/31/24.
Resident #32 significant change assessment has been completed and transmitted 12/27/24.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Current residents will be audited to ensure all overdue MDS assessments have been completed and submitted. Current residents have been audited and are up to date with MDS assessments.

- The interdisciplinary team will be re-educated by the administrator/designee will be re-educated on the requirement for significant change assessments to be completed within 14 days of significant change in mental and/or physical condition including being signed onto and off of hospice services.
- DON/Designee will review the MDS planner for timing of assessments 3 times weekly for 4 weeks, then weekly x4.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
1/16/25

F638
Corrective action taken for residents found to have been affected by deficient practice
Resident #4 quarterly MDS was completed and submitted on 12/19/2024.
Resident #5 quarterly MDS was completed and submitted on 12/19/2024.
Resident #7 quarterly MDS was completed and submitted on 12/27/2024.
Resident #8 quarterly MDS was completed and submitted on 12/27/2024.
Resident #9 quarterly MDS was completed and submitted on 12/19/2024.
Resident #12 quarterly MDS was completed and submitted on 12/19/2024.
Resident #19 quarterly MDS was completed and submitted on 12/19/2024.
Resident #23 quarterly MDS was completed and submitted on 12/19/2024.
Resident #34 quarterly MDS was completed and submitted on 12/19/2024.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

- Current residents will be audited to ensure all overdue MDS assessments have been completed and submitted. Current residents have been audited and are up to date with MDS assessments.
- DON/Designee will review the MDS planner for timing of assessments 3 times weekly for 4 weeks, then weekly x4.
- Interdisciplinary team will be re-educated by the administrator on the requirements of quarterly MDS assessments to be completed every 3 months.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.

01/16/2025

F640

Corrective action taken for residents found to have been affected by deficient practice

Resident #26 had their discharge assessment completed and transmitted on 12/19/24.
Resident #32 had their quarterly. assessment completed and transmitted on 12/19/24.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Current residents will be audited to ensure all overdue MDS assessments have been completed and submitted. Current residents have been audited and are up to date with MDS assessments.
- DON/Designee will review the MDS planner for timing of assessments 3 times weekly for 4 weeks, then weekly x4.
- Interdisciplinary team will be re-educated by the administrator/designee on the requirements of timely completion of MDS assessments.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.

01/16/2025

F656

Corrective action taken for residents found to have been affected by deficient practice

Resident #6 insulin was added to the care plan.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- DON/designee will review residents on insulin and update care plans as needed.
- DON/designee will re-educate the licensed nurses to include medications such as insulin on care plans.
- DON/designee will audit new orders for insulin being added to the care plan. This audit will be done weekly x6 weeks.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
01/16/2025

F657
Corrective action taken for residents found to have been affected by deficient practice
Resident #21 had the use of smokeless tobacco added to their care plan.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- DON/designee will audit current residents for the use of flame-lit and smokeless tobacco and update the care plan as needed.
- DON/designee will re-educate the licensed nurses on the requirement to have tobacco use added to the care plan.
- DON/designee will audit the care plans for the use of tobacco products weekly x6.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
01/16/2025

F688
Corrective action taken for residents found to have been affected by deficient practice
Residents #1, #8, #9, #19, #30, #32 have been screened for a restorative program and care plans updated.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents who require assistance with activities of daily living have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Therapy staff will screen current residents for restorative needs and care plans will be updated.

- DON/designee will re-educate current staff on the restorative program requirements and documentation.
- DON/designee will audit restorative plan for progress and documentation weekly x6.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
01/16/2025

F689
Corrective action taken for residents found to have been affected by deficient practice
Resident #21 had a smoking assessment completed and the care plan updated to reflect interventions.
Resident #8 has been care planned to have an escort with appointments.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.
- Current residents have been audited for smoking and have had their smoking assessments updated and care plan updated with interventions.
- Current residents have been audited for the ability to attend appointments without an escort and have had their care plans updated.
- Administrator/designee will re-educate current staff on residents requiring an escort to appointments.
- Adminitrator/designee will re-educate current staff on smoking interventions.
- Administrator/designee will audit 5 random smoking times weekly x6 weeks for appropriate interventions.
- Adminstrator/designee will audit appointments Monday-Friday for level of assistance needed x4 weeks.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facility's QAA Committee. One a weekly basis for four weeks.

Date when corrective action will be completed.
01/16/2025

F758
Corrective action taken for residents found to have been affected by deficient practice

Resident #15 has Seroquel side effect monitoring added to their electronic health record.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- DON/designee will re-educate licensed nurses on monitoring residents who take psychotropic medications for side effects.
- Current residents will be audited for psychotropic medication use and will have side effect monitoring added.
- DON/designee will audit the electronic health record for completion of side effect monitoring weekly x6.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
01/16/2025

F761
Corrective action taken for residents found to have been affected by deficient practice
Resident #6 had their controlled medications counted and reconciled. They have had their controlled medication orders reviewed and cards inspected for correct verbiage.
Resident #20 has passed away. Medications have been disposed of.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- DON/designee will re-educate licensed nurses on controlled medication count reconciliation shiftly and/or when they take responsibility for a medication cart.
- DON/designee will re-educate licensed nurses on removing discontinued medications including narcotics from the medication carts for destruction. Education will include the 6 rights on medication administration to verify that the instructions in the electronic health record match the medication label.
- DON/designee will audit controlled medication count for reconciliation weekly x4 weeks then monthly x2.

