STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING _____ B. WING _____	09/18/2023

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CENTERVILLE SPECIALTY CARE	1208 EAST CROSS STREET CENTERVILLE, IA 52544

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F 000 ✓ ok/cp	INITIAL COMMENTS Correction date: 10/9/23 The following deficiencies resulted from the facility's Annual Recertification Survey and investigation of Facility Reported Incident #115431-I, conducted September 11, 2023 to September 18,2023. Facility reported incident #115431-I was unsubstantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
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	F 584	**Plan of Correction:** Education to environmental and maintenance regarding timely reporting of rusty equipment, stained flooring, completion of work orders, deep cleans, removing soiled linen from floor, and utilizing floor care as needed. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Stool riser replaced and bathroom floor was cleaned in resident #39's room; carpets shampooed. **Measures or systemic changes made to ensure this will not recur and affect others:** Administrator will monitor deep cleaning to ensure completion. Work orders will be discussed during morning meeting to ensure communication on the completion.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: RDO | (X6) DATE: 10/10/2023

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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F 584	Continued From page 1 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, resident representative interview, and staff interview, the facility failed to ensure the provision of housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 3 of 24 residents reviewed (Residents #9, #12, #39) for the environment. The facility reported a census of 51 residents. Findings include: 1. On 9/14/23 at approximately 2:00 p.m., Resident #39's toilet riser was covered with a thick layer of rust in multiple areas. The floor in front of the toilet was stained brown and multiple areas of the off-white flooring had brown discoloration present.	F 584	**Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Environmental will provide a schedule of hallway carpet shampooing and deep cleans and will be discussed in morning meeting. Department heads will assess assigned rooms during morning quality assurance rounds for concerns and provide concerns to the appropriate department. 3 audits per week for 3 weeks then 2 audits per week for 3 weeks to monitor for completion. Results of the audit will be submitted to QAPI committee for review. **Anticipated Date of Completion for this plan of correction:** 10/9/23	

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F 584	Continued From page 2 On 9/18/23 at approximately 1:00 p.m., the carpeting down East Hall had multiple dark stains present throughout. On 9/18/23 at 1:35 p.m., the Director of Nursing (DON) stated if a resident had a rusty toilet riser, they would try to get this replaced and stated if there were stains on the floor around the toilet, ideally she would like it replaced or repaired. On 9/18/23 at 1:49 p.m., the Administrator stated she was not aware of the resident's rusty riser and stated if it could not be cleaned, they should notify her. On 9/18/23 at approximately 2:15 p.m., the Administrator stated the facility replaced the resident's toilet riser. 2. The Quarterly Minimum Data Set (MDS) dated 8/10/23 for Resident #9 revealed the Brief Interview for Mental Status (BIMS) scored 15, which indicated intact cognition. On 9/11/23 at 11:00 AM, Resident #9 stated this place is dirty and always stinks Observations 09/11/23 at 09:55 AM revealed hall and room carpets were old and worn with stains included a strong odor of urine in East and West hallway during initial observations and interviews. 3. On 09/11/23 at 4:57 PM, Resident #12's Family member visited resident, stated that the housekeeping is poor and the odor is strong throughout the facility. Resident #12 sat in a recliner and had an indwelling urinary catheter. Family member reported visiting most every day to advocate for her father over the last year.	F 584		

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F 584	Continued From page 3 Family member relayed last week, piles of towels were left on his room floor to soak up a brownish substance, the towels were just left there, and stated that they knew it was urine because of the strong urine odor. On 9/18/23 at 2:01 PM, the Family member of resident #12 elaborated on conversations with the previous administrator who reportedly, recognized the odor problem in the facility. Family member stated repeatedly reported concerns of carpet and odors to the last administrator who responded are in the process of replacing the old carpets to rid of urine odors. Prior Administrator relayed will be moving down the hall with new flooring. Family relayed only three (3) rooms are done on the other hall and felt at that rate, will be too long to wait. Family member relayed she feels that every carpet square has been stained with urine. Stated, is embarrassed when extended family visit, stated family members have gone outside because the odor is so bad especially when the humidity is up. Relayed her father did not live like this with old stained carpet that smells of urine that is prevalent throughout the entire facility. The facility policy "Floors", revised December 2009, stated floors should be maintained in a clean and sanitary manner. The facility policy "Work Orders, Maintenance", revised April 2010, stated maintenance work orders would be completed in order to establish a priority of maintenance service.	F 584		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658	**Plan of Correction:** Education provided to nursing staff regarding administering medications, administering medications in a timely manner, infection control with medication administration, and tube feeding	

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F 658	Continued From page 4 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, resident interviews, record review and policy review the facility failed to follow professional standards of medication administration for 3 of 7 residents reviewed. (Resident #2, #5, #37). The facility reported a census of 51. Findings include: On 9/12/23 at 8:50 AM, Staff #C Licensed Practical Nures (LPN) prepared two syringes of Levimer insulin. One syringe of 50 units and one syringe of 5 units. Observed Staff C gave two insulin injections to Resident #37, one syringe of 50 units, one syringe of 5 units. On 9/12/23 at 8:50 AM, Staff C reported the facility is out of stock of the large insulin syringe. Staff C state that Resicent#37 gets injected twice as a result of not having stock of the larger insulin syringe required for one injection. On 9/12/23 at 8:53 AM, Resident #37 relayed it is her understanding they have to inject her twice because they cannot use her insulin pen that she used at home that held larger amounts of insulin. Resident #37 was not aware the facility could use a larger syringe to avoid two injections. She was not aware she received two injections because the large insulin syringe stock depleted.	F 658	medication administration. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Resident #37 will receive insulin in 1 syringe. Infection control will be maintained when administering medications to resident #5. Medication residual will be checked prior to medication administration. Resident #2 will have accu checks performed with personal glucometer. Resident #37 will receive medication in a timely manner. **Measures or systemic changes made to ensure this will not recur and affect others:** Education to nursing staff, competency audits on medication administration. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Nursing will complete weekly audits 3x weekly for 3 weeks and 2 audits for 3 weeks. Results of audits will be submitted to the QAPI committee for further review. **Anticipated Date of Completion for this plan of correction:** 10/9/23	

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F 658	Continued From page 5 On 09/13/23 at 07:44 AM, Staff #D, Registered Nurse (RN) prepared resident #5 medications listed on the Medication Administration record (MAR) for gastric tube administration. Staff #D attempted to expel from medication package, Sertraline 25 milligram into the medication cup. The pill dropped to the medication cart. Staff D picked up the pill with her ungloved hand and put it in the medication cup. Tablet medications that were listed on the MAR for AM (refers to morning) administration crushed together and added to the liquid Depakane solution also ordered for AM administration. Staff D proceeded to Resident #5 room, checked placement of the gastric tube by pushing air into the gastric tube while listening for placement. Staff D added water to drain in the tube via gravity, followed by the medications that were crushed together with the Depakane liquid. Medications added to the tube followed by additional water to drain via gravity. On 9/13/23 following Medication Administration for Resident #5, Nurse Staff D stated all medications can be given together. Staff D relayed two hundred (200) milliliters (ml) of total liquid was added to the gastric tube during the morning medication administration. Record review of Medication Administration Record for August 2023 for Resident #5 included specific direction to check gastric residual, flush with water between the administration of each medication. The MAR noted the following: a. Sertraline Hydrochloride (HCl) Tablet 25 MG (Sertraline HCl) Give 1 tablet b. Sertraline HCl Tablet 100 milligram (mg) Give 1 tablet c. Buspirone HCl Tablet 5 mg Give 1 tablet	F 658		

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F 658	Continued From page 6 d. Docusate Sodium Tablet 100 mg Give 2.5 tablet via PEG-Tube one time a day, crush e. Depakene Oral Solution 250 mg/5 ml (Valproate Sodium) Give 15 ml via PEG-Tube f. Levothyroxine Sodium, 50 Microgram (mcg) Give 1 tablet via PEG-Tube (refers to gastric tube) one time a day. In addition, directed to: verify tube placement, check for gastric residual-flush with 15-30 ml of water before and after administration, flush with 5-10 Milliliter (ml) of water between the administration of each medication. g. Meloxicam Tablet 7.5 milligram (mg) Give 7.5 mg via gastric tube in the morning, verify placement, check for gastric residual-flush with 15-30 ml of water before and after administration (flush with 5-10 ml of water between the administration of each medication. On 09/13/23 at 07:57 AM, Resident #2 relayed she did not want her insulin since her blood sugar was seventy-five (75) and she did not have breakfast yet. Staff D responded, needed to check blood sugar again. Staff D took glucometer of another resident from the medication drawer and proceeded to check residents blood sugar using another resident's glucometer. On 9/13/23 at 08:00 AM, Staff #D acknowledged she grabbed the wrong glucometer. She acknowledged using another resident's glucometer when checked blood sugar for Resident #2. On 9/13/23 at 10:10 AM, Staff D relayed she had not given all the morning medications. She acknowledged Resident #37 had not been given her oral medication and had not been given her	F 658		