- DON/designee will audit controlled medications for the electronic health record instructions to match the instructions on the medication card weekly x4 weeks then monthly x2.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
1/16/25

F808
Corrective action taken for residents found to have been affected by deficient practice
Residents #30, #22, #3 diets have been reviewed and their care plans updated.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Director of nursing/designee will audit current resident's diet order, care plan and tray card to ensure they match.
- Administrator/designee will re-educate the dietary staff on therapeutic diets and how to read and follow a menu.
- Administrator/designee will audit 5 random meal trays per week x6 weeks for correct diet texture.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
1/16/25

F812
Corrective action taken for residents found to have been affected by deficient practice
No residents were affected.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Dietary staff will be re-educated by the administrator on the proper food handling safety and procedures related to glove use during service and using food scoops.
- Hot water has been increased and the dishwasher reaches appropriate temperature for sanitation.
- The wood countertop has been sealed.
- Administrator/designee will audit glove use during food handling at 5 random mealtimes per week x6 weeks.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance

Date when corrective action will be completed.
01/16/2025

F838
Corrective action taken for residents found to have been affected by deficient practice
The facility will develop a facility assessment that outlines what resources the facility needs to meet the needs of the residents during day-to-day operations as well as during emergencies. This plan will be reviewed annually and as needed.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Administrator/designee will re-educate the interdisciplinary team on the components of the facility assessment.
- Administrator/designee will review the facility assessment monthly x3 months for changes that would require and update to the assessment.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.

1/16/25

F865

Corrective action taken for residents found to have been affected by deficient practice

The facility will develop a QAPI plan that outlines what clinical and operational outcomes and quality indicators will be monitored.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Administrator/designee will re-educate the interdisciplinary team on what clinical and operational outcomes and quality indicators will be monitored during QAPI.
- QAPI documentation will be monitored x3 months by the administrator/designee for the presence of clinical and operational outcomes.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.

1/16/25

F867

Corrective action taken for residents found to have been affected by deficient practice

The facility will develop a QAPI plan that outlines how the facility will monitor and evaluate clinical and operational outcomes and quality indicators. The QAPI plan will outline how to track and performance improvement projects.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Administrator/designee will re-educate the interdisciplinary team on how the facility will monitor and evaluate clinical and operational outcomes and quality indicators. The QAPI plan will outline how to track and performance improvement projects.
- QAPI documentation will be monitored x3 months by the administrator/designee for presence of quality indicators.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
1/16/25

F868
Corrective action taken for residents found to have been affected by deficient practice
The facility will develop a QAPI plan that includes who is part of the committee, the frequency of meetings, the agenda of the meetings and how to perform improvement activities.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Administrator/designee will re-educate the interdisciplinary team on the function of the QAPI committee, the frequency of meetings, the agenda of the meetings and how to perform improvement activities.
- QAPI documentation will be monitored x3 months by the administrator/designee for status of performance improvement activities.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
01/16/2025

F880
Corrective action taken for residents found to have been affected by deficient practice
Resident #30 has a sign on the door indicating they are on enhanced barrier precautions (EBP) and a PPE cart has been placed outside of the room. The ice machine has been cleaned and added to the preventative maintenance log. The facility has developed a water safety plan.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Current residents will be audited for the need for EBP. These residents will have a sign on their door indicating they are on EBP and a PPE cart outside their room.
- Current staff will be re-educated by the DON/designee on EBP and hand hygiene.
- DON/designee will make 5 random audits weekly x4 weeks for proper PPE use for residents on EBP. DON will make 3 random audits weekly x4 weeks for proper dressing change procedure.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee Recommendations for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
01/16/2025

F881
Corrective action taken for residents found to have been affected by deficient practice
The facility has implemented an infection control log to monitor for appropriate antibiotic use.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- DON/designee will re-educate licensed nurses on McGeer's criteria for antibiotic use.
- DON/designee will audit current antibiotics for appropriateness and add to the infection control log.
- DON/designee will audit antibiotic use for appropriateness weekly x6 weeks.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
1/16/25

F882
Corrective action taken for residents found to have been affected by deficient practice
The facility will employ a staff member with additional education in infection control to oversee the infection control program.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Administrator/designee will re-educate the interdisciplinary team on the requirement for a staff member with additional infection control education to oversee the infection control program.
- The infection control preventionist will oversee the infection control program. They will audit antibiotic use and infection surveillance weekly x6 weeks and report findings to QAPI.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
1/16/25

F883
Corrective action taken for residents found to have been affected by deficient practice
Resident #34 has had their immunization status reviewed and updated.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected. Current residents will be audited for vaccination status and their records updated.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- DON/designee will re-educate the licensed nurses on the requirement to obtain consent and educate residents/responsible parties on obtaining consents for vaccines prior to administration.
- DON/designee will audit new residents for documentation of consents and education of risks and benefits or declinations weekly x4 weeks then monthly x2.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
1/16/25

F887

Corrective action taken for residents found to have been affected by deficient practice

Residents #20 and #30 have had their immunization records reviewed and updated.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- DON/designee will re-educate the licensed nurses on the requirement to obtain consent and educate residents/responsible parties on obtaining consents for vaccines prior to administration.
- Current residents will be audited for vaccination status and their records updated.
- DON/designee will audit new residents for documentation of consents and education of risks and benefits or declinations weekly x4 weeks then monthly x2.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.

Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.

1/16/25

L257

Corrective action taken for residents found to have been affected by deficient practice

Residents #11, #32 and #33 have had their veterans' benefits verified.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents with veteran's benefits have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur.

- Administrator/designee will educate IDT team on verification of veterans' benefits on admission.
- Current residents will be audited for veterans' benefits and their face sheets updated completed 1/10/25.
- Administrator/designee will audit new residents for documentation of veterans' benefit verification weekly x4.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.
Identified concerns shall be reviewed by the facilities QAA Committee recommendation for further corrective action will be discussed and implemented to sustain compliance.

Date when corrective action will be completed.
1/16/25