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F 658	Continued From page 7	F 658		

insulin. Staff #D acknowledged the morning medication administration should be between 7:00 and 9:00 in the morning.

On 9/13/23 at 3:00 PM, interview with the Administrator and Assistant Director of Nursing (ADON) who relayed, had ran out of the larger insulin syringe and ordered more as a result. The ADON and administrator acknowledged resident would need two injections until they receive the ordered shipment. The administrator and ADON could not explain the system for ordering before stock was depleted.

On 9/14/23 at 04:30 PM, Administrator and Corporate Nurse Consultant, Staff #E relayed would expect staff to ask for help if not able to meet medication time frames for administering, expectation is staff will follow the appropriate orders and processes with medication administration.

The facility policy titled Administering Medication revised April 2019 documented, medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions

The facility provided a policy titled Administering Medications through an enteral tube revised November 2018 directed to administer each medication separately and flush between medications.

The facility provided document relayed the time

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F 658	Continued From page 8 frame of 7:00 to 9:00 for morning medications.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review, and policy review, the facility failed to provide bathing needs for 2 of 3 residents reviewed for Activities of Daily Living (#2, #7). The facility reported a census of 51. Findings include: 1. The Admission Minimum Data Set (MDS) dated 9/5/23 for Resident #2 revealed the resident had a Brief Interview for Mental Status (BIMS) scored 15, which indicated intact cognition. The MDS documented diagnoses of heart and lung disease, diabetes, renal disease and osteoporosis. The MDS documented the resident required total assistance with personal hygiene, and required extensive assistance of staff for bed mobility, transfers, and toilet use. . Bathing assistance was coded as required physical help in part for bathing activity and noted resident weighed two-hundred fourteen (214) pounds. The MDS documented the resident's admission date as 8/29/23 The Care Plan revised 9/11/23 for Resident #2 indicated resident needed assistance of one person with bathing needs.	F 677	**Plan of Correction:** Education provided to nursing staff to ensure residents are receiving showers as scheduled and as they prefer. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Resident #2 and Resident #7 have been provided baths. **Measures or systemic changes made to ensure this will not recur and affect others:** Education provided to nursing staff to ensure alternative options are provided if needed. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** DON or ADON will complete weekly audits 3x weekly for 3 weeks and 2 audits for 3 weeks. Results of the findings will be submitted to the QAPI team for further review. **Anticipated Date of Completion for this plan of correction:** 10/9/23	

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The bathing record for September for Resident #2 indicated resident had physical help with bathing on 9/1/23 and documented refused on 9/5/23 and 9/8/23, no other entries for September.

A Purchase order dated 8/31/23 was provided by the Administrator noted is for the extra wide shower chair. The purchase order documented "in approval status".

On 9/11/23 at 10:12 AM, Resident #2 reported no shower since admit to the facility. Resident #12 stated that staff did one bed bath and it didn't get me clean so, he refused and continues to wait for a shower to get clean. Resident #2 reported skin problems, which included yeast under skin folds that are not getting better because the need for water to clean and stated, not a bed bath. Resident #2 reported the nursing staff stated, I am too big and they do not have a shower chair big enough.

On 9/13/23 at 2:12 PM, Director of Nurses (DON) reported that a bariatric chair was ordered a couple weeks ago. She acknowledged resident #2 has not had a shower in September as a result of not having a large shower chair. The DON confirmed awareness that the resident has wanted a shower, and confirmed Resident #2 did have a shower in the afternoon on 9/11/23 when surveyors came, by utilization of a facility wheel chair. The DON relayed the resident can transfer from one chair to another, and staff can continue to ensure showers with use of the wheel chair until the bariatric chair is delivered.

On 9/14/23 at 02:40 PM, Staff #B, Certified Nursing Aide (CNA) reported it was about a

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F 677	Continued From page 10 month ago since the large bath chair broke. On 9/14/23 at 03:02 PM Staff #A, Licensed Practical Nurse (LPN) stated several weeks ago, the PVC cracked and the chair was thrown away (PVC refers to polyvinyl chloride material of the shower chair). On 9/14/23 at 04:30 PM, Administrator and the, Staff #E Corporate Nurse Consultant (CNC), stated the expectation was residents are to be clean. Staff E stated safety was the main concern and reason resident was not showered. The Administrator and Staff #E acknowledged alternative options for resident's shower was not presented until surveyors arrived on 9/11/23. The Facility Assessment dated 6/22/23 outlined services offered based on residents needs included bathing, showers support and documented the facility provided bariatric equipment, which included shower chairs. On 9/18/23 at 9:10 AM Staff E, CNC stated there is no policy for bathing, staff are expected to offer at a minimum twice a week baths. 2. The Minimum Data Set(MDS) assessment tool, dated 7/6/23, listed diagnoses for Resident #7 which included heart failure, quadriplegia(paralysis of all four limbs), and reduced mobility. The MDS stated the resident required extensive assistance of 1 staff for eating, depended completely on 1 staff for bathing, personal hygiene, and dressing, and depended completely on 2 staff for bed mobility and transfers. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out	F 677		

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of 15, indicating intact cognition.

9/28/18 Care Plan entries stated the resident had the potential for skin breakdown and a self-care deficit related to quadriplegia.

A 5/11/22 Care Plan entry stated the resident required assistance with bathing.

An 8/21/23 Grievance/Concern Investigation Form stated the resident reported he did not have a shower in "I don't know how long" due to no appropriate shower chair availability. The form stated the resident had lupus (an inflammatory disease which can cause symptoms such as a rash) for 25 years and it caused him to be very itchy. The form stated a bariatric chair was "on order" and staff provided bed baths on regular shower days.

On 9/12/23 at 9:20 a.m., Resident #7 stated he had not had a shower for over a month due to the shower chair being broken. He stated he received bed baths but it was not the same. He stated he kept asking the staff about it but they said it was on order.

On 9/18/23 at 10:05 a.m., Staff F Certified Medication Assistant(CMA) stated the facility did not have a shower chair to fit certain residents for a few weeks. She stated the facility had to go through "corporate" to get approval because of the price if it is over a certain amount.

On 9/18/23 at 1:07 p.m., the resident stated he still did not receive a shower. He stated the facility obtained a temporary shower chair but it did not work for him. He stated he did not like the fact that he had not had a shower.

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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 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 observation, clinical record review, policy review, resident interview, and staff interview, the facility failed to ensure residents could safely administer medications for 1 of 24 residents (Resident #1). The facility reported a census of 51 residents. Findings Include: 1. The Quarterly Minimum Data Set (MDS) assessment tool, dated 8/24/23, listed diagnoses for Resident #1 which included anxiety, depression, and post traumatic stress disorder. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 15 out of 15, which indicated intact cognition. The facility policy, "Administering Medications", revised April 2019, stated medications were administered in a safe and timely manner and stated a resident may self-administer their own medications only if the physician determined that they had the decision-making capacity to do so safely. The resident's clinical record and Care Plan lacked documentation the resident was able to	F 689	**Plan of Correction:** Education provided to nursing staff regarding the process for residents self-administering medications. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Self administration audit completed for resident #1, nursing staff will continue to administer residents' medications at this time. **Measures or systemic changes made to ensure this will not recur and affect others:** Education to all nursing staff regarding the process of having residents self-administer their own medications. Will discuss in our weekly standard of care meetings any residents who have requested to self-administer and complete evaluations as needed. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Nursing will complete 3 audits weekly for 3 weeks and 2 audits for 3 weeks. Results of the audits will be submitted to the QAPI team for further review. **Anticipated Date of Completion for this plan of correction:** 10/9/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165225	A. BUILDING _____ B. WING _____	09/18/2023

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F 689	Continued From page 13 self-administer her medications. On 9/14/23 at 1:05 p.m., Resident #1 laid in bed. A medication cup containing 3 pills (a blue pill, a yellow pill, and an orange and white pill) sat on the over bed table. The resident stated the nurse gave them to her. No staff were present in the resident's room. Immediately after this observation, Staff D Registered Nurse (RN) stated she gave the resident the medication and the resident was able to self-administer. Staff D stated that the resident did not feel good though so she would go down and retrieve them. Staff D went down the hall and entered the resident's room. On 9/14/23 at 2:27 p.m., the Director of Nursing(DON) stated staff should observe residents consume medications and they had no residents who requested the ability to self-administer medications.	F 689		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, policy review, resident interview, and staff interview, the facility failed to ensure call light	F 919	**Plan of Correction:** Education provided to nursing staff to ensure the call lights are in easy reach of the resident if they were in bed or confined to a chair. **How residents affected & residents with potential of being affected were identified:** Residents who reside to Centerville Specialty Care have the potential to be affected. **Corrective action taken for resident(s) affected:** Resident #3, #27, and #37 have call lights within reach.	

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F 919	Continued From page 14 devices were accessible for 3 of 24 residents observed for call systems (Residents #3, #27, and #37). The facility reported a census of 51 residents. Findings Include: 1. The Quarterly Minimum Data Set(MDS) assessment tool, dated 8/31/23, listed diagnoses for Resident #3 which included heart failure, diabetes, and abnormalities of gait and mobility. The MDS stated the resident required extensive assistance of 1 staff for bed mobility, extensive assistance of 2 staff for transfers, walking, and toilet use, completely depended on 1 staff for dressing and personal hygiene, and completely depended on 2 staff for bathing. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 12 out of 15, which indicated moderately impaired cognition. The facility policy "Answering the Call Light", revised March 2021, directed staff to ensure the call light was in easy reach of the resident if they were in bed or confined to a chair. Care Plan entries, dated 12/24/20, stated the resident was at risk for falls and directed staff to encourage the resident to utilize the call light. During an observation/interview on 9/12/23 at approximately 11:10 a.m., Resident #3 sat in her recliner in her room and yelled "help" several times. The resident stated her TV remote was under her chair and she could not reach it. She stated her call light was over on her bed and she could not reach it. The resident's call light laid on the resident's bed and was not in reach of the resident. The surveyor notified the MDS	F 919	**Measures or systemic changes made to ensure this will not recur and affect others:** Education to nursing staff regarding ensuring call lights are within reach when residents are in bed or confined to a chair. **Planned monitoring of corrective actions to ensure practice is corrected and will not occur:** Nursing will complete 3 audits a week for 3 weeks and 2 audits for 3 weeks. Results of findings will be submitted to the QAPI team for further review. **Anticipated Date of Completion for this plan of correction:** 10/9/23	

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F 919	Continued From page 15 Coordinator that the resident needed assistance and she entered the resident's room. On 9/18/23 at 1:35 p.m., the Director of Nursing (DON) stated call lights should be in reach of the resident. 2. The Annual Minimum Data Set (MDS) dated 5/11/23 coded Resident #27 for severe cognitive impairment, the Brief Interview of Mental Status (BIMS) was blank, not completed. The Activities of Daily Living (ADL) section documented, total dependence of staff for dressing, toilet use and personal hygiene and extensive assist of two persons for transfers. The Care Plan completed on 8/25/23 for Resident #27 did not document call light use. On 09/12/23 at 10:27 AM, Resident #27 sitting in her recliner, call light on the floor near resident's bed, out of resident's reach. 3. The Admission Minimum Data Set (MDS) dated 8/9/23 for Resident #37 revealed diagnoses, included diabetes, renal disease, stroke with hemiplegia or hemiparesis. The BIMS assessment score was 15 which indicated cognition intact. Assistance needed in the Activities of Daily Living (ADL) section documented total dependent for mobility on or off the unit, transfers, dressing, toilet use and personal hygiene.	F 919		

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F 919	Continued From page 16 The Care plan completed 8/11/23 for Resident #37 documented a focus area of fall risk with intervention, to use call light for assistance. On 09/12/23 at 09:08 AM Resident #37 sat in her wheel chair, the bed was behind her and the call light was on the bed near the wall, out of residents reach On 9/12/23 at 9:09 AM Resident reported she did not have her call light, could not see it nor reach it.	F 919		